Identifying the true picture of pressure ulcers in a combined acute and community trust

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Introduction

- Pressure ulcers have been on the NHS agenda for over 10 years (Porter 2015) and yet pressure ulcer occurrence continues to challenge healthcare providers (Fletcher 2015)
- As part of the East Lancashire Hospitals NHS Trusts commitment to provide **"Safe Personal and Effective Care"** a steering group was set up to drive pressure ulcer prevention and reduce avoidable harm
- Over the financial year the **1395 electronic incident forms** were completed by clinical staff to report pressure ulcers
- The challenge we set as an organisation at the end of the previous year was to look at new pressure ulcer incident reports, check accuracy and build a picture of the numbers of pressure ulcers that had occurred under our care

Method

The steering group together with the Quality and Safety team looked at how we could capture better data that would lead to more accurate reports. The reports could then inform action plans.

The process agreed on

- Fields within the electronic form added to allow staff to indicate the pressure ulcer had developed whilst the patient was under the care of the Trust
- A search for previous reports for the same incident to be undertaken as part of the incident management process
- Verification that the tissue damage reported is a pressure ulcer and that the category is correct is undertaken by a tissue viability nurse within the hospitals and nominated band 6 or band 7 staff in the community
- Removal by cleansing of all non-adherent debris/residue on the surface of the pressure ulcer prior to categorisation
- If applicable: use of a monofilament fibre debridement pad* to assist clinical assessment where the wound bed is not visible and devitalised tissue may be obscuring exposed structures
- Alongside all mandatory reporting to external agencies, all pressure ulcers acquired under the Trusts care to be investigated and a route cause analysis to be discussed at a harm free care panel. A decision by the panel is then made as to whether the incident was avoidable or not
- All lessons learnt inform the action plans that are monitored by the steering group

* **Debrisoft®** – Activa Healthcare an L&R company

Results

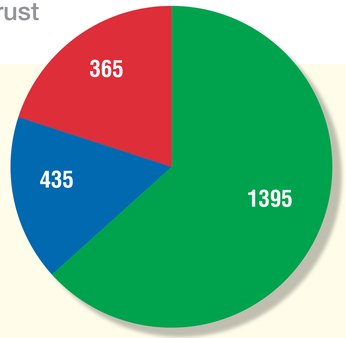

Chart 1 - Following the agreed process we found that the **1395 incidents** included **365 previously reported** and **435 where the cause of tissue damage was found to be other than pressure**

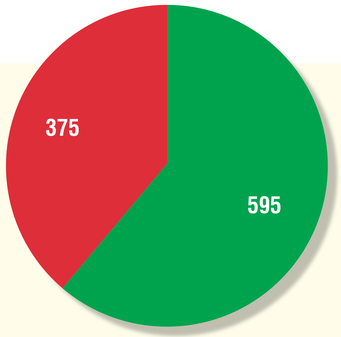

Chart 2 - Of the remaining **595 incidents 375 were inherited by the Trust** (did not happen whilst under the Trusts care)

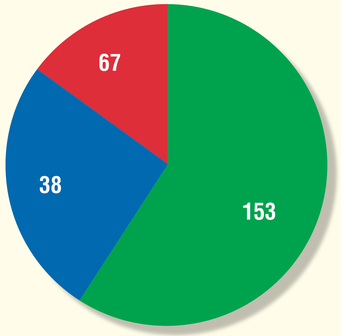

Chart 3 - We then investigated **153 community service acquired** and **67 hospital acquired pressure ulcers**. The investigations indicated that **38 patients sustained avoidable pressure damage under our care**

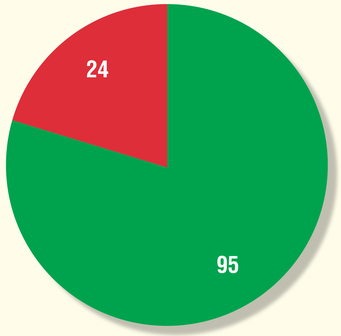

Chart 4 - Other information that came out was the numbers of pressure ulcers incorrectly categorised. **95 were reported as higher** and **24 lower than the verified category**

Discussion

If the data used to engage staff in pressure ulcer prevention doesn't reflect what they are seeing within their caseloads then they understandably find it hard to relate to.

By being able to give more accurate data and also to share the lessons learnt from the investigations undertaken staff are able to focus on the specific changes to practice required.

Conclusion

Having a clearer picture of how many pressure ulcers we are seeing has helped when looking at resources required to manage these. Knowing where these pressure ulcers are happening has helped provide focus for education and support within the Trust and has driven collaboration with the clinical commissioning groups to support work with care homes and care agencies.

Staff are more engaged when they know the discussions about prevention and the extent of the problem include more accurate numbers and that the data shows progress made.

The next stage is to look at the pressure ulcers we see that didn't occur under our care and see were these are happening and what actions we could take to spread the prevention message.

References

Porter M (2015) Does debridement help with classifying pressure ulcers? Wounds UK 11(3) 10-13 (Supplement 1)
Fletcher J (2015) Is categorising pressure ulcers useful? Wounds UK 11(3) 4 (Supplement 1)

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