Pressure Ulcer Case Studies

Purpose of this report

Pressure ulcer reduction is a priority work stream of the Scottish Patient Safety Programme (SPSP) Acute Adult and Primary Care with a current aim to reduce newly acquired pressure ulcers in hospitals and care homes by 50% by December 2017.

Over the last 3 months of 2016, the SPSP Acute Adult team visited three NHS boards, NHS Greater Glasgow and Clyde, NHS Highland and NHS Tayside, to undertake a study of the current state of progress with pressure ulcer reduction in acute hospitals. The purpose of this report is to describe our findings from these boards including factors that are supporting and impeding improvement and provide recommendations for SPSP and boards to help achieve the SPSP Acute Adult aim.

Background

In January 2014, pressure ulcer improvement work migrated from Leading Better Care to SPSP. A driver diagram, change package and measurement plan were developed in collaboration with subject matter experts. SPSP uses Quality Improvement (QI) methodology, a key part of which is to support staff to test different approaches to achieve reliable processes (for example, SSKIN bundle) and to understand the impact that their changes are having on outcomes (pressure ulcer incidence). By connecting process reliability and outcomes for patients, health and social care staff can understand which processes are leading to improved outcomes and design and test changes which may include innovations beyond existing or measured processes.

SPSP has a role in supporting staff to generate new ideas to improve patient outcomes and in collating outcome data to support boards to understand their current state and learn from each other. Over the last two and a half years, SPSP has worked with boards in a variety of ways to support improvement in pressure ulcers. There have been individual breakout sessions at learning events focusing on pressure ulcers as well as a full day event in May 2016. At this time we took the opportunity to ask delegates what support was required to help them take their improvement work forward. A number of delegates' responses indicated a lack of QI support as an existing barrier to improvement. Other barriers raised included education and provision of equipment.

SPSP has collated data from hospitals and boards on the rate of all newly acquired pressure ulcers grade 2–4. This data is reported quarterly and shared via the password protected SPSP dashboard to accelerate progress through the collaborative use of data.

Over this time data reporting has improved and now includes all boards in Scotland. The national data suggests that NHSScotland has an increasing incidence of newly acquired

pressure ulcers grade 2–4. However, this needs to be seen in the context of the narrative supplied by boards as part of the routine self assessment process.

In all cases where pressure ulcer rate is apparently rising, boards are providing descriptions of improved reporting systems and improved data capture as a result of focused improvement work. Additionally, a number of these self assessments describe challenges around providing QI support to clinical staff that will be required to underpin improvement.

Reporting of pressure ulcer rate from Scotland's hospitals has improved significantly over the last two years which can be viewed as a positive step towards improvement. While the incidence appears to be rising we have information from boards which suggests that this is underpinned by improved reporting. It is therefore reasonable to assume that, while we cannot yet be confident of the size of the problem, achieving the original aim may require a greater improvement than originally understood.

Given the above factors, there was a need for SPSP to better understand the barriers and enablers to pressure ulcer reduction and consider any revisions required to the current approach.

Findings of case studies

The three case studies provided helpful information in a number of areas. Across the participating boards there was commonality and variation within these themes.

Leadership and governance

Arrangements for leadership and governance of pressure ulcers commonly sit within nursing structures though there is variation on how this connects with board SPSP teams. Support from the Nurse Director was identified as an enabler, in particular relating to regular review of incidents and supporting an ongoing focus on pressure ulcer reduction.

Tissue Viability resource

There is variation in the participating boards on the availability of expertise in Tissue Viability and the degree to which these subject matter experts are engaged with and supported by people with knowledge in QI methods. All participating boards have met challenges with accurate grading and classification of pressure ulcers which can act as a barrier to understanding their data and using it effectively to support improvement. In particular, this barrier is seen in the issue of 'avoidability' where boards are seeking to improve documentation of risk assessment and care planning which will allow them to focus their resources on learning from incidents for future prevention strategies. Within these case studies, there were examples of where dedicated support from Tissue Viability nurses has supported improved outcomes.

Data – reporting and use for improvement

There was variation in the level of QI resource in boards to support staff to display, interpret and use their data for improvement. Two boards continue to use the original Clinical Quality Indicators from LBC to report and review process data. All boards are using incident

management systems to record pressure ulcer incidence and all participating boards describe processes for review of this data at strategic level to target improvement work. Processes for review and feedback of reported incidents vary but include a form of incident review of any reported pressure ulcers. NHS Greater Glasgow and Clyde are operating a double review system to improve diagnosis and grading. This review is supported by Tissue Viability, carried out in the place of care and used as an opportunity for education and coaching to generate ideas for improvement. There is variation across boards on the use of data in the clinical setting.

Risk assessment and care planning

The boards who participated in the case studies have a variety of approaches to risk assessment and care planning. Common approaches are the adoption of risk assessment tools and the SSKIN bundle. This tool which defines and ties best practices together has been highlighted as a valuable bundle to prevent pressure ulcers and has been adopted by NHS boards. In the case of NHS Greater Glasgow and Clyde, a linked process for risk assessment (PUDRA) and care planning (active care) has been developed and implemented across acute care. Designing documentation in this way has helped the board significantly reduce the number of pressure ulcers that are classed as 'avoidable' and better understand the impact of systems and processes on incidence. It is worth noting that this board is now demonstrating a sustained reduction in all acquired pressure ulcers grade 2 -4.

Education

The role of consistent education, delivered at the place of care, was identified as an important enabler of this work from both case studies and feedback at networking events. This requires staff who are specialised in the relevant subject matter and are able to dedicate time to engage and support clinical staff on wards.

A continuous promotion of practice development that focuses on an appreciative enquiry approach was identified as important for both education and incident review.

One board identified a need for nationally supported QI training for clinical staff working on pressure ulcer reduction.

Equipment

The availability and proactive use of pressure relieving equipment was identified as an important enabler to reduction of pressure ulcers.

The role of Quality Improvement (QI) and the Model for Improvement

There is variation on how QI expertise and methods have been deployed to support this work. All of the participating boards have limited QI capacity. NHS Greater Glasgow and Clyde has upskilled their workforce and specialist teams in QI techniques including the use of coaching skills with clinical teams. Boards described challenges in the transition of this work to SPSP as risk assessment and the SSKIN bundle were already implemented making it difficult to identify a pilot ward. There are a number of system wide factors described in these findings including service provision, coaching skills, education and equipment which do not all lend themselves easily to the Model for Improvement. It will certainly be useful for

elements including redesign of documentation but it is important to recognise the breadth of interventions required that may need a different approach.

Better links between Tissue Viability and SPSP

There was variation in links between SPSP and Tissue Viability groups in boards. Two of the participating boards stated that better national links between these groups would support their efforts.

Working across care sectors

All of the participating boards have or are attempting to make connections between acute and community settings to support pressure ulcer reduction.

Recommendations

The following recommendations have been identified for SPSP based on the three case study meetings.

- Share these findings with all boards in NHSScotland.
- Explore improved links with national Tissue Viability groups.
- Revise the existing driver diagram and change package to better reflect the breadth of these findings.
- Develop and publish a data story which describes the work in NHS Greater Glasgow and Clyde which has supported their improvement.
- Increase the level of support for this work in terms of networking opportunities which include education on subject matter and QI skills.
- Consider the addition of an optional outcome measure for pressure ulcers grade 3-4.

Summary

SPSP is grateful to NHS Greater Glasgow and Clyde, NHS Highland and NHS Tayside for participating in the case studies and openly sharing their successes and challenges.

Pressure ulcer reduction remains a priority across health and social care in Scotland. The work in SPSP aligns with the recently published standard on pressure ulcer care and will be an important element in the delivery of Excellence in Care.