

How Ward 22 Vascular stopped the clock on pressure ulcers

A rise in hospital-acquired pressure ulcers on ward 22 vascular at University Hospitals Coventry and Warwickshire prompted a review of current practice and the development of a new ward-based intervention: the Stop the Clock board. This 12-bedded specialist vascular ward cares for patients at high risk of pressure ulcers due to complex comorbidities and reduced mobility. An investigation identified delays in skin assessments, inaccuracies in risk assessment documentation and time lost navigating the newly launched electronic patient record system. Several improvements were introduced, including earlier patient reviews, supportive clinical education, collaborative skin assessments and the implementation of a Stop the Clock board – a centralised visual tool used twice daily to prioritise essential assessments and tasks. This intervention reduced time spent searching the electronic patient record system, enabled staff to plan and deliver care more effectively, and enhanced teamwork. Since implementation, the ward has achieved 12 months free from hospital-acquired pressure ulcers, and other wards have adopted the Stop the Clock board due to its simplicity, adaptability, and demonstrated impact on patient safety.

A rise in pressure ulcer numbers prompted staff on a vascular ward to consider new methods of pressure ulcer prevention and inspired the development of a Stop the Clock board. Ward 22 Vascular is a 12-bedded ward at University Hospital Coventry and Warwickshire (UHCW), which specialises in providing care for patients with peripheral vascular disease. Surgeries carried out include grafts, embolectomy, fasciotomy, endarterectomy and amputation.

While anyone is potentially at risk of developing a pressure ulcer, several factors are known to increase the risk. These include limited mobility, loss of sensation due to neurological impairment, poor posture, inability to independently reposition, and conditions that cause inadequate blood flow to the skin and soft tissues, such as diabetes and peripheral vascular disease (National Institute for Health and Care Excellence, 2018). These risk factors are present in most patients in Ward 22 Vascular.

Monitoring of key performance indicators highlighted an increase in pressure ulcers on the ward. A review of data from January to December 2024 confirmed 17 patients developed hospital-acquired pressure ulcers, predominantly located on heels and buttocks. Thirteen of these were classified as category 2, and four were classified as unstageable.

Attempts made to reduce these harms throughout the year produced limited results, so increasing pressure ulcer numbers was

added as an area of concern to the ward focus board, and priority was given to reduction. Several methods of investigation were employed to identify specific areas of practice that could be improved; these included observation of direct patient care and of the daily ward routine, detailed review of patient records, and the experiences of ward staff.

This investigation highlighted several aspects of care relating to pressure ulcer prevention that could be improved. These included accuracy of the Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE T) risk assessments, initiation of the correct pressure ulcer prevention care plan in correlation with identified level of risk, accuracy, timeliness and prioritising completion of skin assessments and a delay in registered nurses reviewing patients because of lengthy morning medication rounds.

What did we do?

UHCW utilises the UHCW Improvement System (UHCWi) methodology. This is based on Virginia Mason's Lean management techniques (Virginia Mason Institute, 2024), which are used to identify and eliminate non-value-added waste. At UHCW, we recognise that the voice of all members of a team has equal value. Effective change often comes through ideas generated from those doing the work because they are best placed to identify what works and what does not and can suggest and test ideas for improvement. Through this process,

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Key words

- Pressure ulcer prevention
- Stop the clock
- Vascular ward

during ward audits, again keeping time spent at the board to a minimum. Furthermore, the enthusiasm to embrace this change in practice to improve patient care, demonstrated by the ward manager and band 6 clinical sisters and championed by some key team influencers, has been crucial in embedding this positive change on Ward 22 Vascular.

How has the Stop the Clock board helped reduce pressure ulcer numbers?

The central position of the Stop the Clock board and its clear, uncomplicated design mean that nursing staff can see, at a glance, which assessments and tasks are due each day. This allows them to plan and deliver care more efficiently adding value to their day. Time spent searching through the new EPR system has been eliminated, freeing up more time for nursing staff to be at the bedside, identify pressure ulcer risk promptly, and implement preventative measures to reduce that risk. This renewed focus on pressure ulcer prevention utilising a team approach and the Stop the Clock board has likely contributed to a significant reduction in pressure ulcers on ward 22 vascular. This has been reiterated by the ward manager, Rosie Wheatley, who said: "Before the implementation of Stop the Clock, we had worryingly high numbers of hospital-acquired pressure ulcers. The client group on Ward 22 Vascular is at very high risk of developing pressure ulcers, which means accurate risk assessments, skin assessments and preventative nursing measures are vital in reducing that risk. During 2024, we were struggling as a ward team to implement the correct measures consistently, and patients were coming to harm. The Stop the Clock board has enabled the team to be more focused and easily see what is required for each patient each day. As a ward manager, I attend Stop the Clock, and now have assurance that standards are maintained and patients are receiving high-quality care whilst on Ward 22 Vascular. It is a simple yet highly effective tool that the team has embraced. I am grateful to our clinical education lead for developing the board and senior nursing team for their support in its implementation, and am very proud of my team for their achievements and commitment to providing safe and effective care for patients."

Clinical sister Leeann Tyrrell said: "I get to see my patients earlier in the shift and can work with our healthcare support workers to provide direct patient care where I can look for the first signs of pressure damage and quickly implement preventative measures."

Healthcare support worker Sarah Shakespear said: "Teamwork has improved

since we started using the Stop the Clock board as registered nurses now have more time, so we now work together with them to provide care to our patients."

Comments from other members of the team include:

"When I update the board during the shift, my contribution to the patients' care is recognised, which makes me feel valued."

"Because of where the board has been placed, I can simply look up and see what I need to do for my patient that day. This means that I don't have to spend too much time on a device and can spend more time with my patients, making sure they have an up-to-date risk assessment and everything in place for pressure ulcer prevention."

"Updating the board when I have completed tasks throughout the day helps me to feel in control, use my time well, and prioritise my tasks."

"The design of the board is really easy to use and understand."

"I definitely find it easier to organise my day."

What has happened since the implementation of the changes?

PURPOSE T risk assessments are completed accurately, patients are reviewed by a registered nurse early in the shift, prevention interventions are implemented promptly, and the team works together to complete skin assessments.

The Stop the Clock board has now been implemented on several wards at UHCW as its simple design means it can be easily adapted to suit different wards and departments. It is hoped that its use will help reduce pressure ulcer numbers wherever it is implemented.

And most importantly the team on Ward 22 Vascular are delighted to have now achieved 12 months free of hospital-acquired pressure ulcers. This commitment to high-quality patient care has been recognised by the chief nursing officer at UHCW, who presented them with a special award recognising their efforts to prevent harm, and emphasised that it is the little things done collectively that can really make a difference.

While we recognise it is inevitable that patients on our ward will develop pressure ulcers in the future, we feel confident that the process we have developed can be applied and further developed to help us continue to reduce hospital-acquired pressure ulcers. ●

References

- National Institute for Health and Care Excellence (2018) *Pressure ulcers: prevention and management*. <https://www.nice.org.uk/guidance/cg179> (accessed 12.10.2025)
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