SPSP Acute Adult Programme
Pressure Ulcer
Change Package
2023
**Introduction**

Welcome to the pressure ulcer change package

The aim of the pressure ulcer change package is to provide evidence-based guidance to support the prevention of acquired pressure ulcers developed in a care setting. A change package consists of high-level outcomes supported by activities that when tested and implemented, lead to improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

**How it was developed?**

This change package was co-designed with clinical and quality improvement experts from across a range of care settings and NHS Boards. Clinical experts were from disciplines including nursing, podiatry and quality improvement. An Expert Reference Group was convened in September 2022 and met four times.

The change package has also been informed by those with lived experience. Through a discovery conversation model, themes from experiences of people with lived experience with pressure ulcers were identified and informed the development of the key drivers for improvement.

We have made this an interactive document, if you click on the primary/secondary driver it will take you to additional information including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow and home button. The arrow button will take you back to the primary driver page and the home button will take you to the main driver diagram page.
Understanding your system

Why understanding your system is important

An initial step in your quality improvement journey is important to understand how your system is currently working. This will enable you to identify the right improvements to make changes where they are needed.

Methods to understand your system

Listed below are some methods to understand your system.

- **Stakeholder Analysis** - used to identify, prioritise and understand your stakeholders.
- **Process Mapping** – used to outline the sequential steps in a process.
- **Cause and Effect Analysis** – used to explore and record likely causes of problems.
- **Forcefield analysis** – helps teams identify, discuss and assess the forces for and against a proposed change.
- **User experience (including surveys)** – method to gather information from the perspective of a person who interacts with and/or receives something from a service (content under development).
- **Pareto charts** – helps teams identify and focus on areas of improvement with the biggest impact.

For more information on Driver Diagrams and other QI tools to support your Quality Improvement journey, visit the [QI Zone](#).
## Pressure Ulcer Driver Diagram 2023

### What are we trying to achieve...
- Reduce the number of acquired pressure ulcers developed in [add care setting]
  - By [locally agreed aim]
  - By [locally agreed date]

### Pressure ulcers graded ≥2, including: combination lesions, device related, mucosal suspected deep tissue injury, and ungradable

### We need to ensure...
- Prevention and identification of pressure damage
- Person centred, evidence based care
- Multidisciplinary Team communication*
- Leadership to support a culture of safety at all levels*

### Which requires...
- Evidence based risk assessment
- Person, family, and carer involvement* in prevention
- Accurate pressure ulcer grading
- Shared decision making
- Person centred care planning*
- Multidisciplinary evidence-based interventions
- Timely review
- Equitable access to clearly defined care pathways
- Transitions in care setting
- Use of standardised communication tools*
- Management of communication in different situations*
- Workforce with skills in prevention and management of pressure ulcers
- Staff wellbeing and psychological safety*
- Safe Staffing*
- System for learning*

*Essentials of Safe Care
<table>
<thead>
<tr>
<th>Secondary Driver</th>
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<td>Evidence based risk assessment</td>
<td>Completion of pressure ulcer risk assessment</td>
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<td>Person, family, and carer involvement in prevention</td>
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<td>Implementation of Nationally agreed pressure ulcer grading tool</td>
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Primary Driver: Prevention and identification of pressure damage

Secondary Driver

- Evidence based risk assessment
- Completion of pressure ulcer risk assessment
- Locally agreed time frames for initial and repeat risk assessments to identify pressure damage
- Standardised process for accessing pressure redistributing equipment
- Timely detailed skin inspection to identify any areas of pressure damage

Evidence and Guidelines:


Tools and Resources:

Primary Driver: Prevention and identification of pressure damage

Secondary Driver: Person, family, and carer involvement in prevention

Change ideas:
- Provision of person centred visiting as an opportunity to discuss concerns
- Local process to engage person, family and carers in pressure ulcer prevention
- Promotion of public information on pressure ulcer prevention available in accessible formats
- Process to identify and mitigate barriers to following pressure ulcer prevention guidance

Evidence and Guidelines:

Tools and Resources:
### Change Ideas

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<td>Evidence of locally agreed documentation within person’s care record</td>
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<td>Implementation of nationally agreed pressure ulcer grading tool</td>
<td>Provision of evidence-based pressure ulcer grading of all skin tones</td>
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### Evidence and Guidelines:


### Tools and Resources:


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<td>Multidisciplinary evidence-based interventions</td>
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<td>Locally defined criteria &amp; process for specialist review and intervention</td>
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- **Primary Driver:** Person centred, evidence based care

- **Secondary Driver:**
  - Shared decision making
  - Person centred care planning
  - Multidisciplinary evidence-based interventions
  - Timely review
  - Equitable access to clearly defined care pathways

- **Change ideas:**
  - What matters to you conversations to inform decision making
  - Evidence of person centred care planning / Individualised care agreement
  - Use of evidence-based interventions
  - Timely reassessment of skin
  - Locally defined criteria & process for specialist review and intervention

- **Use of realistic medicine approach to inform decision making**

- **Collaborative care planning involving person, family and carer**

- **Delivery of evidence-based wound management**

- **Regular collaborative review of person centred care plan**

- **Standardised process for accessing pressure redistributing equipment**

- **Standardised process for accessing pressure redistributing equipment**

- **Locally agreed process to include skin assessment in handover between care settings**

- **Non-concordance documented in line with locally defined process**

- **Locally agreed use of what matters to you conversations**

- **Locally defined criteria & process for pressure ulcer photography to inform wound management**

- **Clear process for people, families, and carers to access healthcare for PU related concerns**

- **Provision of accessible treatment information to facilitate shared decision making**

- **Testing of tools to communicate person’s physical and cognitive ability**

- **Appropriate and timely use of pressure redistributing equipment**

- **Standardised care rounding process**

- **Locally agreed process to include skin assessment in handover between care settings**

- **Clear process for people, families, and carers to access healthcare for PU related concerns**
Primary Driver: Person centred, evidence based care

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Person centred, evidence based care

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**Evidence and Guidelines:**


**Tools and Resources:**


Primary Driver:
Person centred, evidence based care

Secondary Driver
Multidisciplinary evidence-based interventions

Change ideas
Use of evidence-based interventions
Delivery of evidence-based wound management
Appropriate and timely use of pressure redistributing equipment
Locally defined criteria & process for pressure ulcer photography to inform wound management

Evidence and Guidelines:


Tools and Resources:


Primary Driver:
Person centred, evidence based care

Secondary Driver

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Evidence and Guidelines:


Tools and Resources:

Primary Driver:
Person centred, evidence based care

Secondary Driver
Equitable access to clearly defined care pathways
Locally defined criteria & process for specialist review and intervention
Standardised process for accessing pressure redistributing equipment
Locally agreed process to include skin assessment in handover between care settings
Clear process for people, families, and carers to access healthcare for PU related concerns

Evidence and Guidelines:

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<td>Identification of people at risk of, or currently with pressure ulcers at team safety briefs / hand overs</td>
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<td>Locally agreed process for sharing information between services</td>
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Primary Driver: Multidisciplinary team communication

Secondary Driver

Transitions in care setting

Change ideas

Locally agreed process to include skin assessment in handover between care settings

Process to include pressure ulcer information in immediate discharge letter

Reliable process for timely access to pressure redistributing equipment in new care setting

Locally agreed process to involve carers in planning for transitions in care

Evidence and Guidelines:


Tools and Resources:


Primary Driver:
Multidisciplinary team communication

Secondary Driver

Use of standardised communication tools

Use of locally agreed communication tools such as SBAR

Evidence and Guidelines:


Tools and Resources:


*Please note these resources may require an NHS login to access.
Primary Driver: Multidisciplinary team communication

Secondary Driver
Management of communication in different situations

Change ideas
Locally agreed process to identify people with a pressure ulcer + NEWS2≥ at organisational huddles
Identification of people at risk of, or currently with pressure ulcers at team safety briefs / hand overs
Use of structured multidisciplinary meetings which include skin related concerns
Locally agreed process for sharing information between services

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## Primary Driver:
Leadership to support a culture of safety at all levels

### Secondary Driver
- Workforce with skills in prevention and management of pressure ulcers

### Change ideas
- Completion of mandatory role specific staff education
- Locally defined process to develop staff knowledge and areas of competence
- Access to local expertise to support workforce development

### Evidence and Guidelines:

### Tools and Resources:
### Primary Driver:

Leadership to support a culture of safety at all levels

### Secondary Driver

**Staff wellbeing and psychological safety**

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<td>• The Kings Fund. The importance of psychological safety: Amy Edmunson. [online]. Available from: <a href="https://www.youtube.com/watch?v=eP6guvRt0U0">https://www.youtube.com/watch?v=eP6guvRt0U0</a></td>
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### Evidence and Guidelines:

## Evidence and Guidelines:


## Tools and Resources:

Primary Driver:
Leadership to support a culture of safety at all levels

Secondary Driver
System for learning

Change ideas
Process for people, families and carers to raise safety issues
Local and organisational level reporting for learning
Standardised PU investigation tool & process to share learning
Accessing shared learning through formal and informal networks

Evidence and Guidelines:

Tools and Resources:
Alongside our Expert Reference Group, the Pressure ulcer change package and measurement framework was developed in collaboration with various teams and departments within Health Improvement Scotland. This One Team approach ensured consistency across programmes with regards to the development of the aim, measures and reporting and presenting data for improvement.

**Evidence and Evaluation for Improvement Team (EEVIT)**
Through the provision of literature searches, best available evidence informed the development of the Change package.

**Acute Care Portfolio**
Responsible for planning, leading and developing the Change package providing care settings with updated evidence, resources and tools for improvement.

**National Adverse Events**
Advising on current National Reporting standardisation to ensure consistency for teams reporting Pressure Ulcers through Adverse Event reporting.*

**Data Measurement and Business Intelligence (DMBI)**
Providing expertise on all measures, developing a measurement toolkit for teams to use when recording data and presenting data for improvement.

**Excellence in Care (EiC)**
Contributing to our Expert Reference Groups to advise and ensure alignment with current EiC measures.

**Primary Care Portfolio**
Ensuring Primary care teams continue to be updated on the development of the change package to promote best practice.

*Currently, the National Standardised Data Set does not require pressure ulcers to be reported as avoidable / unavoidable. The term ‘acquired’ will be used to inform the aim of the Pressure Ulcer driver diagram and will be updated if any changes develop.
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