The emergency department's response to pressure ulcer crisis

KEY WORDS
- Emergency department
- Pressure ulcer
- Tissue viability

Traditionally, emergency departments (EDs) provide initial lifesaving treatments, but basic patient care is not always a priority. Aims of the authors' ED were to gain 100% completion of the Exeter Pressure Risk Assessment Tool — a tool designed to prevent tissue damage during a patient's stay in ED — and ensure that every patient has the pressure-relieving equipment they require while they are in the ED. Over the past 18 months, there has been a massive change in attitude and culture towards caring for patients' skin within the authors' ED.

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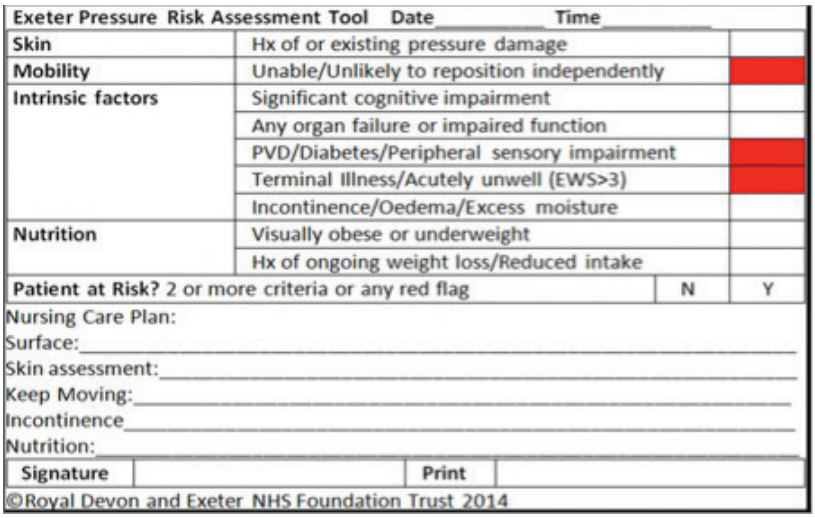
Pressure ulcer prevention has risen higher up the agenda for nursing care, with campaigns like 'Your Skin Matters' being launched by the Royal College of Nursing ([RCN], 2012). This is because pressure ulcers are painful and embarrassing for patients, adversely affecting the way they live their lives (Denby and Rowlands, 2010). Pressure ulcers are time-consuming and costly for the NHS to treat, and often result in increased length of hospital admission (National Institute for Health and Care Excellence [NICE], 2014a). The amount spent in compensation to patients who have obtained pressure ulcers due to the poor care they have received while in hospital could be better spent within hospital trusts, enabling them to provide better care for patients. As a result, acute trusts are being encouraged by organisations to set up different initiatives in order to combat preventable pressure ulcers from occurring (Department of Health, 2011).

Eighteen months ago, the emergency department (ED) commenced the process of improving the care we give to patients with regard to pressure ulcer prevention. NICE (2014b) guidelines stipulate that all patients must be risk-assessed to determine not only if they are at risk, but what the level of risk is. Prior to this project, the ED did not routinely use risk assessment, as the prescribed tool within the hospital was Waterlow (Judy Waterlow, 2007). This was felt to be too time-consuming to complete accurately when lifesaving interventions were the department priority. This led to a delay in the provision of early pressure ulcer prevention as this aspect of nursing care was left to the admitting ward to address. Following the 'Your Skin Matters' campaign (RCN, 2012) the authors realised how short-sighted this was. This opinion had been reflected by Denby and Rowlands (2010), who expressed that pressure ulcers can begin to form after 2 hours if the patient is immobile or being cared for on the wrong type of mattress, therefore making it imperative that pressure ulcer prevention commences in ED. Working alongside the tissue viability team, a less cumbersome tool was developed to identify patients with high risk for obtaining pressure ulcers and implement pressure-relieving equipment as appropriate. This resulted in the creation of the Exeter Pressure Risk Assessment Tool (EPRAT) This initiative was developed because the authors' department was failing to be proactive in the prevention of tissue damage during a patient's stay in ED. It was felt to be too time-consuming and the priority was to provide initial and potentially lifesaving treatments, leaving basic patient-centred care until patients were transferred to the ward.

Although it could be argued that nurses should already be providing high standards of basic nursing care — in particular, pressure ulcer care — it was not deemed important by ED nurses because they felt it was not part of their role. Therefore, through education for every member of nursing staff within the ED, the authors strived to achieve a change in attitude so that patients commenced their journey with the correct pressure-relieving equipment in



Exeter Pressure Risk Assessment Tool Date_____ Time_____		
Skin	Hx of or existing pressure damage	
Mobility	Unable/Unlikely to reposition independently	
Intrinsic factors	Significant cognitive impairment	
	Any organ failure or impaired function	
	PVD/Diabetes/Peripheral sensory impairment	
	Terminal Illness/Acutely unwell (EWS>3)	
	Incontinence/Oedema/Excess moisture	
Nutrition	Visually obese or underweight	
	Hx of ongoing weight loss/Reduced intake	
Patient at Risk? 2 or more criteria or any red flag	N	Y
Nursing Care Plan:		
Surface:_____		
Skin assessment:_____		
Keep Moving:_____		
Incontinence_____		
Nutrition:_____		
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Figure 1: The Exeter Pressure Risk Assessment Tool that was developed by the tissue viability department.

order to prevent future chronic complications with pressure ulcer formation.

The tissue viability team recognised that change is difficult to achieve in isolation and, therefore, initiated a pressure ulcer collaboration to encourage wards and departments to work together to improve pressure ulcer prevention. ED was linked with the orthopaedic ward and, therefore, it was decided that patients with fractured neck of femurs would be transferred onto dynamic air mattresses in ED as opposed to waiting until patients were transferred to the ward. The ED is also trying to improve the care that frail, older people receive during their time in the department, and the pressure ulcer prevention initiative aided in this quest. It was important for change to occur with regard to pressure area care within the ED because the department strives to provide compassionate gold standard care for every patient and, therefore, promote best practice.

AIMS AND METHOD

The aim of the initiative is that every patient who is admitted will have the EPRAT completed, allowing the nurses to identify which patients are at high risk of developing pressure ulcers (*Figure 1*). The EPRAT is easy and quick to complete. If a patient has a tick in either of the red boxes or two or more ticks in any of the other boxes, then they are deemed to be at risk of developing a pressure ulcer. Following the completion of the EPRAT, the correct pressure-redistributing equipment is implemented and documented in the care plan at the bottom of the tool.

On admission, every patient has a body map completed, which is then signed by the ED nurses. On the transfer of the patient from the ED to the ward, the ward nurses will check that the body map is correct and sign it to confirm. Younger patients often refuse to let the nurses check their skin for pressure damage. This group of patients are often low risk and, therefore, they are asked to sign the body map to confirm they have refused to have their skin checked.

Any patient who arrives with a suspected fractured neck of femur will be nursed on a trolley with a mattress topper and then be transferred onto an dynamic air mattress following X-ray and the administration of analgesia. Patients are unable to go onto an airwave mattress from the ambulance trolley because, unlike the mattress toppers, clinicians are unable to X-ray through them. Previously, this patient group would have been nursed on hard ED trollies until they were transferred to the ward and then onto an dynamic air mattress.

On average, all patients with fractured neck of femurs are transferred onto an dynamic air mattress within 90 minutes of their arrival in ED. This is being expanded so that all patients identified as being at high risk of developing pressure ulcers are transferred onto a bed with the correct mattress for the individual on arrival to the department. The triage nurse will identify the correct surface for the patient to be nursed on and the ambulance crews can transfer the patient direct onto this surface. In some cases, this will mean that frail, older patients will not spend any time on a hard ED trolley, improving patient comfort and pressure ulcer prevention.

In order to achieve these aims, individual teaching sessions were provided for every member of staff. This is because everyone learns at different speeds and it was important to ensure that all members of staff were able to use the EPRAT effectively. The teaching session involved a PowerPoint teaching session on how to grade pressure ulcers, followed by looking at pictures of pressure ulcers on a computer and asking the staff member to grade them correctly. Then we showed them how to use the EPRAT and gave them some scenarios to try, so they could show that they understood how to use it. Every staff member was made aware of all the different pressure-relieving equipment that is used and how to obtain it.

"Since the commencement of the collaboration — intended to transfer all patients with fractured neck of femurs onto airwave mattresses within 90 minutes of arrival — substantial improvements have been made in patient care with regard to prevention of pressure ulcer damage."

EPRAT documentation was promoted daily on the Comm Cell board, highlighting the importance of pressure area care, comfort rounding and repositioning of patients. Comm Cell is a board in the ED and every other morning the nurse in charge of the shift will explain to every member of staff on the shift all the notices that are on the board. Weekly audit results were reported, acknowledging the improvement made and areas that still needed to be improved. This also allowed staff to provide feedback and suggestions as to how we could improve the care given to patients to increase the success of the initiative. It allowed staff not only to identify difficulties that they had encountered, but also offer solutions. Patient Transfer Passports were created, which had to be signed off prior to transfer to the ward, ensuring that all documentation was completed correctly. The team driving this change included all levels of nursing bands, so that everyone felt involved. It was not just imposed on staff from management downwards.

The initiative was audited weekly for the first 12 weeks and then once a month for the next 2 months to ensure that the changes were being embedded into practice. Since then, random audits have occurred each month to ensure practice is maintained at a high standard.

RESULTS

Compliance with all patients who have a fractured neck of femur being transferred onto dynamic air mattresses within 90 minutes currently stands at 98%. Additionally, 100% compliance within 6 months was achieved in regard to the completion of body maps. ED currently have a 99% compliance of the correct completion of the EPRAT. This not only includes it being completed correctly but that it has been documented what pressure-relieving equipment has been implemented. We have struggled to gain higher than 68% with the countersigning of body maps upon transfer to the ward. This is because, although some of the wards were very good at checking the patient's pressure areas and then countersigning the body map, some of the ward nurses did not feel that it was important and they did not have enough time to do this. We are currently trying to combat this by speaking to the Matrons of the wards that we regularly transfer patients to and asking them to cascade down through their teams the importance of this initiative. We have also encouraged our nursing staff to challenge the nurses that are non-compliant and if they do not feel comfortable with this then to feed back to the ED nurse in charge of the shift.

DISCUSSION

Since the commencement of the pressure ulcer collaboration, which intended to transfer all patients with fractured neck of femurs onto dynamic air mattresses within 90 minutes of arrival, substantial improvements have been made in the care that patients receive with regard to prevention of pressure ulcer damage; for example, heel boots are now applied in the department and the EPRAT is always completed. There are always mattress toppers available to be used for frail, older people that have been lying on the floor for long periods, which are also used for every patient with a suspected fractured neck of femur, as X-rays are not possible through dynamic air mattresses.

There is a departmental supply of dynamic air mattresses so that, from the beginning of the patient's journey, they can be nursed on a bed with the most appropriate mattress for their needs. Beds, as opposed to trollies, are available in four out of our five bays in majors so that patients can be transferred directly onto a bed by ambulance crews if they do not require X-rays of their legs or abdomen. This not only provides improved patient comfort, but saves nursing time in transferring them onto a bed later during their time in ED. The department has its own stock of heel boots, which are used to protect their heels. This prevents individuals having to wait until they reach the wards before their nursing care can commence.

During the period when this change in practice was occurring, the ED was using high levels of bank and agency staff, resulting in the EPRAT not always being completed and the body maps rarely being countersigned. Throughout the department, agency nurses, or at least one of the ED staff on their behalf, were encouraged to complete the EPRAT, but this was not always possible. However, the department is gradually recruiting to fill the nursing vacancies, which

will hopefully improve compliance with both objectives. This is because all of the new nurses are set to be taught how to complete the EPRAT correctly, effectively grade pressure ulcers and also how to provide the requisite standard of care with regards to patients' skin.

However, in the interim regular bank and agency nurses have also been trained in the importance of pressure area care to ensure that patient care is not affected by the lack of our own staff. An introduction booklet is also being created for bank and agency staff with templates of correct documentation so they are aware of the standards that are expected of them.

During the period of change, the ED saw a massive increase in the numbers of patients that staff were caring for, creating a strain on resources. In order to combat this, some of the patients from ED were transferred by the relevant specialist nurses. For example, the stroke nurse practitioners always come and review all patients referred to them in the department and then often transfer them to the ward. Therefore, as none of the ED nurses transfer patients to the ward, ED nurses would check the pressure areas and get the specialist nurses to countersign the body maps prior to transfer. This aided in the improvement of compliance of countersigning the body maps.

The initiative has improved the patient experience by providing increased comfort for the patient, preventing pressure ulcer formation and providing education for the patient to reposition regularly to prevent skin damage, which is a condition that can be debilitating, extremely painful, embarrassing and distressing for them. Patients with skin damage require skilled nursing care, including specialist management of their wound, dressings, additional nursing time and frequently an increased length of stay. There are also the financial costs, which constitute the nursing care delivered, cost of dressings/wound care, pressure-relieving aids and financial compensation for patients who obtain pressure ulcers due to poor care they have received while in hospital. Ensuring that patients are transferred onto a bed with the correct mattress not only reduces the risk of them obtaining pressure ulcers, but also promotes patient comfort.

Meanwhile, the initiative has also improved nursing practice because nurses now regard assessment of patients' skin and pressure ulcer prevention as one of the main priorities during the initial nursing assessment. This has also led to the development of other initiatives regarding frail, older patients and ensuring that all of their care needs are met in the department so they get off to a good start to their hospital journey. The department strives to achieve compassionate gold standard care for every patient and we feel this initiative has achieved this with regard to pressure area care.

CONCLUSION

Since the commencement of the pressure ulcer initiative, 100% of ED staff have completed their PUCLAS training. This has required a massive change in the culture and attitude of staff with regard to their role on the frontline of preventing pressure ulcer development. The team is always trying to improve the care provided to patients and take the prevention of pressure ulcers extremely seriously. This has required all members of staff — nurses, doctors and support workers — to work together with the shared objective to ensure patients remain free from harm. The effectiveness has been demonstrated in the results achieved and no patients have obtained pressure ulcers due to the care received in ED in the past year, up until the time of writing. The department is proud to have achieved a change in culture and attitude towards the way pressure ulcers are viewed.

In future, the department will continue to work towards a higher compliance rate for the countersigning of body maps. There is also an aim to ensure that every patient who is to be admitted to a ward is on a bed, with the correct mattress, within 90 minutes of arrival in the department. This has been achieved with the patients who have a fractured neck of femur and, therefore, should be achievable for all patients. WUK

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