#ihubpu2017

Pressure Ulcer Prevention in Community nursing

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Background

- Pressure Ulcer Safety Cross
- SPSP SSKINS bundle
- Pressure Ulcer Prevention Policy
- Partnership TV group
- Introduction of SSKINS on CNIS
- Top 10 tools – including implementation of red day review tool

What are we doing?

- Identifying patients at risk
- Developing individual SSKINS care plans
- Measuring outcomes on safety cross
- Reporting red days via Datix
- Investigating & peer reviewing red days
- Developing team improvement plans
- Completing SSKINS audit monthly

Red day review tool?

- **When**; use it for any caseload acquired pressure ulcers
- **How**; use information contained within the electronic patient record
- **Why**; to determine if the pressure ulcer was avoidable and to develop action plans for team and shared learning

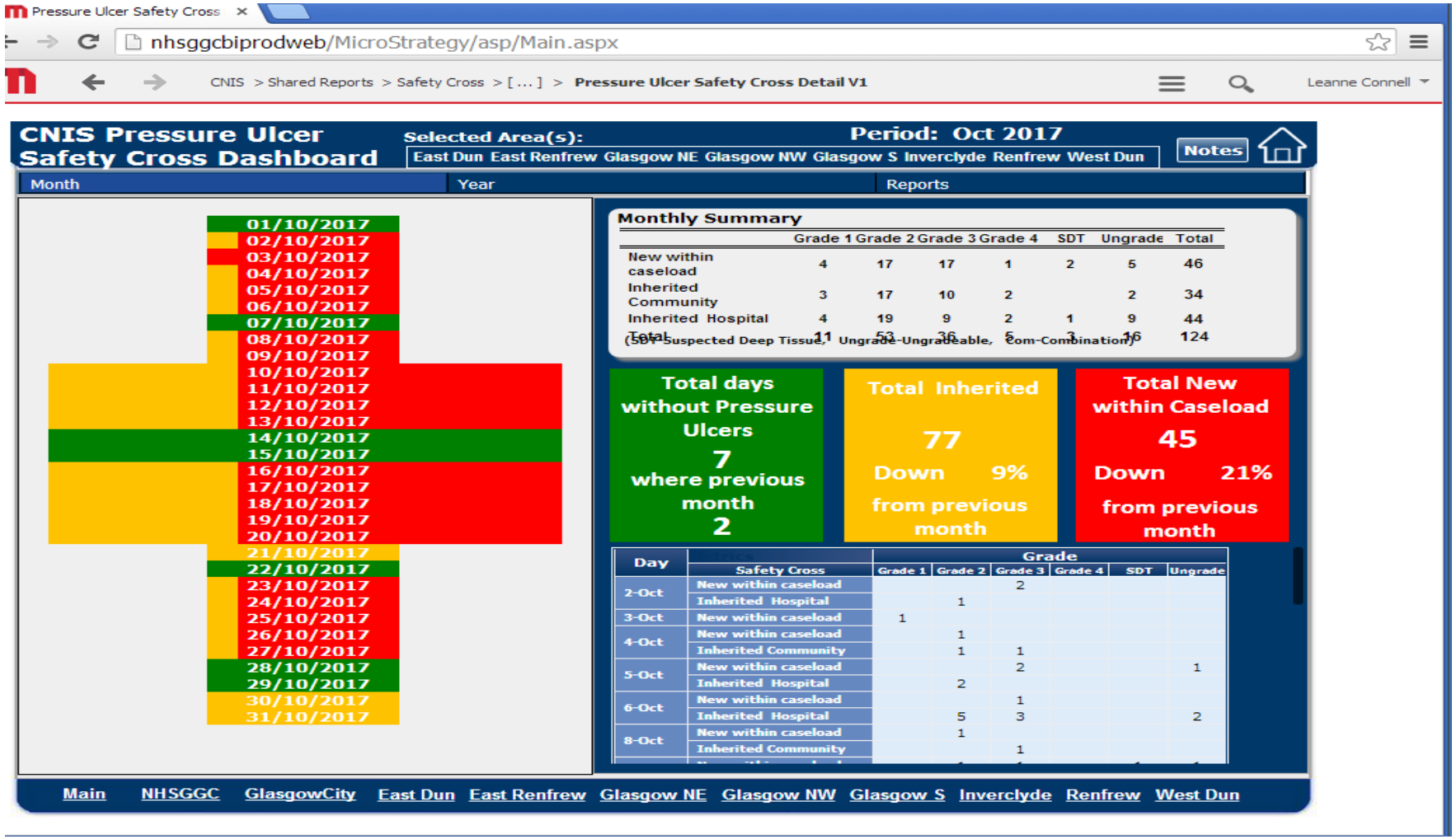
What we learned?

- Caseload acquired PU incidence was higher than expected
- Record keeping systems have to support the Pressure Ulcer Prevention process
- Not all pressure ulcers are avoidable
- SSKINS care bundle needs to be planned in conjunction with patients/carers/care at home services

Tools and resources we developed

- CNIS records adapted
- Microstrategy dashboard and audit platform
- TV training sessions for PU grading
- TV training for PU prevention

Highlights – microstrategy outcomes



Local Improvements – SSKINS compliance

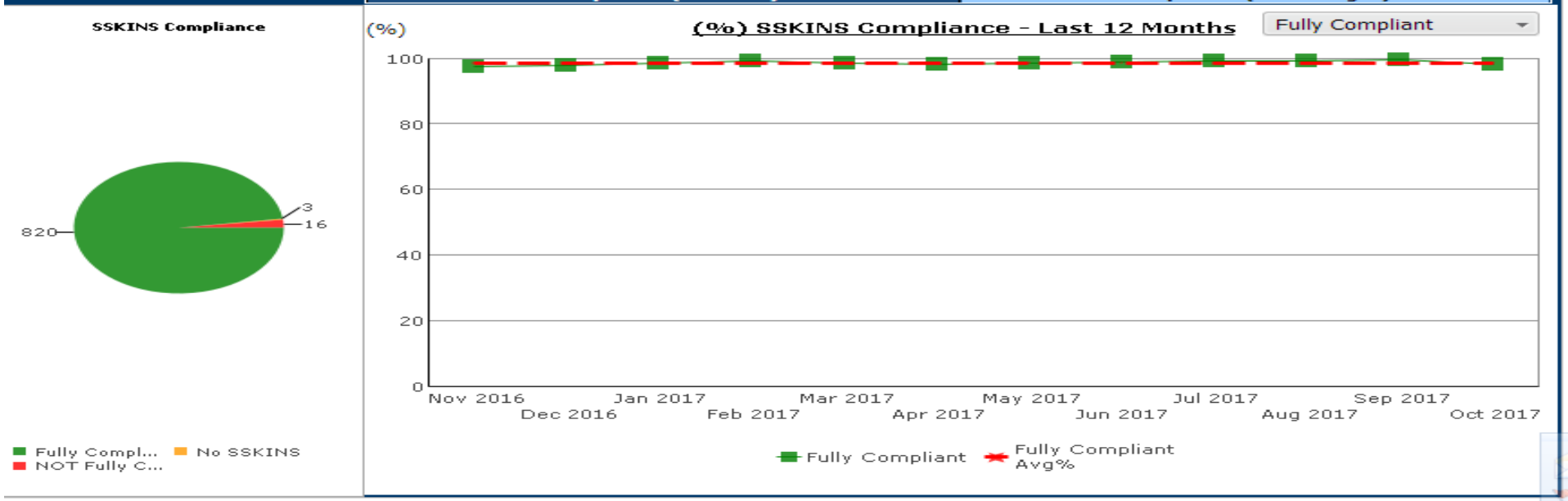
SSKINS Bundle Report Summary

Main | Area | Analyse Data | Notes

Glasgow South CHP

Compliance Group	Waterlow >= 10 All Patients	Patients With Pressure Ulcers: Unique Patients	%Unique Patients	Pressure Ulcers	Pressure Ulcers - New Within Caseload: Avoidable / Unavoidable: Not Recorded	Wound Avoidable	Wound Not Avoidable	PU Grades: Combine	Ungrad	Susp DT	Grad 1	Grad 2	Grad 3	Grad 4
Fully Compliant	820	55	7%	74	0	1	26	0	1	0	4	13	7	2
No SSKINS	3	1	33%	1	0	0	0	0	0	0	0	0	0	0
NOT Fully Compliant	16	1	6%	1	0	0	0	0	0	0	0	0	0	0
Total	839	57	7%	76		1	26		1		4	13	7	2

Compliance (Numbers) | Compliance (Percentages)



Patients at risk

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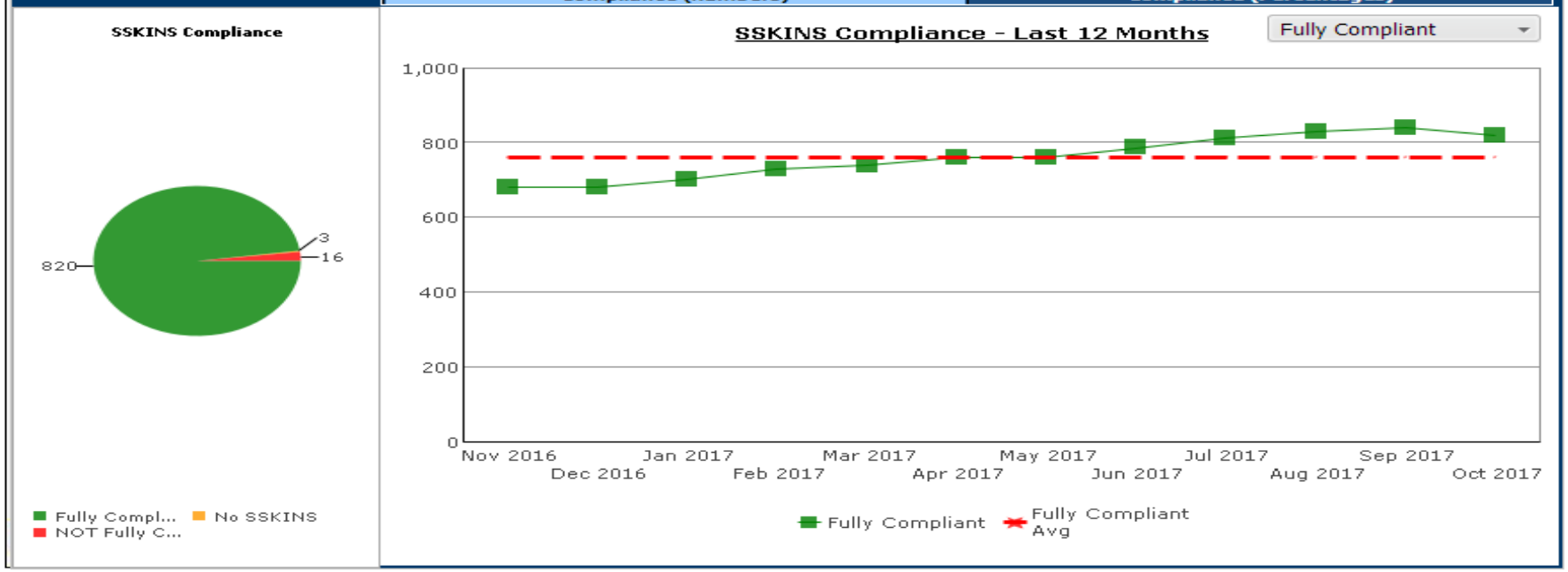
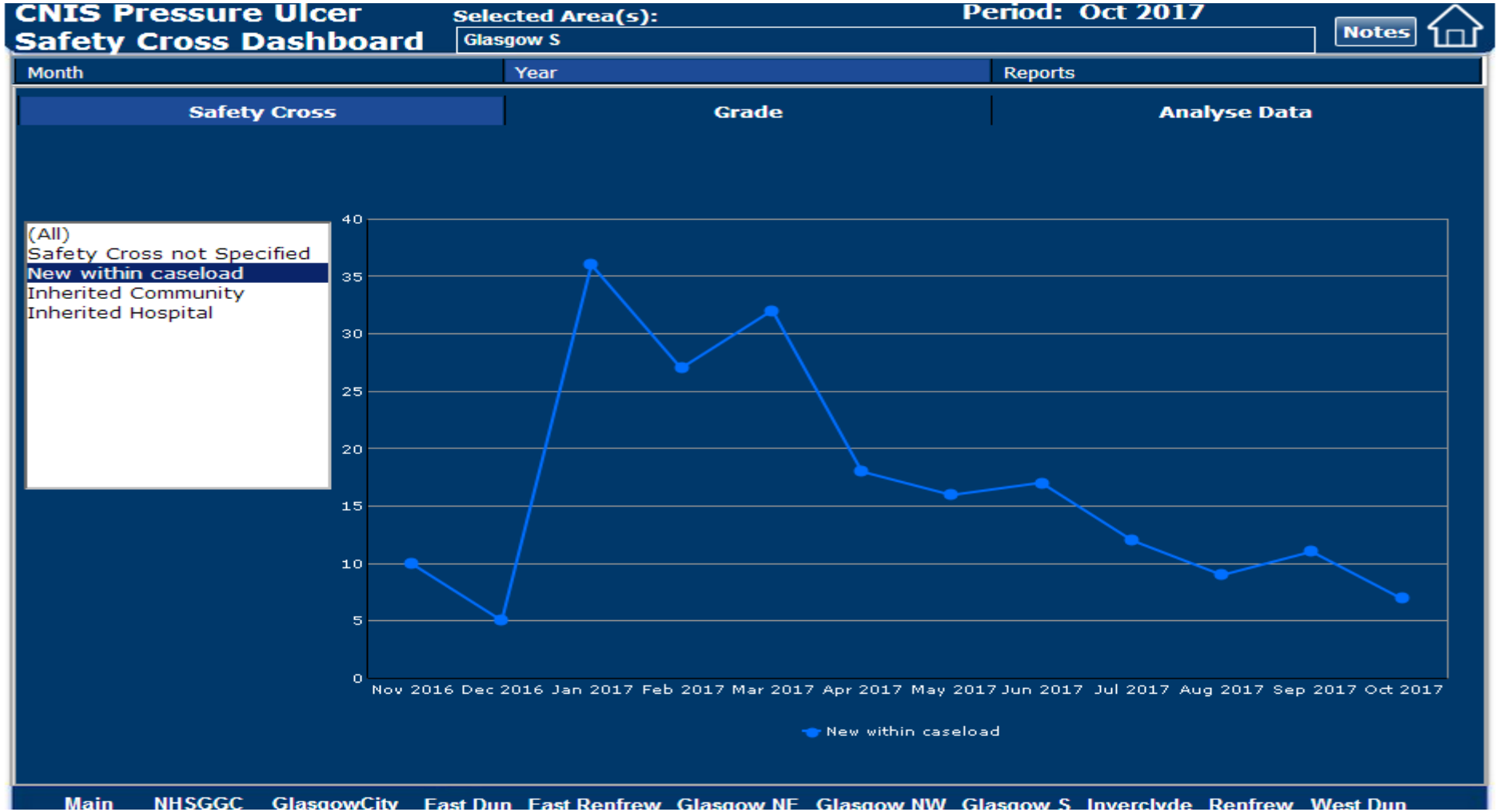


Reported red days

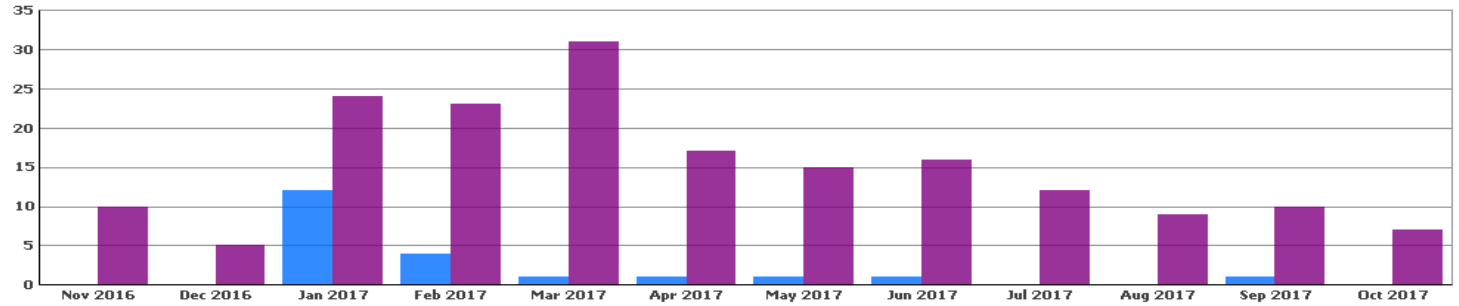


Red day review outcomes

CNIS > Shared Reports > Safety Cross > [...] > **Safety Cross Wounds Avoidable Report**

Referral Area	Pressure Ulcer Grade	Where Wounds Developed	Month	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Total
			Wound Avoidable													
Glasgow S	Grade 1	New within caseload	Avoidable			2	3		1	1	1					8
			UnAvoidable	3	1	4	6	9	2	3	4	3	1	1		37
	Grade 2	New within caseload	Avoidable			2		1						1		4
			UnAvoidable	4	1	7	12	7	8	8	10	4	8	2	4	75
	Grade 3	New within caseload	Avoidable			2	1									3
			UnAvoidable	2	3	3	2	6	6	2	2	4		7	1	38
	Grade 4	New within caseload	Avoidable			1										1
			UnAvoidable			2	1	1		1		1			1	7
	SDT	New within caseload	UnAvoidable			7		2		1						10
	Ungrade	New within caseload	Avoidable			5										5
			UnAvoidable	1		1	1	5	1						1	10
	Com	New within caseload	UnAvoidable				1	1								2
Total				10	5	36	27	32	18	16	17	12	9	11	7	200

New on Caseload - Avoidable v Unavoidable v Not Recorded



Next steps

- Focus on outcomes
- Continue with training
- Care assurance through caseload management/shadowing etc.
- Establish formal care plan sharing with care at home services