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| **Project Title: Airflow Mattress Error Reduction** |
| **Background** |
| Airflow mattresses provide pressure relief to the skin of people assessed to be at risk or have existing pressure damage. Errors in their use and settings has led to pressure damage. A survey of staff showed that often no formal training had been given and almost half reported witnessing errors with an airflow mattress that had led to pressure damage. It is believed the provision of training and access to a checklist may reduce the number of errors. |
| **Understanding the problem** |
| As there are a wide variety of airflow mattresses the challenge was developing training that would cover the crucial elements of airflow mattress use. However through the use of a staff questionnaire we were able to determine that the majority of pressure damage was related to the same errors despite the type of mattress that was being used. We were then able to develop a generic training package. Emphasising that staff should be familiar with the type of mattress being used in their care home. |
| **Aim of the project** |
| **By January 2024, all airflow mattresses used by residents at Mosswood Care Home will have the number of errors that could lead to pressure ulcer injury, reduced by 50%.** |
| **Key measures for improvement** |
| **Outcome Measures**: Percentage of risk factors/incorrect settings that could lead to pressure ulcer injury  **Process Measures***:*   * Percentage of errors identified   pre and post training/checklist*.*   * Referrals to Housekeeper by staff   **Balance measures**:   * Cost related to replacement sheets, bedrail extensions. * Possible increase in errors due to increased use of airflow functions. |
| **What changes were made during the project?** |
| Working together with the care home team from Mosswood we were able to test and develop: an airflow mattress checklist, audit and a train the trainer package that has been shown to reduce the number of errors that could lead to pressure damage significantly. |
| **Process of gathering information** |
| Weekly audit carried out on airflow mattresses in use, this was documented on an excel spreadsheet and a run chart was created. |
| **Strategy for change** |
| Initial buy in came from the manager and housekeeper who recognised that staff knew very little about how to check for errors or troubleshoot if there were issues with the airflow mattress. |
| **Effects of change** |
| * Weekly data collection indicated a reduction in errors prior to testing change concepts. This may have been due to immediate risks being identified and amended and the Hawthorne Effect (alteration of behaviour by subjects due to awareness of being monitored). * The percentage of errors remained low signalling an improvement however on testing staff 8 weeks after training only 18% could identify three or four out of four pre set errors. * As a result a checklist was tested which increased this to 83% of staff were able to identify three or four out of four pre-set errors and remedy them. |
| **Analysis and interpretation of data** |
| * Data shows we have exceeded our aim with a more than 50% reduction in errors. |
| **Next steps** |
| * Airflow mattress audit to be used by care home to monitor and sustain change. * Change package and train the trainer program to support sustainability and spread developed. * A laminated checklist provided. |