Introduction and Background

A Pressure Ulcer (PU) is a “localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear” (1). The human cost in terms of suffering and distress is incalculable however, it is estimated that up to €250 million per annum is spent to manage PU’s across all health care settings (2). Pressure Ulcer to Zero is a HSE initiative to reduce the incidence of unavoidable hospital acquired PU’s. Using the Plan, Do Study, Act (PDSA) cycle processes were introduced to implement the initiative:

- Introduction of the Pressure Ulcer Safety Cross
- Introduction of the Patient Information leaflet
- Intense education sessions

Project Aim and Methods

The aim of this project was to achieve 100 days without any patient developing a pressure ulcer on an acute Care of the Elderly and Stroke Unit named Ward One.

Discussion

Patient Safety is not a new concept. Florence Nightingale said “The very first requirement in a hospital is that it should do the sick no harm” (3). To achieve the aim of the initiative the following interventions were introduced:

<table>
<thead>
<tr>
<th>Pressure Ulcer Safety Cross</th>
<th>Patients /relatives education</th>
<th>Staff education re staging of pressure ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers posters</td>
<td>Record Pressure Ulcer risk on White Board</td>
<td>Introduce the SSKIN Bundle</td>
</tr>
</tbody>
</table>

While the aim of the initiative was not achieved the results provide quality data and a platform to monitor & improve clinical practice to reduce the incidence of unavoidable hospital acquired PU’s. This initiative also highlights staff engagement as critical during a change initiative. PU Champions have been identified in each ward to promote best practice and clarify any queries. Significant progress has been made in the assessment, prevention & management of patients in Connolly hospital.

Conclusion

Application of different theories of change management were invaluable in bring about change in clinical practice. Engagement with frontline staff is the cornerstone to success. This along with strong support from senior management will contribute to the success of this initiative. This Pressure Ulcer to Zero Initiative demonstrates how a nurse-sensitive quality measure can provide factual feedback to the knowledge and skills required to reduce or prevent pressure ulcers at clinical, operational & strategic levels.