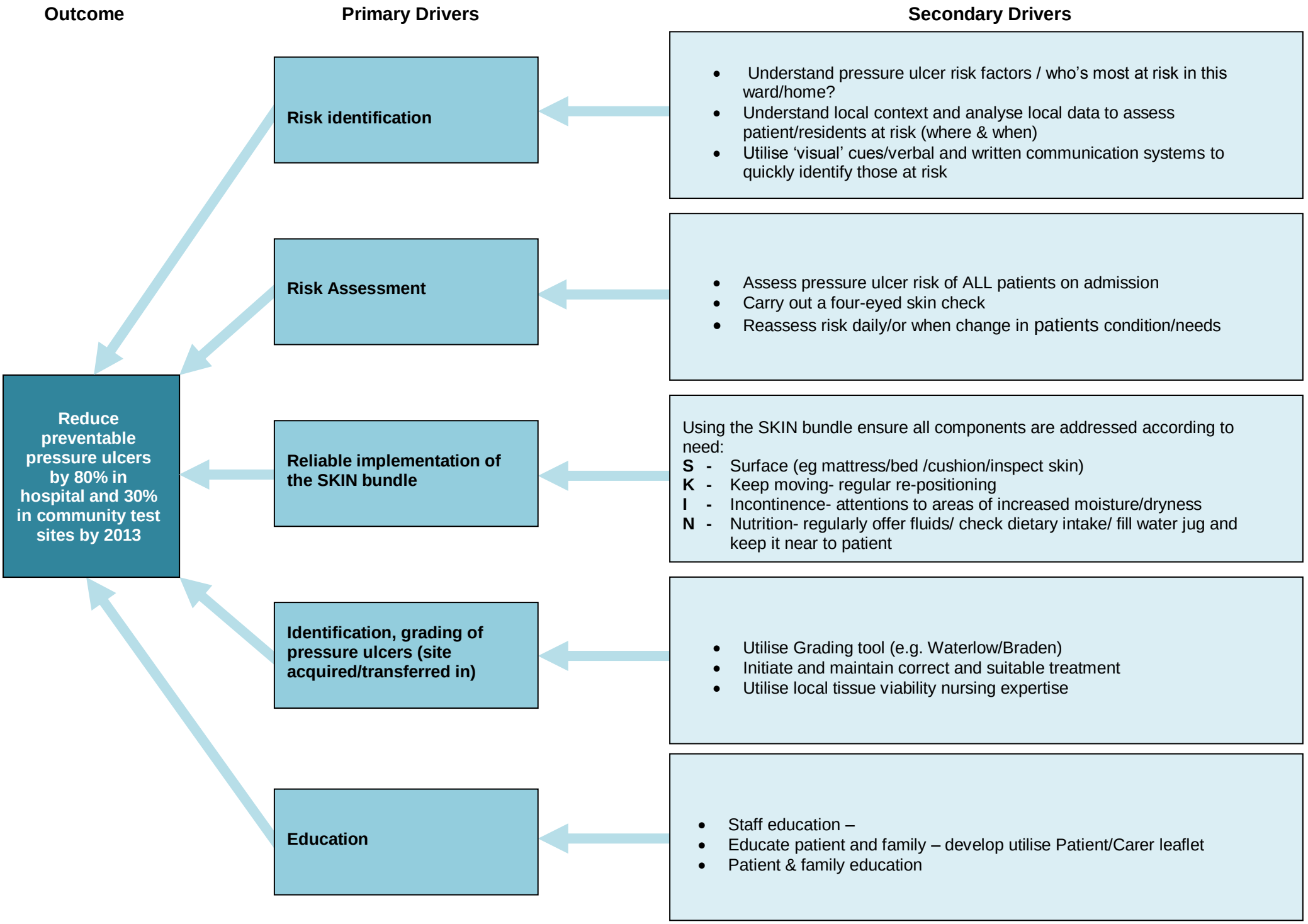
NHS
South of England

South of England Improving Safety in Mental Health Collaborative

# Pressure Ulcer Prevention

## Driver Diagram and Change Package

A driver diagram is used to conceptualize an issue and to determine its system components which will then create a pathway to achieve the goal. Primary drivers are system components which will contribute to moving the primary outcome. Secondary drivers are elements of the associated primary driver. They contain change concepts that can be used to create projects that will affect the primary driver.
Adapted from the South West Quality and Patient Safety Improvement Programme.


Outcome
Primary Drivers
Secondary Drivers
Reduce preventable pressure ulcers by 80% in hospital and 30% in community test sites by 2013
Risk identification
Understand pressure ulcer risk factors / who's most at risk in this ward/home?
Understand local context and analyse local data to assess patient/residents at risk (where & when)
Utilise 'visual' cues/verbal and written communication systems to quickly identify those at risk
Risk Assessment
Assess pressure ulcer risk of ALL patients on admission
Carry out a four-eyed skin check
Reassess risk daily/or when change in patients condition/needs
Reliable implementation of the SKIN bundle
Using the SKIN bundle ensure all components are addressed according to need:
S - Surface (eg mattress/bed /cushion/inspect skin)
K - Keep moving- regular re-positioning
I - Incontinence- attentions to areas of increased moisture/dryness
N - Nutrition- regularly offer fluids/ check dietary intake/ fill water jug and keep it near to patient
Identification, grading of pressure ulcers (site acquired/transferred in)
Utilise Grading tool (e.g. Waterlow/Braden)
Initiate and maintain correct and suitable treatment
Utilise local tissue viability nursing expertise
Education
Staff education –
Educate patient and family – develop utilise Patient/Carer leaflet
Patient & family education

| Secondary Drivers | Key change concepts and change ideas for PDSA testing |
|---|---|
| • **Understand pressure ulcer risk factors**<br>• **Understand local context and analyse local data to assess patient/residents at risk**<br>• **Utilise 'at risk' visual cues, verbal and written communications systems to quickly identify those at risk** | • Educate staff, patient/residents on pressure ulcer factors |
| | • Utilise patient/resident and carer information leaflet |
| | • Engage with the MDT and develop a shared vision |
| | • Set a clear local aim for reducing preventable pressure ulcers |
| | • Engage with staff to learn about the barriers to risk assessment being done with 6 hours from admission |
| | • Understand the local issues,(who is 'at risk' on this unit/home) |
| | • Work with staff to develop a system where at risk patients/residents can be identified easily<br>– Visually – Use of visual cues above the beds/doors of at risk patients/residents to alert staff to patients risk of acquiring a pressure ulcer<br>– Verbally- Incorporate patients/residents at risk into safety briefings/handover processes<br>– Safety Briefings/SBAR approach<br>– Documentation- SKIN Bundle Communication tool |
| • **Assess Pressure ulcer risk on admission**<br>• **Reassess risk daily/when change in condition** | • Build reliable risk assessment into bundle/rounding process (first steps – see above) |
| | • Monitor compliance with on admission Pressure Ulcer risk assessment and aim for >95% compliance by developing a monitoring/feedback and learning loop to improve this process |
| | • Monitor compliance with daily re-assessment of risk and increase compliance to >95% by developing a monitoring/feedback and learning loop (incorporate this reassessment into bundle /rounding process) |
| • **S – Surface/Skin inspection**<br>• **K – Keep moving**<br>• **I – Incontinence/Increased moisture**<br>• **N – Nutrition** | • Reliably implement all elements of the SKIN BUNDLE |
| | • All elements of the bundle must be evident and effectively carried out or it will not be counted as compliance |
| | • **Surface** - Ensure patient/resident is on the correct surface (mattress/ cushion etc) |
| | • Build reminder checks into routine care process and daily re-assessment |
| | • Skin Inspection – Inspect skin/pressure areas to identify quickly pressure damage |
| | • **Keep Moving** - Ensure patients/residents are encouraged/assisted to move positions regularly dependent on individuals needs<br>Minimise pressure damage by ensuring manual handling equipment is available when turning patients/residents, kept by the bedside of patients/residents who have been assessed as at risk<br>Introduce systems acceptable to all so that ward/care home team can reposition at risk patients/residents or encourage all patients/residents to move themselves at regular intervals<br>Introduce in partnership with the patient/resident a daily goals sheet, which will ensure that both the patient/resident and the wider MDT are aware of how long the patient/resident should be sat out of bed, when anti embolic stockings should be removed, that they should have repose boots (a pressure relieving device for heels) insitu etc |

| Secondary Drivers | Key change concepts and change ideas for PDSA testing |
|---|---|
| | • **Incontinence (increased moisture) -** Manage the moisture of patients/residents whose skin is exposed to increased moisture (wound drainage/continence issues/ leaks/discharge/excessive sweating)<br>Ensure skin is kept clean and dry (but note that excessively dry skin presents an increased risk so use barrier creams appropriately)<br>Consider introducing a continence assessment tool which will inform the care plan/ pathway<br>Move supplies nearer to the bedside to enable prompt cleansing when required include a barrier cream, cleansing wipes, incopads<br>Use prompts to remind staff to ask at regular intervals if the patient/resident would like to go to the toilet<br>Where appropriate introduce written guidance for staff for the appropriate use of faecal management systems to protect skin |
| | • **Nutrition -** Introduce protected mealtimes to ensure patients/residents are not interrupted when eating.<br>Introduce prompts that alert nursing and catering staff to patients/residents who are at risk and may need support at mealtimes, for example 'red tray'<br>Use water jugs with a red lid on water jug so staff know to encourage fluids and to refill<br>Consider use food charts to monitor intake. Alternatively record fluid input/output on SKIN bundle communication tool<br>Use a recognised nutritional risk assessment tool to identify all patients at risk of malnutrition and refer to dietician as appropriate<br>Introduce intentional rounding prompts 'would you like a drink?', 'Can you reach your drink?', or 'soft drink cocktail hour' where juices are served to encourage patients/residents to keep hydrated<br>Ensure patients/residents on fortified supplements receive their drinks. If they find it difficult to tolerate, use condensed "shots" |
| • Utilise standardized grading tool<br>• Initiate and maintain correct and suitable treatment<br>• Utilise local tissue viability nursing expertise | • Agree use of National pressure ulcer grading tool |
| | • Make sure staff know about tool to aid with pressure ulcer recognition and assist with their education |
| | • Utilise the SKIN bundle/rounding approach |
| | • Work in partnership with patient/residents, their family and MDT members |
| | • Know how to contact your local tissue viability nurse/other specialist if required |
| • Staff education - Educate patient and family – utilize Patient/Carer leaflet<br>• Utilise relevant tools (bundle/rounding/SBAR) | • Utilise formal and informal learning opportunities to educate staff about pressure ulcer risk |
| | • Use patient/resident stories to motivate and inspire staff, to learn from and educate |
| | • Provide patients/residents and relatives with information on the risks of pressure ulcers on admission or when there is a change in their condition that puts them at risk |
| | • Educate patients/residents and families as to how they help to minimize pressure ulcer risk whilst in hospital/care home, at home where relevant (e.g. the SKIN bundle) |
| | • Work with patients/residents and families as co-partners in their care |
| | • Use the guides for various tools to educate staff on how they could be used in their care |