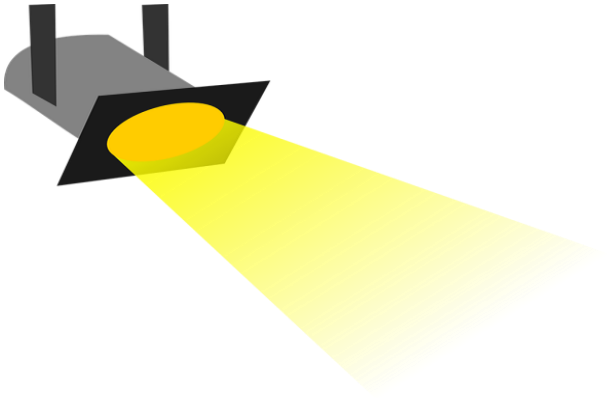


CTMUHB Patient Care & Safety Spotlight

Focus on Pressure Damage

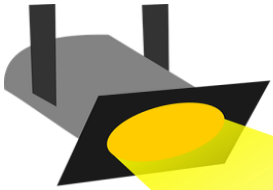
Background:

In Wales it is estimated that pressure ulcers affect approximately 9% of all in hospital patients. Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death. With pressure ulcers thought to increase the length of stay by between 5 and 8 days, there are also logistic and significant financial burdens to health care providers. Initiatives such as 1000 Lives+ and Fundamentals of Care have gone some way to raise the profile of pressure ulcers, however it remains imperative that robust reporting and investigations are key to successfully improving the position within health boards and the care provided to our patients.

Within CTMHB each of the ILG's work is underway to improve the overall management of pressure damage. The ILG's are working to identify the current position and are considering reporting issues, data issues where the data needs cleansing, and assuring the integrity of the data. There are known issues with the identification and grading of pressure ulcers and the TVNs have been working with Nursing leads and central safeguarding teams to roll out training in recognition, grading and management of pressure ulcers.

In terms of management, weekly scrutiny panels have recommenced following a pause during the peak of the COVID response and the ILG's have agreed a set principles to support a standardised approach across the health board. This includes:

- The structure of the panel
- Membership at panel
- Frequency
- The tools that are used
- Agreed that all Grade 2 and above would go through panel



All Grade 2 and above pressure ulcers will be taken through the panel due to issues in relation to correct grading of wounds. It is agreed that medical illustration will support with taking images which will be stored on Datix and used within panel to aid decision making. It should be considered that with a change of process in panel, the statistics may demonstrate an increase in the number of harm cases. Whilst in strict terms this is true, reassurance should be gained by the more robust process that has been introduced and not necessarily an increase in harm.

It is also apparent that there is an increase in the number of cases throughout ITU across the health board. There are a number of influential factors which include a significantly increased capacity within this area, a change in nurse to patient ratio, and a change in guidance and procedures, particularly around proning of patients with COVID-19 infection.

Across the health board there are also some legacy challenges, in most part worsened by the pandemic and the reduced number of panels being held. Additional panels have been arranged to address legacy work, however this is a time consuming task and there are no quick fix solutions.

Assurance work is ongoing and the findings and recommendations of a central team deep dive dip sample of avoidable pressure damage and a safeguarding reporting review will be shared at the CTMHB Listening and Learning Forum.