Meeting Date	**29 March 2022**	**Agenda Item**	**3.2**
Report Title	Pressure Ulcer Prevention Strategic Group (PUPSG) 2021/2022 Quarter 3 Report		
Report Author	Karen Kembery Senior CNS Tissue Viability		
Report Sponsor	Gareth Howells, Director of Nursing and Patient Experience		
Presented by	Rachel Govier-Williams TVN		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide an update regarding current Health Board performance relating to pressure ulcer prevention in Q3 and the ongoing actions of the Pressure Ulcer Prevention Strategic Group (PUPSG).		
Key Issues	Quality improvement programmes and initiatives led by the PUPSG have resulted in significant success in reducing the number of patients suffering this mostly avoidable harm leading up to the COVID 19 pandemic. However, the recent unprecedented challenges seen during the Covid 19 pandemic, together with a depleted tissue viability team and a significant increase in new and less experienced staff has made it difficult to sustain the improvements.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☐
Recommendations	Members are asked to: • **RECEIVE AND NOTE THE REPORT**			

PRESSURE ULCER PREVENTION STRATEGIC GROUP (PUPSG)
2021/2022 QUARTER 3 REPORT

1. INTRODUCTION

The purpose of this report is to provide Committee with an update regarding current Health Board performance relating to pressure ulcer prevention in Q3 and the ongoing actions of the Pressure Ulcer Prevention Strategic Group (PUPSG).

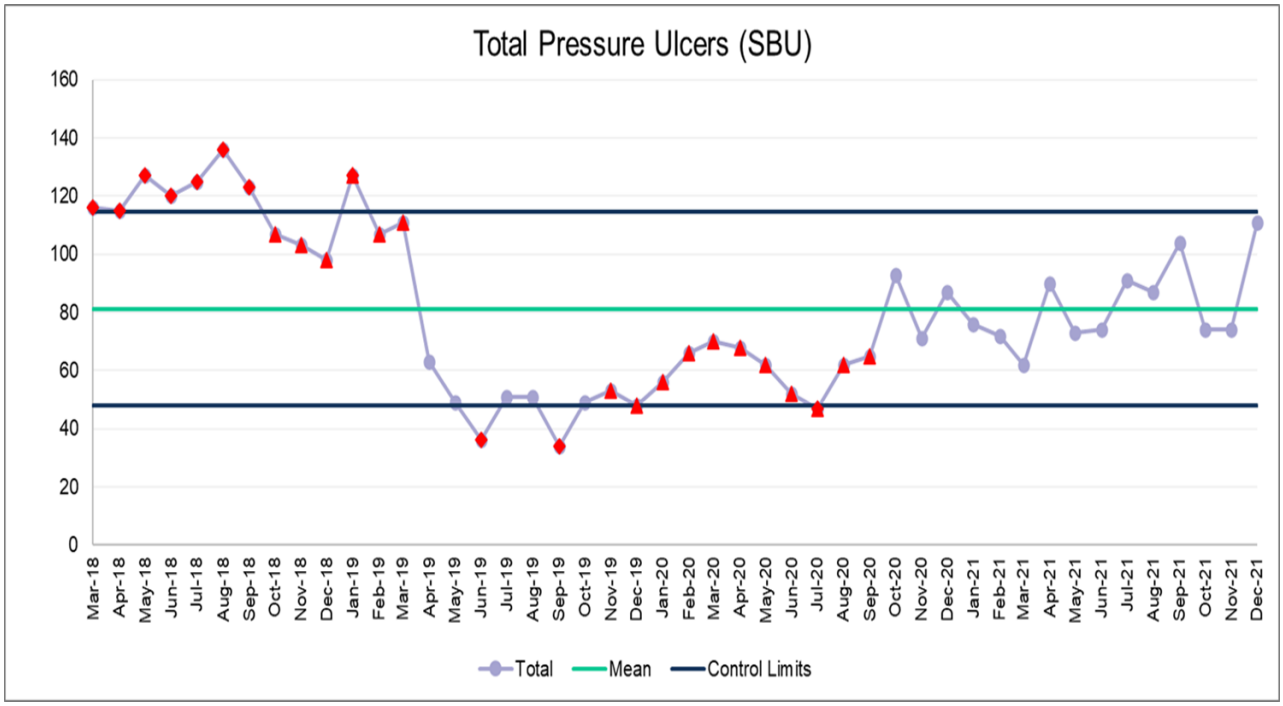
2. BACKGROUND

A Pressure Ulcer has been defined in the 2019 Clinical Practice Guidelines as "localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear; pressure ulcers usually occur over a bony prominence but may also be related to a medical device or other object".

Pressure ulcers are mostly preventable. When they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating. For the Health Board, the patient with a pressure ulcer has an increased demand for resources in terms of equipment and nursing time. Therefore, preventing pressure ulcers improves quality of care for vulnerable patients and reduces avoidable demands on the NHS.

3. GOVERNANCE AND RISK ISSUES

Swansea Bay UHB Number of pressure ulcers



SBU HB Number of pressure ulcers

(Data sourced from the Pressure Ulcers WG Monthly Submission Proforma)

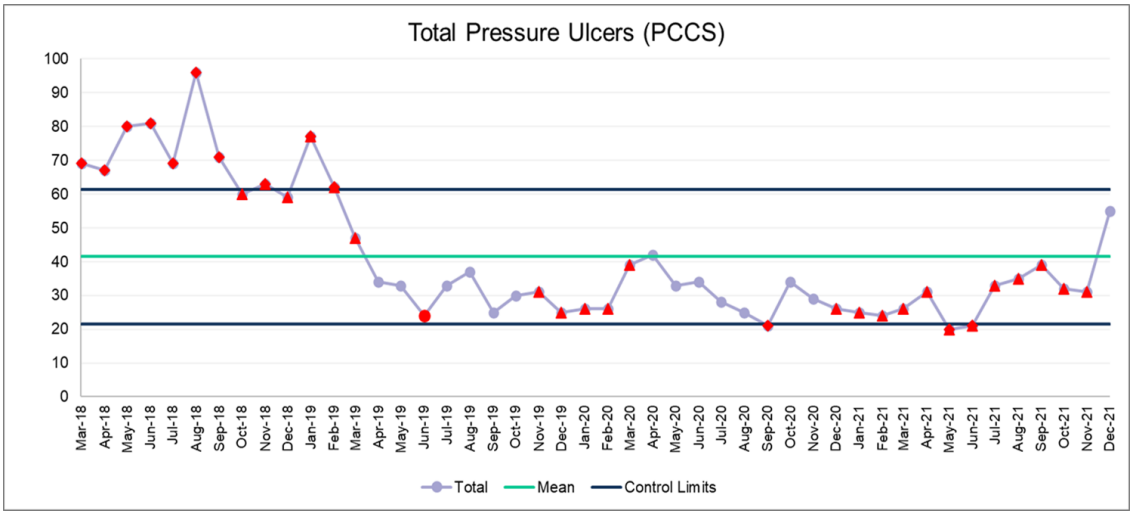
The SPC graph above illustrates the combined primary and community and in-patient care performance. We can see that for Q3 there was an initial decrease in incidents in October and November but the trajectory for the number of healthcare acquired pressure ulcers spiked in December coinciding with the 4th wave of Covid.

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

(Data sourced from the Pressure Ulcers WG Monthly Submission Proforma)

Primary care has seen an increase in cases compared to Q2. Whereas, there is some good news for the hospital sites, even with the increase in December, overall, compared to Q2 there has been a 17% reduction in incidents in hospital acquired pressure ulcers. Giving a combined reduction for SBU of 4.8% for this quarter.

Pressure Ulcers in Community



Despite the pressures of the COVID 19 epidemic, the community setting had consistently achieved a reduction in pressure ulcer incidents. That is until recently, when we have seen an increase in incidents reported in Quarters 2 and 3. A verbal report to the PUPSG meeting by the PC&C representative identified a continued high volume of patients being cared for at the end of life and increased numbers of very frail patients being discharged from hospital, putting additional strain on the service already stretched by on-going staffing difficulties.

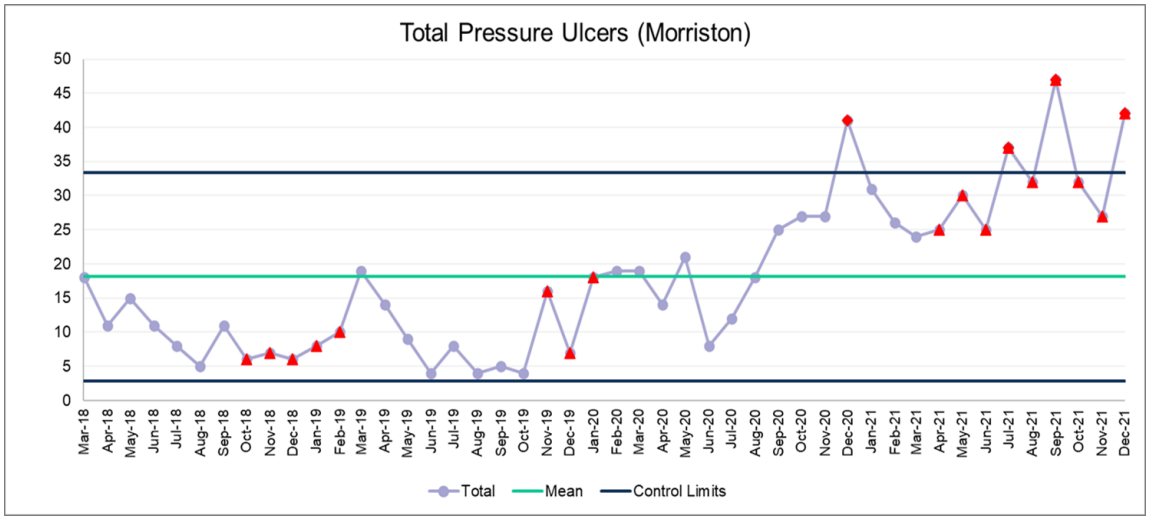
There has also been an influx of staff who are new to the community setting and are less experienced in pressure ulcer prevention in the home setting. The PC&CS TVN team has also seen major changes recently with the loss of an experienced TVN, long term staff sickness and new recruits to the TVN team.

Pressure Ulcers Developed in Hospital

All the Swansea Bay Hospitals continue to be under severe pressure particularly in relation to staff sickness, the mix of nursing staff, and a continued high reliance on bank and agency staff. Even with these pressures, inpatient areas have achieved a reduction in the number of pressure ulcers in Q3, suggesting an improvement in performance at every hospital site.

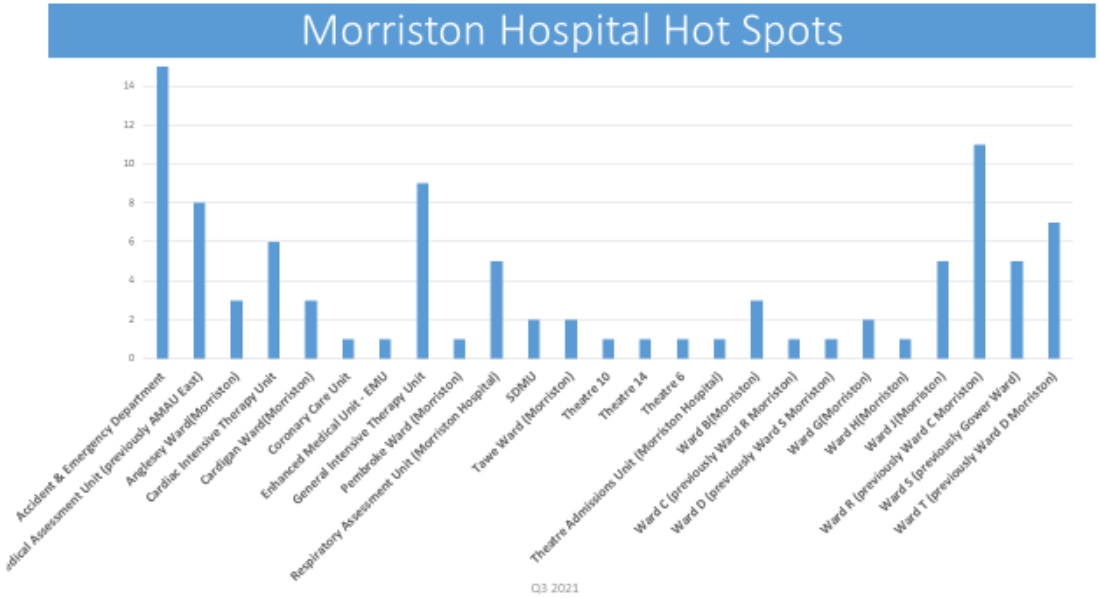
	Q2	Q3	% Change
Morriston Hospital	114	101	-11.4%
Singleton Hospital	46	35	-23.9%
NPTH	7	4	-42.9%
MH & LD	3	1	-66.7%

Morriston Hospital



There remain significant challenges at Morriston Hospital. The largest in-patient hospital in SBU Health Board, Morriston, has been without a dedicated TVN for the last two years, with no funded position to support reinstatement.

Without an onsite TVN to support scrutiny, identify hot-spot areas, deliver direct ward education and lead quality improvement in pressure ulcer prevention it will difficult for the site to achieve a sustained reduction in the amount of avoidable harm occurring from pressure ulcers.

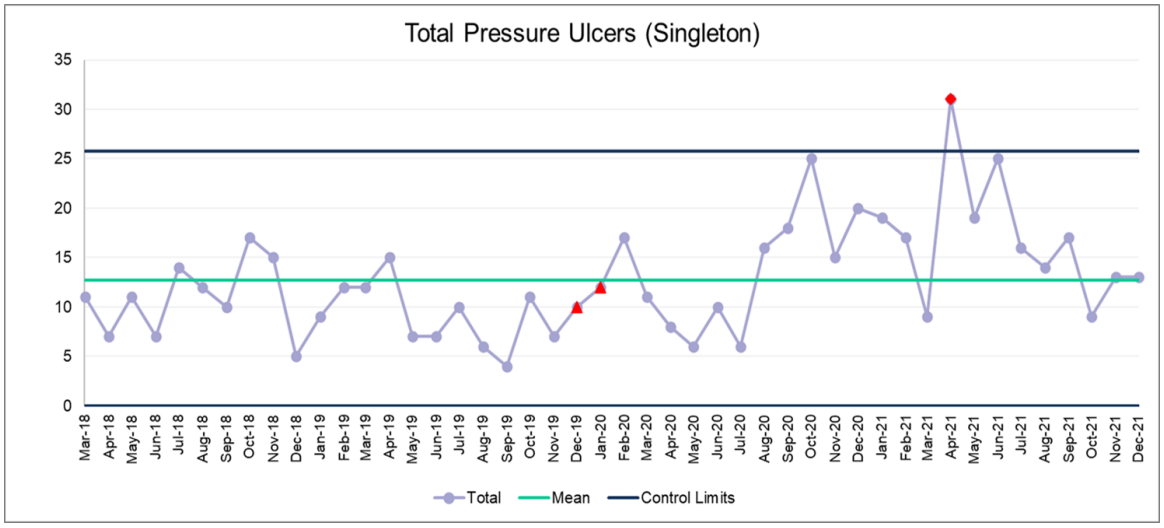


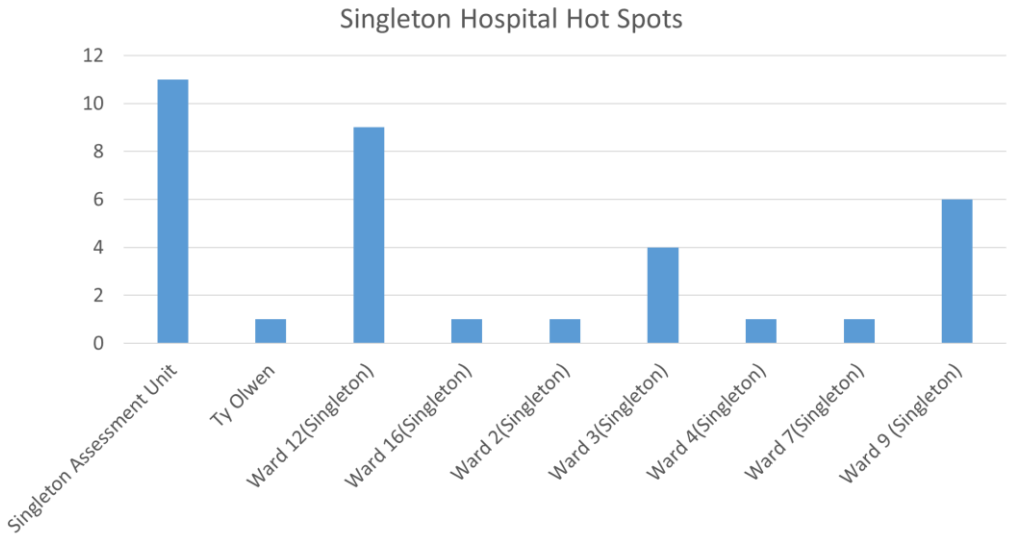
The current in-patient hot spots for Morriston remain mostly unchanged. However, a reduction has been seen in the number of incidents developing on ITU, RAU and Ward S.

Singleton & Neath Port Talbot Hospitals

Singleton and Neath Port Talbot Hospitals appear to be bucking the trend and have seen a relatively sustained decrease in pressure ulcers over the last two quarters. There continues to be an enhanced focus on investigating and scrutinising hospital acquired pressure ulcers at the sites and the sharing of learning from the incidents.

It is important to note that compared to Morriston, NPTH & SSG has a dedicated tissue viability service delivering education, supporting scrutiny and hot spot areas and the roll out of the Hot de-brief tool.

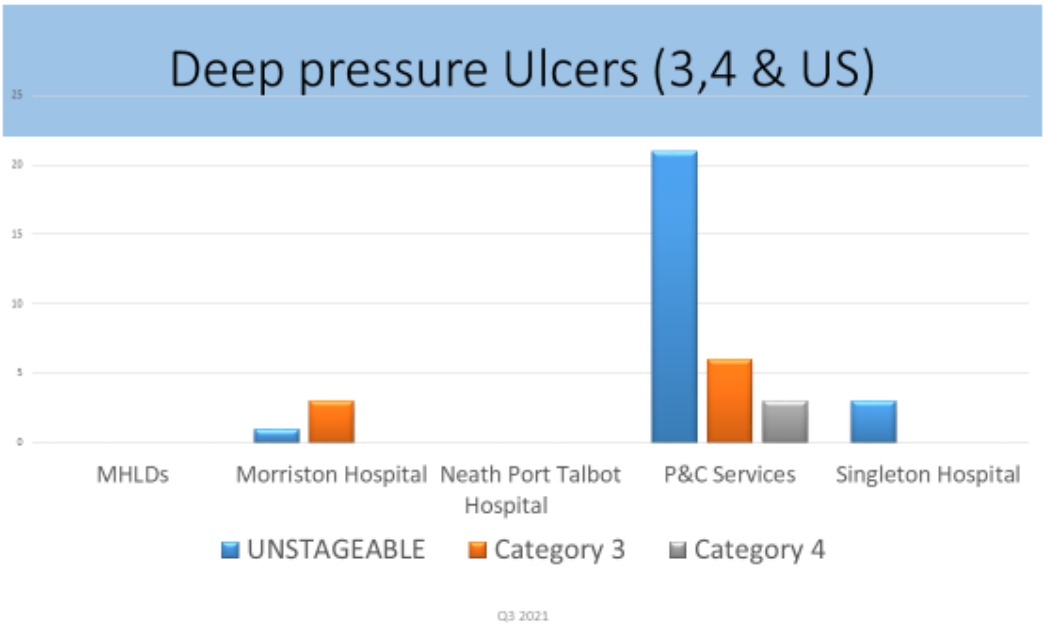


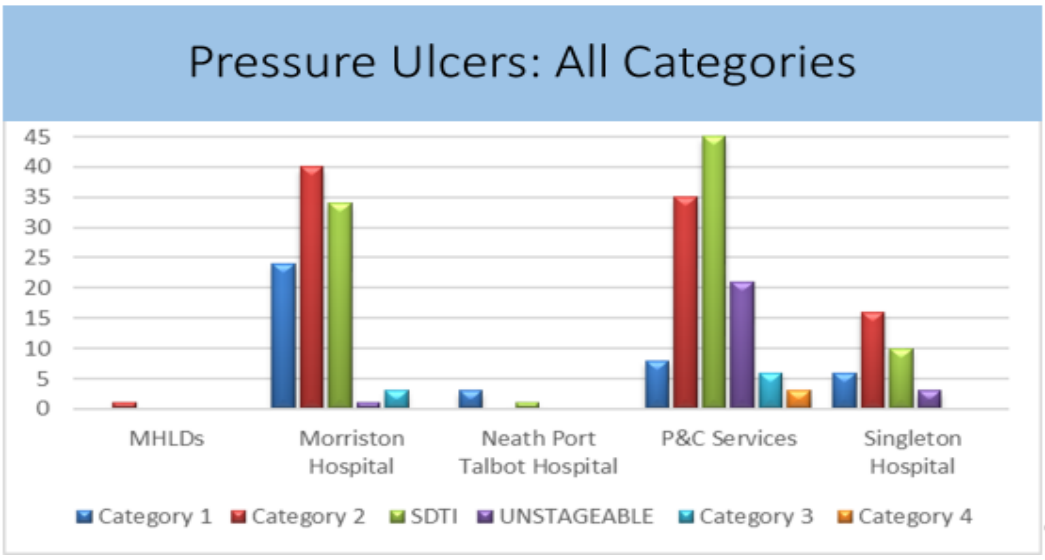


In Singleton Hospital the hot spot areas remain SAU, Ward 12 and Ward 9. Improvements have been seen in both SAU and Ward 9, but there has been an increase in incidents on Ward 12, oncology.

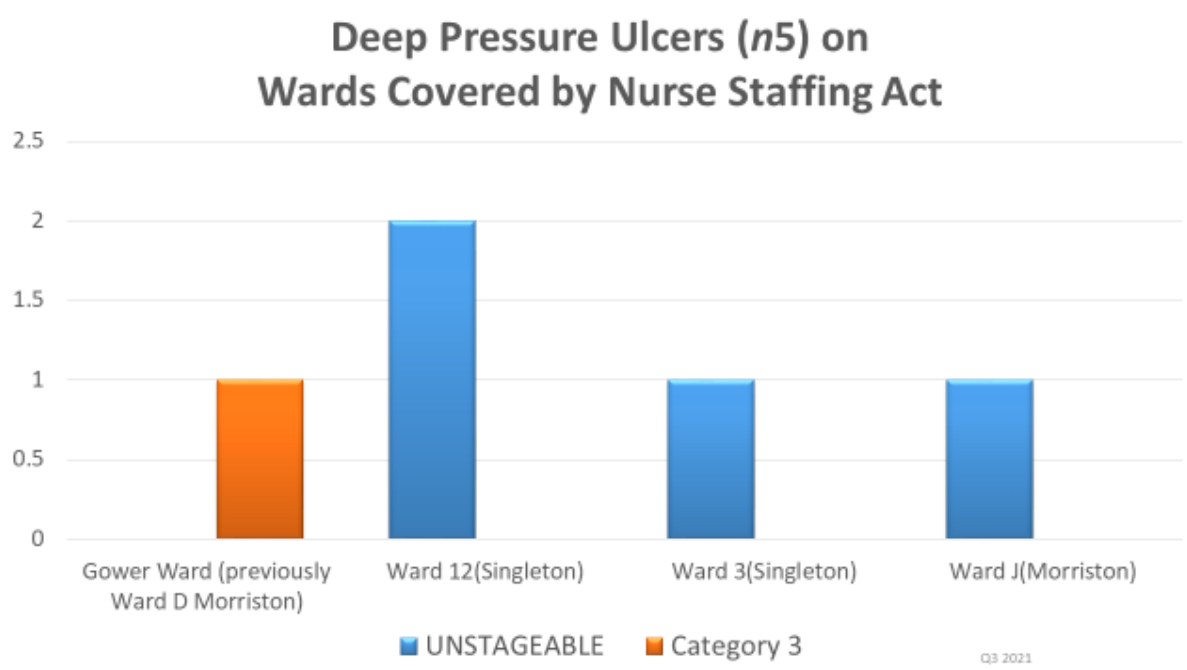
Pressure Ulcer Severity

The majority of healthcare acquired pressure ulcers continue to be superficial in nature. An increase in the number of deep pressure ulcers has been noted in Q3 compared to Q2. Increasing from 8% of the total pressure ulcers in Q2 to 14% in Q3. The PC&CS sector accounts for the majority of the deep ulcers and the rise in numbers is consistent with the increase in the total number of pressure ulcers seen in Q3 the community.


Deep pressure Ulcers (3,4 & US)
25
20
15
10
5
0
MHLDs
Morriston Hospital
Neath Port Talbot Hospital
P&C Services
Singleton Hospital
UNSTAGEABLE
Category 3
Category 4
Q3 2021


Pressure Ulcers: All Categories
45
40
35
30
25
20
15
10
5
0
MHLDs
Morriston Hospital
Neath Port Talbot Hospital
P&C Services
Singleton Hospital
Category 1
Category 2
SDTI
UNSTAGEABLE
Category 3
Category 4
Q3 2021

Nurse Staffing Act



During Q3 five incidents of deep pressure ulcers were identified as developing on wards covered by the Nurse Staffing Act. Two incidents have been investigated and three remain under investigation (Data sourced 16.02.2022). The two that have been investigated occurred on Ward 12 Singleton Hospital, both were found to be avoidable, one had staffing issues identified in the investigation where the rota had unfilled shifts.

Incident number	Hospital site	Outcome of investigation	Was the nurse staffing level adequately maintained in the 72 hours before identification of PU?
169610	Singleton	Avoidable	Yes
169062	Singleton	Avoidable	No
167727	Singleton	Under investigation	-
165810	Morriston	Under investigation	-
168118	Morriston	Under investigation	-

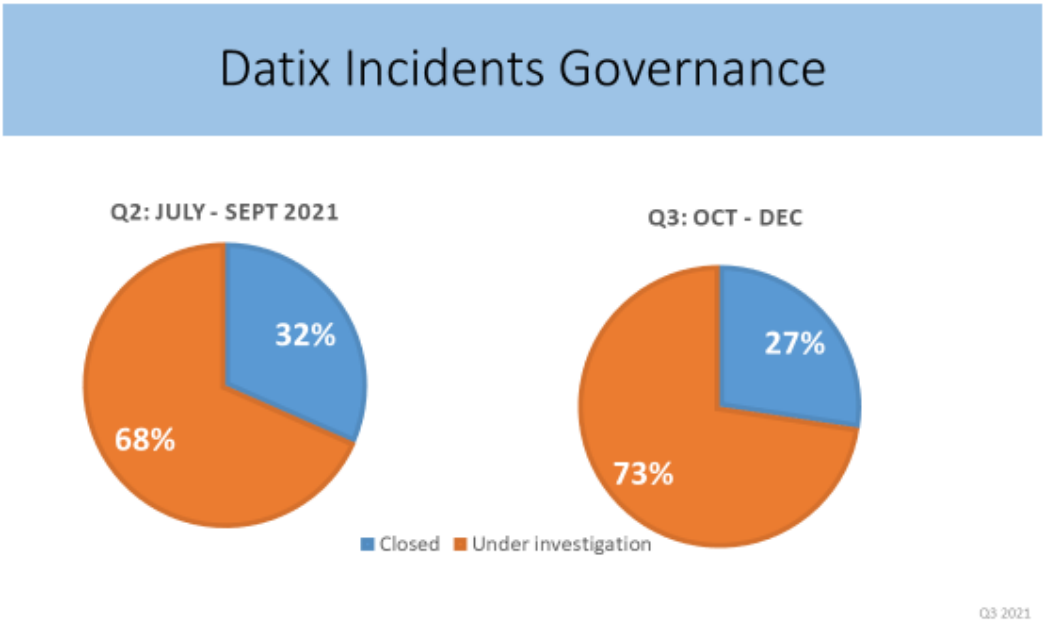
Pressure Ulcer Investigation and Scrutiny Governance

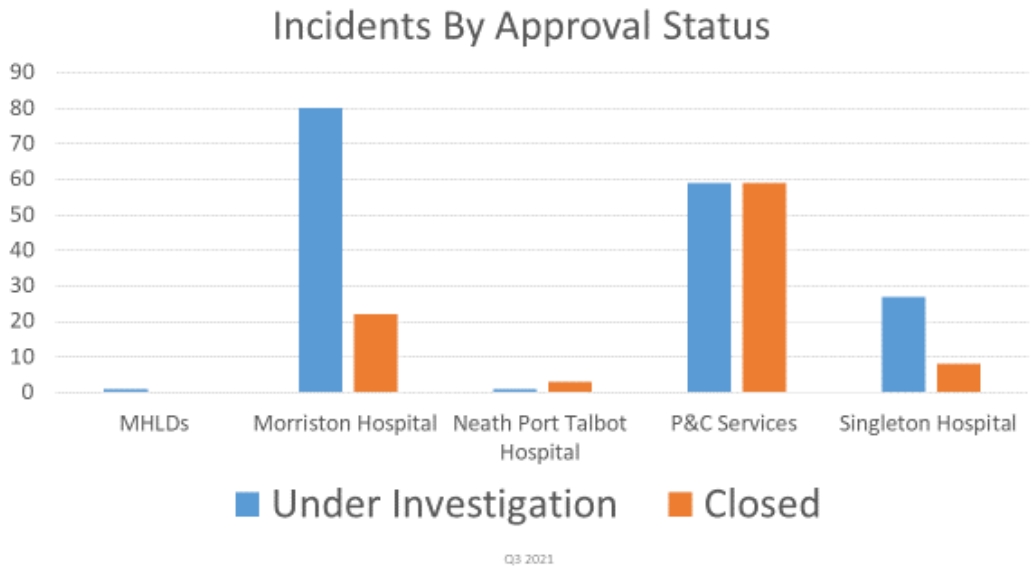
Identification of causal factors and learning from pressure ulcer incidents relies on timely investigation and scrutiny of Individual cases. The learning and causal factors for incidents

that are under investigation and not closed, remain inaccessible and will have an impact on the ability to reduce future risk for each Service Group. The progress made in closing

incidents within the expected time frame has yet again slipped in Q3 and the percentage of incidents still under investigation has risen:

- Under investigation: 47% in Q1
- Under investigation: 68% in Q2
- Under investigation: 73% in Q3.

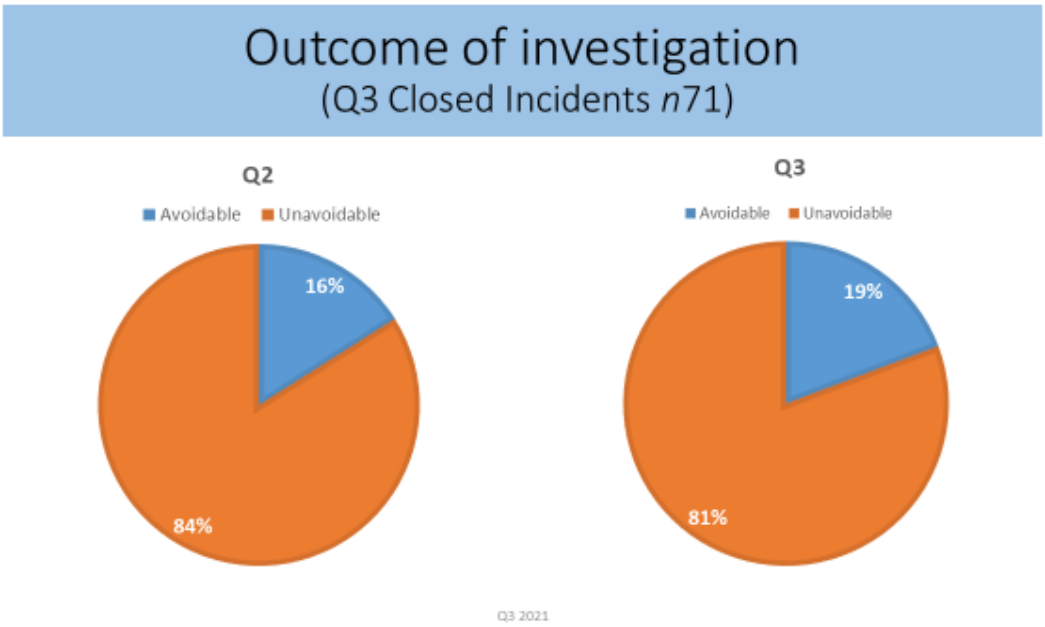




(Data sourced from Datix 07/02/2022)

It can be seen from the graph above that for Q3, Morriston Hospital has the greatest proportion of incidents that remain under investigation. Plans are underway at Morriston to address the governance around investigating and closing incidents.

The Morriston Hospital pressure ulcer scrutiny process has been redesigned to empower individual directorates to undertake local scrutiny to improve the efficiency and efficacy of pressure ulcer investigations and the identification of learning. Directorate leads feedback outcomes at a monthly Service Group Scrutiny meeting where complex cases can be discussed and peer reviewed and learning for quality improvement shared across the organisation



The chart above illustrates that there has been an increase in the number of avoidable pressure ulcers in Q3 - 19% compared to Q2 – 16%. We must be cautious in how we interpret this large percentage of unavoidable pressure ulcers and remember that the literature tells us that the majority of pressure ulcers are avoidable.

A survey carried out by the TVN team in August 2021 (Appendix 1) to validate the accuracy of pressure ulcer identification and classification, found that out of a total of 33 incidents of pressure ulcers reported on Datix during the one week survey period only 12 incidents

(36%) were actually pressure ulcers. The other 21 incidents (64%) were identified by the TVN as skin damage not attributable to pressure.

PC&CS and NPTH & SSG have measures in place to mitigate incorrect pressure ulcer Datix reporting. Their TVN's are able to validate incidents either in person or by photograph, approximately 70% of the time, providing assurance for the majority of the Datix reports in these areas.

Morriston Hospital A&E department have plans in place to reduce the significant amount of inaccurate incidents submitted in their area by developing an SOP for Datix reporting and utilising department photography.

Causal Factors

Data available from pressure ulcer investigations identify that in over 80% of avoidable hospital acquired pressure ulcers, the most common causal factor was that the frequency of patient repositioning was not adequate to reliably prevent pressure damage.

In the community setting the most common causal factors found at scrutiny for pressure ulcers are patient concordance and end of life issues.

4. RECOMMENDATION

The last two years has pushed us as people and healthcare professionals to new levels of stamina, courage and compassion and now, exhaustion. Staff have worked above and beyond to support our patients and colleagues in practice and to protect the most vulnerable in extremely difficult circumstances, but have not always been able to achieve the high standards we expect of ourselves.

The challenges that staff are still facing for the prevention of pressure ulcers are reflected in the performance data and have been and still are compounded by staffing issues on the wards, in the community and in the TVN team.

Ongoing quality improvement is imperative for pressure ulcer prevention, improved patient outcomes and to ensure the sustainability of practice change. We know that targets are key drivers for quality improvement, but over the last two years, as a consequence of the pandemic and the exceptional demands on staff, PUPSG had not set targets for quality improvement and has relied on incident figures to measure performance.

As we emerge from the pandemic, PUPSG plans to set mutually agreed targets for the year 2022/2023 at its next meeting. The aim will be to set targets to reduce the incidence of the most common measurable contributory factors implicated in avoidable pressure ulcers.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐

Quality, Safety and Patient Experience

Pressure ulcers are mostly preventable. When they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating. For the Health Board, the patient with a pressure ulcer has an increased demand for resources in terms of equipment and nursing time. Therefore, preventing pressure ulcers improves quality of care for vulnerable patients and reduces avoidable demands on the NHS.

Financial Implications

Central estimate of pressure ulcer cost to heal (NHS Productivity Calculator 2017)

Per ulcer:
Superficial pressure ulcer (Category 1, 2 & SDTI) = £4,500
Deep pressure ulcer (Category 3, 4 & unstageable) = £14,000

Excludes Putting things Right compensation or Legal Claims

Legal Implications (including equality and diversity assessment)

Potential for Legal claims for avoidable healthcare acquired pressure ulcers

Staffing Implications

Without an onsite TVN to support scrutiny, identify hot-spot areas, deliver direct ward education and lead quality improvement in pressure ulcer prevention at Morriston Hospital it will difficult for the site to achieve a sustained reduction in the amount of avoidable harm occurring from pressure ulcers.

Report History	
Appendices	**Appendix 1**