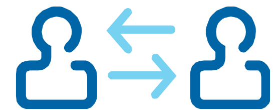
Category: Pressure Ulcer Special Project

Preventing: Deterioration of Healthy Skin and Pressure Ulcer Development

Key words: Pressure Ulcers, Deteriorating Patient

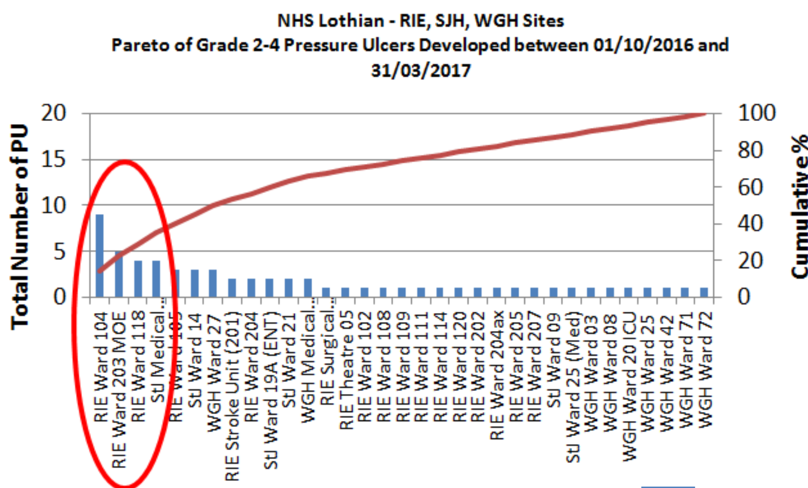
Sharing Learning Points

LOCALLY



What happened?

Aim: To support the work towards the national target of 50% reduction in hospital acquired pressure ulcers (HAPU), Grade 2 -4, by December 2017
A Pareto chart was used to identify the areas for focused improvement work July 2017 – January 2018



Diagnostic Work

- Review Datix incidents for 6 months (Jan – June 2017) to identify areas of learning and themes
- Process map of a patient journey in each area and process map for equipment
- Case note review to identify compliance with standards for assessment and intervention
- Conversations with staff, patient and carers
- Educational needs analysis for staff
- Conversations with patients/carers about current experience

What went well?

- Learning from case reviews
- Feedback to ward areas on findings to generate change ideas
- Process map for accessing equipment
- Conversations with patients

What, if anything, could we improve?

- Timely availability of specialist equipment
- Completion of special risk section on Waterlow
- Response rate from staff survey
- Involving patient/carer in care planning

What have we learnt?

- There may be a delay in availability of specialist equipment
- Moisture on skin contributing to skin breakdown
- Scoring of Waterlow assessment may be incorrect – parameters missed
- Inaccuracy of calculation of score on TRAK – electronic solution
- Care plans may not always in place for patients at risk of skin breakdown
- Pressure ulcer prevention leaflet could be shared with patients more often
- Care Rounding – patients may not be repositioned as per care plan

Learning from Patient Experience

- “No recliner chair to help me raise my legs”
- “Nursing staff always very busy”
- “Nursing staff help me to have a wee walk to keep moving”
- “I was uncomfortable once and left a wee bit too long in one position”

Tests of change identified

- Reliable process for equipment to be available post surgery for ITU/HDU patients
- Staff education in MAU to improve accuracy of Waterlow
- Reliable protected time for completing clinical documentation
- Highlighting patients at risk in safety brief,
- “Check skin” bedside tool,
- “Think pink” magnets for patient board

If you have any comments about this issue or approach please send them to the Quality Improvement Support Team (QIST).
With thanks to Shona Baird and QIST members’ support for this project