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Learning from claims virtual forum – Hospital Acquired Pressure Ulcers

NHS Resolution

Justine Sharpe
Safety & Learning Lead
London

Naomi Assame
Safety & Learning Lead
North

Michelle Stafford
Safety & Learning Lead
South

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Learning from claims virtual forum – Hospital Acquired Pressure Ulcers

Welcome to today's programme:

Learning from Claims
Hospital Acquired Pressure Ulcers

Date: Thursday 14th October 2021
Time: 12.30 – 13.30
Eventbrite link here:
https://14102021.eventbrite.co.uk

NHS Resolution

Learning forum for managers and clinicians:
Hospital Acquired Pressure Ulcers

NHS Resolution's Safety and Learning team is sharing our data and learning insights on hospital acquired pressure ulcer (HAPU) claims to support improvements in safety and experience. Working in partnership with a range of experts in the topic area to help spread best practice.

Our claims insights will highlight common risk themes we have observed regionally as well as sharing solutions as to how some of the risks have been reduced by making systemic and systematic changes. The format is interactive and our experts are a combination of providers, commissioners, patient safety leads and policy makers.

Hospital Acquired Pressure Ulcers programme:

- Value and volume of HAPU claims for NHS providers
- National and regional initiatives.
- Case stories – highlighting common learning themes.

Contributors:

Jacquie Fletcher, Senior Clinical Advisor, NHS England/Improvement

Glenn Smith, Advanced Nurse Practitioner, St Helens Medical Centre, Isle of Wight.

Dr Fania Pagnamenta, Clinical Academic Nurse Consultant (Tissue Viability)
Newcastle upon Tyne Hospitals NHS Foundation Trust &
Faculty of Health and Life Science, Northumbria University, Newcastle

Beverley Hunt, Safety & Learning Mediation Lead, NHS Resolution

How to access the forum

Registration is via Eventbrite portal. This virtual forum will be hosted on Microsoft Teams once you have registered and the invitation can be downloaded to your electronic calendar.

You will need:

- a laptop or tablet with a working webcam
- to check that all equipment and broadband is in working order prior to the forum
- a quiet environment where you are unlikely to be disrupted for 60 minutes

Please avoid:

Please do not record the forum. This is in line with GDPR guidance, and encourages open discussion. Future forum dates and topics:

DATE	TOPIC
11/11/2021	CNSGP
TBC	Diabetes – Lower Limb Complications
TBC	Medication Errors
TBC	Extravasation
TBC	Assaults

Format: interactive

Duration: 60 minutes

Guest speakers:

Beverley Hunt, Safety and Learning Mediation Lead, NHS Resolution

Jacquie Fletcher, Senior Clinical Advisor, NHS England/Improvement

Glenn Smith, Advanced Nurse Practitioner, St Helens Medical Centre, Isle of Wight.

Dr Fania Pagnamenta, Clinical Academic Nurse Consultant (Tissue Viability)
Newcastle upon Tyne Hospitals NHS Foundation Trust &
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National Hospital Acquired Pressure Ulcer claims

*1 April 2016 – 31 March 2019**

137

Claims settled with damages paid

£ 3,197,318

Total cost of settled claims

£ 23,000 per claim (mean value)

**All NHSR notified claims related to Hospital Acquired Pressure Ulcers 1April 2016-31 March 2021*

Number of claims by region

Total claims: 137

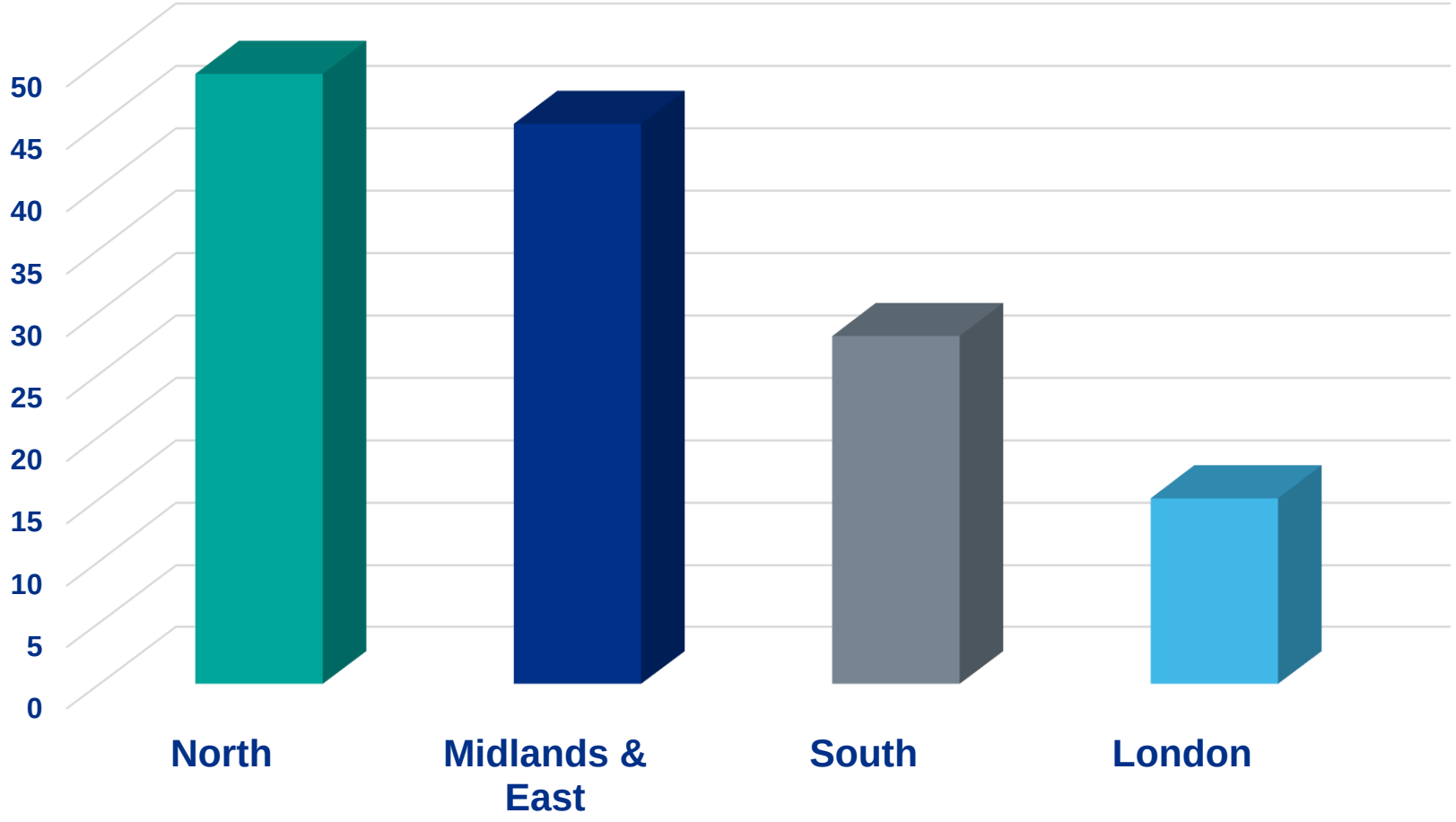
Number of Trusts per region (2016-2019):

North: 70

Midlands: 60

South East: 62

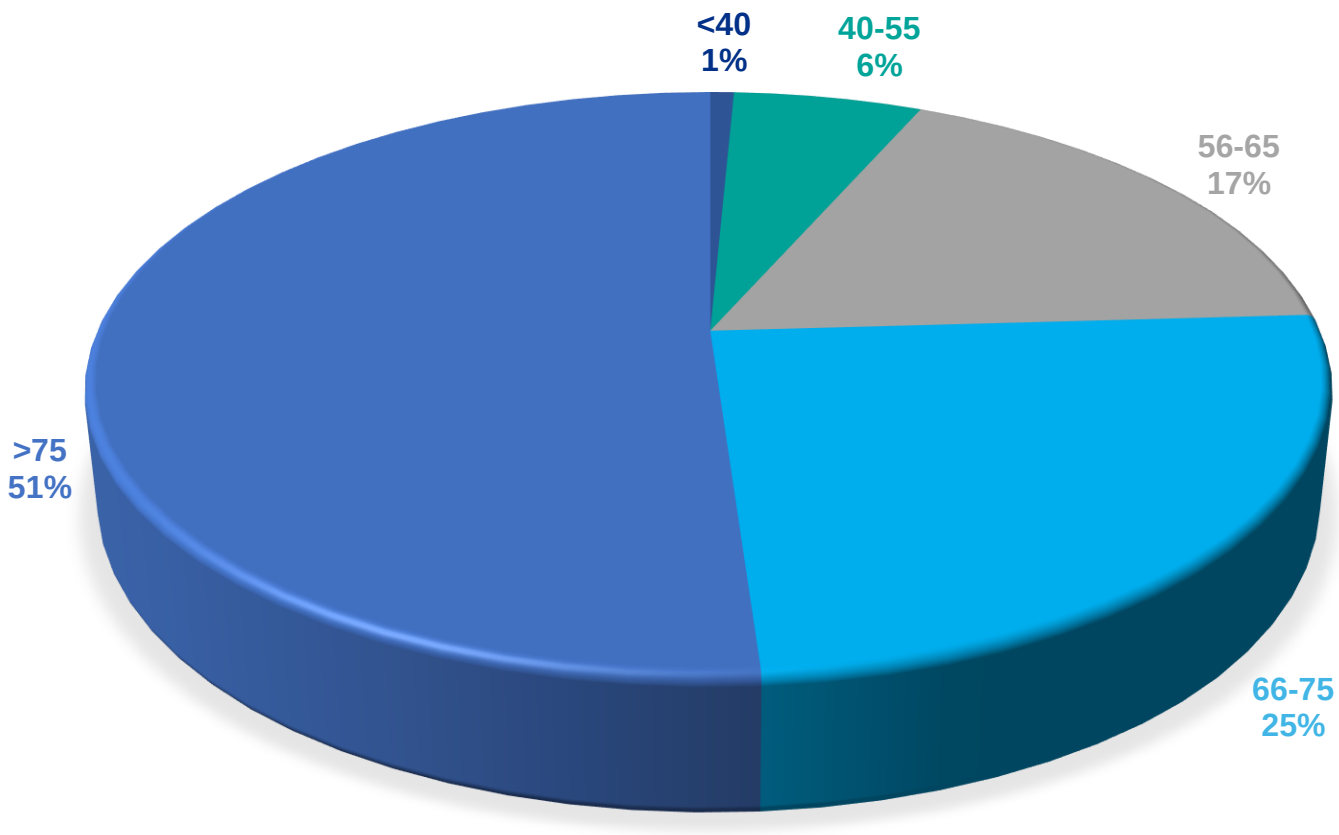
London: 38



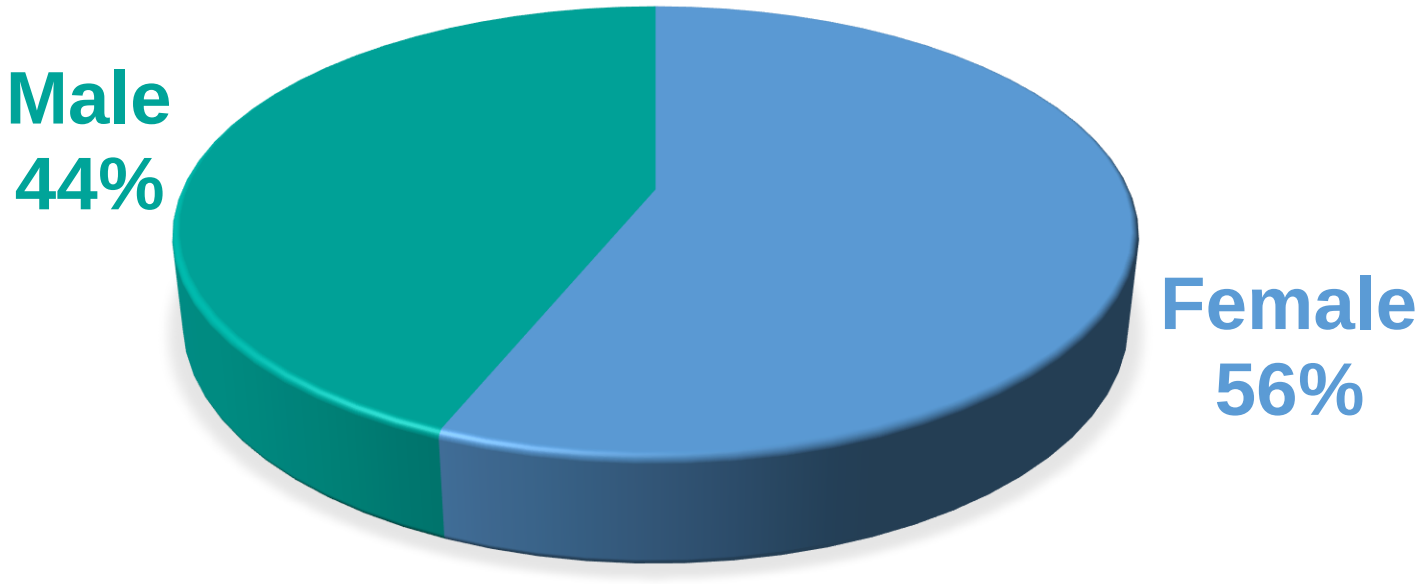
Age

Age ranges:

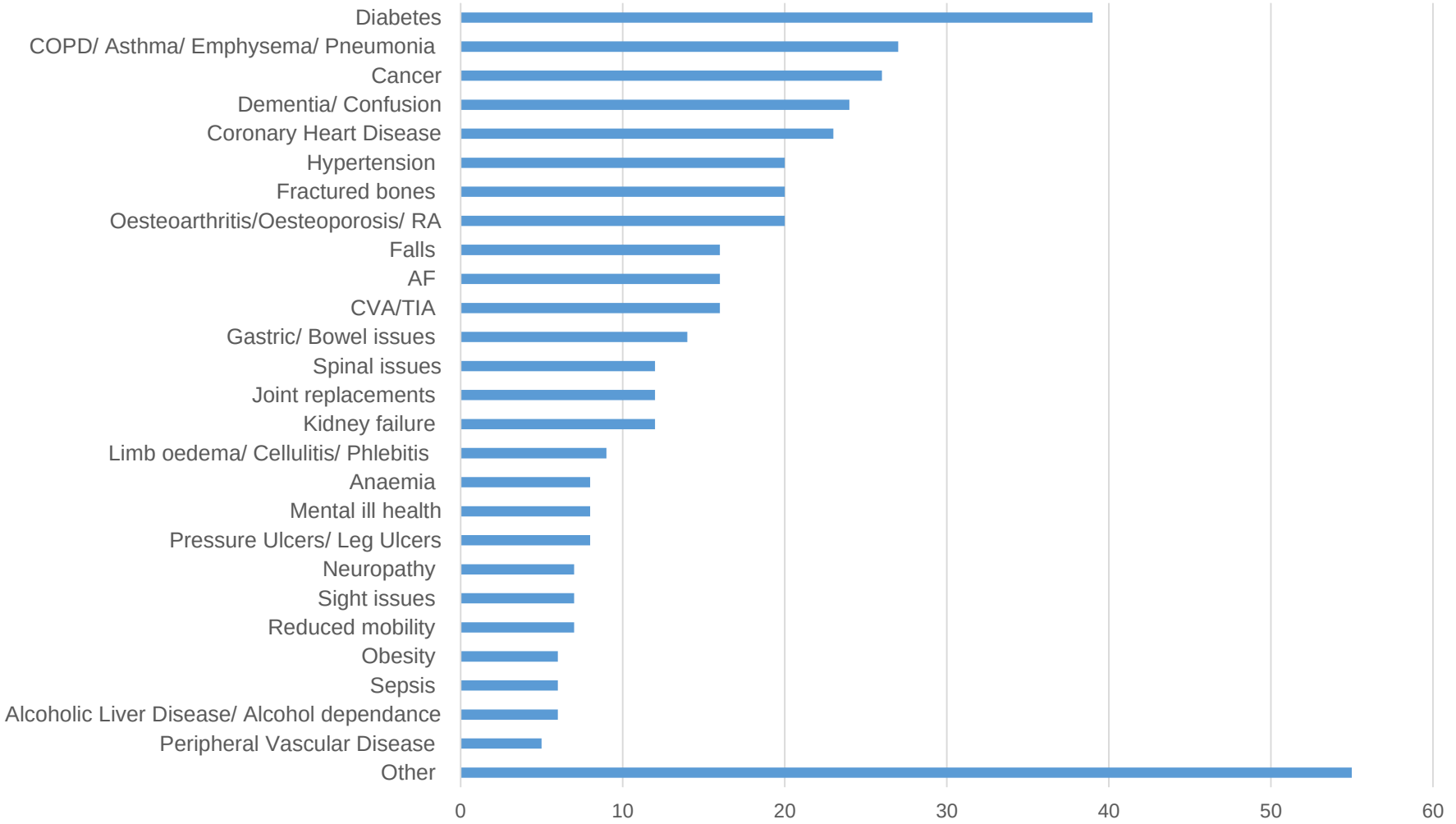
- <40: 1
- 40-55: 8
- 56-65: 24
- 66-75: 34
- >75: 70



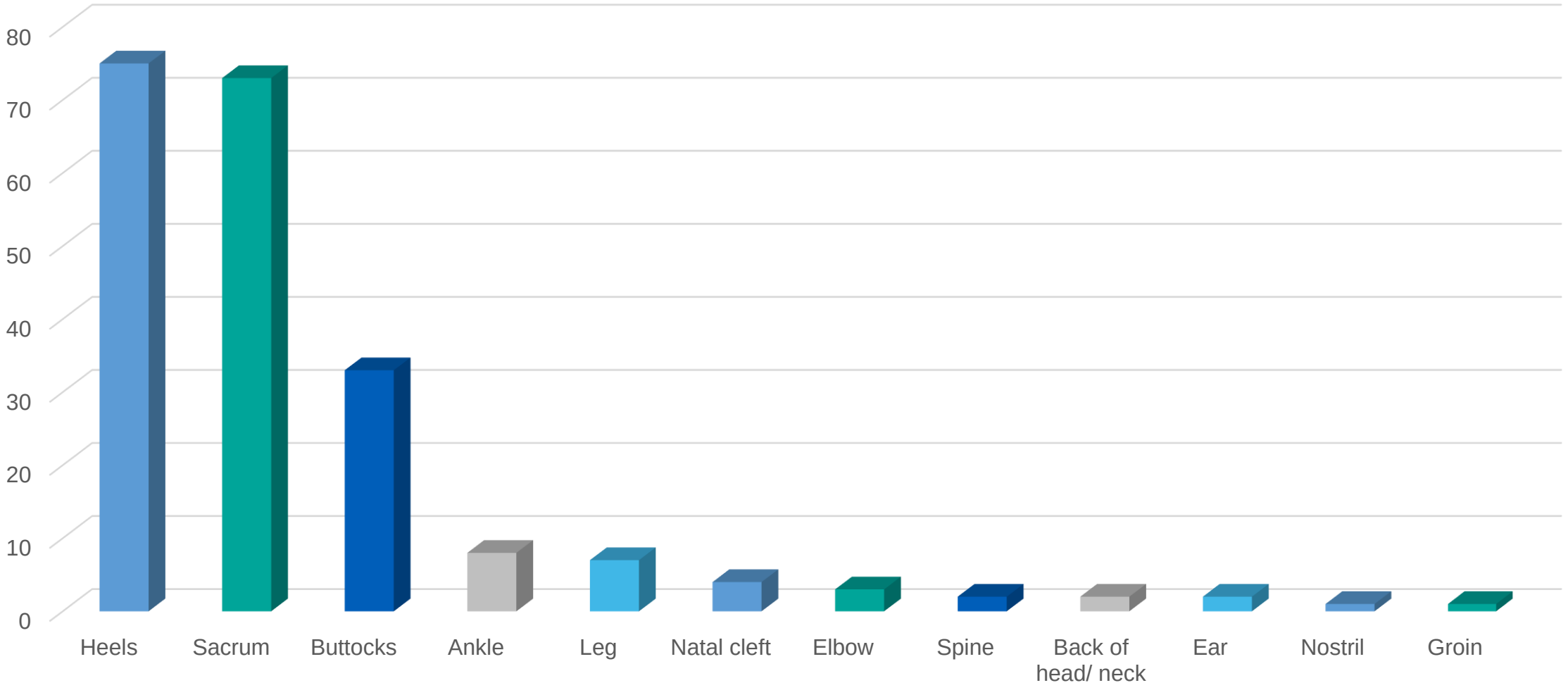
Gender



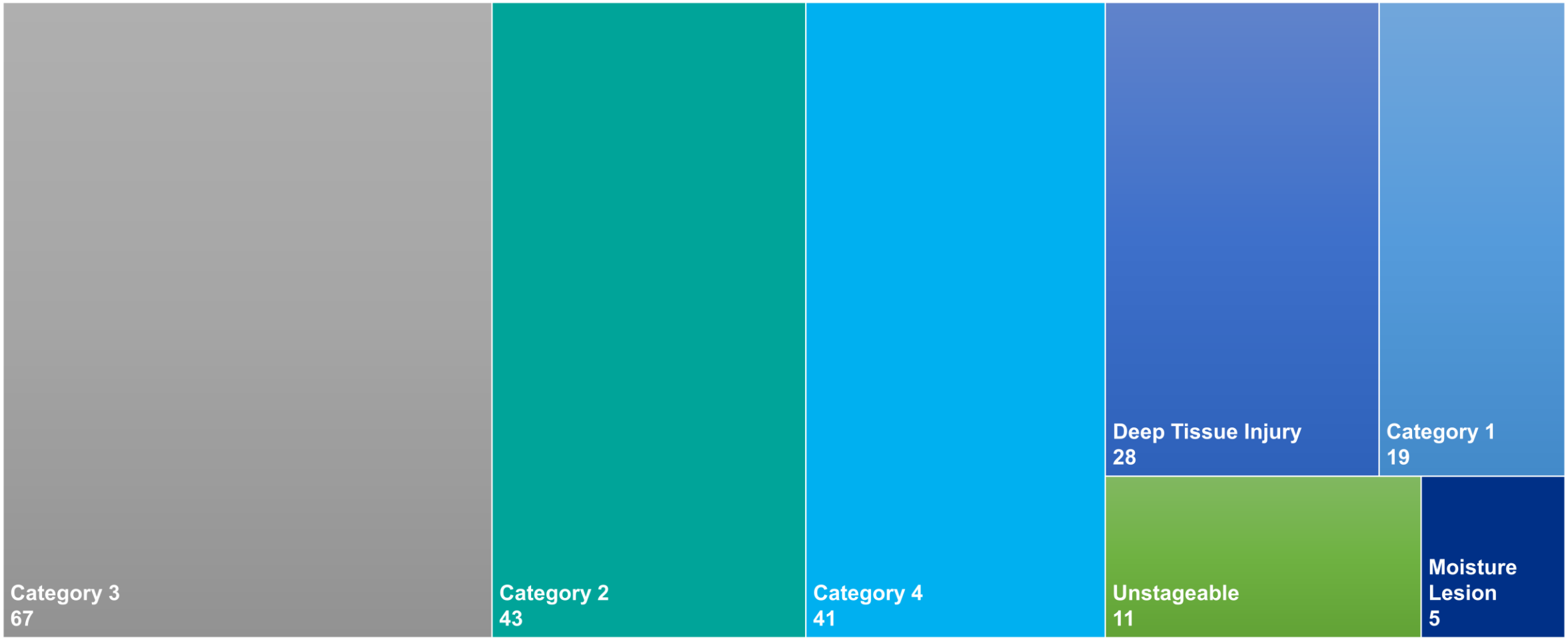
Medical comorbidities



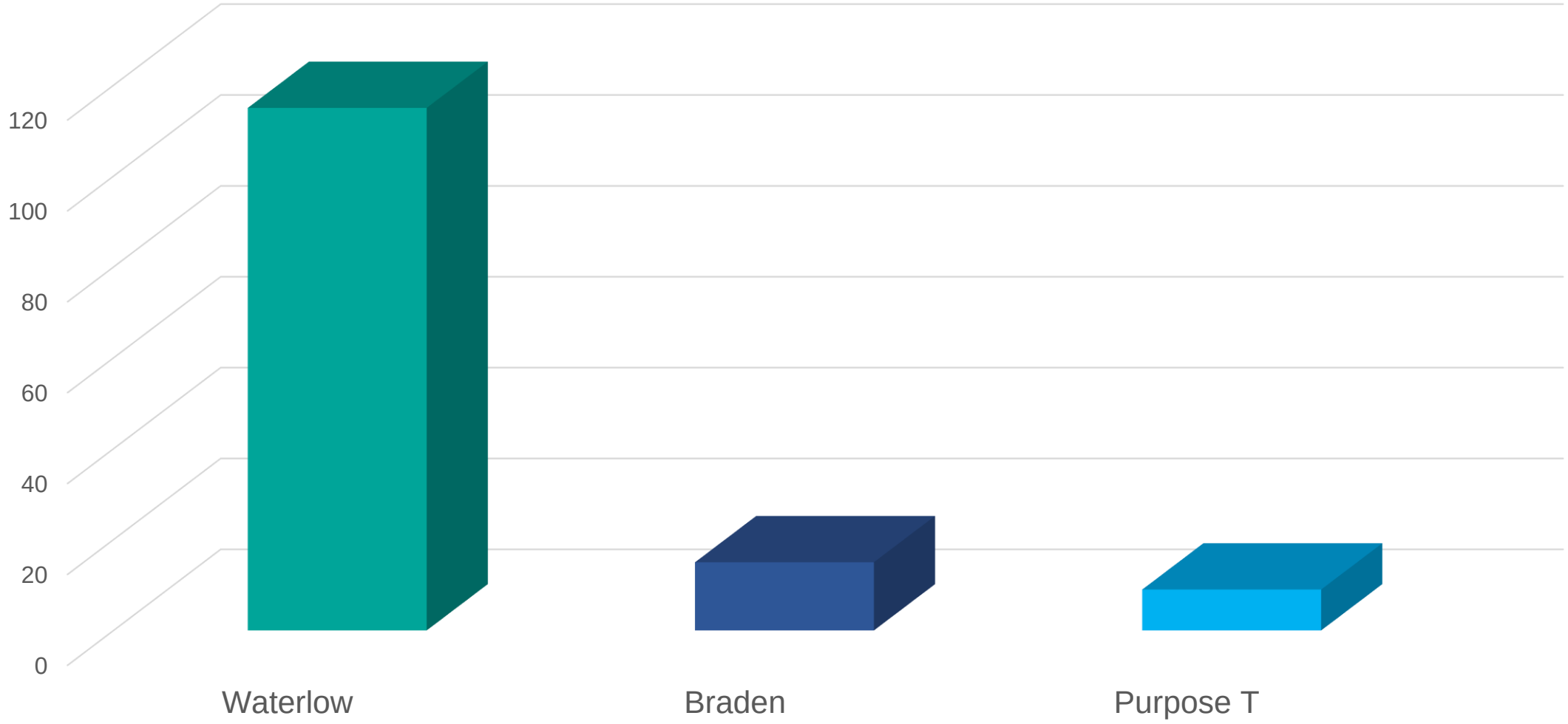
Location of Pressure Ulcer



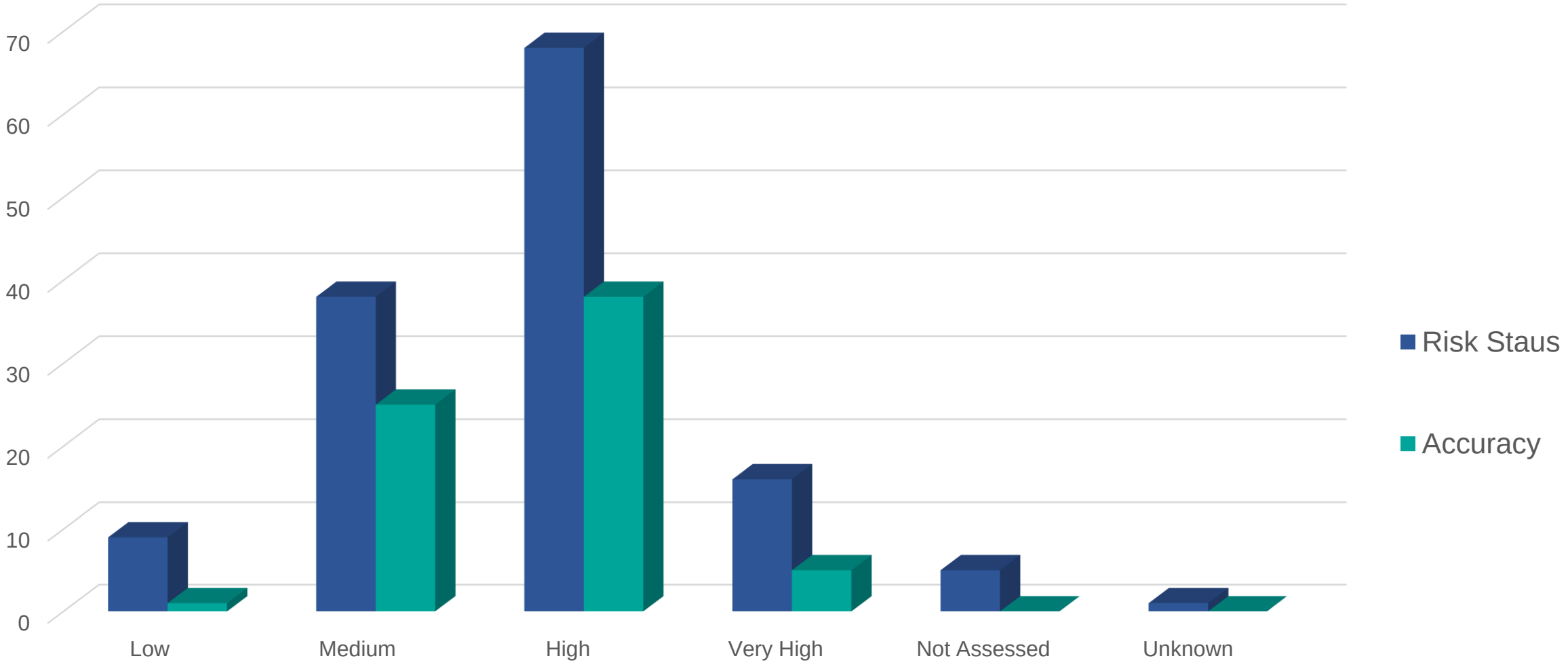
Category of pressure ulcer



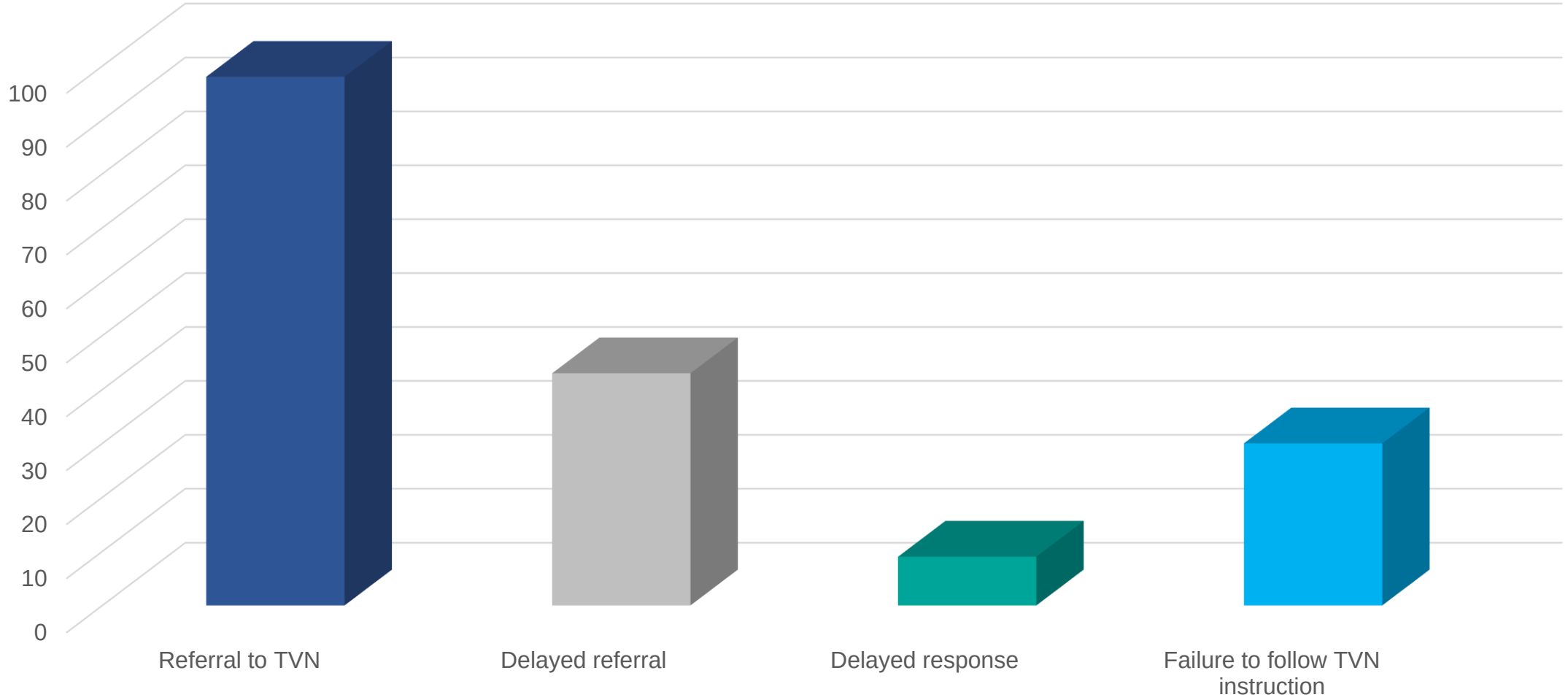
Risk assessment



Risk assessment



Referral to Tissue Viability Nurse (TVN)



Learning from claims – hospital acquired pressure ulcers

Bev Hunt
RGN RM MSc
Safety and Learning Lead - Mediation
NHS Resolution

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HAPU: case study

Illustrative case from a number of similar claims

152 claims analysed (15 claims part of the Emergency Medicine thematic analysis report)

Excluded claims:

- Maternity
- Paediatric

HAPU: background

- Margaret is an 81 year old lady
- Lives alone and is reasonably active
- BMI 20
- Past medical history:
  - Diabetes
  - Hypertension
  - Basal Cell Carcinoma

HAPU: admission

- Admitted to Emergency Department (ED) early evening via ambulance following a fall at home, unaccompanied
- Triaged within 15 minutes – level 3, to be seen within 60 minutes
- Medical review completed an hour later
- X-ray performed and reviewed
- Plan:
  - Fractured humerus diagnosed
  - Admit to ward
  - Consultant Orthopaedic review in the morning

HAPU: care in ED

- Triage swift
- Medical review within triage plan
- No risk assessments undertaken
- Nursed in majors
- Food and drink provided, but no regular toileting
- Spends 16 hours in ED
- Waterlow assessment performed @ 12 hours = high risk
- Pressure relieving trolley mattress

HAPU: admission

- Transferred to an orthopaedic ward
- Further risk assessments completed within 3 hours of admission
- Care plan generated
- Nursing care rounds implemented
- Surgery required
- Category 2 pressure ulcer to sacrum identified day 4, progressed to category 3

HAPU: Incident investigation

- No duty of candour meeting with family or empathetic apology
- No root cause identified
- No contributing factors
- No action plan to mitigate future risk
- No context to environment – staffing levels, skill mix or patient acuity

HAPU: shortfalls

- No robust handover of risk of harm
- Risk not reassessed on change of condition (surgery)
- Risk assessment not accurate (underestimated)
- Nursing care plan did not reflect needs to prevent injury
- Pressure areas not regularly inspected
- Incomplete documentation of nursing care rounds
- Inadequate investigation to learning and mitigate risk

HAPU: the claim

- Margaret made a claim for compensation
- NHS Resolution instructed a nursing expert
- Expert concluded:
  - Breach of duty:
    - *Failing to complete a risk assessment in ED*
    - *Failing to regularly reassess risk*
    - *Failing to regularly observe pressure areas*
    - *Failing to provide level of care in line with perceived risk*
  - Causation:
    - *On the balance of probability if the above had been completed it would have avoided the level of harm sustained*
- Liability admitted
- Damages paid for pain, suffering and loss of amenity: £20,000,
- Legal costs totalled £35,000

HAPU: discussion

Clinical issues:

- *Risk assessment*
- *Nursing care plan*
- *Nursing care*

Post incident investigation:

- *Duty of candour*
- *Learning not clearly identified*
- *Would not mitigate reoccurrence*

HAPU: discussion

- Are risk assessments seen as a box ticking exercise?
- Do clinicians see the value in risk assessments?
- How are risk assessments informing nursing care plans?
- If you audited your clinical area for compliance with NICE guidelines how good would your performance be?

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Safety@resolution.nhs.uk

Learning from claims – hospital acquired pressure ulcers

Jacqui Fletcher

Senior Clinical Advisor

NHS England and Improvement

@NHSresolution

National Wound Care Strategy Programme

Excellence. Every Patient. Every Time.

NHS Resolution and Hospital acquired pressure ulcers virtual forum

Interested in wound care? Sign up at: www.nationalwoundcarestrategy.net

Twitter: #NatWoundStrat

Stop the Pressure Programme key activities

- Pressure ulcer surveillance system
- Revision of Definition and Measurement document
- Development of Clinical Navigation Tool
- Development of Standards of Care
- Working with the Patient Experience Network

Where were we at with PU numbers and severity?

High level messages from the PU and quality of care audit

- In total, 10,144 patients from 36 hospitals representing 18 NHS Trusts (see appendix 2) were included in the audit.
- Over half of the sample was elderly, with 55.2% of patients being over 70 years of age, and 33.5% over 80 years of age.
- The number of patients with 1 or more pressure ulcers (PUs), excluding moisture-associated skin damage (MASDs), was 917.
- The overall prevalence of PUs recorded, in terms or proportion of patients with 1 or more PUs, was **9.04%** (95% confidence interval (CI) 8.48% to 9.60%). Individual Trust proportions ranged from 3.90% to 27.7%.

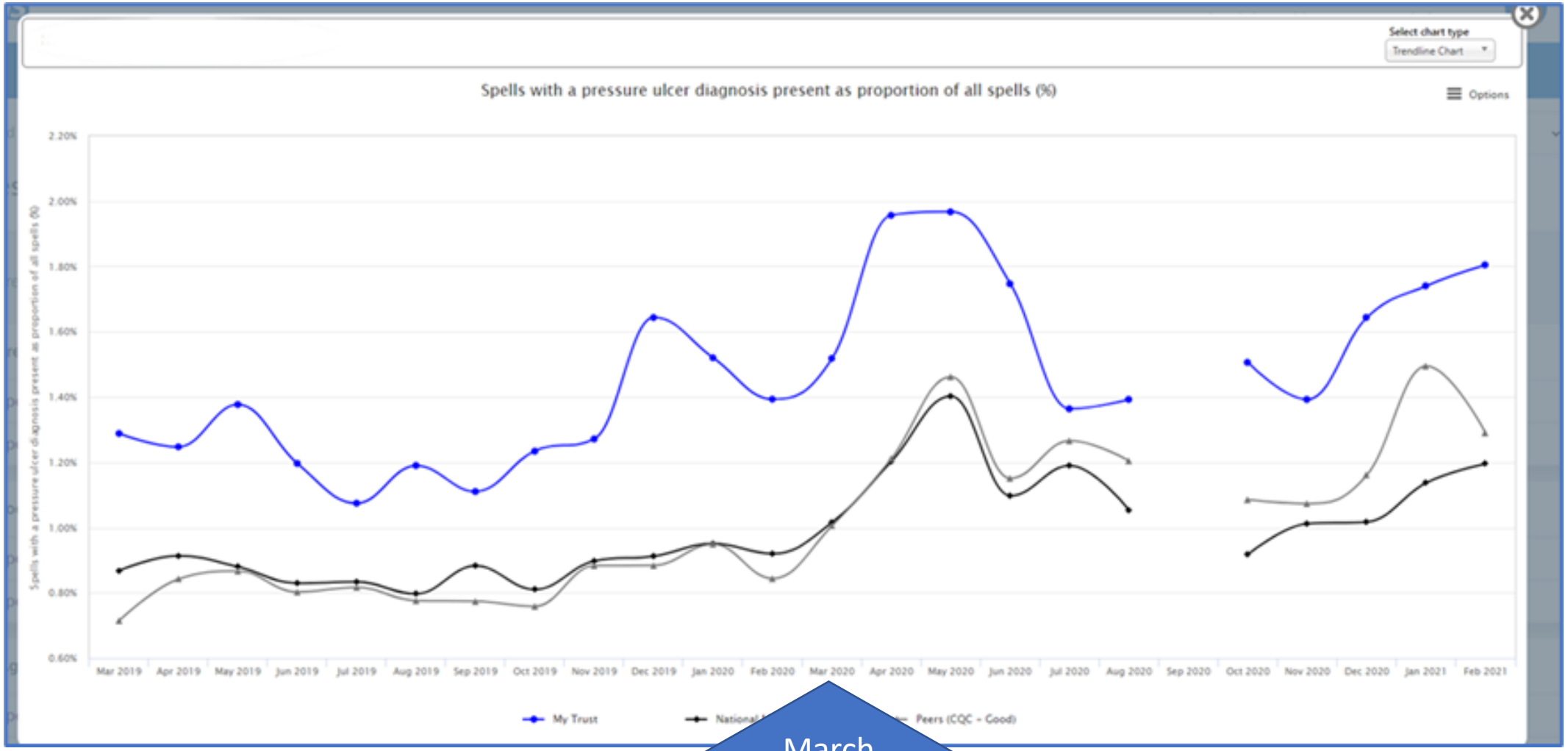
Stephenson and Fletcher 2020 available from https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/PU-audit-final.pdf

Quality of care - aSSKINg

Key elements of the aSSKINg bundle were measured.

- 7086 patients (69.8%) had a risk assessment completed within 6 hours.
- 6576 out of 8076 patients considered to be at risk (81.4%) had a care plan in place
- 5216 patients (51.3%) had a planned repositioning regimen in place.
- 26.9% of patients were incontinent.
- A variety of risk assessment tools were in use, with
  - Waterlow 56.6%
  - Braden/Braden Q 21.3%
  - PURPOSE T 9.44%.
- There continues to be over prescription of equipment with patients being allocated higher specification equipment than their risk score identifies and no clinical reason apparent.

What happened during COVID?



COVID and PU

- Proning patients
  - PU in positions previously uncommon as patients were:
    - Nursed face down
    - Not moved for up to 16 hours
  - Many more DRPU
- High numbers of respiratory patients
  - Nursed with high HoB elevation
  - Oedematous and sweaty
  - Increased shear forces through the sacral area
- Many staff translocated from their usual areas of practice
  - Discrepancies in knowledge & skills
  - Lack of familiarity with processes and policies

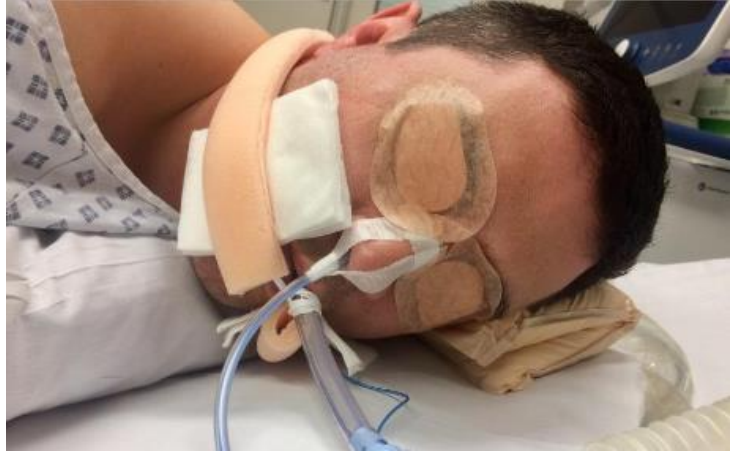
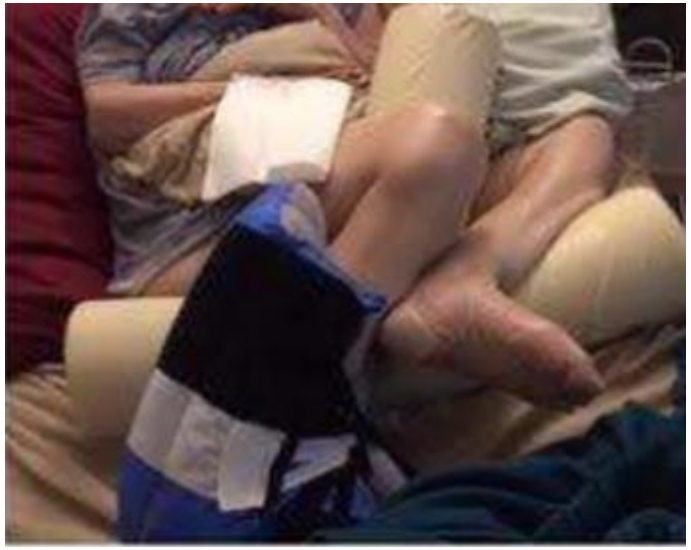


Image courtesy of Irena Pukiova OUH

Image used with patient's consent

COVID and PU

- In the community setting
  - Reduction in foot fall through patients' homes
  - Patients reluctant to seek help
  - Increase in severity of category
- In Nursing Homes
  - Reduction in patient contact
  - Increase in frequency and severity of contracture
    - 1 specialist unit identified that 30% of their patients had contracture



#Stop the Pressure

Stop the Pressure: Pressure Ulcer Surveillance

Aims

To develop a surveillance system that uses pressure ulcer data captured at the point of care (i.e. routine data collection) rather than requiring additional data collection which require additional resource. This will:

- Improve the quality of routine clinical data input through more accurate clinical coding and clinical record keeping.
- Improve the quality of pressure ulcer surveillance,
- May reduce TVN time spent on spontaneous incident reporting
- Support the long-term aim of improving the continuity of patient care across the local health system.

2021 Q3 and Q4

- Development of national metrics – secondary care
- Quality assurance and data improvement
- Education and training

2022 Q1

- Development of national metrics – community services

EDITORIAL

A brief history of pressure ulcer measurement in England: the last 20 years

JACQUI FLETCHER
Clinical Editor, *Wounds UK*

ANN JACKLIN
Lead for Digital, Data and Information Workstream, National Wound Care Strategy

UNA ADDERLEY
Director, National Wound Care Strategy Programme

Pressure ulcers (PU) have long been recognised as a challenge to healthcare, are a cause of significant pain and distress for patients and are costly for healthcare providers in term of finances and use of human resource (Guest et al, 2020).

This paper, the first in a series of three, describes the predominant methods that have been used to capture the prevalence of PUs in England over the last 20 years. The second paper will describe the proposed system for national PU measurement in England and the third paper will outline proposals for implementing this system to drive quality improvement.

BACKGROUND

Measurement of the occurrence of PUs (also known as pressure sores, decubitus ulcers, pressure injury and bed sores) has been a part of nursing activity for many years. The first paper on the epidemiology of what were then called pressure sores was published by Petersen and Bittmann in 1971. These initial audits aimed to identify the size of the problem to focus efforts on reducing occurrence through implementing the seminal work of clinicians such as Norton et al (1962). Since then, there have been many publications on this topic, seeking to identify the number of PUs occurring in specific organisations (Barbenel et al, 1977; Stevenson et al, 2013) as well as studies on specific populations such as intensive care (Chaboyer et al, 2018; Jacq et al, 2021), palliative care (Ferris et al, 2019), paediatrics (Delmore et al, 2020; Marafia et al, 2021), spinal injuries (Chen et al, 2020). There have also been larger scale studies across countries (Barrois et al, 2008, Gunningberg et al, 2013), or continents (O'Dea, 1995; Vanderwee et al, 2007; Moore et al, 2019). Recently, because of the COVID-19 pandemic, studies have been published reporting the pressure damage in health professionals related to personal protective equipment (Abukamn et al, 2020; Jiang et al, 2020).

Measuring pressure ulcers: prevalence and incidence

During this time, the most reported forms of measurement have been prevalence and incidence. Prevalence is the proportion of a population who have a specific characteristic in a given time period. Therefore, the prevalence of PUs is the proportion of a defined patient population with pressure damage during a specified time period. Incidence is the number of specified new events, during a specified period in a specified population. Therefore, the incidence of pressure damage is the number of people in a defined patient population who develop a new PU during a specified time period.

Prevalence of pressure damage is a good indicator of the overall burden and clinical workload related to pressure damage but does not identify when and where the PU occurred, how long it had been present, probability of healing or the cost of care (International Guidelines, 2009). As incidence only identifies new occurrences within the specified time frame, it provides a measure of the quality of care and can be used to help identify possible patterns relating to interventions such as quality improvement initiatives such as the introduction of new equipment or education (International Guidelines, 2009).

Although there are many publications reporting the results of audits and similar studies, unfortunately, these use a range of reporting approaches and definitions. (Box 1; Fletcher, 2001). This lack of a consistent, systematic,

Box 1. Examples of inconsistencies

- Data may be collected by reviewing patients notes, asking ward staff if damage is present or by inspecting patients' skin for evidence of pressure ulcers.
- Some audits include category 1 pressure ulcers, others do not.
- Inclusion/exclusion of 'avoidable' pressure ulcers.
- Inclusion/exclusion of device related pressure ulcers.

Surveillance system

EDITORIAL

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Paper 1

A brief introduction to national secondary care data sets and their use in capturing and reporting pressure ulcer occurrence

HAZEL NYAMAJIYAH
CNO Senior Clinical Fellow, NHS England and NHS Improvement
JACQUI FLETCHER OBE
Clinical Lead Pressure Ulcer Workstream National Wound Care Strategy Clinical Editor, *Wounds UK*
ANN JACKLIN
Lead for Digital, Data and Information Workstream, National Wound Care Strategy
KEN W DUNN
FRCS (plast), Advisor, Data, Digital and Information Group, National Wound Care Strategy Programme
UNA ADDERLEY
Director, National Wound Care Strategy Programme

Pressure ulcers (PU) are a long-standing challenge to health care, impacting on quality of life (QoL) and allocation of time and resources (Guest et al, 2020). The COVID-19 pandemic has posed additional challenges, and an increase in PU occurrence was identified during the first wave of the pandemic (Preshma, 2020). Cohesive data capture and reporting processes are crucial in underpinning any local or system wide quality improvement initiatives in PU prevention and care.

This paper is the second of a three-part series. The first paper in the series described the predominant methods that have been used to capture the prevalence of PUs in England over the last 20 years. This second paper describes the use of one of the secondary care data set, the Secondary Use Services (SUS) which will form the basis for a new PU reporting system in acute care. Work on community reporting will form a second phase of the project.

A third paper will describe the use of the Model Health System to report on PU metrics and to drive quality improvement in PU prevention and care.

Background

The Patient Safety Thermometer (STh), launched in 2010, was one of the largest and longest-lasting non-mandated data collection exercises in NHS history. It had a powerful impact in its early years (Power et al, 2016) but more recent evaluations (NHS, 2013), research (Armstrong et al, 2018) and feedback have shown that the data were incomplete (Smith et al, 2016) and it was no longer able to support improvement in the intended way. The STh was riddled with variation in interpretation of definitions and data collection and validation processes across NHS organisations (Coleman et al, 2016). Due to this lack of standardisation and under-reporting, the STh data was not suitable for commissioning or benchmarking purposes, or to underpin quality improvement initiatives (Smith et al, 2016; Coleman et al, 2016).

Following a public consultation as part of changes to the NHS Standard Contract (NHS, 2021), data collection for the STh ceased in March 2020. Many NHS organisations now use their local incident reporting systems for capturing and reporting on PU data but, as discussed in the first paper of this series, PU incident reporting data is not adequate for commissioning, benchmarking or quality improvement purposes.

This paper introduces the concept of using more suitable data sources for the purposes of capturing and reporting PU metrics. The proposed new system uses data from existing data sources, reducing the burden of data collection for clinical staff. This approach is in line with the draft '*Data saves lives: reshaping health and social care with data*' (DHSC, 2021) strategy, which sets out the NHS data ambition which includes reducing the burden of data collection on the frontline staff and improving data quality to inform decision making at local and national level. The first phase of this work covers acute care and the use of the Secondary Use Services (SUS). A second phase of the work will address reporting in community settings using the Community Services Dataset Submission (CSDS) and work to develop the use of this data set will commence in summer 2021.

DATA SETS

An introduction to SUS

When a patient or service user receives care from a secondary care service, data are collected that records this activity. The recorded data are sent to NHS Digital and stored in the SUS, which is a secure data warehouse that stores

Paper 2

Paper 3 – due for publication November 2021

https://model.nhs.uk

NHS

Model Health System
model.nhs.uk

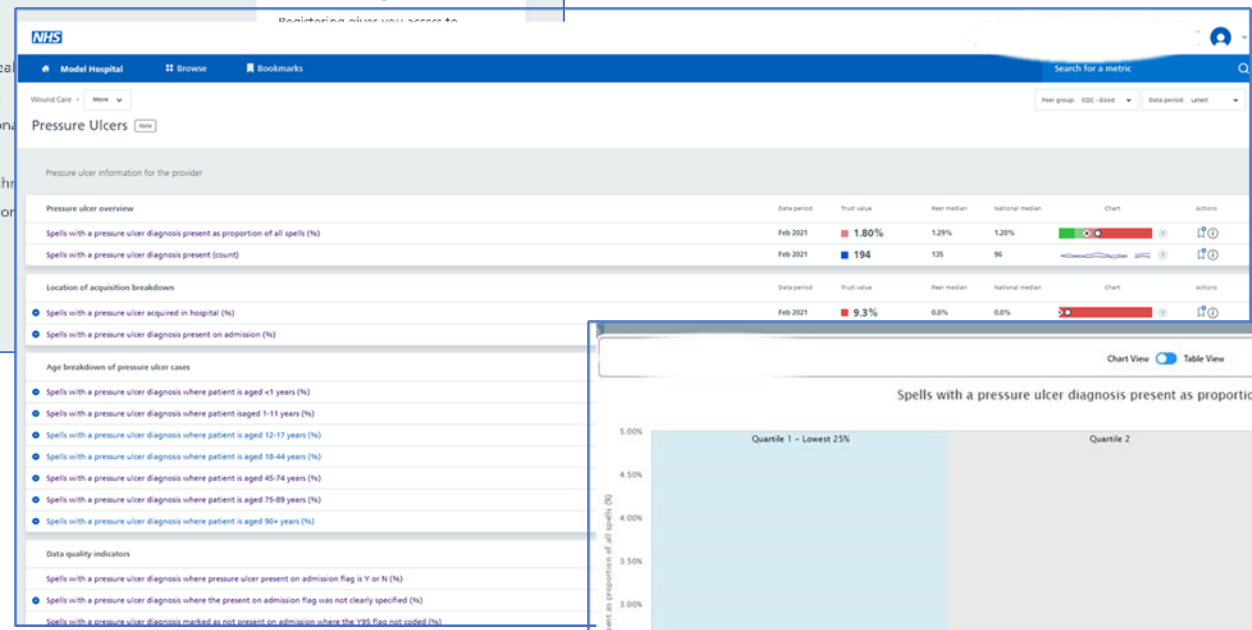
Supporting NHS teams to provide high quality patient care and continuous improvement.

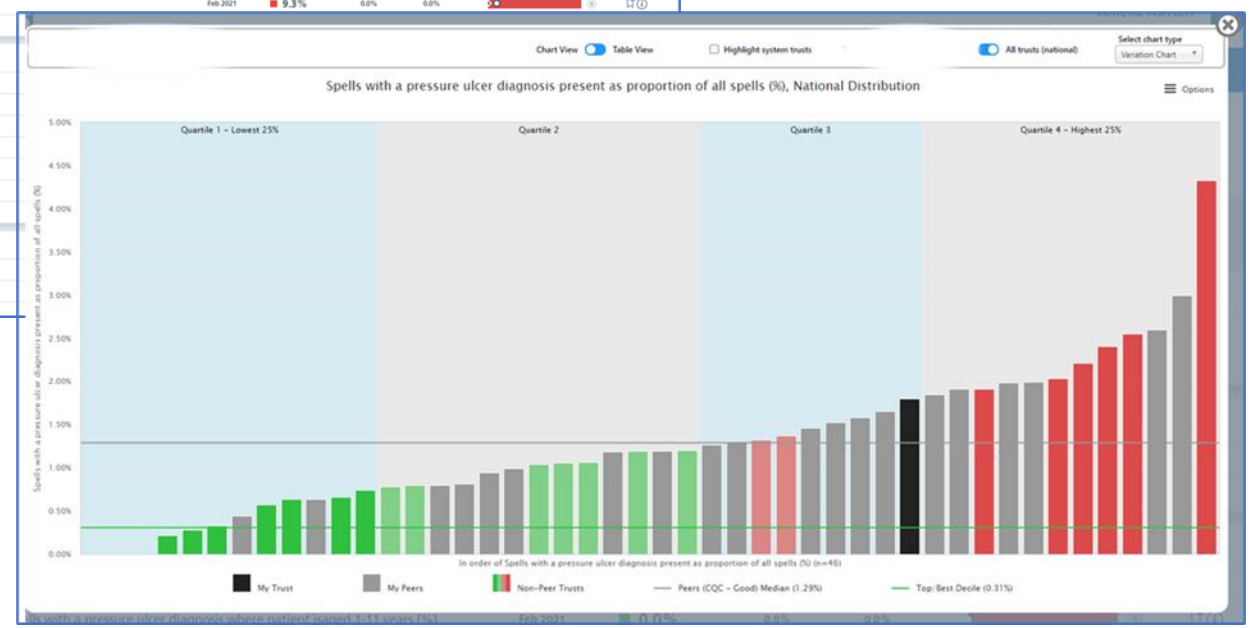
The Model Health System is a data-driven improvement tool that supports hea
care systems to improve patient outcomes and population health. It provides
benchmarked insights across the quality of care, productivity and organisationa
culture to identify opportunities for improvement. The Model Health System
incorporates the Model Hospital, which provides hospital provider-level benchr
Access to the Model Health System is currently available for all NHS commissior
providers in England.

Get help and further information

Register or log in

Click on the button below to register
via the portal Insights Platform.





Revision of definition and measurement

- To smooth out areas of discrepancy
  - When is it your patient?
- To address newly identified areas
  - When is it a recurrence and when is it new
- To reduce the workload around PU verification
  - Significant discussions around the use of the current categorisation system

Development of CNT & Standards

- The pathway and the standards are in draft format but not being sent for consultation until completion of Surveillance and D & M
- Alignment of wording!

Are you aSSKINg the right questions about Great Skin and Pressure Ulcer Prevention?

assess risk
Skin assessment and care
Surface selection and use
Keep moving
Incontinence and increased moisture
Nutrition and hydration
give information

#Stopthepressure
#aSSKINg
#LoveGreatSkin

International Stop the Pressure Day
Thursday 18th November
Please join us
#stopthepressure

@NHSresolution

NHS Resolution

Learning from claims virtual forum: Hospital Acquired Pressure Ulcers

Safety@resolution.nhs.uk

Learning from claims – hospital acquired pressure ulcers

Glenn Smith,
Advanced Nurse Practitioner
St Helens Medical Centre
Isle of Wight

@NHSresolution

Pressure Ulcer Prevention – Moments That Matter

Glenn Smith

Advanced Nurse Practitioner, St Helens Medical Centre,

Isle of Wight.

Pressure Ulcer Prevention Is Not Complex

- Most reasons that a care provider cannot prove that they have done everything possible to prevent a pressure ulcer come down to the basics.
  - Doing the right assessments at the right time
  - Making the right choices on the basis of those assessments
  - Clear, accurate, dated, signed documentation

The Five Moments of Pressure Ulcer Prevention

- “Five Moments” refer to key points of a patient journey
  - Admission to Caseload or care provider.
  - Change in Condition
  - Routine multidisciplinary review.
  - Change/handover between teams.
  - Discharge from care provider

Admission to caseload

- Risk assessment is essential
- Demonstrate that the risk assessment has informed the appropriate actions.
- Admission to caseload needs to include body map and photographs including wound descriptors and accurate measurements in mm on admission.
- Much litigation hinges on proving that the wound or skin condition was present on admission, and poor documentation is pivotal in preventing care providers demonstrating that they have fulfilled their responsibilities.

Change in Condition

- If you document a change in a patient's skin condition, it should trigger a thought process, particularly if it shows that the patient's skin is deteriorating.
- Change in Condition should indicate that what the care provider is currently doing is not adequate for preventing pressure ulcers and should be reviewed.
- Far too many occasions there is clear evidence that deterioration has occurred without the attendant change in care planning.
- Escalation is key. If you see it, tell someone about it. Tell everyone about it. Just make sure everyone knows that something needs to change.

Routine Multidisciplinary Review.

- Two heads are better than one, and many heads are often better than two when it comes to getting a rounded view of a patient’s risk.
- Multidisciplinary Review should be arenas in which all professional groups have the opportunity to contribute to the assessment of an individual’s risk.

Change/Handover between teams.

- Change between care providers or within care providers between teams should prompt reassessment from scratch.
- A fresh set of eyes may see things that a previous team did not.
- This is often the source of much disagreement between the observations of the patient.
- It should be an opportunity to review everything and not assume that the care being provided accurately reflects the patient’s needs.
- Also a change between teams often indicates a change in needs by itself so this needs to be taken into account and reflected in the assessment.

Discharge from Care provider.

- At the point of discharge, record the state of patient on discharge.
- This includes full body map description of wounds and photography if at all possible.
- Much controversy about pressure ulcer development happens at the point of discharge from care provider.
- There are often discrepancies between the description of the care by the claimants and those of the defendants.
- The more detailed the documentation the better.
- If the patient has capacity, they should if possible also be asked to sign that the documentation is accurate on discharge and that they understand their safety netting advice.
- Ensure that any discharge documentation is promptly available.

Key points.

- Document, document, and document.
- Manage the Five Moments of Pressure Ulcer Prevention – Admission, Change in Condition, MDT Review, Change in Team, Discharge.
- Show that change in the patient is reflected in change in their care planning.
- Ensure that guidance is clearly written and available to everyone.

Learning from claims – hospital acquired pressure ulcers

NHS Resolution

Dr Fania Pagnamenta,
Clinical Academic Nurse Consultant
(Tissue Viability)

Newcastle upon Tyne Hospitals NHS Foundation Trust

Faculty of Health and Life Science, Northumbria University, Newcastle

@NHSresolution

Tissue Viability provision at entry point

Dr Fania Pagnamenta RN

Clinical Academic Nurse Consultant

Tissue Viability, Newcastle upon Tyne Hospitals NHS Foundation Trust and
Faculty of Health and Life Science, Northumbria University, Newcastle
fania.pagnamenta@nhs.net

Background

- 700 000 patients are affected by PU each year
- 180 000 are newly acquired
- DATIX are completed for each patient admitted with existing pressure damage and/or new
- Accuracy of reporting remains poor
- Not knowing what a PU looks like on admission = unsure how it progresses
- Open to litigation

fania.pagnamenta@nhs.net

The Project

- Nurse Consultant Tissue Viability at front of house
- Wound care in this setting is complex
- Requires high level expertise
- Patients are screened on e-records
- All wounds (pressure ulcers, leg ulcers, skin tears, etc) are assessed, treated, care planned and referred to appropriate teams if necessary
- Diabetic Foot Ulcers – Advanced Podiatrist at front of house
- All wounds and skin problems are photographed by medical photography and uploaded on our electronic system

fania.pagnamenta@nhs.net

Outcome

- Improved care based on informal patients feedback
- Improved communication between settings
- Improved communication between Assessment Suite and wards
- Improved teamwork within multi-disciplinary health professionals.
- Development of clinical skills for RNs, ANs, APs, HCA
- Increased confidence amongst RNs to grade pressure damage accurately and report any skin damage
- Support to establish source of sepsis

fania.pagnamenta@nhs.net

Output

- (April 2020 – March 2021) **3787** patients were referred to TV

  1320 were seen in AS

- (April 2021 – mid-September 2021) **1952** patients were referred to TV. (3% increase in referrals)

- **34% seen in AS**

- Too soon to see if litigations have reduced

fania.pagnamenta@nhs.net

Patients satisfaction

- Patients describe how their wounds are dressed by different nurses who *'do it all differently'.*
- Literature suggests that this variation in care may be due to poor communication between staff and different settings [1].
- This initiative has seen an improvement in patient's satisfaction – anecdotal evidence

1 Adderley et al. 2017 Reducing unwarranted variation in chronic wound care. *WoundsUK* 13(4), 22-27

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Question Time

Learning from claims virtual forum: Hospital Acquired Pressure Ulcers

Safety@resolution.nhs.uk

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Question Time

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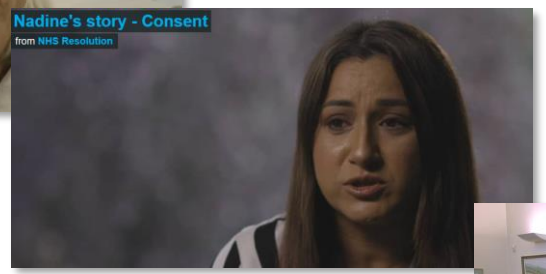
Summary - have we achieved our purpose?

- Sharing our data and learning insights on pressure ulcer claims
- Identifying service and quality improvements
- Learning new insights
- Safety@resolution.nhs.uk

A range of products for learning



Case story
Better joint working and specialist help benefits patients, families and the NHS

https://resolution.nhs.uk/resources/