

**SPSP Acute Adult Programme Pressure Ulcer Change Package 2023**

Improvement Hub

Enabling health and social care improvement

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Contents

[Introduction 4](#_Toc139530257)

[Contents and how to use the package 5](#_Toc139530258)

[Project Aim 6](#_Toc139530259)

[Driver Diagram and change ideas 7](#_Toc139530260)

[Pressure Ulcer Driver Diagram 2023 8](#_Toc139530261)

[Primary Driver: Prevention and identification of pressure damage 10](#_Toc139530262)

[Secondary driver: Evidence based risk assessment 11](#_Toc139530263)

[Secondary driver: Person, family, and carer involvement in prevention 12](#_Toc139530264)

[Secondary driver: Accurate pressure ulcer grading 13](#_Toc139530265)

[Primary Driver: Person centred, evidence based care 14](#_Toc139530266)

[Secondary driver: Shared decision making 16](#_Toc139530267)

[Secondary driver: Person centred care planning 17](#_Toc139530268)

[Secondary driver: Multidisciplinary evidence-based interventions 18](#_Toc139530269)

[Secondary driver: Timely review 19](#_Toc139530270)

[Secondary driver: Equitable access to clearly defined care pathways 20](#_Toc139530271)

[Primary Driver: Multidisciplinary team communication 21](#_Toc139530272)

[Secondary driver: Management of communication in different situations 21](#_Toc139530273)

[Secondary driver: Transitions in care setting 22](#_Toc139530274)

[Secondary driver: Use of standardised communication tools 23](#_Toc139530275)

[Secondary driver: Management of communication in different situations 24](#_Toc139530276)

[Primary Driver: Leadership to support a culture of safety at all levels 25](#_Toc139530277)

[Secondary driver: Workforce with skills in prevention and management of pressure ulcers 26](#_Toc139530278)

[Secondary driver: Staff wellbeing and psychological safety 27](#_Toc139530279)

[Secondary driver: Safe staffing 28](#_Toc139530280)

[Secondary driver: System for learning 29](#_Toc139530281)

[Healthcare Improvement Scotland – One Team Approach 30](#_Toc139530282)

[Measurement 31](#_Toc139530283)

[Outcome measures 31](#_Toc139530284)

[Process measures 31](#_Toc139530285)

[Balancing measures 31](#_Toc139530286)

[Contact 32](#_Toc139530287)

[END 32](#_Toc139530288)

# 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 [discovery conversation model](https://ihub.scot/project-toolkits/people-led-care/care-experience-discovery-conversation-guide/), 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

What is included in this change package?

This change package includes: a driver diagram, a national aim, primary drivers, secondary drivers, and change ideas.

Guidance on using this change package

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?”**

Understanding your system

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.

Listed below are some methods to understand your system. For more information, visit the [QI Zone](https://learn.nes.nhs.scot/1262).

* [Stakeholder Analysis is used to identify, prioritise and understand your stakeholders](https://learn.nes.nhs.scot/27433/quality-improvement-zone/qi-tools/stakeholder-analysis).
* [Process Mapping is used to outline the sequential steps in a process.](https://learn.nes.nhs.scot/2272/qi-tools/quality-improvement-zone/process-mapping)
* [Cause and Effect Analysis is used to explore and record likely causes of problems](https://learn.nes.nhs.scot/2363/qi-tools/quality-improvement-zone/cause-and-effect-diagram).
* [Forcefield analysis helps teams identify, discuss and assess the forces for and against a proposed change](https://learn.nes.nhs.scot/2338/qi-tools/quality-improvement-zone/force-field-analysis).
* [User experience (including surveys) methodology is used to gather information from the perspective of a person who interacts with and/or receives something from a service (content under development)](https://learn.nes.nhs.scot/10493/quality-improvement-zone/improvement-journey/understand-system/why-it-is-important-to-understand-your-system).
* [Pareto charts help teams identify and focus on areas of improvement with the biggest impact.](https://learn.nes.nhs.scot/2348/qi-tools/quality-improvement-zone/pareto-chart)

# Project Aim

Setting a project aim

All quality improvement projects should have an aim that follows the acronym known as STAN - Specific, Time bound, Aligned to the NHS board’s objectives and Numeric.

NHS boards are encouraged to set their own local aims specific to their context.

The national aim for SPSP Acute Adult Pressure Ulcer is:

* reduce the number of acquired pressure ulcers developed in [*insert care setting*], by [*insert* *locally agreed aim*], by [*insert* *locally agreed date*]

*(Pressure ulcers graded greater than or equal to 2, including: combination lesions, device related, mucosal suspected deep tissue injury, and ungradable)*

# Driver Diagram and change ideas

What is a driver diagram?

A driver diagram presents an organisation or teams’ theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way, and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers.

The following pages provide a list of change ideas for the early recognition and response to pressure ulcers. They are grouped by the primary driver that they influence. Project teams should select change ideas to implement. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way of generating ideas is to use the question “How might we?” For example, “How might we engage with patients and their families to improve the experience of care when in hospital?”

# Pressure Ulcer Driver Diagram 2023

Aim:

National Aim:

* Reduce the number of acquired pressure ulcers developed in [*insert care setting*], by [*insert* *locally agreed aim*], by [*insert* *locally agreed date*]

*(Pressure ulcers graded greater than or equal to 2, including: combination lesions, device related, mucosal suspected deep tissue injury, and ungradable)*

Primary Driver: Prevention and identification of pressure damage

Secondary Drivers:

* Evidence based risk assessment
* Person, family, and carer involvement in prevention
* Accurate pressure ulcer grading

Primary Driver: Person centred, evidence based care

Secondary Drivers:

* Shared decision making
* Person centred care planning
* Multidisciplinary evidence-based interventions
* Timely review
* Equitable access to clearly defined care pathways

Primary Driver: Multidisciplinary Team communication

Secondary Drivers:

* Transitions in care setting
* Use of standardised communication tools
* Management of communication in different situations

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

Secondary Drivers:

* Workforce with skills in prevention and management of pressure ulcers
* Staff wellbeing and psychological safety
* Safe Staffing
* System for learning

### Essentials of Safe Care

Elements of SPSP Essentials of Safe Care are integrated throughout this driver diagram. The full list of relevant sections is provided below.

Primary Driver: Prevention and identification of pressure damage

* Person, family, and carer involvement in prevention

Primary Driver: Person centred, evidence based care

* Person centred care planning

Primary Driver: Multidisciplinary Team communication

* Use of standardised communication tools
* Management of communication in different situations

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

* Staff wellbeing and psychological safety
* Safe Staffing
* System for learning

For further information, please see the [Essentials of Safe Care](https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/).

# Primary Driver: 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

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 prevention of pressure ulcers
* Promotion of public information on pressure ulcer prevention available in accessible formats
* Process to identify and mitigate barriers to following pressure ulcer prevention guidance

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

Primary Driver: 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](https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx).

[Walker RM, Gillespie BM, McInnes E, Moore Z, Eskes AM, Patton D, et al. Prevention and treatment of pressure injuries: A meta-synthesis of Cochrane Reviews. Journal of Tissue Viability. 2020;29(4):227-43](https://pubmed.ncbi.nlm.nih.gov/32624289/).

### Tools and Resources:

[Care Inspectorate. Tissue Viability. Template policy for adult services [online] 2017.](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.](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.](https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability.aspx)

[National Institute for Health and Care Excellence. Social Care Institute for Excellence. Helping to prevent pressure ulcers: A quick guide for registered managers of care homes [online] 2019.](https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/helping-to-prevent-pressure-ulcers#download-this-guide)

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. Patient involvement in pressure ulcer prevention and adherence to prevention strategies: An integrative review International Journal of Nursing Studies. 2020;101: e103449](https://pubmed.ncbi.nlm.nih.gov/31706155/).

[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. International Journal of Nursing Studies. 2021;122: e104014](https://pubmed.ncbi.nlm.nih.gov/34274772/).

### Tools and Resources:

[Healthcare Improvement Scotland. What matters to you? [online]. 2021.](https://www.whatmatterstoyou.scot/)

[NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021.](https://www.healthliteracyplace.org.uk/toolkit/techniques/)

[NHS Education for Scotland. Person centred care [online]. 2021](https://www.nes.scot.nhs.uk/our-work/person-centred-care/).

[NHS Inform. About pressure ulcers [online]. 2020](https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers).

Primary Driver: 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. Journal of Clinical Nursing. 2022;00:1-14](https://pubmed.ncbi.nlm.nih.gov/35191111/).

[NHS Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019](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](https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx).

### Tools and Resources:

[Care Inspectorate. Tissue viability. Template policy for adult services [online]. 2017](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.](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](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](https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.aspx).

[Society of Tissue Viability. Skin assessment: Assessing skin on patients with darker skin tones in relation to PU prevention [online]. 2021](https://societyoftissueviability.org/resources/skin-assessment-assessing-skin-on-patients-with-darker-skin-tones-in-relation-to-pu-prevention/).

# Primary Driver: Person centred, evidence based care

Secondary driver: Shared decision making

### Change ideas:

* 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

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

Secondary driver: Multidisciplinary evidence-based interventions

### Change ideas:

* Use of evidence-based interventions
* Delivery of evidence-based wound management
* Appropriate and timely use of pressure redistributing equipment
* Locally defined criteria & process for pressure ulcer photography to inform wound management

Secondary driver: Timely review

### Change ideas:

* Timely reassessment of skin
* Regular collaborative review of person centred care plan
* Standardised care rounding process

Secondary driver: Equitable access to clearly defined care pathways

### Change ideas:

* 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

Primary Driver: Person centred, evidence based care

## 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 [online] 2021](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](https://www.gov.scot/publications/cmo-annual-report-2022-realistic-medicine-fair-sustainable-future/pages/1/).

### Tools and Resources:

[Healthcare Improvement Scotland. What matters to you? [online]. 2021](https://www.whatmatterstoyou.scot/).

[NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021.](https://www.healthliteracyplace.org.uk/toolkit/techniques/)

[NHS inform. Pressure ulcers [online]. 2020](https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers).

[TURAS: NHS Education for Scotland. Realistic Medicine [online]. 2022](https://learn.nes.nhs.scot/18350/realistic-medicine).

Primary Driver: Person centred, evidence based care

## 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 [online]. 2021](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](https://www.gov.scot/publications/cmo-annual-report-2022-realistic-medicine-fair-sustainable-future/pages/1/).

### Tools and Resources:

[Alzheimer Scotland. Getting to know me [online]. 2013](https://www.alzscot.org/our-work/dementia-support/information-sheets/getting-to-know-me).

[NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021.](https://www.healthliteracyplace.org.uk/toolkit/techniques/)

[NHS inform. Pressure ulcers [online]. 2020](https://www.nhsinform.scot/illnesses-and-conditions/skin-hair-and-nails/pressure-ulcers).

[Nursing & Midwifery Council. Person-centred care [online]. 2020](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](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](https://lms.learn.sssc.uk.com/course/view.php?id=6).

Primary Driver: Person centred, evidence based care

## Secondary driver: Multidisciplinary evidence-based interventions

### Change ideas:

* Use of evidence-based interventions
* Delivery of evidence-based 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](https://www.healthcareimprovementscotland.org/our_work/standards_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](https://pubmed.ncbi.nlm.nih.gov/34398473/)

### Tools and Resources:

[Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019](https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.aspx).

[Healthcare Improvement Scotland. SSKIN care bundle [online]. 2020](https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/sskin_care_bundle.aspx).

[Healthcare Improvement Scotland. What matters to you? [online]. 2021](https://www.whatmatterstoyou.scot/).

[NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021.](https://www.healthliteracyplace.org.uk/toolkit/techniques/)

Primary Driver: Person centred, evidence based care

## Secondary driver: Timely review

### Change ideas:

* Timely reassessment of skin
* Regular collaborative review of person centred care plan
* Standardised care rounding process

### Evidence and Guidelines:

[Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020](https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx).

[Royal College of Physicians. Modern ward rounds [online]. 2021](https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds).

[Ryan L, Jackson D, Woods C, Usher K. Intentional rounding – An integrative literature review. Journal of Advanced Nursing. 2018; 75(6): 1151-61](https://pubmed.ncbi.nlm.nih.gov/30375025/).

### Tools and Resources:

[Healthcare Improvement Scotland. Grading and prevalence tools [online]. 2019](https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/grading_and_tools.aspx).

[Healthcare Improvement Scotland. SSKIN care bundle [online]. 2020](https://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/sskin_care_bundle.aspx).

[Healthcare Improvement Scotland. What matters to you? [online]. 2021](https://www.whatmatterstoyou.scot/).

[NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021.](https://www.healthliteracyplace.org.uk/toolkit/techniques/)

Primary Driver: Person centred, evidence based care

## Secondary driver: Equitable access to clearly defined care pathways

### Change ideas:

* 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](https://www.healthcareimprovementscotland.org/our_work/standards_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](https://pubmed.ncbi.nlm.nih.gov/34398473/)

### Tools and Resources:

[Healthcare Improvement Scotland. What matters to you? [online]. 2021](https://www.whatmatterstoyou.scot/).

[NHS Education Scotland. SBAR [online]](https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar).

[NHS Education for Scotland. The Health Literacy Place: Techniques [online]. 2021.](https://www.healthliteracyplace.org.uk/toolkit/techniques/)

[NHS inform. Pressure ulcers [online]. 2020](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](https://www.gov.scot/publications/works-support-promote-shared-decision-making-synthesis-recent-evidence/).

[TURAS: NHS Education for Scotland. Realistic Medicine [online]. 2022](https://learn.nes.nhs.scot/18350/realistic-medicine).

# Primary Driver: Multidisciplinary team communication

Secondary driver: Transitions in care setting

### Change ideas:

* Locally agreed process 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

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

## 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 conditions
* Locally agreed process for sharing information between services

Primary Driver: Multidisciplinary team communication

## Secondary driver: Transitions in care setting

### Change ideas:

* Locally agreed process 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

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

[Rowan B et al. The impact of huddles on a multidisciplinary healthcare teams' work engagement, teamwork and job satisfaction: A systematic review. Journal of Evaluation of Clinical Practice. 2022;28(3):382-92](https://pubmed.ncbi.nlm.nih.gov/35174941/).

[Suva G et al. Strategies to support pressure injury best practices by the inter-professional team: A systematic review. International Wound Journal. 2018;15(4):580-89](https://pubmed.ncbi.nlm.nih.gov/29600545/).

### Tools and Resources:

[Care Inspectorate. Good practice communication guide for managers [online]. 2019](https://hub.careinspectorate.com/media/3538/good-practice-communication-guide-for-managers.pdf).

[NHS Education Scotland. Structured Handover Education Project [online]](https://learn.nes.nhs.scot/704/patient-safety-zone/structured-handover-education-project).

[NHS Education Scotland. SBAR - structured communication format [online]](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. Systematic Review of Quality Improvement Projects Related to Intershift Nursing Handover. J Nurs Care Qual. 2022; 37(1):8-14](https://pubmed.ncbi.nlm.nih.gov/34231504/).

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

### Tools and Resources:

[Care Inspectorate. Good practice communication guide for managers [online]. 2019](https://hub.careinspectorate.com/media/3538/good-practice-communication-guide-for-managers.pdf).

[NHS Education Scotland. Structured Handover Education Project [online]](https://learn.nes.nhs.scot/704/patient-safety-zone/structured-handover-education-project).

[NHS Education Scotland. SBAR - structured communication format [online]](https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar).

[Park LJ. Using the SBAR handover tool. Br J Nurs. 2020;29(14):812-13](https://pubmed.ncbi.nlm.nih.gov/32697634/).

Primary Driver: 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 conditions
* 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. Journal of Evaluation in Clinical Practice. 2022; 28(3):382-92](https://pubmed.ncbi.nlm.nih.gov/35174941/).

[Ryan S et al. Do safety briefings improve patient safety in the acute hospital setting. A systematic review. Journal of Advanced Nursing. 2019;75(10):2085-98](https://pubmed.ncbi.nlm.nih.gov/30816565/).

[Suva G et al. Strategies to support pressure injury best practices by the inter-professional team: A systematic review. International Wound Journal. 2018;15(4):580-89](https://pubmed.ncbi.nlm.nih.gov/29600545/).

[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](https://pubmed.ncbi.nlm.nih.gov/35257515/).

### Tools and Resources:

[Institute for Healthcare Improvement. Conduct Safety Briefings [online]. 2018](https://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx).

[Institute for Healthcare Improvement. Huddles [online]. 2021](https://www.ihi.org/resources/Pages/Tools/Huddles.aspx).

[NHS Education Scotland. SBAR - structured communication format [online]](https://learn.nes.nhs.scot/3408/quality-improvement-zone/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](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:

* Completion of mandatory role specific staff education
* Locally defined process to develop staff knowledge and areas of competence
* Access to local expertise to support workforce development

Secondary driver: Staff wellbeing and psychological safety

Change ideas:

* Mechanisms for staff to discuss safe delivery of care
* Celebrate success in pressure ulcer improvement work
* Process to access senior support and discussion

Secondary driver: Safe staffing

Change ideas:

* Mechanism for effective rostering
* Process for mitigation of staffing shortfalls
* Process to escalate staffing shortfalls which impact on safe delivery of care

Secondary driver: System for learning

Change ideas:

* 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

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:

* Completion of mandatory 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:

[Kim G, Park M, K Kim. The effect of pressure injury training for nurses: A systematic review and meta-analysis. Advances in skin and wound care. 2020;33(3):1-11](https://pubmed.ncbi.nlm.nih.gov/32058443/).

[Healthcare Improvement Scotland. Standards for prevention and management of pressure ulcers [online]. 2020](https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx).

### Tools and Resources:

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

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

## Secondary driver: Staff wellbeing and psychological safety

### Change ideas:

* 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](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](https://www.cambridge.org/core/elements/workplace-conditions/25C68A33BEA428485932BB4E66847133).

### Tools and Resources:

[National Wellbeing Hub [online]](https://wellbeinghub.scot/).

[Scottish Social Services Council. Coaching for Wellbeing [online]](https://news.sssc.uk.com/news/coaching-for-wellbeing).

[The Kings Fund. The importance of psychological safety: Amy Edmundson [online video]](https://www.youtube.com/watch?v=eP6guvRt0U0).

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

## Secondary driver: Safe staffing

### Change ideas:

* Mechanism for effective rostering
* Process for mitigation of staffing shortfalls
* Process to escalate staffing shortfalls which impact on safe delivery of care

### Evidence and Guidelines:

[Scottish Government. Health and Care (Staffing) (Scotland) Act 2019 [online]. 2019](https://www.legislation.gov.uk/asp/2019/6/contents/enacted).

[Griffiths P, et al. The association between nurse staffing and omissions in nursing care: A systematic review. Journal of Advanced Nursing. 2018;74(7):1474-87](https://pubmed.ncbi.nlm.nih.gov/29517813/).

### Tools and Resources:

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

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

## Secondary driver: System for learning

### Change ideas:

* 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 [online]](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](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](https://hub.careinspectorate.com/how-we-support-improvement/improvement-support-section/).

[Clark M, Young T, Fallon M. Systematic review of the use of Statistical Process Control methods to measure the success of pressure ulcer prevention. International Wound Journal. 2018;15(3):391-401](https://pubmed.ncbi.nlm.nih.gov/29446244/)

### Tools and Resources:

[Healthcare Improvement Scotland. Essentials of Safe Care, Readiness for Change Assessment & Prioritisation Tool. 2021 [online]](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](https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-essentials-of-safe-care/).

[NHS Education for Scotland. Quality Improvement journey [online]. 2021](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.
* Acute Care Portfolio - Responsible for planning, leading and developing the Change package providing care settings with updated evidence, resources and tools for improvement.
* National Adverse Events - Advising on current National Reporting standardisation to ensure consistency for teams reporting Pressure Ulcers through Adverse Event reporting (Currently, the National Standardised Data Set does not require pressure ulcers to be reported as avoidable or 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.)
* 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.
* Excellence in Care (EiC) - Contributing to our Expert Reference Groups to advise and ensure alignment with current EiC measures.
* Primary Care Portfolio - Ensuring Primary care teams continue to be updated on the development of the change package to promote best practice.

# Measurement

Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

## Outcome measures

Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

## Process measures

Process measures demonstrate that change ideas are improving the underlying processes that contribute towards pressure ulcer prevention.

## Balancing measures

Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

More detailed information can be found in the measurement framework on the [ihub website](https://ihub.scot/media/10177/20220113-pressure-ulcer-measurement-framework-v10.pdf).

# Contact

You can get in touch to provide feedback or share your plans for using the Pressure Ulcer Driver Diagram and change package by:

Email: [his.acutecare@nhs.scot](mailto:his.acutecare@nhs.scot)

Twitter: [SPSP Acute Adult twitter profile](https://twitter.com/SPSP_AcuteAdult) [ihub twitter profile](https://twitter.com/ihubscot)

#spsp247 #spspPressureUlcer

If this accessible version of our driver diagram does not fulfil your needs, please get in touch with us via email at [his.acutecare@nhs.scot](mailto:his.acutecare@nhs.scot)

[To find out more, visit the ihub website](https://www.ihub.scot)

# END

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Please contact our Equality and Diversity Advisor on 0141 225 6999   
or email his.contactpublicinvolvement@nhs.scot

Improvement Hub  
Healthcare Improvement Scotland

|  |  |
| --- | --- |
| Edinburgh Office Gyle Square 1 South Gyle Crescent Edinburgh EH12 9EB  0131 623 4300 | Glasgow Office Delta House 50 West Nile Street Glasgow G1 2NP  0141 225 6999 |

www.ihub.scot