

Scottish Patient Safety Programme - Reducing Pressure Ulcers in Care Homes Improvement Programme

Case Studies

December 2017

As part of Healthcare Improvement Scotland's Improvement Hub (ihub), Scottish Patient Safety Programme (SPSP) is a coordinated campaign of activity to increase awareness of and support the provision of safe, high quality care, whatever the setting.

This document was commissioned by SPSP's Primary Care team. The authors of the document are Cathy Sharp and Joanna Kennedy (Framework Agreement Associates). The process was supported by Sarah Harley of the Evidence and Evaluation Improvement Support Team (EEvIT).

Special thanks go to the staff of Abbey Gardens, Canniesburn and Catmoor House.



The Scottish Patient Safety Programme (SPSP) is a unique national initiative that aims to improve the safety and reliability of health and social care and reduce harm, whenever care is delivered.

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Introduction

Building on the progress being made to reduce pressure ulcers within acute hospital settings and ongoing improvement activities currently being delivered within care homes, the Scottish Patient Safety Programme (SPSP) has been working in partnership with the Care Inspectorate and Scottish Care to develop and implement a Reducing Pressure Ulcers in Care Homes Improvement Programme. Based on the Institute for Healthcare Improvement's Breakthrough Series (BTS) Collaborative model, participating care homes across five Health and Social Care Partnerships have been engaged in a process of collaborative learning and practice improvement to reduce acquired pressure ulcers.

SPSP commissioned three case studies to show how care homes are making a difference through a range of changes implemented to improve the recognition and response to pressure ulcer development; and what contextual issues have been important, namely what has helped or hindered the process.

In the context of an improvement aim to reduce acquired pressure ulcers by 50% by December 2017, each of the case study care homes found they had a low incidence of pressure ulcers at the start of the improvement programme. This shifted the focus of the programme to prevention and developing an understanding of how care homes could work proactively to prevent them becoming a problem.

The case studies that follow illustrate the use of the following approaches to improving the recognition and response to pressure ulcers:

- raising levels of knowledge and awareness amongst nursing and care staff
- improving identification, risk assessment and recording
- developing care plans
- reviewing use and availability of equipment, and
- collecting data that highlights incidence, severity and trends over time.

These changes, tested and implemented using quality improvement (QI) methodology based on the Model of Improvement, have offered the care homes an overarching approach to learning and change.

The investment of time by the participating care homes has been well spent as managers, nursing and care staff, residents and their relatives have all reported benefits.

A range of tools and resources have been developed as part of this improvement programme.

Key learning from the case studies

The following themed sections summarise the learning across the case studies in relation to how pressure ulcer recognition and response is improving, and the contextual issues that have been important.

The difference an improvement approach is making to residents' care

Greater awareness, recognition and understanding of risk and linkage of risk assessment to care planning as part of a QI approach is helping to establish more person-centred, tailored approaches for care home residents.

Through using QI methodology, staff are realising that safety isn't about adopting a single approach with all residents or not taking any risks, instead it is about assessing risks, enabling choice by honouring autonomy and dignity, acknowledging the abilities of residents and engaging relatives in decisions about care.

This approach is helping both nursing and care staff to understand what works well for different people given their care needs, preferences and capacities. This includes the timely use of more appropriate equipment and decisions about pain relief.

Better communication and relationships with relatives are also helping to enable greater choice by honouring resident autonomy and dignity, acknowledging retained abilities and engaging relatives in decisions about their family member's care. This helps to ensure a better quality of life for residents, notably at the end of life.



The role of leadership and collaborative working

Local leadership at all levels has been a crucial enabler of success in each care home. Those involved in delivering the programme in care homes have often shown great enthusiasm and commitment, frequently putting their own time into researching and developing materials or undertaking training. The successes of the initiative in each care home are based on taking the time to develop good supportive relationships between care home managers, nursing and care staff, local leads and other professionals such as district nurses and care home liaison nurses (CHLNs).

Each of the programme leads from the participating care homes has benefited from meeting others involved, receiving training and hearing about progress elsewhere. The development of leadership potential and skills has also been a benefit of involvement.

The local leads from Scottish Care, NHS boards and Health and Social Care Partnerships have provided crucial support through training, advice and access to specific interventions and tools, for example, from the NHS. They have supported care homes to develop their knowledge of QI methodology by identifying small tests of change, gathering data and recording their impact.

Focusing on carers and not just nurses has been particularly important. Carers see residents daily and are crucial in preventing the development of pressure ulcers. Their engagement has helped them to feel more knowledgeable and be more involved in developing and implementing treatment plans as individuals and teams.

Support from the managers and owners of the care homes has been fundamental to ensure that the time and resources needed have been available.

The difference an improvement approach is making to process and practice

An understanding of QI methodology provides an enduring and systematic approach to learning and change by testing, assessing and recording what works. Rather than assuming a tool from elsewhere, such as the NHS, will simply transfer to a care home context, staff used QI methodology to test a whole range of tools, adapt them and devise new ones themselves. Whilst this approach is still in its relative infancy, these case studies show that it can help staff to try out new approaches in very small ways, monitor their impact and build on their success.

Knowledge of and support to use improvement methodology has made the recording, use and sharing of data about incidence, severity and treatment more systematic. This is helping staff to see where the inherited pressure ulcers are coming from and so enables a less defensive and more systemic response.

Each care home has used multiple and simultaneous interventions/tools and the case studies show that they worked synergistically, mutually reinforcing each other. Revising the risk assessment tools to include links to treatment plans and timely use of equipment is highlighted as a particular success.

Opportunities for education and training have been crucial in building knowledge and confidence. Visual tools seem to be especially helpful in raising awareness of something that potentially few staff have seen. New tools such as the 'safety culture cards' (which allow for exploration of values, attitudes and experience) have also been well received and simple phrases like 'reacting to red' help nursing and care staff talk about what's expected of them. Staff now have better relationships with one another, and feel that they are listened to. They feel able to initiate improvements for residents themselves and support each other.

Risk assessment and better recording practices have been empowering for staff and the key has been noticing when there's a change in a resident's condition, so that care can be responsive to change. This means that staff really understand why pressure ulcers are developing and what they can do to prevent them; in this way better recording reassures staff that they are doing all they can to prevent pressure ulcers.

Embedding and sustaining improvement

All three care homes that took part in the evaluation process have plans in place to sustain the work after December 2017. The work now has a momentum of its own in each of the care homes, reflected in their enthusiastic desire to continue to use the approaches that they have trialled. In one, the pressure ulcer champions will continue to meet with the CHLNs and the tissue viability nurses to undertake training, which will be cascaded within the care home. In another, the new approaches have been embedded into the induction process for new staff. One care home is looking at how QI methodology can be used to focus on other issues such as diet or exercise. In addition, care homes are keen to share their success with other providers locally and within their own organisations.



Case study 1: Abbey Gardens

This case study is based on one-to-one and group interviews with the current improvement advisor in NHS Dumfries & Galloway, the district nurse, the care home manager and a carer in Abbey Gardens.

Introduction

Abbey Gardens is a care home in Dumfries owned by Voyage Care. It has 44 beds and provides 24-hour care and support to older people with complex mental health needs and associated sensory and physical disabilities.

Like many of the participating care homes, Abbey Gardens had a very low incidence of pressure ulcers at the start of the improvement programme. Nevertheless, the leadership in the care home was keen to work proactively to prevent them becoming a problem, so they also adopted the aim of the SPSP collaborative to reduce the incidence of pressure ulcers by 50% by December 2017.



When the SPSP work began in this care home in September 2016, there were two pressure ulcers recorded in Abbey Gardens. Since December 2016, there has been no incidence of newly acquired pressure ulcers and those inherited from other settings have been successfully treated.

The reducing pressure ulcers work was led by one member of staff, a carer, who provided an exceptional level of enthusiasm and motivation. She was well supported both by the care home manager and the care home owner, and by another carer, with whom she worked closely.

All the participating care homes in Dumfries & Galloway Health & Social Care Partnership received an education session on improvement methodology in the summer of 2016 from the NHS Dumfries & Galloway improvement advisor and the care home education facilitator (CHEF).

The CHEF already had a strong relationship with Abbey Gardens and regularly worked in the care home with staff. The carer also received strong support from both the CHEF and the improvement advisor, meeting for regular feedback sessions on the work, many of these in her own time, as she works nightshifts. Her leadership and commitment to the work was crucial. She is described by the Improvement Support Team as *'practical, down to earth, passionate and skilled in engaging – she just embraced it!'*

Being part of the work gave the carer both confidence and motivation, *'I didn't have confidence before . . . it makes your job worthwhile.'* The improvement advisor also invested a significant amount of time in Abbey Gardens, walking through the process with the staff so that they could see the benefits.

Although the improvement methodology was challenging at first, the district nurse taking part in the improvement programme commented, *'It has made all the difference, when it is used properly, it works well. It helps it to spread . . . it is there forever because of the paperwork . . .'*

The carer and the improvement advisor worked together on the small tests of change, writing them up and analysing the results. The carer said, *'It opened my eyes to different ways of thinking. She [the improvement advisor] explained the method using simple steps . . . [and] she stopped us from running.'*

The emphasis was on culture change across the whole care home, which led to changes in practice, and changes in processes and systems. This ensured that the skills and knowledge about how to reduce pressure ulcers would become embedded in the way staff work.

What's working well in terms of practice improvement?

From the outset, the carer and improvement advisor recognised that in order to reduce pressure ulcers there would need to be a change in the culture of the care home, and in staff attitudes and behaviour.

Staff surveys

They began by carrying out a baseline survey with staff to find out how they felt currently about pressure ulcer management in the care home. Initial responses were quite negative, with staff highlighting concerns about recording the incidence and severity of pressure ulcers, facilitating the potential for a 'blame culture'. As they introduced the idea of the pressure ulcer work, they met with some resistance, particularly from nursing staff who had doubts about what they were doing.

The carer overcame this resistance by using a gentle, subtle approach, taking one step at a time, getting feedback, providing information and focusing first on those staff who were keen to get involved, which often meant the night staff who were on shift with her.

The carer began with a QI board, on which she posted information about pressure ulcers, improvement methodology and a 'Wordle' created from the results of the survey. A Wordle is an online tool that creates a visual 'word cloud' from text that you provide. The clouds give greater prominence to words that appear more frequently in the source text.

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manager, to ask about anything on the QI board. This gave an opportunity to inform staff about the work, to listen to their concerns, and to give them some ownership of how it was taken forward.

The carer then introduced 'safety culture cards' in one-to-one and group meetings with staff, prompting both feedback and discussion.

The carer also held a review meeting to assess the progress of the pressure ulcer collaboration group. Six staff attended – all of whom were supportive. This was yet another test of change, whereby she monitored the difference between asking staff specifically to attend and just letting them know it was on by putting up a notice on the QI board. Now staff are asking her advice and asking her to look at residents, finding that a fresh pair of eyes is helpful.

Each test of change was carefully documented and kept in a folder. The carer created a library of resources with a library card system. She was aware that staff have different styles of learning and worked hard to make materials accessible by creating graphics, cartoons, word searches and crosswords to get simple messages across.

Tools

Particular tools that staff have found helpful include the traffic cones system where the skin condition is graded from 1-10 and the pressure ulcer body map.

Management support

The pressure ulcers work has been made possible by strong support from the care home manager, who ensured that the carer had the time to attend training and do the paperwork.

'She lets us have our wings and there are no boundaries. She says you find something and I will send you on it and I will pay for it.'

The work has also had support from the care home owner who showed a real interest in the project and was happy to support staff being freed up to go on training and, when necessary, to pay for it.

As well as attending training courses, the carer undertook her own research on how to reduce pressure ulcers, testing new ways of turning people and recording the results.

'We showed them we were learning along with them.'

The carer passed on some of her own knowledge, such as using a pillow to help move a resident/individual without waking them up, which prompted one nurse to confess, *'I had never thought of doing that.'* When the day staff could see that some things were working and benefiting the residents, they also wanted to be involved.

What difference is this making to residents' care?

Being involved in the collaborative has made a huge difference to staff morale, which will undoubtedly have an impact on residents. It has strengthened the team and made all the staff more curious. They talk to each other more.

The district nurse commented, *'It has had an impact on everything that's happening in the care home. Staff now feel both valued and respected. Before, they were frightened about making changes in case they got it wrong. Now they feel more confident to try things and run with them. It has changed the whole culture . . . which is more significant than pressure ulcers being reduced by a squidge.'*

The direct benefits to residents are a reduction in redness or pressure ulcers. The carer was particularly pleased that she was able to heal one man's pressure ulcer before he passed away.

Staff are asking for specialist equipment and the manager recently provided a £700 hoist in response to a request from staff. The manager said, *'We always had a good record on pressure ulcers, although some people came in with them from hospital or home. Now we have none.'*

How will improvement embed and sustain?

The culture change has been accompanied by structural change, which means that it is more likely to be sustainable because it not only becomes the 'way we do things round here' but is written down in policies, procedures and in training materials. For instance, the manager has ensured that the pressure ulcer work now forms part of staff induction.

Having seen the difference being involved in the collaborative made to staff and residents, the care home manager now encourages new staff to take on responsibility for different areas of research and activity.

'I would love to see this done on everything.'

Groups have been set up for physical activity, nutrition and infection control, and individual staff invited or volunteered to take a lead on them.

The success in taking forward the pressure ulcer work has inspired other care home staff to approach the improvement advisor to ask for her support. The care home company has adapted the tools for use across all their care homes.

For the manager, the pressure ulcer work has been an example of the NHS and private sector 'working together as they should be.' She has always had good relationships with the local NHS lead, the district nurses and the CHLN, but this collaborative has given them a joint piece of work which has made a big difference to the care home staff and improved the lives of residents within it.

Case study 2: Canniesburn

This case study is based on face-to-face interviews at Canniesburn Care Home with staff, a telephone interview with the CHLN and a group interview with two of the local leads for East Dunbartonshire from Scottish Care and the NHS.

Introduction

Canniesburn is an independent care home in Bearsden managed by Thistle Healthcare Ltd. It is a large home with capacity for 115 residents and with over 200 staff, of which around 10-12 are registered nurses.



The care home recently had an unannounced inspection by the Care Inspectorate that led to an improvement in grades across the board and described the home as having ‘a calm atmosphere’ where ‘staff were attentive to residents’ needs’. The home manager says they are, of course, very pleased with this inspection report and that he has been happy to support their involvement in the work to reduce pressure ulcers, which originally began under his predecessor.

The work has been taken forward enthusiastically by the deputy manager who is a nurse with over 20 years’ experience. She comments that whilst they had experience of pressure ulcers, at the start of the improvement programme, they didn’t really know their true incidence as they weren’t being asked for data, so would not have been able to produce figures to show incidence or severity. This was true across all the care homes in the locality where incidence seems to have been low; in effect, this shifted the focus of the pilot from reduction to prevention. Now the work on data collection means that the care homes are able to review their own real-time data. The biggest surprise has been that:

‘There’s not as many pressure ulcers as you might think!’ – Deputy manager

What’s working well in terms of practice improvement?

Canniesburn did not start from a blank sheet, with their record keeping being based on existing best practice:

‘We’ve been keen for some time to make sure that everything we do is documented, so we have been using a recording sheet based on SSKIN Bundles for a few years. We use this as our repositioning chart, because it gives us more detailed information. It’s kept in the person’s room – it covers the surface, skin inspection, mobility, incontinence, nutrition – and we use it with everyone who

needs repositioning. We also have an internal skin integrity referral form, to make sure that we record any change.'

This has worked well and it's an approach that they have chosen to stick with as they have embraced some new approaches too.

'Now we talk about 'reacting to red' [skin] – it's a kind of motto.'

Pressure Ulcer Daily Risk Assessment tool

Canniesburn is testing multiple and simultaneous interventions with the Pressure Ulcer Daily Risk Assessment (PUDRA) tool at the heart of the work. Much of the success rests on the good relationships and support from the CHLN, the tissue viability nurse, the local steering group and the NHS Greater Glasgow and Clyde (NHS GGC) clinical effectiveness team.

The PUDRA tool is used in all acute hospitals in Glasgow and was introduced into Canniesburn by the tissue viability nurse, who saw the opportunity to test it in care homes. It is a daily assessment that encourages checks and documentation, although it doesn't give a score like other risk assessment tools. There is general agreement that this has worked very well, although the CHLN notes it does need some revisions to apply well in a care home context. The local leads are also pleased that Canniesburn has really embraced the PUDRA:

'There was a light bulb moment for the deputy manager when she said 'I think this will work!' They really wanted to test the risk assessment tool.

There was an appetite amongst the staff - they were proactive, they engaged and they stayed engaged.'

The deputy manager now says she doesn't know what she would do without the PUDRA.

A senior care assistant who works on a unit with 18 frail residents takes a similar view.

'When someone's health declines, the SSKIN bundle alone wasn't giving us the reasons. The PUDRA tool helps care assistants see why something has happened, it helps them to check. It helps you to have much more useful information, for example, what kind of mattress do they need? It helps us to put things into place for residents much sooner, you're reassessing it every day so you can see any decline. We can then make a judgement if we need to step back, for example, if someone is in palliative care.'

Because it's company policy, staff are still using the Waterlow risk assessment tool as well for the moment, but they find it doesn't distinguish sufficiently between levels of risk and there's no automatic link to a treatment plan. The deputy manager reports that the nurses and the senior carers like the PUDRA tool and that daily 'flash meetings' help to share information about who's being assessed with the PUDRA tool.

Having better recording practices in place is helping to reassure staff.

‘We’re finding that each pressure ulcer gets classified as “unavoidable” – in other words, we have done everything we should have. For example, one resident went out with their family wearing ill-fitting shoes, against our advice and came back with blisters on their heels. It’s reassuring to us to know that we have done everything; people are frail and they will still develop pressure ulcers.’

Staff training

This success has been underpinned by other interventions. The tissue viability nurse has trained several groups of registered nurses and care support staff, with a focus on accurate diagnosis and grading. Having a CHLN in post supports the embedding of training into practice in the care home. The NHS Education for Scotland workbooks are being completed by staff nurses, team leaders and senior carers. The Scottish Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool and Scottish Excoriation and Moisture-related Skin Damage Tool have also been important resources for teams.

Red Day Review tool

The Red Day Review tool, which is also being used in the acute setting within NHS GGC, has been adapted and linked to Healthcare Improvement Scotland’s Prevention and Management of Pressure Ulcers Standards. This tool is used where the care home identifies a resident who has acquired a pressure ulcer within the care home. Together with the CHLN, they each make an assessment and come to a view about the grading, they then compare and discuss. The CHLN notes that the tool itself has been revised several times with the latest version asking explicitly about the learning.

‘We were worried that homes might find it a bit ‘big brother-ish’, but it seems to give them affirmation, validation, peer support and advice, and puts an emphasis on recording.’ – Local leads

The deputy manager agrees and likes that this grading helps staff to test their new knowledge from training and see whether they are coming to similar judgements about the categorisation. Staff take photographs and put them into care plans. In this way, they are detecting pre-grade 1 pressure ulcers.

Pressure reducing equipment

Another significant element of the work was understanding how equipment delays may have previously contributed to otherwise avoidable pressure ulcers; and how the more efficient and effective use of appropriate equipment is able to contribute to prevention and better healing times.

‘Our system for ordering wasn’t reliable, which might mean a delay for people needing something different. We’ve found we’re able to have better ordering and make savings. We also found a better option than single use heel protector boots, by ordering cheaper heel boots that are used by the NHS in Glasgow that really help people to heal. For example, one lady acquired a pressure ulcer when she was in

hospital after a fall. She's now back and we applied the PUDRA tool and she uses these boots and is healing well.' – **Deputy manager**

'We have identified that there aren't as many care home acquired pressure ulcers as people may think and those that we do have are often unavoidable. Where they are avoidable, we now understand how they have come about and have often been able to do something about the causes, for example, by addressing equipment issues.' – **Care home liaison nurse**

Using quality improvement methodology

Another important part of the new approach has been the use of QI methodology. There's acknowledgement that knowledge of QI methodology is relatively recent and not universal as it hasn't been a feature of nursing training. This element of the work has benefited from the support of NHS GGC's clinical effectiveness team. Whilst the language might have been mystifying at first, the concept hasn't been difficult to grasp.

'To some extent, this has been encouraging them to understand that what they're doing is improvement, but they are not good at recording. They need to recognise and record if they are to share.' – **Local leads**

'It's what you do every day! We had done a few tests of change without actually seeing it as that. Now we're recording it.' – **Deputy manager**

The first test of change explored whether the use of the PUDRA tool helped to identify and reduce the development of pressure ulcers. From a cohort of 60 residents, the PUDRA tool identified 18 people who had redness. A range of pressure reducing interventions were offered and none of the 18 went on to develop a pressure ulcer. Care staff feedback was positive too and helped to embed the approach for all residents who were identified at risk of pressure ulcers.

After the success of the first test, they were asking if the PUDRA tool should be used for all residents, so their second test of change was with people that were not obviously at risk but who were going to bed early. The staff tried this with three residents, asking them if they were willing to be assessed for redness. The results were that not every resident was receptive – this was a useful test in giving the care home staff a better understanding of the conditions under which they might not use the PUDRA as a matter of routine.

The NHS GGC clinical effectiveness manager acknowledges that it's been a lot of work to support all the participating care homes in East Dunbartonshire to fully embrace a more systematic, methodological approach to improvement, so that there is data to support the trialling and any wider use of specific tools. Whilst she says that Canniesburn hasn't adopted a 'textbook' approach to QI, she is pleased with their progress and would like to see more care homes using QI techniques to inform learning and change.

'It told us that the PUDRA is not for everyone and to say to the NHS who wanted us to use the PUDRA tool with everyone, "It's different here." Whilst some people might have pressure ulcers, some people do have capacity and are aware of the risks, they might have a poor appetite or a low Body Mass Index (BMI), but nevertheless, they are able to say that they don't want a daily risk assessment or perhaps wouldn't let us do it. One gentleman in this position goes out to the pub a few times a week. Even people who don't have capacity, but who are mobile, might still not be suitable for a PUDRA. Someone like that would be seen daily by a carer, helping with washing and dressing, so if redness was seen the PUDRA would be done in response to the change.' – **Deputy manager**

This useful feedback helps to establish appropriate approaches within the care home context, what works well and for whom.

'This is their home, it's not a hospital. It works better when something changes, say someone is more tired than usual and is spending more time in bed or during the hot weather people were going to bed much earlier. Staff are more alert to the kind of changes that might lead to greater risk – this is the time to do the PUDRA. If we did it for everyone, it would become a tick box exercise; it would get diluted and take a lot of extra time.' – **Deputy manager**

What difference is this making to residents' care?

This has all helped to establish better communication and relationships with relatives and better quality of life for residents, notably at the end of life.

'We didn't hide pressure ulcers before, but now I will tell family members what we're doing and why – it's more about having an open channel of communication. We've never had such a frank conversation with families before. It helps us to have good relationships with families.' – **Deputy manager**

'... It's good for families – it helps us to explain things and make good judgements. There was one lady that we were turning every two hours. She was in palliative care and we thought 'why are we doing this? Is it just to show that we're doing it?' If we turned her, we had to give her more painkillers and that made her sleepy. We consulted with the family and agreed to turn her less often. This meant that she was actually in less pain, didn't need the pain relief and was less sleepy and able to talk to her family in her last days of life.' – **Senior care assistant**

The senior care assistant is passionate about it all and says that what has been most satisfying for her is that *'... people are not in pain and have a better quality of life.'*

There are undoubted benefits for staff too in terms of motivation, feedback, communication, and confidence in their practice as individuals and teams.

'... it works! ... it makes our job easier. We can try to prevent, but when it occurs it does help us to know that you have done your job right. The carers feel more knowledgeable – they feel that they are part of the treatment plan. It gets over the stigma that carers feel. They're thinking about it, not just presuming that the nurses will know about something, when really, how could they possibly look closely at everyone's skin? The PUDRA makes it a team effort, a joint effort. It helps us do our job. Some families might question our judgement, perhaps want us to reposition someone every 15 minutes, but we can say, "Here is why we've come to this decision." There's less paperwork too, because if you do have a pressure ulcer there's a lot of paperwork. And it helps us with hospital transfer letters; we would put information on the letter so we will know if a resident's skin is intact or not when someone goes into hospital and also when they come back.' – **Senior care assistant**

How will improvement be embedded and sustained?

There is clear sense that the safety culture is changing, as these new approaches are becoming embedded. Other initiatives are also underway or planned. For the future, pressure ulcer champions will link to regular CHLN meetings and twice a year they will meet with the tissue viability service for training which they will then cascade to local teams. The deputy manager would have liked this role to be taken on by a senior carer or team leaders, but acknowledges this role will probably fall to her as a trained nurse. Working with the CHLN, the CHLN pathway for pressure damage monitoring and reporting is being tested and redesigned with the nurses and carers to suit what happens at Canniesburn.

'I'd say most of the staff, certainly all care staff, would know who's had a PUDRA. I did find that a bank staff on a night shift hadn't filled in the PUDRA, but that's been a one-off ... People are now talking about this – it's in our language.' – **Deputy manager**

The senior care assistant says they'd miss the PUDRA if they didn't have it. It's clear that this is becoming the way they work at Canniesburn and that there are potential knock-on benefits beyond the care home itself as knowledge and information improves. The deputy manager is keen to share their experience with another local care home and across all the homes in the company, whilst the manager would like to see it adopted nationwide.

'I can see that the impact goes well beyond skin integrity – even someone like the chef has an involvement when we're thinking about diet for example.' – **Home manager**

For the deputy manager, the difference is that it's protecting residents by making it more routine to write things down. This makes it easier for staff because what they are recording is more relevant to the practical measures they can take through links to an active care plan. Her view is that safety isn't about not taking any risks, but enabling choice by honouring resident autonomy and dignity, acknowledging retained abilities and engaging relatives in

decisions about their family members care – a risk assessment has to be done to let people take risks.

The key to recording is noticing when there's a change, not about making it a blanket 'one size fits all' approach, so that care can be responsive to change. The team don't think that the PUDRA is for everyone or for all of the time.

'We have a man who's had a stroke, so at the moment he can't reposition himself in bed at night. But if he recovers sufficiently to do so, we will take him off it.'

Discussing sustainability and spread, the deputy manager suggests that after the pilot ends, she's confident the improvement work will keep going and her priority is to make sure that staff continue to be involved in adapting and shaping approaches to suit the care home.

Whilst there have been some barriers to efficient data collection and questions about how best to present the data back to the care homes, having better data is really helpful for the home itself and across the wider health and social care system. For example, it allows the NHS board tissue viability nurse to see where the inherited pressure ulcers are coming from and so enables a more systemic response.

Canniesburn has relied on external help and support throughout the pilot. Having wide support from the company and wider health and social care stakeholders from the local steering group has given the deputy manager the confidence and the backing to lead the work in the care home. She has enjoyed seeing what other people are doing and sharing their activity within a collaborative, especially since care homes often feel quite isolated from one another.

'You know that we don't really speak to other care homes. I'm wondering why more care homes don't want to take this on board?'

Case study 3: Catmoor House

This case study is based on face-to-face interviews at Catmoor House with staff, a telephone interview with the professional and practice development nurse (PPDN), and a group interview with the three local leads for Perth and Kinross from Scottish Care and the Health and Social Care Partnership.

Introduction

Catmoor House in Scone, is a 40-bed nursing home managed by HC One. A recent Care Inspectorate report gave it very good grades and described a *‘welcoming, friendly and relaxed atmosphere in the home.’* Like many of the other care homes participating in the improvement programme, it has had a low incidence of pressure ulcers. When new residents have come in to the home with a pressure ulcer, the staff are proud of their record in healing them as quickly as possible.



The work to reduce pressure ulcers at Catmoor House has been carried out by a small team, led by the deputy manager and the clinical lead, with support from the care home manager. The clinical lead, who is relatively new in post after 28 years' experience in the NHS as a nurse was surprised incidence was so low.

‘We’re proud of the fact that we have such low incidence. At the moment, we have three residents who are in bed for 24 hours a day and one is on a PEG [percutaneous endoscopic gastrostomy] feed, but we have no skin issues.’

Catmoor House joined the pilot work in February 2017 and staff were keen to be part of the initiative.

‘We like to keep up with where we are – to maintain standards and keep up to date.’

They started a bit later than the other care homes so they had a dedicated, local educational workshop.

Staff are testing several different tools and interventions and are now much more confident about using improvement methodology. The Catmoor team have had QI methodology support from local leads and the PPDN for Adults and Older People, who is employed by the Health and Social Care Partnership.

Whilst the clinical lead had some knowledge of NHS improvement methodology, the deputy manager said, *'At the first meeting I was lost! I didn't know the terminology and was too embarrassed to ask. That did put me on the back foot a bit at the steering group.'*

The PPDN put this into context, *'QI methodology is even unfamiliar to some in the NHS. Catmoor [staff] were very open to trying things out and progress things. They've been really good to work with. I have mainly co-ordinated and supported on the periphery. I have visited and contacted them for updates and fed information through to the local steering group. I feel I've been a resource to them – provided information and advice and written up and analysed their questionnaires and Plan Do Study Act cycles (PDSAs).'*

What's working well in terms of practice improvement?

The Catmoor team acknowledge that they got off to a slow start. To gauge existing knowledge of pressure ulcers, they carried out an initial staff questionnaire that the PPDN analysed. This revealed the need for staff education. The PPDN observed that the team may have been nervous and it's often difficult for people to say 'I don't know'.

Over six months later, the nurses and carers are still completing the NHS Education for Scotland workbooks on the prevention and management of pressure ulcers. The Catmoor team describe this as 'work in progress'; the staff mostly complete these at home after working 12-hour shifts. Nevertheless, the learning is getting across – a repeat of the survey demonstrated more promising results and the PPDN said it was clear that staff had given it more thought.

Visual tools

Visual tools help nursing and care staff to distinguish between moisture lesions, skin tears and pressure ulcers. For example, both nursing and care staff use the Scottish Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool which shows the different categories of pressure ulcers. Posters on the walls in the staff areas of the care home also have similar visual prompts and reinforce the messages of the workbooks. An established tool within HC One, known as 'body mapping' records comments about an individual resident's skin condition as part of risk assessment. This is not necessarily done daily, although it is compulsory monthly or earlier if there are changes in skin condition, but helps to record and share anything that has changed for that resident.

Safety Cross

In taking an overview of incidence within the care home, staff have found the Safety Cross to be a useful tool. It shows, at a glance, a visual map of ongoing and newly acquired occurrence. The local leads and the care home staff agree that this is working very well.

'We have found that it's not cumbersome to do this. The care staff didn't know how to implement it at first, because the nursing staff complete the Safety Cross, but it's easy enough to make a record every day of any changes. We weren't originally recording Grade 1 pressure ulcers on the Safety Cross, but now we do. We record at the first sign of anything that's a change.'

Preliminary Pressure Ulcer Risk Assessment

The Catmoor team are most pleased about their experience of changing their use of risk assessment tools. The NHS Tayside Preliminary Pressure Ulcer Risk Assessment (PPURA) is used in both hospitals and the community. The local leads suggest that it would be a big advantage to use the same documentation across care homes as well as in the NHS and it seems as if the experience at Catmoor House would support this development.

The PPURA differs from the previously used Waterlow risk assessment tool as it has four simple questions linked to three treatment plans: A, B and C. The care home ran a trial of using the PPURA in the care home, with the top floor using PPURA and ground floor using Waterlow. The PPURA was well received by the nursing staff and the result of this trial suggested that there is no need to use the Waterlow as well and now the PPURA has replaced the Waterlow throughout the care home.

'The Waterlow could give you a high-risk score but no imperative to do anything, whereas the PPURA leads to a skin integrity care plan. A high dependency resident would be assessed more than once a day. With a low dependency resident, where there is no pressure ulcer, it would be invasive and unnecessary to check skin condition every day, although those with the retained ability can be encouraged to check their own skin. Overall, it draws attention on a more regular basis to the condition of someone's skin.'

Whilst the treatment plans can also be used with Waterlow, in practice, the local leads suggest that the Waterlow seems to be used as a measurement tool that produces a simple score, whereas PPURA has triggers for intervention and puts the emphasis on the 'So what? What's the treatment?' The Catmoor team endorse this distinction and particularly like the fact that the tool and the treatment posters come together as a package. This makes an immediate and practical difference.

'We've changed mattresses because the PPURA identified the need for better equipment, which would not have been identified from the Waterlow. We are able to get new equipment very quickly in a care setting, for example, mattresses that suit the weight of the person, individual or resident, or pressure reducing cushions. We can just order in the equipment we need. We've got rid of the standard mattresses for people at risk, which means that the intervention is at an earlier stage with better outcomes for our residents.'

Visual tools seem to be especially helpful in raising awareness of something that potentially few staff have seen. One of the carers reported, *'In eight years of being a carer I have never seen a pressure ulcer. If someone is in bed, it's always on your mind – even if I get called away, I remember that I need to go and turn someone. If I see redness I would get a nurse to come and look.'*

The Catmoor team see role modelling as an important way to influence the safety culture and get the best out of staff. By putting their leadership programme 'Caring Leaders' into practice, they lead by example to promote effective communication, good listening and sharing knowledge.

What difference is this making to residents' care?

There is clear evidence from their own tests of change that residents are benefiting due to a greater focus on prevention, improved treatment approaches and better use of equipment. Importantly, these practices are now part of the routines of the home, applied in a way that is person-centred to meet the specific individual needs of residents:

'We look at all their needs; diet, good nutrition and hydration, continence, mobility, conditions and so on. We have to treat people as individuals – what works with one won't necessarily work with another.'

'We have a resident of the day, so that no one is missed. On this day we do all the personal file assessments, diet, PPURA, body mapping and clinical assessment.'

How will improvement embed and sustain?

The care team explained that the range of changes in relation to education, risk assessment tool development, equipment access and improvement methodology are helping to embed improved practice:

'There's nothing that we would stop doing. Why would we not keep going? We've got a better risk assessment tool, we now know how to do PDSAs, we've got access to better equipment, the education materials are useful and we will continue to take pride and keep up to date . . . This work is no longer person dependent; the PPURA is just a start, but it's embedded now so it will happen anyway.'

However, the Catmoor team have needed more support and facilitation than the PPDN originally expected, partly because of the very limited time that district nurses had to support the programme. The PPDN suggests that a key lesson from her experience of implementing a QI approach in care homes is around the language:

'The jargon can be off-putting. "Test of change" is better terminology than PDSA. We need to make it simple for them – give them a good example, show them how they can tweak their existing paperwork to collect what they need.'

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