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Introduction:

Pressure ulcers have been described as one of the most costly and physically debilitating complications since the 20th century. Pressure ulcers are a serious health issue for patients in all kinds of health care settings and even at home thus reduction of pressure ulcer prevalence in long-term care. Pressure ulcers are the common conditions among patients hospitalized in acute and chronic care facilities and impose significant burden on patients, their relatives and caregivers.

Hemodynamic instability, immobility, and limited nutrition increase the risk for pressure ulcer development among critically ill patients. The prevention of pressure ulcers can be a clinical challenge. The pain and discomfort due to pressure ulcer prolongs illness, rehabilitation, time of discharge and even contribute to disability and death.

Purpose:

The purpose of the quality improvement project was to reduce the occurrence of pressure ulcer in Narayana Superspeciality Hospital, Guwahati as there was increased incidence of pressure ulcer in prolonged stayed patient. The aim was to assess knowledge, practice and factors associated with pressure ulcer prevention among nurses in Narayana Superspeciality Hospital, Guwahati.

Objective of the Project:

To systematically review the incidents & find the interventions to prevent pressure ulcers.

Benchmark for Comparison:

Benchmark as a rate of three (3) was adopted from Indian society of critical care medicine.

Methodology:

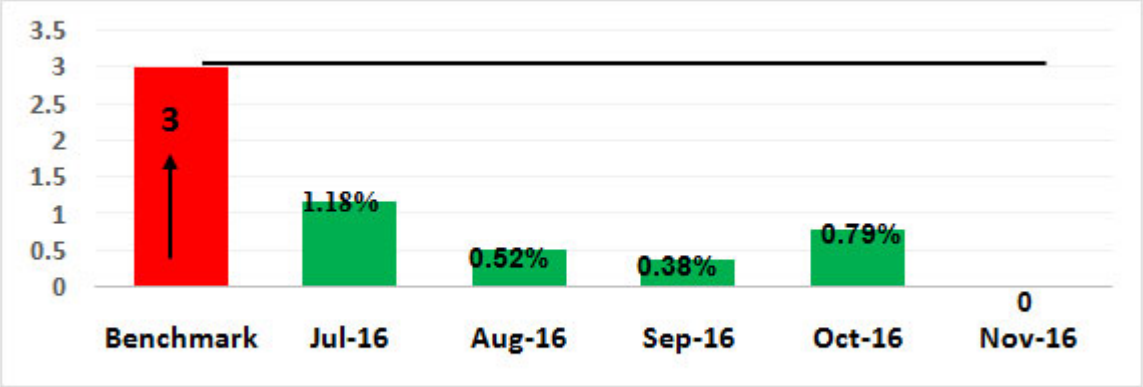
Study Setting: NH Narayana Superspeciality Hospital, Guwahati.

Period: 5 months (July to November 2016) & all in-patients were included during that period.

Data Collection Tool: Daily Surveillance form of pressure ulcer.

Data Analysis:

Parameters	July, 16	Aug, 16	Sept, 16	Oct, 16	Nov, 16
No of patient who develop new/ worsening of pressure ulcer	1	3	2	4	0
No of discharges / deaths	544	575	519	505	495
Rate	**0.18%**	**0.52%**	**0.38%**	**0.79%**	**0**
Total Admission	529	579	508	528	481



Problem Associated with Development of Pressure Ulcer:

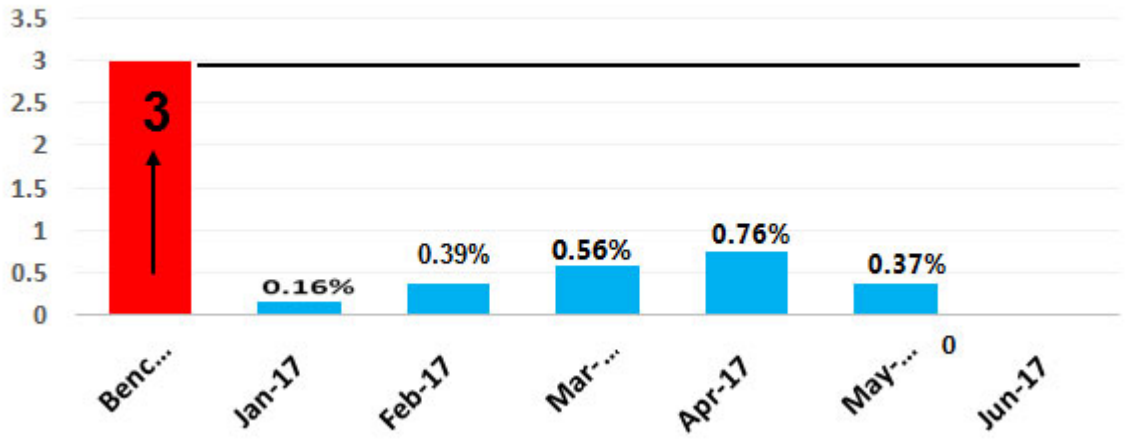
- Nurses were not following position changing protocol.
- Air mattresses for vulnerable patients for pressure ulcers were not applied, applied only after developing ulcers.
- Un-availability of adequate numbers of air mattresses.
- Meticulous care of patients where frequent skin care is advisable but not followed.

Intervention:

- Periodic training conducted for nurses in the hospital including expert from outside.
- Numbers (30%) of air mattress was increased for use.
- All in-patients are assessed for skin integrity in each shift by using Braden scale.

- Nurses are empowered (administrator approval) to decide for application of air mattresses.

Pressure Ulcer Status after intervention:



Recommendations for continuity of Quality of Care:

- Refresher & continuous training to all nurses on management of pressure ulcer.
- Appropriate assessment of vulnerable patients for pressure ulcers.
- Optimize nutritional status.
- Instant reporting of pressure ulcer at the first degree.

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