Manitoba
Health, Healthy Living and Seniors

Manitoba Health, Healthy Living & Seniors (MHHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Summary:

An aggregate review was completed on six patients that developed Stage 3/4 pressure ulcers after admission to a health care facility. This review involves three acute care sites and two long term care sites.

Keywords:

Pressure ulcer

Device Name *(if applicable)*: **n/a**

Drug/Name/Fluid Name: (*if applicable*): **n/a**

Type of Analysis: multiple events

Topic: Pressure Ulcer

Findings of the Review:

The absence of an indicator for predicting pressure sore risk, such as the Braden Scale, increased the likelihood that the health care team would not have a meaningful measure of risk that would guide care plan development.

The absence of a Safe Client Handling and Injury Prevention Program (SCHIPP) increased the likelihood that best practices would not be implemented with regards to turning and repositioning clients and this may have increased the likelihood that there would be skin breakdown.

The lack of readily accessible pressure reduction and redistribution equipment increased the likelihood that the most appropriate equipment may not be implemented in a timely manner.

The absence of a plan of care that integrates the Braden Scale for predicting pressure sore risk and the Bates - Jensen Wound Assessment Tool (measure of the severity of the ulcer) increased the likelihood that the pressure ulcer would progress to Stage 3/4.

The uncertainty about what interventions are appropriate, what resources are available and what wound care products were indicated complicated the decision making for health care providers and increased the likelihood that prevention and treatment strategies would not be fully implemented.

Recommendations for Improvement:

Continue to educate all the interdisciplinary staff on the use and implementation of the Braden Scale for predicting pressure sore risk and the Bates-Jensen Wound Assessment Tool in combination with the Care Plan.

Provide education to health care providers on pressure reduction and redistribution practices.

Update with current best practices and continue to roll out a pressure ulcer prevention/wound treatment clinical care algorithm.

Continue to roll out the Safe Client Handling and Injury Prevention Program throughout the Region.

Date Posted: **September 16, 2014**