Pressure ulcer prevention: how documentation can help

KEY WORDS

- Pressure ulcers
- Care bundles
- SSKIN
- Documentation

The prevalence rates of pressure ulcers (PUs) worldwide continue to be reported at significant rates (Dealey et al, 2012; Moore et al, 2013a). This article looks at the role documentation can play in the strategy to prevent avoidable PUs, in particular the pressure ulcer (PU) prevention care bundle. Areas considered with regard to the PU prevention care bundle are: the design/format; how to implement it in practice; measuring its effectiveness; and the audit cycle. The actual audit — with the subsequent dissemination of learning — of the PU prevention care bundle is a fundamental part of measuring the success of the bundle in preventing PUs.

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The prevalence rates of pressure ulcers (PUs) worldwide continue to be reported at significant rates, with Dealey et al (2012) and Moore et al (2013a) reporting rates from 8.9–25%. These prevalence rates indicate that PUs remain a real issue in healthcare organisations, with the associated negative effect on health and wellbeing (Gorecki et al, 2009), and the associated financial cost of the management of the PU (Posnett et al, 2009; Dealey et al, 2012). Recently in the UK, there have been several government and local health authority initiatives to decrease the prevalence and incidence of PUs (Department of Health [DH], 2010, 2011; Guy et al, 2013; DH, 2012). Despite this welcome high profile, avoidable PUs rates remain high.

In a recent paper, Downie et al (2013a) reported a rate of 43%, of category III and IV PUs acquired in five acute UK Trusts, as being avoidable PUs over one financial year (April 2012–March 2013). It is, therefore, reasonable to assume that these avoidable PUs could be eliminated, if all strategies with regard to PU prevention were to be employed by healthcare professionals. Moore et al (2013b) noted in a literature review of PU risk assessment and prevention in Scandinavia, Iceland and Ireland that "nurses' documentation of PU prevention strategies was erratic, lacking consistency and standardisation in approach". This article discusses the role documentation can play in the strategy to prevent avoidable PUs, in particular the PU prevention care bundle.

PU PREVENTION CARE BUNDLES

Where did the simple care bundle come from? Healthcare bundles were first developed for use in the critical care setting with the initial aim of reducing ventilator-associated pneumonia (Resar et al, 2005). In units where the care bundles were introduced, rates of infection were reduced by up to 44%. This success was closely followed in the area of infection prevention and control, where care bundles have been embraced, particularly in the area of prevention (Pronovost, 2008; Saint et al, 2009), and latterly in the surviving sepsis care bundle (Levy et al, 2010). It would seem logical, therefore, that PU prevention would be greatly enhanced if a PU prevention care bundle is implemented in practice settings for patients at risk of PU development (Kiernan and Downie, 2011).

What should an effective care bundle be made up of? It should contain usually no more than five interventions that need to be implemented on every care occasion. Each element should be based on best practice (Fulbrook and Mooney, 2003; Downie et al, 2013b; McGregor Clarkson, 2013). Anthony et al (2010), in a prospective randomised control trial evaluating an evidence-based bundle for preventing surgical site infection in patients undergoing colorectal surgery, concluded that for a care bundle to be effective all elements included must be first piloted before full implementation, and evaluated subsequently for effectiveness.

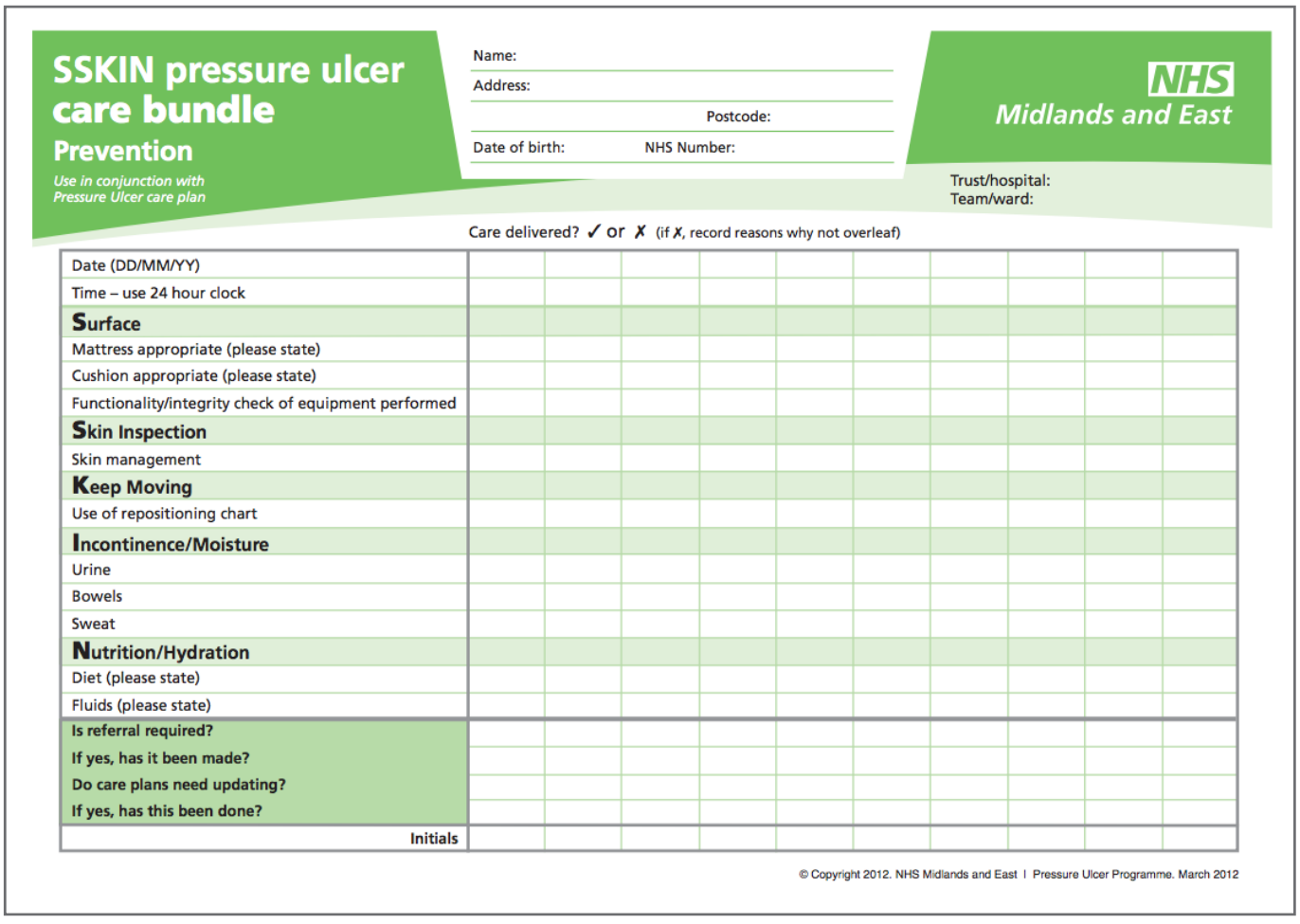
Box 1. The SSKIN care bundle elements
S = Surface
S = Skin inspection
K = Keep moving
I = Incontinence/moisture
N = Nutrition

In PU prevention, any patient identified as being at risk of PU development in any practice setting, including the community, should be placed on a PU prevention care bundle. An example of the key elements of a PU prevention care bundle is the SSKIN bundle (*Box 1*) (NHS Scotland, 2009; NHS Midlands and East, 2012).

HOW TO IMPLEMENT THE SSKIN CARE BUNDLE INTO PRACTICE

The format of the SSKIN care bundle is important and it should be designed in paper and electronic form. It can come in many forms; with the simple checklist approach (*Figure 1*) appearing to be the easiest way to implement into practice (McGregor Clarkson, 2013). However, the problem with the pure checklist format for the care bundle is its over simplicity. A checklist points the clinician to the essential care that must be delivered; however, the problem with the pure checklist approach to a care bundle is that it is necessary to have a PU care plan running alongside it, where the actual details of the care delivered to the patient are recorded. This approach is not only open to error because of individual interpretation and lack of adequate detail in the documentation, but also requires staff to complete two sets of care records.

A solution to this issue is the integration of the PU prevention SSKIN care bundle with any existing PU documentation in place (Downie et al, 2013b). The result is a combined PU prevention SSKIN care bundle/plan (*Figure 2*) as an example of the 'Surface' element of the bundle in the combined care bundle/plan format. If this combined format is employed for use in the practice setting, it is necessary that the checklist approach is retained as a very important



SSKIN pressure ulcer care bundle

Prevention

Use in conjunction with Pressure Ulcer care plan

Name:

Address:

Postcode:

Date of birth: NHS Number:

NHS Midlands and East

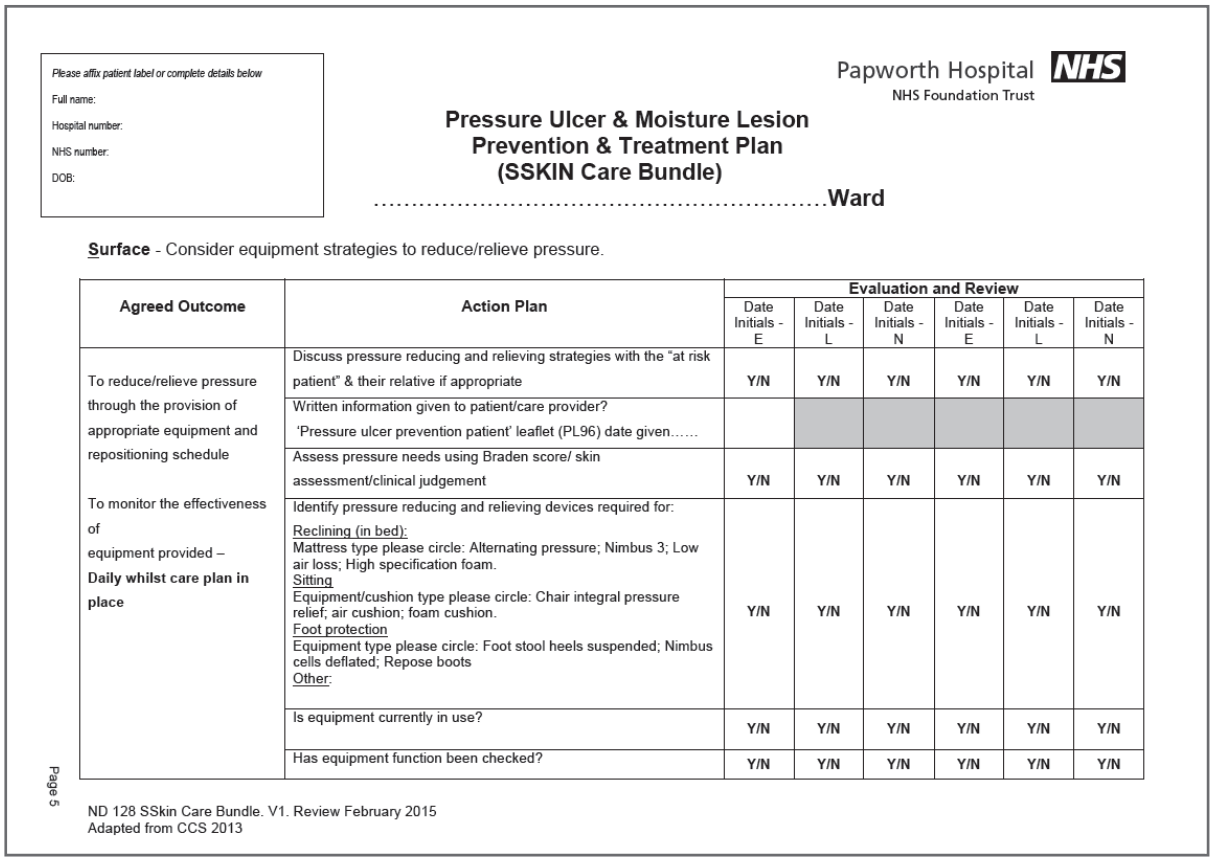
Trust/hospital:

Team/ward:

Care delivered? ✓ or ✗ (if ✗, record reasons why not overleaf)

Date (DD/MM/YY)										
Time – use 24 hour clock										
Surface										
Mattress appropriate (please state)										
Cushion appropriate (please state)										
Functionality/integrity check of equipment performed										
Skin Inspection										
Skin management										
Keep Moving										
Use of repositioning chart										
Incontinence/Moisture										
Urine										
Bowels										
Sweat										
Nutrition/Hydration										
Diet (please state)										
Fluids (please state)										
Is referral required?										
If yes, has it been made?										
Do care plans need updating?										
If yes, has this been done?										
Initials										

Figure 1. NHS Midlands and East SSKIN care bundle adapted from the NHS Scotland SSKIN care bundle (NHS Scotland, 2009; NHS Midlands and East, 2012).



Please affix patient label or complete details below
Full name:
Hospital number:
NHS number:
DOB:

Papworth Hospital NHS
NHS Foundation Trust

Pressure Ulcer & Moisture Lesion Prevention & Treatment Plan (SSKIN Care Bundle)

.....Ward

Surface - Consider equipment strategies to reduce/relieve pressure.

Agreed Outcome	Action Plan	Evaluation and Review					
		Date Initials - E	Date Initials - L	Date Initials - N	Date Initials - E	Date Initials - L	Date Initials - N
To reduce/relieve pressure through the provision of appropriate equipment and repositioning schedule To monitor the effectiveness of equipment provided – **Daily whilst care plan in place**	Discuss pressure reducing and relieving strategies with the "at risk patient" & their relative if appropriate	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
	Written information given to patient/care provider? 'Pressure ulcer prevention patient' leaflet (PL96) date given.....						
	Assess pressure needs using Braden score/ skin assessment/clinical judgement	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
	Identify pressure reducing and relieving devices required for: Reclining (in bed): Mattress type please circle: Alternating pressure; Nimbus 3; Low air loss; High specification foam. Sitting Equipment/cushion type please circle: Chair integral pressure relief; air cushion; foam cushion. Foot protection Equipment type please circle: Foot stool heels suspended; Nimbus cells deflated; Repose boots Other:	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
	Is equipment currently in use?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
	Has equipment function been checked?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

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Adapted from CCS 2013

Figure 2. An example of the Surface element of the SSKIN bundle as a combined PU prevention/treatment care bundle plan.

aide-memoir element to the document. In addition, caution should be taken if extra elements are added to the care bundle, because of the risk of it becoming unwieldy over time (McGregor Clarkson, 2013). The combined PU SSKIN care bundle/plan, if completed correctly, should facilitate the audit cycle.

Once the PU prevention SSKIN care bundle format/design is agreed on and ratified by key staff involved in using it in practice, it is important that simple steps are followed to ensure engagement of staff using the document and that it becomes embedded in practice before the audit cycle is undertaken (*Box 2*). In addition, multidisciplinary use should be encouraged, i.e. if a physiotherapist is walking a patient who is on PU prevention SSKIN care bundle it is they who should sign to say that repositioning has taken place. It should be recognised that the implementation process for introducing a care bundle can take several months from design, pilot and full adoption.

Box 2. How to implement the SSKIN care bundle in practice.
1. Decide on preferred format
2. Involve stakeholders in design
3. Pilot
4. Host teaching/awareness sessions prior to introduction
5. Have multidisciplinary team responsibility for completing the SSKIN care bundle
6. Embed in practice
7. Audit cycle
8. Monitor pressure ulcer prevalence and incidence rates
9. Hold on-going teaching/awareness sessions

MEASURING THE SUCCESS OF PU PREVENTION SSKIN CARE BUNDLE

To measure the effectiveness of the PU prevention SSKIN care bundle, it is essential that the organisation implementing the bundle has the following in place: PU prevalence auditing; PU

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incidence recording; and audit of the use of the bundle, with dissemination of the results to relevant personnel.

The PU prevalence audit, such as the monthly National Safety thermometer audit (DH, 2012) and PU incidence recording/reporting, in particular, will inform organisations of actual PU numbers acquired in their care. This may help to identify that PU numbers are falling in conjunction with the use of a PU prevention SSKIN care bundle. PU incidence reporting triggers an associated investigation into the potential root causes of the PU that have been acquired by the patient. During this investigation, the PU prevention care bundle will be scrutinised, and becomes a useful tool to identify areas of care that may need improving.

In addition, the actual audit of the PU prevention SSKIN care bundle is a fundamental part of measuring the success of the bundle in preventing PUs. The audit of the bundle, once embedded in practice, looks in detail at each element of the SSKIN care bundle with the aim of identifying to the organisation/individual clinical areas where there may be shortcomings that need to be remedied (Kiernan and Downie, 2011). The audit process will also, importantly, identify areas of exemplary practice that should be shared within and outside the organisation. The wider dissemination of the compliance and learning results from the audit process plays a vital role in maintaining team involvement and motivation in the continued use and effectiveness of the care bundle (McGregor Clarkson, 2013).

CONCLUSION

The rise and popularity of care bundles in healthcare today is playing an important role in attaining consistent patient care with the associated reduction/elimination of adverse patient outcomes. To introduce an effective PU prevention care bundle or an integrated PU prevention care bundle care plan, it is essential that the design process involves all the key stakeholders and that a pilot of the document takes place, with any necessary amendments carried out, before full implementation into practice. The ultimate test of the document's success is the fall of PU numbers and the analysis of audit results from the care bundle being used in practice. Audits can only be useful if the results are acted on and disseminated for wider learning. As the PU prevention care bundle becomes more widespread in healthcare, a corresponding wealth of information on its effectiveness will become available. It is of utmost importance that this information is shared and published so that the PU prevention care bundle can be further adapted, if necessary, to ensure its continued effectiveness. WUK

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