Pressure Ulcer Improvement Collaborative

**Our aim:** To work in partnership with residential homes to reduce the adverse impacts of pressure ulcers for residents, improve their quality of life and reduce demand for district nursing staff, by empowering and enabling residential home carers to deliver better care outcomes.

1. **Focus**
   We chose to focus improvement work within the community setting with residential homes. We identified a specific residential home where there was a high number of calls to the district nursing team. Also there were some relational challenges that could be addressed by improving the communication. Overall, we wanted to focus on an area that would benefit our staff and patients but also empower our partners to provide better care outcomes.

2. **Understanding the issue**
   We used a driver diagram to unpick the issues and plan against our aim.

3. **Tests of change**
   We decided to start by introducing a simple traffic light guide with advice on dealing with patients vulnerable to heel pressure ulcers. We refined the guide using the PDSA model.

4. **Measuring for improvement and success**
   We conducted interviews with 12 members of staff at the selected residential home, asking for their feedback on the form.
   - 100% knew the guide existed
   - 56% use the guide ‘often’ 44% use the form ‘sometimes’
   - All those who ranked their confidence in identifying pressure ulcers, patients who are vulnerable and the right course of action as 3 or less out of 5 said that their confidence improved as a result of the guide.
   - Comments included: “the guide is easy to use” and “information on the guide is clear.”

5. **Sustainability and spread**
   **Communications channels** – sharing our learning through the QI newsletter, intranet, weekly round up and latest Trust news.
   **Poster** – sharing the presentation poster at events and displaying around the Trust
   **Meetings** – including District Nurse, community matron and Integrated Community Rehabilitation team meetings, Tissue Viability steering group and link nurse meetings.
   **Other networks** – work together with the home, encouraging them to share information with residents’ visitors and across their other homes. Plan to roll this out across DHC localities.
   **Looking ahead** – we will be exploring how we can develop the learning, for example providing patients with discharge packs so they can check themselves and training videos for care home staff.

We have started analysing the number of calls to the district nursing team that are referring residents due to pressure ulcers. We currently only have three months of data so numbers are very small, but we will continue to monitor this data. We would hope to see a reduction in inappropriate referrals.