South Tees Hospitals NHS
NHS Foundation Trust

agenda item 11

Meeting / committee:	Board of Directors	**Meeting date:**	25 November 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). An additional £296k is dependent on achieving the implementation plan submitted to Commissioners.

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.

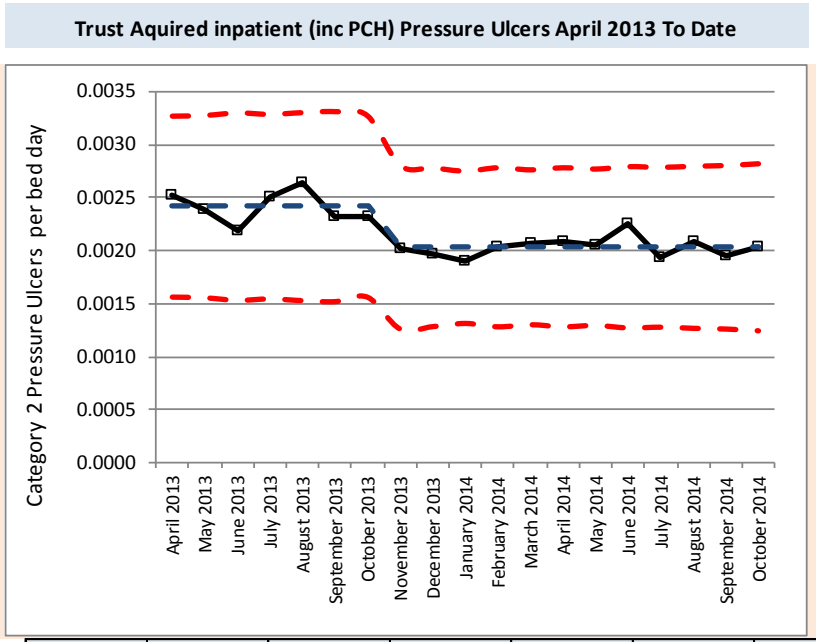
As an integrated provider we deliver care across a number of settings including the patient's own home. In terms of pressure ulcer prevention some of our biggest challenges are in this area where colleagues must address patient / carer / care agency compliance with plans of care.

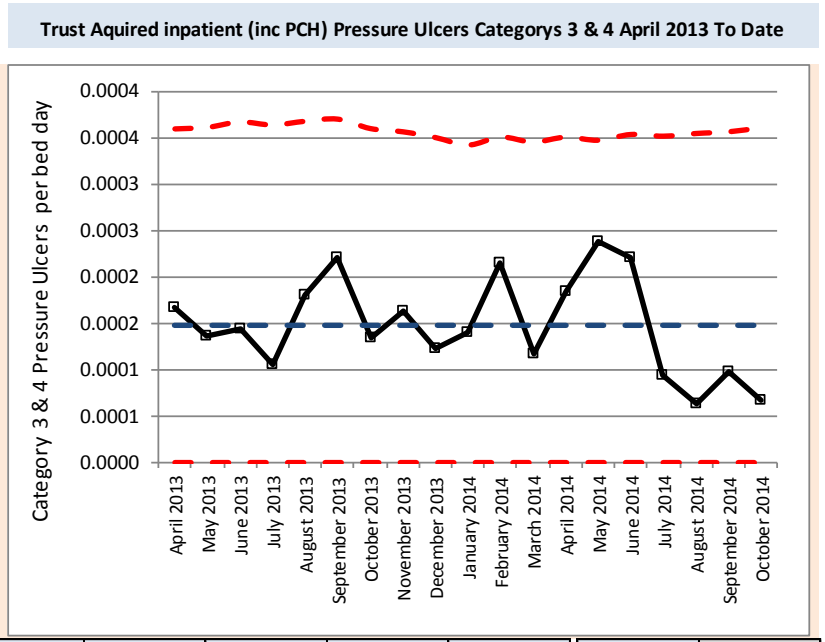
2.0 Current performance

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 Inpatient (inc PCH) Pressure Ulcers Category 2 per patient bed day: Trust - All Centres between April 2013 & October 2014



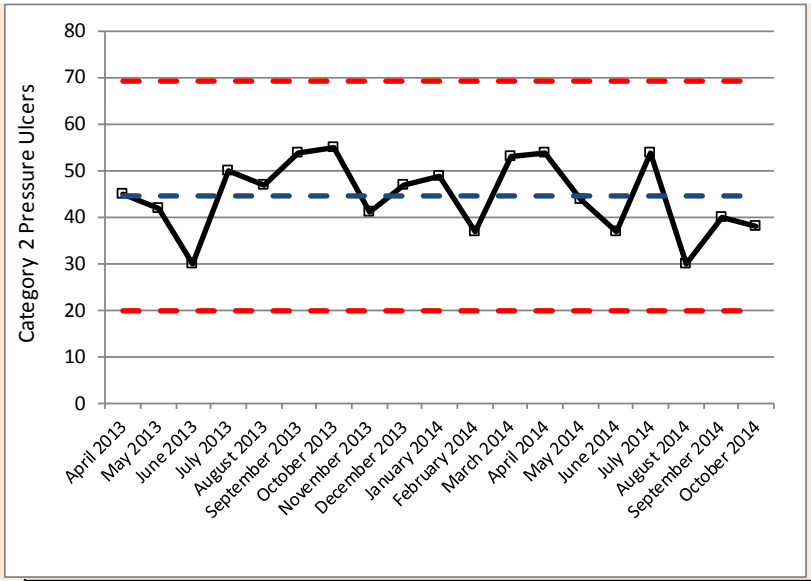


Inpatient (inc PCH)	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	2013/14	2012/13
Pressure Ulcers Category 1	28	36	26	31	18	28	33	31	21	37	25	40	354	336
Pressure Ulcers Category 2	75	70	61	72	73	63	69	62	64	67	66	71	813	800
Total Category 1 & 2	103	106	87	103	91	91	102	93	85	104	91	111	1167	1136
Per 1000 Bed Days	3.5	3.6	3.1	3.6	3.3	3.4	3.4	3.0	2.6	2.9	2.8	3.2	3.2	3.1
Category 3 and above	5	4	4	3	5	6	4	5	4	5	7	4	56	47

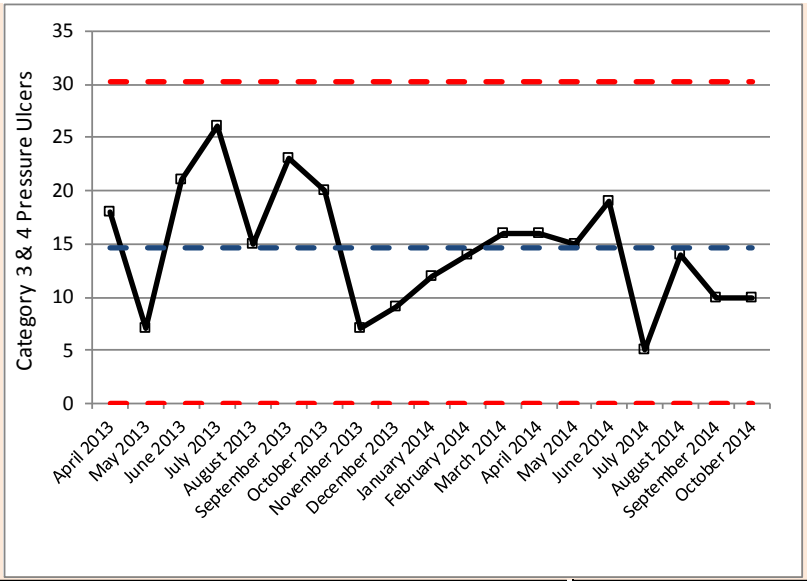
Inpatient (inc PCH)	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	2014/15	2013/14
Pressure Ulcers Category 1	47	40	27	23	28	22	26						213	200
Pressure Ulcers Category 2	68	69	71	62	65	60	60						455	483
Total Category 1 & 2	115	109	98	85	93	82	86						668	683
Per 1000 Bed Days	3.5	3.2	3.1	2.6	3.0	2.7	2.9						3.0	3.4
Category 3 and above	6	8	7	3	2	3	2						31	31

Trust Acquired Community Pressure Ulcers Category 2 per patient bed day: Trust - All Centres between April 2013 & October 2014

Trust Aquired Community Pressure Ulcers April 2013 To Date



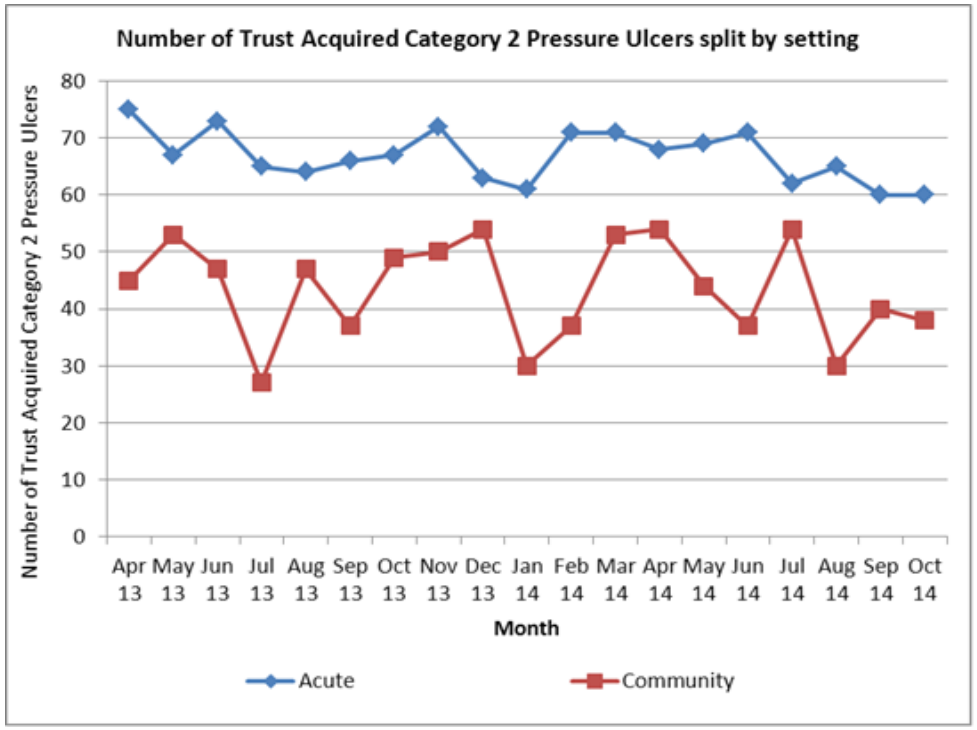
Trust Aquired Community Pressure Ulcers Categorys 3 & 4 April 2013 To Date

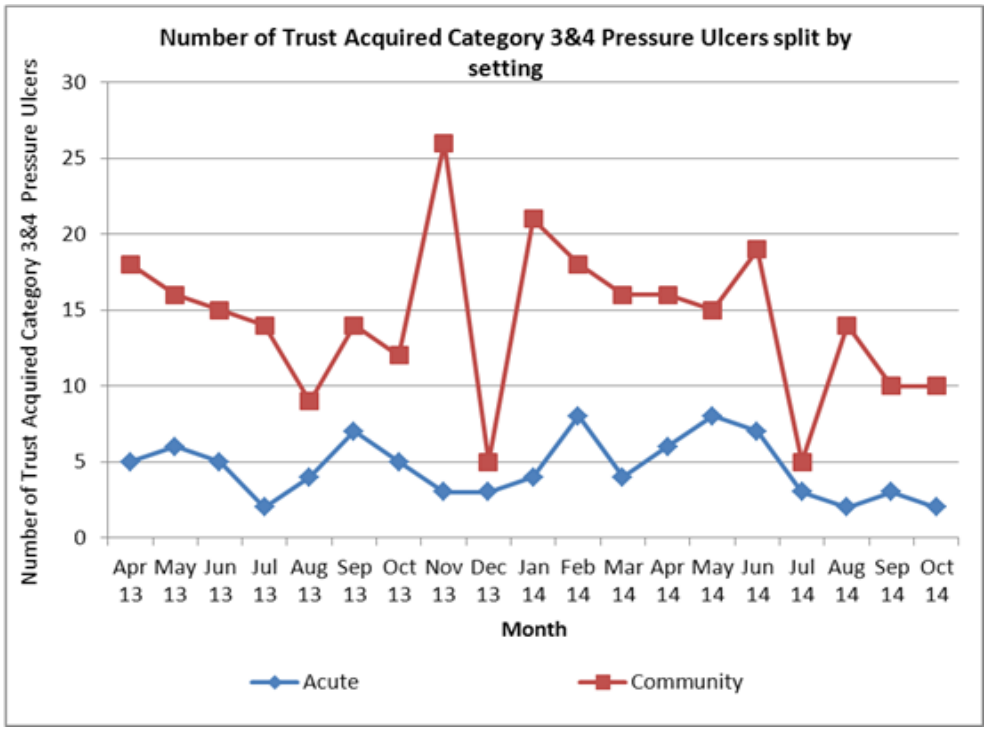


Community	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	2013/14	2012/13
Pressure Ulcers Category 1	17	10	12	17	16	11	19	18	15	12	13	10	170	162
Pressure Ulcers Category 2	45	42	30	50	47	54	55	41	47	49	37	53	550	486
Total Category 1 & 2	62	52	42	67	63	65	74	59	62	61	50	63	720	648
Category 3 and above	18	7	21	26	15	23	20	7	9	12	14	16	188	90

Community	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	2013/14
Pressure Ulcers Category 1	14	14	18	12	11	11	2						82	102
Pressure Ulcers Category 2	54	44	37	54	30	40	38						297	323
Total Category 1 & 2	68	58	55	66	41	51	40						379	425
Category 3 and above	16	15	19	5	14	10	10						89	130

2.2 Trust acquired pressure ulcers by setting April 2013 – September 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
Category 2	75	67	73	65	64	66	67	72	63	61	71	71
Category 3&4	5	6	5	2	4	7	5	3	3	4	8	4

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Category 2	68	69	71	62	65	60	60					
Category 3&4	6	8	7	3	2	3	2					

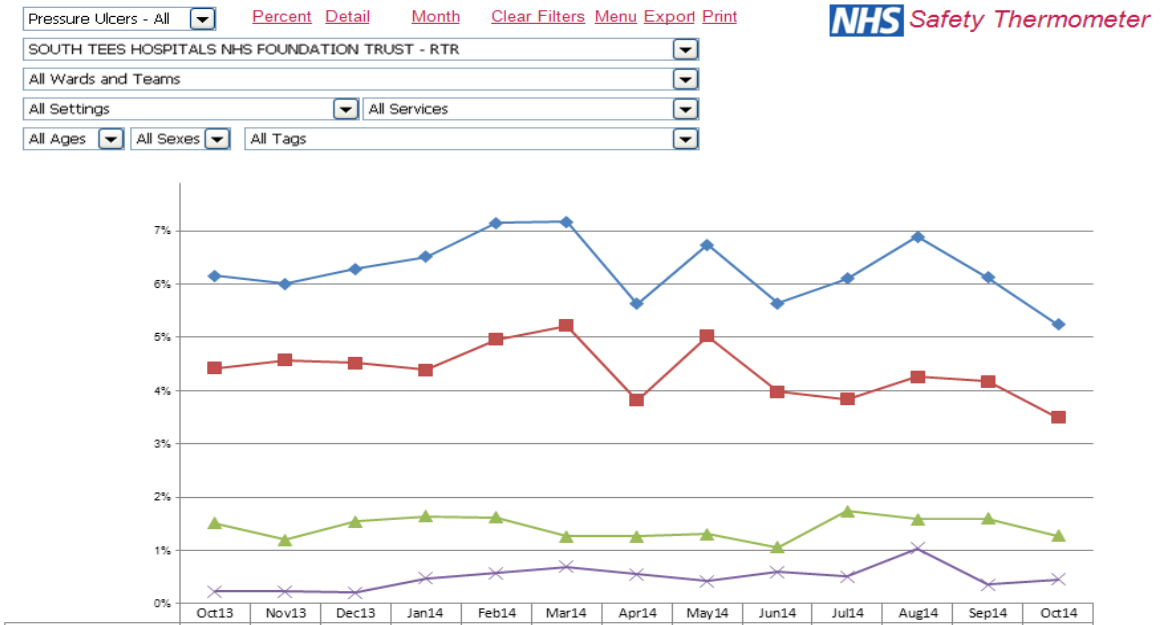
Community

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Category 2	45	53	47	27	47	37	49	50	54	30	37	53
Category 3&4	18	16	15	14	9	14	12	26	5	21	18	16

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Category 2	54	44	37	54	30	40	38					
Category 3&4	16	15	19	5	14	10	10					

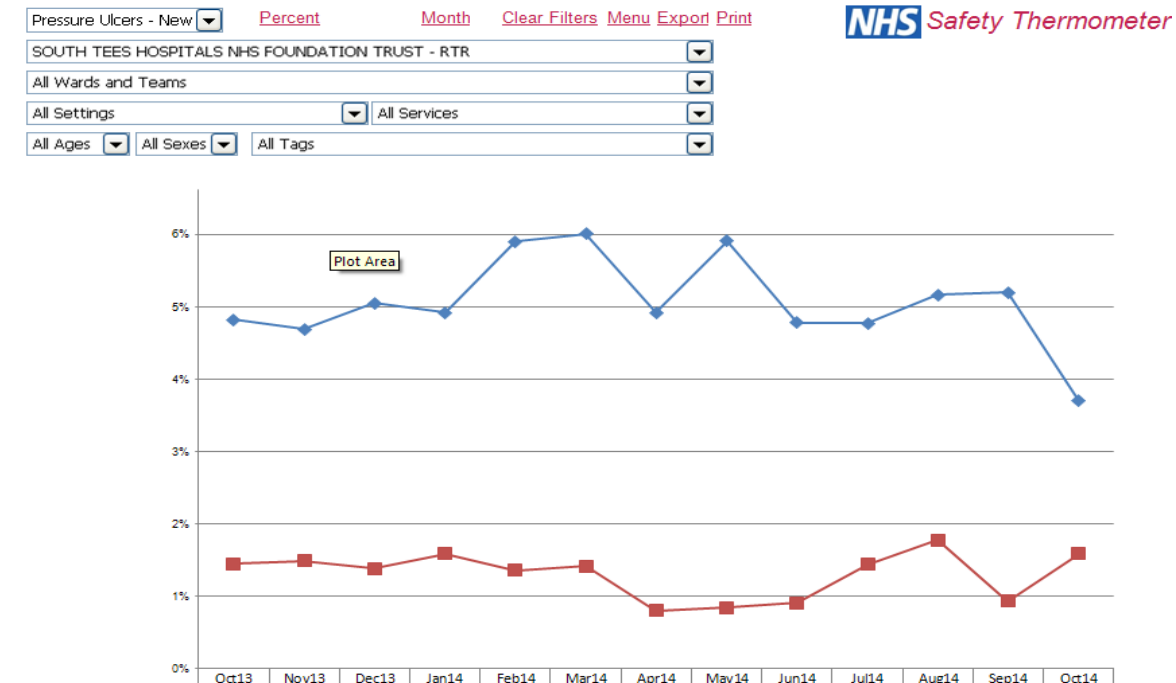
2.3 Safety Thermometer data

Pressure Ulcers all



	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14
Pressure Ulcers - All	6.16	6	6.28	6.51	7.15	7.17	5.63	6.74	5.64	6.1	6.89	6.12	5.24
Category 2	4.42	4.57	4.52	4.39	4.96	5.22	3.82	5.02	3.98	3.84	4.26	4.17	3.49
Category 3	1.51	1.2	1.54	1.64	1.62	1.27	1.26	1.31	1.06	1.74	1.59	1.6	1.28
Category 4	0.23	0.23	0.21	0.48	0.57	0.69	0.55	0.42	0.6	0.51	1.04	0.36	0.46
Patients	1721	1749	1880	1890	1915	1896	1991	1913	1986	1951	2017	1943	1947

Pressure ulcers old and new



	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14
Pressure Ulcers - Old	4.82	4.69	5.05	4.92	5.9	6.01	4.92	5.91	4.78	4.77	5.16	5.2	3.7
Pressure Ulcers - New	1.45	1.49	1.38	1.59	1.36	1.42	0.8	0.84	0.91	1.44	1.78	0.93	1.59
Patients	1721	1749	1880	1890	1915	1896	1991	1913	1986	1951	2017	1943	1947

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.

In September the use of the category 'unstageable' was agreed with the Commissioners. Historically this classification has not been applied within the organisation but its use is consistent with both the National and European Pressure Ulcer Advisory Panels (NPUAP / EPUAP) and guidance from the Tissue Viability Society. To safeguard against inappropriate use the category will only be applied by a Tissue Viability Nurse in cases where damage is apparent but the true extent cannot be established. This may be because the wound needs to be debrided or in some instances a suspected deep tissue injury can self-resolve without any break in skin integrity / further breakdown. Historically we have not applied this category which can result in over reporting.

In October there were 12 category 3/4 pressure ulcers, 1 was reported as a SI's

(The reported numbers may be subject to change during the process of investigation)

The Safety Thermometer point prevalence percentage has reduced in October to 5.24%, and is below the 5.43% target, this is predominately due to a reduction in old pressure ulcers.

4.0 Action

4.1 South Tees Pressure Ulcer Prevention Collaborative

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 October / November includes:

- Production of a 'Patient Repositioning Guide' and revision of the 'Pressure Ulcer Aide Memoire' have been completed, for implementation in November 2014

- The CALCULATE risk assessment tool was implemented in general critical care areas on both the JCUH and FHN sites in November 2014. This is a tool devised by the Critical Care Network specifically for use with this high risk patient group. Early feedback is positive and further roll out will be considered for other critical care areas

- Planning for events to raise awareness during worldwide 'Stop the Pressure Day' on 20 November. This includes stands on both the JCUH and FHN sites with competitions and educational activities across the organisation as a whole

- The revised intentional rounding chart to be launched 17 November, with emphasis on pressure ulcer prevention

- A pressure ulcer prevention audit tool has been agreed, to be undertaken across all inpatient areas during December 2014

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.

Recent panel reviews have seen a much improved position in terms of adherence to prevention strategies.

Assurance

A revised validation process has been agreed and implemented within Centres to be absolutely assured that Safety Thermometer reporting is robust.

In order to be assured that grading of pressure ulcers is accurate Tissue Viability colleagues have been asked to confirm category 3 / 4 ulcers prior to reporting, providing training in relation to grading as required.

The tissue viability team have reviewed a sample of those community cases which were deemed unavoidable (and therefore not reported as an SI). This was to provide independent assurance that the 'unavoidable' decision is being applied appropriately and consistently and that all aspects of care were fully undertaken in line with policy. The team have confirmed that based on the criteria the cases were 'unavoidable' and therefore the decision had been applied appropriately.

An assurance framework is being produced in relation to pressure ulcers and will be included in the December Board report.

5.0 Summary

Continued focus and commitment to secure reductions is an absolutely imperative.

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
Deputy Director of Nursing

17 November 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/