

SPSP Acute Adult Programme Pressure Ulcer Change Package 2023



Introduction



Welcome to the pressure ulcer change package

The aim of the pressure ulcer change package is to provide evidence-based guidance to support the prevention of acquired pressure ulcers developed in a care setting. A change package consists of high-level outcomes supported by activities that when tested and implemented, lead to improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

How it was developed?

This change package was co-designed with clinical and quality improvement experts from across a range of care settings and NHS Boards. Clinical experts were from disciplines including nursing, podiatry and quality improvement. An Expert Reference Group was convened in September 2022 and met four times.

The change package has also been informed by those with lived experience. Through a <u>discovery conversation model</u>, themes from experiences of people with lived experience with pressure ulcers were identified and informed the development of the key drivers for improvement.

Contents and how to use the package







The change package includes:

- a driver diagram;
- a national aim,
- primary drivers,
- secondary drivers, and
- change ideas.

The change package splits each primary driver into secondary drivers and associated change ideas.

Evidence, guidelines, tools, and resources are also included to support teams to deliver improvement with an evidence base relevant to the secondary driver.

Project teams can also generate their own change ideas. One way of generating change ideas is to use the question:

"How might we improve pressure ulcer prevention and identification in our care setting?"

We have made this an interactive document, if you click on the primary/secondary driver it will take you to additional information including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow and home button arrow button will take you back to the primary driver page and the home button will take you to the main driver diagram page.

Understanding your system



Why understanding your system is important

An initial step in your quality improvement journey is important to understand how your system is currently working. This will enable you to identify the right improvements to make changes where they are needed.



Methods to understand your system

Listed below are some methods to understand your system.

- <u>Stakeholder Analysis</u> used to identify, prioritise and understand your stakeholders.
- Process Mapping used to outline the sequential steps in a process.
- <u>Cause and Effect Analysis</u> used to explore and record likely causes of problems.
- <u>Forcefield analysis</u> helps teams identify, discuss and assess the forces for and against a proposed change.
- <u>User experience (including surveys)</u> method to gather information from the perspective of a person who interacts with and/or receives something from a service (content under development).
- Pareto charts helps teams identify and focus on areas of improvement with the biggest impact.

For more information on Driver Diagrams and other QI tools to support your Quality Improvement journey, visit the QI Zone

Pressure Ulcer Driver Diagram 2023



What are we trying to achieve...

Reduce the number of acquired pressure ulcers developed in [add care setting]

By [locally agreed aim]
By [locally agreed date]

Pressure ulcers graded ≥2, including: combination lesions, device related, mucosal suspected deep tissue injury, and ungradable

*Essentials of Safe Care

We need to ensure...

Prevention and identification of pressure damage

Person centred, evidence based care

Multidisciplinary Team communication*

Leadership to support a culture of safety at all levels*

Which requires...

Evidence based risk assessment

Person, family, and carer involvement* in prevention

Accurate pressure ulcer grading

Shared decision making

Person centred care planning*

Multidisciplinary evidence-based interventions

Timely review

Equitable access to clearly defined care pathways

Transitions in care setting

Use of standardised communication tools*

Management of communication in different situations*

Workforce with skills in prevention and management of pressure ulcers

Staff wellbeing and psychological safety*

Safe Staffing*

System for learning*

Primary Driver: Prevention and identification of pressure damage





Secondary Driver

Change ideas

Evidence based risk assessment

Person, family, and

carer involvement

in prevention

Completion of pressure ulcer risk assessment

Provision of person centred visiting as an opportunity to discuss concerns

Accurate pressure
ulcer grading

Implementation of
Nationally agreed pressure
ulcer grading tool

Locally agreed time frames for initial and repeat risk assessments to identify pressure damage

Local process to engage person, family, and carers in prevention of pressure ulcers

Evidence of locally agreed documentation within person's care record

Standardised process for accessing pressure redistributing equipment

Promotion of public information on pressure ulcer prevention available in accessible formats

Provision of evidencebased pressure ulcer grading of all skin tones Timely detailed skin inspection to identify any areas of pressure damage

Process to identify and mitigate barriers to following pressure ulcer prevention guidance

Prevention and identification of pressure damage







Secondary Driver

Evidence based risk assessment

Change ideas

Completion of pressure ulcer risk assessment

Locally agreed time frames for initial and repeat risk assessments to identify pressure damage

Standardised process for accessing pressure redistributing equipment

Timely detailed skin inspection to identify any areas of pressure damage

Evidence and Guidelines:

- NHS Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020; Available from:
 - https://www.healthcareimprovementscotland.org/our work/st andards and guidelines/stnds/pressure ulcer standards.aspx
- Walker RM, Gillespie BM, McInnes E, Moore Z, Eskes AM,
 Patton D, et al. <u>Prevention and treatment of pressure injuries: A meta-synthesis of Cochrane Reviews</u>. J Tissue Viability. 2020;29(4):227-43.

- Care Inspectorate. Tissue Viability. Template policy for adult services. 2017. Available from:
 https://www.careinspectorate.com/images/documents/4187/HWT%20policy%20template%20tissue%20viability%20MASTER.pdf
- National Pressure Ulcer Advisory Panel EPUAP, and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/ Injuries: Quick Reference Guide. 2016. Available from:
 https://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf
- NHS Health Improvement Scotland. Tissue viability toolkit [online]. 2017. Available from: https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability.aspx
- National Institute for Health and Care Excellence. Social Care Institute for Excellence. 2019. Helping to prevent
 pressure ulcers. A quick guide for registered managers of care homes. 2019. Available from:
 https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/helping-to-prevent-pressure-ulcers
- CTRU Leeds Research Portal. PURPOSE-T Registration [online]. Available from: https://ctru.leeds.ac.uk/purpose/purpose-t/

Primary Driver: Prevention and identification of pressure damage







Secondary Driver

Person, family, and carer involvement in prevention

Change ideas

Provision of person centred visiting as an opportunity to discuss concerns

Local process to engage person, family and carers in pressure ulcer prevention

Promotion of public information on pressure ulcer prevention available in accessible formats

Process to identify and mitigate barriers to following pressure ulcer prevention guidance

Evidence and Guidelines:

- Ledger L, Worsley P, Hope J, Schoonhoven L. <u>Patient involvement in pressure ulcer prevention and adherence to prevention strategies: An integrative review</u>. Int J Nurs Stud. 2020;101: e103449.
- Engelen M, van Dulmen S, Vermeulen H, de Laat E, van Gaal B.
 The content and effectiveness of self-management support interventions for people at risk of pressure ulcers: A systematic review.

 Int J Nurs Stud. 2021;122: e104014.

- Healthcare Improvement Scotland. What matters to you? [online]. 2021. Available from: https://www.whatmatterstoyou.scot/
- NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021. Available from: http://www.healthliteracyplace.scot.nhs.uk/toolkit/techniques/
- NHS Education for Scotland. Person centred care [online]. 2021. Available from: https://www.nes.scot.nhs.uk/our-work/person-centred-care/
- NHS inform. Pressure ulcers [online]. 2020. Available from: https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers

Prevention and identification of pressure damage







Secondary Driver

Accurate pressure

ulcer grading

Change ideas

Implementation of nationally agreed pressure ulcer grading tool

Evidence of locally agreed documentation within person's care record

Provision of evidence-based pressure ulcer grading of all skin tones

Evidence and Guidelines:

- Chung ML, Widdel M, Kirchhoff J, Sellin J, Jelali M, Geiser F, et al. Risk factors for pressure ulcers in adult patients: A meta-analysis on sociodemographic factors and the Braden scale. J Clin Nurs. 2022;00:1-14.
- NHS Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019; Available from: https://www.healthcareimprovementscotland.org/our_work/patient-safety/tissue-viability/grading-and-tools.aspx
- NHS Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020; Available from:

https://www.healthcareimprovementscotland.org/our_work/st andards and guidelines/stnds/pressure ulcer standards.aspx

- Care Inspectorate. Tissue viability. Template policy for adult services [online]. 2017. Available from:
 https://www.careinspectorate.com/images/documents/4187/HWT%20policy%20template%20tissue%20viability%20MASTER.pdf
- National Pressure Ulcer Advisory Panel EPUAP, and Pan Pacific Pressure Injury Alliance. Prevention and Treatment
 of Pressure Ulcers/Injuries: Quick Reference Guide [online]. 2016. Available from:
 https://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf
- NHS Healthcare Improvement Scotland. Assessment tool for darkly pigmented skin [online]. 2019; Available from:
 https://www.healthcareimprovementscotland.org/our work/patient safety/tissue viability resources/dark pigment assessment tool.aspx
- NHS Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019; Available from:
 https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.as
 px
- Society of Tissue Viability. Skin assessment: Assessing skin on patients with darker skin tones in relation to PU prevention [online]. 2021. Available from: https://societyoftissueviability.org/resources/skin-assessment-assessing-skin-on-patients-with-darker-skin-tones-in-relation-to-pu-prevention/





Secondary Driver

Change ideas

Shared decision making

What matters to you conversations to inform decision making

Use of realistic medicine approach to inform decision making

Provision of accessible treatment information to facilitate shared decision making

Non-concordance documented in line with locally defined process

Person centred care planning

Evidence of person centred care planning / Individualised care agreement

Collaborative care planning involving person, family and carer

Testing of tools to communicate person's physical and cognitive ability

Locally agreed use of what matters to you conversations

Multidisciplinary evidence-based interventions

Use of evidence-based interventions

Delivery of evidencebased wound management Appropriate and timely use of pressure redistributing equipment

Locally defined criteria & process for pressure ulcer photography to inform wound management

Timely review

Timely reassessment of skin

Regular collaborative review of person centred care plan

Standardised care rounding process

Equitable access to clearly defined care pathways

Locally defined criteria & process for specialist review and intervention

Standardised process for accessing pressure redistributing equipment

Locally agreed process to include skin assessment in handover between care settings

Clear process for people, families, and carers to access healthcare for PU related concerns





Secondary Driver

Shared decision making

Change ideas

What matters to you conversations to inform decision making

Non-concordance documented in line with locally defined process

Provision of accessible treatment information to facilitate shared decision making

Use of realistic medicine approach to inform decision making

Evidence and Guidelines:

- Care Inspectorate. Guide for Providers on Personal Planning –
 Adults. 2021. Available from:
 https://hub.careinspectorate.com/media/4665/personal-plans-guide-adults-final-05112021.pdf
- Scottish Government. Realistic Medicine: A Fair and Sustainable Future: Chief Medical Officer for Scotland annual report [online]. 2022; Available from: https://www.gov.scot/publications/cmo-annual-report-2022-realistic-medicine-fair-sustainable-future/pages/1/

- Healthcare Improvement Scotland. What matters to you? [online]. 2021; Available from: https://www.whatmatterstoyou.scot/
- NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021. Available from: http://www.healthliteracyplace.scot.nhs.uk/toolkit/techniques/
- NHS inform. Pressure ulcers [online]. 2020. Available from: https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers
- TURAS: NHS Education for Scotland. Realistic Medicine [online]. 2022. Available from: https://learn.nes.nhs.scot/18350/realistic-medicine







Secondary Driver

Person centred care planning

Change ideas

Evidence of person centred care planning / Individualised care agreement

Collaborative care planning involving person, family and carer

Testing of tools to communicate person's physical and cognitive ability

Locally agreed use of what matters to you conversations

Evidence and Guidelines:

- Care Inspectorate. Guide for Providers on Personal Planning –
 Adults. 2021. Available from:
 https://hub.careinspectorate.com/media/4665/personal-plans-guide-adults-final-05112021.pdf
- Scottish Government. Realistic Medicine: A Fair and Sustainable Future: Chief Medical Officer for Scotland annual report [online]. 2022. Available from: https://www.gov.scot/publications/cmo-annual-report-2022-realistic-medicine-fair-sustainable-future/pages/1/

- Alzheimer Scotland. Getting to know me [online]. 2013. Available from: https://www.alzscot.org/ourwork/dementia-support/information-sheets/getting-to-know-me
- NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021. Available from: http://www.healthliteracyplace.scot.nhs.uk/toolkit/techniques/
- NHS inform. Pressure ulcers [online]. 2020. Available from: https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers
- Nursing & Midwifery Council. Person-centred care [online]. 2020. Available from: https://www.nmc.org.uk/standards/code/code-in-action/person-centred-care/
- Scottish Government. Shared decision making in realistic medicine: what works [online]. 2019. Available from: https://www.gov.scot/publications/works-support-promote-shared-decision-making-synthesis-recent-evidence/
- Scottish Social Services Council. Building collaboration and compassion for integrated working. A booklet of stories for the social service workforce [online]. 2018. Available from: https://lms.learn.sssc.uk.com/course/view.php?id=6







Secondary Driver

Multidisciplinary evidence-based interventions

Change ideas

Use of evidence-based interventions

Delivery of evidencebased wound management Appropriate and timely use of pressure redistributing equipment

Locally defined criteria & process for pressure ulcer photography to inform wound management

Evidence and Guidelines:

- Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020. Available from:
 - https://www.healthcareimprovementscotland.org/our_work/st andards and guidelines/stnds/pressure ulcer standards.aspx
- Shi C, Dumville JC, Cullum N, Rhodes S, McInnes E, Goh EL, et al. Beds, overlays and mattresses for preventing and treating pressure ulcers: an overview of Cochrane Reviews and network meta-analysis. Cochrane Database of Systematic Reviews. 2021;8:CD013761.

- Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019. Available from:
 https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.aspx
- Healthcare Improvement Scotland. SSKIN care bundle [online]. 2020. Available from:
 https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/sskin_care_bundle.aspx
- Healthcare Improvement Scotland. What matters to you? [online]. 2021. Available from: https://www.whatmatterstoyou.scot/
- NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021. Available from: http://www.healthliteracyplace.scot.nhs.uk/toolkit/techniques/







Change ideas

Timely reassessment of skin

Regular collaborative review of person centred care plan

Standardised care rounding process

Timely review

Evidence and Guidelines:

- Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020. Available from: https://www.healthcareimprovementscotland.org/our_work/st andards and guidelines/stnds/pressure_ulcer_standards.aspx
- Royal College of Physicians. Modern ward rounds [online]. 2021.
 Available from:
 https://www.rcplondon.ac.uk/projects/outputs/modern-ward
 - https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds
- Ryan L, Jackson D, Woods C, Usher K. <u>Intentional rounding An integrative literature review</u>. J Adv Nurs. 2018; 75(6): 1151-61.

- Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019. Available from:
 https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.aspx
- Healthcare Improvement Scotland. SSKIN care bundle [online]. 2020. Available from:
 https://www.healthcareimprovementscotland.org/our work/patient safety/tissue viability/sskin care bundle.

 aspx
- Healthcare Improvement Scotland. What matters to you? [online]. 2021. Available from: https://www.whatmatterstoyou.scot/
- NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021. Available from: http://www.healthliteracyplace.scot.nhs.uk/toolkit/techniques/





Change ideas

road process to Clear process for p

Equitable access to clearly defined care pathways

Locally defined criteria & process for specialist review and intervention

Standardised process for accessing pressure redistributing equipment

Locally agreed process to include skin assessment in handover between care settings

Clear process for people, families, and carers to access healthcare for PU related concerns

Evidence and Guidelines:

- Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020. Available from:
 - https://www.healthcareimprovementscotland.org/our_work/st andards and guidelines/stnds/pressure_ulcer_standards.aspx
- Shi C, Dumville JC, Cullum N, Rhodes S, McInnes E, Goh EL, et al. Beds, overlays and mattresses for preventing and treating pressure ulcers: an overview of Cochrane Reviews and network meta-analysis. Cochrane Database of Systematic Reviews. 2021;8:CD013761.

- Healthcare Improvement Scotland. What matters to you? [online]. 2021. Available from: https://www.whatmatterstoyou.scot/
- NHS Education Scotland. SBAR [online]. Available from: https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar
- NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021. Available from: http://www.healthliteracyplace.scot.nhs.uk/toolkit/techniques/
- NHS inform. Pressure ulcers[online]. 2020. Available from: https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers
- Scottish Government. Shared decision making in realistic medicine: what works [online]. 2019. Available from: https://www.gov.scot/publications/works-support-promote-shared-decision-making-synthesis-recent-evidence/
- TURAS: NHS Education for Scotland. Realistic Medicine [online]. 2022. Available from: https://learn.nes.nhs.scot/18350/realistic-medicine

Primary Driver: Multidisciplinary team communication





Secondary Driver

Change ideas

Transitions in care setting

to include skin assessment in handover between care settings

Process to include pressure ulcer information in immediate discharge letter

Reliable process for timely access to pressure redistributing equipment in new care setting

Locally agreed process to involve carers in planning for transitions in care

Use of standardised communication tools

Use of locally agreed communication tools such as SBAR

Evidence of locally agreed pressure ulcer documentation

Management of communication in different situations

Locally agreed process to identify people with a pressure ulcer + NEWS2≥ at organisational huddles

Identification of people at risk of, or currently with pressure ulcers at team safety briefs / hand overs Use of structured multidisciplinary meetings which include skin related concerns

Locally agreed process for sharing information between services

Primary Driver:Multidisciplinary team communication







Secondary Driver

Change ideas

to include skin assessment in handover between care settings

Process to include pressure ulcer information in immediate discharge letter

Reliable process for timely access to pressure redistributing equipment in new care setting

to involve carers in planning for transitions in care

setting

Transitions in care

Evidence and Guidelines:

- National Institute for Health and Care Excellence (NICE).
 Emergency and acute medical care in over 16s. Quality standard [QS174]. Quality statement 4: Structured patient handovers [online]. Available from:
 - https://www.nice.org.uk/guidance/qs174/chapter/Quality-statement-4-Structured-patient-handovers
- Rowan B et al. <u>The impact of huddles on a multidisciplinary healthcare teams' work engagement, teamwork and job satisfaction: A systematic review</u>. J Eval Clin Pract.
 2022;28(3):382-92.
- Suva G et al. <u>Strategies to support pressure injury best practices</u>
 <u>by the inter-professional team: A systematic review</u>. Int Wound J.
 2018;15(4):580-89.

- Care Inspectorate. Good practice communication guide for managers [online]. 2019. Available from: https://hub.careinspectorate.com/media/3538/good-practice-communication-guide-for-managers.pdf
- NHS Education Scotland. Structured Handover Education Project [online]. Available from: https://learn.nes.nhs.scot/704/patient-safety-zone/structured-handover-education-project
- NHS Education Scotland. SBAR [online]. Available from: https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar

Primary Driver: Multidisciplinary team communication







Secondary Driver

Use of standardised communication tools

Change ideas

Use of locally agreed communication tools such as SBAR

Evidence of locally agreed pressure ulcer documentation

Evidence and Guidelines:

- Cho S, Lee J L, Kim K S, Kim E M. <u>Systematic Review of Quality Improvement Projects Related to Intershift Nursing Handover</u>. J Nurs Care Qual. 2022; 37(1):8-14.*
- National Institute for Health and Care Excellence (NICE).
 Emergency and acute medical care in over 16s. Quality standard [QS174]. Quality statement 4: Structured patient handovers [online]. Available from:

https://www.nice.org.uk/guidance/qs174/chapter/Quality-statement-4-Structured-patient-handovers

- Care Inspectorate. Good practice communication guide for managers [online]. 2019. Available from: https://hub.careinspectorate.com/media/3538/good-practice-communication-guide-for-managers.pdf
- NHS Education Scotland. Structured Handover Education Project [online]. Available from: https://learn.nes.nhs.scot/704/patient-safety-zone/structured-handover-education-project
- NHS Education Scotland. SBAR [online]. Available from: https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar
- Park L J. Using the SBAR handover tool. Br J Nurs. 2020;29(14):812-13.*

^{*}Please note these resources may require an NHS login to access.

Multidisciplinary team communication







Secondary Driver

Management of communication in different situations

Change ideas

Locally agreed process to identify people with a pressure ulcer + NEWS2≥ at organisational huddles

Identification of people at risk of, or currently with pressure ulcers at team safety briefs / hand overs

Use of structured multidisciplinary meetings which include skin related concerns

Locally agreed process for sharing information between services

Evidence and Guidelines:

- Rowan B et al. The impact of huddles on a multidisciplinary healthcare teams' work engagement, teamwork and job satisfaction: A systematic review. J Eval Clin Pract. 2022; 28(3):382-92.
- Ryan S et al. Do safety briefings improve patient safety in the acute hospital setting. A systematic review. J Adv Nurs. 2019;75(10):2085-98.
- Suva G et al. Strategies to support pressure injury best practices by the inter-professional team: A systematic review. Int Wound J. 2018;15(4):580-89.
- Tran TH, de Boer J, Gyorki D E, Krishnasamy M. Optimising the quality of multidisciplinary team meetings: A narrative review. Cancer Med J. 2022;11(9):1965-71.

- Institute for Healthcare Improvement. Conduct Safety Briefings [online]. 2018. Available from: https://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx
- Institute for Healthcare Improvement. Huddles [online]. 2021. Available from: https://www.ihi.org/resources/Pages/Tools/Huddles.aspx
- NHS Education Scotland. SBAR [online]. Available from: https://learn.nes.nhs.scot/3408/quality-improvementzone/qi-tools/sbar
- Scottish Social Services Council. Building collaboration and compassion for integrated working. A booklet of stories for the social service workforce [online]. 2018. Available from: https://lms.learn.sssc.uk.com/course/view.php?id=6

Primary Driver: Leadership to support a culture of safety at all levels







Secondary Driver

Workforce with skills in prevention and management of pressure ulcers

Change ideas

role specific staff
education

Locally defined process to develop staff knowledge and areas of competence Access to local expertise to support workforce development

Staff wellbeing and psychological safety

Mechanisms for staff to discuss safe delivery of care

Celebrate success in pressure ulcer improvement work

Process to access senior support and discussion

Safe Staffing

Mechanism for effective rostering

Process for mitigation of staffing shortfalls

Process to escalate staffing shortfalls which impact on safe delivery of care

System for learning

Process for people, families and carers to raise safety issues

Local and organisational level reporting for learning

Standardised PU investigation tool & process to share learning

Accessing shared learning through formal and informal networks

Leadership to support a culture of safety at all levels





SCOTTISH **PATIENT**



Workforce with skills in prevention and management of pressure ulcers

Change ideas

role specific staff
education

Locally defined process to develop staff knowledge and areas of competence Access to local expertise to support workforce development

Evidence and Guidelines:

- G Kim, Park M, K Kim. <u>The Effect of Pressure Injury Training for Nurses: A Systematic Review and Meta-analysis</u>. Adv Skin Wound Care. 2020;33(3):1-11.
- Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020. Available from:

https://www.healthcareimprovementscotland.org/our_work/standards and guidelines/stnds/pressure_ulcer_standards.as_px

Tools and Resources:

NHS Education for Scotland (NES). Prevention and management of pressure ulcers [online]. 2022. Available from: https://learn.nes.nhs.scot/3886/infection-prevention-and-control-ipc-zone/sipcep-intermediate-layer/skin-integrity/prevention-and-management-of-pressure-ulcers

Leadership to support a culture of safety at all levels







Secondary Driver

Change ideas

Staff wellbeing and psychological safety

Mechanisms for staff to discuss safe delivery of care

Celebrate success in pressure ulcer improvement work

Process to access senior support and discussion

Evidence and Guidelines:

- Institute for Healthcare Improvement. IHI Framework for Improving Joy in Work [online]. 2017. Available from: https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
- Maben J, Ball J, Edmondson A.C. Workplace Conditions.
 Cambridge University Press [online]. 2023. Available from: https://www.cambridge.org/core/elements/workplace-conditions/25C68A33BEA428485932BB4E66847133

- National Wellbeing Hub [online]. Available from: https://wellbeinghub.scot
- Scottish Social Services Council. Coaching for Wellbeing [online]. Available from: https://news.sssc.uk.com/news/coaching-for-wellbeing
- The Kings Fund. The importance of psychological safety: Amy Edmunson. [online]. Available from: https://www.youtube.com/watch?v=eP6guvRt0U0









Secondary Driver

Change ideas

Process for mitigation of staffing shortfalls

Process to escalate staffing shortfalls which impact on safe delivery of care

Safe Staffing

Mechanism for effective rostering

Evidence and Guidelines:

- Scottish Government. Health and Care (Staffing) (Scotland) Act 2019 [online]. 2019; Available from: https://www.legislation.gov.uk/asp/2019/6/contents/enacted
- Griffiths P, et al. <u>The Association Between Nurse Staffing and Omissions in Nursing Care: A Systematic Review</u>. J Adv Nurs. 2018;74(7):1474-87.

Tools and Resources:

Healthcare Improvement Scotland. Staffing (workload) tools and methodology [online]. Available from:
 https://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_program_me/staffing_workload_tools.aspx

Leadership to support a culture of safety at all levels









Secondary Driver

Change ideas

System for learning Process for people, families and carers to raise safety issues

Local and organisational level reporting for learning

Standardised PU investigation tool & process to share learning

Accessing shared learning through formal and informal networks

Evidence and Guidelines:

- Healthcare Improvement Scotland. Adverse events Guidance on national notification data: January 2022. Available from: https://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=105f7c3e-fcbd-4887-8eb9-f7e37c16a0b3&version=-1
- Healthcare Improvement Scotland. Learning from adverse events through reporting and review. A national framework for Scotland [online]. 2019. Available from: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx
- Care Inspectorate. Quality Improvement and Involvement Strategy 2022-2025. 2022. Available from: https://hub.careinspectorate.com/how-we-support-improvement/improvement-support-section/
- Clark M, Young T, Fallon M. <u>Systematic review of the use of Statistical Process Control methods to measure the success of pressure ulcer prevention</u>. Int Wound J. 2018;15(3):391-401.

- Healthcare Improvement Scotland. SPSP Essentials of Safe Care, Readiness for Change Assessment &
 Prioritisation Tool. 2021. Available from: https://ihub.scot/media/8197/20210308-eosc-readiness-tool-v012.pdf. Further details here: Essentials of safe care | Scottish Patient Safety Programme (SPSP) | ihub-Essentials of Safe Care
- NHS Education for Scotland. Quality Improvement journey [online]. 2021. Available from: https://learn.nes.nhs.scot/4095

Healthcare Improvement Scotland One Team Approach



Alongside our Expert Reference Group, the Pressure ulcer change package and measurement framework was developed in collaboration with various teams and departments within Health Improvement Scotland. This One Team approach ensured consistency across programmes with regards to the development of the aim, measures and reporting and presenting data for improvement.

Evidence and
Evaluation for
Improvement Team
(EEvIT)

Through the provision of literature searches, best available evidence informed the development of the Change package.

Data Measurement and Business Intelligence (DMBI)

Providing expertise on all measures, developing a measurement toolkit for teams to use when recording data and presenting data for improvement.

Acute Care Portfolio

Responsible for planning, leading and developing the Change package providing care settings with updated evidence, resources and tools for improvement.

Excellence in Care (EiC)

Contributing to our Expert Reference Groups to advise and ensure alignment with current EiC measures.

National Adverse Events Advising on current National Reporting standardisation to ensure consistency for teams reporting Pressure Ulcers through Adverse Event reporting.*

Primary Care Portfolio Ensuring Primary care teams continue to be updated on the development of the change package to promote best practice.

^{*}Currently, the National Standardised Data Set does not require pressure ulcers to be reported as avoidable / unavoidable. The term 'acquired' will be used to inform the aim of the Pressure Ulcer driver diagram and will be updated if any changes develop.

Contact details





his.acutecare@nhs.scot



@SPSP_AcuteAdult @ihubscot

Edinburgh Office Glasgow Office

Gyle Square Delta House

1 South Gyle Crescent 50 West Nile Street

Edinburgh Glasgow

EH12 9EB G1 2NP

0131 623 4300 0141 225 699