Pressure ulcers
A guide to eliminating all avoidable grade 2, 3, and 4 pressure ulcers

BEST PRACTICE
NURSING STANDARD
Royal College of Nursing
NHS England
The RCN and the former NHS Midlands and East are delighted to present this best practice booklet to provide you with details of some of the excellent work that has been put in place to support the ambition to eliminate all avoidable grade 2, 3 and 4 pressure ulcers.

Research carried out on behalf of the NHS Midlands and East showed that front line staff understand the dangers of pressure ulcers but experienced significant challenges in their attempts to prevent them.

This unique research provided a better understanding of the barriers to preventing pressure ulcers and how they could be addressed. Thanks to the participation of many hundreds of NHS front line staff, the insight provided through this research led to some effective communications that helped to motivate staff to take the steps required to prevent and treat pressure ulcers.

We know that most pressure ulcers are avoidable, and the risk of them occurring is increased by poor hydration, nutrition and a lack of individualised care. They also have a detrimental effect on patients’ health and wellbeing. Engaging all nurses was essential to achieve this ambition,
which not only applied to the Midlands and East, but throughout the country.

Nurses are at the forefront of this ambition. We are crucial to ensuring that motivation and enthusiasm are maintained, and must support each other’s successes and create a ‘can do’ attitude.

The treatment and prevention of pressure ulcers is a critical part of providing holistic nursing care. Central to this, is a good understanding of the most up to date care and treatment available to patients at risk of developing pressure ulcers.

The cost to the NHS of treating pressure ulcers and related conditions is up to £4 billion a year, with the most severe cases ranging from £11,000 to £40,000 per person. Pressure ulcer prevention can improve patient outcomes and reduce the costs to the service. Combine this with the human suffering and there is an increasing need to find innovative and simple ways for nurses and clinical colleagues to address this as part of everyday practice.

Nursing staff and clinical colleagues have devised innovative ways to help in the prevention of pressure ulcers, some of which are showcased in this booklet. We have selected six case studies from colleagues in the former NHS Midlands and East cluster as examples of some of the good work that has been initiated to prevent pressure ulcers. These range from awareness campaigns to communications campaigns, and simple innovations such as nurses now having access to pocket-size mirrors to check patients’ heels.

If you would like more information about any aspect of the case studies, please contact the named person for each case study or Lyn McIntyre, who was the associate nurse director – ambition leadership (lyn.mcintyre1@nhs.net)
Here at the Burton Hospitals NHS Foundation Trust we have several streams of work to reduce the occurrence of pressure ulcers in our patients.

Tissue viability champions are proactive in educating their clinical colleagues, they are visible on the wards and engage in a monthly tissue viability forum. We have also instigated some educational work on tissue viability. This includes the purchase of hand mirrors to ensure staff can check patients’ heels and the backs of oedematous legs.

Matrons and head nurses monitor pressure ulcer work by asking staff on ward rounds the following:

- How many patients on the ward are at risk of pressure ulcers?
- How many have pressure ulcers?
- What preventive measures are in place?

If the nurse does not know, he or she is advised that the matron will be back in an hour expecting the answers, this has the consequence of all staff ensuring they know the risks and the actions.

We have also been doing some work with healthcare assistants and our tissue viability lead nurse has designed a PULSE skin assessment card (see below). The healthcare assistants are given this information on a credit card-sized prompt so they can use it with all patients all of the time.

P = Press reddened skin to check for blanching
U = Uncover the skin and remove stockings and socks
L = Lift and check heels with a mirror
S = Search for redness on the sacrum
E = Evaluate elbows for redness.
We have also been working as part of a collaborative and have a pilot ward. This is an orthopaedic ward that has been raising the profile of pressure ulcer prevention with the team and has a group of people attending the collaborative, including a consultant and patient representative.

The buy-in from the consultant is important as no other team in the collaborative has a consultant on board. The pilot ward is an example of good practice that we intend to roll out across the trust.

Another initiative is the introduction of safety crosses. These are a table that is used on a daily basis to highlight any patients at risk. It also flags up all the pressure ulcer-free days. The aim is for all patients to be pressure-ulcer free.

The team has also made a video that spoofs the TV drama Holby City. It is used as a training aid on how to prevent pressure ulcers by identifying poor practice and showing how this can be improved.

Julie Thompson, head nurse medicine
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The role of data intelligence cannot be underestimated in any improvement project. It needs to be accurate and real-time with regular analysis of underlying themes and trends.

We tailored the Datix incident-reporting system to facilitate the recording of multiple sites of pressure damage. Each incident is automatically sent to the tissue viability nurse, who screens the report and follows up with a clinical review of the patient and discussion with staff on how to provide optimum care. Themes are aggregated from Datix/panel reviews and training is given to the tissue viability link nurses and the wards.

Simple innovations, including the introduction of heel checks, have been built into the bedside handover.

The Take the Pressure Off campaign primarily targets staff education and examines compliance with procedures and policies. The documentation for pressure ulcers was lengthy and complicated, so it was reviewed and the SSKIN (surface, skin inspection, keep patients moving, incontinence/moisture, nutrition/dehydration) bundle was developed – a package of care for patients identified ‘at risk’.

Baseline data were recorded for staff education and compliance with the SSKIN bundle and incidence of pressure ulcers. Varying strategies were used to promote awareness and compliance.
When the project began it became evident that staging of ulcers and accurate reporting were an issue, as a result the trust committed to ensuring 100 per cent of nursing staff received pressure ulcer prevention training.

All inherited and acquired moisture lesions and stage 1-4 ulcers are now reported via DATIX. Process mapping took place with the ‘high risk’ areas and the equipment library. The library now has a target to deliver pressure-relieving equipment within two hours of a request.

A pressure ulcer group meets weekly. All wards that report a hospital-acquired stage 3 or 4 pressure ulcer have to do a root cause analysis and present it to the group, with an appropriate action plan. Common themes are escalated to the pressure ulcer operational group. This group, chaired by the chief executive, holds fortnightly ‘performance’ meetings. A ward scorecard, subsequent exception reports and action plans are monitored through this group.

Nicky Lindley, matron – tissue viability services
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Making performance data visual and easily accessible via run charts and quality dashboards to reflect trends ensures that meaningful information can be distributed to support local, multidisciplinary ownership of the agenda.

Quality indicators, including a matrons’ daily checklist, daily multidisciplinary team safety board briefings and a newly developed internal assurance process called the clinical area assessment programme, have been put in place. A quality dashboard provides healthy competition among teams to see who can improve the most.

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A FOCUSED CAMPAIGN
University Hospitals Coventry and Warwickshire NHS Trust

The team at University Hospitals Coventry and Warwickshire NHS Trust came up with a series of measures to incorporate into the SSKIN bundle. Intentional rounding was introduced where nurses on wards carry out regular checks with individual patients every one to two hours, which included the SSKIN bundle.

Tissue viability link workers were trained to ‘focus on five’ – assess, surface skin, keep moving, incontinence, and nutrition. They then cascade this information in the wards and staff have a ‘check and challenge’ interview to ensure they understand the tool.

The ‘100 days free’ campaign was introduced in March 2012 with wards rewarded for going 100 days without a grade 2, 3 or 4 pressure ulcer. After this, wards aim for 200 days free, and so on. In the emergency department, a separate target was given to identify 100 pressure ulcers as they came into the trust and by early June 2012 this target had been met.

A focused awareness campaign was launched in March 2012. All clinical staff were targeted but particular emphasis was placed on nursing staff and allied health professionals, who have a role in assessing risk factors and repositioning patients.

Power training involves giving ten-minute shots of training at a time that suits the demands of the ward/department. The message delivered during the training is to focus on five elements of preventive care. Wards then submit updates on their progress on training and pressure ulcer free days, which is corroborated by the Datix reporting system and the tissue viability team.

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ACCOUNTABILITY IS KEY
The Royal Wolverhampton NHS Trust

At the trust we implemented the pressure ulcer prevention care package for the health economy, with slight alterations for particular services such as community and outpatient settings. We realised early in the project that good lines of communication are paramount in tracking patients at high risk and those with existing pressure ulceration between care settings – acute and community. Using an incident reporting computerised system, the trust is able to demonstrate a sharp decline in acquired avoidable pressure ulcers.

We believe that staff need to be accountable for their actions to ensure patient-centred holistic care is delivered to prevent pressure ulceration. To avoid lengthy root cause analyses, we complete a concise investigation within 48 hours and attend a meeting with the chief nurse, deputy chief nurse, head nurse matron and tissue viability nurse lead. The ward or service leaders and matrons discuss the key findings and decide if the pressure ulcer was avoidable or not. This has led to ward ownership and improved accountability for pressure ulcer prevention.

Action learning takes place in the form of team meetings or divisional governance groups to ensure the themes that come out of a pressure ulcer incident are discussed and learning takes place. All of this work is supported by the pressure ulcer policy.

Our leadership approach provides a timely analysis of investigation; an objective scrutiny of documented evidence at a senior level; raises awareness of accountability; reviews systems and processes; leads to appropriate outcome-based action plans and incorporates the performance management process.

Lorraine Jones, tissue viability lead nurse
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The ‘Under Pressure’ campaign was launched as part of a commitment to eliminate pressure ulcers. It was designed to introduce the new SSKIN care bundle and pressure ulcer grading system.

The campaign is headed up by the tissue viability team but relies on all healthcare professionals to help prevent pressure ulcers. Patients are at the heart of the project.

‘Under Pressure’ runs alongside the Safety Thermometer national reporting tool, which is promoted by all ward sisters and matrons. The tissue viability nurses (TVNs) work closely with the clinical audit department to review the Safety Thermometer data each.

**Pressure Ulcer Prevention Cycle**

**WHY?**
- Improved patient safety
- Costs to patient
- Pain, debilitation, loss of self-esteem, delayed discharge
- Costs to trust
- Category 2 – £6,000/ulcer
- Category 4 £14,000/ulcer
(Source: Department of Health 2010)

**Assess**
- Who is at risk?
  - People with
    - Reduced mobility
    - Vascular damage
    - Sensory impairment, reduced consciousness
    - Over 65 years old
    - Malnourished/dehydrated

- Initial assessment within six hours of admission

**Assessment methods:** Andersen, Waterlow, MUST, Wound assessment and Management tool, Moving and Handling

**Apprentice Role**

Queen Elizabeth Hospital King’s Lynn
NHS Foundation Trust

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month and compare it with the data they collect from other sources to ensure accuracy.

This level of multidisciplinary co-operation allows timely prevention of pressure ulcers to all at risk.

To meet the challenge of eliminating avoidable grade 2 to 4 pressure ulcers, the tissue viability team employed an apprentice. The position developed the skills and knowledge of the apprentice and it is hoped that the apprentice will go on to a career in the NHS supported by the TVNs.

After discussion with staff, the team developed a poster to highlight the main issues in the pressure ulcer policy. As patient care is based on the problem-solving cycle, it was decided to structure the poster around the nursing process (shown above).

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