Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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From: Other

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Subject: Pressure ulcer - top 10 root causes/lessons learnt

Q1 When a patient develops a pressure ulcer category 2 -4 within your organisation, what are the top 10 root causes/lessons learnt you identify from the investigation?

A1 **Lessons learnt from pressure ulcer incidents (August 2018 – August 2019)**

- **Importance of close skin inspection** – heels and sacrum are highest risk sites – to monitor for early warning signs. Use prophylactic foam dressing (Allevyn Life advised – 5 layers) as part of prevention plan for high risk/bony prominences

- Importance to apply light finger pressure, ask if patient is in any pain/discomfort at specific sites – can be early sign, prompt action to relieve pressure at that site

- Take actions to prevent moisture damage – increases risk of pressure ulcer development

- Manual handling is important in preventing skin damage:
  - when sitting a patient up in bed, using knee breaks prior to back elevation, to prevent 'draaaaag' effect
  - when transferring the patient from bed to chair, roll the patient onto their side and then laterally transfer from side lying to sitting position, to reduce shear and friction effects on the sacrum

- **Heels are high risk**: if patient is high risk/spending long periods in bed, always position something under heels to offload pressure. If patient will not tolerate Repose/pillow or if agitated, use slide sheet under lower legs/heels to reduce shear and friction.

- Pressure ulcer prevention care plan and skin inspection record should be completed **early and late shift on wards** and also on nights on critical care

- **A change in position = a change in position**. In the repositioning record, *choose bed or chair;* then what position if in bed.

- Close skin inspection and appropriate pressure reducing aid (dermal strip) are essential when **medical devices** are in use