Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 12 May 2021

TB2021.28

Title:	**Learning from a Serious Incident Requiring Review (SIRI)**

Status:	**For Information**
History:	**Regular Reporting**

Board Lead:	**Chief Nursing Officer**
Author:	**Natasha Walker, Ward Sister 6A. Supported by Heather Talbot, Matron for Specialist Surgery, Louise Johnson, Deputy Divisional Nurse, and Ria Betteridge, Tissue Viability Nurse Consultant**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The purpose of this paper is to demonstrate learning from previous practice and exemplify how change can be implemented.
2. In June 2020 a patient was reported to have been discharged home with multiple areas of significant Hospital Acquired Pressure Ulceration (HAPU). In response to this, the ward team, alongside senior nurses, identified areas of practice that required improvement and subsequent change to help prevent recurrence.
3. Since June 2020, the clinical team have demonstrated on-going learning and a change of culture; this has been evident in subsequent HAPU investigations.

Recommendations

4. The Public Trust Board is asked to:
    - Note the content of the story
    - Share good practice

Contents

Learning from a Serious Incident Requiring Review (SIRI)

1. Purpose

1.1. This paper presents the actions and learning that took place following a safeguarding concern raised by district nurses. This had related to a patient who reportedly developed category 4 pressure ulceration[1] whilst an inpatient at the John Radcliffe (JR) Hospital.

1.2. The purpose of this paper is to report our learning from this patient experience and demonstrate how the ward has worked together to implement change to prevent recurrence.

2. Background

2.1. This story combines the learning and reflections of nursing and the podiatry teams whilst supporting an acutely unwell and frail gentleman in his 80's. The gentleman was admitted to the JR in June 2020, towards the end of the first wave of the COVID pandemic.

2.2. This story particularly focuses on the care of the gentleman's Category 2, 3 and 4 hospital acquired pressure ulcers (HAPU).

2.3. A HAPU can result in a SIRI investigation (Serious Incident Requiring Investigation) being undertaken depending on the severity of the harm incurred. HAPUs can also be a safeguarding concern, depending on severity of harm and the vulnerability of the person concerned.

2.4. It is usual in these circumstances that one investigation is undertaken to maximise the team effort into learning and changing clinical practice. In this instance a SIRI was undertaken, and the questions required by the Section 42 enquiry were incorporated and then submitted to the Oxfordshire County Council as part of the Trust's duty under the Care Act 2014.

3. Story of investigation

3.1. On 30 May 2020, 'George' (not his real name), a gentleman in his 80's was admitted to the John Radcliffe Hospital from home following a 999 call, because he was acutely unwell.

3.2. Whilst George was being looked after in the Emergency Department the staff noticed that he had two category 2 pressure ulcers on his lower back.

[1] Pressure ulcers are caused when an area of skin and/or the tissues below are damaged as a result of being placed under sufficient pressure or distortion to impair its blood supply. Pressure ulcers are graded with increasing severity from category 1–4.

3.3. George was initially admitted to an acute medical ward but was transferred to Ward 6A as he was experiencing symptoms of COVID-19. Ward 6A is usually a vascular surgery ward, but due to the COVID-19 pandemic the ward was caring for patients suspected of having COVID-19. The ward comprised of a mixture of nursing staff from Ward 6A, Specialist Surgery Inpatient Unit and Orthopaedics.

3.4. On 17 June 2020 nursing staff noticed and documented that George had a suspected deep tissue injury (SDTI)[2] to the left medial malleolus[3].

3.5. The nursing staff made referrals to the Trust's Tissue Viability Team and to the inpatient Podiatry Team[4]. George was reviewed by podiatry the following day, who documented necrotic ulceration[5] to the left medial malleolus and necrotic damage to the right heel. George's feet were then re-dressed by podiatry.

3.6. On 24 June 2020, George was discharged home and a District Nurse referral was made detailing the SDTI to George's left ankle and the pre-existing category 2 pressure damage to his lower back.

3.7. On 8 July 2020, following concerns from George's District Nurses, the Trust received a request from the Oxfordshire County Council Safeguarding Team to undertake an investigation under Section 42 of the Care Act 2014[6].

3.8. The District Nurses raised a concern that suggested George had nine areas of pressure ulceration, including two category 4 pressure ulcers.

3.9. Upon receiving this enquiry an investigation was started by the Matron and Ward Sister.

3.10. Following investigation and discussions with the Podiatry Team, it was concluded that George was discharged home with four pressure ulcers: the two Category 2 pressure ulcers that were present on admission and detailed in the referral to the District Nurses and two Category 4 hospital acquired pressure ulcers (HAPU) that were not handed over to the district nurses.

3.11. The remaining five pressure ulcers reported by the District Nurses were confirmed by the Podiatry Team as being present on arrival or not pressure related.

3.12. During the investigation it became evident that the ward nursing staff were not aware of the necrotic pressure damage to George's feet. This damage was documented by the Podiatry Team but was not verbally handed over to the

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[2] Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister.
[3] A malleolus is the bony prominence on each side of the human ankle.
[4] A patient with any wounds below their ankles should be referred to the Podiatry Team.
[5] Necrotic ulceration refers to dead tissue
[6] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

nursing staff, and an incident report was not submitted. Due to significant dressings to both feet the nursing staff were not able to complete daily foot inspections. The dressings should not have been disturbed daily and only as required or as planned by the Podiatry Team.

3.13. George was discharged home from Ward 6A and the District Nurses were supported by the Community podiatry Team who continued to care for him.

4. How has this learning improved and shaped our practice?

4.1. There have been four areas of learning following this SIRI investigation, namely Training, Communication and Teamwork, Safety Huddles and FotoApp.

4.2. **Training**: Following this incident, training and re-education on pressure area care has been one of the Ward's main priorities.

It was felt that a refreshed approach should be used to gain focus in order to improve our patient outcomes and safety for future practice.

Risk assessments, including Braden[7] and MUST[8] should be completed within 6 hours of admission and weekly thereafter. Training by the Ward Sister, Clinical Practice Educator and link nurses has been provided to the whole team to ensure everyone had the required knowledge and skill needed to complete these assessments accurately and appropriately.

The Tissue Viability Link Nurse provided training on the completion of SKINS[9] assessments, which must be completed once per shift, to ensure a full skin inspection and remedial interventions are in place.

From subsequent pressure ulcer investigations, we have found 100% compliance with the completion of SKINS assessments.

The Podiatry Team provided training on identification and prevention of pressure ulcers to the feet and the importance of heel offloading[10] on several occasions to reach as many members of the team as possible.

Prompt Cards were given to each member of the team, to help them with categorisation of pressure damage.

Finally, the Podiatry Team and Ward Sister decided that the ward should use Prevalon boots[11] for all high-risk patients to help reduce the incidents of

[7] Braden assessments give patients a score which determines their risk of developing pressure ulceration.
[8] MUST- Malnutrition Universal Screening Tool. This allows nursing teams to identify if patients are at risk of malnutrition.
[9] SKINS is an acronym used to prevent pressure damage, it stands for Skin Inspection, Keep moving, Incontinence and moisture management, Nutrition and Surface.
[10] Heel offloading involves lifting the heels off the surface of the bed using either pillows or special devices to avoid pressure damage.

pressure damage. The Podiatry Team have trained the Ward Sister on how these should be used, who then cascaded this information to the rest of the team. The Education Team also provided training on the completion of district nurse referrals, to ensure they reflect all necessary information relating to pressure damage and the patients care needs.

4.3. **Communication and Teamwork**: Communication between the nursing staff and the Podiatry Team has now greatly improved.

Previous to this incident it was noted that the Podiatry Team would review their patients and document in the patient's notes but may not verbally communicate the findings with the nursing staff on duty.

The nursing and Podiatry Teams are now working more closely and cohesively together. Previously, the Podiatry Team would rely on the nursing staff to report incidents if they found pressure damage while reviewing a patient. This led to miscommunication between the two teams, and neither could be sure whether an incident report had been completed.

To avoid recurrence in future the Podiatry Team decided to report all pressure damage that was discovered by their team. They would then inform the ward coordinator of the incident number to ensure this is added to the nursing handover sheet.

This has had a significant impact on the ward practice, as it is now clear whether each patient's pressure damage has been reported. The Podiatry Team attend Ward Rounds[12] on Tuesdays and Thursdays, which has provided great support to the ward team. This allows for regular education and communication as well as ensuring appropriate care plans[13] are in place for all patients including interventions such as repositioning and heel offloading.

4.4. **Safety Huddles:** Safety Huddles[14] were already embedded on the Ward and they were used to improve communication and escalation of safety concerns could help to prevent future HAPU.

A Safety Huddle provides a prompt for the Coordinator to remind all nursing staff that risk assessments must be completed, along with a reminder to escalate any patient-related safety concerns. This has been particularly helpful for subsequent pressure ulcer investigations where patients have declined care aimed at preventing pressure damage.

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[11] A soft comfortable boot designed to lift the heel off the mattress and therefore minimising pressure on the heel.
[12] Ward Rounds are completed daily with the medical team and nurse coordinator where the patient is reviewed, and a plan is put in place.
[13] A nursing care plan is a part of the nursing process which outlines the plan of action that will be implemented during a patients' medical care**.**
[14] A short multi-professional briefing held at a regular time and place in both clinical and non-clinical areas, focusing on patient and staff safety.

A recent example of this was related to an incident of patient who developed a Category 3 HAPU to his sacrum and refused a dynamic mattress[15] or preventative repositioning schedule. The nursing staff ensured that he had appropriate and timely referrals to the pain and psychological medicine teams and then followed the advice provided as this was thought to be contributing to his resistance to repositioning and preventative care. This was all well documented in his notes.

4.5. **FotoApp**: The use of the FotoApp[16] has made a considerable difference to our practice. Staff can easily log into the FotoApp via appropriate phones or the ward iPad and with the consent of the patient they can upload multiple pictures direct to EPR.

In subsequent pressure ulcer related investigations this has helped support accurate classification, as the photographs can be taken earlier and are easily accessed by multiple health care professionals through EPR.

5. Staff Reflections

Ward staff have found that their practice has changed as a result of the actions from this SIRI investigation. Staff were recently asked to reflect on the changes since this incident and their comments are captured below.

[15] A mattress designed for assisting the healing of pressure sores can rapidly prevent the problem from worsening.

[16] The Fotoapp can be downloaded on to ward iPads and allows nursing staff to take photographs of their patients pressure areas allowing for better documentation.

Vascular Specialist Nurse:

"As a result of the shared learning, I consider that staff have really benefited from the measures we have put in place to address the deficits in care which were revealed during the initial investigation and the sharing of the learning.

During my tissue viability audit time I have noticed a considerable improvement in the quality of information provided within the patient's skin assessments both on the point of a patient's admission and also during their future skin assessments and within the nursing evaluations.

The level of compliance in completion of preventative pressure ulcer care plans also improved.

The safety huddle encourages a holistic review of patients, prompting staff to raise any concerns about patient's pressure damage or need for additional equipment or resources. The board round also provides the opportunity for patients' nutritional needs to be reviewed and optimised by prompting referrals to the Speech and Language Therapy Team or dietetics."

Staff Nurse:

"Following on from training, documentation has improved to include whether heels are offloaded and documentation over patient compliance.

Safety huddles allow for better communication between the multi-disciplinary team including the podiatry team for better advice on wound management and classification of pressure ulcers."

Nursing Assistant:

"Pressure area care is the responsibility of everyone giving direct care to patients.
For us NA's, it is important that we are made aware of such information so that we can help in providing proper care to patients who are at risk or have developed inherited pressure damage.

Most importantly, communication and teamwork allow us to provide best practice."

Deputy Divisional Nurse:

"It has been so fantastic to see the learning from this incident in subsequent HAPU investigations. The Vascular patients are extremely high risk of pressure damage and I have been overwhelmed with how evident the learning has been when we have met with the 6A team in other HAPU Patient Safety Team response visits, albeit virtual at the present time!"

6. Recommendations and Action Plan

6.1. Please refer to Appendix 2 for the action plan.

6.2. Appendix 2 demonstrates that we have achieved100% compliance with our action plan and recommendations.

6.3. Appendix 3 outlines the position of the Trust in relation to the reporting of Hospital Acquired Pressure Ulceration (HAPU) in a recent Clinical Governance Committee paper ‘Learning from a Serious Incident Requiring Review’.

7. Conclusion

7.1. The ward team has demonstrated significant learning and rapid improvements were made as a result of this SIRI investigation.

7.2. There has been an increase and refreshed approach to creating awareness of HAPUs.

7.3. Ownership and leadership from the nursing team has resulted in improvements in the quality of our patient care delivery.

7.4. It also showcases the benefits of collaborative and multidisciplinary working.

7.5. This learning has been evident in subsequent HAPU investigations and has become embedded within the team function.

8. Recommendations

8.1. The Public Trust Board is asked to:

- Note the story
- Share learning

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APPENDIX 1: Safety Huddle Form

Date: 1st April 2021

Ward 6A Safety Huddle

Please ask the following questions at the safety huddle and initial when complete:

Have staff taken or plan to take their breaks? .....
Have staff checked their patients pressure areas today and heels offloaded if necessary? .....
All patients on correct mattress and is it working correctly? .....
Are there any outstanding tasks for patients? .....
Are there any safety concerns that need to be escalated to a senior nurse? .....

Early Shift: Claire

Patient initials	Bed Number	Trigger score	Actions and outcome

Late Shift: Claire

Patient initials	Bed Number	Trigger score	Actions and outcome

Night Shift: Emma

Patient initials	Bed Number	Trigger score	Actions and outcome

Natasha Walker-Ward Sister 2020

Appendix 2: Recommedations and Actions

No.	Recommendation	Action	Evidence	Responsibility	Deadline	Progress Update
1	To develop a (re)education programme to include the following: • Prevention of development and deterioration of pressure ulcers • Braden and skin assessments • Wound assessment and management • Heel off loading	In house training for all staff to include identifying and treating pressure ulcers, accurately completing the Braden, wound and skin assessments and the importance of heel off loading. The Podiatry Team came to the ward and training took place on 24 September, 1 October, 6 October and 15 October 2020. The Ward Sister and Tissue Viability Nurse (TVN) also provided in house training on the use of Prevalon boots and their contraindications. This training took place daily for 2 weeks in October 2020.	A register will be kept for all training. Audits to show completion of all nursing assessments to demonstrate 100% compliance.	Ward Sister	All Ward staff completed by 31 December 2020.	Complete.

2	To utilise safety huddles and board rounds to identify patients at risk of developing pressure damage or malnutrition to wider team.	Safety Huddles to be occur daily and led by the nurse in charge. A safety huddle form to be completed (appendix 1) on each shift to include a prompt for all nurses to have checked their patients pressure areas and ensure all risk assessments up to date and escalate any concerns.	Audits of safety huddles and board rounds – Aim 100% compliance.	Ward Sister	31 December 2020.	Audits show 100% compliance.
3	All nursing staff to be trained to use Fotoapp so photos can be taken of pressure damage.	Ward Sister to provide training to all Deputy Sisters who can the cascade this to their teams. The Fotoapp should be used for all areas of pressure damage when medical photography is unavailable.	Audit of use of the app in response to any pressure damage reported.	Ward Sister	31 December 2020	All Deputy Sisters have received training in the use of the Fotoapp.
4	To ensure all nursing staff follow Trust policy to complete MUST assessment within 6 hours and then weekly thereafter.	Refresher training for all staff on how to complete MUST assessments and when to refer to specialist teams. This was completed by the MUST link nurse and ward educators on 25 November 2020. Weekly audit until consistently achieving 100% compliance and then monthly thereafter.	Training register Audit results	Ward Sister Ward Sister	31 December 2020 31 December 2020	Complete

5	Podiatry to attend ward rounds and safety huddles.	Invite podiatry team to attend ward rounds and safety huddles to ensure appropriate inspection of patient's heels and feet. The Podiatry Team will aim to attend ward rounds on Tuesday's and Thursday's and will report any new pressure damage to Ulysses.	Record of safety huddle kept by nurse coordinator.	Podiatry Team, Ward Sister	31 October	Complete
6	Discharge must be safe and appropriate for all patients.	EPR discharge checklist to be followed to include line removal. Documentation training completed by education team and email information sent to all staff. Training to ensure nurses give an accurate nursing handover to district nurses including the condition of patient's pressure areas and wound assessment. Deputy Sister's to read all district nurse referrals to ensure they contain all information relating to pressure damage.	Audit Audit of District Nursing letters	Ward Sister and Clinical Practice Educator. Ward Sister and Clinical Practice Educator	31 December 2020 31 December 2020	Complete

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Appendix 3

Clinical Governance Committee Meeting

Meeting: 45T

Title:	**Learning from a Serious Incident Requiring Review (SIRI)**

Status:	**For Information**
History:	**Previous Report to Patient Safety and Clinical Risk Committee**

Board Lead:	**Chief Nursing Officer**
Author:	**Melanie James & Ella Reeves Confidential: No**
Key Purpose:	**The purpose of this paper is to inform the Clinical Governance Committee of the position of the Trust in relation to the reporting of hospital acquired pressure ulceration and the continuing work undertaken to reduce overall incidents.**

Table of content

Learning from a Serious Incident Requiring Review (SIRI)

5. Purpose

The purpose of this report is to inform the Clinical Governance Committee of the position of the Trust in relation to the reporting of hospital acquired pressure

ulceration and aims to assure the committee of the arrangements for the monitoring and oversight for closure of associated action plans and the continuing work undertaken with the aim of reducing overall incidence.

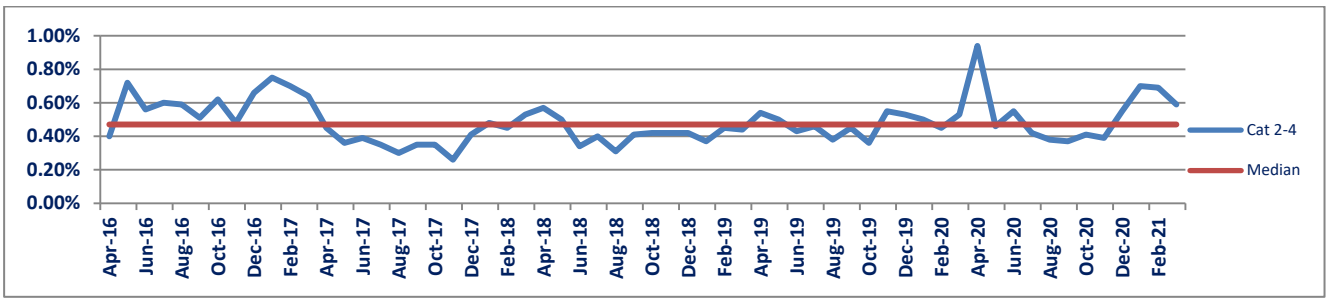
6. Background

Pressure ulceration is categorised as per the Trust's Pressure Ulcer Prevention Policy (2019), utilising the EPUAP categorisation tool, Category1 pressure damage, presenting as unbroken areas of non-reactive hyperaemia, through to Category 4, full thickness tissue loss. On discovery of Category 1 pressure damage or above, the clinician identifying the damage must report as a clinical incident on Ulysses. Patient throughput numbers are acquired from Informatics and incidence figures are currently calculated and analysed by the Nurse Consultant for Tissue Viability. This paper is presented from the Harm Free Assurance Forum as a regular bi-annual report.

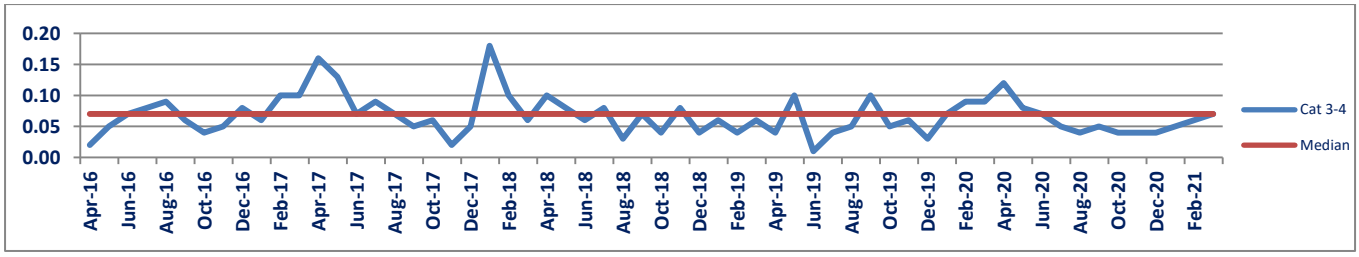
7. Main Paper

There is no current National benchmarking platform with which to compare the incidence data. Issues surrounding different reporting practices within different organisations further limit the benefits of such systems. The OUH have a record of full, clear and transparent reporting for HAPU, as reflected in the reported numbers and absence of missed incident reports from other providers. Methods of measuring improvement in specific clinical areas will be explored, such as QI programmes and agreeing KPIs to target incident reduction.

Graph 1: Hospital Acquired Pressure Ulcer Category 2-4 incidence, April 2016 to March 2021



Graph 2: Hospital Acquired Pressure Ulcer Category 3 and 4 incidences, April 2016 to March 2021



The graphs above show the incidence of HAPU over the past 4 years. An increase in the incidence of all incidents during April and May 2020 may be related to a reduction in admission numbers over the same time period ranging from approximately 8k to 10K, which may have adversely affected incidence figures in early Q1, but supports a continued culture of safety and reporting. Increases in reporting may also be associated with the organisational pressure on the system due to Covid-19 peaks in December, Jan and Feb when admission numbers remained around 16K a month. The increase in incidence is noted to be more sensitive to the reporting of Category 2 pressure damage, which may not all have been verified by the Tissue Viability team due to clinical workload during peak times.

Table 1: Medical Device Related Pressure Ulcers (MDRPU) as a subset of reported incidents April 2020- March 2021

Incidents	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Cat 1 - MDRPU	4	4	5	6	4	10	7	17	11	7	12	7
Cat 2 - MDRPU	18	7	8	15	5	7	18	13	19	31	30	18
Cat 3 - MDRPU	3	2	1	1	2	3	4	2	1	1	2	5
Cat 4 - MDRPU	0	0	0	0	0	0	0	0	0	0	0	0
Mucosal - MDRPU	7	12	4	10	5	5	3	8	16	13	12	8
Total	32	25	18	32	16	25	32	40	47	52	56	38
Cat 2-4 and Mucosal	21	9	9	16	7	10	22	15	20	32	32	23

The table above outlines the incidents that were associated with a medical device, as a subset of the reported incidents. The associated devices vary in function from posture and anatomical alignment devices, such as casts, urinary catheters, oxygen delivering devices, glasses and nasogastric tubes. It is noted that there was a considerable increase in device related pressure damage associated with peak Covid-19 pressures, specifically Category 2 and mucosal pressure damage.

Table 2: Category 3, 4 and full thickness mucosal HAPU levels of investigation

Incidents Cat 3&4	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Local	10	7	8	7	7	8	8	9	10	8	12	13
Divisional	0	1	0	0	0	0	0	0	0	0	0	1
Serious Investigation	0	0	0	1	0	1	0	0	0	1	0	0
Total	10	8	8	8	7	9	9	9	10	9	12	14

All verified category 3, 4 and full thickness mucosal HAPU follow the Trust processes for reporting Moderate Harms. These incidents are monitored with oversight from the Harm Free Assurance Forum. Investigations have been undertaken for all these incidents and 30 day action plans agreed with the Divisional Teams.

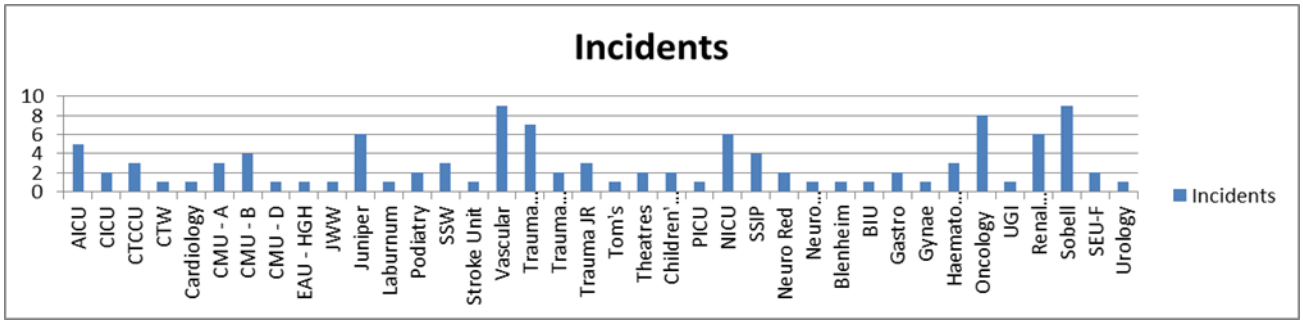
8. Harm Free Assurance Forum

This oversight and improvement group is chaired by the Chief Nursing Officer. The principle focus is of the quality of care and reduction in Harms related to HAPU, Falls and Nutrition and Hydration. The group is represented by all Divisions, Allied Health Professionals, and the education team, the Clinical Commissioning Group's (CCG) Quality Improvement Manager, Safeguarding and Trust's Patient Safety Team along with the Specialist Leads. The forum convenes monthly and the group monitor the progress of the action plans and escalates any issues identified in care delivery or support.

Following confirmation of a HAPU Category 3 and above (or moderate harm mucosal) a Patient Safety Response Review is conducted that includes the Ward Leader, or deputy for the area, Matron, Divisional Director of Nursing, or deputy, CGRP and a senior member of the Tissue Viability Team to review a 72 hour report with the aim of identifying opportunities for learning and any associated good practice.

In the past year, three patients have developed Category 4 pressure damage as inpatients. All were classified as Serious Incidents and have been submitted to the CCG.

Chart 1: HAPU Category 3 and 4 by clinical area April 2020 to March 2021



Work is currently underway to establish a Ward to Board dashboard that will dynamically display data to enable Divisional teams to report by exception. It is proposed that this will highlight clinical areas that demonstrate consistent improvement and those in need of differing levels of support.

9. After Action Reviews

The action plans from the Moderate Harm HAPU are reviewed and closed at After Action Reviews held with the Divisional teams in order to capture wider learning that is reported to the Harm Free Assurance Forum. This has resulted in 2 x Safety Alerts communicated across the Trust for Device and heel related incidents. Further modes of communication are being explored in order to disseminate wider learning. Themes are collated and result in collaborative improvement actions.

Identified Themes From Investigations:

- Darker coloured bedside curtains have been identified as inhibiting thorough skin assessment, especially in patients with darker skin tones.
- Patient seating needs to be regularly checked and appropriate seating selected
- Bed angles should be below 45 degrees to reduce the pressure on the sacral and buttock area
- Early identification of Category One pressure damage improves outcomes and reduces risk of deterioration of the skin
- Changes to nurse staffing, results in inconsistent approaches to prevention and care delivery
- Devices can cause significant damage to the tissues below, this includes patients own equipment such as glasses.
- Inaccurate assessment and ineffective care planning result in inconsistency of care delivery

10. Trust Level Actions:

- **A service evaluation** has been proposed to review the outcomes of patients cared for in the prone position in Critical Care from March 2020/March 2021. A funding bid to the Research Capability Fund (RCF) has been approved to support this project and will be led by the Nurse Consultant in Tissue Viability and Senior Clinical Academic Physiotherapist.

- **The Annual Pressure Ulcer Prevention Clinical audit** was undertaken in October 2020 conducted utilising the “My Assurance” platform. The audit examined the compliance with the Trust Pressure Ulcer Prevention Policy. The full audit report was presented at the Clinical Effectiveness Committee in February 2021, and showed a significant improvement in documentation. The My Assurance platform hosts a short version pressure ulcer prevention audit that can be undertaken by clinical areas as per their own identified schedules.

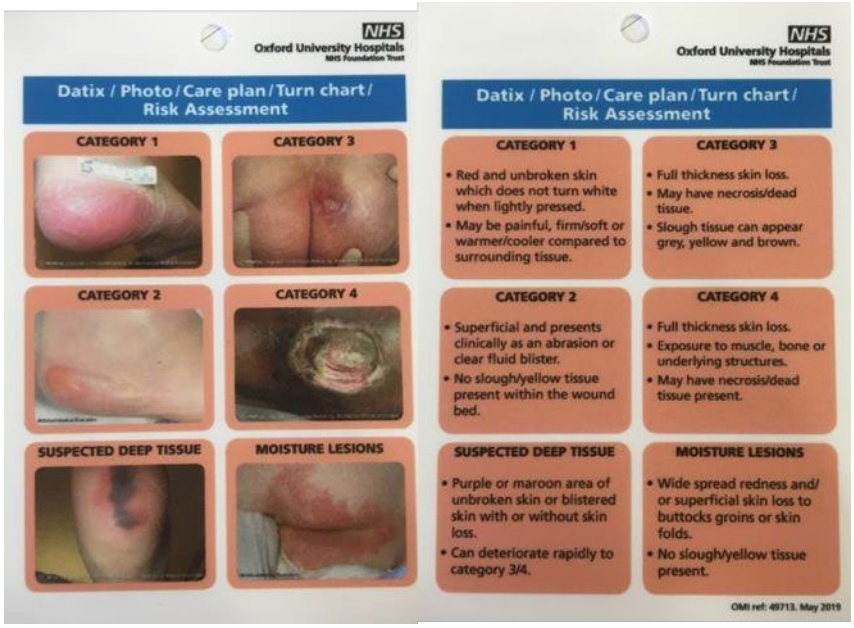
- **Stop the Pressure:** International pressure ulcer prevention awareness day (19th November 2020). The Tissue Viability and Podiatry teams collaborated to organise short sessions to raise awareness of foot health and the benefits of good patient positioning using QR codes.

- **Resource documents for the prevention of pressure damage** have been reviewed by the Tissue Viability team and updated by OMI. The revised

documents are available electronically on the Tissue Viability Intranet site and available in print form from the OMI print room. These have been circulated to all clinical areas along with an “at a Glance” summary of the Pressure ulcer prevention Policy.

- **The Tissue Viability Team** has met with the clinical team at Katherine House Hospice regarding governance, education and support related to Tissue Viability and pressure ulceration. A training plan has been agreed to support the transition to the new systems of working and commences in April 2021.

- **Categorisation of pressure damage:** Categorisation of pressure damage has been identified as an area for clinical support. The TV team secured funding for the design and distribution of the categorisation card below. This card was designed by a Nursing Assistant from SEU who identified an issue in language used to describe the damage for non-registered nurses. Over 3000 cards have since been distributed to clinical teams. Continual focus on early identification of pressure damage is vital in reducing the incidents of more significant pressure ulceration.



- **The pressure ulcer prevention E-Learning module** is hosted on the My Learning Hub platform. It is recommended that all patient facing clinicians complete this Module every 3 years.

  Compliance with completion of the module for those applicable in January 2021;

Division	% Compliance
CSS	90%
MRC	87%
NOTTSCAN	86%
SUWON	89%
All	**87%**

- **Medical Device Related Pressure Damage:** Medical Devices continue to be associated with approximately 33% of all reported pressure damage, this reflects published evidence. A project group has worked to develop specific resources to support staff training and awareness (including collaborative work with NHSi). This has led to increased reporting of Device Related Pressure Ulcers (DRPUs).

- **Pressure redistributing equipment** provision has been reviewed and a Business case approved to improve the availability and quality of the products available. A new contract is in the process of being signed with an implementation plan scheduled from April/May 2021.
  In March 2021, a significant investment was made to supply 1100 patient chairs to replace the existing. All chairs ordered for this project had integral pressure redistributing cushions as standard and the majority were height adjustable. Ongoing monitoring of the condition of patient seating is recommended.

- **Heel damage**: An updated information poster has been developed and distributed to clinical areas review in association with the Podiatry team following recent incidents. A teaching package is being developed to support the effective repositioning of patients to relieve pressure. Further work is scheduled to look at the quality of patient pillows in circulation to measure their ability to provide effective comfort and off-loading capabilities.

- **Documentation and Care planning**: A consistent theme from all investigations continues to be lack of appropriate nurse/ medical care planning. Care planning is essential to communicate interventions and support in order to reduce the risk of pressure ulcer formation or deterioration of pre-existing damage. A review of the standards of care and associated nursing documentation has been proposed and forms a strand of the NMAHPs strategy.

- **Monitoring Interventions:** The inconsistent documentation of care delivery and planning related to the above themes was common. Lack of care panning reflecting the patient needs results in unwarranted variation of remedial interventions.
  A schedule of audits will be approved and delivered in Q1 2021. Documentation audits and monitoring of compliance remain the responsibility of the Ward Sisters and Matrons.

11. Conclusion

This report highlights the incident analysis, governance and ongoing work of the Trust to address the issues related to Hospital Acquired Pressure Ulceration (HAPU) in an ambition to significantly reduce incidence of Category 2-4 by 25% in 2021/22, based on 2019/20 outturn data and increase the reporting of Category one skin damage by 25% based on 2020/21 outturn data. This will be supported and communicated by a Trust-wide quality improvement campaign.

12. Recommendations

The Clinical Governance Committee is asked to note the content of this Report.