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CLINICAL PRACTICE GUIDELINES

# Pressure ulcer risk assessment and prevention

Implementation guide and  
audit protocol 2003



Royal College  
of Nursing

# improving practice: *improving care*

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# PART 1 – IMPLEMENTATION GUIDE

## Introduction

“It is for every nurse, midwife and health visitor to strive for quality improvement in all aspects of practice.” (Department of Health, 1999). This implementation guide describes how to improve the quality of care for people at risk of developing pressure ulcers by implementing the Royal College of Nursing (RCN) clinical practice guideline *Pressure ulcer risk assessment and prevention* (RCN, 2001). It builds on previous RCN Quality Improvement Programme publications designed for other clinical topics (Duff et al, 2000).

Pressure ulcer prevention can improve patient outcomes and reduce health service resource use. The costs to the health services of managing patients with pressure ulcers are substantial – estimated at around £321 million per annum (Department of Health, 1992). Combine this factor with the human suffering and there is increasing interest in clinical guidelines; their implementation is integral to the success of clinical governance and improving patient safety.

“I had an operation on my gall bladder. I told the staff that I was prone to getting pressure sores. They assured me that I would not get any while in their care. Low and behold when I came around from the anaesthetic, they found a beauty... it is now six and a half years old.” Person with a spinal injury (Rycroft-Malone & McInnes, 2000)

Clinical guidelines are developed using systematic reviews, which classify research studies according to their design, and evaluate the reliability and validity of their findings. This evidence is then linked to recommendations for practice. Evidence-based guidelines are recommendations for good practice and should be used to complement clinical judgement in nursing. They are not intended to stifle or replace clinical judgement, but to enhance it.

The implementation of clinical guidelines into practice is not a straightforward linear process and implementation is more likely to occur when certain factors are optimised (Rycroft et al, 2002). The aim of this implementation guide is to help you turn the guideline recommendations on pressure ulcer risk assessment and prevention into reality. The guideline formed the basis of the National Institute for Clinical Excellence [NICE] inherited guideline *Pressure ulcer risk assessment and prevention* (NICE, 2001). The evidence base from this guide was used to develop the relevant *Essence of care benchmarks* (Department of Health, 2001).

The implementation guide identifies the factors that will increase the chances of successfully putting the guideline recommendations into practice, by setting out practical steps and using examples from practice.

The clinical audit cycle (fig 1) provides a useful framework for both implementing the guideline and evaluating any subsequent improvement. A good implementation strategy begins and ends with audit. It is a continual dynamic process, which results in quality improvement for both patients and nurses.

“Quality improvement is about constantly looking for ways to do things better,” (Morrell and Harvey, 1999).

There are six steps to implementing clinical guidelines (Table 1). Each step within this guide is illustrated with examples from practice. The steps are intended to provide a flexible model, recognising that organisations and teams will be starting from different places.

The audit cycle begins with involving the entire team and finding the right leadership. The steps end by feeding into a programme of regular re-audit to ensure that care is continually reviewed and improved. The steps in between vary slightly from those identified in the implementation guide, but draw on the same sets of skills.

Figure 1. The clinical audit cycle



Table 1. Steps to implementing the guideline for pressure ulcer risk assessment and prevention

Step 1	Decide who will lead and co-ordinate the work
Step 2	Determine where you are now
Step 3	Preparing the people and environment for guideline implementation
Step 4	Decide which implementation techniques to use to promote the guideline
Step 5	Devise an action plan for implementation
Step 6	Evaluate your progress

## 1

# Decide who will lead and co-ordinate the work

## 1.1 Identify a project lead and facilitator

The audit cycle provides a useful model for considering the implementation of a guideline, in that it begins with involving a team and finding the right leadership. The first step is to decide who will lead and co-ordinate the work. Ideally this person should have local credibility and the visible support of the chief executive of the trust (National Prescribing Centre, 2001). This person could be a director of quality, a tissue viability nurse or other clinical leader and will become the project lead.

Studies also show that inter-professional work groups achieve more when they have an identified facilitator (Harvey & Kitson, 1996). Kitson et al (1998) described facilitation as a technique by which one person makes things easier for others. A facilitator is someone who enables the group to work together to achieve its goals by attending to the group dynamics and the needs of the participating individuals. Ideally you may be able to identify a person locally to undertake this role – for example, a practice development nurse or a member of the clinical governance/clinical audit support team.

Successful behaviour change can be achieved when people who may not usually work in the same team, are brought together to achieve a common goal. Therefore it is helpful to set up a project group to lead and co-ordinate the implementation of the guideline. The group should include representatives of everyone affected. These people are referred to as the stakeholders (see Example 1).

## 1.2 Set up a group

The project group should be representative of all those affected by the clinical guideline, for example, nurses, physicians, patients and occupational therapists. Throughout this guide, the group leading the implementation of the guideline will be referred to as the implementation team. This team will be key to encouraging the organisation and the people to work with the recommendations of the clinical guideline.

Ownership of the guideline by the team will enhance the sustainability and spread of the proposed changes throughout the organisation (NHS, 2002). It will also help ensure that profession specific practices, possible barriers and facilitating factors for bringing about change are taken into account and listened to by other group members (Thomas et al, 1998).

### Example 1 – Involving all interested parties

From our experience of implementing clinical guidelines in Lincolnshire, one of the most important aspects of implementation is to involve all interested parties from the beginning. If you do not do this, you are likely to find that some people will be resistant to any proposed changes. Regular meetings of the guideline team are also important. We found that monthly meetings worked best.

**Mark Collier, Lead Nurse and Tissue Viability Consultant**  
United Lincolnshire Hospitals NHS Trust

## 1.3 Identify stakeholders to lead implementation of the guideline

The stakeholders involved in preventing pressure ulcers may include:

- ◆ tissue viability nurse
- ◆ all grades of clinical nursing staff
- ◆ student nurses
- ◆ consultant dermatologist
- ◆ dietician

- ◆ pharmacist
- ◆ moving and handling adviser
- ◆ infection control nurse
- ◆ patient representative
- ◆ patient advice and liaison representative
- ◆ receptionists and clerical staff
- ◆ occupational therapists and physiotherapists.

This list is not exhaustive and will be dependent on individual organisations and the local population. For example, if the area has a high ethnic minority population, an interpreter may be included on the team. If you work in a nursing home, you may work with a different range of professionals and you may wish to include and use the expertise of your local trust.

## 1.4 Clarify and agree the roles and contributions of all group members

All members of the implementation team should be clear about their contribution to the group and to the work involved in implementing the clinical guideline. If roles and responsibilities are not agreed at the outset, one or two people might take on all the work, thereby limiting the degree to which others can feel involved and able to participate in the change. Sharing the work will also make the tasks quicker and less onerous. The implementation team may then carry out each step in the process of implementing the guideline themselves or may enlist the support of others, for example, to conduct the clinical audit or to review the environment. It is the responsibility of the project lead to identify and agree the roles and contributions of all team members.

## 1.5 Agree the purpose of the clinical guideline implementation

It is important for the team to agree what it wants the clinical guideline to accomplish. Otherwise members may disagree about priorities and feel confused and disillusioned if their expectations are not met. An organisation that is open, values an individual's contributions, and has a shared vision is more likely to succeed (Sally and Donaldson, 1998).

## 2

## Determine where you are now

To prepare to implement a clinical guideline, first you have to know what changes are needed, whether the organisation is ready to make them, and what resources you have to support them. In other words, you need to evaluate current clinical practice to find out the degree to which care conforms to that recommended by the guideline. You need to review the environment to find out how ready health professionals and patients are to implement the guideline. You need to know what systems and structures are already in place, and what systems are needed to support any changes required – for example is there sufficient equipment to implement the guideline recommendation? Organisations need to support the implementation of guidelines, encouraging practitioners to critically appraise and evaluate their practice, becoming involved in clinical audit and research as required.

### 2.1 Measure current clinical practice

The degree to which current care conforms to the guideline recommendations and what changes are needed can be determined by conducting a local audit. Measurement of clinical practice can be achieved by using an audit tool. During the audit you need to evaluate different aspects of the care you provide, including the resources that are available (**structure**), the actions and decisions you take in practice (**process**), and the use and outcomes of care (**outcome**). More information about clinical audit can be found in part 2 of this guide.

There are three stages in measuring current care provision:

- 1 collecting audit data
- 2 collating audit data
- 3 summarising audit data.

Tools for clinical audit of pressure ulcer risk and prevention can be found at the end of this publication.

### 2.2 Consider benchmarking

As a part of your clinical audit programme you may wish to consider benchmarking: “A process through which **best practice** is identified and continuous improvement pursued through comparison and sharing.” (Department of Health, 1999).

**Internal** benchmarking can provide a way towards continuous quality improvement. This can be achieved by comparing results between similar clinical areas. Staff might then take on a role of sharing their practice and supporting others within the trust.

**External** benchmarking can be achieved by comparing results between organisations. Networks within similar practice settings – for example, clinics or nursing homes – can come together to share best practice and support development.

The assessment and management of patients for risk of pressure ulcers is seen as routine nursing practice but is often identified as not happening. The following study highlights this.

In a study of the knowledge and practice of qualified nurses in a large teaching hospital (Gerrish et al, 1999), the following were identified: 97 per cent of nurses indicated they assessed patients for risk of pressure ulcers on admission to hospital or as soon as possible afterwards. Of these, 18 per cent acknowledged a change in the patient's condition as a significant reason for re-assessment of risk, and 23 per cent were aware that patients should be reassessed every week, if their medical condition had not changed. In the same study there were shortfalls identified in record keeping – 60 per cent of patients had been assessed for risk of pressure ulcers on admission, with 33 per cent updated weekly. However, 58 per cent showed no updating or evaluation during the patient's stay. Record keeping was more likely to be up-to-date and accurate when the clinical nurse specialist for skin care had been involved in the care of patients.

Table 2 is taken from the *Essence of care* document (Department of Health, 2001). It includes examples of benchmarks of best practice for reducing the risk of developing pressure ulcers.

In order to help staff take ownership of the guideline and clarify the implications of each recommendation, it may be useful to adapt it for local use by developing a local guideline protocol or care pathway.

Table 2. Benchmark of best practice for reducing risk of pressure ulcers

FACTOR	BENCHMARK OF BEST PRACTICE
1 Screening/assessment	For all patients/clients identified as 'at risk', screening progresses to further assessment
2 Who undertakes the assessment?	Patients/clients are assessed by assessors who have the required specific knowledge and expertise, and have ongoing updating
3 Informing patients/clients/carers (prevention and treatment)	Patients/clients and carers have ongoing access to information and have the opportunity to discuss this and its relevance to their individual needs, with a registered practitioner
4 Individualised plan for prevention and treatment of pressure ulcers	Individualised documented plan agreed with multidisciplinary team, in partnership with patient/client/carers, with evidence of ongoing reassessment
5 Pressure ulcer prevention – repositioning	The patient/client's need for repositioning has been assessed/documented/met/evaluated, with evidence of ongoing reassessment
6 Pressure ulcer prevention – redistributing support surfaces	Patients at risk of developing pressure ulcers are cared for on pressure redistributing support surface that meet their individual needs, including comfort
7 Pressure ulcer prevention-availability of resources – equipment	Patients/clients have all the equipment they require to meet their individual needs
8 Implementation of individualised plan	The plan is fully implemented, in partnership with the multidisciplinary team/patients/clients/carers
9 Evaluation of interventions by a registered practitioner	An evaluation which incorporates patients/clients /carers' participation in forward planning is documented

(Table taken from: Department of Health 2001 *Essence of Care: Patient-focused benchmarking for health care practitioners 2001:122*. Reproduced with permission).

## 2.3 Determine receptivity to the guideline

Once the guideline has been adapted for local use by the implementation team, you need to find out what professionals and patients think about the recommendations. Knowing who will be affected by the clinical guideline and how they are likely to respond to its introduction should help you tailor the way in which the clinical guideline is implemented locally. It may also be helpful to think about how changes to clinical practice have been handled in the past. As well as helping you understand people's expectations, finding out about previous attempts at managing change – both successes and failures – will help you select the most suitable methods for implementing the clinical guideline locally.

It may be helpful to talk to clinical audit staff, information specialists, medical records staff, receptionists, contract managers, primary care trusts (PCTs), strategic health authorities (SHTs), the clinical governance lead and others when you evaluate clinical practice and review the environment. It could also be helpful to talk to people who have experience of working in project groups – for example, staff development managers, university lecturers, patients and carers, clinical governance support staff, and members of the RCN Quality Improvement Network.

As well as the stakeholders involved in the implementation team, there may be other individuals who need to be included and accounted for in your strategy and plan. Many people within or external to the organisation may influence the implementation of the guideline. This includes health care professionals with their own ideas and patients and their representatives. Increasingly, patients' views are included in guidelines, helping to ensure that their preferences are included in the clinical decision-making process (RCN, 2000).

## 2.4 Identify the systems and structures you need to support implementation of the guideline

Conducting a review of the structures and systems of the organisation into which the clinical guideline will be introduced allows you to identify what aspects of that organisation will help you to implement it – and what aspects are likely to hamper you. Identifying these features enables you to take actions to overcome difficulties and to capitalise on any strengths. You will then be able to plan how to prepare the organisation and the people who work within it, to implement the clinical guideline. For example, does the organisation have an efficient mechanism for communication between its employees or will it need to develop a new system? This might include a hospital newsletter, intranet or website.

Organisational structures play a strong part in determining culture; a hierarchical structure may inhibit initiative and discourage teamwork across professions. Departmental structures may allow for teamwork but may not allow for communication between departments (Clinical Guidelines Education Team, 2001).

Reviewing the environment is a complex goal. However, there are a number of tools that can be used to help you with this task. Illes and Sutherland (2001) provide a review of a number of tools and models that could be adopted and adapted to help you make an assessment of the implementation context. A few examples of useful techniques are discussed below:

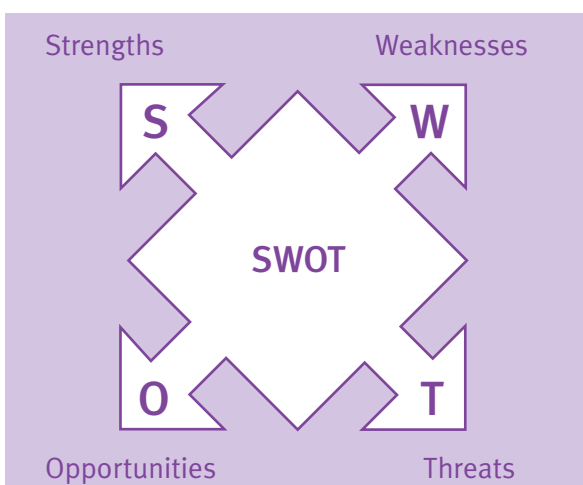
**Brainstorming** is used to free up people's thinking and to help them to think in new ways. A facilitator encourages people to explore an issue by saying whatever comes into their heads. Each point is recorded and, at this stage, there is no 'for and against' discussion. When no more ideas are forthcoming, the facilitator helps the group to look at all those recorded and to engage in a 'for and against' debate. Eventually, ideas considered to be worth further exploration are prioritised, while others are deleted or saved for later consideration. Brainstorming is usually very lively and great fun.

**Force field analysis** is a technique to help people to look at the features of their work situation that either drive or restrain change. Driving forces are factors that cause instability and the need for change, including staff changes, finances, and the openness to change. Restraining forces are those that promote stability and the maintenance of the status quo, including resistance to change. The facilitator writes 'driving forces' at the top of a flipchart sheet of paper, 'current situation' in the middle and 'restraining forces' at the bottom. Group members are invited to brainstorm the driving and restraining forces, writing them on the flip chart.



The forces are then analysed by the group to determine the needs and priorities to be addressed in planning for change.

**SWOT (strengths, weaknesses, opportunities, threats) analysis** is a similar technique to the force field analysis in that it is also a method for identifying promoters of and those opposing change. In this case, four key dimensions are studied: strengths, weaknesses, opportunities and threats – hence 'SWOT'. A facilitator divides the board or flipchart paper into four squares and heads each square as illustrated below:



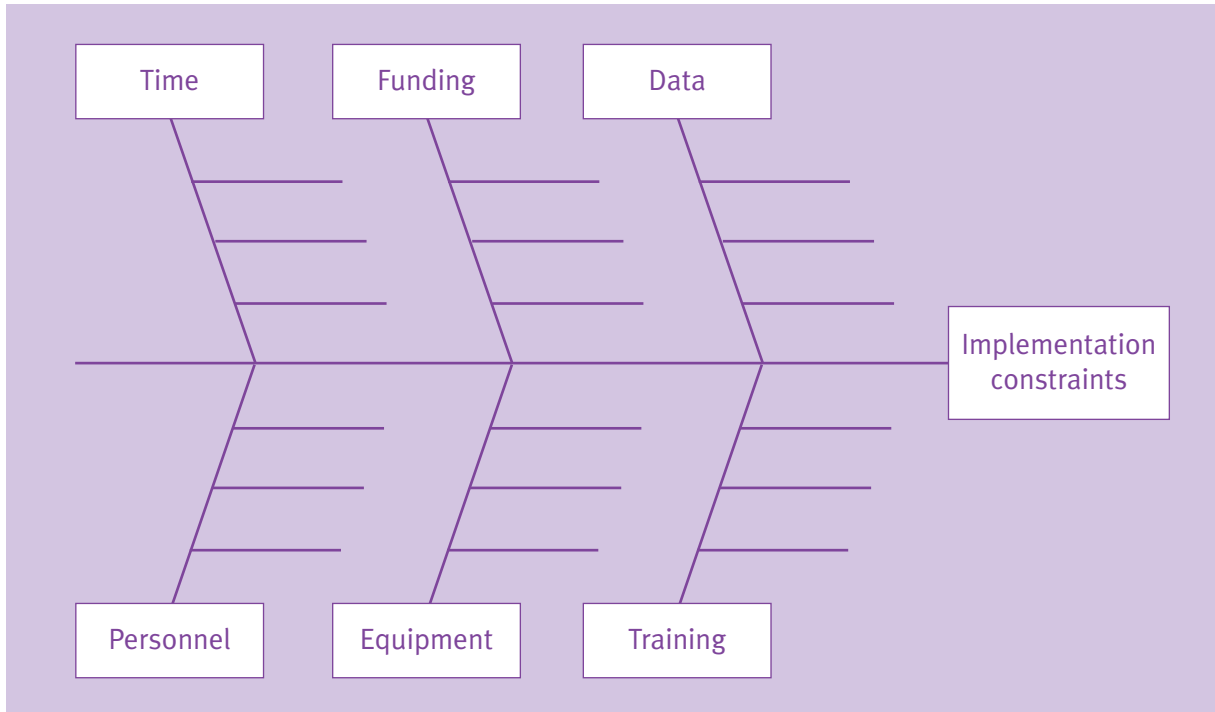
Group members then brainstorm under each of the headings, either in a large group, or by breaking into smaller sub-groups, depending on the numbers involved.

**Nominal group technique** helps a group to move towards a consensus decision. A facilitator invites each member of the group to put forward their views on the topic under discussion. Going round the group is an effective way of making sure that everyone contributes. Each person's statement is written on the flipchart and discussion is kept to a minimum at this point. When all views have been recorded, each statement is discussed in turn. Only those statements with which everyone agrees are retained and the others are scrapped.

**Snowballing** is another way of reaching consensus and ensuring that even the most reticent group members contribute. A facilitator asks the group to divide into pairs and to discuss the topic for a timed period. The length of time for discussion will vary according to group size and how much time is available. The pair is asked to identify areas where they can reach agreement. The facilitator is the timekeeper and tells the pair to join with another, when the time is up. In fours, each pair shares with the other the consensus statements. All the statements are discussed for a timed period and those agreed by all four are retained. The process is repeated with the four joining up with another four, then eight with eight and so on, until the group has become one again. By this time, the whole group will have agreed consensus statements.

**Fishbone diagram.** A fishbone is designed to focus on the cause of a problem instead of the problem itself. The name 'fishbone' comes from the way the diagram looks. It is made up of a horizontal line (the spine) with a box at one end (the head) with the problem stated. Several angled lines come off the horizontal line forming the ribs of the fish. Each rib will have a probable cause of the problem listed at the end of the rib. Contributors to the cause are usually put on the small branches of the rib. Fishbone diagrams are most useful when you know that a specific area needs to be analysed but you are not sure which aspect of it is creating the problem.

Fishbone diagram



## 3

## Prepare the people and the environment for guideline implementation

### 3.1 Prepare the people

There are two purposes in preparing people to implement a guideline. Firstly, to ensure that they are receptive to the clinical guideline and know how to use it and secondly, that they have the clinical skills and knowledge to carry out care as recommended in the guideline – this is absolutely crucial to your success in implementing the guideline. To achieve this, you may wish to identify what their knowledge base is. A way of doing this is to administer a self-assessment questionnaire, such as that found at the end of part 2. The results of self-assessment could highlight individual training needs and this could be incorporated into their own professional development training plan. This tool was used in the RCN national pilot audit project (Stephens & Bick, 2003) (see Example 2).

Clinical guidelines do not refer to a patient's social background or ethnic origin, although greater awareness of both is vital in achieving equitable and culturally competent care for all patients.

An increased awareness is required when caring for patients with darker skin pigmentation, as the development of a pressure ulcer is less visible to the patient or carer. This is highlighted in the guideline, *Pressure ulcer risk assessment and prevention* (RCN, 2001) and *Working together to prevent pressure ulcers* (NICE, 2001), which can be found at [www.nice.org.uk/pdf/clinicalguidelinepressuresoreguidancenice.pdf](http://www.nice.org.uk/pdf/clinicalguidelinepressuresoreguidancenice.pdf). Health care professionals, patients and carers need to be aware of signs that may indicate incipient pressure ulcer development in this group, as this may be difficult to recognise.

Some individuals who will be affected by the clinical guideline will support its implementation and others may oppose it. Lots of people will probably be indifferent. Health care professionals and patients may react differently to the proposed changes. Some people may feel that the care provided is already the best possible; others may cling to outmoded practices because they are familiar. It is important to be aware of the views of all people who can influence the implementation of the guideline, in order to make plans to capitalise on support and identify resistance to change.

#### Example 2 – Using the self-assessment questionnaire

As part of the RCN national pilot audit project, a self-assessment questionnaire was designed. Completed by the individual practitioners, its aim was to establish baseline knowledge of pressure ulcer risk assessment and prevention. It provided a non-threatening tool for individuals, which highlights possible training areas. It can, if necessary, be amended to take into account local adaptation of the guideline.

As part of the national project, both trained nurses and health care assistants used it at the implementation workshops, prior to implementing the guideline recommendations.

Comments from individual nursing staff and the project link nurses were mostly positive. All felt it useful to identify where they needed additional training or update.

**Fiona Stephens, Former Project Manager, RCN Institute**  
RCN national pilot audit project: pressure ulcer risk assessment and prevention.

### 3.2 Identify your supporters and the possible resisters

Block (1991) suggests that classifying people into one of five groups can be a useful way of assessing those people who are likely to be enthusiastic about introducing a clinical guideline and those who will be more reluctant. People can be classified as bedfellows, allies, fence sitters, adversaries and opponents (Block, 1991). The willingness of each group to change is summarised in Figure 2 and explained below.

**Allies** are people with influence who both support your implementation agenda, and in whom you have high trust. On the positive side, you can mobilise them to support your aims, but on the negative side they will not necessarily challenge your view and help to create new perspectives.

**Opponents** are those people with influence in whom you have great trust, but who do not necessarily share your aims. These individuals are useful because they provide a sounding board for your ideas and plans, and they can be counted on not to block your aims unfairly or without notice. However, if you do not deal with opponents openly, the trust you share may be eroded and they may become adversaries

**Bedfellows** are those people with influence whom you are not able to fully trust. This is probably because you do not know them very well, or because your past dealings

with them have been at arm's length. However, they do share some of your aims. These individuals are useful because they can be included in the implementation of the guideline – by inviting their involvement, seeking their opinions, and developing appropriate working relationships where they feel able to trust your aims.

Adversaries are those people with influence whom you feel unable to trust and who do not share your commitment to your guidelines.

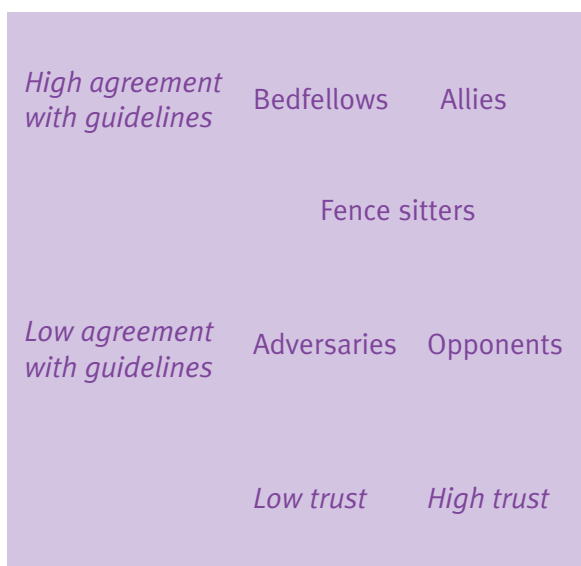
Fence sitters are those people with influence who neither agree nor disagree with your aims and in whom you consequently feel little trust. Block (1991) characterises these as the archetypal bureaucrat, the person who always plays safe and takes refuge in the rules. On the positive side, they generally encourage review and debate but are reluctant to commit themselves. To counter this, Block (1991) suggests asking what they need for them to offer their support.

### 3.3 Plan activities to overcome negative attitudes to clinical guidelines

Here are some suggestions about how negative attitudes to clinical guidelines can be tackled:

- ◆ explain what clinical guidelines are – and what they are not
- ◆ ask staff what they think about the guideline recommendations
- ◆ explain the implications of the guideline, how the organisation is contributing to its successful implementation, and what is expected of staff
- ◆ demonstrate why a clinical guideline is needed, its benefits and how it can improve care for patients
- ◆ be honest about the advantages and disadvantages of the clinical guideline
- ◆ find out the myths and legends surrounding clinical guidelines, and clarify the ways in which they threaten professionals and patients. Off-set these with their advantages
- ◆ agree to review the use of the clinical guideline and its impact on care and working practices after a set period.

Figure 2. Identify your supporters



**Table 3 Checklist: disseminating the clinical guideline**

Adapted from Palmer &amp; Fenner (1999) and reproduced with permission

Which of the following individuals or groups need to use or know about the guideline?	Need to use guideline	Need to know about guideline
Tissue viability nurse and nursing staff, including health care assistants		
Medical staff		
Operating room staff		
Student nurses		
Medical students		
Occupational therapists		
Physiotherapists		
Service manager(s)		
Clinical staff from other specialties		
Patients		
Carers of service users, formal and informal		
Local user advocacy /voluntary organisations		
Chief executive		
Director of nursing		
Clinical audit /quality improvement /risk management/ clinical governance personnel		
Training department staff		
Local education provider		
Practice development nurses		
Health and safety/occupational health staff		
Administrative and support staff		
Internal communications or public relations staff		
Library staff		
Information systems staff		
Public health personnel		
Health authority staff		
Contracts department		
OTHER, PLEASE LIST:		
Equipment department		
Commissioning manager PCT		
Ambulance service		
Receptionists		
Clerical staff		

A key factor in improving people's receptivity to a clinical guideline is to make sure that everyone is aware of its existence, what it involves and its benefits. It is helpful for people to be given the chance to think about and comment on plans for implementing the guideline before any changes take place in practice. This two-way communication allows health care professionals to advise the implementation team about anything to do with the patients they work with, in their environment or related to their skills and knowledge that might influence the implementation of the guideline. It will also help share ideas about how difficulties in implementation can be overcome. It may be that the recommendations have been tried in the past and did not succeed.

To make sure that everyone is aware of the clinical guideline and what its recommendations mean for practice, it is important that it is widely disseminated. A common reason why clinical guidelines are not used is that the intended audience have often never heard of them (Tunis, 1994, Gupta et al, 1997). Dissemination and implementation of a clinical guideline will be promoted by an effective communication strategy. Table 3, on the previous page provides you with an example of a checklist that you can use to identify everyone who should receive a copy of the clinical guideline.

Once you have disseminated the guideline you will need to think about the following:

- ◆ how will you know that everyone who needs to hear about the clinical guideline has done so?
- ◆ how can you collate and feedback ideas about implementing the guideline?

### 3.4 Devise a communication strategy to support implementation of the clinical guideline

A communication strategy needs to take account of the people who need to know about the guideline, the way in which that information will be presented and how to evaluate its effectiveness. An example of how this can be achieved is provided in Example 3.

#### ◆ People

- all those who are affected by the clinical guideline, including patients and carers (an example of a locally adapted patient information leaflet is included on page 18 and 19)
- all those who will use it in practice, for example, nurses, physiotherapists
- the 'gatekeepers' through which information is channelled – for example, to convey information to staff nurses, do you need to go via ward managers?

#### ◆ Presenting information

What makes information about the guideline more accessible for different individuals or groups?

- vary the media of presentation rather than only using paper formats, for example, use visual representation of the guideline or audit results
- use different settings, for example, presentations, meetings, educational sessions, administrative meetings, hand-over meetings, ward rounds, social gatherings
- use information technology, for example, your trust intranet
- use incentives that highlight and 'sell' the guideline, for example, positive audit results that highlight a reduction in the number of pressure ulcers
- use different methods for different individuals and groups
- promote the credibility and rigour of the clinical guideline
- be aware of language – patient information may need to be interpreted.

#### ◆ Evaluation

- How will you know that everyone who needs to hear about the clinical guideline has done so?
- How can you collate and feedback ideas about implementing the guideline?

### Example 3 – Communication strategy

The trust guidelines on pressure ulcer risk assessment and prevention were revised and updated when the NICE inherited guideline, *Pressure ulcer risk assessment and prevention*, was published in 2001, based on the RCN guideline. Two main changes were made to the existing guidelines: the first was to change terminology from ‘skin’ to ‘skin integrity’. The second was to specify a length of time when restricting sitting, to a maximum of two hours.

The updated guideline was then discussed with the tissue viability interest group, prior to being sent to the:

- ◆ trust nursing and midwifery board
- ◆ clinical risk management board
- ◆ nursing divisional boards
- ◆ clinical practice forums in four sites.

Hard copies of the guideline and information were circulated to:

- ◆ ward managers
- ◆ directorate managers

Information on the new guideline was circulated in the following ways:

- ◆ global e-mail
- ◆ on the hospital intranet
- ◆ the hospital newsletter
- ◆ posters
- ◆ workshops for health care assistants

The process of dissemination took six months to complete.

**Melanie Delve, Equipment Resource Nurse  
Oxford Radcliffe Hospitals NHS Trust**

As Example 4 highlights, your trust may have a high ethnic minority population and patient/carer information may require translation into the appropriate language.

### Example 4 – Patient information

The hospital trust serves and delivers care to a high ethnic minority population, many originating from India and Pakistan, with darkly pigmented skin. The majority of patients do not speak or read English.

In 1994, the Department of Health issued patient and carer booklets for the prevention of pressure ulcers, however these were not available in any other languages apart from English and Welsh. To address this, trust guideline booklets on how to prevent pressure ulcers were developed and translated into Hindi and Urdu. A copy was given to patients and carers when discharged from hospital.

We are in the process of reviewing these information leaflets to encompass the new recommendations. The new information leaflets will be based on the NICE guidance, *Working together to prevent pressure ulcers - A guide for patients and their carers*. This suggests that you look for:

- ◆ purplish/bluish patches on dark-skinned people. These can appear as areas of darker pigmentation, and both staff and patients and their carers need to be made aware of this
- ◆ assessment and vigilance for carers, for example heat and coolness.

**Elaine Bethnall, Tissue Viability Nurse  
City Hospital, Birmingham**

A copy of the NICE publication *Working together to prevent pressure ulcers – a guide for patients and their carers* can be found at [www.nice.org.uk/pdf/clinical\\_guidelinepressureulcersguidancenice.pdf](http://www.nice.org.uk/pdf/clinical_guidelinepressureulcersguidancenice.pdf). This publication is copyright free and can be reproduced by local departments in their own literature (see page 17).

### 3.5 Prepare the environment

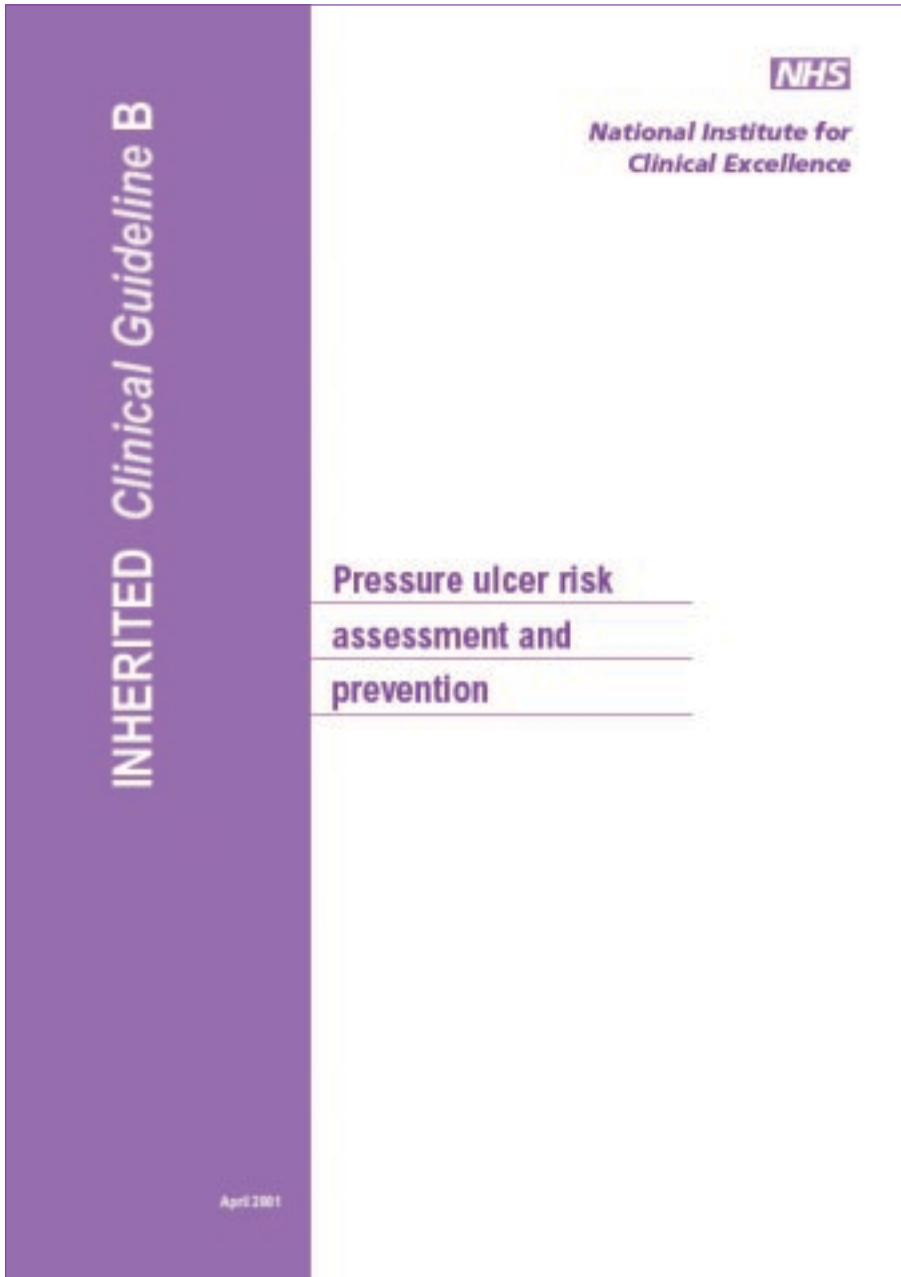
To implement a clinical guideline, structures and systems may have to be changed or modified. For example patient admission sheets or computer systems may need to be designed or altered. Systems may have to be created, such as the inclusion of reminders in patients' notes or teaching sessions for clinical staff, see Example 5.

#### Example 5 – Documentation and assessment rationale

Following a local audit of the existing pressure ulcer risk assessment documentation, a risk assessment tool was developed, based on the Waterlow score. In light of this audit, the trust introduced a policy requesting that initial pressure ulcer risk assessment occurs at the first point of contact with the patient - this is usually in the outpatient clinic. Subsequent risk assessment will be reviewed at the pre-admission clinic, preoperatively and daily for two to three days, post-operatively. A new form was designed to meet this requirement.

**Shelia Benton-Jones, Tissue Viability Nurse Specialist, Nuffield Orthopaedic Centre NHS Trust**

## 1 Information for patients and carers from NICE



A copy of the NICE publication *Working together to prevent pressure ulcers – a guide for patients and their carers* can be found at [www.nice.org.uk/pdf/clinicalguidelinepressuresoreguidancenice.pdf](http://www.nice.org.uk/pdf/clinicalguidelinepressuresoreguidancenice.pdf). This publication is copyright free and can be reproduced by local departments in their own literature.

## 2 Example of a locally adapted patient information leaflet

(Julie Brown, Tissue Viability Nurse for Trauma, John Radcliffe Hospital – reproduced with permission)

### Under pressure? Your guide to pressure sores and their prevention

June 2001

#### What is a pressure sore?

A pressure sore is an area of damaged skin and flesh. It is usually caused by sitting or lying in one position for too long, without moving to relieve the pressure.

Pressure sores are also sometimes known as 'bed sores'.

A pressure sore can develop in only a few hours. It usually starts with the skin changing colour – it may appear slightly redder or darker than usual.

If the pressure is not relieved, it can develop in a few days into an open blister and over a long period into a deep hole in the flesh.

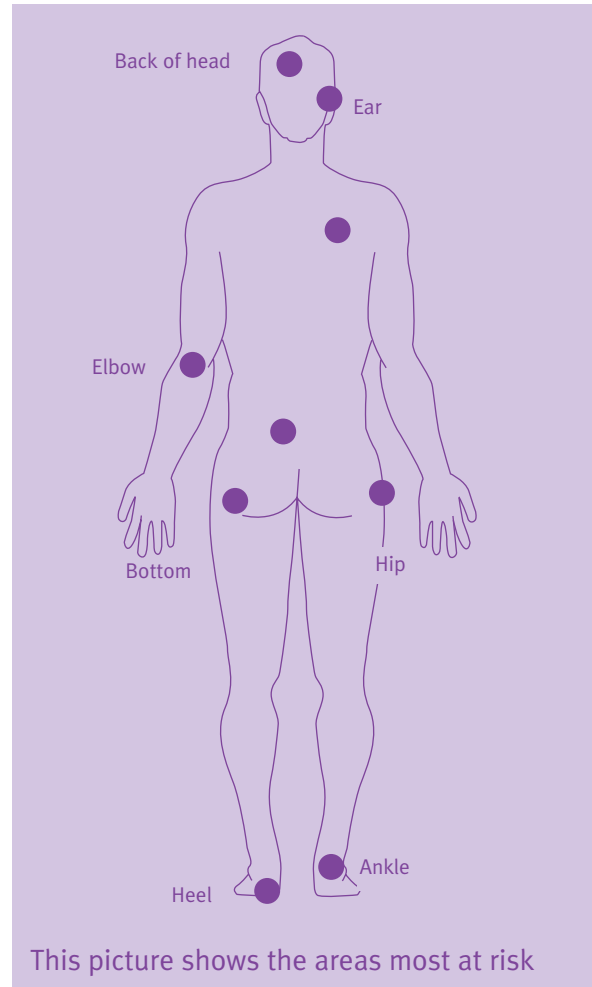
#### Which part of my body can get sores?

Pressure sores are most likely to develop on parts of the body which take your weight and where the bone is close to the surface.

#### Am I at risk of getting a pressure sore?

You are at risk of getting a pressure sore if:

- ◆ you have to stay in bed
- ◆ you are in a wheelchair
- ◆ you have difficulty moving about
- ◆ you spend long periods in an armchair
- ◆ you have a serious illness
- ◆ you are elderly and weak
- ◆ you are incontinent



- ◆ you have poor circulation
- ◆ your body is not very sensitive, for example because you have had a stroke
- ◆ you are not eating a balanced diet or having enough to drink.

#### How can I avoid pressure sores?

##### If you are in bed:

- ◆ If possible, change your position every two to three hours, alternating between your back and sides. If you find this difficult, the nurses will help you.
- ◆ You may be given a special mattress that helps relieve the pressure which will be passed on to another patient when you no longer need it.

- ◆ Use pillows to stop your knees and ankles touching each other, particularly when you are lying on your side.
- ◆ Try to avoid creases and crumbs in your sheets.
- ◆ If you sit up in bed, make sure you do not slide down because this can drag on your heels and bottom.

#### **If you are in a wheelchair:**

- ◆ If possible, try to take the weight off your bottom every half an hour by leaning forward and pushing up on the arms of your chair. Or you could roll from cheek to cheek for a short while.

## **What else can I do to help myself?**

- ◆ Eat a healthy diet and drink plenty. If your skin is healthy, it is less likely to be damaged.
- ◆ Keep your skin clean and dry.
- ◆ Avoid talcum powder because it soaks up the natural oils in your skin and dries it out.
- ◆ If you suffer from incontinence, ask your nurse for help.
- ◆ If you are unable to move yourself, allow the nurses and physiotherapists to help you.

### **TRY NOT TO WORRY!**

Pressure sores can sometimes occur even if you are doing everything you can to avoid them.

Pressure sores can be cured if you get the right treatment and look after yourself.

Please do talk to your nurse if you require more information.

**We are here to help you.**

## 4

## Decide which implementation techniques to use to promote use of the clinical guideline in practice

This section outlines some of the techniques used to implement changes in practice in health care settings. Research findings show that it is important to use a variety of implementation methods and to integrate them with a strategy for change (NHS Centre for Reviews and Dissemination, NHS CRD, 1999; Dunning et al, 1997; Grimshaw & Russell, 1993; Thomas et al, 1998).

Traditionally, education and training have been used to change the behaviour and practices of health care professionals; to inform and convince people of the need to change; and to ensure consistency in the care provided. However, providing information by itself is not enough to persuade people to change their behaviour (Freemantle et al, 2002). Instead, other methods and techniques also need to be used including: education, social influence, facilitation, audit, sanctions, marketing and reminders. Various factors such as the target audience, the educational influence and practical considerations for each implementation technique need to be considered, alongside an understanding of change management (see Iles & Sutherland, 2001 for more details). These factors could be identified using one of the techniques described on page 8 of this guide. With this information, you would formulate an action plan using a number of interventions.

### 4.1 Identify education and training

In order to implement the clinical guideline, it is important to provide education and training to everyone within an organisation so that they understand:

- ◆ the benefits of clinical guidelines
- ◆ how and why they are developed
- ◆ the content of the guideline and how it applies to them
- ◆ what they are being asked to do with the guideline
- ◆ how they can use the guideline
- ◆ how they can monitor its use and ensure that patient care improves.

Education may be required to develop particular clinical skills relevant to the guideline. As previously suggested, it is a good idea to establish what staff actually know about pressure ulcers. It is also essential to include all staff who may be involved in caring for the patient, including health care assistants, as highlighted in Example 6.

#### Example 6 – Pressure ulcer teaching packs

In North Wales, a guideline has been developed for community and acute trusts. This is to help ensure consistency and provision of the same standard and quality of care for patients, whether they are in hospital or the community.

Included within the guideline are recommendations for staff education. Two specific teaching packs have been devised - one for trained nurses and another for health care assistants – and each includes a workbook. The packs are divided into units enabling the nurse or health care assistant to work at their own pace. Within each unit, activities are highlighted and should be completed before moving on to the next.

The aim is to ensure that the nurse or health care assistant can:

- ◆ define a pressure ulcer
- ◆ understand the factors that contribute to the development of pressure ulcers
- ◆ recognise the first signs of pressure ulcer development
- ◆ plan the care of a patient in order to minimise the risk of developing pressure ulcers.

Both education packs include details of the tissue viability nurses for further information of assistance with the pack.

**Menna Lloyd Jones, Senior Nurse Tissue Viability, North West Wales NHS Trust**  
**Trudie Young, Tissue Viability Nurse, Conwy and Denbighshire NHS Trust.**

Education is more likely to be effective when it is tailored to the needs of the individuals concerned and combined with another activity, for example, audit and feedback. Example 7 shows how one trust has used a different approach for staff.

### Example 7 – Skills development programme

In Tower Hamlets Primary Care NHS Trust, staff education programmes come under the umbrella of the skills development programme. Within this, there is a pressure ulcer two-day course, with a half-day reflective practice session four to six weeks later. Practitioners attending this course are both community and hospital based.

Two documents have been developed to assist staff in the learning process:

#### 1. Clinical skills objectives

Practitioners can use these documents to identify their learning needs, their strengths and any gaps in their pressure ulcer knowledge and practice. It is a working record of their development that they can dip in and out of, and incorporate in their professional portfolios. It is practitioner-

centered and is about how they see their practice. It can be used in conjunction with the course, in a ward or community situation with a mentor, or could link into clinical supervision.

#### 2. Reflective practice

This document was developed in recognition that attending the short pressure ulcer course alone did not necessarily lead to a change in practice. Attending the study days can enthuse practitioners; however pressures of day-to-day workloads often prevent relating the theory to practice.

At the half-day course, practitioners are split into small-facilitated groups that encourage individuals to share their experiences in a non-threatening way. Groups identify relevant issues, before coming together to discuss common themes and differing views.

In addition to the two-and-a-half day programme, other sources include:

- ◆ a pressure sore care programme
- ◆ a CD-Rom that includes the care programmes
- ◆ a wound care formulary, devised with the Bart's and London NHS Trust, and aiming to offer a seamless service between hospital and community.
- ◆ access to a specialist centre
- ◆ a pressure ulcer teaching session for nursing homes
- ◆ clinical audit to inform practice and the development of guidelines
- ◆ equipment tendering
- ◆ multidisciplinary links – for example to podiatrists, the wheelchair service, dieticians, occupational therapists and physiotherapists.

**Fran Worboys, Alison Hopkins, Mike O'Brien, Clinical Nurse Specialists in Tissue Viability, Tower Hamlets Primary Care NHS Trust**

With those you have identified as being your keen supporters, education alone may be sufficient to achieve guideline implementation – but it is unlikely to achieve successful implementation of the guideline with other groups. As we all know, people react differently to change. An alternative strategy is to use techniques that work by using social influence (Mittman et al, 1992).

Mittman et al (1992) defined social influence as: “The process in which the behaviour of one person has the effect of changing how another person behaves feels or thinks about something.” They go on to propose that when there is an opportunity for discussion, particularly with a small group of peers, this will exert social influence and increase the likelihood of successful dissemination and implementation. Certain individuals have been identified who are likely to have this social influence, namely:

- ◆ clinical leaders
- ◆ opinion leaders
- ◆ product champions
- ◆ peer support
- ◆ facilitators.

## 4.2 Find out who are clinical leaders, opinion leaders and product champions

### Clinical leaders

Much of the literature on guideline implementation, as well as that on quality improvement, stresses the need for gaining the support of influential or senior colleagues for any changes proposed. It is important to get support from senior colleagues, even where the development and implementation activity is managed as a ‘bottom-up’ process.

### Opinion leaders

Opinion leaders are influential, respected individuals who are experts in their chosen field (Lomas et al, 1991; Rogers, 1995). When compared to their peers, opinion leaders tend to have a higher social status, are more innovative and tend to be the centre of an interpersonal network. Opinion leaders encourage others to use new information by using it themselves,

thus setting an example and creating new implicit or explicit social norms. However, they have to believe in information. If they do not, they could become opponents of the proposed change (Locock et al, 2001). Opinion leaders are highly visible and are accessible to others because of their extensive interpersonal networks. This enables their influence to travel beyond their immediate clinical team. They are often referred to as change agents.

### Product champions

Some individuals literally ‘champion’ a product and ‘sell’ it to their colleagues (Stocking, 1985). The amount of time that the product champions put into supporting an innovation is directly related to how well it is implemented. These individuals usually focus on a specific product – for example pressure ulcer prevention – unlike opinion leaders, who have a more general cause.

Once you have identified who the opinion leaders and product champions are in your team and organisation, ask them for their opinion of the guideline, and think about how to enlist their help in implementation. You will also need to identify managerial influences and leaders in your organisation including locality managers, clinical directors, general practitioners, practice managers, chief executives etc. These people can then be targeted with information. Ask yourself: what is it about the clinical guideline that will appeal to them?

- ◆ might it save money?
- ◆ might it reduce the chances of litigation?
- ◆ is it a Department of Health initiative?
- ◆ does it relate to targets set by strategic health authorities or primary care trusts?
- ◆ does it address a personal interest?
- ◆ is it a guideline recommended by a royal college or other professional organisation?
- ◆ do patients like the guideline? Is it recommended by carers?

Possible cost reductions from implementing a clinical guideline on this topic have been highlighted in Australia by Prentice and Stacey (2001). These savings would be the result of a reduction in the length of stay and infection rates, as well as prevalence and incidence; earlier discharge; fewer re-admissions as a result of

pressure ulcers; increased patient satisfaction; and reductions in morbidity and mortality. Cost pressures may include increased staffing levels and equipment purchase. The consequence of not implementing clinical guidelines on pressure ulcer risk assessment and prevention could result in the possibility of litigation (Tingle, 1997).

### 4.3 The role of peer support, organisational support and facilitation

#### Peer support

People commonly learn and formulate new opinions through discussion with their peers and are influenced by opinion leaders within the organisation (Mittman et al, 1992). For example, nurses may want to talk to others in their group about the implications of the guideline to help them decide whether to use it. They will ask each other questions such as:

- ◆ is the guideline valid?
- ◆ does it apply to the work we do and the patients we see?
- ◆ will it improve practice or may it have a harmful effect?

These conversations often happen in social situations, for example, whilst taking the lift or in the staff canteen, and often have a great influence on people's decision-making. It has been argued that this social influence may be the biggest factor in whether a new initiative is implemented. Therefore, providing opportunities for discussion is likely to have a beneficial effect on the adoption of the guideline. Discussion can be incorporated into education sessions, team meetings and presentations.

#### Organisational support

The organisation's commitment, with effective managerial and clinical leadership, is essential to facilitate and support the process and maintain momentum (Kalazinga and Giebling, 1994). Barriers within the clinical setting preventing the implementation of evidence into practice have been identified (Currie and Morrell, 2001; Gerrish et al 1999) and the role of managers is important in overcoming these, as well as

supporting the application of theory to practice. Their support is needed to ensure professionals are willing and interested in changing practice, providing guidance and identifying areas for improvement. Currie and Morrell (2001) identified that an absence of managerial support led to difficulties in getting commitment from nurses. Meanwhile Gerrish et al (1999) found that a lack of enthusiasm and interest from managers resulted in little progress being made. This lack of support from managers and doctors – along with dissemination difficulties, poor support for innovations, time constraints and a lack of resources – were all barriers to successful implementation.

#### Facilitation

Facilitation has been identified as a key factor in the successful implementation of clinical guidelines, along with consideration of contextual factors and clarity about the role and nature of evidence context (Rycroft-Malone et al, 2002; Kitson et al, 1998). The role and function of a facilitator is different from that of an opinion leader or product champion in that this is an appointed role. It is about enabling and helping, as opposed to telling or persuading, and the facilitator needs to be flexible to appropriately assess, interpret and act on the context (Harvey et al, 2002). The skills and competencies needed for facilitation mean that careful selection and support of individuals is required. It is important that the training needs for the role of facilitator are identified and met.

Earlier in this guidance, it was suggested that ideally you should identify a project facilitator who could be the tissue viability nurse or practice development nurse. The role of the project facilitator would be to guide, enable and support members of the implementation team to perform tasks themselves (Duff, 2001). Link nurses within clinical areas will be responsible for enhancing implementation at ward level (see Example 8).

#### Example 8 – Using clinical leadership and facilitation to implement guidelines

My trust covers three large acute sites and two smaller units. I am the only tissue viability nurse in post, with the remit to provide advice on all aspects, including pressure ulcer prevention. A decision was made with senior management and ward

managers to recruit a tissue viability nurse on each ward or unit within the trust. This person would be responsible for the dissemination and implementation of evidence in that area. The tissue viability nurse would provide support.

The objectives identified were to:

- ◆ attend study sessions on tissue viability
- ◆ facilitate the implementation of theory into clinical practice within individual wards or units
- ◆ liaise with other tissue viability link nurses within the site
- ◆ maintain an up-to-date register of sessions provided
- ◆ devise an annual action plan
- ◆ identify resources required to effectively undertake the link nurse role and report back to ward manager.

Link nurses are expected to act as a resource for advice on tissue viability. They act as the first point of contact and contribute to in-house educational programmes. Currently, 76 per cent of clinical areas have a link nurse in post

**Elaine Gibson, Tissue Viability Specialist Nurse, East Kent Hospitals NHS Trust**

#### 4.4. Maximise feedback and reward

Management theorists and psychologists describe how important it is for us to achieve and for others to recognise our achievements. Achievement and recognition motivate us and provide the confidence to continue to perform well and to develop further, to try new things and to perform even better. A key part of an implementation strategy is the reward and celebration of achievements.

Positive results from clinical audit demonstrate success. There may be opportunities to celebrate these at team meetings, to tell others about the achievements through the organisation's internal communications systems, or at one-off events. Internal or external rewards or accreditation schemes can also be used. Recognising and rewarding success not only motivates those already involved in implementing a guideline, but it also acts as a marketing device for those who remain sceptical.

#### 4.5. Consider recording systems or integrated care pathways

As well as social influence techniques there are also a number of other practical steps that you can take to improve implementation of the clinical guideline. These include the use of recording systems and care pathways.

##### Recording systems

Incorporating the recommendations of a clinical guideline into the system you use to record clinical information can be a powerful way of reminding everyone to use the guideline. Recording systems can also be helpful in promoting a systematic approach to clinical care and the accurate recording of information for clinical audit. There is no evidence that suggests any particular pressure damage risk assessment recording system is better than another, although some practitioners may have preferences.

##### Integrated care pathways

Integrated care pathways (ICPs) present a plan for the clinical management of patients with a particular condition, specifying the optimum course of events to happen within a set time-scale. They are developed by local multi-professional teams and may be based on, or include recommendations from clinical guidelines. Variations from the pathway are documented and the reasons for the variations analysed. Avoidable variations from the pathway can then be addressed and changes made to the pathway, if necessary.

## 4.6. Decide which combination of techniques is most suitable for implementing a clinical guideline locally

Having reviewed the range of techniques that you can use to encourage people to use the clinical guideline in practice you now need to decide which ones will be most useful in your locality. Remember that education alone is likely to be ineffective, if not combined with other methods and techniques. The recommendations made by clinical guidelines can be used in whatever format your hospital or organisation prefers or is more familiar with – for example, a care pathway (see below).

### Example 9 – A care pathway approach

The introduction of a trust-wide standardised care planning approach contributed to a reduction in the incidence of pressure ulcers. However, nursing audits and point prevalence studies indicated that there were still aspects of care that needed improvement. There were wide variations in practice relating to pressure area prevention and differences in the quality and effectiveness of care delivered to patients. This was particularly so with regard to clinical decision-making about the risk factors involved in the development of pressure ulcers and the types of interventions prescribed to minimise those risks. Following a review of current practice, Scarborough Trust developed and piloted a care pathway for pressure area risk assessment and management.

A key feature of a care pathway approach is that it enables audit and quality assurance to be incorporated into the everyday provision of care.

The care pathway approach allows staff to demonstrate that patients receive all the elements of care that contribute to pressure ulcer prevention.

In developing the pathway, essential factors included:

- ◆ ease of use for practitioners
- ◆ ensuring that all risk factors were considered
- ◆ ensuring at risk patients received interventions to minimise risk before the selection of appropriate pressure relieving/reducing aids
- ◆ ensuring that patient and carer involvement was central to the process of care delivery
- ◆ emphasis on holistic assessment and multidisciplinary involvement
- ◆ incorporating the principles of effective risk management
- ◆ promotion of evidence-based care
- ◆ addressing misconceptions, such as risk score relates directly to risk status
- ◆ providing education and support for practitioners using the care pathway.

The initial pilot identified that the pathway approach was a useful and valid means to enhance clinical decision-making. The care pathway continues to be updated, with reference to clinical effectiveness, best practice and published guidelines.

**Jane Jones, Senior Nurse Support/ Tissue Viability Nurse, Scarborough and North East Yorkshire Healthcare NHS Trust**

Using the information that you have about your locality think about:

- ◆ which implementation techniques are most attractive?
- ◆ which are most feasible?
- ◆ what are the resource implications of each idea?
- ◆ are some ideas more suitable for some of the groups of people you work with than others?

- ◆ are some ideas more suitable for different stages of the work?
- ◆ how effective do you think the different techniques will be, based on the knowledge you have gained whilst working through this guide?

You will probably want to use different techniques at different stages in the process of implementing the guideline. For example, in the early stages, techniques that promote people's awareness of the guideline will be most useful. Later, you will need to use techniques that encourage and sustain the guideline in practice. Whatever techniques you decide to use, success is more likely if you 'mix and match' them according to the group, or groups, into which you are introducing the guidelines.

Jot down your ideas about implementation:

- ◆ have you identified everyone who will be affected by the guideline?
- ◆ have you used a range of different techniques for each group?
- ◆ have you chosen techniques according to how ready the group members are to implement the guideline?
- ◆ have you chosen techniques that suit the different backgrounds and preferred learning styles of all your target groups, for example, patients, carers, nurses, doctors etc?
- ◆ have you included a technique that addresses education and information provision?
- ◆ have you included a technique that makes use of social influences?
- ◆ have you considered the different techniques you will use over time?
- ◆ have you considered and addressed the practical implications of the techniques you have identified?
- ◆ have you considered the cost implications of each technique?
- ◆ are all the techniques realistic and achievable?

## 5

## Devise an action plan for implementation

The answers to the questions posed during this guide provide you with the information that you need to devise a strategy for implementing a clinical guideline locally. The final parts of developing the strategy are: organising the information into a set of actions, allocating each action to a named individual (or individuals) and setting targets and deadlines for each activity – that is turning your strategy into manageable activities in the form of an action plan. An action plan needs careful consideration. For each issue identified you will need to consider:

### 5.1 The appropriate course of action

Having identified the priorities for action, these need to be clearly documented and broken down into steps if necessary.

### 5.2 Identify a named person responsible for the action

It is important that the group identifies a named individual or individuals to be responsible for leading or co-ordinating each of the actions specified. Most of the implementation team will have responsibility for some aspect of the plan, depending on their particular skills and the group that they represent. Agree how that named person or people will be supported and by whom.

### 5.3 Decide on a time-scale for action

The group needs to determine how long it needs to implement each of the actions identified. This depends on the nature of the problem and the type of action required. **Short-term actions** are those that can be remedied almost immediately, in less than six weeks. **Medium-term actions** require a longer period of up to six months to implement, while **long-term actions** are those that will take more than six months to achieve.

### 5.4 Develop contingency plans

What problems might you encounter? How will you deal with problems, should they arise? For example, what do you do if you do not have enough, or access to the right type of equipment?

An example of an action plan is provided. You may of course have your own approach to project planning which you would rather use. To ensure that your action plan will be effective, check it against the following criteria.

- ◆ What are you trying to achieve?
- ◆ Are implementation team members clear about what actions they are responsible for and the time frames concerned?
- ◆ Is the timetable realistic?
- ◆ Have you communicated your plans to everyone involved in implementing the guideline?
- ◆ Who will ensure that the work has been done?
- ◆ How will all those affected by the work be kept informed?
- ◆ Who will monitor variance from the action plan?
- ◆ Have you made contingency plans?

Once a strategy is agreed and you have an action plan, you are ready to implement the guideline. The example which follows describes the course of action necessary in terms of aim, method and activities (see Example 10).

**Example 10 –  
Action plan for implementing a clinical guideline on pressure ulcer risk assessment and prevention**  
*Worked example – Fiona Stephens, Former RCN Project Manager*

Aim	Method	Activities	By who	When
To ensure pressure ulcer risk assessment and prevention complies with trust guideline	Review guideline and disseminate	Identify and inform stakeholders	Project facilitator	Monthly meetings
	Recommend changes, amend current guideline	Present to management team, patient liaison and clinical governance groups	Implementation team, including patient representatives	
	Check resources		Wound Interest group	
To ensure standards set in the guideline are met: risk assessment at first visit or within six hours of admission, reviews are undertaken, care is documented	Educate	Education programme in line with clinical guidelines for nursing and PAMs staff.	Project facilitator and link nurses	Road shows throughout trust
		Accredited courses	Local higher education provider	As staff access courses

Practical needs	Aim achieved?	Who is responsible for evaluation?	Evaluation
<p>Protected time</p> <p>Amended copies of:</p> <ul style="list-style-type: none"> <li>◆ guideline</li> <li>◆ posters</li> <li>◆ pocket summary guide</li> <li>◆ patient/carer information leaflet</li> </ul> <p>Access to team monthly meetings</p>	<p>All nurses and PAMs will be assessing patients and putting preventative actions into place appropriately</p> <p>Patients/carers will be provided with leaflet and verbal information.</p>	<p>Project facilitator</p> <p>Clinical audit department</p> <p>Link nurses</p>	<p>Annually</p>
<p>Venues</p> <p>Copies of guideline</p> <p>Pocket summary guide</p> <p>Poster summary displays</p> <p>Trust intranet</p> <p>Patient/carer information leaflet in appropriate language</p>	<p>All nurses and PAMs will be using guideline recommendations</p>	<p>Project facilitator implementation team and local education provider</p> <p>Clinical audit department</p>	<p>Audit of patient documentation prevalence monitoring</p>

continued on next page

## Example 10 continued

Aim	Method	Activities	By who	When
Equipment provision, both mattress and seating is as recommended in the guideline	Inform staff and patient liaison group	<p>Inform district nursing teams and community hospitals (nursing &amp; PAMs) of available equipment and means of acquisition</p> <p>Patient/carer information leaflet</p>	Project facilitator home loan store, ward managers	Road shows  Equipment directory
All nursing and PAMs staff have attended educational update on pressure ulcer risk assessment and prevention	Inform staff and managers	<p>Training provision: In-house – to all staff</p> <p>Identification of staff for further training</p> <p>Include training for all new employees</p>	<p>Managers to identify staff</p> <p>Project facilitator</p> <p>Implementation team</p> <p>Local higher education provider</p>	<p>Training updates to be incorporated in trust training manual</p> <p>As university prospectus</p>

Practical needs	Aim achieved?	Who is responsible for evaluation?	Evaluation
<p>Budget</p> <p>Copies of directory in all bases</p> <p>Hospital equipment stores catalogue</p>	<p>All at risk patients nursed on pressure redistributing mattress, very high risk patients on alternating pressure equipment</p> <p>All high risk patients have seating requirements assessed</p>	<p>Project facilitator</p> <p>Link nurses</p> <p>Home loan store</p> <p>Clinical audit</p>	<p>Ongoing, reported six-monthly</p>
<p>Budget</p> <p>Copies of training manual</p> <p>Copies of prospectus</p>	<p>Continuing professional development for all staff</p>	<p>Project leader via:</p> <ul style="list-style-type: none"> <li>◆ district nurse managers</li> <li>◆ hospital managers</li> <li>◆ PAMs managers</li> <li>◆ clinical audit department</li> </ul>	<p>Annual audit of staff training and development</p>

## 6

## Evaluating your progress

### Clinical audit

Clinical audit has been defined as: “A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery,” (National Institute for Clinical Excellence, 2002).

#### 6.1 Plan a programme of regular clinical audit

The ongoing task is to re-audit and to see whether care has improved in comparison with your previous results. Clinical audit is a continuous process and you will need to continue to measure practice against the audit criteria at regular intervals. You may choose to monitor care more frequently to track your progress as care is improved. **Incidence** and **prevalence** are two ways to measure pressure ulcer frequency.

**‘Incidence’** is the rate at which people initially admitted without an ulcer develop one during a specific period of time. This may be determined by the type of patients admitted – for example, those at high risk – and the effectiveness of preventive care (RCN 2001).

**‘Prevalence’** is the proportion of people with pressure ulcers in a defined period of time. This is affected by, for example, people admitted with existing ulcers, patient healing rates, rates of discharge and successful treatment (RCN 2001).

For the pressure ulcer risk assessment and prevention national pilot audit project – for which this implementation guide was developed – two audit tools have been developed and these are included at the end of part two of this guide.

It is essential that you establish a programme of regular clinical audit in order to maintain the high standards you achieve. As staff change and other issues compete for people’s attention, it is easy to lose the momentum necessary to sustain clinical excellence. An example of how audit can be undertaken is provided in example 11.

#### Example 11 – Clinical audit

The Clinical Resource Efficiency Support Team (CREST) in Northern Ireland divides the audit of pressure ulcers into two specific areas.

##### The patient:

Has a risk assessment been undertaken?  
Has the patient been identified as being at risk?

Has the at risk patient a plan of care that includes the following:

- ◆ type of bed in use?
- ◆ frequency of position change?
- ◆ involvement of other disciplines?
- ◆ does the patient with pressure damage also have the following documented in the care plan:
  - site, size and grade of pressure ulcer?
  - type and frequency of dressing?
  - referral to a dietician?
  - the effectiveness of the plan?

##### The facility:

- ◆ Has the unit a pressure ulcer policy?
- ◆ Is there a mattress replacement policy?
- ◆ Is there guidance provided on allocation of equipment?
- ◆ Does the policy advocate the use of a single assessment tool?
- ◆ Is there guidance provided on the use of the grading tool?
- ◆ Does the staff know of the existence of the policy?

*Guidelines for wound management in Northern Ireland* (Clinical Resource and Efficiency Support Team, 1998).

The clinical audit cycle – as shown at the beginning of this guide – provides a systematic process, taking you through a range of activities to evaluate care, plan and make changes and finally to re-evaluate care. The cycle follows this framework, describing the activities involved as they lead to implementation. Moving around the cycle begins with involving the entire team and finding the right leadership. The cycle ends with a re-evaluation of care and to ensure that care is continually reviewed and improved. Part 2 of this publication describes the process in more detail and includes tools to assist you.

## 7

## Summary

### 1 Decide who will lead and co-ordinate the work

- 1.1 Identify a project lead and facilitator
- 1.2 Set up a group
- 1.3 Identify stakeholders to lead implementation of the guideline
- 1.4 Clarify and agree the roles of all group members
- 1.5 Agree the purpose of the clinical guideline

### 2 Determine where you are now

- 2.1 Measure current clinical practice
- 2.2 Consider benchmarking
- 2.3 Determine receptivity to the guideline
- 2.4 Identify the systems and structures you need to support implementation of the guideline

### 3 Preparing the people and environment for guideline implementation

- 3.1 Prepare staff and other stakeholders
- 3.2 Identify your supporters and possible resisters
- 3.3 Plan activities to overcome negative attitudes to clinical guidelines
- 3.4 Devise a communication strategy to support implementation of the clinical guideline
- 3.5 Prepare the environment

### 4 Decide which implementation techniques to use to promote use of clinical guidelines in practice

- 4.1 Identify needs for education and training
- 4.2 Find out who are your clinical leaders, opinion leaders and product champions
- 4.3 The role of peer support, organisational support and facilitation
- 4.4 Maximise feedback and reward
- 4.5 Consider recording systems or integrated care pathways
- 4.6 Decide which combination of techniques is most suitable for implementing the clinical guideline locally

### 5 Devise an action plan for implementation

- 5.1 Consider an appropriate course of action
- 5.2 Identify a named person responsible for that action
- 5.3 Decide on a time scale for action
- 5.4 Develop contingency plans

### 6 Evaluating your progress

- 6.1 Plan a programme of regular clinical audit

## PART 2 – AUDIT PROTOCOL

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### 8

## How the audit tools were developed

Audit tools have been developed in collaboration with clinicians in England and Wales. They aim to provide nurses with usable tools with which to monitor the quality of care. They have been developed from clinical practice guidelines (RCN 2001).

Guidelines are inclusive as they assist the decision-making process, covering all potential decisions confronting the health professional or patient. Audit criteria are exclusive; they are used to judge the quality of care and concentrate on those aspects of care that have the greatest impact on quality and outcomes.

### 8.1 The evidence base

The clinical guideline (RCN, 2001) is evidence-linked, rather than evidence-based, as there was insufficient research evidence to guide all clinical decisions. A number of recommendations were all, or in part, based on consensus expert opinion. Although a formal consensus process was used, the guideline development group considered research evidence alongside their clinical opinion to make their judgements (see RCN, 2000 and Rycroft-Malone, 2002 for more details). Evidence grades are used in the clinical guideline to show the type of evidence supporting each recommendation. All recommendations are endorsed equally and none are regarded as optional.

### 8.2 The pilot project

A national pilot audit project was undertaken over a period of 18 months. Six pilot sites were recruited across England and Wales, comprising four NHS trusts and two independent nursing care homes. These sites provided care to all or some of the following care groups: medical, orthopaedic and older people. Two rounds of data collection took place. There was an initial baseline data collection, followed by a second collection, which occurred after an implementation session. The focus of the data collection was patient documentation and skin inspection. Training sessions occurred in each site. The link person in each site was responsible for facilitating staff to implement the guideline recommendations. Data was analysed and compared to the baseline data. The results showed improvement in documented assessments, care planning and review (Stephens & Bick, 2002).

## 9

# Planning an audit of pressure ulcer risk assessment and prevention

## 9.1 Preparing to audit

This section sets out the issues that you will need to consider when planning a local clinical audit project. To be successful, a clinical audit project needs to involve all those who have a part to play in the prevention and risk assessment of pressure ulcers. The best way to ensure that everyone's views are represented may be to bring together a group, who may be the same as your implementation group (as described in section 1, page 4). The group will enable you to consult with all stakeholders, who can then be involved in making decisions throughout the process. The example given here relates to secondary care. Clearly, a group based in the community or a small nursing home will look very different.

### Example 12 – a clinical audit project team

Jane Smith – Clinical Audit Officer (project facilitator)

Susie Webb – Tissue Viability Nurse

Mark Davis – Clinical Manager

Simon Taylor – staff nurse (medicine)

Carol Gupta – staff nurse (surgery)

Sheila Crabtree – Specialist Registrar, Dermatology

George and Enid White – husband and wife – service user and carer

Florence Adams and Jenny Lea – mother and daughter – service user and carer

It is important to review the clinical practice guideline for pressure ulcer risk assessment and prevention (RCN, 2001) to remind the group of the essential elements under review. You will need to address a number of issues as you design your audit. It is a good idea to consider these within the project team, reaching agreement on each issue.

Consider the following:

- ◆ what is the time scale of the audit?
- ◆ how will the data be collected?
- ◆ who will collect the data?
- ◆ who will train the data collectors?
- ◆ how will the data be analysed and by whom?
- ◆ who needs to know about the findings?
- ◆ how will the findings be disseminated?
- ◆ how will improvements be taken forward?
- ◆ who needs to be involved?

In addition it can be helpful to develop a contingency plan, by asking:

- ◆ what might occur that would disrupt this plan?
- ◆ how could we avoid these problems?
- ◆ what will we do if these problems occur?

Gantt charts can provide a useful way of setting out the timetable for the project so that everyone is clear what will be happening and when. Figure 3 provides an example.

## 9.2 Ethical issues and project approval

At present, there is no nationally agreed guidance to help local NHS trusts address ethical concerns raised by clinical audit. It is necessary to ensure:

- ◆ confidentiality – ensuring that data collected for audit purposes protects the identity of those participating
- ◆ consent – determining whether direct written consent is necessary for participation and agreeing an acceptable process for this

Figure 3. Example of a Gantt chart for a local pressure ulcer audit project

Project step	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Convene project group	█											
Seek project approval	█	█										
Baseline data collection			█	█	█	█						
Collate and analyse data					█	█						
Present findings						█	█					
Develop action plan							█					
Implement the action plan							█	█	█	█	█	█
Re-audit								█	█	█		
Collate and analyse data										█	█	
Present findings											█	█
Plan ongoing audit												█
Plan to maintain standards												█

- ◆ the effectiveness of audit - that the methodology of the project is rigorous and produces high quality data on which to base decisions about changing practice
- ◆ accountability - ensuring that the issues highlighted by audit results are addressed and improvements made (Morrell & Harvey, 1999).

It is important to ensure that your project proposal has been approved by whatever mechanism exists locally. You need to check that you have obtained approval for the clinical audit project to be undertaken within your organisation. Currently, arrangements for clinical audit project approval vary. Your local clinical audit team will be able to guide you.

Given the nature of the project and the inclusion of skin inspection, it is recommended that written consent be obtained. An example consent form is included with the audit tools at the end of this publication. One copy of the consent form should be kept for the project, another copy for the patient themselves and the third copy filed in the patient's notes.

Information sheets have been designed for you to adapt locally to show to patients and carers. These can be translated into appropriate languages. You need to ensure that patients and carers are given the opportunity to ask any questions. It may be useful to display a poster, which tells people about the project. These sheets can be found at the end of this section.

### 9.3 Collecting data

It may be necessary for data collectors to have specific training. This is important to ensure that the same approach to data collection is applied across the organisation. You need to consider carefully who the data collectors should be - for example, staff within that unit, a member of clinical staff from another area, or a member of the clinical audit team. Those involved in skin inspection should be nurses.

For this audit project, the sample includes every patient on the day of the audit. This may be every patient on the caseload of a community nurse, every person resident in a nursing home, or all in-patients on a ward on the day of the audit. This is called a point prevalence survey and ascertains what is happening at

one point in time. Data on the frequency with which patients develop pressure ulcers is collected as either prevalence – the proportion of a defined group of patients with a pressure ulcer at a defined point in time – or incidence – the proportion of a defined group of patients developing a pressure ulcer within a predetermined time span – as previously defined in greater detail in step 6 (see page 32, 6.1).

The rate of pressure ulcer occurrence is often viewed as an indicator of effective clinical management (Hillian and Frazer, 1998), with lower rates indicating quality care (Leshem and Skelsky, 1994). However, currently there is no consistent, systematic and valid approach to data collection and therefore data comparisons are impossible. Organisations such as the European Pressure Ulcer Advisory Panel (EPUAP) are attempting to address these complex issues by identifying a minimum dataset for pan-European prevalence data collection. This may not solve the problems but will hopefully raise the profile of pressure ulcer data collection among clinicians, managers and at government level, enabling the collection of meaningful data that can be utilised for benchmarking (Fletcher, 2001).

Before beginning the data collection, you need to ensure that you have everything ready. This includes:

- ◆ sufficient data collection sheets
- ◆ a method of identification which maintains confidentiality
- ◆ a secure way of storing the completed data collection sheets
- ◆ a data entry system.

Examples of the audit tools and instructions for use are included at the end of this section.

## 9.4 Analysing data

It is important to remember the objective of the audit. The purpose of analysing the data is to try to reach conclusions about the degree to which actual practice is meeting the guideline recommendations in order to improve care. Data analysis needs to be a collaborative venture between audit and clinical staff, who may need to interpret the results in order to help prioritise issues for action.

It is often helpful to present information in the form of graphs, making interpretation of the data clearer to those reading it. A computer package – such as Microsoft Excel or Access – will help with this process. A template could be set up with ‘pull down’ boxes for the possible variables. Using this kind of programme allows easy comparison of data from different sources – see page 39 for examples of Excel graphs.

## 9.5 Feeding back the findings

An important part of any clinical audit is to make sure that the findings are fed back to all the relevant stakeholders. This usually includes providing passive, written reports, and active discussion of findings feedback to:

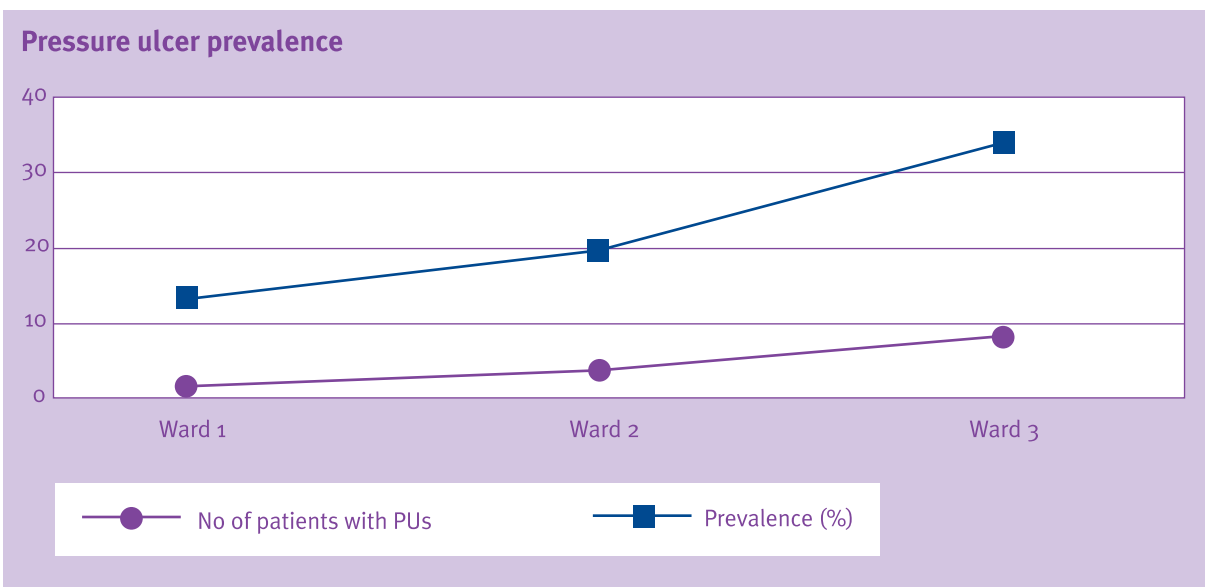
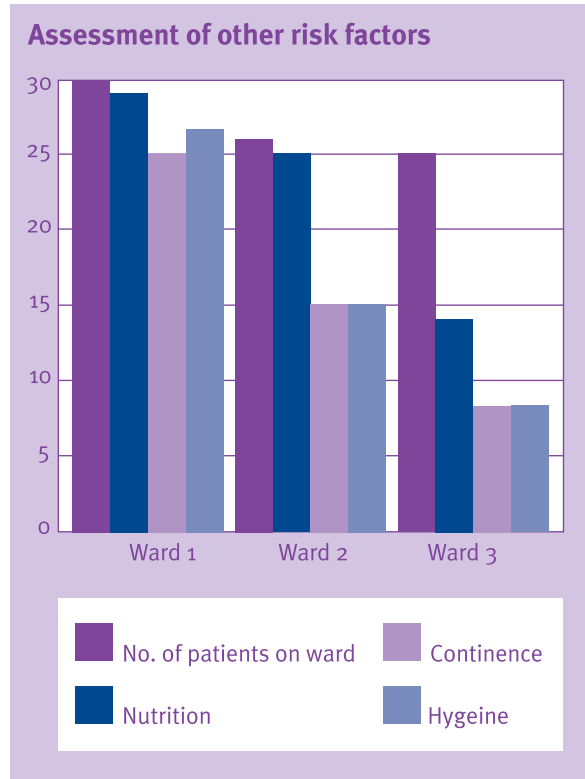
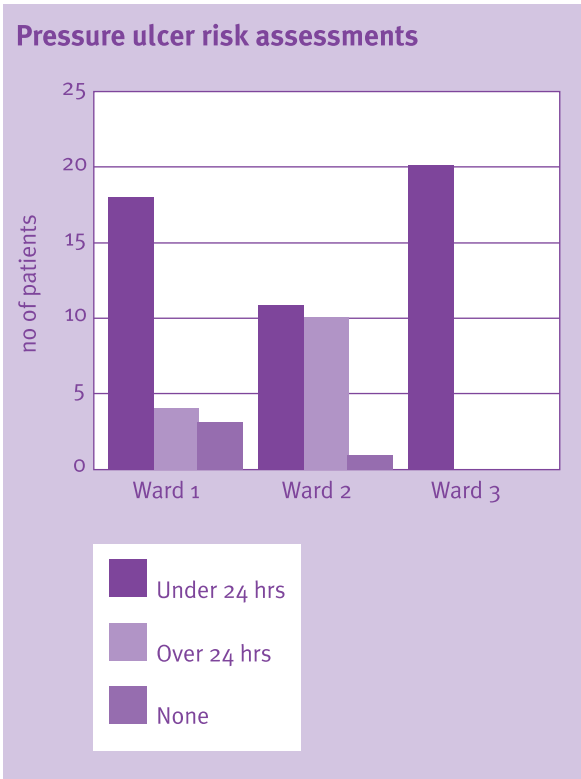
- ◆ service users - patients and carers
- ◆ the clinical audit team
- ◆ staff in the clinical areas involved
- ◆ managers responsible for those services
- ◆ the clinical governance committee.

You need to ensure that people who ask to see results are able to get hold of any project reports. Various stakeholders may need different information and several versions of the written report may be needed. Discussion of the results with all the stakeholders is essential in order to identify and agree any changes that may need to be made as a result of the audit findings.

You will need to include the following in your final audit report:

- ◆ rationale – your reasons for choosing the topic
- ◆ evidence base – the evidence on which your standard is based
- ◆ standard – the standard against which you have compared practice
- ◆ involvement – professional and patient groups involved
- ◆ implementation – the steps you took to implement the standard
- ◆ methods – audit tool, sample and data collection strategy
- ◆ results – summary of data analysis and changes in practice

## Examples of graphs



- ◆ cost – an approximation of the direct costs involved in the project
- ◆ lessons learned – summary of the impact of the project
- ◆ recommendation – issues for the reports audience
- ◆ references (Morrell and Harvey, 1999:186)

## 9.6 Changing practice

Changing practice can be complex. Here are a few principles that can guide you through this process:

The implementation guide in part one of this publication gives a full account of the sorts of issues which need considering. An action plan is central to this process and it should specify:

- ◆ what needs to change, why and how?
- ◆ the actions needed to initiate the changes
- ◆ the people affected
- ◆ the individuals who will take responsibility for specific actions
- ◆ the time-scale, with a start date
- ◆ the support and resources involved
- ◆ how the changes will be monitored, to assess whether the actions taken achieve the desired outcomes
- ◆ when re-audit will take place.

Practical information on running a successful clinical audit project can be found in *The clinical audit handbook* (Morrell and Harvey, 1999). An overview of factors that lead to effective clinical audit can be found in *Principles of best practice in clinical audit* (NICE, 2002).

## 9.7 Improving care within a strategy for clinical governance

Clinical governance is defined as: “A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care, by creating an

environment in which excellence in clinical care will flourish,” (Sally and Donaldson, 1998).

If you want to maximise the opportunities to improve this aspect of care, your project needs to be clearly integrated within your organisation’s strategy for clinical governance. There are four reasons for this:

### 1. To ensure that the work is visible within the wider organisation

Clinical governance reports go to NHS trust executive boards, strategic health authorities and the Commission for Healthcare Audit and Inspection (CHAI), formerly the Commission for Health Improvement (CHI). It is important that your clinical audit project gets the recognition it deserves from those at executive level. In this way you are able to share the lessons you learn and receive feedback from others.

### 2. To obtain support from those with clinical audit expertise

Clinical audit programmes are planned well in advance. In order to get the support you need for the smooth running of your project, you need to let others know in time for the clinical audit planning process. This way the clinical audit team can allocate the resources needed to guide you.

### 3. All staff are required to be actively involved in clinical audit\*

Involvement in this project will enable staff to fulfil this requirement as a part of their continuing professional development.

### 4. To link the issues necessary to make genuine service improvements

By focusing on one important clinical topic in this project, links can be made between individual continuing professional development, patient experience, organisational development, teamwork, clinical effectiveness and risk management.

Further information on clinical governance can be found in *Clinical governance: a resource guide* (RCN, 2003) or on the clinical governance support team web site at: [www.clinicalgovernance.net](http://www.clinicalgovernance.net)

\* This was a recommendation of the Bristol Royal Infirmary Inquiry (Kennedy, 2001)

## 10

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## 11

## Further reading and useful websites

### Identifying individuals 'at risk', prevalence and incidence

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European Pressure Ulcer Advisory Panel (1998) *Pressure ulcer prevention guidelines*. Oxford: EPUAP.

Papanikolaou L (2000) An empirical investigation of pressure ulcer risk factors. *Nursing Standard* 14(49):46-53.

### Use of risk assessment scales

Gould D, Kelly D, Goldstone L, Gammon J (2001) Examining the validity of pressure ulcer risk assessment scales: developing and using illustrated patient simulations to collect the data. *Journal of Clinical Nursing* 10:697-706.

### Risk factors

Defloor T (1999) The risk of pressure sores: a conceptual scheme. *Journal of Clinical Nursing* 18:206-216.

Scott E M (2000) The prevention of pressure ulcers in the operating department. *Journal of Wound Care* 8(1):18-21.

### Skin inspection

Bennett M A (1995) Report on the taskforce on the implications for darkly pigmented intact skin in the prediction and prevention of pressure ulcers. *Advances in Wound Care* 8(6):34-35.

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### Pressure redistributing devices

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Scott E M, Baker E A, Kelly P J (1999) Measurement of interface pressures in the evaluation of operating theatre mattresses. *Journal of Wound Care* 8(9):437-441.

### Use of aids

Agency for Health Care Policy and Prevention (AHCPR) (1992) Pressure ulcers in adults: prediction and Prevention. *Clinical Practice Guideline Number 3*. Maryland: US Department of Health and Human Sciences (now known as Agency of Health Care Research and Quality, AHRQ)

### Positioning

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### Seating

Collins F (2001) How to assess a patient's seating needs: some basic principles. *Journal of Wound Care* 10(9):383-386.

Collins F (2001) Selecting cushions and armchairs: how to make an informed choice. *Journal of Wound Care* 10(10):423-437.

### Education and training

Moore Z (2001) Improving pressure ulcer prevention through education. *Nursing Standard* 16(6):64-70.

### Users and carers

Defloor T (1997) The effect of posture and mattress on the development of pressure ulcers. In programme for the 7th European conference on advances in wound management. London: Macmillan magazines.

Garber S L, Rintala D H, Rossie D et al (1996) Reported pressure ulcer prevention and management techniques by persons with spinal cord injury. *Archives of Physical Medicine and Rehabilitation* 77:744-749.

### Nutritional status

Lewis B K (1998) Nutrient intake and the risk of pressure sore development in older patients. *Journal of Wound Care* 7(1):31-35.

Pope R (1999) Pressure sore formation in the operating theatre 1. *British Journal of Nursing* 8(4):211-217.

### Continence management

Defloor (1999) The risk of pressure sores: a conceptual scheme. *Journal of Clinical Nursing* 18:206-216.

Goldstone L A, Goldstone J (1982) The Norton Score: an early warning of pressure ulcers? *Journal of Advanced Nursing* 7(5):419-426.

### Hygiene

Stephens F (2001) Raising the profile of effective skin care in the older person. *Community Nurse* March 2001.

## Websites

### Guideline

Royal College of Nursing: Pressure ulcer risk assessment and prevention.

This is the full version of the RCN guideline as an HTML version.

<http://www.nelh.nhs.uk/guidelinesdb/html/PrUlcer-con.htm>

A version of the document as a portable document format (PDF) is available on the RCN website in two parts:

[http://www.rcn.org.uk/professional/clinical\\_downloads/pressure\\_ulcer\\_risk\\_assess\\_1.pdf](http://www.rcn.org.uk/professional/clinical_downloads/pressure_ulcer_risk_assess_1.pdf)

[http://www.rcn.org.uk/professional/clinical\\_downloads/pressure\\_ulcer\\_risk\\_assess\\_2.pdf](http://www.rcn.org.uk/professional/clinical_downloads/pressure_ulcer_risk_assess_2.pdf)

### Agencies

European Pressure Ulcer Advisory Panel:  
<http://www.epuap.org>

European Wound Management Association:  
<http://www.ewma.org>

Tissue Viability Society: <http://www.tv.s.org.uk>

### Conference proceedings

Wounds UK 2002: <http://wounds-uk.com/>

### Online journal

World Wide Wounds: <http://worldwidewounds.com/>

### Patient information sites

<http://www.familydoctor.org/handouts/039.html>

<http://www.skincarecampaign.org/>

# THE AUDIT TOOL

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# Information sheet

## Getting better at preventing pressure ulcers

You are being invited to take part in a local audit to help us improve care. Before you decide whether you would like to take part, please read the following information, which explains why this clinical audit project is taking place and what it involves. Please take your time to read this. It will help you decide whether or not you wish to participate.

### What is the purpose of clinical audit?

Clinical audit is the way in which we continually review our practice in order to improve our services so that you receive the best possible care. This project is about recognising and assessing individual patient's risk of developing pressure ulcers. We need your comments to help show us where we need to improve.

### What are pressure ulcers?

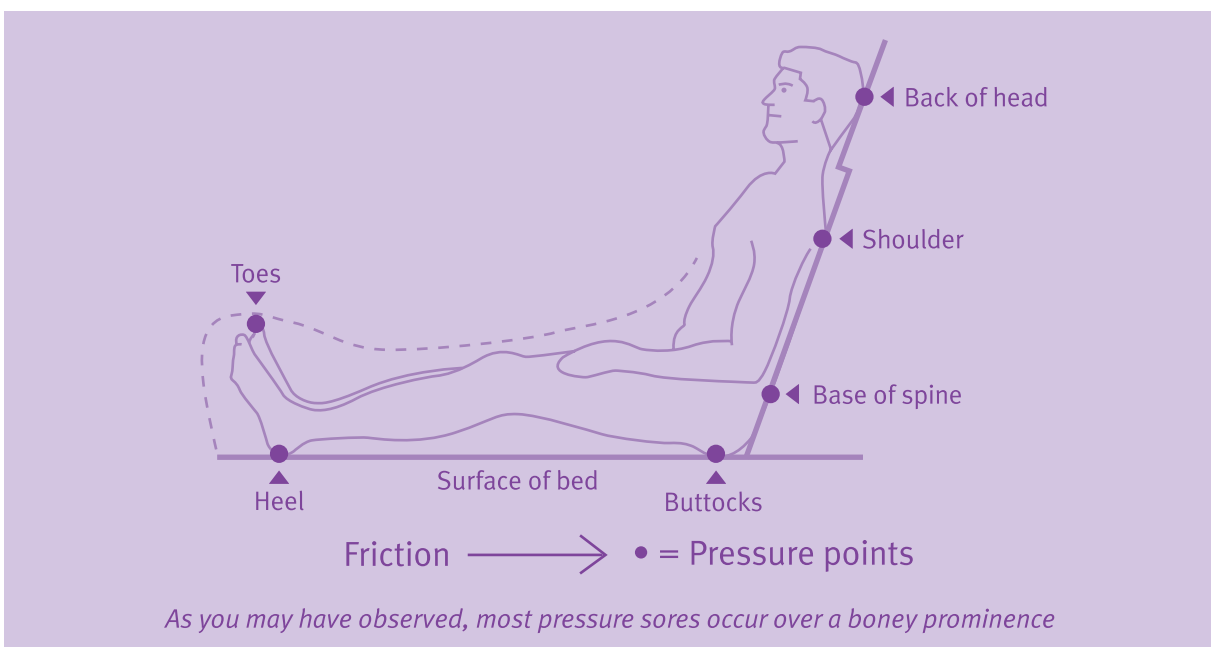
Pressure ulcers – previously known as pressure or bed sores – are areas of damage to the skin and deeper tissue and can affect all patients. They may cause discomfort and become infected or, in extreme cases, damage muscle and bone. They can lead to a longer stay in hospital.

### What happens if you decide that you want to take part?

- ◆ You will be asked to sign a consent form:

This gives us permission to look at your records to find out about the care you have received to prevent pressure ulcers. We would also like to examine areas of your skin that are more likely to be at risk of developing a pressure ulcer, and we need your permission to do this.

These areas are shown on the diagram below:



Taken from *Working together to prevent pressure ulcers – a guide for patients and their carers*, (page 12) NICE. This publication is copyright free.

**Confidentiality**

- ◆ All information collected about you during the course of this project will be kept strictly confidential.
- ◆ We may share our results with other hospitals, so that we can learn from one another. Any information about you that leaves this hospital will have your name and address removed, ensuring that you cannot be identified.
- ◆ The results of the project may be published or presented at meetings or conferences. No individual will be identified in any report or publication.

**Contact for further information**

If you require further information, the contact person is:

**What happens if you decide that you do not want to take part?**

Simply tell the nurse that you do not want to take part. You are free to withdraw from the project at any point without giving a reason. This will not alter or affect the care that you receive.

**Thank you for your time.**



# Example consent form

Unique identifier:

## Audit of pressure ulcer risk assessment and prevention

Please initial box

1. I confirm that I have read and understand the information sheet and have had the opportunity to ask questions.
2. I understand that sections of any of my health care records may be looked at by the person collecting information for this project. I give permission for the individuals to have access to these records.
3. I give permission for a member of nursing staff to examine areas of my skin that are more likely to be at risk of developing a pressure ulcer.
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without either my medical care or legal rights being affected.

Name of patient

Date

Signature

Project leader

Date

Signature

Translator

Date

Signature

*Three copies needed: one for project leader; one for patient; one to be kept with notes.*

# Instructions for audit forms

*All forms should be completed either by placing a cross in the appropriate box or using free text where indicated.*

## Ward/nursing home/caseload audit form

### Data collection – one form per ward, nursing home or district nursing caseload

One form should be completed per ward, caseload or nursing home. All sections of the form should be completed as described below. The form requires information on bed occupancy, training and education, current guidelines and patient information.

### Unit information

Questions 1 to 4 identify the unit and ward or district nursing caseload. Information is required on total bed occupancy or patients registered on the caseload on the day of the audit. This enables information to be identified on the numbers of patients at risk of and with pressure ulcers. Date of completion is required on the audit form.

### Training and education

Questions 5 to 11 are to find out about the training and education available to staff – nursing, medical and professions allied to medicine – in relation to pressure ulcer risk assessment and prevention. Numbers of nursing staff by grade – covering the 24-hour period – and their training, competency and updating is required.

## Patient/carer information

Questions 12 and 13 seek information on patient and carer education and how this is provided.

## Clinical guidelines

Questions 14 and 15 seek information on use of existing guidelines, their date of development/publication in the trust and if they have been updated in line with the RCN clinical guideline, *Pressure ulcer risk assessment and prevention* (RCN 2001).

## Clinical effectiveness

Question 16 requires information on current methods used in the audit of pressure ulcers and whether data collected are presented as prevalence or incidence.

Prevalence – the proportion of individuals in a defined population who have a pressure ulcer at a given point in time.

Incidence – the proportion of individuals in a defined population who develop a pressure ulcer over defined period of time.

## Collection of completed forms

Please ensure all items on the form are filled in. Once completed the form will be collected by the tissue viability specialist nurse or link nurse for data collection on the day of the audit. The ward may make photocopies of the completed form for use in future planning and development.

## Patient audit form

### Inclusion criteria for the audit

All patients resident on the ward, in the nursing home or registered on the district nursing caseload on the day of the audit. A patient information sheet should be given to each patient, prior to undertaking the audit, and written consent sought.

### Data collection – one form per patient

One form should be used for each individual patient. All sections of the form should be completed as described below. The form requires patient information from the patient's nursing notes and skin inspection. 'Documentation' referred to in the audit tool means the patient's record.

### Unit information

Questions 1 to 4 identify the unit, ward and patient and include the date the audit is undertaken.

### Patient information

Questions 5 to 8 require information on the patient relating to gender, age, reason for admission and date of initial nursing assessment following admission.

### Pressure ulcer risk

Questions 9 to 14 require information on the risk assessment of the patient. If this has not occurred, this needs to be noted. The date of the first pressure ulcer risk assessment, grade of nurse undertaking the assessment (where possible), the risk assessment scoring tool used and the most recently dated documented risk assessment score should be included, with date undertaken. The auditor should assess the patient, using the same risk assessment tool, and document their findings on the form. Evidence of other factors being taken into account in identifying risk may include previous history of pressure ulcers, existing ulcers, etc and should be included. Evidence of reassessments and their frequency should be included. This may not be applicable, depending on the length of time elapsed since the patient's admission.

### Skin inspection

Questions 15 to 17 require information from both the patient's notes and skin inspection by the auditor. This section requires identification of the pressure ulcer scoring tool used, the presence of any pressure ulcers and grading – both documented and actual – based on the auditor's inspection of the patient's skin. Further information is sought on planning, implementing and

reviewing skin inspection as part of the nursing care plan. Again, this will depend on the time elapsed since the patient's admission.

### Equipment

Questions 18 and 19 look at the provision of equipment; the chart should be completed using the key (**I** – in use; **R** – requested, not arrived; **N** – not available) taking into account pressure redistributing or pressure relieving equipment provided. Reviews of the equipment provision should be included. NB. 'Basic hospital mattress' refers to those without any pressure relieving/redistributing qualities.

### Other aids

Question 20 requires information on other aids that are being used as 'pressure relieving/redistributing' devices. Any aids used, other than those listed, should be recorded on the form.

### Repositioning/moving and handling

Questions 21 and 22 require information from the nursing notes on planning, implementing and reviewing repositioning schedules and movement and handling procedures.

### Seating

Questions 23 and 28 require information from the patient's notes of seating assessment, the assessor and length of time recommended in the documentation for patients to be seated, and information on implementation and review.

### Completed forms

As the form is completed in conjunction with the tissue viability nurse specialist or link nurse, they will remove them for data analysis.

## RCN Pressure ulcer risk assessment and prevention audit project

# Patient audit form

Please refer to instructions for the completion of the audit tools. Complete all sections of this form by placing a cross in the appropriate box or using the free text sections as directed

### Unit information

1. Name of ward/nursing home

\_\_\_\_\_

2. Ward

\_\_\_\_\_

3. Patient identifying numbers

\_\_\_\_\_

4. Date of completion of audit form

\_\_\_\_\_

### Patient information

5. Gender of patient M  F

6. Age of patient on admission: \_\_\_\_\_ years

7. Reason for admission

\_\_\_\_\_

\_\_\_\_\_

8. Date of initial nursing assessment following admission

\_\_\_\_\_

### Pressure ulcer risk

9. First pressure ulcer risk assessment date

10. Nursing grade assessor (please tick):  A  B  C  D  E  F  G  H

Other health professional, please specify: \_\_\_\_\_

11. Risk assessment scale used: (please tick)

Waterlow  Norton  Braden  Walsall  Medley/Maelor

Other, please specify: \_\_\_\_\_

12. Risk score (number): \_\_\_\_\_ as documented (most recent)

Date: \_\_\_\_\_ as assessed by auditor

13. Is there evidence in the documentation of other risk factors for pressure ulcer development being taken into account in the assessment process?

Nutritional status  Continence management  Hygiene

Other, please specify: \_\_\_\_\_

14. Within the documentation is there evidence of reassessments being undertaken?

Yes  No  Not applicable

Frequency:  Daily  Weekly  Monthly Other, please specify: \_\_\_\_\_

**Skin inspection**

15. Pressure ulcer/s present Yes  No

16. Grading system used (e.g. Stirling, EPUAP, Torrance, etc.): \_\_\_\_\_

16a. Location and grade of ulcer/s, if present (indicate number of ulcers of each grade in each area and left or right as appropriate):

Grade of ulcer	Documented						Actual					
	0	1	2	3	4	5	0	1	2	3	4	5
<b>Location</b>												
Sacrum												
Buttocks												
Ischials												
Trochanter												
Heels												
Elbows												
Ankles												
Other, please specify:												

17. From the nursing documentation is there evidence that inspection is:

Planned: Yes  No  Implemented: Yes  No  Reviewed: Yes  No

**Equipment**

18. Type of equipment on which patient is being nursed

Key: I = in use R = requested, not arrived N = not available.

	Overlay	Mattress	Cushion/chair	Specialist bed
Basic hospital, for example, contract NHS bed				
Foam pressure reducing				
Fibre/gel-filled				
Static air overlay				
Alternating pressure device				
Low air loss device				
Air fluidised/ fluidised bead				
Rotational device				
Electric bed frame				

19. Is there evidence in the nursing documentation that use of equipment is reviewed: Yes  No

**Other aids**

20. Are any of the following pieces of equipment in use for relieving/reducing pressure?

- Sheepskin sheet                       Protector                       Water filled glove  
 Pillow for 30° tilt                       Pillow for seating                       Donut device

Other (please specify: \_\_\_\_\_)

None of the above

**Repositioning/moving and handling**

21. From the nursing documentation, is there evidence that repositioning schedules are:

Planned                      Yes     No

Implemented                      Yes     No

Documented                      Yes     No

22. From the nursing documentation, is there evidence that movement and handling procedures are:

Assessed                      Yes     No

Planned                      Yes     No

Reviewed                      Yes     No

**Seating**

23. Does the patient sit out of bed?    Yes     No

**If yes:**

24. Is there evidence within the patient record that a seating assessment has been undertaken?

Yes     No

25. Did an occupational therapist or physio complete the assessment?

Yes     No

26. Is the optimal length of time seated at any one time documented?

Yes     No

27. If yes, please indicate the time specified within the notes:

Up to one hour     one to two hours     two to four hours     over four hours

28. From the documentation is there evidence that the time seated is:

Implemented     Reviewed

*Thank you for your time in completing this audit form*

## RCN Pressure ulcer risk assessment and prevention audit project

# Ward audit form

Please refer to instructions for completion. Complete all sections of this form either by placing a cross in the appropriate box or by using the free text sections as directed

### Unit information

1. Name of trust/nursing home

---

2. Ward/DN caseload

---

3. Total bed occupancy/total caseload number

---

4. Date of completion of audit form

---

### Pressure ulcer risk assessment and prevention training and education

5. Is training available in pressure ulcer risk assessment and prevention as part of the trust or ward training programme?

Yes  No  Don't know

6. Who provides training?

Tissue viability nurse  Nursing team member  Commercial company

Educational institution  Other health care professional

Other, please specify: \_\_\_\_\_

7. Do other health professionals receive training?

Yes  No  Don't know

If so, who? For example, occupational therapists, physiotherapists, medical staff etc.

---

Don't know

8. Approximately what percentage of nursing staff on the ward is trained in pressure ulcer risk assessment and prevention?

Grade	A	B	C	D	E	F	G	H
No of staff on ward by grade								
No. of staff trained in pressure ulcer risk assessment & prevention								
0 – 25%								
26 – 50%								
51 – 75%								
76 – 100%								

9. Is nursing competence in risk assessment for pressure ulcers assessed?

Yes  No

If yes, how is competency assessed? \_\_\_\_\_

10. Is regular updating provided on risk assessment and prevention?

Yes  No

Frequency:

Annual  Three Yearly Other, please specify: \_\_\_\_\_

If yes, please state how these updates are provided?

\_\_\_\_\_

12. Is information/education given to patients/carers about pressure ulcer risk assessment and prevention documented?

Yes  No

13. If yes, in what form is this information/education given?

Leaflet/booklet

Teaching session

Other, please specify: \_\_\_\_\_

**Clinical guidelines**

14. Are there any existing local guidelines, policies or protocols for pressure ulcer risk assessment and prevention?

Yes  No Date developed: \_\_\_\_\_

15. If yes, have these documents been reviewed in line with the *RCN Clinical Guidelines for Pressure Ulcer Risk Assessment and Prevention 2001*?

Yes  No  Don't know

**Clinical effectiveness**

Are any of the following regularly audited?

(a) Prevalence of pressure ulcers

Yes  No  Don't know  Frequency \_\_\_\_\_

(b) Incidence of pressure ulcers

Yes  No  Don't know  Frequency \_\_\_\_\_

The completed form will be collected by \_\_\_\_\_

Thank you for your time in completing this audit form

## Pressure ulcer risk assessment and prevention

# Self-assessment questionnaire

Circle the answer/s you feel apply or complete list as requested.

- 1) How soon after admission should a pressure ulcer risk assessment be carried out?
  - Immediately
  - Within six hours
  - Within 24 hours
  - Within one week
- 2) If a patient is not considered at risk on initial assessment, what would trigger a reassessment?
  - Ward policy
  - Surgery
  - Deterioration in condition
  - Discharge from ward
- 3) Risk assessment scales should be used as:
  - They are accurate indicators of risk
  - They are usable in all clinical settings
  - To assist clinical judgement
- 4) A person's potential to develop pressure ulcers will be influenced by intrinsic factors (factors within the individual) that should be considered when undertaking a risk assessment. Nine intrinsic factors have been identified that may influence your assessment, list as many as you can:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- 5) Extrinsic factors (factors external to the individual) are involved in tissue damage; these should be removed or diminished to prevent injury. List three extrinsic factors:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- 6) Other factors may exacerbate the patient's potential for pressure ulcers, list as many as you can:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- 7) Skin inspection provides essential information for both assessment and prevention of pressure ulcers; regular inspection of vulnerable parts of the body enables early detection of pressure damage. List the parts of the body, that are most susceptible to damage:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

8) Which of the following describe the appearance of the skin that may be showing early signs of pressure ulcer damage?

- Bruising
- Persistent erythema
- Blisters
- Blanching hyperaemia
- Localised heat or oedema
- Non-blanching hyperaemia
- Rash

9) Decisions about support surfaces should be influenced by holistic assessment of the patient's risk and their general health. *Circle indicating whether you feel the following statements are true or false:*

- Risk assessment scores should be used to decide on equipment provision.  
True / False
- Assessment should be ongoing throughout the patient's episode of care and equipment changed to suit alterations in risk.  
True / False
- At risk patients should be placed on a standard NHS type mattress.  
True / False
- Patients identified as being at very high risk should be placed on alternating pressure mattresses or other high-tech pressure redistributing systems.  
True / False
- Pressure redistributing mattresses or overlays should be used on operating tables for patients identified as being at high risk.  
True / False
- At risk patients should be placed on pressure redistributing mattresses in the postoperative period.  
True / False

10) List the considerations you may take into account when planning a patient's preventive care:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Score one point for every correct answer, using the answer sheet.

**The answers are derived from the *RCN clinical guideline pressure ulcer risk assessment and prevention (2001)*.**

Question	Maximum Score	Actual Score
1	2	
2	2	
3	1	
4	9	
5	3	
6	4	
7	9	
8	4	
9	6	
10	10	
<b>Total</b>	<b>50</b>	

**What does your score mean?**

- Less than 18 – good try
- Less than 30 – well done
- Between 35 – 40 – very good
- Over 40 – excellent

## National pilot audit project

### Pressure ulcer risk assessment and prevention

# Self-assessment questionnaire

## Answer sheet

(Text in **bold** indicates correct answers)

- 1) How soon after admission should a pressure ulcer risk assessment be carried out:
  - Immediately**
  - Within six hours**
  - Within 24 hour
  - Within one week
- 2) If a patient is not considered at risk on initial assessment, what would trigger a reassessment:
  - Ward policy
  - Surgery**
  - Deterioration in condition**
  - Discharge from ward
- 3) Risk assessment scales should be used as:
  - They are accurate indicators of risk
  - They are usable in all clinical settings
  - To assist clinical judgement**
- 4) A person's potential to develop pressure ulcers will be influenced by intrinsic factors (factors within the individual) that should be considered when undertaking a risk assessment. Nine intrinsic factors have been identified that may influence your assessment, list as many as you can:
  - **Reduced mobility or immobility**
  - **Sensory impairment**
  - **Acute illness**
  - **Level of consciousness**
  - **Extremes of age: over 65, less than 5**
  - **Previous history of pressure damage**
  - **Vascular disease**
  - **Severe chronic or terminal illness**
  - **Malnutrition and dehydration**
- 5) Extrinsic factors (factors external to the individual) are involved in tissue damage; these should be removed or diminished to prevent injury. List three extrinsic factors:
  - **Pressure**
  - **Shearing**
  - **Friction**
- 6) Other factors may exacerbate the patient's potential for pressure ulcers, list as many as you can:
  - **Medication**
  - **Moisture to the skin**
  - **Nutritional status**
  - **Hygiene**
- 7) Skin inspection provides essential information for both assessment and prevention of pressure ulcers; regular inspection of vulnerable parts of the body enables early detection of pressure damage. List the parts of the body, that are most susceptible to damage:
  - **Heels**
  - **Sacrum**
  - **Ischial tuberosities**
  - **Trochanter**
  - **Elbows**
  - **Temporal region of the skull**
  - **Shoulders**
  - **Back of the head**
  - **Toes**

- 8) Which of the following describe the appearance of the skin that may be showing early signs of pressure ulcer damage:
- Bruising
- Persistent erythema**
- Blister**
- Blanching hyperaemia
- Localised heat or oedema**
- Non-blanching hyperaemia**
- Rash
- 9) Decisions about support surfaces should be influenced by holistic assessment of the patient's risk and their general health. *Circle indicating whether you feel the following statements are true or false:*
- Risk assessment scores should be used to decide on equipment provision.  
**False**
  - Assessment should be ongoing throughout the patient's episode of care and equipment changed to suit alterations in risk.  
**True**
  - At risk patients should be placed on a standard NHS type mattress.  
**False**
  - Patients identified as being at very high risk should be placed on alternating pressure mattresses or other high-tech pressure redistributing systems.  
**True**
  - Pressure redistributing mattresses or overlays should be used on operating tables for patients identified as being at high risk.  
**True**
  - At risk patients should placed on pressure redistributing mattresses in the postoperative period.  
**True**
- 10) List the considerations you may take into account when planning a patient's preventive care:
- **Breathing**
  - **Medical condition**
  - **Results of skin inspection**
  - **Patient comfort**
  - **Other activities, for example, physiotherapy, mealtimes, etc**
  - **Support surface**
  - **The patient's own knowledge and routine, for example, spinal injury patients**
  - **Positioning/repositioning**
  - **Existing pressure damage**
  - **Time seated**



improving practice:  
*improving care*

CLINICAL PRACTICE GUIDELINES

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