Essex County Council
Adult Social Care

Outcome/Aim	Primary Driver	Secondary Driver
By [DATE] achieve a staged reduction in Pressure Ulcers based on previous year/six months Stage 2 – 30% Stage 3 – 40% Stage 4 – 100%	Risk Identification	• Understand pressure ulcer risk factors • Understand local environment and multidisciplinary information to assess residents at risk • Utilise Safety Handovers/Safety Huddles
	Risk Assessment	• Assess pressure ulcer risk on admission • Reassess daily / when a change in condition • Communicate risk status to resident, staff and families • Incident Reporting / RCA
	Reliable implementation of aSSKINg Framework	• Reinforce the use of Skin and Safety Walk around **a** – Assess Risk **S** – Surface / S – Surface **S** – Skin inspection / A – Availability of Aids **K** - Keep moving / F – Falls Risk **I** – Incontinence / E – Evaluation **N** – Nutrition / T – Tell **g** – Get advice / Y – Your initials
	Identifying, Category of pressure ulcers	• Utilise a category tool • Initiate and maintain correct & suitable treatment • Initiate and maintain correct use of equipment • Utilise DN's and specialist tissue viability nurses experience
	Education/Training	• Staff education & training – ASSKING bundle • Resident & family/carer education • Utilise 'How to guides' • Introduce Staff pressure ulcer prevention workbook • e-learning/SSKIN game

Prosper

Primary Driver	Secondary Driver	Key ideas for change (PDSA)
Risk Identification	• Understand pressure ulcer risk factors • Understand local environment and multidisciplinary information to assess residents at risk • Utilise Safety Handovers/Safety Huddles	• Educate staff, residents and families on pressure ulcer factors • Utilise resident and carer information leaflets • Engage with multidisciplinary teams to identify those at high risk • Look at the local environment of the residents – bed bound, lack of mobility, things that prevent movement. • Set a clear aim for reducing pressure ulcers • Engage with staff to find out the barriers that prevent risk assessments from being completed within in 6hrs of admission (for pressure ulcers) • Identify processes to remove barriers and work with staff to achieve • Utilise safety handovers / SBAR approach/ Safety Huddles • Review documentation – SSKIN bundle, Body Maps
Risk Assessment	• Assess pressure ulcer risk on admission • Reassess daily / when a change in condition • Communicate risk status to resident, staff and families • Incident Reporting / RCA	• Incorporate into pre admission assessment • Utilise skin pressure body maps • Monitor compliance with completion of risk assessments, aim for 95% compliance • Consider feasibility of visual communication processes to identify residents at risk • Verbal communication – incorporate residents at risk in safety handovers • Monitor compliance with daily re-assessment of risk • Develop monitoring/feedback and learning loop • Develop weekly reporting process to identify resident harms, including pressure ulcers

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Primary Driver	Secondary Driver	Key ideas for change (PDSA)
Reliable implementation of Skin Safety Care Bundle	• Reinforce the use of Skin and Safety Walk around, use the aSSKINg framework which incorporates the SSKIN care bundle. **a** – Assess Risk **S** – Surface **S** – Skin inspection **K** - Keep moving **I** – Incontinence **N** – Nutrition **g** – Get Advice/Give Information **S** – Surface **A** – Availability of Aids **F** – Falls **E** – Evaluation **T** – Tell **Y** – Your initials	• Consider identifying SSKIN champions • Consider introducing Skin and Safety walk around **Surface** • Review the use of pressure relieving devices, have the resident's weight/needs changed? • Make sure residents sheets are smooth • Use the 30 degree tilt approach where appropriate **Skin inspection** • Inspect skin/pressure areas with a frequency dependant on risk and clinical advice, dependant on individual's needs. • Utilise pressure area body maps • Consider Introducing the Heals up campaign/compact mirrors for heal inspection **Keep moving** • Make sure residents are encouraged /assisted to move positions regularly. • Minimise pressure damage by using manual handling equipment when turning residents at high risk. • Consider introducing intentional SSKIN walk around to prompt residents to change position. **Incontinence** • Identify methods to manage the moisture of residents whose skin is exposed to increased moisture (wound drainage, continence issues, leaks, discharge, excessive sweating, fit of underwear).

Primary Driver	Secondary Driver	Key ideas for change (PDSA)
		• Make sure skin is kept clean and dry (N.B excessive dry skin presents an increased risk). • Use Skin and Safety Walk around to encourage use of toilet, catheter care, check to meet resident's hygiene needs. **Nutrition** • Introduce nutrition and hydration tools (Gulp , MUST tool) to monitor nutritional and fluid balance. • Use prompts that alert staff to support residents with fluid intake, at risk of malnutrition, require assistance at meal times • Develop monitoring, feedback and learning loop. • Refer residents to dietician where appropriate according to risk assessment. • Use aSSKNg and/or Safety Walk around to introduce prompts such as 'would you like a drink? Can you reach your drink?' • Make sure residents on fortified supplements receive their drinks. • Make sure oral hygiene needs of residents are met. **Surface** • Review the use of pressure relieving devices, have the resident's weight/needs changed? • Make sure residents sheets are smooth • Use the 30 degree tilt approach where appropriate **Availability of aids** • Make sure call bell is within reach for resident

Primary Driver	Secondary Driver	Key ideas for change (PDSA)
		• Make sure drinks are within reach for resident • Make sure adapted cutlery is made available to resident's dependant on individual need • Make sure moving and handling equipment is available **Falls Risk** • Make sure aids are within reach • Make sure areas are de-cluttered to promote a safe environment • Make sure footwear of resident is appropriate and safe **Evaluation** • Consider introducing a Skin and Safety walk around • Make sure any changes are recorded on revised documentation. **Tell** • Make sure the appropriate people are aware of any changes i.e staff, seniors, nurses, district nurses
Identifying, grading of pressure ulcers	• Utilise a grading tool • Initiate and maintain correct & suitable treatment • Initiate and maintain correct use of equipment • Utilise DN's and specialist tissue viability nurses experience	• Reinforce the use of the pressure ulcer grading tools • Make sure staff know about the tool to aid with pressure ulcer recognition and assist with their education/competency • Utilise the SSKIN care bundle approach • Utilise the 30 degree tilt approach • Work in partnership with residents, families and multi-disciplinary teams to improve the quality of pressure of ulcer prevention care provided to residents • Know how to contact the Tissue Viability Advisors if required • Make sure the skills, knowledge and competency of your team

Primary Driver	Secondary Driver	Key ideas for change (PDSA)
		are up to date.
Education/Training	• Staff education & training – sSSKINg Framework • Resident & family/carer education • Utilise 'How to guides' • Introduce Staff pressure ulcer prevention workbook • e-learning/SSKIN game	• Utilise formal and informal learning opportunities to educate your staff • Consider 10 min power training sessions for care staff on duty – sSSKINg framework. • Utilise E-learning, Stop the pressure website online games and educational resources • Use resident stories to educate, motivate and inspire staff. • Provide residents and families with information on risks of pressure ulcers on admission or change in their condition • Educate residents and families on how they can help minimise pressure ulcer risk. • Work with residents and families as co-partners in care • Review and update tissue viability guidance • Introduce incident reporting and RCA process for all pressure ulcers stage 2 and above, use for knowledge and learning loops.

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Resources

National Wound Care Strategy: https://www.nationalwoundcarestrategy.net/pressure-ulcer/

aSSKINg Framework; www.nationalwoundcarestrategy.net/wp-content/uploads/2023/10/The-aSSKINg-Framework.pdf -

http://www.nice.org.uk/guidance/cg179 NICE guidance on prevention and management of pressure ulcers

http://www.epuap.org/ - Pressure Ulcer resource section with guidance and downloadable posters etc.

SBAR: Situation Background Assessment Recommendation is an effective and efficient way to communicate important information. SBAR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

https://www.ihi.org/resources/tools/sbar-tool-situation-background-assessment-recommendation - SBAR tool kit

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