GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

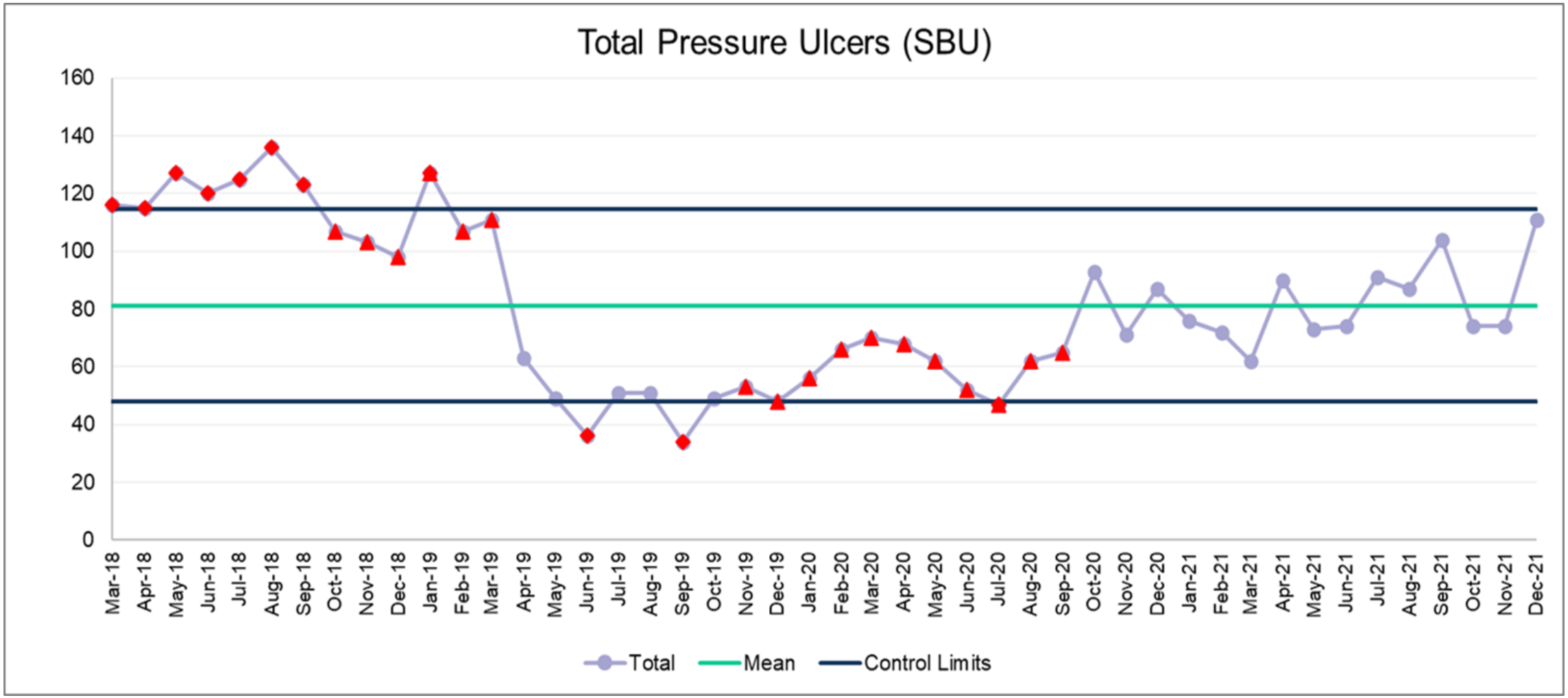
Preventing Harm from Pressure Ulcers

Quarter 3

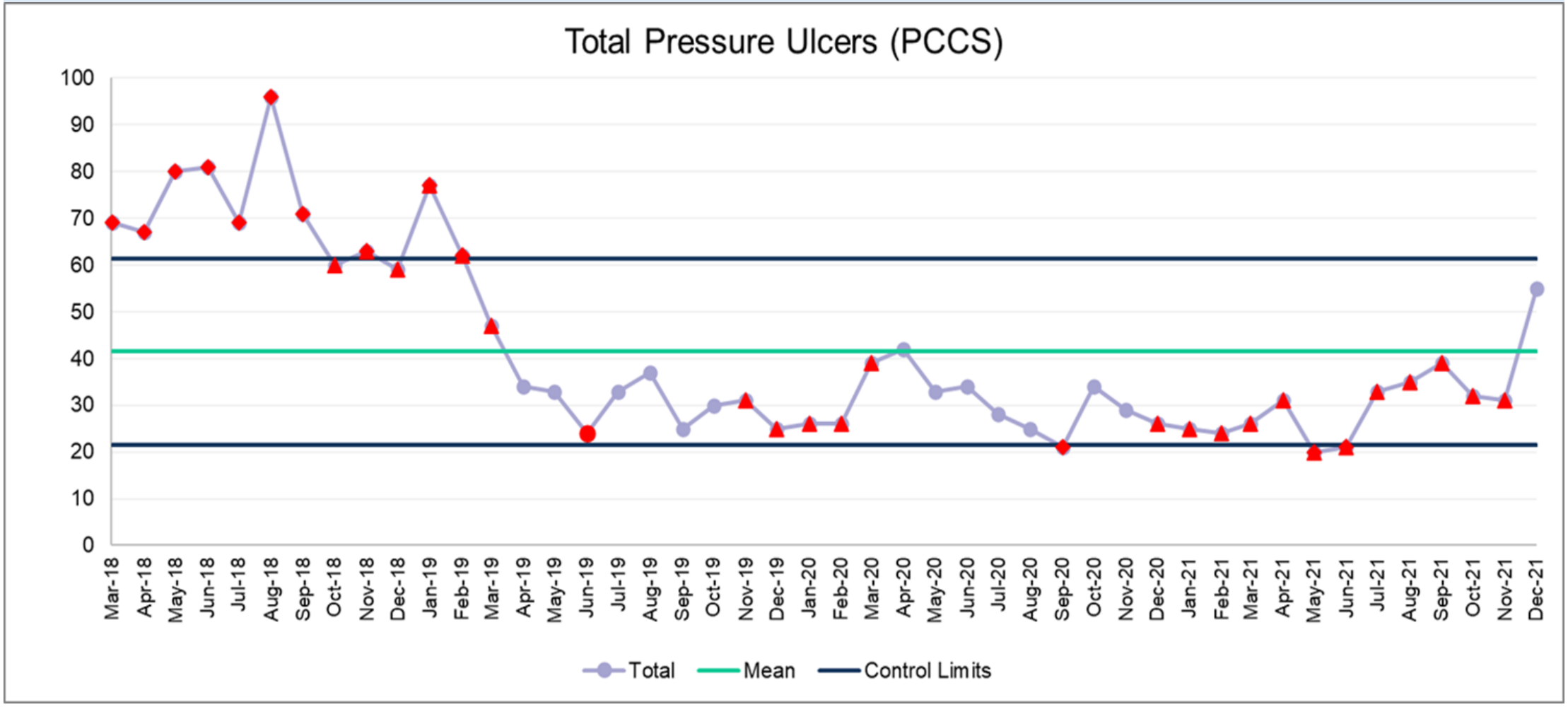
October - December 2021

(Data sourced from Datix 07/02/2022)

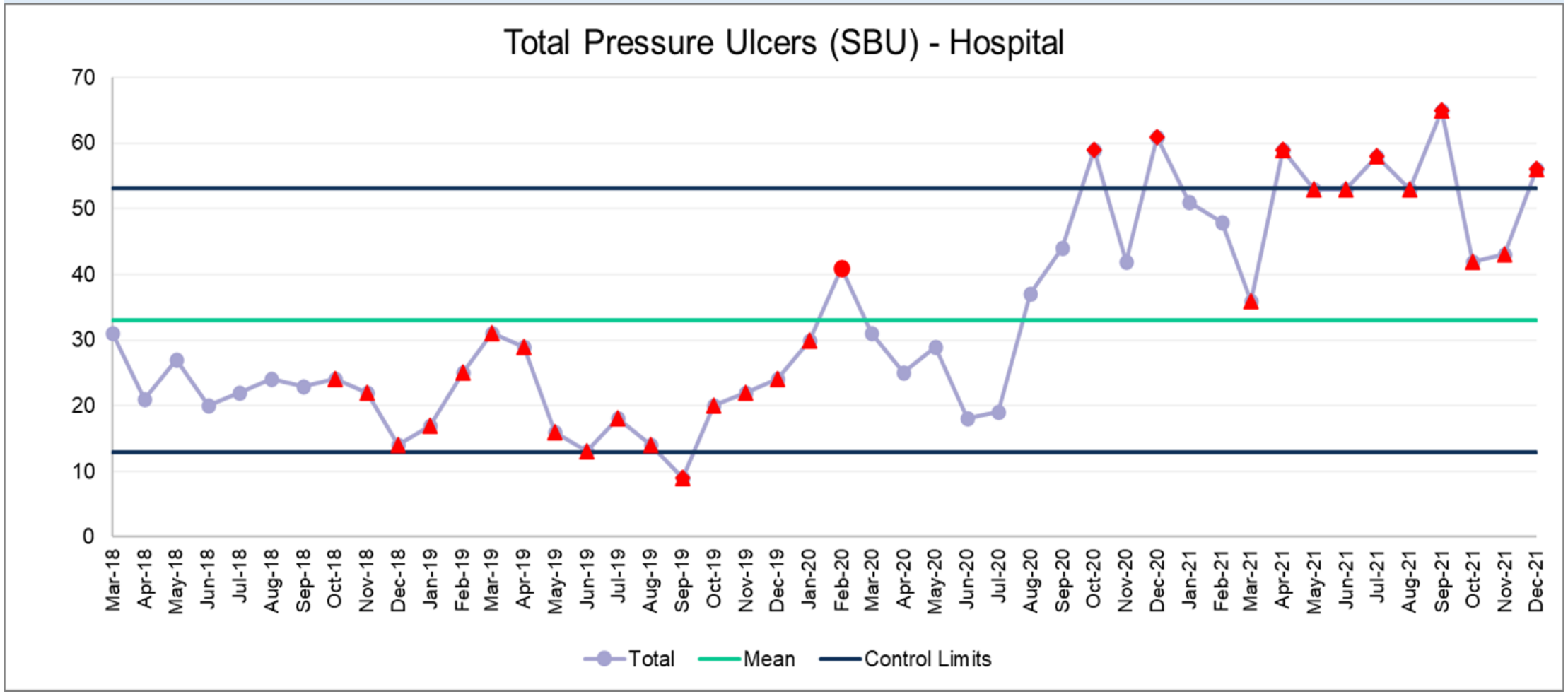
SBU HB Combined Community & Hospital Health Acquired Pressure Ulcers



Primary Care & Community Acquired Pressure Ulcers

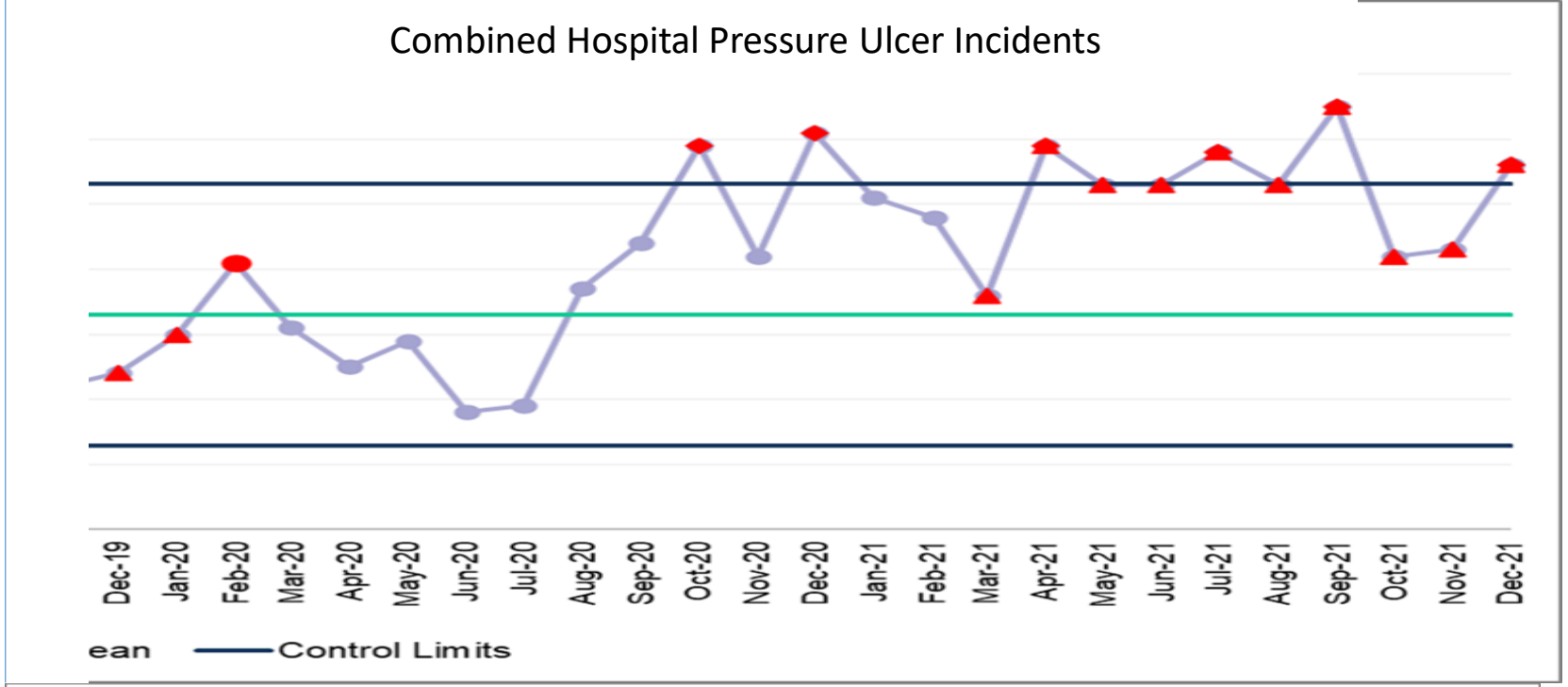


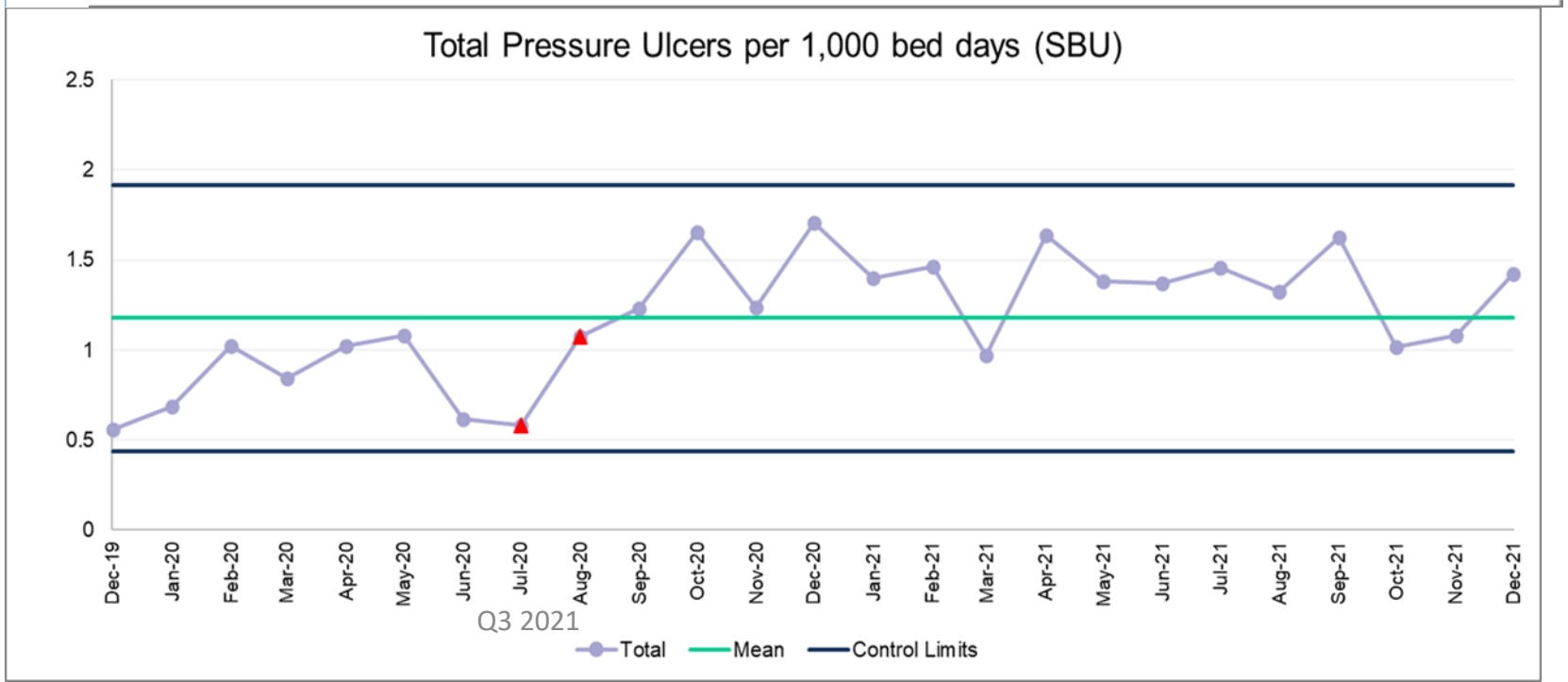
Combined Hospital Acquired Pressure Ulcers



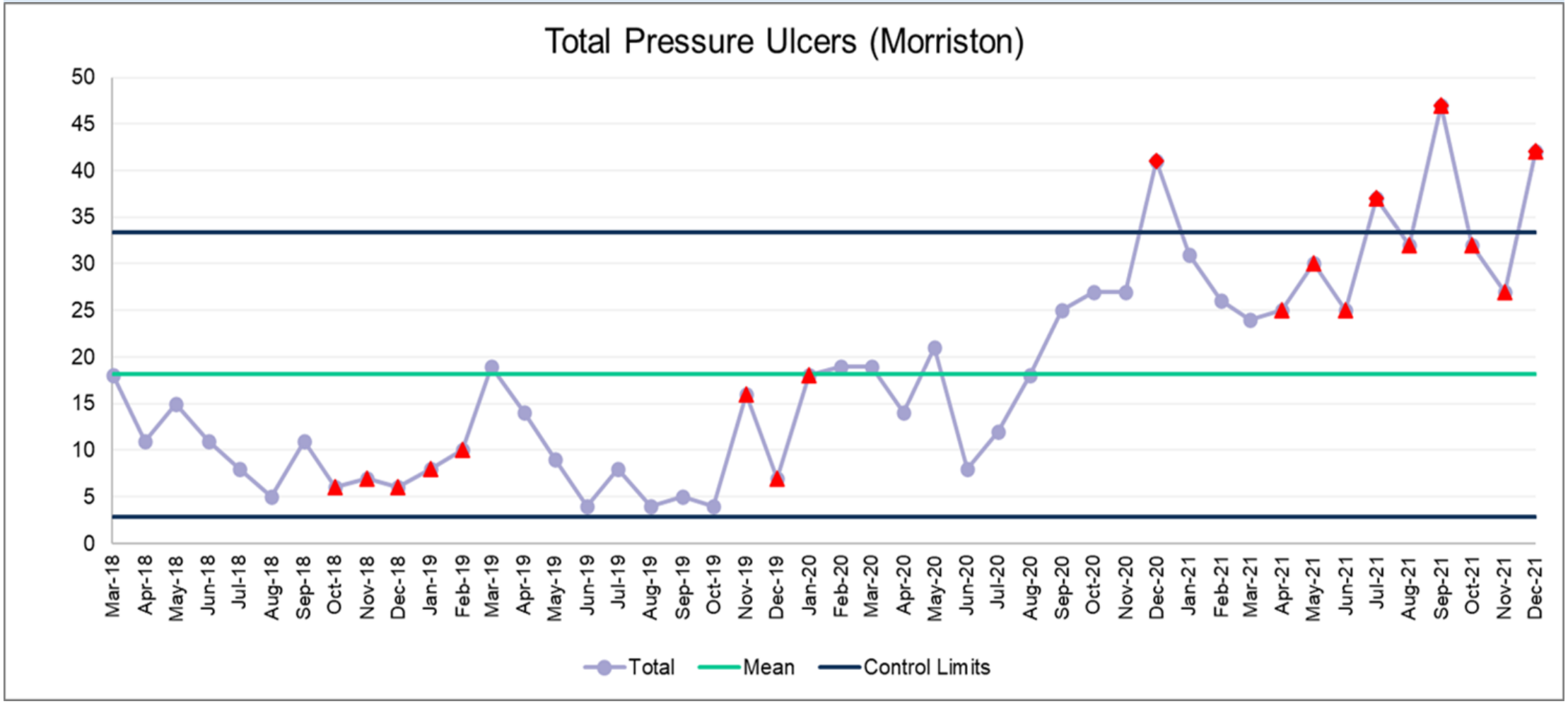
SBU HB Combined Hospitals

Comparison between total number of pressure ulcers and number per 1000 bed days

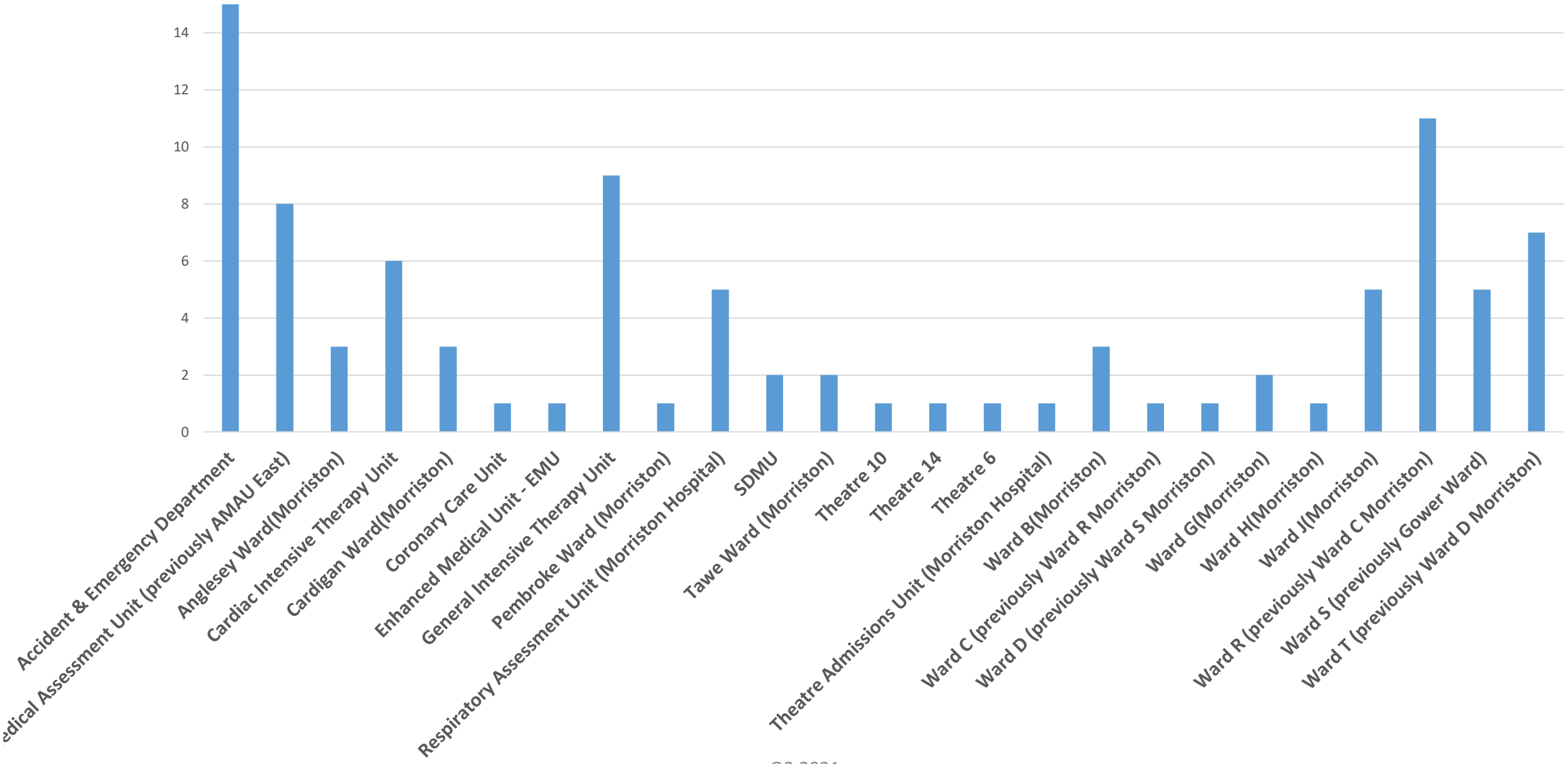




Morriston Hospital

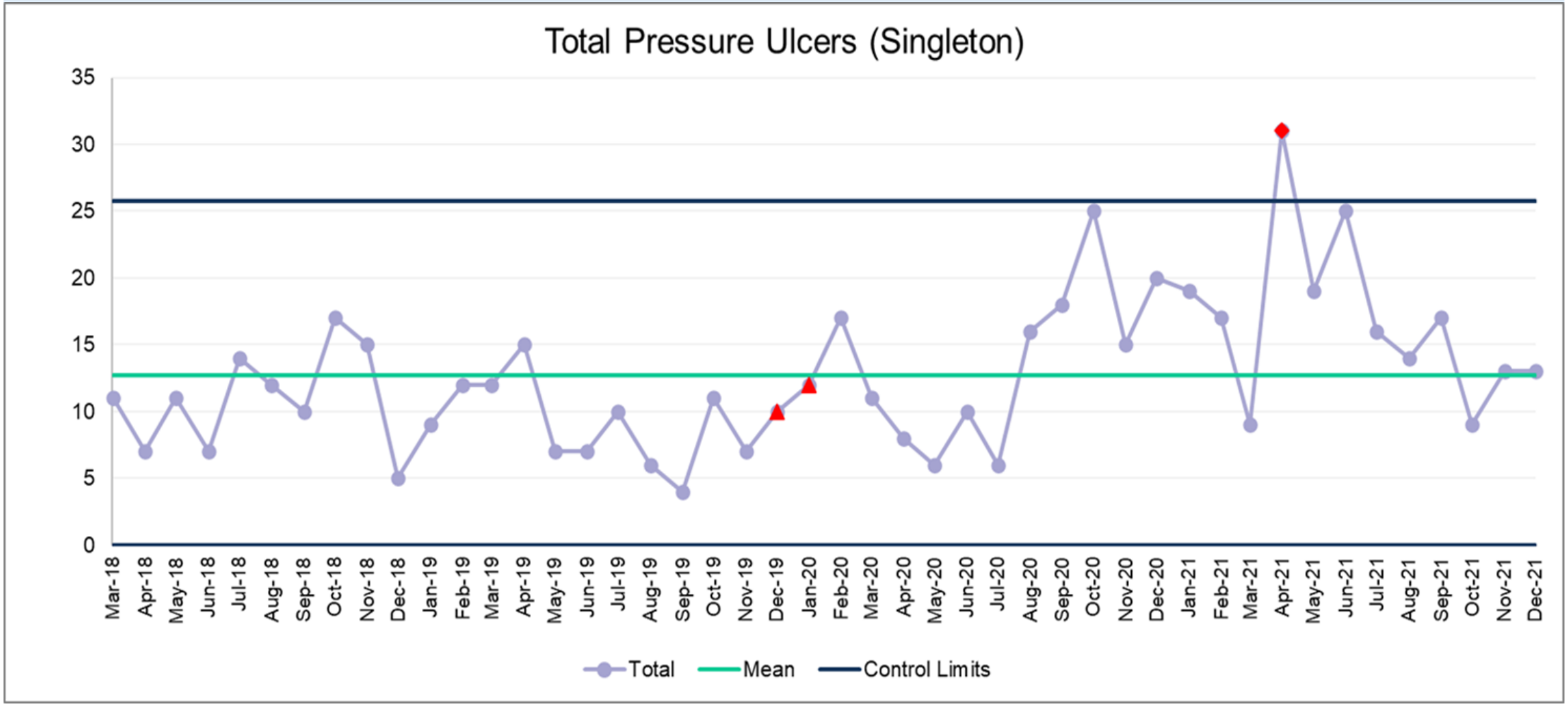


Morriston Hospital Hot Spots

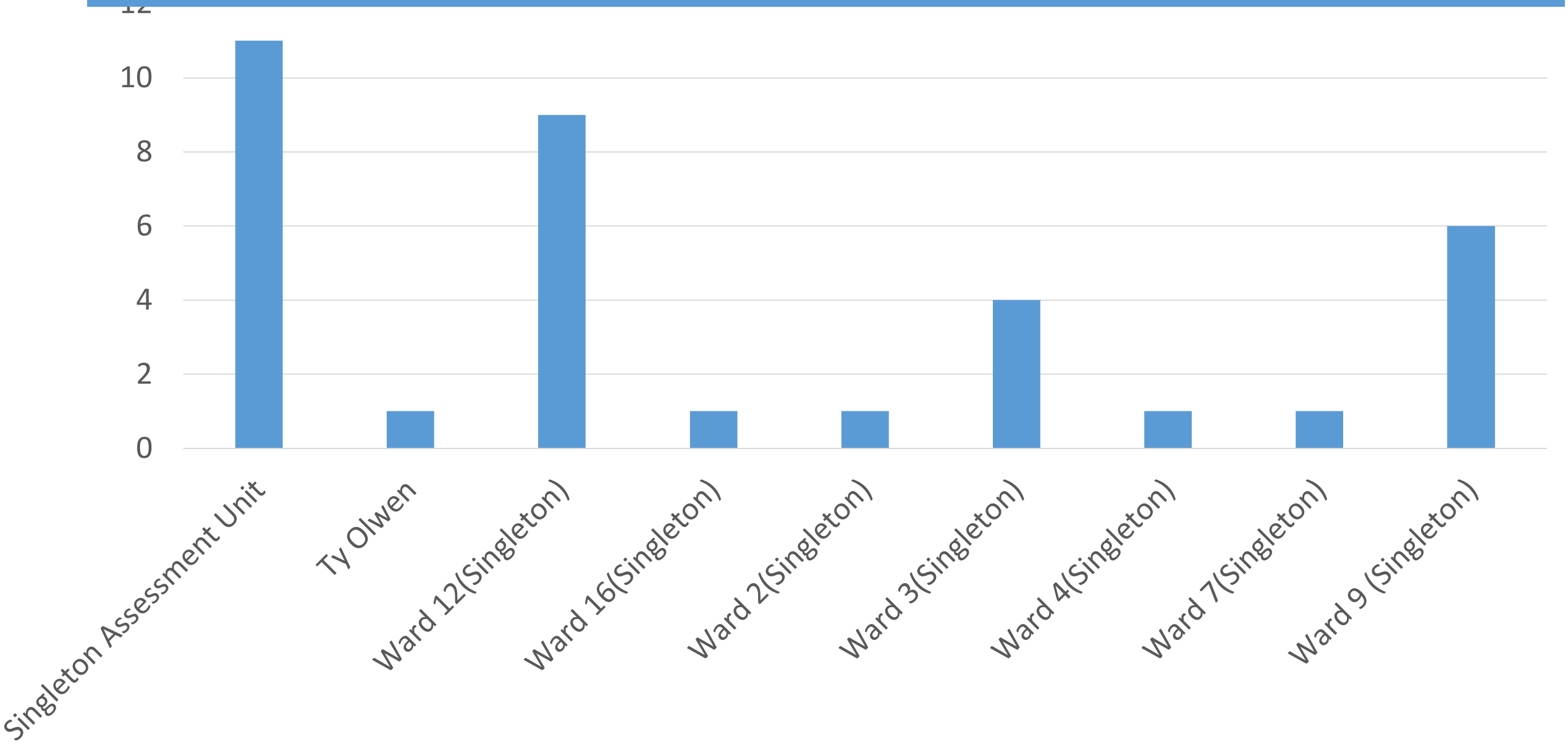


Q3 2021

Singleton Hospital



Singleton Hospital Hot Spots



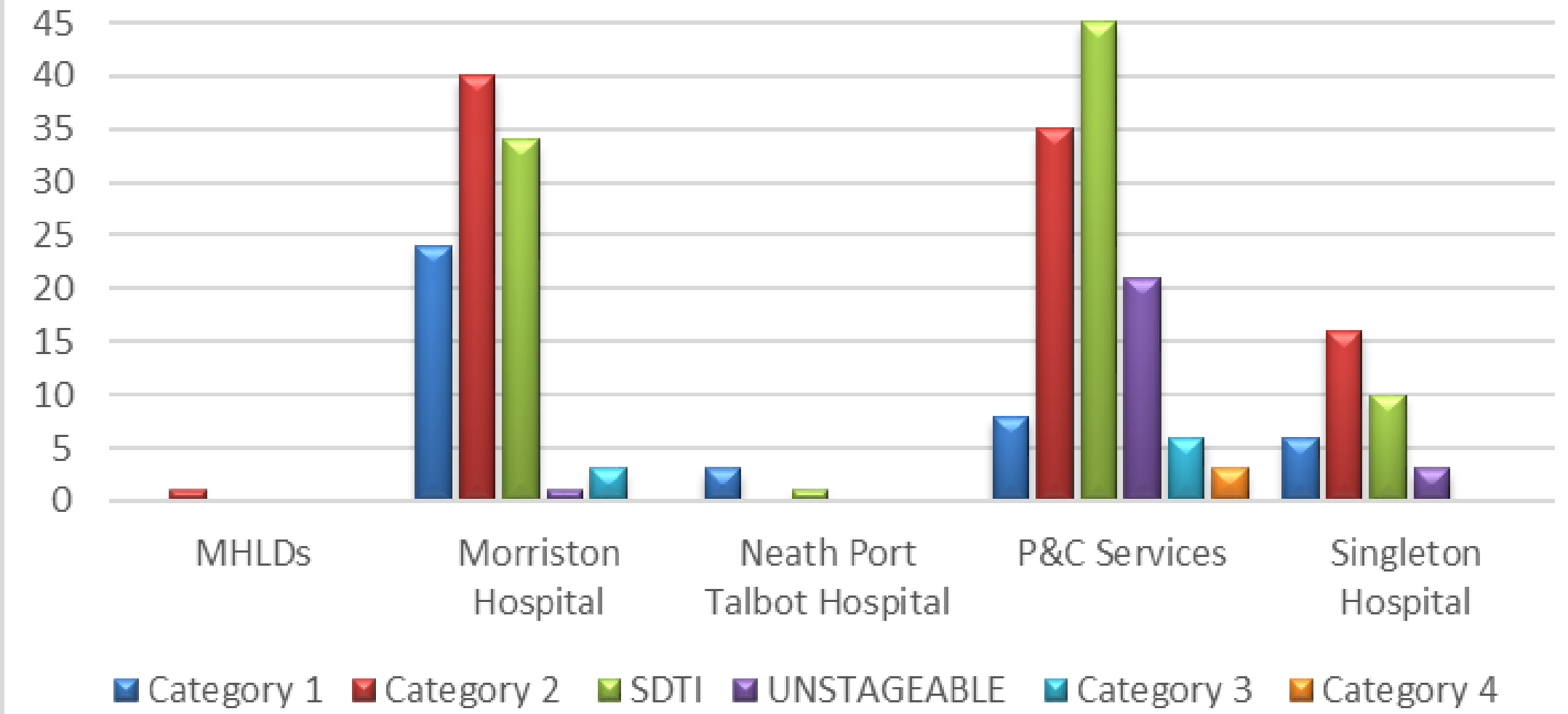
Numbers of Pressure Ulcers Q2 & Q3

	Q2	Q3	% Change
PC&C	102	118	+13.6%
Hospital	170	141	-17%
Total	**272**	**259**	**-4.8%**

Pressure Ulcers per Hospital

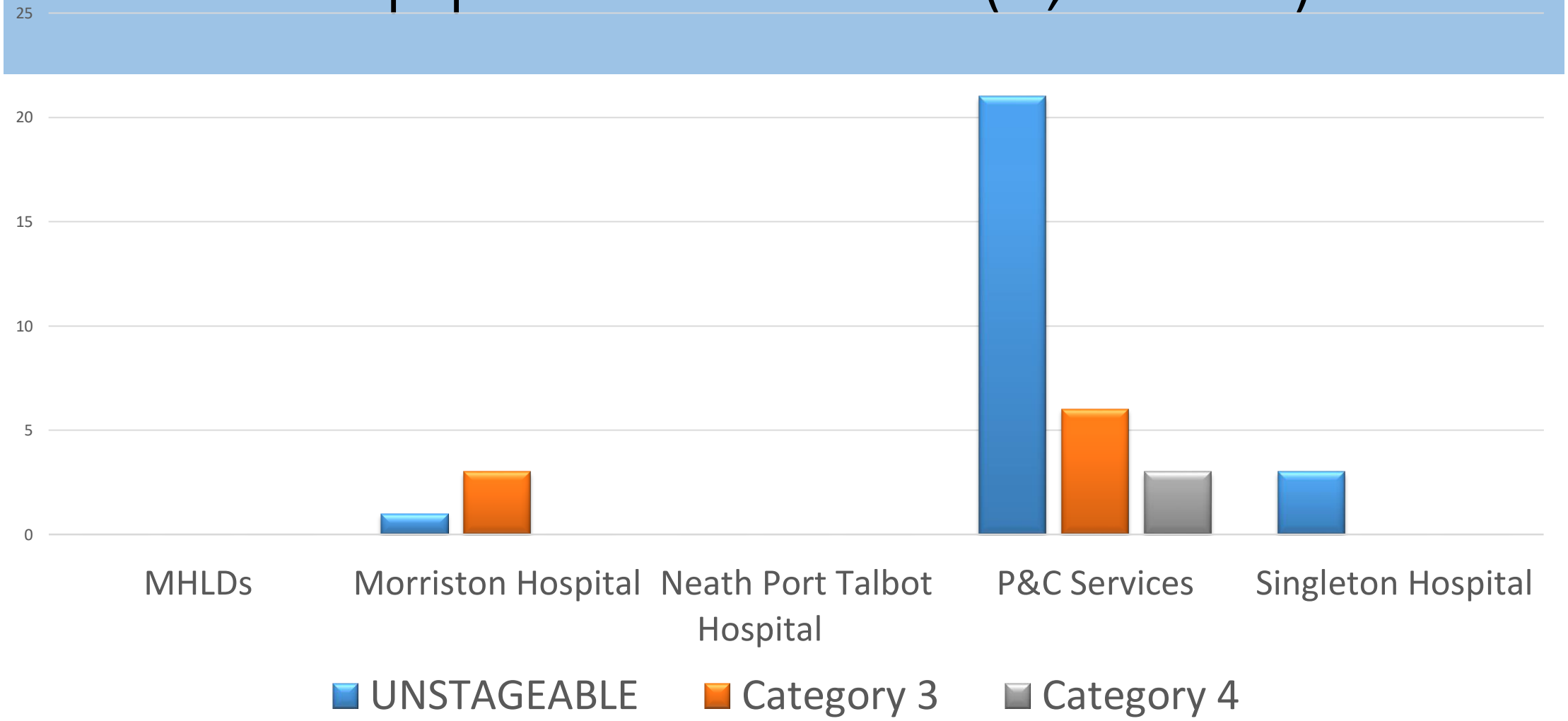
	Q2	Q3	% Change
Morriston Hospital	114	101	-11.4%
Singleton Hospital	46	35	-23.9%
NPTH	7	4	-42.9%
MH & LD	3	1	-66.7%

Pressure Ulcer Categories

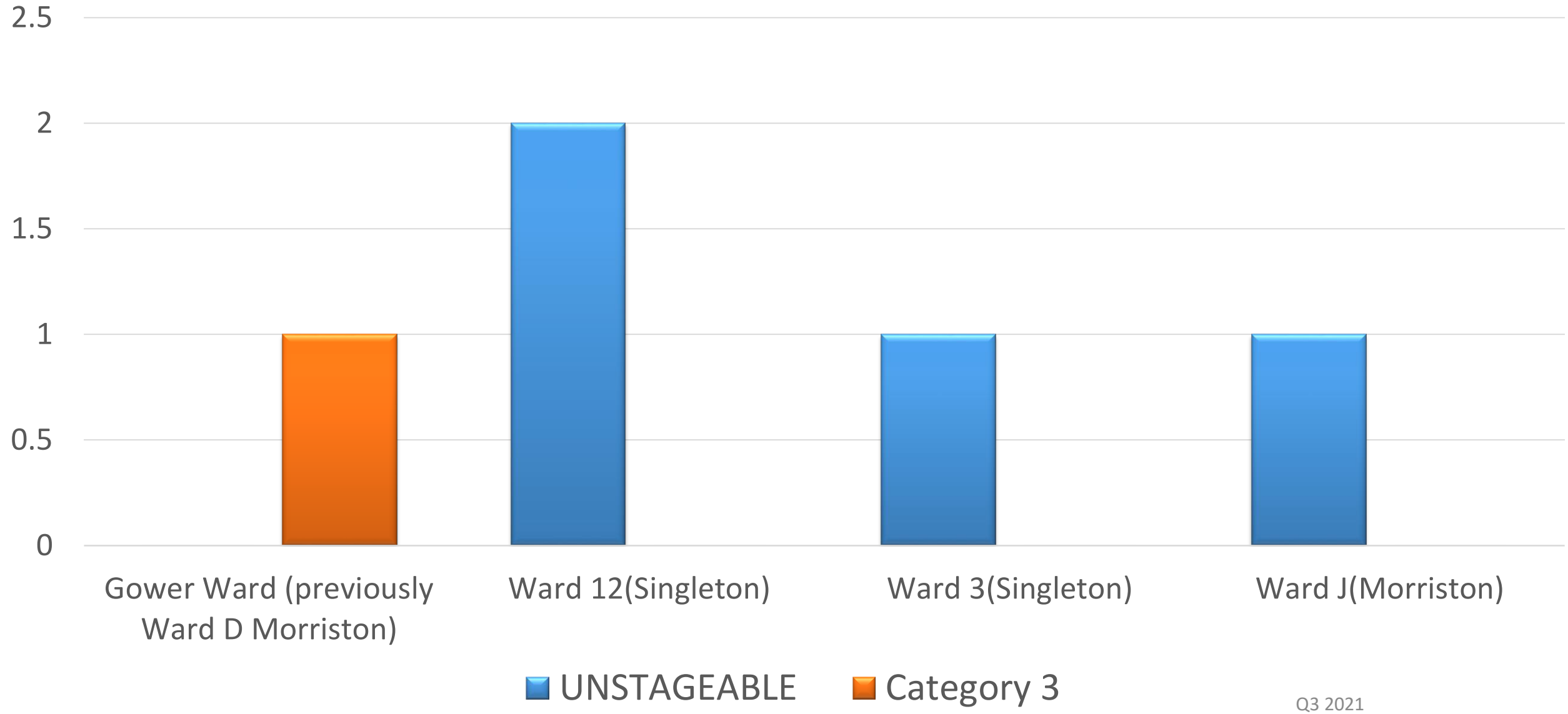


Q3 2021

Deep pressure Ulcers (3,4 & US)

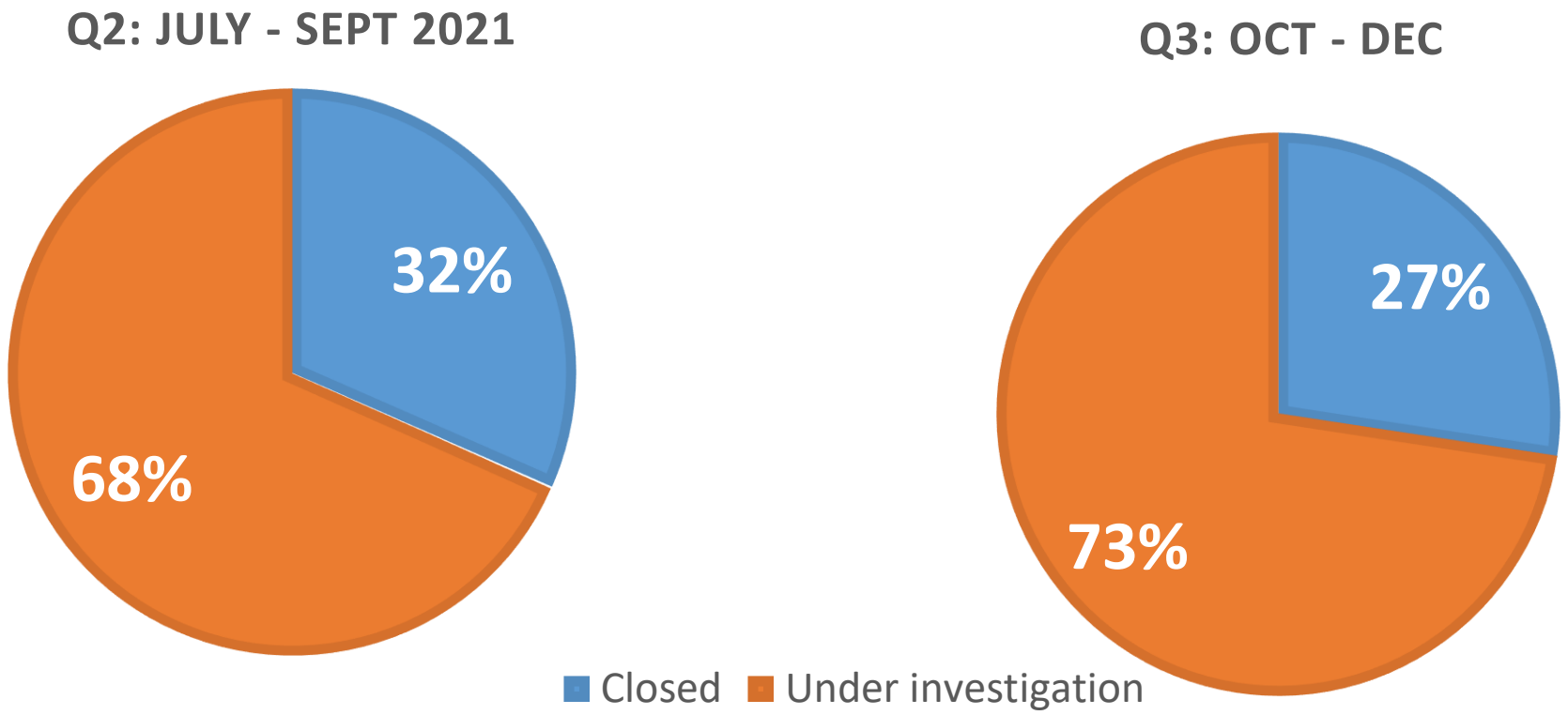


Deep Pressure Ulcers (*n*5) on Wards Covered by Nurse Staffing Act

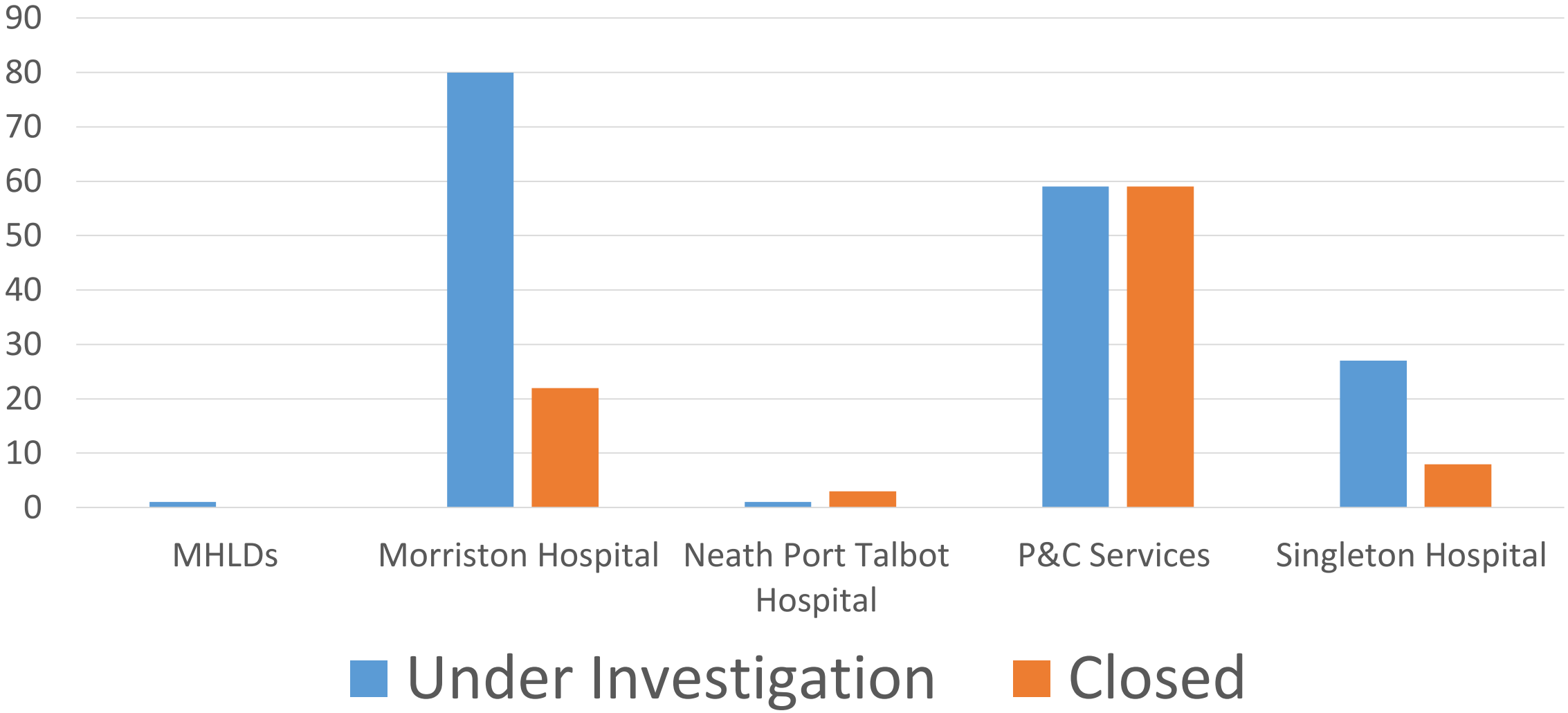


Q3 2021

Datix Incidents Governance

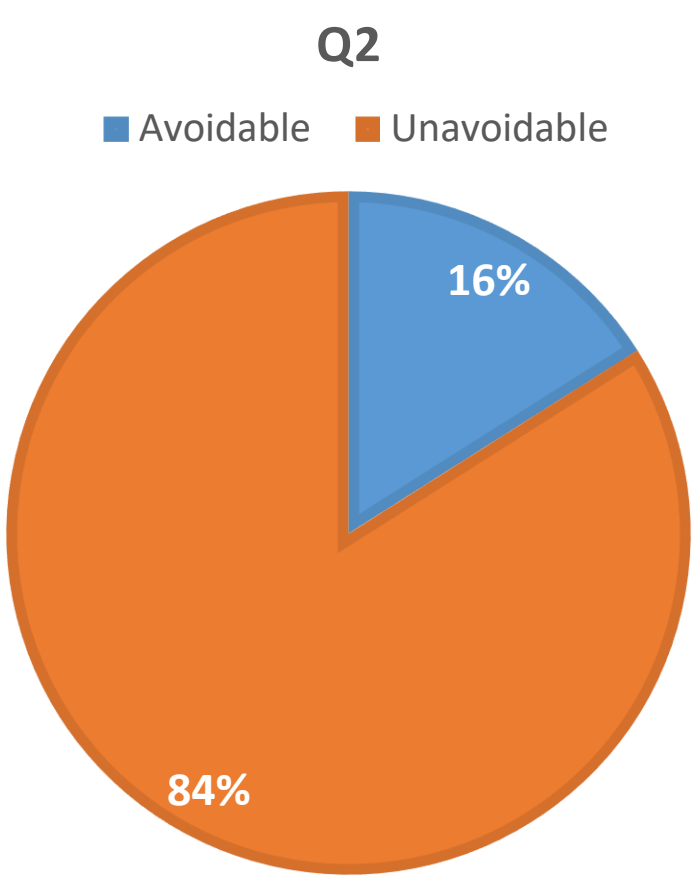


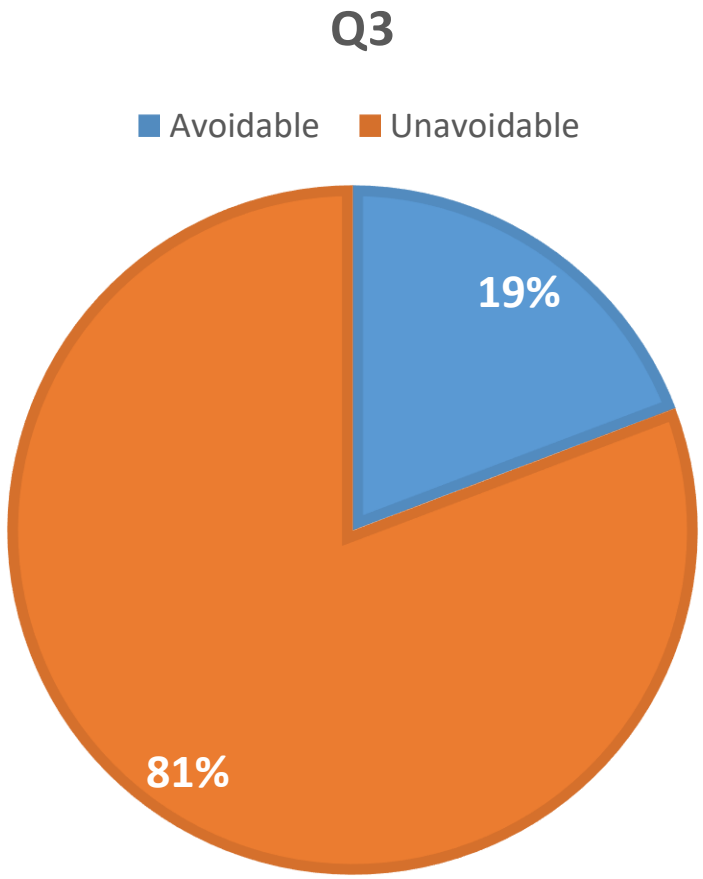
Incidents By Approval Status



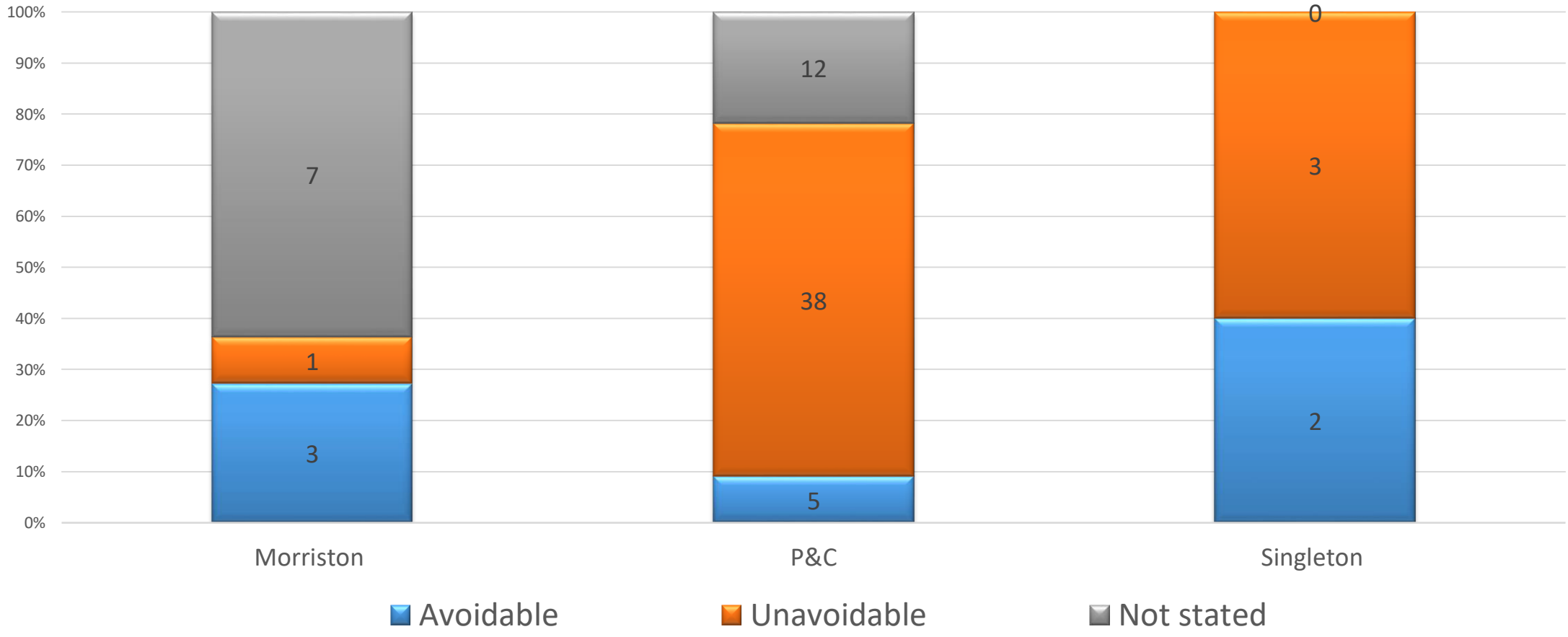
Q3 2021

Outcome of investigation
(Q3 Closed Incidents *n*71)

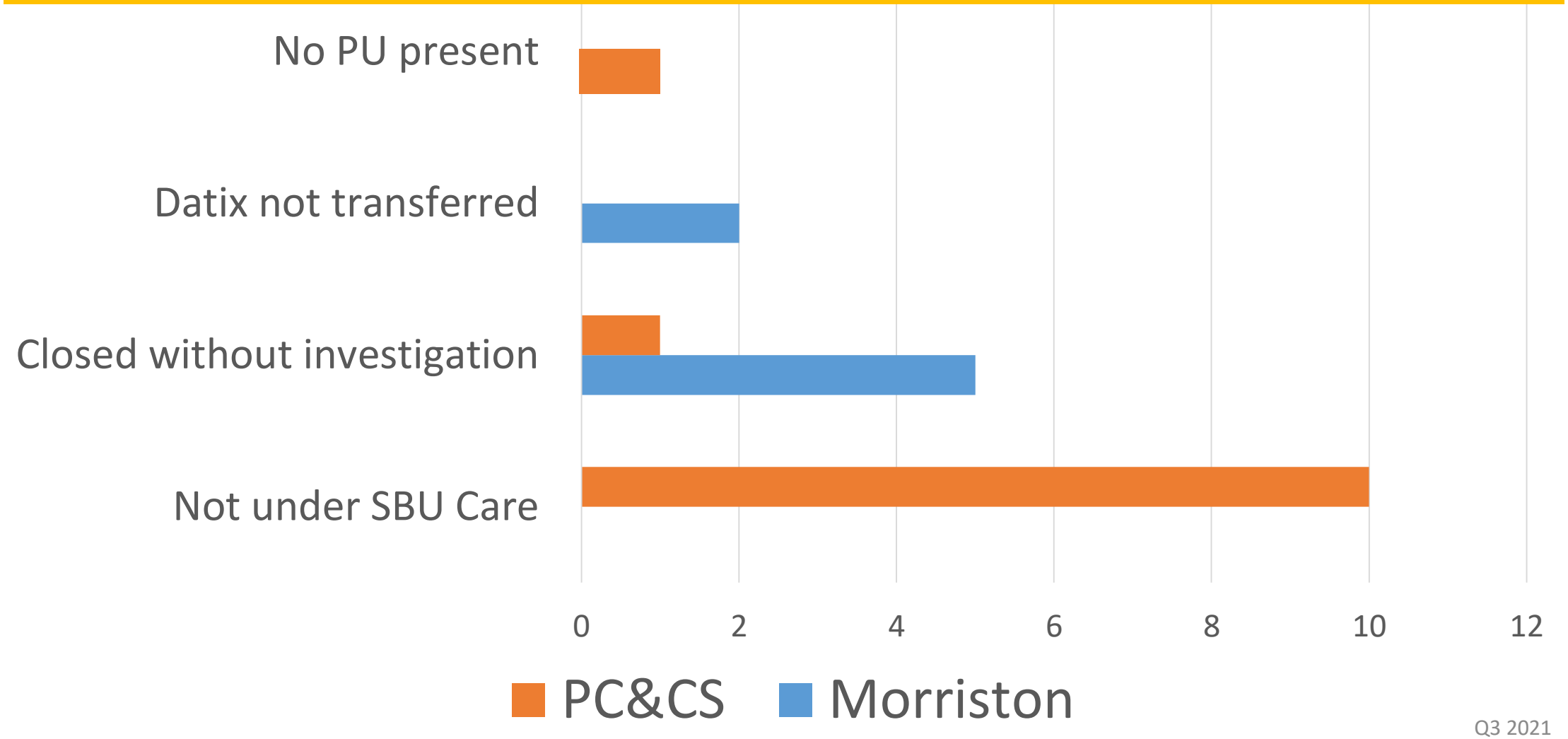




Outcome of Incidents Closed



19 Pressure ulcers closed without decision on Avoidability (Q2: 12)



Q3 2021

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current search

Click here to view the Grading Framework Guidance

- Issues/Failures causing MINOR harm > Lessons or Learning points identified -Grade 2 (Low)
- Issues/Failures causing MODERATE harm>Lessons or Learning points identified -Grade 3 (Moderate)
- Issues/Failures causing SIGNIFICANT harm>Lessons or Learning points identified -Grade 4 (Severe)
- Issues/Failures causing DEATH harm>Lessons or Learning points identified - Grade 5 (Death)
- Withdrawn (Complaints and Claims Module only)

★ Feedback to Reporter of what action was taken

The information in this field is sent back to the incident reporter on closure.

Also, please do not include patient, staff or location identifiable information in this field.

Correct procedure followed - Patient refused preventative equipment

★ Lessons learned

The information in this field is sent back to the incident reporter on closure.

Also, please do not include patient, staff or location identifiable information in this field.

Correct procedure followed - Patient refused preventative equipment

★ End of Life Care Issues: No

★ Is this a grade 2,3,4, ungradeable or SDTI pressure ulcer incident that was developed in our care?

Please ensure this is correctly completed as if it is coded (CCS2) as a pressure Ulcer that was acquired under our care and is classified as a grade 2 or above then Yes WILL need to be selected

No

Save | Cancel

Q3 2021

* Specialty	Oncology
* Location (type)	Ward 12(Singleton)
Specific Location	
* Was any other delivery unit or specialty involved in this incident	No

If another Delivery Unit or Directorate is added you must email the relevant Governance team as no triggers will be automatically sent

Type of Incident (CCS2)

* Incident type tier one	Pressure Ulcers
* Incident type tier two	Developed prior to admission to current clinical area/caseload
* Incident type tier three	Own Home, with Community Nurse Care

- Care Home
- Deteriation after admission
- Other Health Board/Trust
- Other Hopsital, SBUHB
- Other Ward, Same Hopsital
- Own Home, no Community Nurse Care
- Own Home, with Community Nurse Care

Pressure Ulcers
Click here to view Pressure Ulcer Classification info

Click here to view the All Wales Principles of Scree l to Adult Safeguarding

* Date of admission to hospital or caseload	
* Reason for admission/caseload	
* Date pressure ulcer identified	15/12/2021

Summary: Quarter 3

- Improvement in performance at all Hospital sites with an overall reduction of 17% in incidents
- PC&CS has seen an increase in incidents for the second quarter in a row
- Hot spot areas identified for in-patients – unplanned admission areas, ITU and oncology
- Increase in incidents still under investigation compared to Q2
- Small increase in avoidable pressure ulcers form 16% to 19%
- 4.8% reduction in SBU healthcare acquired pressure ulcers for Quarter 3