# Patient Safety Learning Advisory

## Patient Safety Event:

Pressure Injury Deterioration While in Care

### Why was this a Critical Incident? What Happened?

A patient's pressure injury was first noted as a dime sized open area and while in care further deteriorated into a stage 3 pressure injury.

As the patient's health deteriorated, a facility wheelchair with a pressure-offloading cushion and tilt feature was used to change positions more frequently.

Assessment of pressure offloading cushion revealed cushion was "bottoming out" when in reclined position thereby increasing pressure.

### What is the Health Care System learning?

Referrals to interdisciplinary team members occurred following deterioration of pressure injury to stage 3.

Not all staff were aware of the pressure injury prevention and management tools and resources or where to find them.

Communication related to the pressure injury assessment was not consistent.

### What are the recommendations?

Improve communication and referral process with appropriate interdisciplinary team members.

Complete an audit of current staff who have completed the pressure injury prevention education.

Facilitate staff completion of the pressure injury prevention education.

Facilitate review of wound care tools and resources to promote utilization, standardized documentation and facilitate consistent care and communication.

Develop and implement a standardized process for information transfer at shift handover.

**Keywords:** pressure injury, wound, stage 3, pressure-relieving device, wheelchair, communication, shift handover

**Glossary:**

**Deteriorate -** to become progressively worse

**Stage 3 pressure injury** (“bedsore”) - Wounds are described by depth, and staged from 1-4. The higher the number, the deeper the wound.

**Shift handover -** process to ensure standard, reliable transfer of key information, tasks and goals of care between shift changes in healthcare providers

**Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It’s important that we can learn from safety events and make changes to improve the care we provide.**