South Tees Hospitals NHS
NHS Foundation Trust

Agenda item 10

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| **Meeting / committee:** | Trust Board | **Meeting date:** | 26 August 2014 |

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|---|---|---|---|
| **This paper is for:** | Action/Decision | Assurance<br>X | Information<br>X |

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| **Title:** | Pressure Ulcer Report |

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| **Purpose:** | To provide a progress report regarding current performance and to inform the Board of Directors of the actions relating to pressure ulcer prevention within the Trust. |

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| **Key issues / items for consideration in the report:** | This report summarises:<br>• Current performance<br>• Progress from the Pressure Ulcer Prevention Collaborative. |

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| **Prepared by:** | Gill Hunt<br>Deputy Director of Nursing | **Presented by:** | Ruth Holt<br>Director of Nursing and Quality Assurance |

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| **Recommendation:** | Board are asked to support the work of the Pressure Ulcer Prevention Collaborative |

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|---|---|---|---|---|---|
| **Implications** | Legal<br>X | Financial<br>X | Safety & Quality<br>X | Strategic<br>X | Risk & Assurance<br>X |

**Pressure Ulcer Report**

## 1.0 Introduction

Around 187,000 patients every year in the UK develop pressure damage whilst in hospital. With around 700,000 people in the UK affected by pressure ulcers the financial burden to the health economy is estimated to be between £1.4 - 2.1 billion per year (4% of total NHS expenditure). Around 80-95% of pressure ulcers are considered to be preventable[1] with pressure ulcer prevention included in domain 5 of the NHS outcomes framework 14/15. The impact to the individual should not be underestimated, with increased length of hospital stay / requirement to access to community services, pain, psychological distress and loss of dignity frequently reported.

Nationally there has been an increased focus on pressure ulcer prevention, formally with associated Department of Health policy such as the High Impact Actions[2] and Nurse Sensitive Outcome Indicators (NSOI) for NHS Provided Care[3] and more recently as part of the CQUIN[4] framework. Pressure ulcers are clearly a marker of quality of care and securing significant reductions is a key objective for the organisation.

The national CQUIN measure for 2014/15 in relation to pressure ulcers is to achieve a 15% reduction in the prevalence of all pressure ulcers (old and new). Point prevalence data is taken from the Safety Thermometer and the financial value is £871k, given our current position the target is challenging. In real terms to secure a 15% reduction in overall numbers requires a 50% - 60% reduction in the development of new pressure ulcers (from data November 2014 – March 2015).

The size of the improvement required and the associated risks have been highlighted to our Commissioners during CQUIN negotiations. Whilst nursing staff clearly play a pivotal role in terms of the assessment, planning and actions necessary to prevent pressure damage multi-professional ownership and responsibility is also essential.

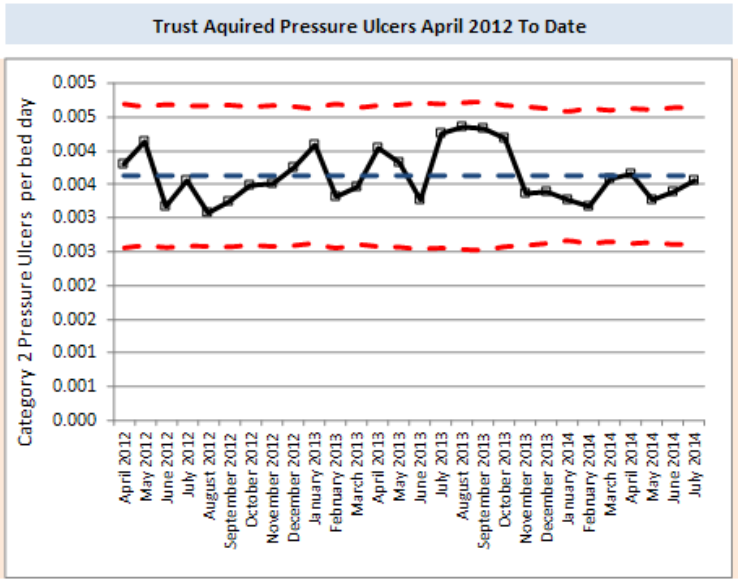
As an integrated provider we deliver care across a number of settings including the patient's own home. In terms of pressure ulcer prevention some of our biggest challenges are in this area where colleagues must address patient / carer / care agency compliance with plans of care.

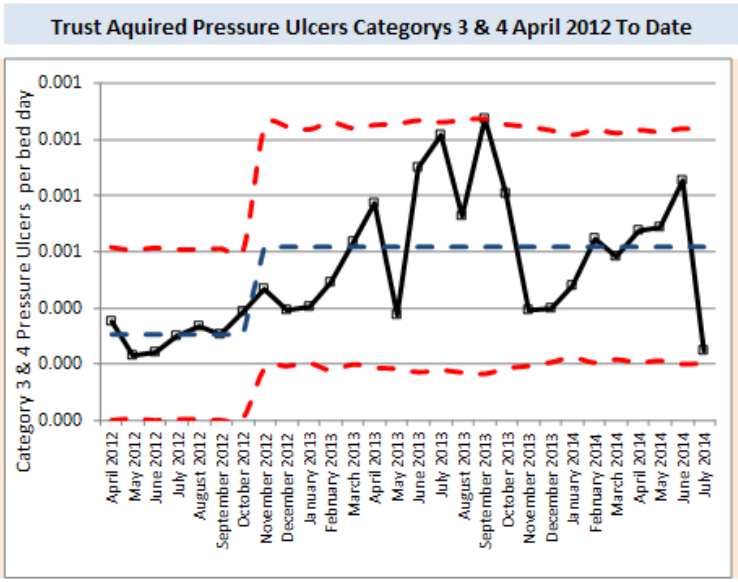
## 2.0 Current performance

Data is displayed in both actual numbers (reported via DATIX) and point prevalence (from the Safety Thermometer)

## 2.1 Trust acquired pressure ulcers, actual numbers per bed day

**Trust Acquired Pressure Ulcers Category 2 per patient bed day: Trust - All Centres between April 2012 & July 2014**




| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 | 2013/14 | Target | 2012/13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure Ulcers Category 1 | 45 | 46 | 38 | 48 | 34 | 37 | 52 | 49 | 36 | 49 | 38 | 49 | 521 | | 498 |
| Pressure Ulcers Category 2 | 120 | 112 | 91 | 122 | 120 | 117 | 124 | 103 | 111 | 116 | 103 | 123 | 1362 | | 1287 |
| Total Category 1 & 2 | 165 | 158 | 129 | 170 | 154 | 154 | 176 | 152 | 147 | 165 | 141 | 172 | 1883 | | 1785 |
| Bed Days | 29815 | 29355 | 27812 | 28651 | 27602 | 27036 | 29703 | 30714 | 32660 | 35471 | 32522 | 34312 | 365653 | | 362040 |
| Per 1000 Bed Days | 5.5 | 5.4 | 4.6 | 5.9 | 5.6 | 5.7 | 5.9 | 4.9 | 4.5 | 4.7 | 4.3 | 5.0 | 5.1 | | 4.9 |
| Category 3 and above | 23 | 11 | 25 | 29 | 20 | 29 | 24 | 12 | 13 | 17 | 21 | 20 | 244 | | 137 |

| | Apr 14 | May 14 | Jun 14 | Jul 14 | Aug 14 | Sep 14 | Oct 14 | Nov 14 | Dec 14 | Jan 15 | Feb 15 | Mar 15 | 2014/15 | Target | 2013/14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pressure Ulcers Category 1** | 61 | 54 | 44 | 32 | | | | | | | | | 191 | | 177 |
| **Pressure Ulcers Category 2** | 119 | 110 | 107 | 115 | | | | | | | | | 451 | | 445 |
| **Total Category 1 & 2** | 180 | 164 | 151 | 147 | | | | | | | | | 642 | | 622 |
| **Bed Days** | 32552 | 33643 | 31678 | 32361 | | | | | | | | | 130234 | | 115633 |
| **Per 1000 Bed Days** | 5.5 | 4.9 | 4.8 | 4.5 | | | | | | | | | 4.9 | | 5.4 |
| **Category 3 and above** | 22 | 23 | 27 | 8 | | | | | | | | | 80 | | 88 |

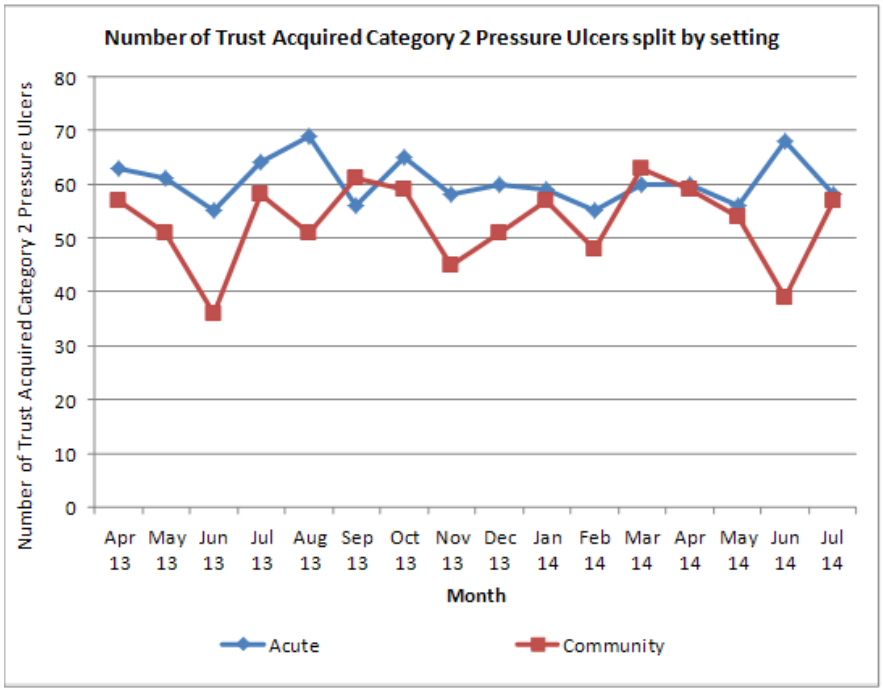
## 2.2 Trust acquired pressure ulcers by setting April 2013 – July 2014

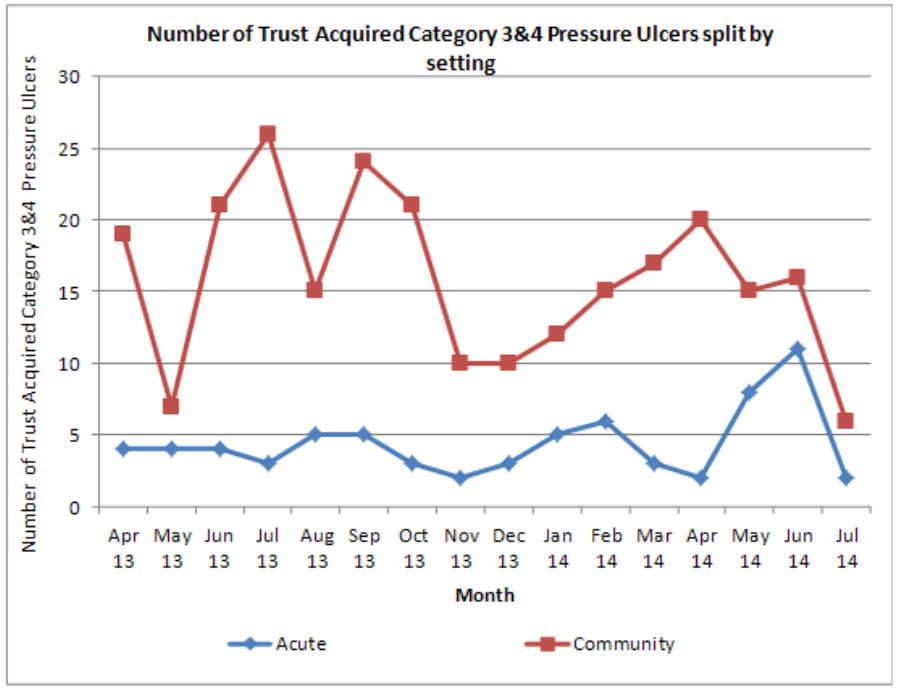
Acute

| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 | Apr 14 | May 14 | Jun 14 | Jul 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Category 2 | 63 | 61 | 55 | 64 | 69 | 56 | 65 | 58 | 60 | 59 | 55 | 60 | 60 | 56 | 68 | 58 |
| Category 3&4 | 4 | 4 | 4 | 3 | 5 | 5 | 3 | 2 | 3 | 5 | 6 | 3 | 2 | 8 | 11 | 2 |

Community

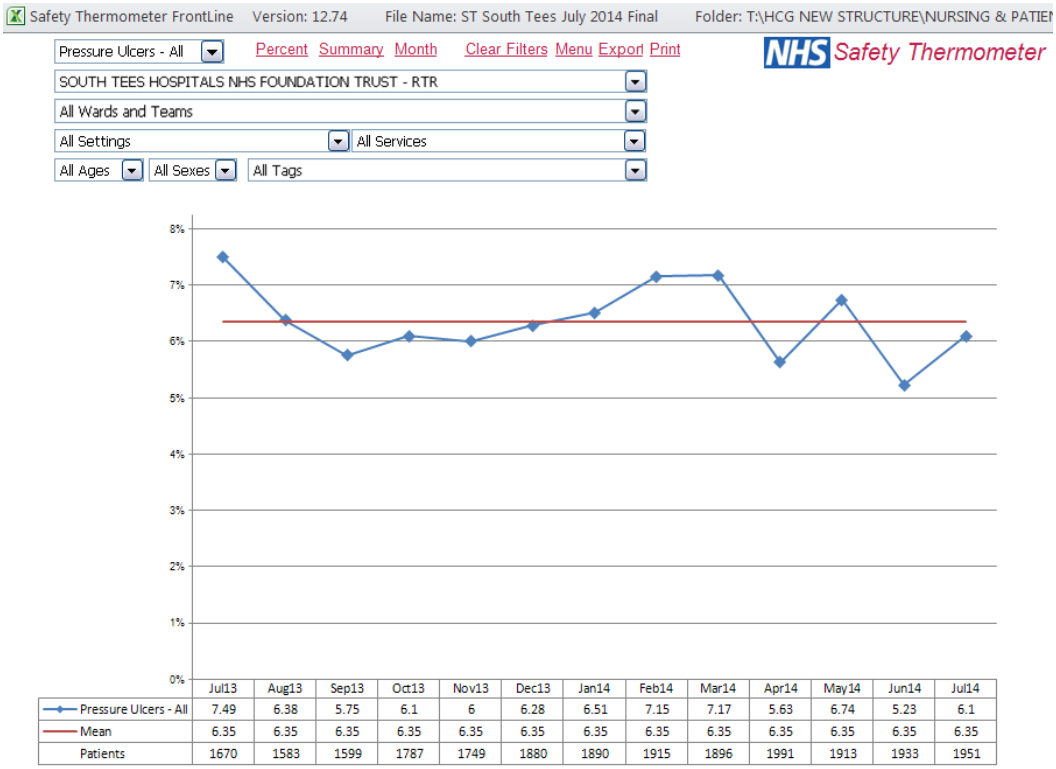
| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 | Apr 14 | May 14 | Jun 14 | Jul 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Category 2 | 57 | 51 | 36 | 58 | 51 | 61 | 59 | 45 | 51 | 57 | 48 | 63 | 59 | 54 | 39 | 57 |
| Category 3&4 | 19 | 7 | 21 | 26 | 15 | 24 | 21 | 10 | 10 | 12 | 15 | 17 | 20 | 15 | 16 | 6 |



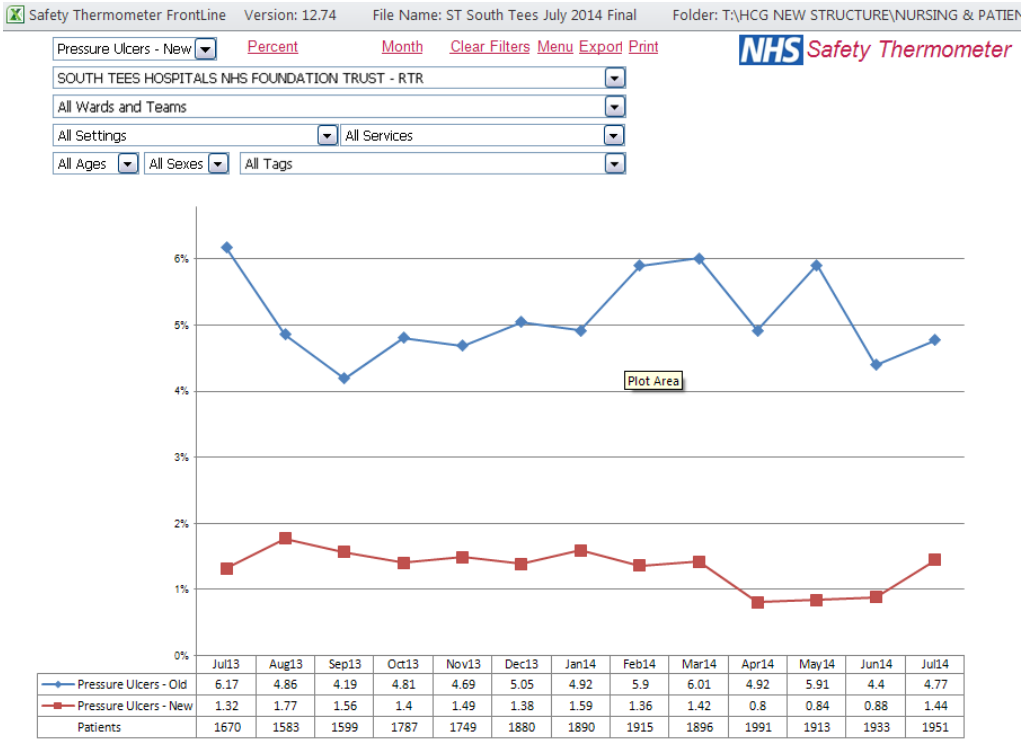
## 2.3 Safety Thermometer data

### Pressure Ulcers all




| | Jul13 | Aug13 | Sep13 | Oct13 | Nov13 | Dec13 | Jan14 | Feb14 | Mar14 | Apr14 | May14 | Jun14 | Jul14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure Ulcers - All | 7.49 | 6.38 | 5.75 | 6.1 | 6 | 6.28 | 6.51 | 7.15 | 7.17 | 5.63 | 6.74 | 5.23 | 6.1 |
| Mean | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 | 6.35 |
| Patients | 1670 | 1583 | 1599 | 1787 | 1749 | 1880 | 1890 | 1915 | 1896 | 1991 | 1913 | 1933 | 1951 |

### Pressure ulcers old and new




| | Jul13 | Aug13 | Sep13 | Oct13 | Nov13 | Dec13 | Jan14 | Feb14 | Mar14 | Apr14 | May14 | Jun14 | Jul14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure Ulcers - Old | 6.17 | 4.86 | 4.19 | 4.81 | 4.69 | 5.05 | 4.92 | 5.9 | 6.01 | 4.92 | 5.91 | 4.4 | 4.77 |
| Pressure Ulcers - New | 1.32 | 1.77 | 1.56 | 1.4 | 1.49 | 1.38 | 1.59 | 1.36 | 1.42 | 0.8 | 0.84 | 0.88 | 1.44 |
| Patients | 1670 | 1583 | 1599 | 1787 | 1749 | 1880 | 1890 | 1915 | 1896 | 1991 | 1913 | 1933 | 1951 |

**CQUIN Target**

The target is a 15% reduction in all pressure ulcers reported using the Safety Thermometer tool, the table below shows the required reductions to achieve the target (based on an assumption that the number of old ulcers remains constant).

| Number of pressure ulcers per month | All | New | Old |
|---|---|---|---|
| Baseline (Median October 13 to March 14) | 121 | 26 | 93 |
| Target (Median November 14 to March 15) | 102 | 9 | 93 |

## 3.0 Reporting

Whilst all pressure damage is reported via DATIX, category 3 and 4 ulcers are reportable as a serious incident (SI). Changes were made in April 2014 to bring us in line with the rest of the region, with the Trust adopting the definitions of avoidable / unavoidable in line with the Tissue Viability Society guidance[5] and Department of Health[6] definitions. Cases which are deemed avoidable will be reported to the Commissioners as SI's, this is for cases where service / care failings have been identified. To be deemed unavoidable all aspects of assessment, implementation and evaluation must have been fully undertaken in line with policy.

Whilst the Safety Thermometer point prevalence data demonstrates an increase in both old and new categories in July the actual reported numbers (via Datix) have reduced in the numbers of category 3 / 4 ulcers acquired in our care. This is in both acute and community services, whilst acknowledging that this is only one data point it is a positive indicator.

## 4.0 Action

### 4.1 South Tees Pressure Ulcer Prevention Collaborative

As is clear from the data robust action is required. The South Tees Pressure Ulcer Prevention Collaborative was established in May 2014. This multi-professional and multi-agency steering group (including Commissioners) reports to the Patient Safety Sub Group and meets on a monthly basis. The steering group is responsible for overseeing the identified work streams and overarching action plan.

The Collaborative has the very clear aim of securing significant reductions in pressure damage. The aspiration is to eliminate category 3 & 4 pressure ulcers which develop in our care, making a 50% reduction in all ulcers this year.

A collaborative approach had been adopted to engage and bring teams together to introduce change in order to achieve improvement. This approach has been successfully used in other organisations, acknowledging that engagement, ownership and a change in culture is fundamental to securing improvements. Learning from others is extremely valuable and is a strategy being actively pursued via both existing and new networks.

The Collaborate has 6 distinct work streams each with a lead(s) and a documented action plan

1. **Engagement, ownership, culture**
2. **Prevention strategies**
3. **Equipment**
4. **Education**
5. **Reporting and Learning**
6. **Partnership working**

Actions arising from the 6 work streams will ensure all areas of practice are systematically reviewed. Specific action during the last month includes:

- The 'intentional rounding' document has been reviewed with an increased focus on pressure ulcer prevention and repositioning. It will be launched with an associated audit tool at the nurse leadership day on 3 September 2014.

- A review of patient / carer information in relation to plaster casts has been commenced.

- Pressure ulcer prevention advice has been incorporated in a patient information DVD as part of surgical pre-assessment.

- The adapted Glamorgan risk assessment tool will be adopted in children's inpatient areas from September 2014. This validated tool has a higher sensitivity, specificity and reliability than the Braden Q which is currently in use.

- A pilot of heel protectors in high risk patients

### 4.2 Training

During 2013 a number of B6 educator posts were utilised to deliver training to senior nursing staff (Band 6 – 8a). The philosophy of the Collaborative is that preventing pressure ulcers is everyone's business and all matrons / sisters / charge nurses must play a key role in the delivery of training in their areas. Matrons / sisters / charge nurses are escalated to at an early stage of any identified damage to skin integrity to be assured that all appropriate measures are taken to prevent further deterioration. The role of the tissue viability nurse (TVN) is to offer specialist input when required rather than general preventive advice, which should be embedded in day to day practice to sustain improvement.

The recruitment process is underway to appoint 1 Wte B6 clinical educator (on a temporary basis for 6 months) to support the Collaborative in terms of education and audit as changes are tested within the work streams.

Practical training in relation to repositioning and use of the 30 degree tilt will be incorporated into mandatory manual handling training from September 2014.

A network of frontline champions is currently being established with a training day planned for September 2014 with regular meetings thereafter.

### 4.3 Learning

A Director / Deputy Director led case review is undertaken for all Category 3 and 4 ulcers, cases are presented by matrons and sister / charge nurses with the attendance of frontline staff actively encouraged to share learning. Performance is also discussed at Director led Clinical Standards meetings.

Specific learning and action is assigned to the ward/department/locality involved with themes reported to the Collaborative leads to influence the action plan to be assured of wider organisational learning.

The recurring theme from case reviews relates to systematic repositioning and the need for consistent focus in relation to prevention. This theme has heavily influenced the specific actions of the Collaborative.

Colleagues in the Corporate Team have produced a 'Pressure Ulcer Prevention Score' (based on a number of available metrics). This translates into a heat map which will be used to identify trends and hotspots at ward, center and organisational level.

### 5.0 Summary

The number of pressure ulcers acquired in our care continues to be an area of significant concern.

The pressure ulcer action plan will be monitored by the Collaborative Steering Group.

The Board of Directors are asked to:

1. Note the current position
2. Support the actions being taken

Gill Hunt
18 August 2014


1. www.nhs.stopthepressure.co.uk
2. NHS Institute for Innovation and Improvement (2010). High Impact Actions for Nursing and Midwifery: the essential collection. http://www.institute.nhs.uk/building_capability/general/aims/
3. Department of health Strategic Health Authorities (2010) Nurse Sensitive Outcome Indicators (NSOI) for the NHS and commissioned care. Version 3. http://www.ic.nhs.uk/webfiles/Services/Clinical%20Metrics/NSOI_Indicators_Version 3-FINAL.PDF
4. Department of Health (2012). Using the Commissioning for Quality and Innovation (CQUIN) payment framework; a summary guide. HMSO, London.
5. Tissue Viability Society (2012). Achieving Consensus in Pressure Ulcer Reporting. Journal of Tissue Viability (2012)
6. [1]National Patient Safety Agency (2010). http://www.nhs.npsa.resources/collections/10-for-2010/pressure-ulcers/