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

Development of a Pressure Ulcer in a Hospitalized Patient

Summary:

A patient was admitted to hospital with pneumonia. At the time of admission, there was no documentation of a baseline skin integrity assessment. Four days later, a pressure ulcer was found on their buttocks. Despite the application of a foam dressing to the area, skin breakdown worsened.

The patient was discharged from hospital with an order for Zinc Oxide to the ulcer.

Nine days later, the patient was re-admitted to hospital with a Stage 4 pressure ulcer to the coccyx and sepsis likely related to the pressure ulcer.

Keywords: Pressure ulcer development

Device Name *(if applicable)*:

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

Type of Analysis: single event

Topic: Pressure Ulcer

Findings of the Review:

1. There was no assessment of the patient's skin at the time of admission. .
2. There was a no standardized documentation tool pressure ulcer risk assessment.
3. There was no policy/guidelines that addressed the need for pressure ulcer prevention or skin and wound care.
4. The documentation of the patient's care was incomplete, lacking sufficient detail.
5. There was a delay in obtaining a pressure reducing sleep surface for the patient.
6. When a transfer of care occurred between physicians, there was no evidence of a verbal report with respect to the patient plan of care.

Members of the interdisciplinary team were not consulted when the pressure ulcer was first discovered. As a result, there was a delay in securing a pressure relieving sleep surface for the patient.

System Learning:

1. A pressure ulcer prevention strategy and a wound care treatment policy with clinical care guidelines must be readily available for staff.
2. Skin integrity must be documented whenever handoffs occur between attending physicians.
3. There must be a greater understanding of the roles that members of the interdisciplinary team can play in the prevention/treatment of pressure ulcers.
4. Opportunities for all members of the health care team to further develop their knowledge with respect to the prevention of pressure ulcers need to be provided regularly. .
5. Communication, both verbally and in writing, must occur between health care professionals to promote continuity of care, even if the patient receives their care in a different setting.
6. Every patient must have a baseline assessment of their skin integrity, on both anterior and posterior surfaces, documented on admission. .
7. Wound assessment and treatment plan flow sheets must be used for patients that require frequent skin/wound assessments and treatment.
8. Digital photographs of wounds should be taken at regular intervals to document the history of the wound and demonstrate changes over time.

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