Improving Pressure Area Care in Critical Care Ward 20, WGH Staff Nurse Lisa Anderson

Quality issue / initial problem

Increased number of hospital acquired pressure ulcers (12 in total) in Critical Care Ward 20, at WGH between 2018-19. In 2017 the Scottish Patient Safety set out targets to reduce all incidents of pressure area damage by 50%.

Specific aim

50% reduction of hospital acquired pressure ulcers within Critical Care Ward 20, WGH by April 2020.

Measurement of improvement

Measures

Outcome: Number of days between hospital

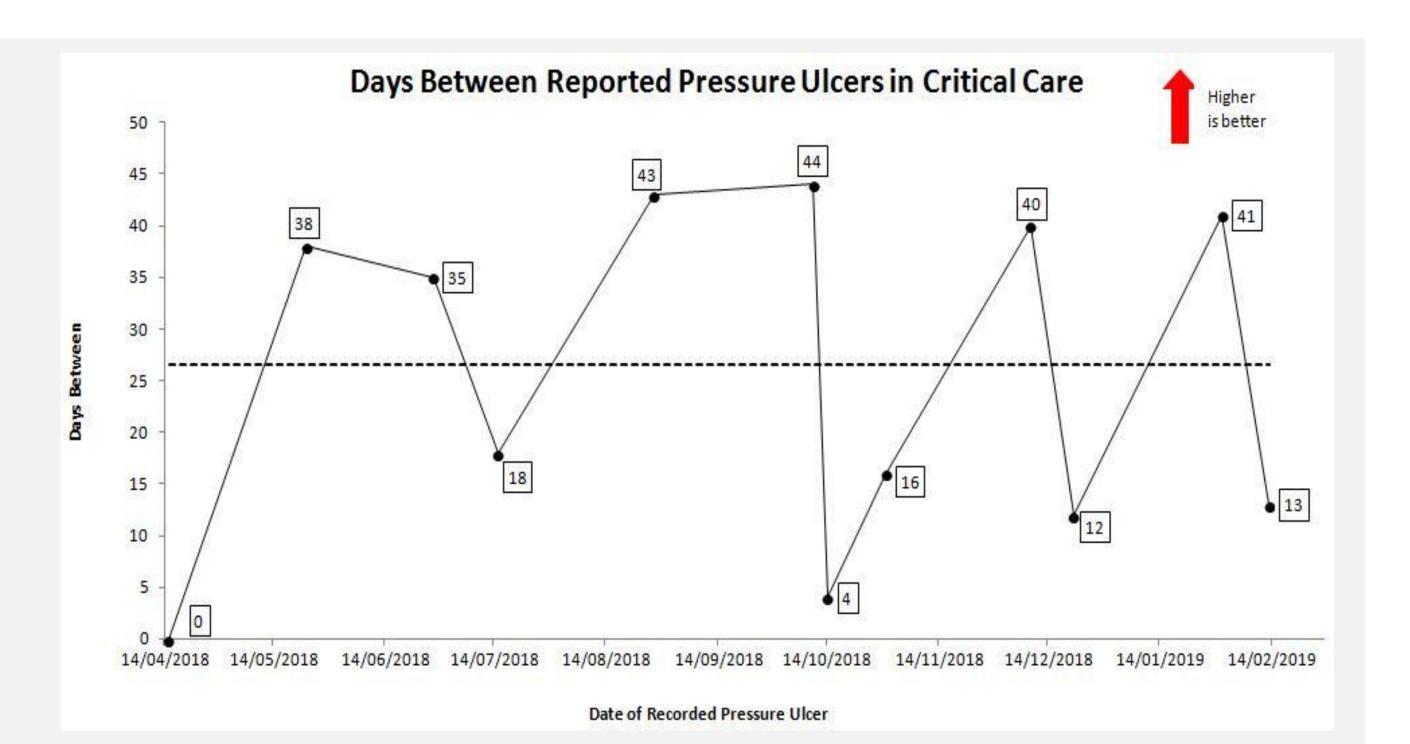
acquired pressure ulcers

Process:- Number of completed Waterlow skin

assessments

Balancing: Staff feedback and staff knowledge

pre and post intervention

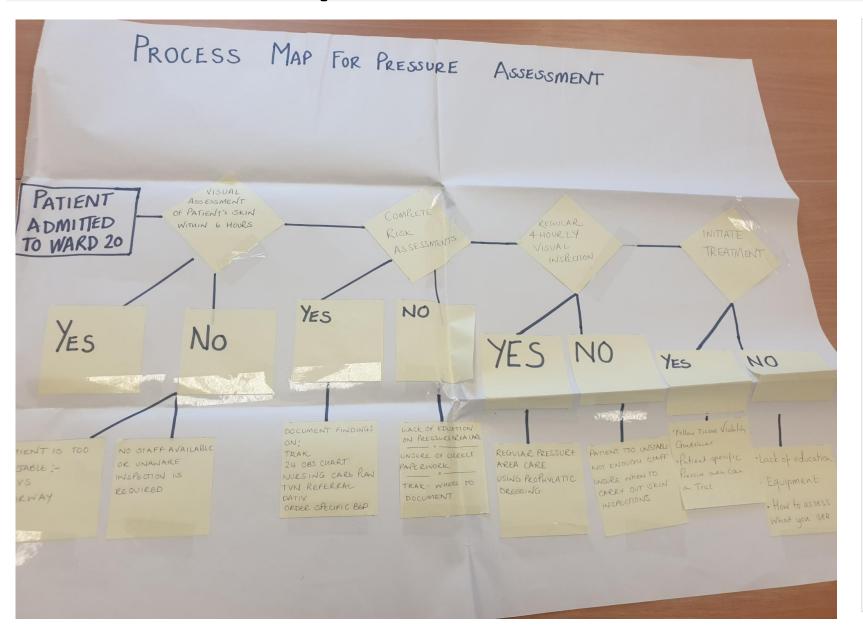


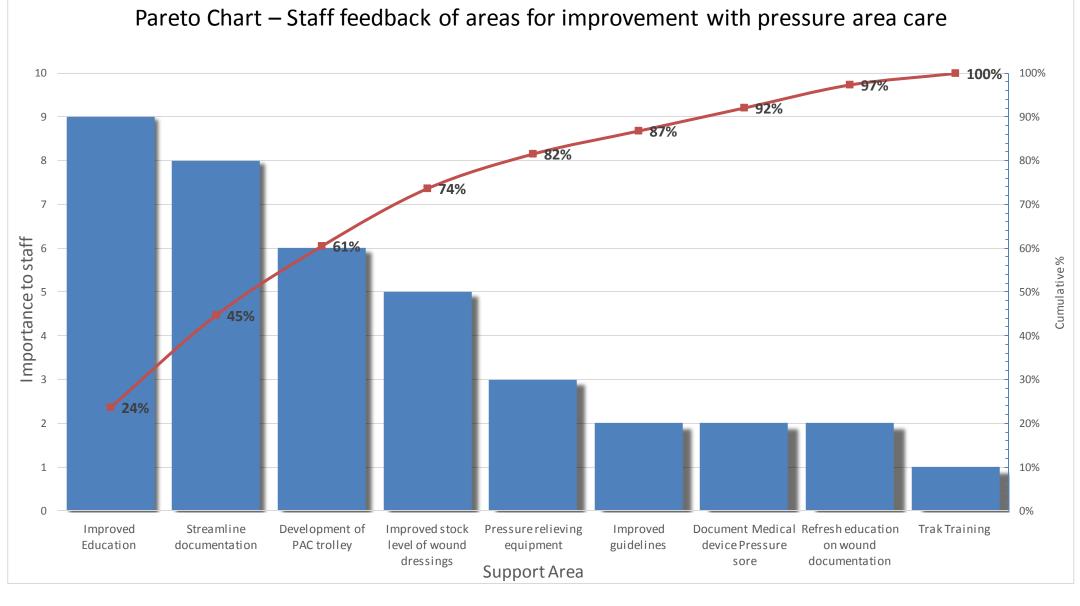
Tests of change

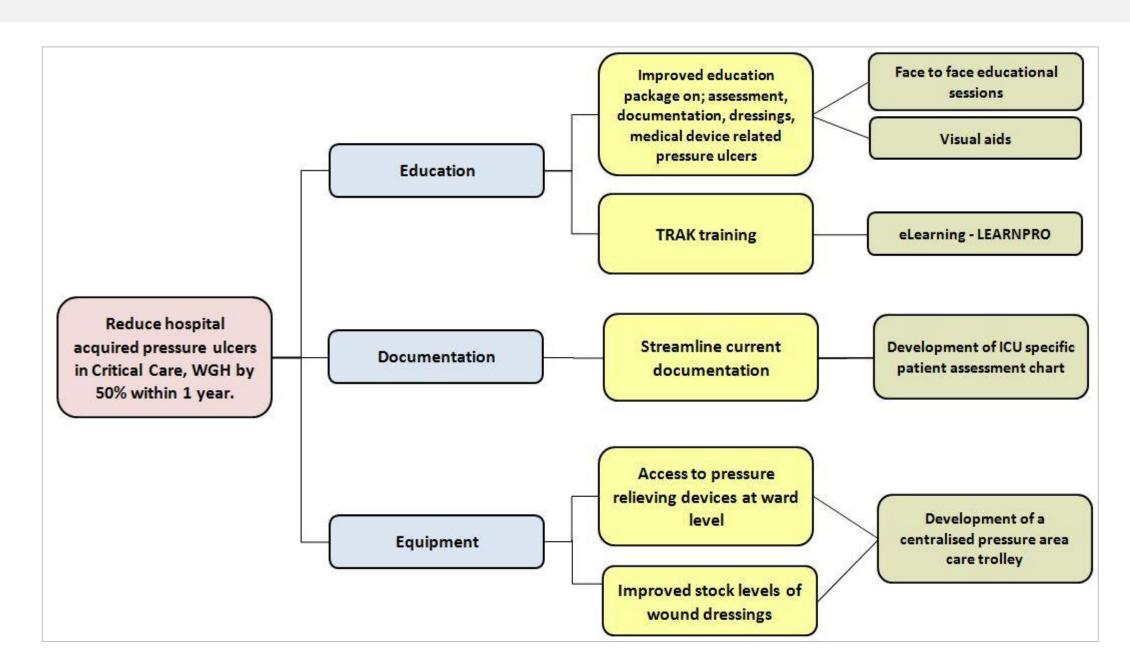
- Visual aid at bed space
- Improve education through e-learning and face to face sessions
- Implement Critical Care patient specific
 Pressure Area Care (PAC) chart
- Development of a PAC trolley

Tools

- Process Mapping
- Pareto Charts
- Driver Diagram
- Staff Questionnaire / Dot voting







Effects of Change

- Improved patient experience
- Staff feel more empowered and valued
- Implementation of an education package

Lessons learned and message for others

- Keep it simple
- Involvement and engagement of colleagues is key to the success of any improvement
- Understanding how to collect and present data in a QI format
- Days between chart is a useful aid when working with small numbers of data





