AGENDA ITEM
6.2.1

QUALITY & SAFETY COMMITTEE

COMMUNITY ACQUIRED PRESSURE ULCER IMPROVEMENT PLAN BRIEFING PAPER

Date of meeting	(22/03/2022)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Becky Thomas Senior Nurse Improvement Louise Mann Assistant Director Quality, Safety & Safeguarding
Presented by	Louise Mann Assistant Director Quality, Safety & Safeguarding
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
CAPU	Community Acquired Pressure Ulcer

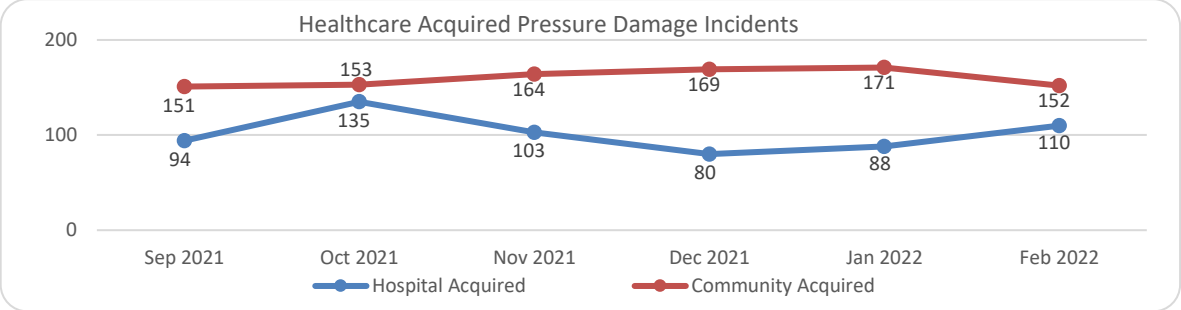
1. SITUATION/BACKGROUND

This report has been developed to inform the Quality & Safety Committee of the current position of avoidable community acquired pressure ulcers and the planned quality improvement focus for 2022/23, and why this is a key issue for the health and well-being of our populations, as well as a significant resource burden for the health board.

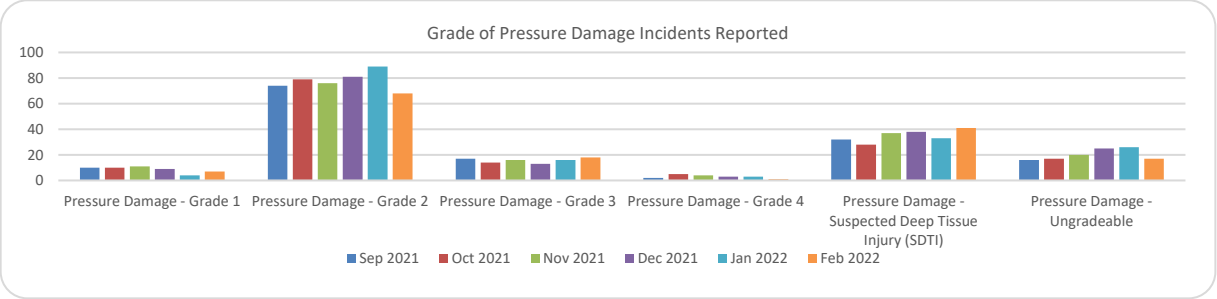
Between the 01.09.21 and 28.02.22, a total number of 2889 pressure incidents were reported. It is relevant to note that pressure damage reporting in terms of harm/grading may be subject to change once investigated. Of these, 2075 were reported as occurring within the patient's home or a community setting. These incidents are further disaggregated by whether there was district nursing input or the patient was admitted from a nursing home. Data collection is not yet sensitive enough to capture if individuals were in receipt of local authority or private social care packages. Analysis of the information has highlighted a need for improved recording of the name of the nursing home when reporting this type of incident, to enable effective feedback and learning.

	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Total
Developed outside of hospital setting, with district nurse input	151	153	164	169	171	152	960
Developed outside of hospital setting, with NO district nurse input	165	176	149	171	152	131	944
Present on admission (from Nursing Home)	13	20	18	16	16	14	97
Present on admission (with no community healthcare)	10	14	11	17	10	12	74
Total	339	363	342	373	349	309	2075

Incidents reported as developed outside of hospital setting, with district nurse input, inform the community acquired pressure damage metric, which is where the greatest number of incidents are reported.

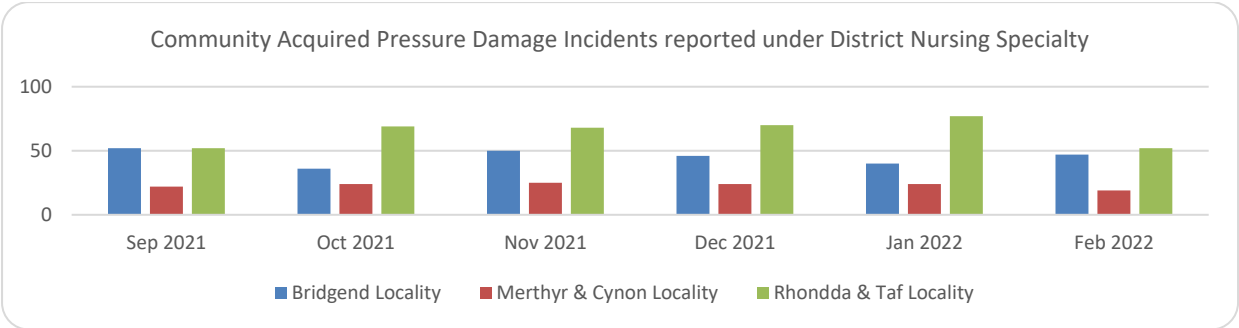


The grade of community acquired pressure damage incidents reported during the 6 month period is summarised in the chart below – initial grading may change when the pressure damage has been investigated.

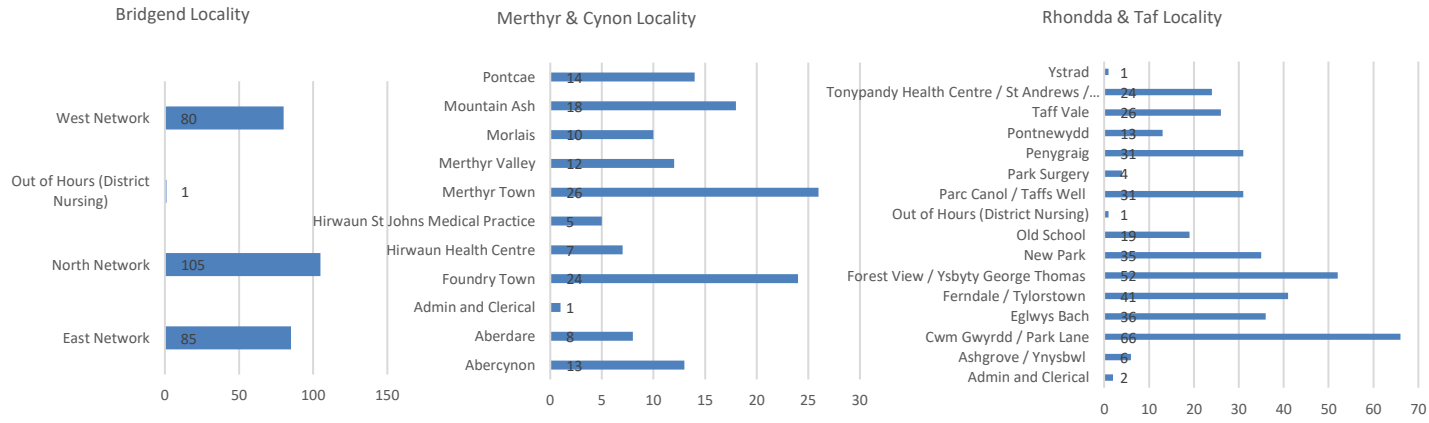


Although incidents reported under this category are predominately reported under the specialty of district nursing (797), there are instances where these incidents are reported under another specialty (163) as the reporter has recorded the location of reporting as opposed to the area of origin. These incidents are updated as part of the review process and data is therefore subject to change at a later date.

Over the 6 month period for incidents reported under the district nursing service, the Rhondda & Taf Ely Locality have reported the highest number of pressure damage incidents which have developed outside of the hospital setting with district nurse input. This is reflected in the chart below:

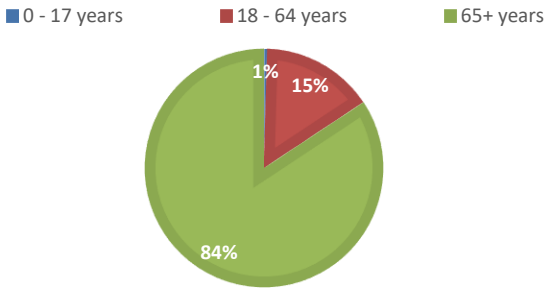


A further breakdown by district nursing area is provided in the charts below:



Of the incidents reported between the 01.09.21 and the 28.02.22, the All Wales Pressure Damage Investigation tool has been completed for 582 out of the 2889 cases. Cases are subject to scrutiny panels within community and secondary care, where outcomes and learning contribute to action planning and prevention. Out of the 582, an outcome of avoidable pressure has been determined in 19 cases. Avoidable pressure damage may meet the criteria for reporting to safeguarding and be considered for solution through Putting Things Right Regulations.

Of the pressure damage incidents reported, the highest number of incidents is reported in the 65+-age band, which is highlighted in the chart below.



The Burden of Wounds study reported that Pressure Ulcers (PU) accounted for 9% (n=153000 patients) of all wounds managed by the UK's National Health Service (NHS) in 2012/2013.[1] The annual NHS cost attributable to managing these wounds and associated comorbidities was estimated to be £531.1million.[2] After adjustment for comorbidities, the annual NHS cost was estimated to be between £507.0 and £530.7 million.[2]

Pressure ulcers are painful and debilitating and many PUs are avoidable. Prevention and management is standardised within the All Wales PU Reporting & Investigation guidance 2018. A successful PU prevention and wound management strategy requires a holistic assessment of the patient, their skin status and their individual risk profile. Management should encompass patient and carer education, repositioning, skin care and the use of suitable pressure relieving devices combined, where necessary, with nutritional support and the use of appropriate wound care products.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Quality Improvement plans for reducing **AVOIDABLE** Community Acquired Pressure Ulcers (CAPU):

During 2022/2023, a CTM UHB CAPU Improvement Group will be convened (see Appendix 1) to undertake focused improvement work, which will include:

1. **Discovery Phase**

Understand the problem

- Further interrogation of available intelligence to understand the system, process and related problems that are contributing to the current prevalence of CAPU
- Process mapping pressure ulcer assessment, reporting and investigation
- Development of a driver diagram outlining a strategy for improvement (see appendix 2)
- use of ease/benefit matrix to prioritise improvements and inform the groups interventions plan

2. **Testing Phase**

During this phase of the programme, we will run our identified tests of change, utilising the recognized Model for Improvement.

3. **Spread and Scale Phase**

On completion of the agreed programme of work, an evaluation will be undertaken to identify learning that can be scaled and spread more widely across the organisation and to our communities.

The focused quality improvement work planned during 2022/2023 for CAPU assessment, reporting and management aims to reduce avoidable patient harm and improve patient experience and outcomes. The progress of the CAPU improvement work will be evaluated monthly and will be reviewed at the CAPU Improvement Group and at each quarterly Quality & Safety Committee via a Quality Report.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Engagement of key stakeholders in delivering identified tests of change – the successful implementation of any agreed changes is dependent on the clinical leadership and ownership of the work at the point of care

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	N/A
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the CTMUHB model for CAPU quality improvement approach to reduce incidence and avoidable patient harm as part of the CTMUHB Quality Strategy

<u>References</u>

1. Guest JF, Ayoub N, McIlwraith T, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 2015;5:e009283.

2. Guest JF, Ayoub N, McIlwraith T, *et al*. Health economic burden that different wound types impose on the UK's National Health Service. *Int Wound J* 2017;1