South Tees Hospitals NHS
NHS Foundation Trust

Agenda Item 9

Meeting / committee:	Board of Directors	**Meeting date:**	29 July 2014

This paper is for:	Action/Decision	Assurance X	Information X

Title:	Pressure Ulcer Report

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.

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

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

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

Implications	Legal X	Financial X	Safety & Quality X	Strategic X	Risk & Assurance 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.

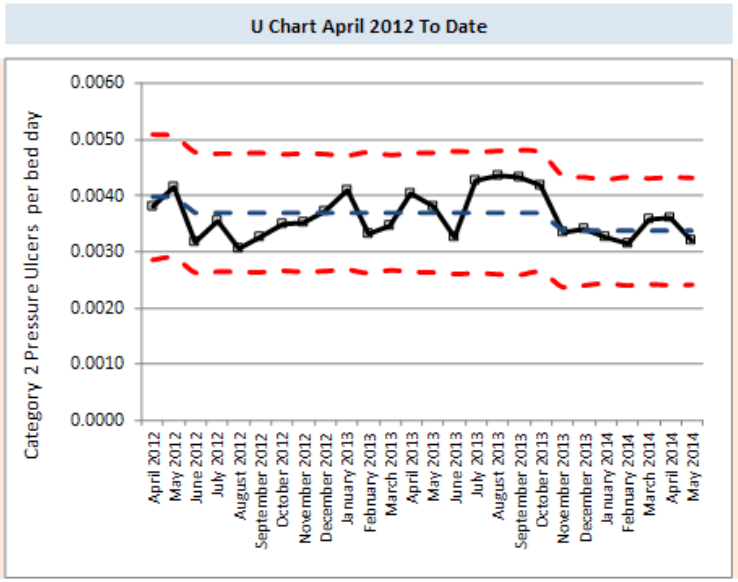
As an integrated provider we deliver care across a number of settings including the patient's own home. In terms of pressure ulcer prevention some of our biggest challenges are in this area where colleagues must address patient / carer / care agency compliance with plans of care.

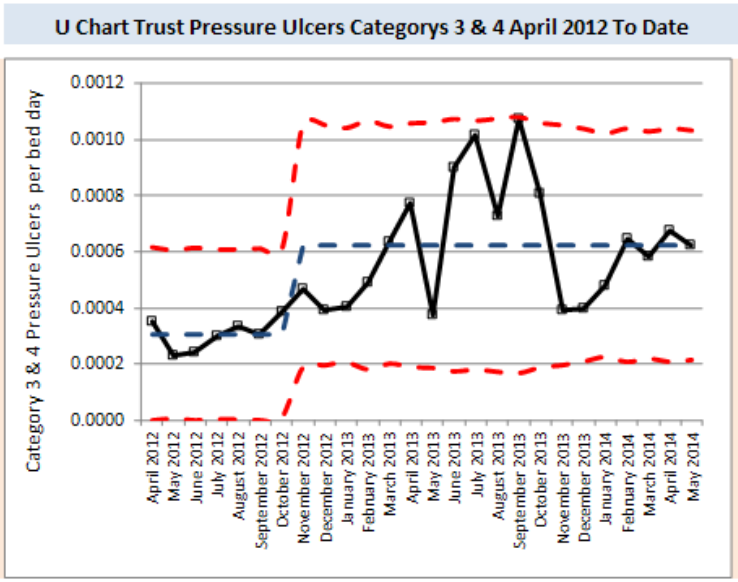
2.0 Current performance

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 & May 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	102	123	1361		1286
Total Category 1 & 2	165	158	129	170	154	154	176	152	147	165	140	172	1882		1784
Bed Days	29815	29355	27812	28648	27602	27036	29703	30714	32660	35471	32522	34312	365650		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

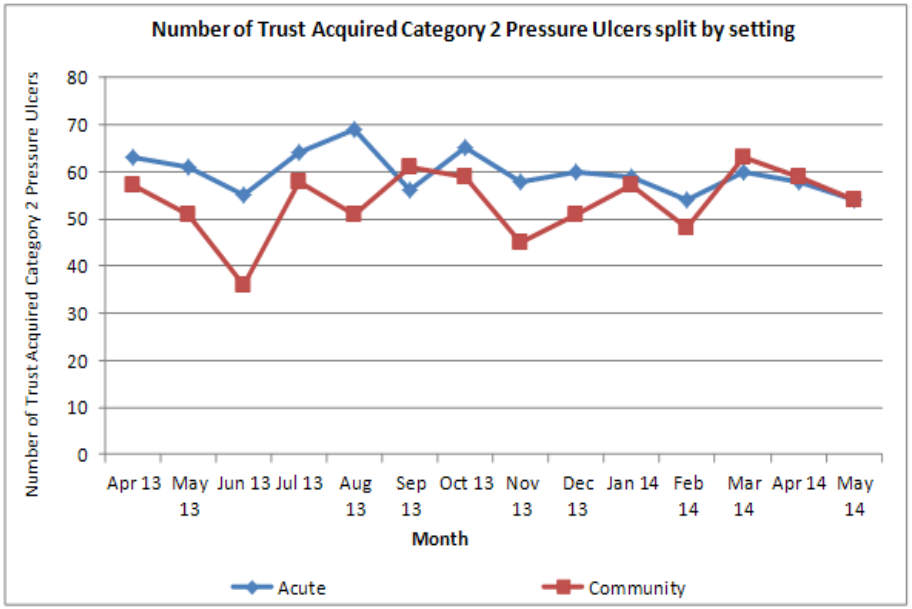
2.2 Trust acquired pressure ulcers by setting April 2013 – May 2014

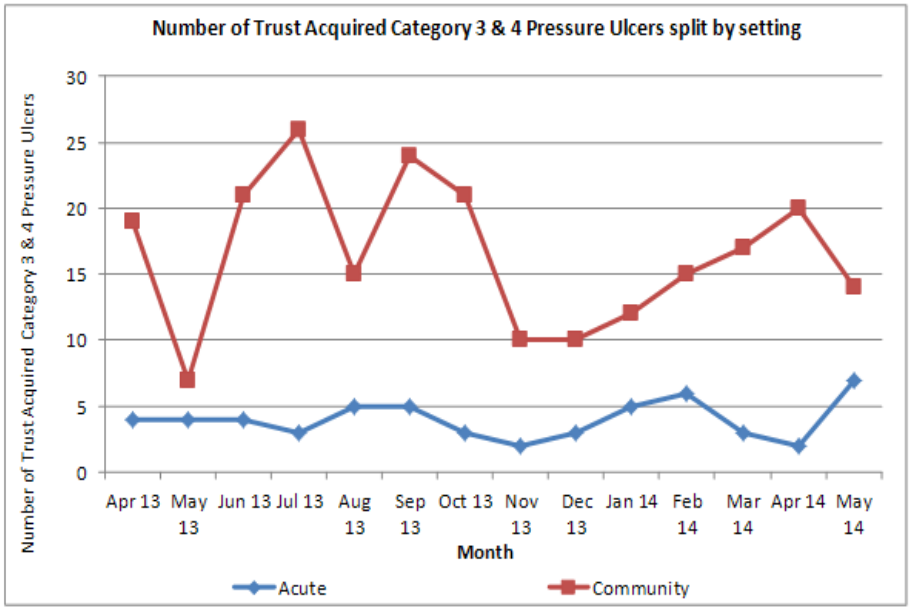
Acute

	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
Category 2	63	61	55	64	69	56	65	58	60	59	54	60	58	54
Category 3 & 4	4	4	4	3	5	5	3	2	3	5	6	3	2	7

Community

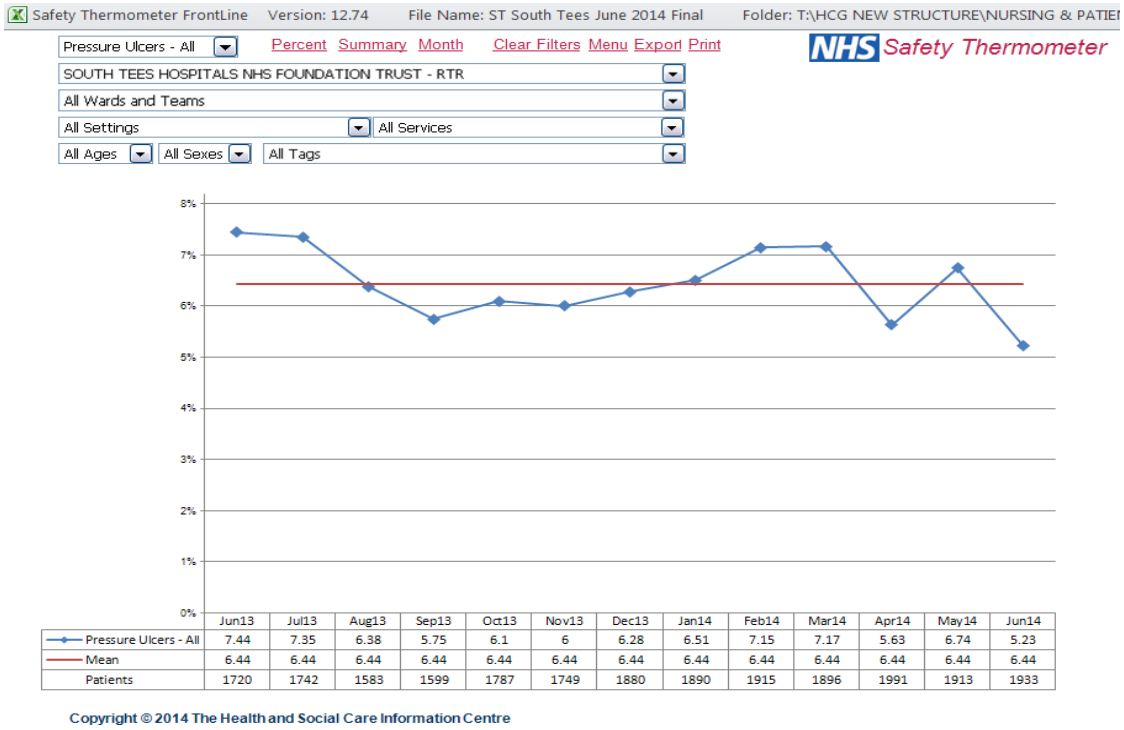
	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14
Category 2	57	51	36	58	51	61	59	45	51	57	48	63	59	54
Category 3 & 4	19	7	21	26	15	24	21	10	10	12	15	17	20	14





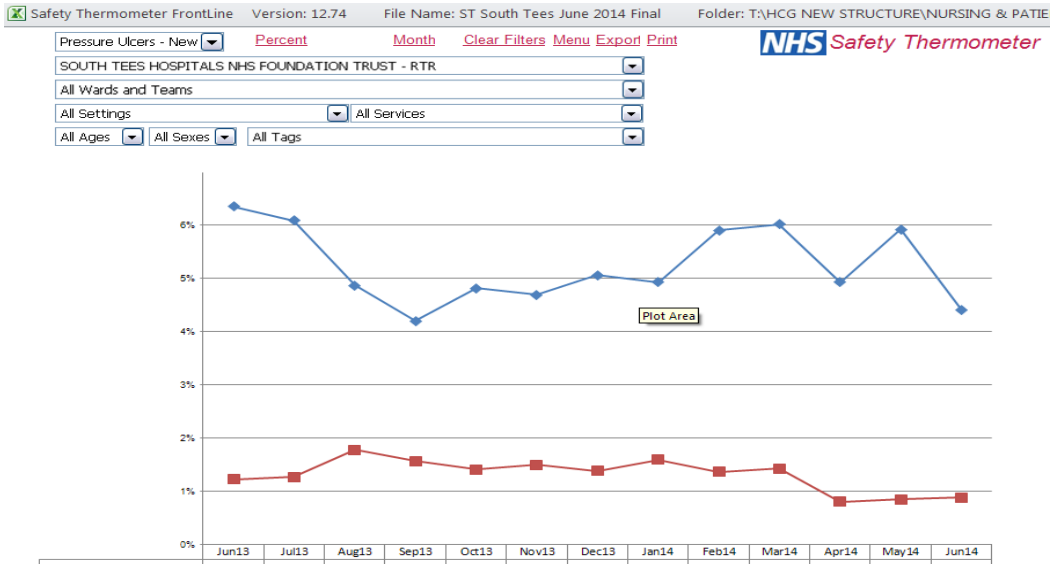
2.3 Safety Thermometer data

Pressure Ulcers all



	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14
Pressure Ulcers - All	7.44	7.35	6.38	5.75	6.1	6	6.28	6.51	7.15	7.17	5.63	6.74	5.23
Mean	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44
Patients	1720	1742	1583	1599	1787	1749	1880	1890	1915	1896	1991	1913	1933

Pressure ulcers old and new



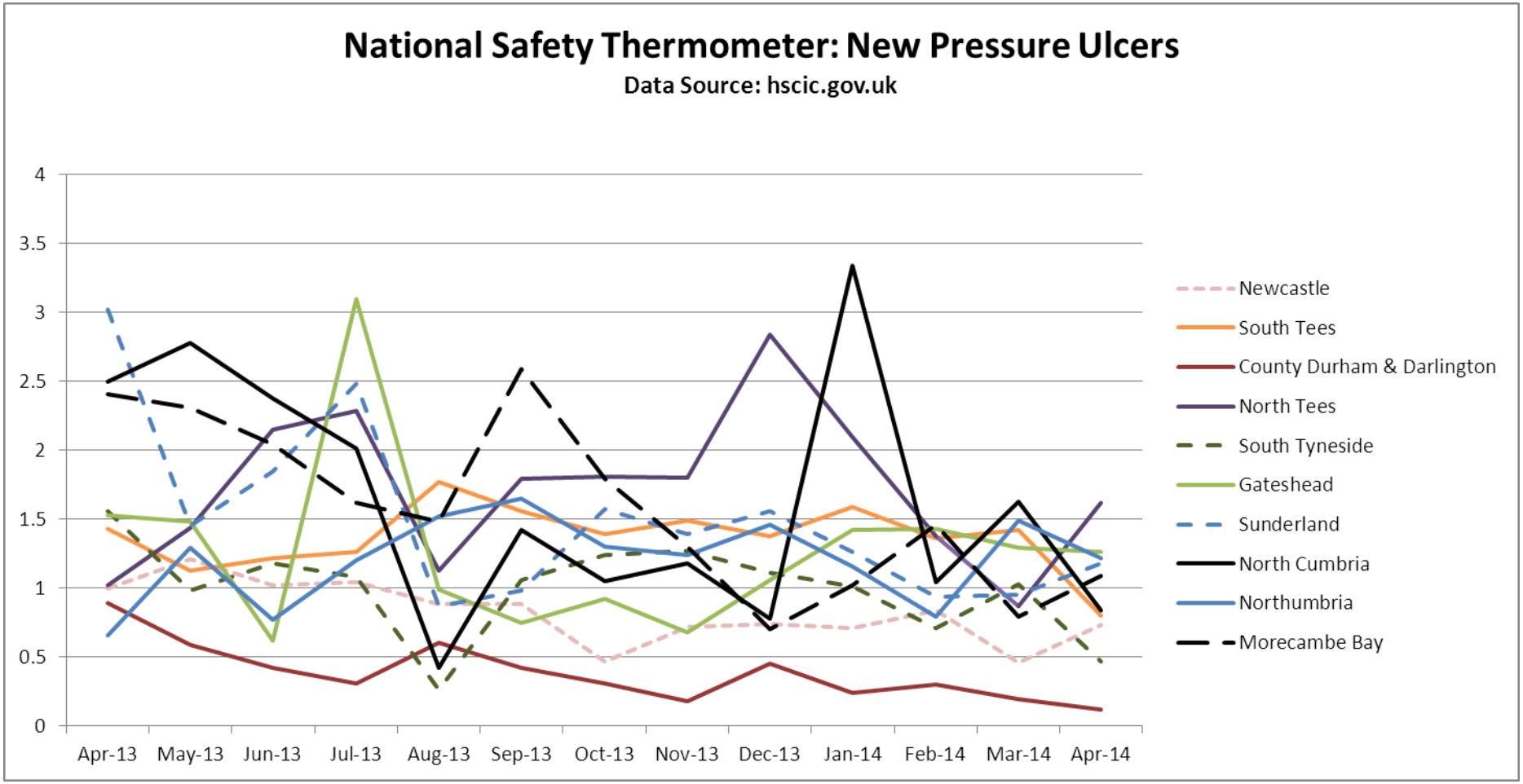
	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14
Pressure Ulcers - Old	6.34	6.08	4.86	4.19	4.81	4.69	5.05	4.92	5.9	6.01	4.92	5.91	4.4
Pressure Ulcers - New	1.22	1.26	1.77	1.56	1.4	1.49	1.38	1.59	1.36	1.42	0.8	0.84	0.88
Patients	1720	1742	1583	1599	1787	1749	1880	1890	1915	1896	1991	1913	1933

CQUIN Target

15% reduction in all pressure ulcers reported using the Safety Thermometer tool, 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

2.4 National Safety Thermometer data – new pressure ulcers



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.

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.

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.

We are planning to recruit 1Wte B6 clinical educator and 1 Wte B3 audit support (on a temporary basis) to support the Collaborative in terms of education and audit as changes are tested within the work streams.

The work of the Collaborative has been presented to over 100 senior nurses in June 2014 (sisters / charge nurses / matrons and heads of nursing) and has been incorporated into the patient safety presentation delivered at Trust Induction and Mandatory Training.

4.3 Patient Experience

The use of patient experience is incredibly powerful; in July 2014 patient stories are being captured to produce a DVD to engage and educate staff.

4.4 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.

Emerging themes from the case reviews are:

- The requirement for more frequent and systematic repositioning and for repositioning to be prescribed on an individual basis
- Staff knowledge in relation to repositioning
- Equipment delays (for a variety of reasons)
- Lack of continuity of care during handover between wards
- Body maps / bony prominence charts not always fully completed
- Earlier intervention for high risk patients
- Frequency of top to toe assessment of skin integrity in the community (when the visit may be for another purpose)
- Compliance with planned care when care is delivered by partner agencies (e.g. residential homes, patients own home)

Specific learning and action is assigned to the ward/department/locality involved with themes reported to the Collaborative leads for wider organisational action and learning

Producing meaningful data for frontline leaders is an imperative, sisters / charge nurses have received a refresher session on the use of the Safety Thermometer and Ward Dashboard. A review of the 'Knowing How You're Doing Board' and use of safety huddles has been identified as part of the action plan.

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

5. 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 implemented and 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
8 July 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/