PRESSURED over Pressure Ulcers???

Eliminating Hospital Acquired Pressure ulcers in Saudi patients at NGHA Al Ahsa

Tissue Viability Al Ahsa, KSA
KING ABDULAZIZ HOSPITAL
MINISTRY OF NATIONAL GUARD
AL AHSA, EASTERN REGION
KINGDOM OF SAUDI ARABIA

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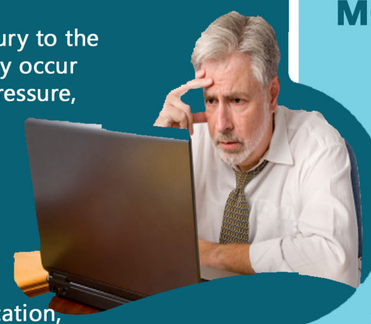
INTRODUCTION

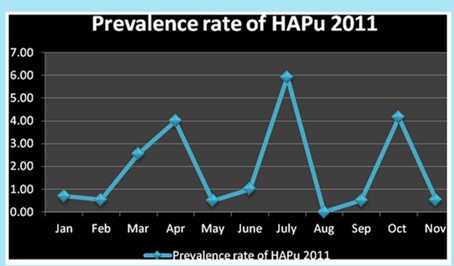


Pressure ulcer is defined as localized injury to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. NPUAP/EPUAP 2009

Although often prevented and treatable if detected early, pressure ulcers can sometimes be very difficult to prevent. And despite of advances in medicine, surgery, nursing care, and self-care education, pressure ulcers remain a huge challenge and additional pressure to healthcare providers.

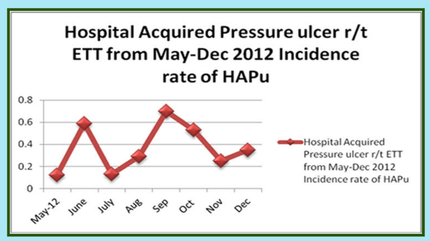
BACKGROUND AND SIGNIFICANCE

As part of Nursing strategy, first prevalence study was conducted on year 2011 ranging from 0%- 5.92%.
This was considered significant leading to the appointment of two Tissue Viability nurses (TVN) who undertook rigid monitoring and proactive action planning in each unit.



Majority of pressure ulcer occurs over bony prominences, however, it was also identified that pressure ulcers related to medical devices were becoming increasingly prevalent, specifically to intubated patients ranging from 0.13% - 0.70% .

TVN realized that hospital-acquired pressure ulcers were often ignored by healthcare providers, patients and relatives and was perceived as an event that cannot be prevented, hence, was not given a priority.



AIM STATEMENT /OBJECTIVES

Nursing Strategic Plan 2011-2016 : reduce the number of hospital acquired pressure ulcers by 20%.

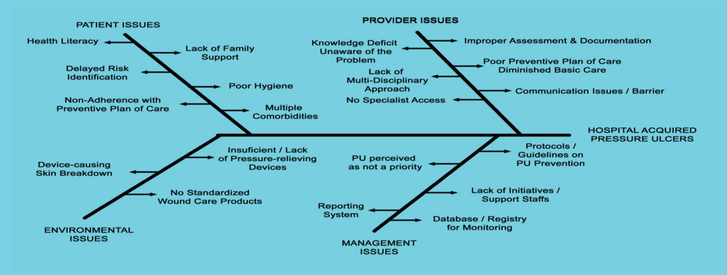
MODEL FOR CHANGE

ADKAR MODEL

- **A** Awareness of the need for change
- **D** Desire to support and participate in the change
- **K** Knowledge of how to change
- **A** Ability to implement required skills and behaviors
- **R** Reinforcement to sustain the change

STRATEGIES FOR CHANGE

☐ Conducted needs assessment (Qualitative analysis)



☐ Multi-disciplinary team approach

TISSUE VIABILITY committee:

Nursing Director, Med-surg, Quality Nursing Director, Plastic Surgeon, Nurse Educator, Wound care nurses, Podiatrist, Product manager Infection control, Nutritionist/Dietician, Pain nurse, Home health care, Primary health care

Allied healthcare team:

Respiratory therapist, physiotherapist, ortho technicians, physicians

LESSON LEARNED

- ✓ Building a desire to patient and healthcare providers in preventing pressure ulcer is essential.
- ✓ Treating patient with dignity and respect makes a big impact. Small changes creates a huge difference and as always, "PREVENTION is better than CURE".
- ✓ Effective improvements start with effective communication. Language may be a potential problem in Saudi Arabia where it involves multi-national healthcare workers vs it's own nationals, but it will never be a barrier for effective care to our patients.

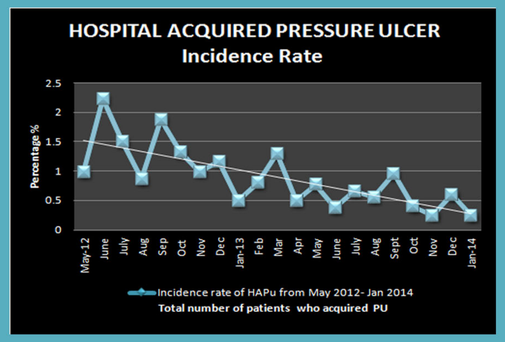
ACTION TAKEN

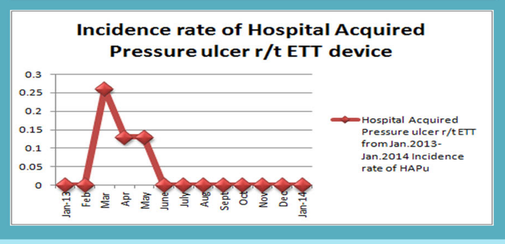
- Developed policy and guidelines for pressure ulcer prevention
- Conducted education through trainings, campaigns, workshops, symposium, including in general orientation program for new nursing staffs.
- Strengthened early risk identification to all admitted patients, ROUNDING and preventive measures with proper documentation
- Established just culture in reporting occurrences, NO BLAME NO SHAME
- Introduced and implemented evidence-based devices, preventions and treatments of pressure ulcers

- Collaborated with all allied health teams and established good teamwork, particularly with respiratory team for eradication of Respiratory device-related pressure ulcers.
- Enhancing patient education, eliminating communication-barrier and involvement of patient and significant others in direct care.
- Created champions in each units and conducted monthly meetings in addressing pressure ulcer as one of quality nursing care indicators
- Achieved full support from management
- Acknowledged the effort of teams and reinforced in sustaining the change and improvements.

RESULTS / SUSTAINABILITY

After implementing selected best practice interventions from evidence based guidelines, data revealed an 85-95% decrease when compared to rate prior to the transition of care program. ETT device related pressure ulcer already achieved zero percentage and maintained for the last eight consecutive months. Results exceeded to what is set and expected.





CONCLUSION

Totally eliminating pressure ulcer is a great challenge and pressure to all caregivers and PU campaign program in NGHA Al ahsa is still in its stage of infancy, but through effective multi-disciplinary approach, ongoing campaign and reinforcement with unswerving administrative support, we will be able to achieve our goal – the big ZERO in HAPu!