The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

1 REPORT TO BOARD OF DIRECTORS (IN PUBLIC)

SUBMITTED BY:	REPORT FOR:		IMPACT:		
Gwyneth Wilson, Director of Patient Experience and Lead for Nursing and Non-Medical Professionals	Decision		High	Med	Low
CONSULTATION:	Information	√	√		
	REPORT TYPE:		RELATED WORK:		
	Strategic	√			
	Operational	√			
	Governance				
BAF ref:					
Monitor Compliance Framework:					
CQC Essential Standard Reference:					
NHSLA Standard Reference:					
Media / Communications:					

Meeting Date: 28th January 2013
Report Title: "Stop the Pressure" (reduction in hospital acquired pressure ulcers)

Purpose: The purpose of this paper is to provide the Board with an update of the work being undertaken as part of the "stop the pressure" campaign.

Summary: The Trust was part of the Midlands and East collaborative to eradicate avoidable grade 2,3 and 4 pressure ulcers by December 2012. This report notes the work undertaken to meet this SHA ambition

Financial Implications / Efficiency Savings / Quality Improvement:

Risk Assessment (cross-reference with Risk Register where appropriate):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
√			√		√

Recommendations:

- To note the work undertaken and the planned roll out plan to the remaining ward areas

Author Valerie Newton, Deputy Director of Patient Experience
Date 11 January 2013

PRESSURE ULCERS

2 INTRODUCTION

1.1 NHS Midlands and East has a number of ambitions, designed to improve quality. One of the ambitions related to the elimination of avoidable pressure ulcers (all grades) by December 2012. This is further supported by the Department of Health Safe Care Work Stream developed as part of the Quality, innovation, Prevention and Productivity (QIPP) programme.

1.2 Pressure ulcers have a detrimental effect on a patient's health and wellbeing as well as placing a significant economic burden on the NHS and in turn, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. Patients who acquire a pressure ulcer may experience a delayed recovery, longer hospital stay and severe discomfort, which further increases the financial burden on the Trust.

1.3 The Trust was part of the SHA Pressure Ulcer Collaborative. This was commenced in August 2012 when all the Tissue Viability nurses in the region were informed of the SHA's ambition to eradicate all avoidable grade 2, 3 and 4 by the end of 2012. The purpose being to support clinical staff in developing techniques and using tools in order to reduce the incidence of pressure ulcers. At the start of the process the Trust was asked to identify a showcase ward where changes to practice could be tested prior to transfer to other clinical areas. After reviewing the numbers of pressure ulcers within ward areas, Stanhoe ward was chosen to be the showcase area, as it was believed to be an area where learning from the changes made would be able to be transferred to other clinical areas at the end of the pilot.

1.4 The ward sister, matron, practice development nurse, occupational therapist and Tissue Viability nurse from the clinical area, were the team that represented the Trust at monthly study events, that commenced in September 2012. At these events, progress was monitored and issues and good practice was shared. The team were also supported with data analysis by the patient safety team, who devised a shared data base to ensure that all data was accurate and complete. A major asset to the project was the request by the practice development nurse on the medical assessment unit (MAU) to be part of the work as there was a realisation that if patients at risk of pressure ulcers could be identified on MAU on admission, then preventive pressure ulcer care could be commenced on admission, thus reducing pressure ulcers within the medical division.

1.5 Monthly reports regarding the process of the project were sent to the collaborative team and the Trust were required to submit storyboards of progress each month so that changes could be monitored

2 ACTIONS TAKEN AND CHANGES MADE

2.1 As part of the work undertaken PDSA (plan, do, study act) cycles were undertaken to make changes to assess whether they could work and be sustained and Stanhoe and MAU had weekly "huddles" (meetings to discuss pressure ulcer care and areas to change), attended by the team to review changes to plan further change.

2.2 Changes made include the following

- Pink dots were placed on patient information board to raise awareness with all staff of the patients potential for developing a pressure ulcer / or that they had a pressure ulcer – compliance was increased (on Stanhoe) to 100% at the end of the project

- Improved multi-disciplinary collaboration in use of the a care bundle entitled SSKIN which look at the **s**urface of the mattress, involves a **s**kin inspection, **k**eeps patients moving, reviews **i**ncontinence and ensures that nutrition and hydration are maintained. – this lead to better communication between team members and significant increase in pressure relieving equipment in use
- 100% compliance with weekly wound assessment for patients with pressure ulcers this lead to 100% compliance achieved for those patients audited.
- The "turning clock" (a laminated clock that indicated the time that the patient was to be next turned placed behind the patient's bed so that staff could then this was done at the correct time) has been trialled on one patient in a side room with good effect. This was rolled out to all the single rooms
- The date of when dressings were to be changed were written on the dressing to indicate when they require changing so that all wound dressings, including pressure ulcers are changed promptly.
- All patients with pressure ulcers / at risk had appropriate mattresses.
- If a Nimbus 3 (pressure reducing mattress) was not available from the medical equipment library, a Repose (pressure reducing) overlay was put into place until one could be obtained from Huntleigh. If an appropriate mattress was not available an incident form was completed to ensure that there was documentary evidence of the problem.
- Staff encouraged those patients who are able to get out of bed and mobilise.
- Staff gave all patients at risk of pressure ulcers and their relatives a Pressure Ulcer information leaflet. The leaflet was then explained to the patient or relative and it was documented in the patient's notes that the patient had received it.
- Continence advisor visited MAU on a daily basis to ask the nurses responsible for each bay if they have any patients with incontinence / moisture lesions so that she could be involved early in their care and prevent skin damage from urine. The Continence advisor then followed patients up when they are transferred to the ward.
- Daily Pressure Ulcer Documentation training sessions were undertaken throughout December for ward based nursing staff across the trust.
- The trust is currently trialling two high specification mattresses, to assess the impact of having these mattresses for use on all hospital beds so that patients are immediately cared for on an appropriate support surface from the time of admission and do not have to wait for delivery of a special mattress.
- As part of the countdown to No Pressure Ulcers at the end of December the Trust developed a pressure ulcer Advent calendar online, in the dining room and at the front of the hospital. Texts were also being sent to bank staff with the daily pressure ulcer message.
- A weekly competition with prize and certificate was instigated throughout December for the individual who did the most to reduce pressure ulcers each week, in an effort to share good practice and reward excellent care.

3 CONCLUSION

3.1 In the final report for the December collaborative meeting the Trust was able to report that MAU had gone 78 days without a patient developing a new pressure ulcer on the unit and Stanhoe ward 48 days.

3.2 It was identified that there is a significant delay in getting pressure relieving equipment onto the patient beds. Support has been provided to lead an initiative to Process Map the system and identify ways in which improvements can be made. The result of the process mapping exercise is a proposal which went to the Trust Executive Committee on 6th November to consider putting Repose mattress overlays on all beds in the trust or

purchasing a new higher specification base mattress. The Trust Executive has agreed in principle for a new combination foam / dynamic mattress to be put on every bed in the hospital. The proposed mattress and alternative are currently being trialled.

3.3 It is possible that patient participation in care and the amount of information provided by staff is better than the SSKIN audit results suggest. Lack of explicit documentation to illustrate discussion with patients has indicated that further work is needed. Discussion with patients is often not possible during audits due to their poor health status. It should be noted that all clinical documentation has been changed in the last 3 months and is currently being embedded. Five weeks of intensive training on completion of care plans and nursing documentation has been carried out. The DVD that is being shown today, was made at the end of the 4 month pilot to demonstrate all the work undertaken and is being used as a teaching aid for new nursing staff joining the Trust to illustrate the principles of pressure ulcer management within the Trust. During December there were daily training sessions on completing Pressure Ulcer Documentation.

3.4 The first quick success has been to embed the use of high risk indicators (Pink Dots) and improve multidisciplinary working to support implementation of the SSKIN Care Bundle. This has been seen positively outside the hospital with an article appearing in the Lynn News and an interview on the local radio station. Handover processes have been changed to increase the focus on high risk patients and those with existing pressure ulcers.

3.5 Weekly ward `huddles` and information board have provided an opportunity to keep the process alive and ensure continued staff engagement.

3.6 All A&E trolleys now have a Repose trolley mattress in place. This means that pressure ulcer prevention starts as soon as the patient enters the trust.

3.7 A new assessment screening tool has successfully been introduced into A&E where it serves to improve the process of identifying patients `at risk` (this is done by assessing the patient's risk factors and developing an appropriate plan of care).

3.8 The Medical Assessment Unit joined the Collaborative at their request. This clearly demonstrated the enthusiasm of trust staff to eliminate pressure ulcers. They recognised the need to implement appropriate assessment and the SSKIN Bundle care from admission. With the involvement of MAU this will became more achievable.

3.9 The use of Pressure Ulcer information leaflets has increased and they are now to be found in holders outside every ward. Every attempt is being made to work in partnership with patients and their relatives and an article to this effect was printed in the Eastern Daily Press on World Stop the Pressure day. A revised leaflet has been designed and is currently being evaluated for patients attending surgical pre-assessment clinics.

3.10 A roll out plan has been devised to roll out the learning from MAU and Stanhoe ward, this commenced in January 2013 and will be completed by the end of March 2013

Valerie Newton
Deputy Director of Patient Experience
11th January 2013