We serve a population of around 344,000 and we also receive 11 million Tourists per year. This brings it’s own challenges. Our Trust comprises of Blackpool Victoria Hospital which is a large busy acute hospital, I smaller community hospital and an elderly rehabilitation hospital 1 and in April 2012 we integrated with community services from Blackpool, Wyre 7 Fylde and North Lancashire. Altogether we are just short of 1000 beds and we employ over 6 ½ thousand staff. Throughout 2009 the Trust had a reported 298 Hospital acquired pressure ulcers, with an estimated cost, using DoH calculation, of between £1.73million and £2.1million. We also know, from hospital numbers reported in the monthly point prevalence audit, that both hospital and non hospital acquired pressure ulcers have not always been reported via the incident reporting systems in place within the Trust. The Global Trigger Tool identified to the Trust Board that Hospital Acquired Pressure Ulcers was causing significant in harm to our patients. We responded by setting up a Trust wide Pressure Ulcer Prevention Project. This work has resulted in a 75% reduction in Hospital Acquired Pressure ulcers since August 2009. There has been a 36% reduction in the number of patients with Hospital Acquired Pressure in the period April 2012 – Feb 2013 compared with the same period 12 months previously. We have set ourselves a ambitious targets for 2013/14 of a further reduction in the acute setting of Stage 2—30%, stage 3—40% and stage 4—100%. With the integration of the community services we are also implementing the processes to prevent pressure ulcers with the aim of a 10% in year. We recognize these are ambitious targets but our improvement work will continue in line with the Trust Strategic Framework of 95% harm free care by March 2015 and 100% harm free care by 2020.

The Process in Brief

Aims and Commitment
Agreed

Driver diagram, communication plan and local action plans developed

Launch Day—educational and harm reducing initiatives

Monitor implementation of action plans in line with data findings and re-evaluate

Sustainability

Key Achievements
- Revisited national guidance/best practice
- Increased awareness & training for all including Health care assistants
- Improved reporting/measurement processes
- Introduction of Therapy on Line for dynamic mattress ordering.
- Introduction of electronic referral system for Tissue Viability Referrals.
- Pressure Ulcer Prevention now included on Pre-registration nursing curriculum.
- Successful Pressure Ulcer Prevention Launch Day
- Launch of intentional rounding
- Launch of mandatory staff training workbook and e-learning linked to appraisal
- Increased patient involvement and education.
- Introduction of Nursing Care Indicator Criteria for Pressure Ulcer Prevention
**Case Study: 000**

**Challenges**

- Whole hospital involvement and motivation
- Creation of innovative education and training programmes
- Staff ownership of patient safety issues
- Achieving improvements within existing resources
- Patient safety issues are quantified and available to the public via Trust website
- Empowerment of multidisciplinary staff and patients
- Development of E-Learning tool to improve knowledge re: Pressure Ulcer Prevention in the clinical areas.
- Improved provision of pressure relieving technologies
- Revamped all Trust documentation pertaining to pressure ulcers

**Successes**

- Improved Risk assessment processes resulting in identification of vulnerable patients earlier on in the patient's journey.
- Guidance on completing critical Incident form and root cause analyses ensures more accurate information is received.
- Pressure Ulcer Prevention back on everyone’s agenda. Increased awareness ensures that everyone has responsibility for preventing pressure ulcers within our organisation.
- Improved reporting processes ensures RCA’s are followed up with action plans for improvement.
- Launch of mandatory staff training workbook and e-learning linked to appraisal
- Improved multi-disciplinary working

**Conclusion**

This is a successful project but our work continues. We have learned that through continuous evaluation of our processes and continued focus on patient safety issues avoidable harms of which pressure ulcers is only one can be avoided. We are applying the same principles and focus to our work on falls prevention and we are confident we will achieve the same success.

As one ward nurse said: "Pressure ulcers were often viewed as unavoidable now we know that is not the case" (Sister, Surgical High Care Unit)