Trust Board meeting: Wednesday 8th May 2013

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<thead>
<tr>
<th>Title</th>
<th>Pressure Ulcer Prevention Report</th>
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<tr>
<td>Status</td>
<td>A paper for information</td>
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<tr>
<td>History</td>
<td>N/A</td>
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<td>Board Lead(s)</td>
<td>Mrs Elaine Strachan-Hall, Chief Nurse</td>
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<td>Key purpose</td>
<td>Strategy</td>
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## Summary

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<tr>
<td>1</td>
<td>This paper presents the overview and background to the key issues related to hospital acquired pressure ulceration within the OUH.</td>
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<td>2</td>
<td>The focus upon addressing the priorities in alignment with the Trust’s Quality Strategies with reference to hospital acquired pressure ulceration.</td>
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<td>3</td>
<td>The action plan addressing the key issues including the tissue viability service, data management and reporting, policies, protocols and guidelines, education, equipment and partnership working with Oxford Health NHS Trust and private providers of care.</td>
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<td>4</td>
<td>On-going audit of implementation and compliance will be reported to the Clinical Governance Committee on a quarterly basis and to the Quality Committee on a six monthly basis.</td>
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<td>5</td>
<td>The Trust Board is asked to note the key issues identified and the focus of actions including those that have already been addressed in the strategy to improve the trust’s position in relation to hospital acquired pressure ulceration and the reduction of harm to patients.</td>
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Introduction

1. This report provides an overview of the actions to address the incidents of hospital acquired pressure ulcers (HAPU) within the Oxford University Hospitals NHS Trust. This principally focuses on the internal priorities that are identified with the Trust’s Quality Strategy, as well as the need to address the entire patient pathway through external collaborative working in partnership with Oxford Health NHS Trust, with the overall aim being to reduce all avoidable pressure ulcers across the health economy.

2. Evidence suggests that 4-10% of patients admitted to Acute Trusts will develop pressure ulcers. The estimated cost of pressure ulcers to the NHS is £1.4-£2.1bn.

3. A national drive to reduce the number of avoidable pressure ulcers has resulted in a number of key documents supporting the monitoring of pressure ulcer incidence:–
   - High Impact Actions – Nurse Sensitive Outcome Indicators for NHS Commissioned Care (DoH, 2009)
   - Patient Safety Federation – No Needless Skin Breakdown (2009)
   - Essence of Care (2010)

4. The Patient Safety First Campaign (PSF 2008) supported the vision of eliminating avoidable pressure ulcers in health care settings. The tool in Figure 1 demonstrates the structure necessary to reduce the number of avoidable pressure ulcers within healthcare settings. The MARS Division has led on demonstrating alignment with this tool and the intention is to roll out this model trust wide in order to reduce avoidable pressure ulcers in the future.

![Figure 1: Patient safety First PU Tool (2008)](image-url)
Background

5. The nurse consultant role in tissue viability has proved challenging to recruit to and has been vacant since 2011. This is probably due to a combination of the competitiveness of the recruitment market, proximity to London and the calibre of the local recruitment pool. The model of a lone specialist within a large acute Trust is untenable and is less sustainable than a trust-wide clinically based team. Currently alternative models are being option appraised and benchmarked with other comparative organisations, to determine the most effective model of future service provision.

6. The Tissue Viability Advanced Nurse Practitioner working within the Musculo-Skeletal and Rehabilitation Division (MARS) has agreed to a secondment from April 2013 to support the development and improvement of the tissue viability function and service across the Trust. This will involve working in conjunction with the Deputy Chief Nurse in order to address tissue viability issues specifically related to reducing avoidable hospital acquired pressure ulceration.

Measurement: Safety Thermometer and Datix incident reporting.

7. The Safety Thermometer national audit process was introduced on a monthly basis to enable nationwide benchmarking with all NHS healthcare providers across 100% of organisations and forms a point prevalence audit process that identifies data at a specified point in time. This includes data for four key harms, one of which is for pressure ulcers of category 2, 3 and 4.

8. Point prevalence data is monitored on a specified day. However if a patient with a pressure ulcer has been an in-patient for longer than a month, this may result in them being double-reported across two data collection periods.

9. Incidence reporting through the OUH Datix system provides data on each and every ulcer on a once only basis and therefore is more accurate for internal monitoring purposes.

10. Additionally the reporting from Oxford Health NHS Trust indicates that a proportion of pressure ulcers are not currently being reported on the trust Datix system. Compliance and standardisation of reporting is currently being addressed so that assurance can be provided in relation to the incidence level of pressure ulcers.

11. The Trust is aiming to report consistently for all categories of pressure ulcers with the result that improvement strategies are anticipated to demonstrate an increase in the level of pressure ulcers identified at an earlier stage i.e. categories 1 & 2. The impact of a more timely intervention reduces the risk of the pressure ulcers becoming categories 3 & 4 over time.

Pressure Ulcer categorisation

12. Pressure ulcers are categorised using the European Pressure Ulcer Advisory Panel (EPUAP) categorisation tool.

13. Category 1 involves superficial intact tissue damage through to Category 4 which is full thickness tissue loss with exposed bone. On the identification of a Category 1
pressure ulcer or above, the clinician must report the skin damage as a clinical event/incident on Datix.

14. The Trust’s intention is to move towards root cause analysis for category 2 pressure ulcers as well as categories 3 & 4 in order to investigate causal themes and develop learning to improve patient outcomes.

CQUIN for Pressure Ulcer Reduction

15. A CQUIN related to pressure ulcers has been nationally mandated, with the aim of reducing all pressure ulcers across the health economy. The CQUIN requires a 50% reduction in all pressure ulcers based on the information provided by the Safety Thermometer. This has been negotiated locally with the Oxfordshire Clinical Commissioning Group for OUH to be a 50% reduction in hospital acquired pressure ulcers.

Actions being undertaken to improve the pressure ulcer prevention strategies within OUH

16. The action plan (appendix 1) addresses six key areas of focus in order to enable the required improvements in pressure ulcer prevention strategies, including:

- Improved tissue viability service
- Data management and compliance with reporting for all categories trust wide
- Improved explicit policies, protocols and guidelines that are auditable for compliance
- Improved collaborative interim and longer term education programmes
- Standardised usage and purchase of equipment that is managed and sustainable
- Oxfordshire wide partnership working with NHS organisations as well as the private sector

Partnership and collaborative working

17. The Trust has established the early stages of working in partnership with a Pan-Oxfordshire Tissue Viability Group which will be chaired by the Oxford Health Tissue Viability Lead Nurse and co-chaired by the OUH Advanced Nurse Practitioner. This involves key stakeholders with a view to sharing resources, including educational programmes, standardising the wound care formulary, joint protocols in wound care, the terms of reference addresses the whole patient pathway. This will progress to identify and include private care providers such as those from care home and private/social care provision in patients’ homes.

Conclusion

18. This paper details a programme of action led by the recently seconded Advanced Nurse Practitioner working with the Deputy Chief Nurse, in order to reduce harm from hospital acquired pressure ulceration (HAPU) through sustainable strategies highlighted in the action plan. This includes improving processes and compliance, as well as efficiency of resources in the implementation of sound evidence based care.
Reporting on compliance with the action plan will be through the Clinical Governance Committee quarterly and the Quality Committee six monthly.

Recommendations

The Trust Board is asked to note the key issues identified and the focus of actions including those that have already been addressed in the strategy to improve the trust’s position in relation to hospital acquired pressure ulceration and the reduction of harm to patients.

Ria Betteridge, Advanced Nurse Practitioner, Tissue Viability
Liz Wright, Deputy Chief Nurse
Elaine Strachan-Hall Chief Nurse

May 2013