Pressure ulcers are a major sickness burden, and cause reduced quality of life for patients. The high impact team reveal how to prevent avoidable skin damage.

**Case Study 1: Ensuring the Right Equipment**

East Kent Hospitals University Foundation Trust was keen to prioritise the use of pressure relieving mattresses to ensure they were available for patients who needed them the most.

The trust employed support workers (seconded healthcare assistants) to manage the use of these mattresses and to promote a “mattress amnesty” to encourage wards to return those they did not need – it took perseverance to convince some wards to do this.

The mattresses were returned to a central equipment library where they were decontaminated and safely stored. Support workers played a crucial role in this, and they needed strength of personality to challenge staff in higher grades.

They also helped to improve the reporting and collation of information about pressure ulcers, which means that grade 1 ulcers can now be targeted to help prevent them from progressing to grade 2. (NHS Institute for Innovation and Improvement, 2010)

Impact of the initiative

No moisture lesions developed on the isolation ward over the course of a year, while an audit of medical wards before and after the intervention found the pressure ulcer rate had reduced from 4.5% to zero. The ward believed the majority of pressure ulcers were preventable and came up with the idea of a direct approach to staff and patients to ensure that best practice continues.

**Case Study 2: Focusing on Containment Care**

The pressure ulcer rate was reduced on Anglesey Ward from 4.5% to zero. The ward went 6/7 days without any pressure ulcers. Across the health board, the rate of pressure ulcers has been cut from 13% to 9%.

Impact of the initiative

There has been a reduction in the number and severity of pressure ulcers in nursing homes. Data from acute providers shows a decrease of 50% in the number of patients with pressure ulcers admitted from the community between April 2008 and August 2009. This has improved the quality of care and patients’ quality of life and there have been fewer grade 3 and 4 pressure ulcers.

The Skin Team have been involved in various projects which have been rolled out voluntarily to nursing homes, with 80% of homes now being partners in the SKIN approach. Patients and families have become partners in the SKIN approach. The cultural shift is such that now staff regard pressure ulcers as unacceptable. This project also won a Nursing Times/NHS patient safety award this year.

**What are the best sources of information?**

- The Essential Collection: NHS/VaPR pressure
- Tissue Viability Nurses Association: www.tvna.org.uk
- Skin Ulcer Advisory Panel: www.sap.org.uk
- Essence of Care: Informed/Compassionate-care

**What is the high impact actions for nursing and midwifery 4: your skin matters?**

Pressure ulcers are a major sickness burden, and cause reduced quality of life for patients. The high impact team reveal how to prevent avoidable skin damage.

**What can nurses do?**

- Pressure ulcers should be seen as preventable.
- Non-invasive, adverse events and ownership of the problem is crucial.
- To prevent while they are often viewed as the result of tissue viability nurses alone, these specialists cannot tackle the problem in isolation – the whole multidisciplinary team needs to work together to address it.
- A cross organisational approach will help to reduce the occurrence of pressure ulcers both in the community and in hospital settings.
- Nurses must investigate to find the root cause of the problem and then compare it with previous occasions.
- As a starting point, you need:
  - Think about your high risk patients
  - Care planning
  - Use the equipment that is available to you
  - Tissue viability specialists, medical staff, dietitians, physiotherapists, occupational therapists, and the patient
  - Make sure all procedures and training focuses on prevention as well as treatment.

A tissue viability multidisciplinary foundation course was created in 2006 and has been repeated over 25 times across the region, with decontaminated and safely stored. Support workers played a crucial role in this, and they needed strength of personality to challenge staff in higher grades.

The skin team have been involved in various projects which have been rolled out voluntarily to nursing homes, with 80% of homes now being partners in the SKIN approach. Patients and families have become partners in the SKIN approach. The cultural shift is such that now staff regard pressure ulcers as unacceptable. This project also won a Nursing Times/NHS patient safety award this year.

**References**