



Service Priorities and Programmes
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The implementation of focused target approach for reduction of pressure ulcer incidence in Prince of Wales Hospital.

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Introduction

Prevention and management of pressure ulcers is multifaceted. Pressure, friction, shear, mobility & moisture are all major contributing factors to pressure ulcer development. One of the major goals of the PWH Pressure Ulcer Prevention Workgroup is to avoid the development of hospital acquired pressure ulcer. Focused target approach in reduction of pressure ulcer was the implementation of specific strategies / interventions in individual department with identified causes for incidence development.

Objectives

(1). To identify causes of pressure ulcer in individual department of PWH. (2). To avoid pressure ulcer development which may prolong hospital-stays of patient (3). To increase nurses' & supporting staff knowledge in pressure ulcer prevention

Methodology

The PWH Pressure Ulcer Workgroup was organized with collaboration of 11 representatives from 9 departments of the hospital in Feb., 2012. It's mission is to provide leadership, recommendations, guidance, and action toward pressure ulcer prevention and management in the hospital. Regular incidence sharing and review was performed by members. Comparison of data was performed between departments and even ward level. Specific causes for ulcer development was identified in each department. Focused target approach was designed by team members and implemented accordingly in each department since May, 2012. Different focused target approach were designed and implemented in the hospital: Incontinence caused ulcer was found in department like Surg., private, ICU, Onc., O&T, M&T. Target approach - mandatory application of Vaseline ointment / zinc oxide during napkin round was implemented. Besides, 30 degree turning video was provided & emphasized to members for pressure ulcer prevention. Inadequate training of supporting staff in private ward was identified, Intensive pressure ulcer prevention training class with evaluations was developed for the ward staff on 17-5-12. Inadequate devices & training was found in M&T. 3 types of pressure relieving devices

(gel pads, heel protector, double angle wedge) were provided by NTEC Pressure Ulcer Workgroup to the department for patient use. Supporting staff educational package was provided for ward base use. Lastly, there was lack of risk assessment tool found in Paed. dept., new and unique risk assessment tool (Glamorgan Paed. Assessment Scale) was developed for all paediatric case in PWH.

Result

Monthly pressure ulcer incidence in PWH was recorded and individual department performance was monitored. Nurses' knowledge and skill on prevention and management of pressure ulcer was enhanced. Dept. incidence rate A B C D E F G H
 June, 12 5.8 0 0 1.58 1.09 0 1.6 0.46 July, 12 5.3 0 0.89 1.0 0.56 0 1.5 0.84 Aug., 12 3.9 0 1.84 1.9 1.27 0 0 0 Sept., 12 1.9 0 0.88 0.55 0.9 0 0 0 Oct., 12 5.1 1.47 0.61 1.04 1.28 0 0 0 The focused target approach for pressure ulcer prevention can help in reduction of incidence rate in 3 main departments of the hospital. And it is a high-efficiency program to reduce pressure ulcer incidence in a short period of time with limited resources.