Reduction in Pressure Ulcer Incidence in a Glasgow Residential Care Home



Authors: Caroline Elsegood, Tissue Viability Nurse Specialist, Care Home Collaborative Patricia Donnelly, Operations Manager, Glasgow City HSCP Residential Home Fiona Cowan, Quality Improvement Advisor, Care Home Collaborative

Introduction:

Care Home

Collaborative

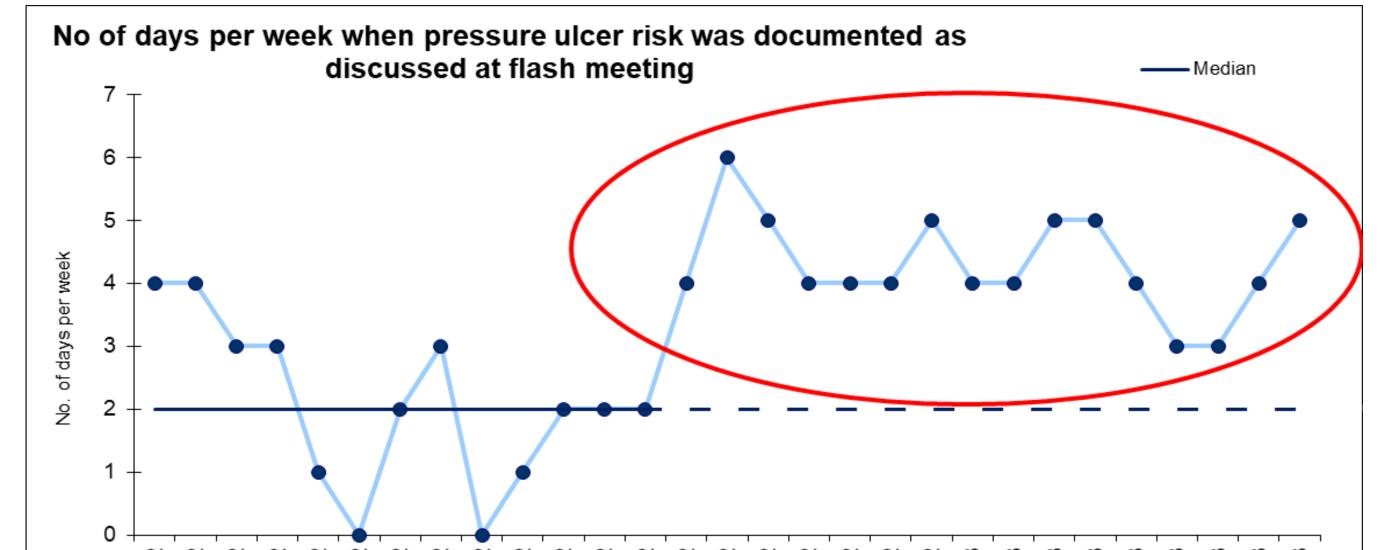
Older people living in care homes have various conditions and illnesses that can increase their risk of developing pressure ulcers. Pressure ulcers are recognised as an unwanted complication of illness, severe physical disability or increasing frailty.² Pressure ulcer prevention (PUP) is a priority work stream for the NHS Greater Glasgow and Clyde (NHSGGC) Care Home Collaborative. An increase in pressure ulcers within a care home and a local review of records identified an opportunity for improvement.

Aim:

By July 2023 there will be a 50% increase in the days between identification of avoidable Grade 2 and above pressure ulcers in line with Health Improvement Scotland Standards for Prevention and Management of Pressure Ulcers.

Measures:

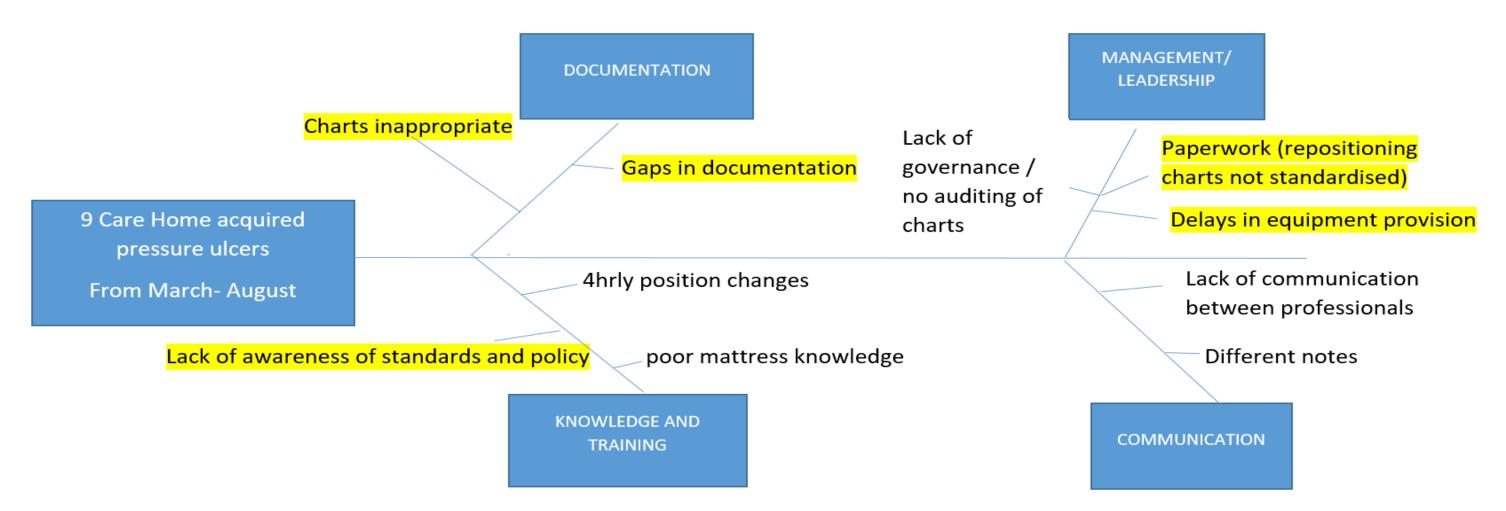
Figure 4:



Methods:

Using the fish bone analysis tool (Figure 1) staff came together to discuss the challenges and complexities of the increased incidence of pressure ulcers. Being involved in identifying changes that could lead to improvement staff felt listened to and engaged with the process.

Figure 1:



Process Changes:

A driver diagram was developed to help the team identify and communicate the change ideas and how the improvement goal could be achieved. The project team selected the change ideas in yellow below.

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- Figure 4 demonstrates that initially there was an inconsistent approach to the inclusion of a PUP section within the flash meetings.
- As staff became familiar with the process, an increase was noted in the number of days each week where PUP was discussed as part of their flash meetings.

Figure 5:

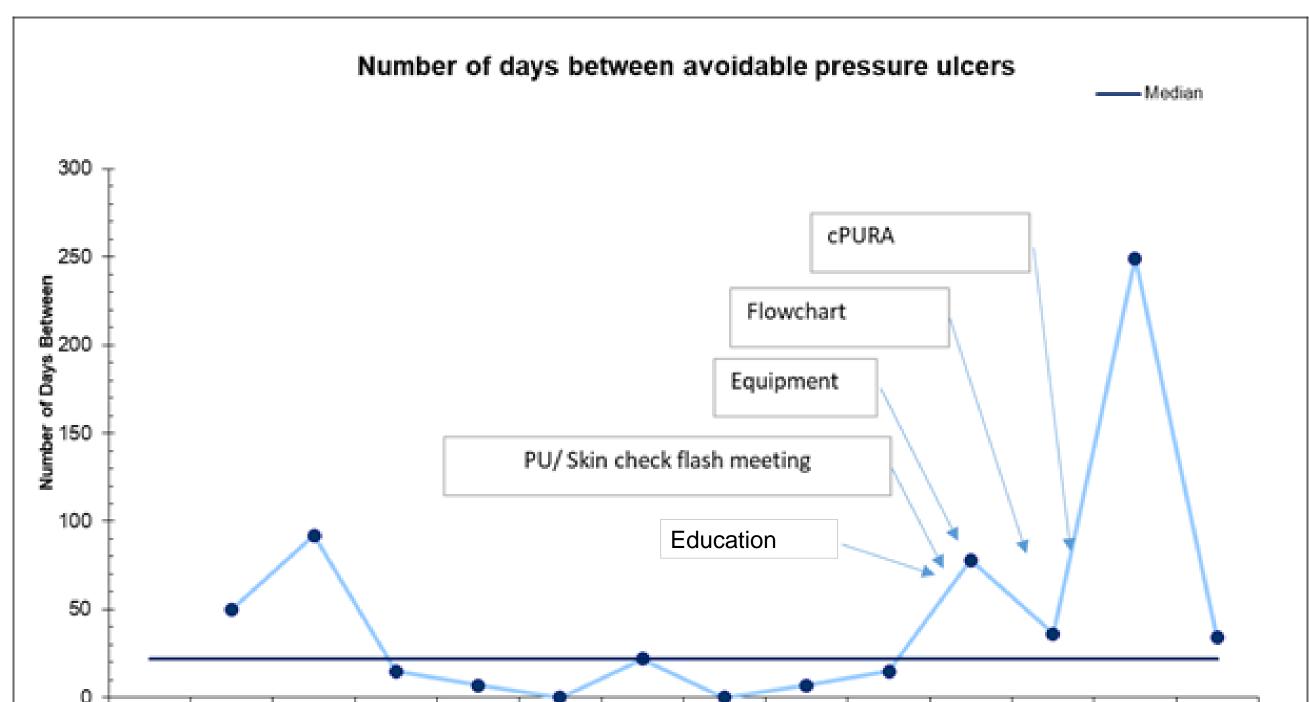
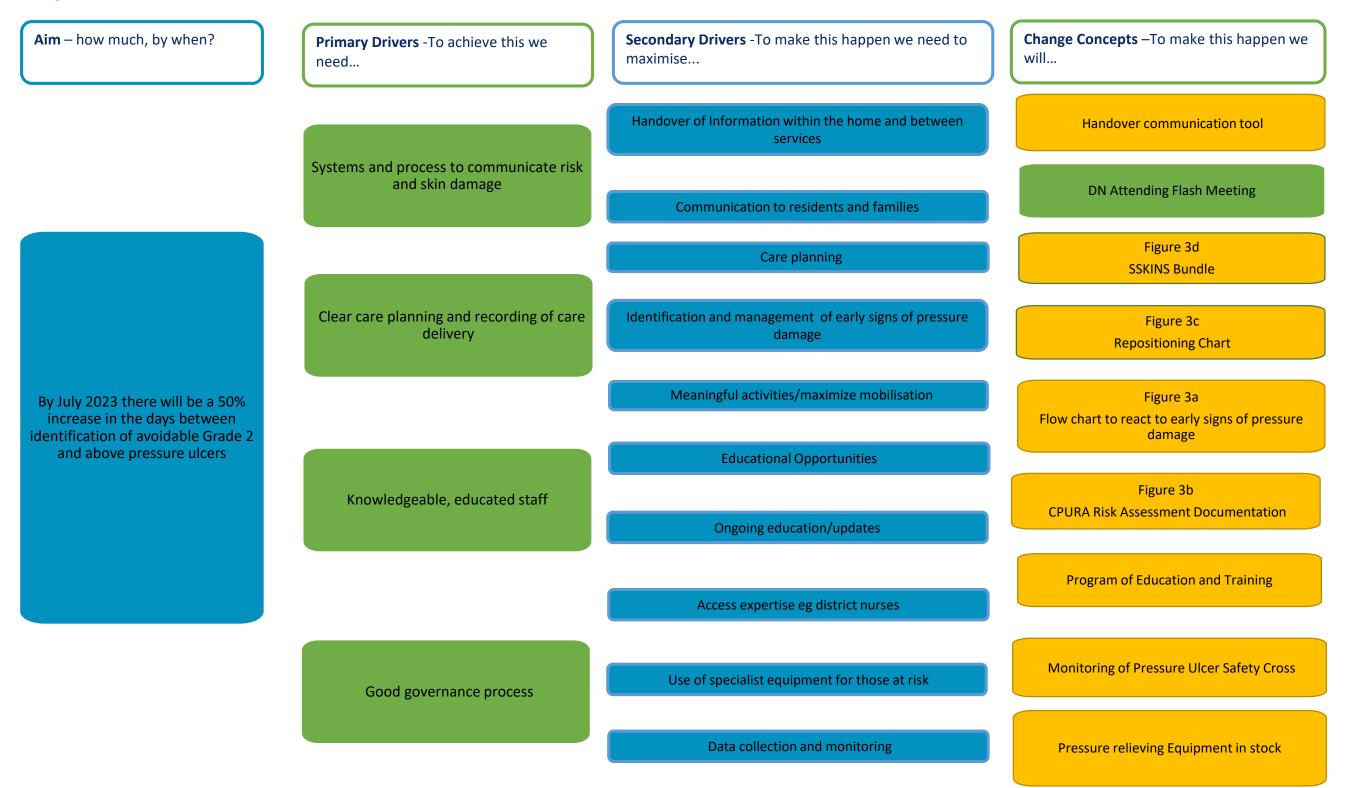
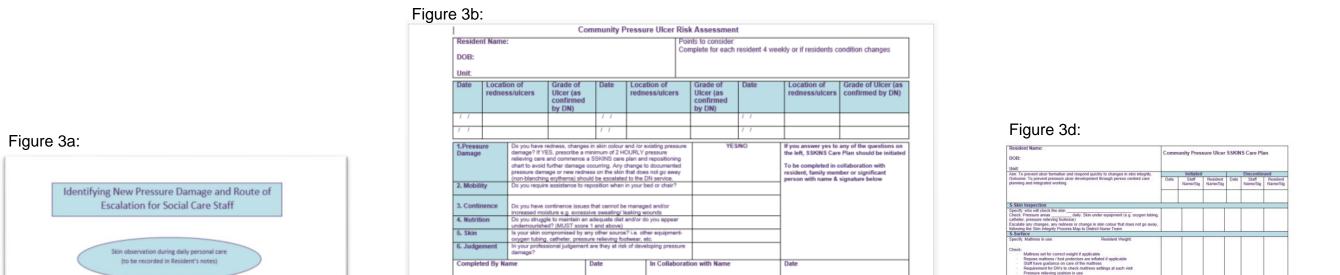


Figure 2:



Examples of documentation developed to support improvements:

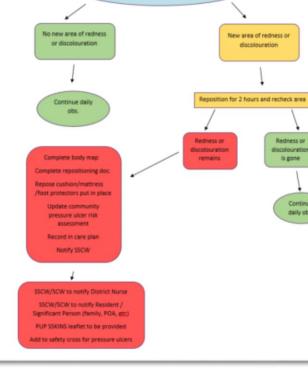


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- Figure 5 highlights an increase in days between the incidence of pressure ulcers following the introduction of the change ideas.
- From Nov 2022 through to July 2023 there were no grade 2 and above avoidable pressure ulcers. In the 6 months prior to the project, 9 care home acquired pressure ulcers were recorded, the average number of days between the ulcers was 20.
- Following testing of the change ideas the home had no grade 2 and above avoidable pressure ulcers for 248 days.
- Pressure ulcers that did occur were recognised early, reported immediately and resolved quickly

Staff Feedback:

- Feedback from District Nurses and the Tissue Viability Team described an improvement in record keeping: accuracy and detail, timely identification, healing rates and a reduction in incidence of pressure ulcers.
- A senior carer commented at the start it felt negative when there was an increased number of pressure ulcers, now it feels much more positive as we can see the changes that we have made and the impact they have had.



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K - Keep moving						
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Specify: What pressure relieving strategies the resident/named person has been advised on	Date	Staff initials	Resident Initials	Date	Staff Initials	Resi
Reposition hourly in bed and chair.						
Overnight, resident/named person has agreed to repositioning hourly						
Any manual handling equipment used:						
 Encourage residents to reposition/mobilise where possible Reposition the resident to reduce the risk of further damage, e.g. using the 30- degree tilt 						
Use manual handling aids to minimise risk of friction and shear e.g. glide sheets						
 Residents on any form of pressure redistribution equipment still require skin inspection and regular repositioning 						
 Provide suitable seating including pressure redistribution cushions as required At risk residents should be seated for no longer than 2 hours and returned to bed 						
for no less than 1 hour (side lying or 30-degree tilt)						
1 - Increased moisture / continence management		15	10 5		-	-
Specify: Products required for management						1
- Change continence garments and clean skin as soon as possible after soiling/wet						
Contact district nurses if skin is broken, a rash is present or there is a change in skin colour / condition						
and sample / sample /						
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N-Nutrition and Hydration						
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Conclusion:

Improving communication, an evidenced based standardised approach, a clear process for escalation and availability of pressure relieving equipment has resulted in an increase in days between pressure ulcer incidence.

Next Steps:

Development of Change Package to spread learning to residential care homes within NHSGGC

References:

1.Healthcare Improvement Scotland, Prevention and Management of Pressure Ulcers, Standards October 2020 2. Barry, Maree, Nugent, Linda, Pressure Ulcer Prevention in Frail Older People, Nursing Standard, Dec 2015 30, 16, 50-60. doi: 10.7748/ns.30.16.50.s46

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Caroline Elsegood

TVN Specialist Nurse, Care Home Collaborative, NHSGGC caroline.elsegood@ggc.scot.nhs.uk

Website: Care Home Collaborative – NHSGGC

