

# Your Skin Matters- no avoidable pressure ulcers in NHS provided care

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Every Pressure Ulcer Matters

# Focus on Quality

- Liberating the NHS
- NHS Constitution
- CQC outcomes
- Francis Report
- Ombudsman report
- QIPP
- Your skin matters / Stop the pressure
- Trust Objectives

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# Energise for Excellence in Care (E4E)

- quality framework for nursing and midwifery
- aims to support the delivery of safe and effective care
- creating positive patient and staff experiences that build-in momentum and sustainability
- underpinned by 'social movement thinking' principles

# Tools to delivery quality include...

- High Impact actions
- Productive Ward
- Safety Express / Safety Thermometer
- Nurse Sensitive Outcome Measures
- Essence of Care
- NICE Guidance

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# High Impact Actions

- In November 2009, nurses and midwives were called to action by the Chief Nurse, Dame Christine Beasley
- 600 submissions of successful quality initiatives to Chief Nurse website
- Proof that nurse and midwives care passionately about the care they provide to their patients

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## 8 National High Impact Actions:-

- Your Skin Matters
- Staying safe-preventing falls
- Keeping nourished
- Promoting normal birth
- Important choices-where to die
- Fit and well to care
- Ready to go no delays
- Protection from infection

## 2 Regional High Impact Actions

- Ward Leader Development
- Dementia

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# Response from Bedford Hospital Case Study

- Identified Executive Lead
- Identified Operational Lead
- Set up a HIA Board
- Identified 10 individual leads
- Commenced 10 work streams to develop a suite of HIA care bundles.

# Your Skin Matters

- Pressure ulcers are a significant source of morbidity and mortality in the NHS, estimated to cost up to £2.1 billion every year (Bennett et al, 2004)
- The impact of pressure ulcers is psychologically, physically and clinically challenging for both patients and staff.

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# Care bundle

‘a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidenced-based practices – generally three to five – that, when performed collectively and reliably, have been proven to improve patient outcomes (Resar et al., 2005)

# The 5 key elements that make up the SKIN+ care bundle are....

- Surface
- Keep Moving
- Incontinence
- Nutrition
- + Pain

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# Key drivers for change...

- Education
- Risk Identification
- Risk Assessment
- Identification and categorisation of pressure ulcers
- Reliable implementation of the bundle

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# Implementation

- Pilot of bundle across 4 wards through March and April 2011 using a PDSA approach
- Agreed CQUIN 2011-12
- June 2011 – training of all ward staff
- July 2011 – roll-out across the trust
- Dissemination throughout the local health economy

# Ongoing assurance

- The number of pressure ulcers are reported monthly to the board.
- Each ward will display a safety cross representing ward acquired pressure ulcers.
- RCA of all categories 3 and 4 ulcers.
- SKIN+ Bundle compliance will be audited
- Longer term impact on other areas

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# National campaign 2012-13

- Simple steps prevent pressure ulcers:
  - **S**urface: make sure your patients have the right support
  - **S**kin inspection: early inspection means early detection. Show patients & carers what to look for
  - **K**eeP your patients moving
  - **I**ncontinence / moisture: your patients need to be clean and dry
  - **N**utrition / hydration: help patients have the right diet and plenty of fluids
- 
- The new *Pressure Ulcer Path: Prevent and Treat, Step by Step* should make it easier for you to care for patients.

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# Tools to help

- 'I trust you to care...'
- [www.stopthepressure.com](http://www.stopthepressure.com)
- **The key messaging:**
  - Pressure ulcers cause patients long term pain and distress.
  - Pressure ulcers can mean longer stays in hospital.
  - 95% of pressure ulcers are preventable.
  - Treating pressure ulcers costs the NHS more than £3.8 million every day.
  - The time and money spent treating pressure ulcers means some patients may not always get the care they need.
  - Giving clear information on what to look for helps patients and carers avoid pressure ulcers.

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**Vision**

**No avoidable pressure  
ulcers**

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# Acknowledgements

- Abertawe Bro Morgannwg University Health Board
- Pressure ulcer Steering Group, Bedford Hospital
- Former East of England SHA now Midlands and East SHA