

Preventing pressure ulcers in the surgical patient

On 19 March 2013, Wounds UK held a Made Easy event at the Palace Hotel, Manchester, aimed at furthering the knowledge of tissue viability specialists, district nurses, link nurses, nursing home nurses, podiatrists, practice, and staff nurses in eliminating avoidable pressure ulcers. The event was chaired by Kath Vowden (Nurse Consultant, Acute and Chronic Wounds, Bradford Royal Infirmary) and Jacqui Fletcher (Ambition Lead, NHS Midlands and East).

An innovative, proactive intensive one-day event facilitated by Wounds UK was held in Manchester aimed at healthcare workers with a passionate focus on the arena of wound care, particularly the pivotal agenda of avoidable pressure ulcers.

The event focused on the reality of the day-to-day challenges that clinicians face in the achievement of performance indicator targets alongside reduced resources, increased patient complexity and the priority of the professional need to provide high standards of pressure ulcer prevention and treatment regimes to both the patient and carer.

The aims of the event were to provide practical advice, support and guidance through the recognition of problematic themes, the sharing of good practice and communicating realistic solutions, bringing clinicians, educators and industry together within a powerful medium.

Avoiding pressure ulcers is a concern at any stage of the high-risk patient journey. The clinical environment of surgical intervention is no exception, yet the risk of pressure ulcers is often overlooked in the perioperative period (Rogan, 2007). The increased pressure ulcer risk for the surgical patient is often due to a combination of comorbidities alongside necessary immobilisation and anaesthetic agent use (Bliss and Simini, 1999), hypothermia (McNeil, 1998), nutritional deficit (Ek et al, 1991), and unsuitable operative surfaces (Walton-Geer, 2009).

My presentation – *Preventing pressure ulcers in the surgical patient* – brought to the fore areas of practice not traditionally led by wound care clinicians.

The session began with asking how many delegates had theatre training or experience, or were involved in pressure ulcer management. Only a small percentage of the large delegate population raised their hands. This was therefore a timely presentation for the audience, sharing the changes

and resulting good practice that had improved patient outcomes in regards to skin integrity and the reduction in theatre-acquired pressure ulcers and moisture lesions.

The session set the scene on pressure ulcer incidence both in my Trust and nationally, and its costs to the NHS and ultimately to the patient. The delegates were then taken through a short history of theatre practice and inadequate equipment, which highlighted that pressure ulcers developing alongside a surgical intervention were recorded as early as ancient Egypt, and were noted in more modern medicine by renowned surgeons as early as 1848. Up to the 1980s, patient risk was increased by the common practices of inadequate manual handling practices, alongside the use of solid inappropriate surfaces, with infection and mortality reduction being the drivers of the surgical approach.

Despite developments in the 1990s, there were – and still are – some clinical areas presenting traditional risks within the surgical journey. Issues include care being seen as separate provisions between ward teams and the “red line” of theatres; the traditional culture with surgeons and nursing teams having their own agendas; equipment consisting of wooden blocks, rolled up towels, and plastic-covered rubber devices; and each surgeon having their own preferred devices. Overall, the pressure ulcer agenda still appeared to be seen as a ward issue which should not concern the theatre or other similar settings. This is still evident today, with many Trusts carrying out prevalence and incidence audits of pressure ulcers which omit theatres, A&E and radiology departments from the data collection.

The session discussed a new way forward as demonstrated in my Trust. To get a snapshot of where the Trust was as an organisation, we began with an initial audit of pressure ulcer prevalence within theatres in line with the rest of the trust, as part of the Commissioning for

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Quality and Innovation (CQUIN) target work. The audit explored percentage of acquired pressure ulcers, length of immobility, documentation, equipment and device choice, body temperature, reposition occurrence, recovery assessment and implementation changes, if any.

It was highlighted that there were patients who had developed lower category pressure ulcers or moisture lesions either perioperatively or within 12 hours postoperatively on the ward, although the prevalence percentage was low. Root cause analysis highlighted inadequate training, diagnosis, equipment use, and lack of consistency in regards to management of skin integrity.

Following a thorough mapping of the patient journey, changes were introduced that incorporated education for all theatre staff on diagnosis and management of skin integrity, a single, trust-wide theatre pathway to be inclusive of all risk assessments carried out in the three stages of surgery (pre-, peri-, and post-operative), equipment review, the concept of skin to device promoted, and agreed repositioning schedules for patients whose operations require a long table stay. Communicating the vision and expected outcomes were the key to involving all stakeholders to ensure full compliance with the change process in line with the productive theatre concept streamlining processes and ensuring verbal discussions were undertaken in regards to at-risk patients.

The success of implemented changes were shared, particularly around the clinical and routine aspects of the patient journey. This provided the delegates with a guideline to follow that focused on communication, education, documentation, equipment, memory aides, and patient risk assessment and reassessment.


At one year after the changes, the audit was repeated and demonstrated a zero prevalence of acquired pressure ulcers, in addition to accurate documentation and diagnosis and the ultimate seamless care provision from ward to theatre to ward. The importance of theatre teams, wound care specialists, educators, and industry working together in a true team approach to achieve this cannot be stressed enough.

Health care is not a static entity and resting on our laurels is not a way forward. There is still work to be done in this area and acknowledging that we

do get things wrong but are actively working on putting them right for our patients was the message that was shared.

The day concluded with the expert panel facilitating a question and answer session which generated a wide range of passionate discussion between the delegates and the key experts. It is clear from the resulting debate that the challenge of avoidable pressure ulcers and how we drive the solutions forward are going to be on all Trust agendas for a long time to come. The key is focusing on robust communication, sharing of sound patient-focused clinical practice, and ensuring that education is available to everyone in order to ensure that as clinicians we can meet the every changing need of our current and future healthcare services. The driving force must include the strong voices of those clinicians at the forefront of wound care service provision if success in preventing the avoidable is to be achieved.

Pressure ulcer prevention and management is the responsibility of all healthcare workers, no matter what the environment. Locally and nationally we have to grow together and ensure that the appropriate changes we do make accommodate the challenges we face and are truly patient focused.

The sharing of good practice through events such as the *Eliminating avoidable pressure ulcers in the real world: solutions and strategies* event held by Wounds UK has successfully promoted this vision across a wide range of clinicians, educators and industry members. 

“Let me tell you now that to do nothing at all is the most difficult thing in the long run. It is quite remarkable how one good action or change always breeds another.”—Oscar Wilde (1890)

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