

Clinical experience series

Independent quality improvement poster

Reducing incidences of pressure ulcers in ICU

About this publication

This publication presents an independently developed quality improvement poster from the Intensive Care Unit at Beaumont Hospital in Dublin, Ireland.

The poster describes a quality improvement project initiated in response to an increase in pressure ulcers among patients receiving intensive care. The project focused on improving staff knowledge, strengthening the local pressure ulcer reporting pathway and implementing a range of pressure injury prevention strategies.

The Maxxcare Heel Pro Evolution was introduced for ICU patients as one component of this broader, multifactorial prevention programme. Other interventions included staff education, the introduction of pressure-redistributing mattresses, improved skin inspection, correct use of anti-embolism stockings, patient repositioning and updated prevention resources.

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Publication details

Publication

Reducing Incidences of Pressure Ulcers in ICU

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Not stated; the poster includes reported data from 2022 to 2024

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Intensive Care Unit, Beaumont Hospital, Dublin, Ireland

Project type

Independent quality improvement project and clinical practice poster

Reporting period

2022-2024

Disclaimer

The statements, experiences, outcomes and clinical observations presented in this publication originate from external healthcare professionals and reflect their own observations, data collection and conclusions.

This publication is shared by Maxxcare B.V. with permission from the original rights holder. The reported outcomes arose from a multifactorial quality improvement programme involving staff education, pressure ulcer reporting, pressure-redistributing mattresses, heel protection, skin inspection, repositioning, hygiene practices and other preventive interventions.

The Maxxcare Heel Pro Evolution was one component of the overall programme. The poster does not present a controlled or product-specific clinical evaluation, and the reported reductions in pressure ulcers and suspected deep tissue injuries cannot be attributed solely to the Maxxcare Heel Pro Evolution or to any other individual intervention.

The reported findings and percentages have not been independently reproduced or verified by Maxxcare B.V. and do not constitute clinical or comparative claims made by Maxxcare B.V. Results may vary depending on patient population, clinical protocols, staff education, reporting practices, care setting and product selection and application.

This publication is not intended to replace clinical judgement or constitute a guarantee of specific clinical, organisational or economic outcomes.

Source

Mangan SK (TVN), Brady G, Smith O, Mc Donald N, Whooley S and O'Hara S. *Reducing Incidences of Pressure Ulcers in ICU*. Quality improvement poster. Intensive Care Unit, Beaumont Hospital, Dublin, Ireland. Undated; includes reported outcomes through 2024.



Reducing Incidences of Pressure Ulcers in ICU

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INTRODUCTION

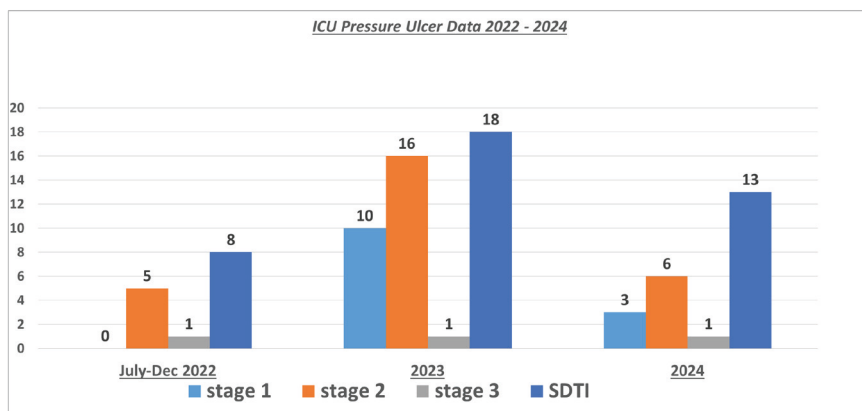
In September 2022 it was observed that there had been an increase in the number of patients in the Intensive Care Unit (ICU) developing pressure ulcers. The increase of these pressure ulcers triggered a Quality Improvement Project (QIP) to reduce harm to patients being cared for in the ICU. The aim of the QIP was to reduce the prevalence of pressure ulcers occurring to patients in the General ICU and to educate and familiarise staff with the Pressure Ulcer Reporting Pathway. The QIP focused on enhancing nurses' knowledge and the implementation of pressure ulcer prevention strategies.

AIMS

The aim of this QIP is to reduce the incidences of pressure ulcers in the ICU by promoting pressure ulcer reporting pathway and pressure ulcer prevention strategies. The Aim is also to maintain the reduction of harm by continuous review and reflection of practice.

METHODOLOGY

In collaboration with the Tissue Viability Nurse (TVN) a Pressure ulcer Prevention Team (PIPT) was formulated in ICU. The PIPT focus was to educate all nursing and health care staff on the promotion of the following practices: Peer to peer education – focusing on disseminating the standardised local reporting guide for critical care. The introduction of the Quattro Acute Air mattresses for every patient in ICU. The application of Maxxcare Heel Pro Evolution heel protectors for all patients. Education on correct sizing and application of TED stockings. The introduction of aloe vera wash sponges for patient hygiene and maintenance of skin integrity. The promotion of 'Saying NO to the INCO' and the 'Peel and Peek' initiative for staff to assess patients' skin. Encouraging the increased repositioning of patients by involving Health Care Assistants as promoters of turning patients. Updating the Pressure Ulcer Prevention Board and Information Folder to ensure dissemination of the most up-to-date information.



RESULTS & DISCUSSION

Feedback from PIPT meetings and critical care nurses indicated improved reporting and knowledge of the reporting pathway for pressure ulcers. Decreased incidences of unit acquired pressure ulcers to heels. The implementation of Quattro Acute Air mattresses & Maxx care heel protection boots for all patients indicated an overall reduction of pressure ulcers and suspected deep tissue injuries by 55% in the first quarter of 2023 since the implementation of the QIP in July 2022. In 2023 there was an overall higher incidences of pressure ulcers as data from 2022 only captured the last 6 months of the calendar year. On comparison of 2024 PU data to 2023 PU data, there was a 70% reduction in stage 1 pressure ulcers, 62.5% reduction of stage 2 pressure ulcers, we had the same amount of stage 3 pressure ulcers as 2023 (1) no stage 4 pressure ulcers and a reduction of 27.7% of SDTI.

CONCLUSION & RECOMMENDATIONS

It is evident from feedback and recent incident reports that there had been a reduction in the prevalence of pressure ulcers in the ICU. From implementation of the QIP we were also able to maintain a safer environment for all patients in the ICU. Recent evidence has led to the identification of cervical collars as a potential cause of skin breakdown and which is an area for future review by the PIPT. The PIPT continue monthly meetings and peer to peer education on skin assessment and unit reporting pathway. Our TVN nurse and the QPS directorate continue to collect and compare data for continuous improvement

