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Too Unstable to Turn (TUtT)

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With Thanks to Kimberley Gardiner and Catherine Taylor – Advanced Critical Care Practitioners

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Datix Reports 2021/22

56 stage 3+ pressure damage /SDTIs

Of those 56, 31 had a deviation from protocol

Of those 31, 3 had supporting documentation for the decision to deviate THEREFORE 28 patients had a deviation from protocol without supporting documentation

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Pressure Ulcer Triage Reports 2021/22

38 PUTR written

21 had learning around robust documentation

- Too Unstable to Turn
- No airway trained doctor for head turn
- Not enough staff available for turns

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Too Unstable to Turn

- Who decides a patient is too unstable to turn?
  - Consultant
  - Registrar
  - Bedside Nurse
  - Medic who reviews patient
- How is the decision made?
- Where should it be documented?

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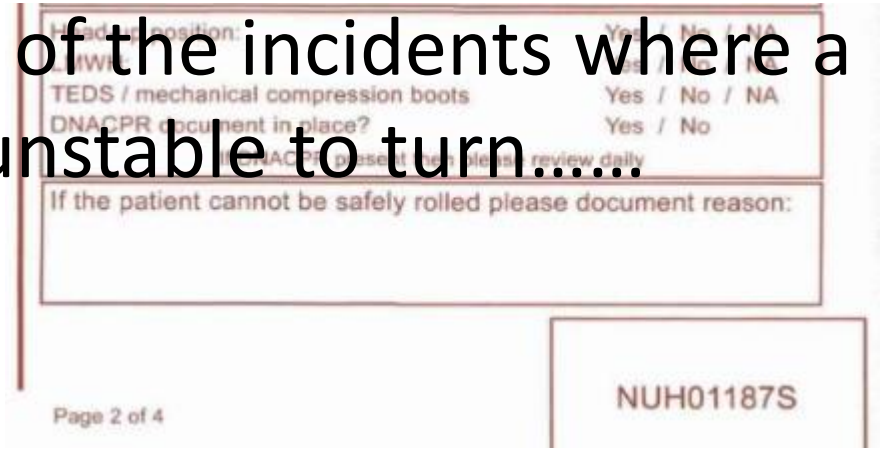
The Box….

There is a box on the daily review sheet – too unstable to turn….

This was not used in any of the incidents where a patient was deemed to unstable to turn……



Simple…….

Get people to use the box and then we have the supporting documentation for TUtT patients

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Not so simple….

- The box isn't used – is this the best place to document the decision?
- Why is a patient deemed TUtT?
- Who makes this decision?
- When is this decision reviewed?

Many Meetings……

Lots of amazing discussions……

Lots more questions…..

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Our Proposal

COME DR to Turn

- **C**ommunicate concerns with senior team
- **O**ptimise Patient
- **M**anoeuvre
- **E**valuate
- **D**ocument
- **R**eview

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What we did….

How to approach "too unstable to turn" patients in Critical Care

Bedside nurse concerned patient is **"too unstable to turn"**

↓

Escalate to a pod / team leader (PL/TL) or the nurse in charge (NIC).

↓

They work with the bedside nurse to consider a trial of turning with **nursing optimisation** i.e. pre-oxygenate, try different side for turn, go slowly, use more staff, enlist help from junior doctors etc.

↓

Patient fails turn (staff concerned for patient safety) despite senior nurse optimisation. Escalate to **Senior Medical Trainee or Consultant.**

↓

Consider trial of turning with **Medical optimisation**. i.e. as above, +/- fluid, deepening sedation, paralysis etc.

↓

Patient fails turn (or senior Clinician decides too high risk of deterioration with turn) (Staff concerned that turn risk outweighs benefit) Patient has now failed 2 turns despite optimisation.

↓

Senior Clinician documents **"too unstable to turn"** decision in medical notes.

↓

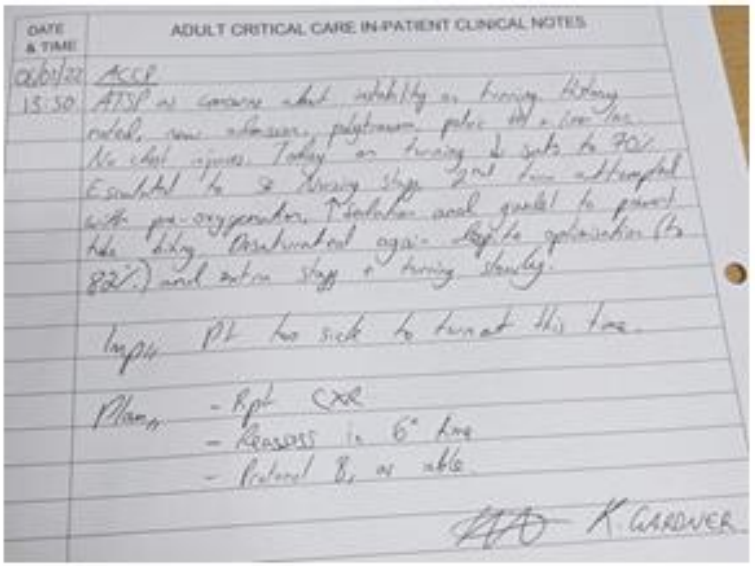
Adopt **Protocol B.** Increase frequency of heel checks/move devices/skin check. Consider turning head side to side and passive limb movements.

↓

Turns should be reconsidered again after **6 hours**, using above approach. If "too sick to turn" sustained ensure documented clearly and reviewed every **12hours.**

Strategies for increasing turn success:

- **Go slow!** Turn in 10 degree increments; pause to gauge patient response, then another small movement until tilt achieved. If patient unable to tolerate full turn and skin check, put pillows in to tilt at least.
- **Get help!** Escalate early to pod/team leader or nurse in charge and medical staff. Use more staff to turn which will help make turn gentler and help to ensure line/tubing safety. Decisions around turning should be made collaboratively between pod/team leaders or nurse in charge and senior medical teams.
- **Individualise care.** Consider if the patient is better positioned on one side over another. Consider their injuries, disease, sedation and analgesia requirement.
- **Optimise** patients before the turn and monitor them closely afterwards. This will vary from patient to patient but may include pre-oxygenating patients that desaturate, or giving fluid/vasopressors to patients with haemodynamic instability etc.



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What we did….

Subject	Additional Information	Day	Handed Over By Name/signature (NiC)	Handed Over By Name/signature (NiC)
Too Unstable to Turn	• Over the past year we have had 20 stage 3 pressure ulcers – of those 20, 15 had turns stopped for a time and of those 15 only 2 had supporting documentation	Monday		
		Tuesday		
So……	• We are introducing a optimisation flow chart and using the process COME DR to turn • **C**ommunicate, **O**ptimise, **M**anoeuvre, **E**valuate, **D**ocument, **R**eview	Wednesday		
		Thursday		
Flow Chart	• Please grab a flow chart if you feel your patient is too unstable to turn – they will be placed at all nursing stations	Friday		
		Saturday		
		Sunday		

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Patients Captured….

- Pt 1 – very unstable admission – possible overdose – problematic ventilation – managed to turn following optimisation
- Pt 2 – Emergency admission following STEMI + bleed – Reduced frequency in turning supported by medical documentation due to cardiac instability – reviewed, pt. optimised and turned.

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- Pt 3 – Burn Victim – highly unstable – turn frequency reduced – patient tilted following optimisation – reviewed on regular basis
- Pt 4 – Post-op decompressive craniectomy – Review of stability documented in notes and TUtT decision – reviewed 6hrs later and patient tilted.

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- Pt 5 – Intracranial Haemorrhage – Craniectomy – TUtT for ICP stability – documented 6hrly for 36hrs – some tilts supported following optimisation.

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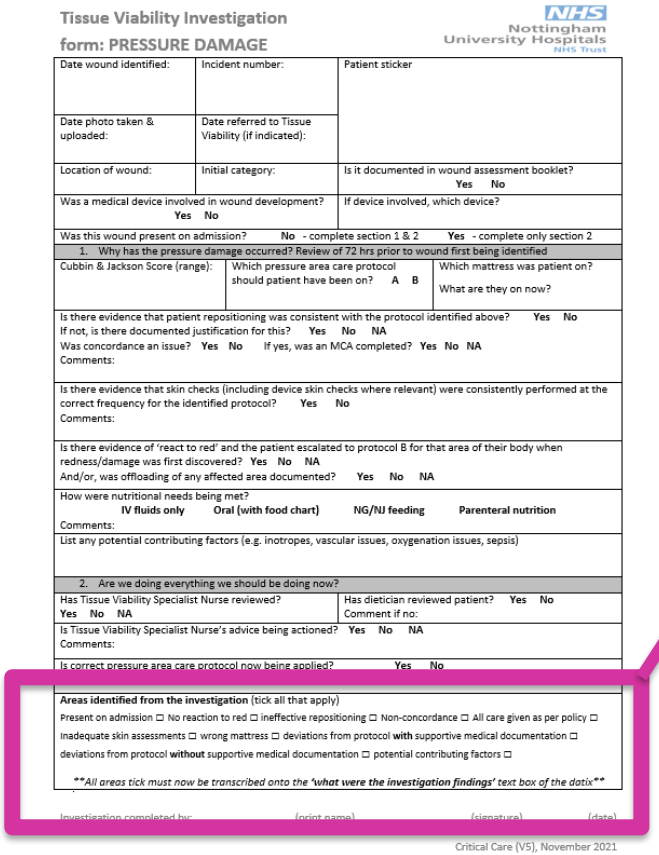
TV Investigation Form



Tissue Viability Investigation form: PRESSURE DAMAGE

NHS Nottingham University Hospitals NHS Trust

Date wound identified:	Incident number:	Patient sticker
Date photo taken & uploaded:	Date referred to Tissue Viability (if indicated):	
Location of wound:	Initial category:	Is it documented in wound assessment booklet? Yes No
Was a medical device involved in wound development? Yes No		If device involved, which device?
Was this wound present on admission? No - complete section 1 & 2 Yes - complete only section 2		

1. Why has the pressure damage occurred? Review of 72 hrs prior to wound first being identified

Cubbin & Jackson Score (range):	Which pressure area care protocol should patient have been on? A B	Which mattress was patient on? What are they on now?

Is there evidence that patient repositioning was consistent with the protocol identified above? Yes No
If not, is there documented justification for this? Yes No NA
Was concordance an issue? Yes No If yes, was an MCA completed? Yes No NA
Comments:

Is there evidence that skin checks (including device skin checks where relevant) were consistently performed at the correct frequency for the identified protocol? Yes No
Comments:

Is there evidence of 'react to red' and the patient escalated to protocol B for that area of their body when redness/damage was first discovered? Yes No NA
And/or, was offloading of any affected area documented? Yes No NA

How were nutritional needs being met?
IV fluids only Oral (with food chart) NG/NJ feeding Parenteral nutrition
Comments:

List any potential contributing factors (e.g. inotropes, vascular issues, oxygenation issues, sepsis)

2. Are we doing everything we should be doing now?

Has Tissue Viability Specialist Nurse reviewed? Yes No NA	Has dietician reviewed patient? Yes No Comment if no:

Is Tissue Viability Specialist Nurse's advice being actioned? Yes No NA
Comments:

Is correct pressure area care protocol now being applied? Yes No

Areas identified from the investigation (tick all that apply)

Present on admission ☐ No reaction to red ☐ ineffective repositioning ☐ Non-concordance ☐ All care given as per policy ☐
Inadequate skin assessments ☐ wrong mattress ☐ deviations from protocol **with** supportive medical documentation ☐
deviations from protocol **without** supportive medical documentation ☐ potential contributing factors ☐

All areas tick must now be transcribed onto the **'what were the investigation findings'** text box of the datix

Investigation completed by: (print name) (signature) (date)

Critical Care (V5), November 2021

Areas identified from the investigation (tick all that apply)

Present on admission ☐ No reaction to red ☐ ineffective repositioning ☐ Non-concordance ☐ All care given as per policy ☐

Inadequate skin assessments ☐ wrong mattress ☐ deviations from protocol **with** supportive medical documentation ☐

deviations from protocol **without** supportive medical documentation ☐ potential contributing factors ☐

All areas tick must now be transcribed onto the **'what were the investigation findings'** text box of the datix

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Datix Reports 2022/23

There were 42 stage 3+ ulcers/ SDTIs

Of those 42, 8 were reported to have deviation from protocol

Of those 8, 5 had supportive and robust medical documentation (all five TUtT and decisions reviewed)

Of the remaining 3:

1 had supporting nursing documentation (TUtT)

1 had verbal agreement (stated in nursing notes)

1 was deviation overnight (nursing decision for sleep promotion)

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Pressure Ulcer Triage Reports

18 PUTR written

5 had learning around robust documentation

- Delirium Management
- Lack of Staff
- Too Unstable to Turn

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Learning.

- Use of Flowchart reported and witnessed however unclear in documentation what steps were followed and how patients were optimized for repositioning
- Decisions not always reviewed
- More documentation in nursing notes than medical

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Next Steps….

- TUtT SOP to include learning from trial
- SOP to be reviewed through Local Governance to embed the flowchart into practice – Oct 2023
- TUtT2 – Proposed new project – Too Unstable to Touch

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Do you have any questions for me?

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