Agenda Item 6.4.1 | 24/05/2023 | Quality and Safety Committee | ED Spotlight: A review of Pressure Ulcers and Falls

FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Richard Hughes, Deputy Executive Director of Nursing
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Approving Executive Sponsor:	Greg Dix, Executive Director of Nursing & Deputy Chief Executive
Report Purpose	Please Select: For Discussion For Noting
Engagement undertaken to date:	Across care group, sites and within corporate teams.

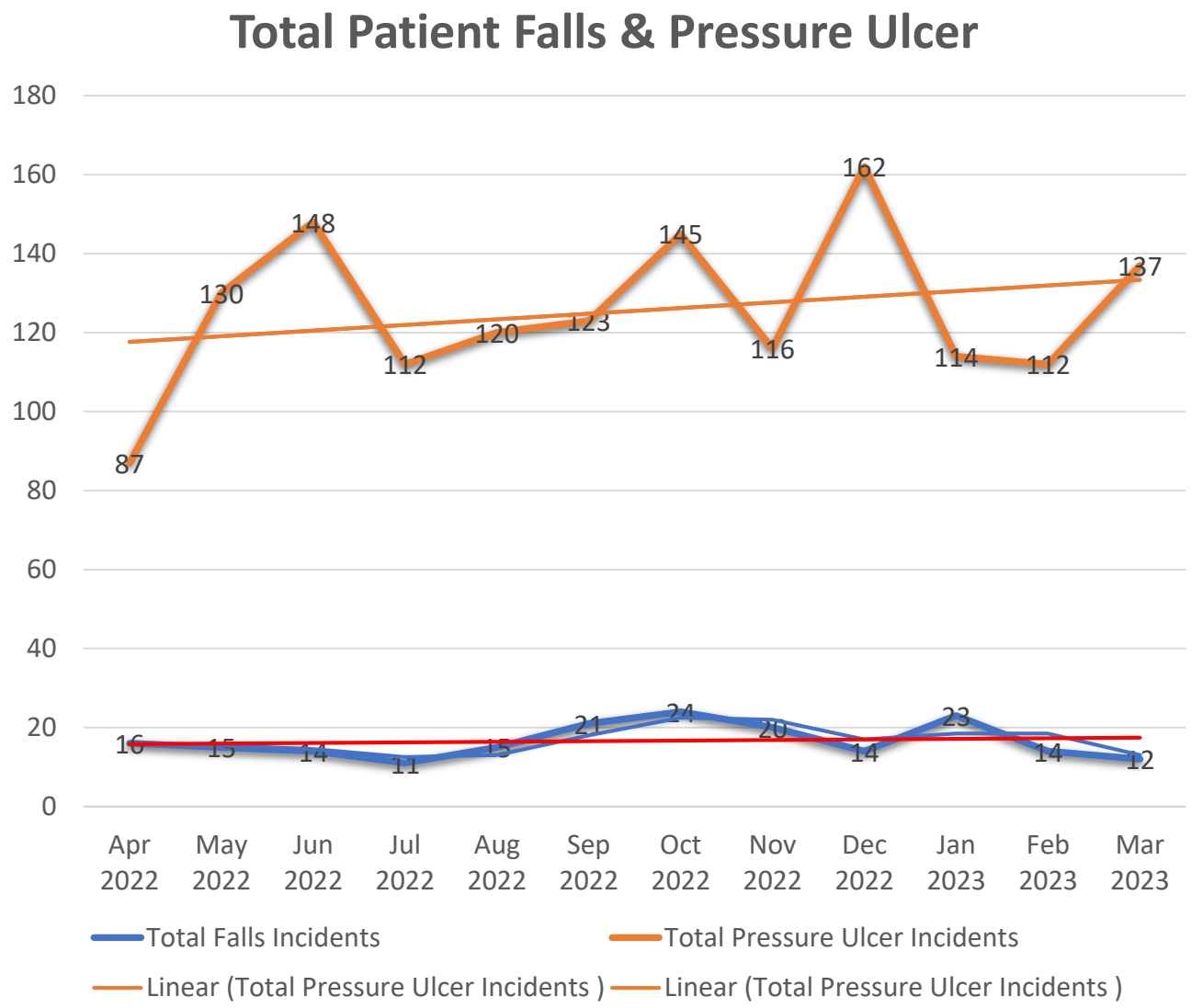
Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Impact will rest with output and associated reporting structures described in presentation.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	No, this is a review of facts and exciting arrangements.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Inspiring People Improving Care

ED Spotlight Presentation

A Review of falls and pressure ulcers

Overview

- Increasing trend of the total number of pressure sores recorded in the Emergency Department (ED) both community and hospital-acquired.
- Recording data points representing irregularity month on month with numbers on the whole sustained above 112.
- The total number of falls remains linear with no statistically significant trends.



Falls

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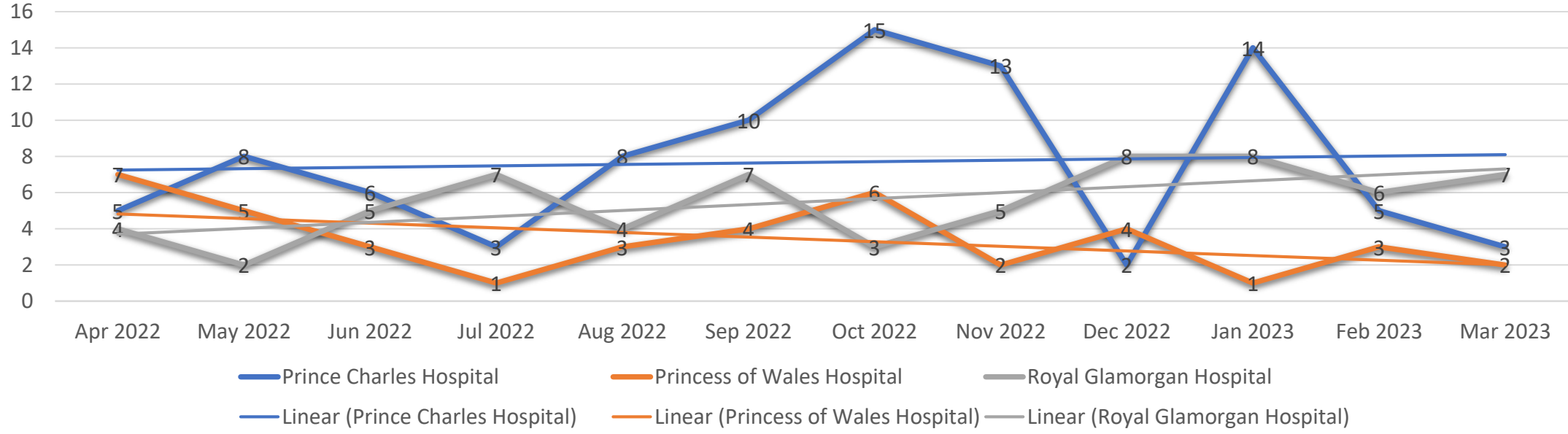
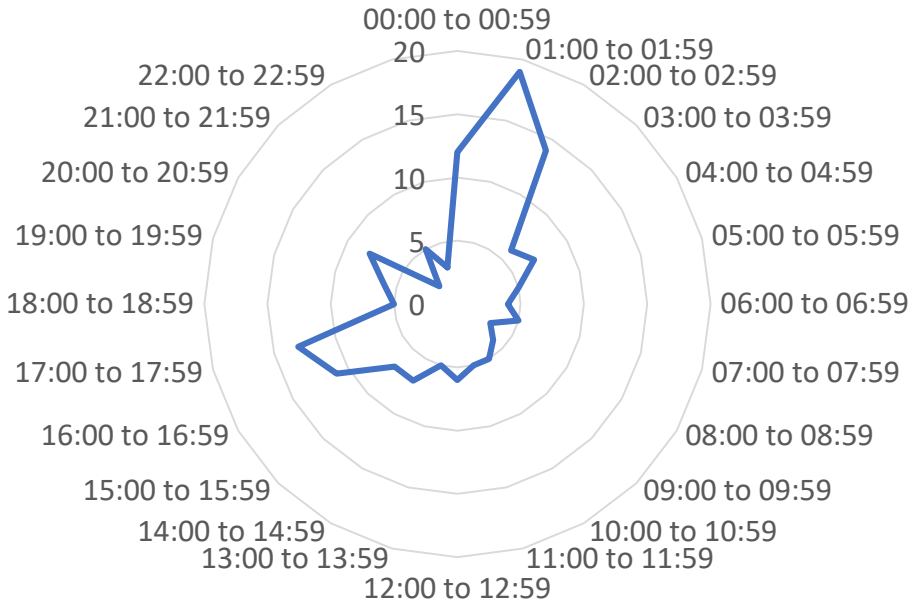
Number of Patient Falls Incidents By Hospital Site

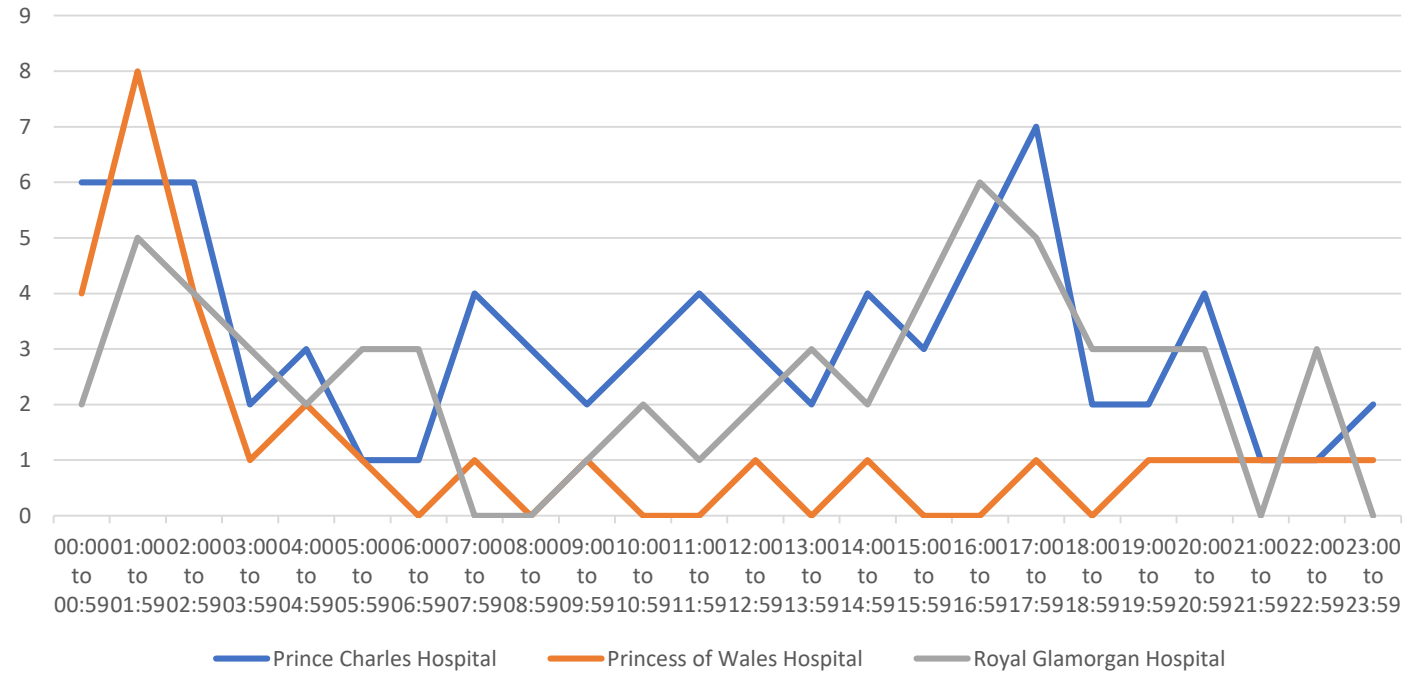


- The chart above describes falls of all types (no harm, low harm, moderate harm, and severe harm) by hospital sites within the ‘ED’ footprint.
- Prince Charles Hospital demonstrates a higher proportion of falls in 6 months out of 12 with The Royal Glamorgan Hospital reporting slightly fewer but more than The Princess of Wales Hospital ED.
- While the Princess of Wales Hospital demonstrates a downward trend in the total number of falls reported, Prince Charles and the Royal Glamorgan Hospitals demonstrate an upward trend in reporting.

Time of Falls Incidents

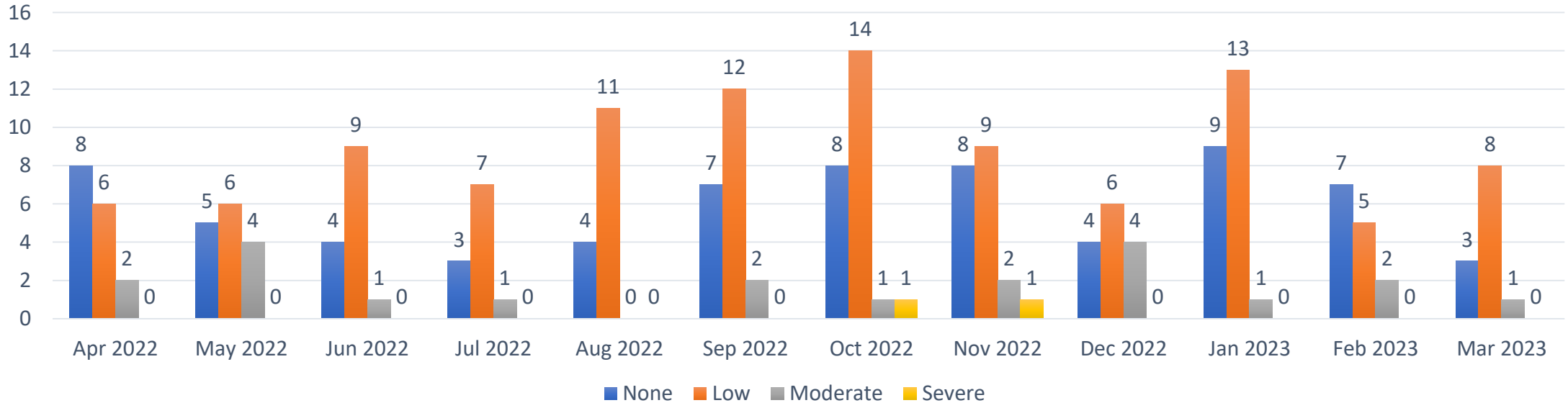


Time Band within which Falls Incident Occurred



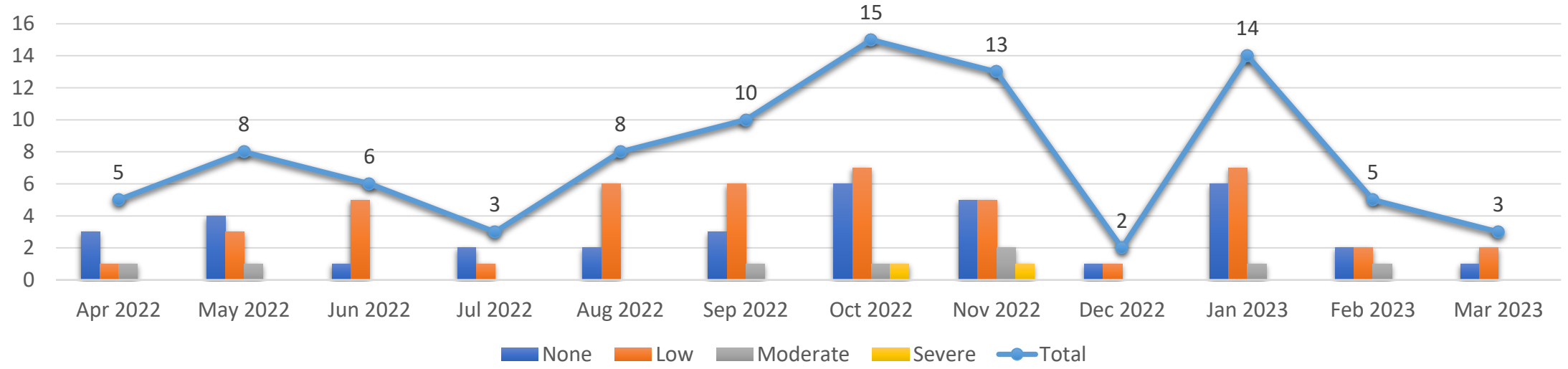
- Whilst the two charts demonstrate variation across the three sites as to the relationship between reported falls and time of the day, there is a clear alignment between all three demonstrating higher numbers between the hours of midnight and 3 am.
- There is a second peak for all three sites between the hours of 4 pm and 6 pm, particularly on the Royal Glamorgan and Prince Charles Hospital sites.

Severity of Incidents Across Emergency Departments



- This chart demonstrates the recorded fall incidents across the 12-month period broken down by the level of harm associated with falling.
- The majority of falls are associated with low and then no harm as an outcome of the incident.
- There is not enough information to demonstrate causation at the organisational level, however, the months of August, September, October and January are all aligned with the reported operational narrative provided at the time in relation to significant patient flow issues, ward boarding and ambulance delays.

Prince Charles Hospital



- The number of fall incidents being reported is higher in low and no harm as the outcome.
- The number of falls being reported is a driver for the overall reported numbers for CTM as a whole.
- The number of fall incidents represented is directly correlating with the length of stay in the extended areas of the department (GP assessment), with some patient stays in ED lasting 96 – 120 hours.
- The available capacity and therefore number of patients within the ED compared to the other two sites may increase the potential for increasing incidents of falling.
- Whilst the number of data points will not yet support a positive response, additional work has been started on clinical assessment for the need for onward admission to the next bed to accommodate frailty and risk of falling as a priority issue.
- The above and improved compliance with falling risk assessments is aligned with improving numbers across February and March.

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How are the team at Prince Charles Hospital responding?

A newly implemented approach to the assessment and scrutiny of falling-related incidents has recognised the positive intervention at the clinical level:

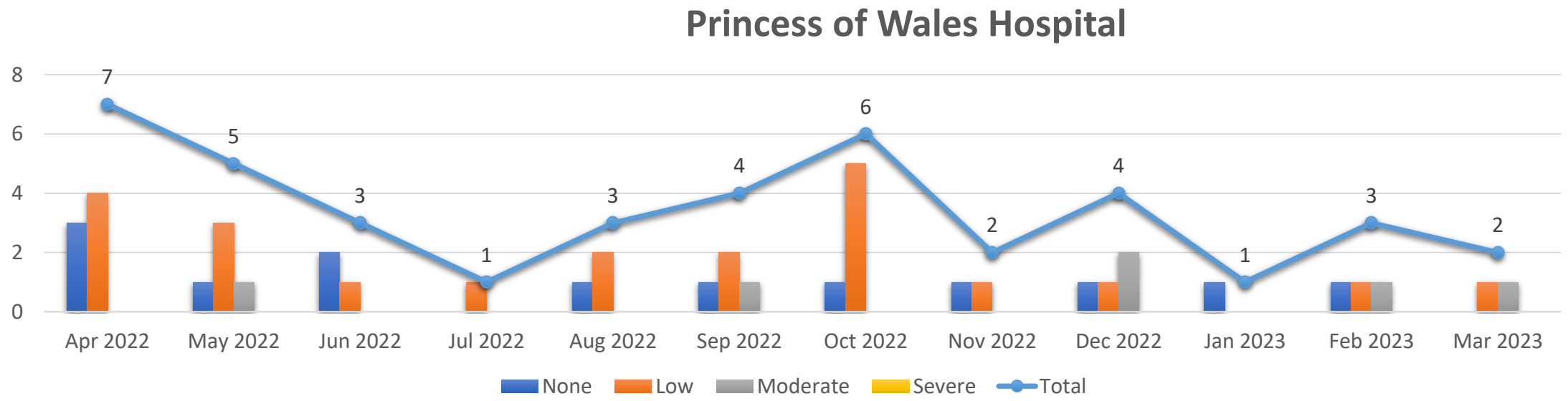
- Improved compliance with at-risk-of-falling risk assessments.
- Improving and considered approaches to appropriate placement and prioritisation for ward placement where admission is required.

With the established Unscheduled Care Group, the Head of Nursing, clinician colleagues and senior nursing team are committed to working in partnership with our other two sites in order to strengthen and extend the capacity to learn and share from incidents with a greater emphasis on prevention.

The two defined peaks in incidents reported have been recognised by the team. Whilst the initial intelligence points towards the movement of the workforce to attend to transfers as well as nocturnal toileting demands, there will be further work and ongoing surveillance of the data to understand potential measures to flatten the peak and mitigate the understood causes.

Recent recruitment strategies have realised an overall reduction in agencies to support vacancies. This has resulted in elevations of consistency and earlier intervention.

Work has begun, however, is required on an ongoing basis as to the geography of the department and what is determined within the ED footprint versus what is required as additional surge space as a result of capacity issues within the hospital. This is important to further understand the data of falls being reported in the ED versus ward or outpatient areas.



- The number being reported for this site are relatively consistent and low in number consisting of low and no harm incidents in the majority.
- The data is also demonstrative of the work being carried out by the clinical and operational team in prioritising ward transfer for those at risk of harm from falling as well as appropriate placement whilst in ED.
- There is also the recognition of long ambulance waits, it is not clear if this impacts the falls data, but with improving ambulance flow in the last three months, there has been a reduction in falls, not an increase.

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How are the team at Princess of Wales Hospital responding?

Whilst very early in the journey, the team were eager for the organisation to recognise the beginning of a new fragility model across the emergency floor. With a section of the acute medical unit being dedicated as a frailty unit, there is now improved flow and early identification of frailty and associated risks (falling). This is proving to be a positive edition which has also seen AMU vacancies reduce by 40%. More to follow in the near future!

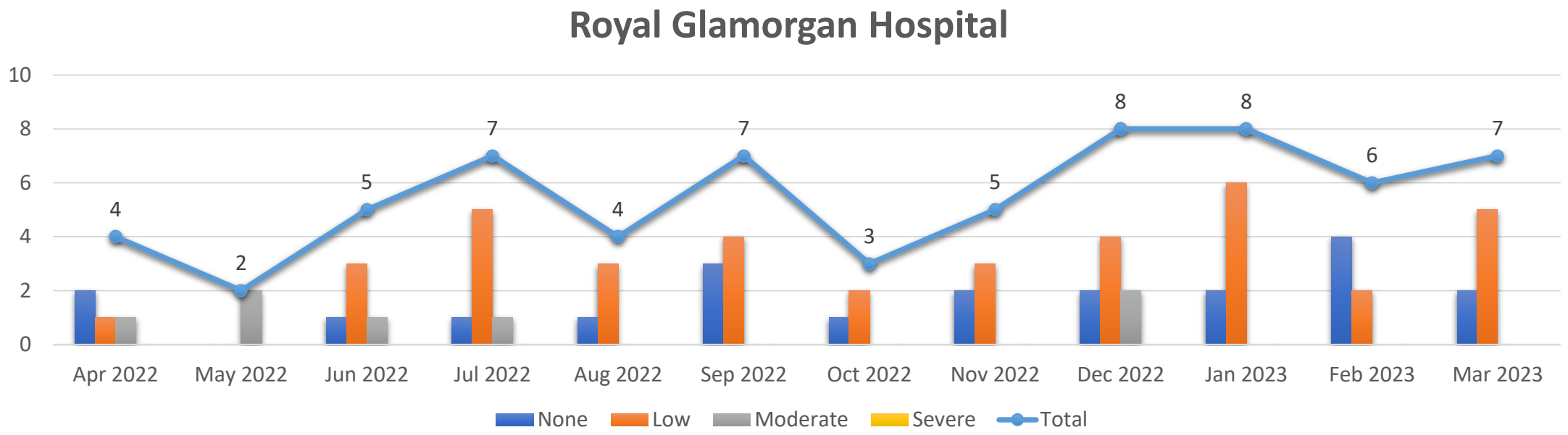
The senior team have reported improving quality and compliance in the assessment of risk in falling as well as an associated improvement in the awareness and documented assessments and actions plans for the treatment of recognised delirium.

With the established Unscheduled Care Group, the Head of Nursing, clinician colleagues and senior nursing team are committed to working in partnership with our other two sites in order to strengthen and extend the capacity to learn and share from incidents with a greater emphasis on prevention.

As part of the work to improve on the quality of assessments and appropriate resource. There has also been a noticeable improvement in the compliance and quality of enhanced supervision needs assessments,

A newly implemented approach resulting in positive interventions at clinical level:

- Improved compliance with at-risk-of-falling risk assessments.
- Improving and considered approaches to appropriate placement and prioritisation for ward placement where admission is required.



- The number being reported for this site are relatively consistent and low in number consisting of low and no harm incidents in the majority.
- The data is also demonstrative of the work being carried out by the clinical and operational team in what is the smallest ED environment within the organisation.
- There appears to be no suggested trend with the numbers of falls being reported below 8, month on month.

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With the established Unscheduled Care Group, the Head of Nursing, clinician colleagues and senior nursing team are committed to working in partnership with our other two sites in order to strengthen and extend the capacity to learn and share from incidents with a greater emphasis on prevention.

As part of the work to improve the quality of assessments and appropriate resources. There has also been a noticeable improvement in the compliance and quality of enhanced supervision needs assessments.

With overall incidents recorded being lower, the team will be looking at the series of moderate-level harm incidents of falling over the course of April, May, June and July to determine if there is a common causation. This will be shared at the first harm-free care board.

How are the team at the Royal Glamorgan Hospital responding?

The care group leadership team are in the process of transforming current site-based processes of falls incident analysis to accommodate the sharing of information across multiple areas, care groups and associated/relevant organisations (WAST). Royal Glamorgan team members will be active with other colleagues across the care group in structuring this over the next few months.

Pressure Ulcers

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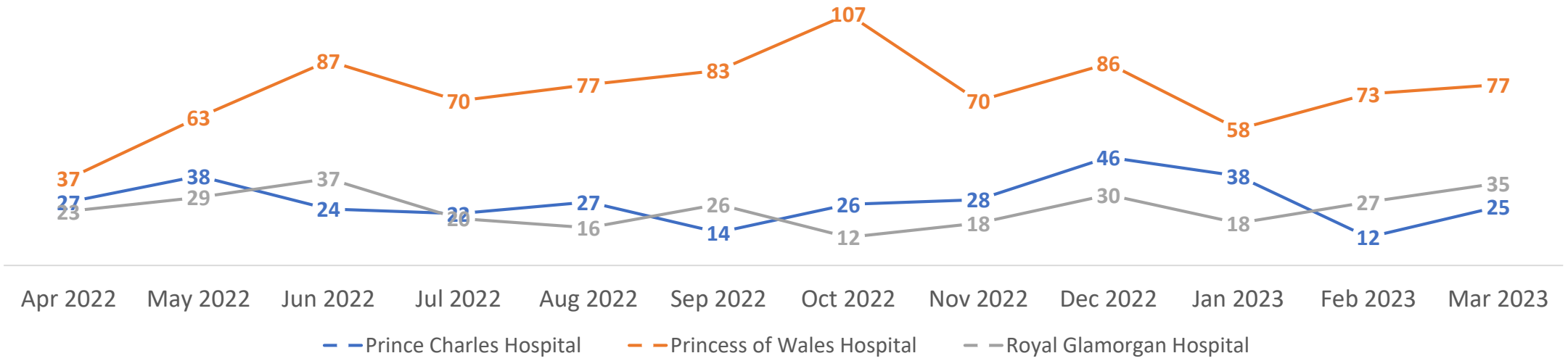
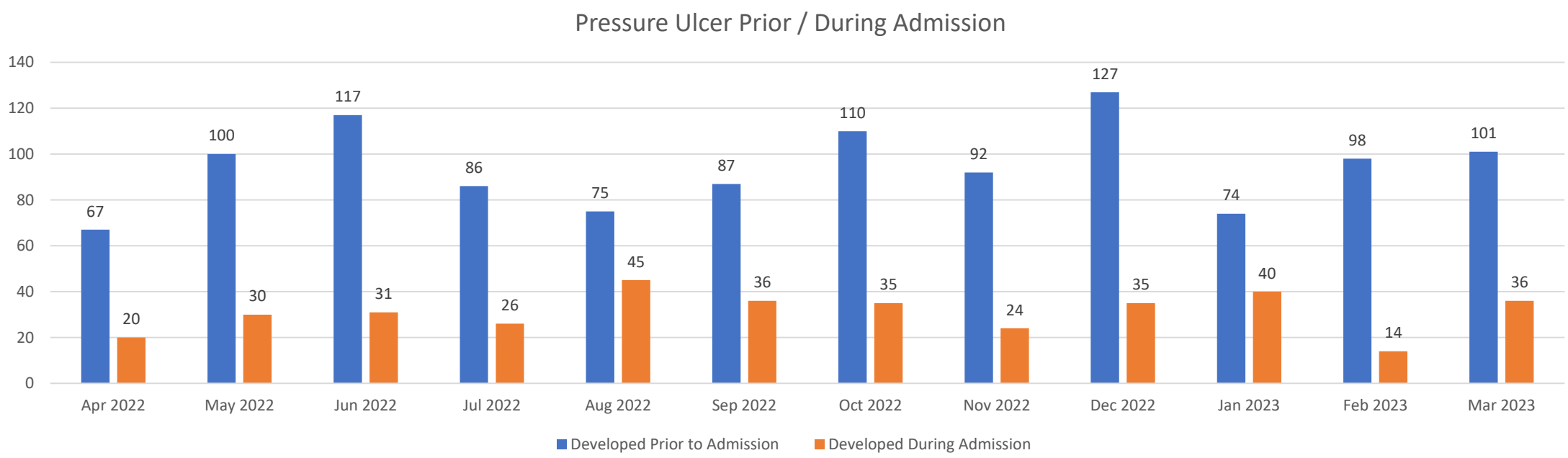
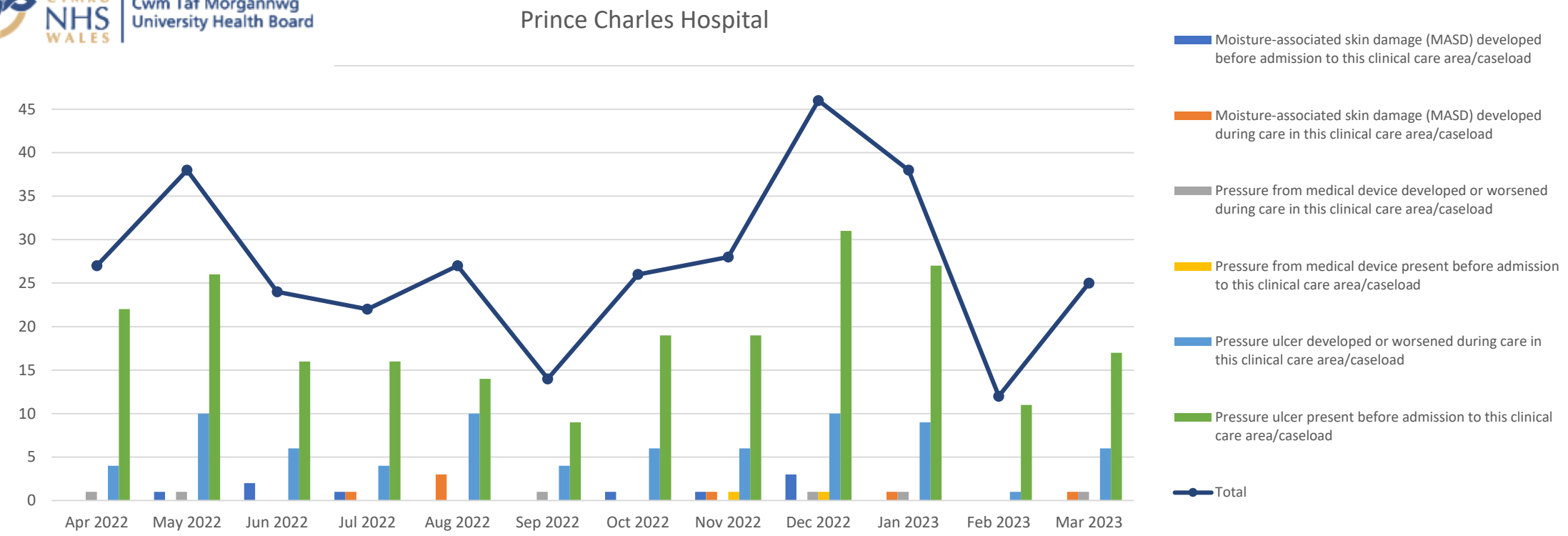
NUMBER OF PRESSURE ULCER INCIDENTS BY HOSPITAL SITE



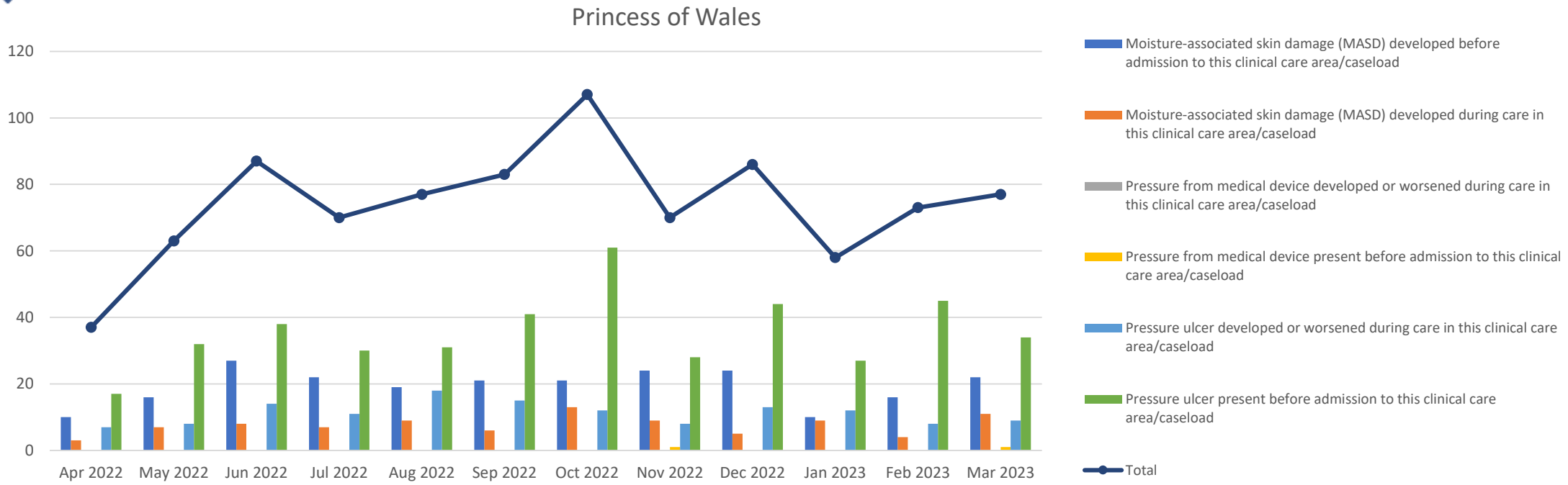
- The table above details the number of **all** pressure ulcers (community and hospital-acquired) reported in our three EDs over a 12-month period.
- Whilst the Royal Glamorgan and Prince Charles sites remain consistent with slight elevations across winter 2022/23, the Princess of Wales site sits as an outlier, demonstrating a significantly higher number of reported incidents.



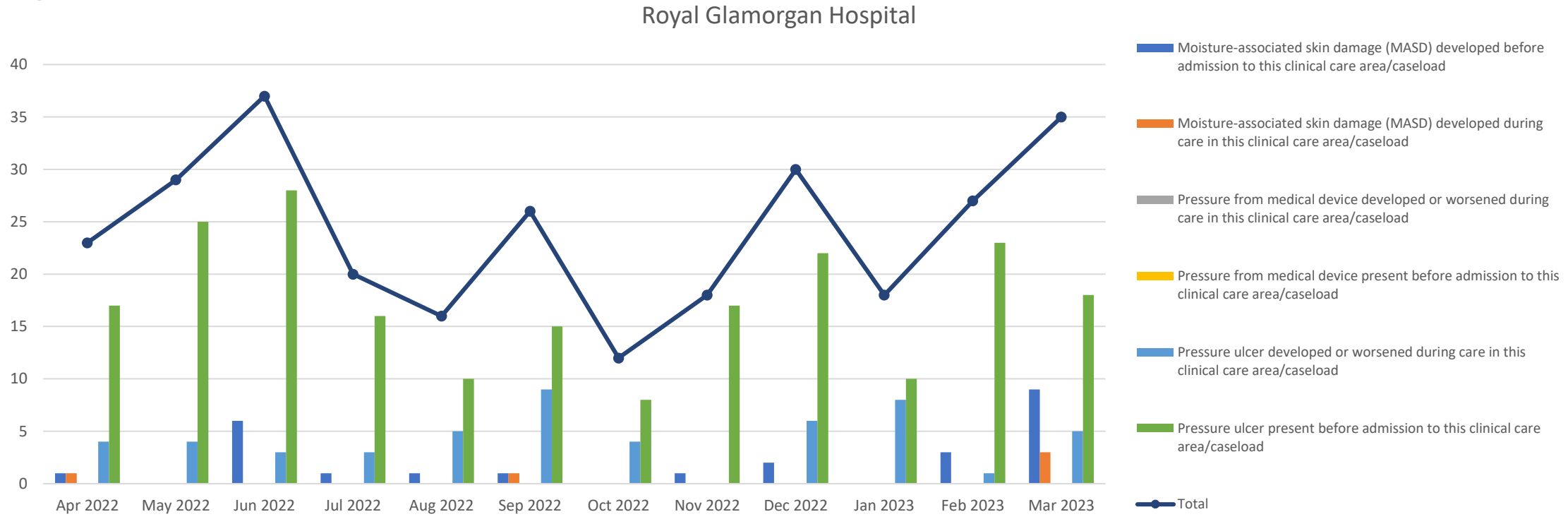
- The table above details the total number of pressure ulcers broken down by prior admission and during admission, reported in our three EDs over a 12-month period.
- The data demonstrates a clear distinction between pressure damage being captured as a community in origin versus damage which may have been acquired as a result of a lapse in hospital-based care.
- There is no statistical significance to determine any correlation to seasonal or other associated relationships.



- The table above details the pressure ulcers, broken down into the described categories for the ED at our Prince Charles site.
- The data suggests a higher proportion of pressure damage as being acquired prior to presenting to ED.
- Whilst lower in numbers, care-associated pressure damage does have a correlation to operational capacity issues, supported by operational situation reporting data and WAST operational reports.
- The recorded data demonstrated very minimal device-related skin damage and small levels of moisture-associated damage.

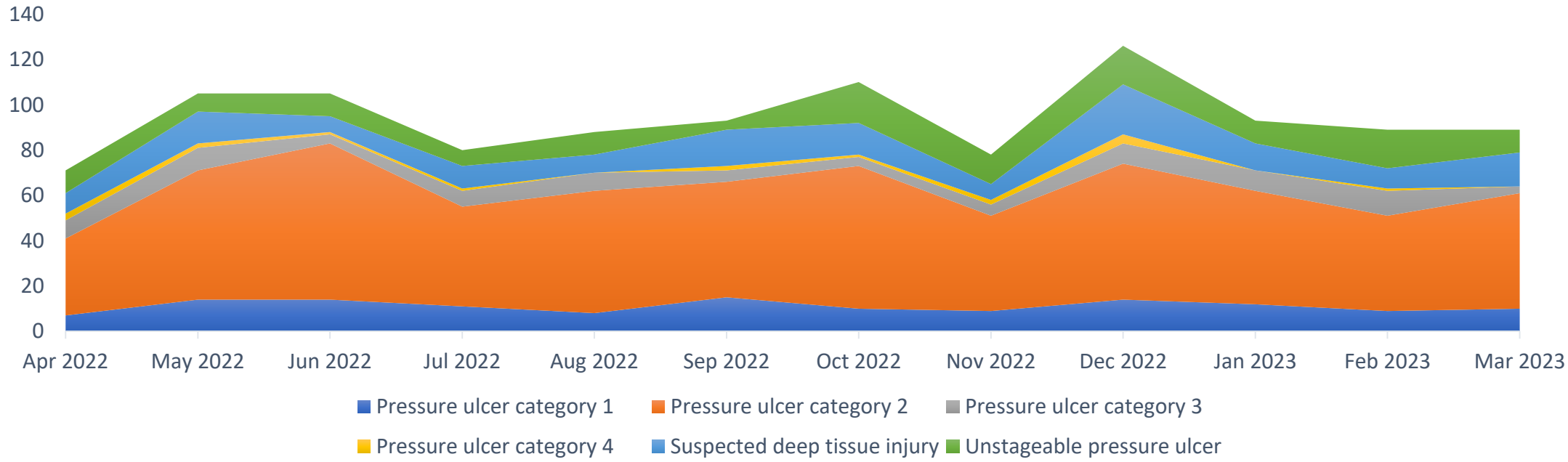


- The table above details the pressure ulcers, broken down into the described categories for the ED at our Princess of Wales site.
- The data suggests a higher proportion of pressure damage as being acquired prior to presenting to ED, but it also demonstrated double the number of Prince Charles and the Royal Glamorgan Hospitals.
- Whilst lower in numbers, care-associated pressure damage does have a correlation to operational capacity issues, supported by operational situation reporting data and WAST operational reports. The total number reported is again, double that of the two other sites.
- The recorded data demonstrated very minimal device-related skin damage and small levels of moisture-associated damage.



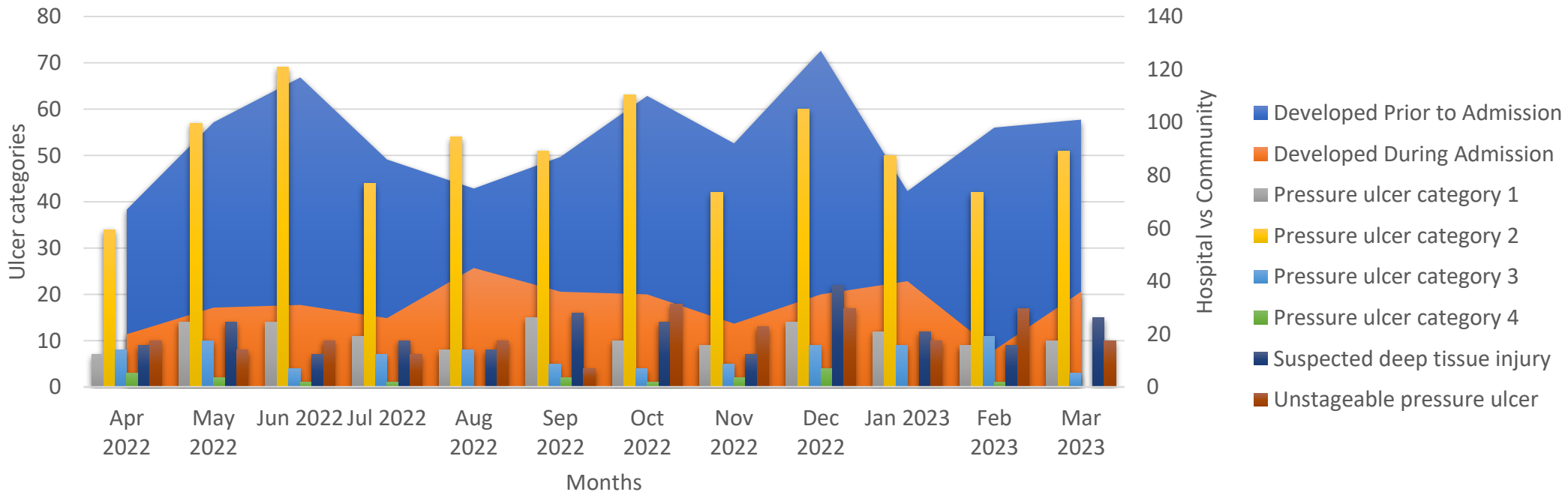
- The table above details the pressure ulcers, broken down into the described categories for the ED at our Royal Glamorgan site.
- The data suggests a higher proportion of pressure damage as being acquired prior to presenting to ED by a significant margin.
- Whilst lower in numbers, care-associated pressure damage does have a correlation to operational capacity issues, supported by operational situation reporting data and WAST operational reports.
- The recorded data demonstrated very minimal device-related skin damage and small levels of moisture-associated damage but does demonstrate higher levels when compared to the two other sites.

Pressure Ulcers by category



- The table above details the pressure ulcers, broken down into their associated categories.
- The data suggests category 2 pressure damage as the primary classification across all months.
- There are clear correlations between elevated numbers of suspected deep tissue injuries with increased numbers of category 3, 4 and unstageable injuries.
- There is an association between the demonstrated peaks in the aforementioned with operational data demonstrating significant patient flow concerns and extended ambulance delays with associated community delays.

Pressure Ulcer Category vs Hospital & Community Acquired



- The table above details the pressure ulcers, broken down into their associated categories against overall pre/during admission numbers.
- Here the data is suggesting a mirroring of category 2 and damaged classified as ‘prior to admission’.
- There is also an identifiable pattern of category 1 and suspected deep tissue injury with an injury sustained ‘during admission’ i.e. in ED.
- There appears to be a disassociation between category 3 and 4 pressure ulcers with the other elements described above.

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So, what now?

When cross-referencing the harm data with operational situation reports, the data is suggestive of some correlation between the numbers of hospital-acquired injuries and increased length of stay within the ED footprint across all three sites, with particular reference to Prince Charles Hospital. This is likely due to the capacity profile and therefore higher numbers of extended bed waits in ED.

There is already work underway between CTM and WAST as to the potential use of 'repose' mattresses for those identified at significant risk of harm who are experiencing delays in being handed over. This is being piloted in SBUHB, however, is in the early stages with some anxiety as to the symptom and not the cause being addressed.

Whilst migrating from the ILG structure to the care group arrangement, additional work is needed to facilitate the holistic review of the relationship between pressure injury identified within the acute environment which may have originated within the community setting. This includes detailed work on the potential for harm with extended delays for ambulances.

It has yet to be established as to the reason for higher levels of reported harm when comparing the Bridgend region to that covered by Royal Glamorgan and Prince Charles sites.

As previously mentioned, the team at the Princess of Wales site are at the beginning of a new fragility model across the emergency floor. With a section of the acute medical unit being dedicated as a frailty unit, there is now improved flow and early identification of frailty and associated risks (pressure damage). This is proving to be a positive in the early stages, particularly in improving flow out of ED.

How does this translate?

January 23 to May 23
Care groups realigning the governance agenda out of the ILG structure

May 23 to June 23
Modelling to establish reporting mechanism and associated performance indicators to the Improving Care Board

May 2023
Implementation of Duty of Candour Act and Quality Principles as part of new arrangements

June 2023
Focused analysis with support form corporate team as to relationship of reporting between three acute sites.

June to August 23
Unscheduled and Community Care groups (with WAST) to carry out focused piece of work on joint surveillance and shared learning

July 2023
Launch of the 'Harm Free Care Board, chaired by Deputy Nurse Director for strategic oversight of learning and intervention across all care groups regarding falls, pressure sores, hydration and nutrition.

May to July 23
Evaluate and describe relationship to the interventions described with stakeholder groups such as iCTM, the pressure ulcer collaborative and wound care innovation.

February to August 23
All care groups reporting on agreed Standardised data sets as to the Quality KPIs complimented by consistent audit cycle

August 23
Triangulation of all governance arrangements to the broader regulatory Learning from Events Reporting requirements

Recommendation:	**The Board or Committee are asked to:**
Harm Free Care Board (in development) to report in September 2023 on the progress of work and update on reporting structure (operational).	• *Consider the narrative against the provided data.* • *Note the future work and prospective governance arrangements at operational levels.* • *Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.*