Patient Safety Webinar Quarter 2 2023

16 November 2023

Welcome. Thank you for joining us today.

We are just setting up. Please do mute yourselves while joining or during presentations. (We may mute you on entry – this is not an audio fault, and you can of course unmute yourself any time).

Please introduce yourself in the Chat Box by full name and organisation and please make use of it throughout for Q&A.

Time	Item	Presenter(s)
13:00	Welcome and Introductions	Julia Russell, Senior Clinical and Quality Improvement Manager, Hospice UK
13.05	Wound Care Strategy updates National Wound Care Strategy Programme - The AHSN Network	Jacqui Fletcher OBE Senior Clinical Advisor The ASHN Network
13.25	Purpose T Risk Assessment Case study	Faith Slater Clinical Practice and Quality Improvement Nurse St Wilfrid's Hospice
13:45	Pressure Ulcer – QI project	Lynn Cornish Tissue Viability Lead St Margarets Hospice Care
14:10	Questions about a Falls Audit	Carina Lowe Hospice Lead Nurse Katherine House Hospice
14.20	Patient Safety Data	Julia Russell, Senior Clinical and Quality Improvement Manager, Hospice UK
14:30	Summary & Close	Julia Russell, Senior Clinical and Quality Improvement Manager, Hospice UK

Jacqui Fletcher OBE
Senior Clinical Advisor Stop the Pressure Programme / National Wound Care Strategy
NHS England

National Wound Care Strategy Programme

Pressure Ulcers

Pressure Ulcer Update

Jacqui Fletcher

Clinical Lead Pressure Ulcers

Working in partnership with

The AHSN Network

NHS

Overview of activities

- Clinical pathway and recommendations
- PSIRF Changes
- Stop the Pressure activities

Clinical recommendations and pathway

- The clinical pathway identifies what good looks like and offers an evidence-informed standardised pathway of care to guide care to prevent and manage pressure ulcers in England.
- It demonstrates what best practice should look like and is based on
  - the NICE Clinical Guideline: Pressure ulcers: prevention and management,
  - the NICE Quality Standard: Pressure ulcers and updated using
  - the EPUAP Pressure Ulcer Guidelines

The recommendations

- Changes the language about categories
- Recognises the treatment of pressure ulcers needs to be evidence based
- Highlights the need to focus on PU healing as well as prevention

National Wound Care Strategy Programme

Pressure Ulcers

Pressure Ulcer Clinical Recommendations and Clinical Pathway

August 2023

Working in partnership with

TheAHSNNetwork

NHS

25 August 2023

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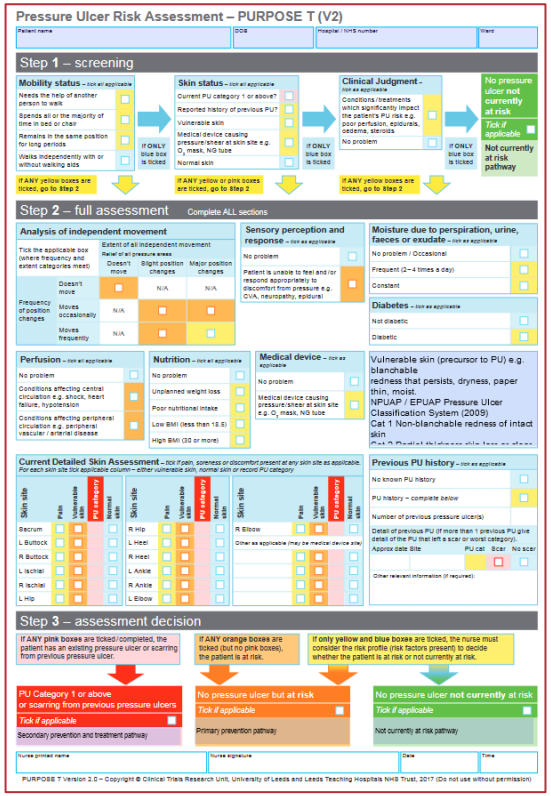
https://www.nationalwoundcarestrategy.net/pressure-ulcer/

3 main tools



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Patient name | DOB | Hospital / NHS number | Ward

Step 1 – screening

Mobility status – tick all applicable
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If ONLY blue box is ticked

Skin status – tick all applicable
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – tick as applicable
- Conditions /treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If ONLY blue box is ticked

No pressure ulcer **not currently at risk** – *Tick if applicable*

Not currently at risk pathway

If ANY yellow boxes are ticked, go to Step 2 | If ANY yellow or pink boxes are ticked, go to Step 2 | If ANY yellow boxes are ticked, go to Step 2

Step 2 – full assessment Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement: Doesn't move	Slight position changes	Major position changes
Doesn't move		N/A	N/A
Moves occasionally	N/A		
Moves frequently	N/A		

Sensory perception and response – tick as applicable
- No problem
- Patient is unable to feel and /or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – tick as applicable
- No problem / Occasional
- Frequent (2– 4 times a day)
- Constant

Diabetes – tick as applicable
- Not diabetic
- Diabetic

Perfusion – tick all applicable
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – tick all applicable
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – tick as applicable
- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category*

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum				
L Buttock				
R Buttock				
L Ischial				
R Ischial				
L Hip				
R Hip				
L Heel				
R Heel				
L Ankle				
R Ankle				
L Elbow				
R Elbow				

Other as applicable (may be medical device site)

Previous PU history – tick as applicable
- No known PU history
- PU history – *complete below*
- Number of previous pressure ulcer(s)
- Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category). Approx date Site | PU cat | Scar | No scar
- Other relevant information (if required).

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable
Secondary prevention and treatment pathway

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk
Tick if applicable
Primary prevention pathway

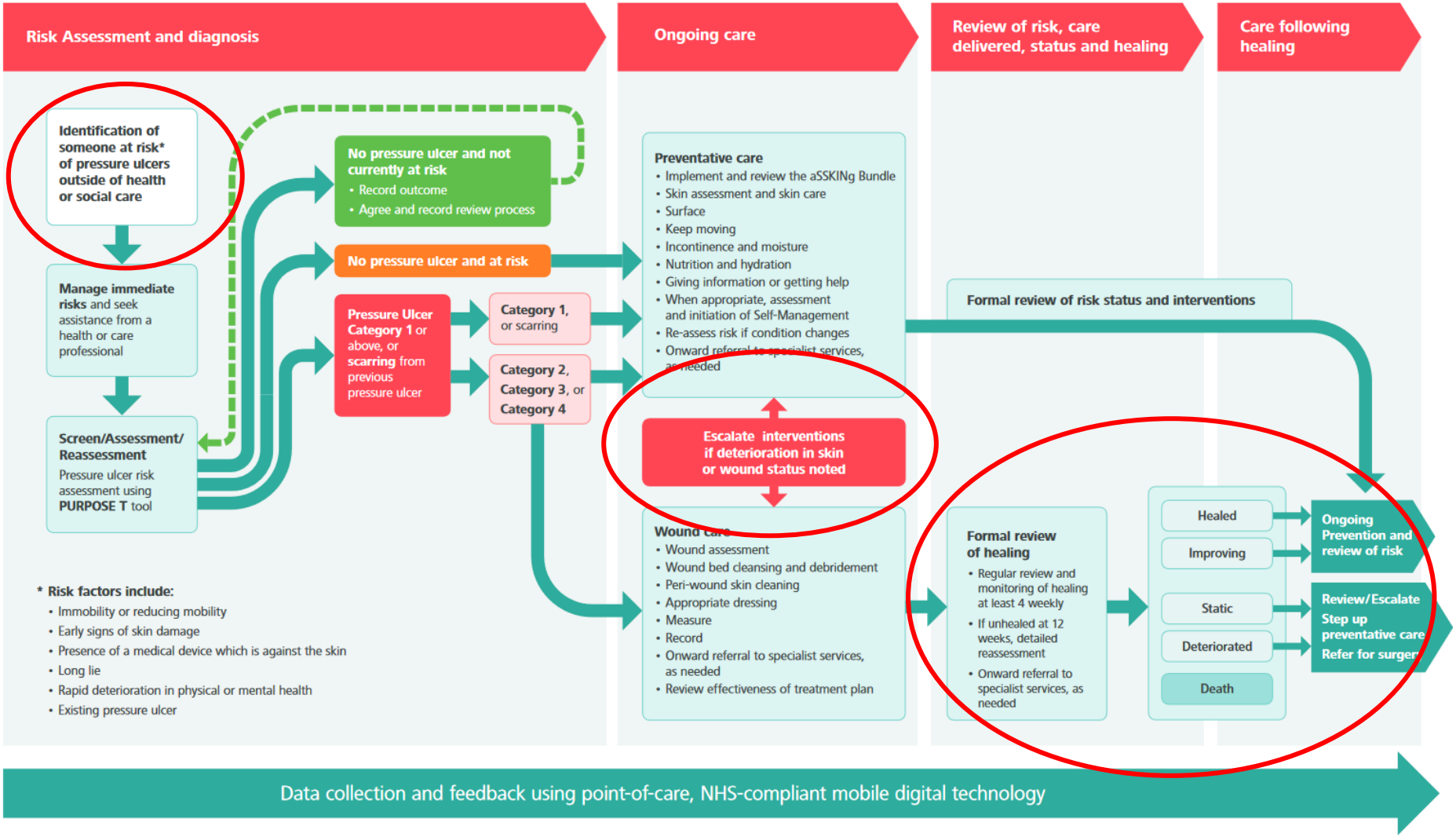
If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk
Tick if applicable
Not currently at risk pathway

Nurse printed name | Nurse signature | Date | Time

The aSSKINg Framework

	Action	Best Practice
a	**Assess risk**	Consider risk factors associated with compromised skin integrity. Undertake screening and risk assessment using the PURPOSE T screening and risk assessment tool or similar evidence-based and validated tool which contains as a minimum, the same risk elements. Refer to appropriate members of the interprofessional team. Be aware of safeguarding policies and take appropriate action when necessary. Document risk status and timing of review in the clinical record.
S	**Skin assessment and skin care**	Carry out a comprehensive skin assessment including skin under devices where it is safe to do so. Consider colour, texture and temperature of the skin. Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb. Consider risk factors associated with impaired skin integrity. Identify complex health conditions that affect skin integrity. Keep the skin clean, dry and well hydrated. Implement evidence-based skin interventions to promote skin integrity. Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
S	**Surface**	Consider risk factors associated with a range of support surfaces including but not limited to beds, mattresses, chairs, cushions, wheelchairs and in vehicle systems. Consider the impact of offloading devices such as boots or other orthoses. Consider the impact of medical devices and their contact with the skin. Consider the range of available equipment, including the mechanism of action, benefits and associated risks. Identify and undertake relevant seating and moving and handling risk assessments. Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. Refer to appropriate members of the inter-professional team throughout the patient journey, including discharge planning.
K	**Keep moving**	Consider level of mobility and risk factors associated with reduced mobility. Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks. Use relevant formal tools to assess mobility - falls risk, moving and handling risk assessments to balance the risk from other harm. Consider the impact of reduced mobility on an individual's posture, engagement in activities of daily living (ADL) and psychosocial functioning (mood, isolation, social engagement). Safely use a range of appropriate equipment to promote self mobilisation and good posture - hoists and slings, standing hoists and frames, electronic bed frames, appropriate seating and mobility aids, sleep systems, wheelchairs etc - to promote individualised plan of mobility and assisted transfers. Refer to appropriate members of the interprofessional team throughout the planning journey, including discharge planning. Consider the individual's usual daily routine when planning repositioning or activity schedules. Identify, understand and, where possible, address the cause of any change in mobility level.
I	**Incontinence or increased moisture**	Identify the cause of moisture-related skin damage ie. incontinence, sweat, saliva, stoma effluent, wound leakage. Where possible, address the cause of the moisture. Consider whether incontinence-related skin damage is an issue. Differentiate between aetiologies associated with incontinence. Consider how increased moisture increases the risk of skin damage caused by skin and friction. Implement appropriate prevention and management strategies. Refer to continence services where necessary. Keep the skin clean, dry and well hydrated. Maintain hydration.
N	**Nutrition**	Consider the impact of key nutritional elements in wound healing. Understand the impact of disease on nutritional need and nutrient absorption. Utilise the relevant tools and documentation which should include food and fluid charts, for example, food diaries, MUST, BMI, MUAC, bloods, feeding risks and PEM assessment. Advise on food fortification, nutritional supplementation and moderation of dietary restrictions in event of pressure ulceration. Collaborate to deliver appropriate care with relevant members of the multidisciplinary teams (MDT) (dietician, speech and language therapist, occupational therapist). Consider the practical elements of maintaining nutrition and hydration including portion sizing, food texture, access and ease of use of implements and good dentition.
g	**Give information**	Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies. Consider the patient's level of capacity and perform the necessary checks. Communicate effective and safe use of interventions effectively for the patient, family and within the MDT. Recognise when clinical concerns need to be escalated. Promote effective pressure ulcer prevention approaches. Consider effective resource allocation and escalate concerns when resources are unavailable. Be aware of safeguarding policies and take appropriate action when necessary. Use the clinical record as the source of documentation to ensure information is available to all members of the MDT. Use appropriate language to ensure the clinical record can be appropriately used for coding/analytic purposes. When capturing/using digital images, ensure appropriate consent has been obtained.


Risk Assessment and diagnosis
Ongoing care
Review of risk, care delivered, status and healing
Care following healing
Identification of someone at risk* of pressure ulcers outside of health or social care
Manage immediate risks and seek assistance from a health or care professional
Screen/Assessment/ Reassessment
Pressure ulcer risk assessment using PURPOSE T tool
No pressure ulcer and not currently at risk
• Record outcome
• Agree and record review process
No pressure ulcer and at risk
Pressure Ulcer Category 1 or above, or scarring from previous pressure ulcer
Category 1, or scarring
Category 2, Category 3, or Category 4
Preventative care
• Implement and review the aSSKINg Bundle
• Skin assessment and skin care
• Surface
• Keep moving
• Incontinence and moisture
• Nutrition and hydration
• Giving information or getting help
• When appropriate, assessment and initiation of Self-Management
• Re-assess risk if condition changes
• Onward referral to specialist services, as needed
Escalate interventions if deterioration in skin or wound status noted
Wound care
• Wound assessment
• Wound bed cleansing and debridement
• Peri-wound skin cleaning
• Appropriate dressing
• Measure
• Record
• Onward referral to specialist services, as needed
• Review effectiveness of treatment plan
Formal review of risk status and interventions
Formal review of healing
• Regular review and monitoring of healing at least 4 weekly
• If unhealed at 12 weeks, detailed reassessment
• Onward referral to specialist services, as needed
Healed
Improving
Static
Deteriorated
Death
Ongoing Prevention and review of risk
Review/Escalate Step up preventative care
Refer for surgery
* Risk factors include:
• Immobility or reducing mobility
• Early signs of skin damage
• Presence of a medical device which is against the skin
• Long lie
• Rapid deterioration in physical or mental health
• Existing pressure ulcer
Data collection and feedback using point-of-care, NHS-compliant mobile digital technology

Consultatio

When does the clock start for 6 hours from admission?

and what constitutes assessment

Categories

Reassessment intervals

Every contact

National Wound Care Strategy update: pressure ulcer consultation

JACQUI FLETCHER OBE
Senior Clinical Advisor Stop the Pressure Programme/National Wound Care Strategy
NHS England Clinical Implementation Manager

In April this year we consulted on the new National Wound Care Strategy Programme (NWCSP) pressure ulcer (PU) clinical recommendations and clinical pathway. There were 187 people from across England who completed the consultation (*Figure 1*). The respondents were mostly from acute or community trusts, with a small number of responses from general practice, care homes, commercial companies, commissioning organisations, as well as patients and their carers.

The feedback generally confirmed that the pathway was easy to follow and that the suggested changes were mostly welcome and long overdue. There were also a good number of strong and well thought through challenges, which have led to some minor amendments in the recommendations and strengthening of the explanations.

Broadly speaking, these challenges related to eight key themes:

- When does the clock start for risk assessment in acute organisations (and how much of the assessment must be completed to meet this criteria)?
- Concerns around virtual assessment
- Concerns about the move to different risk assessment tool
- Uncertainties about frequency of reassessment
- Uncertainty about PU categorisation
- Uncertainties about the definition of device-related pressure ulcer (DRPU) or medical device-related pressure ulcer (MDRPU)
- Concerns about referral to surgeons for hard-to-heal PUs
- Issues relating to 'every contact counts'.

When does the clock start?

The recommendation that risk assessment should be completed within six hours of admission comes from the National Institute for Health and Care Excellence (NICE) quality standard (NICE, 2015) which recommends that:

'People admitted to hospital or a care home with nursing have a pressure ulcer risk assessment within six hours of admission'.

However, no further detail is provided within the NICE quality standard. The aim is to add clarity by recommending that in the acute setting, the six hours begins at the point that the patient is first seen by a registered healthcare professional. This brings the statement in line with the NICE quality standard for community assessment which is 'at first visit'.

To illustrate, for patients admitted via the emergency department, this means that risk assessment should be completed within six hours from when the patient is seen by a registered clinician (most likely the triage nurse). There is no requirement for the triage nurse to complete the whole assessment, but within the following six hours the remainder of the risk assessment process should be completed. So, if the triage nurse uses step 1 Screening of the PURPOSE T tool (*Figure 1*) and ticks only blue boxes, which identifies that they are on the green pathway (not at risk), then that completes the assessment. If, however, they identify pink or yellow boxes, this indicates that Step 2 full risk assessment should be completed so, to achieve the risk assessment within six hours, the full assessment must be completed within that time frame.

Virtual assessment

The NWCSP clinical recommendations state that it should be documented whether assessments were in person or virtual (contact via telephone or video). Some respondents were vehemently opposed to the use of virtual assessments in the community, but the recommendations do not suggest that virtual assessment of either risk or skin should be a normal practice, but that for a small number of patients it may not be possible to do an in-person assessment. This may be due to the patient's mental health, or a safety concern for the healthcare professional.

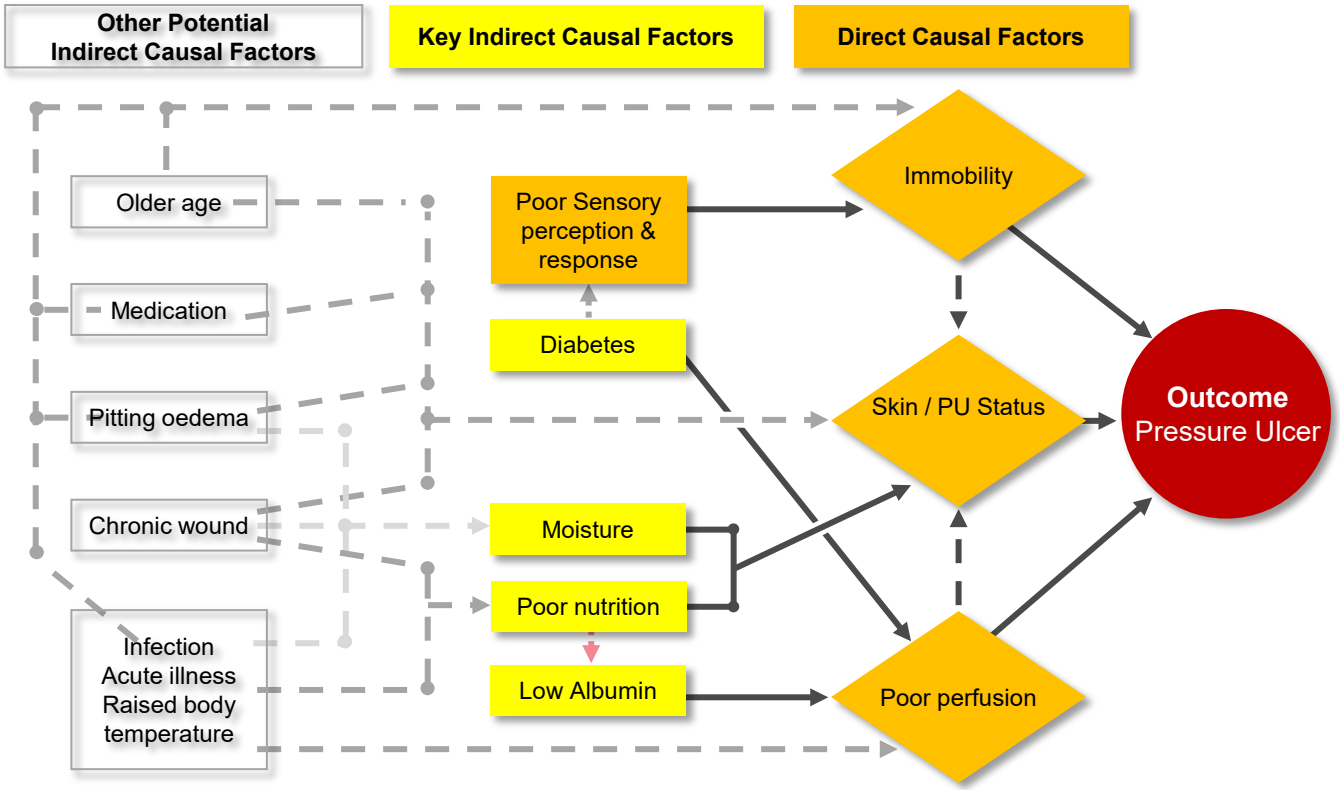
National Wound Care Strategy Programme

Single risk assessment tool

- Understandably this is challenging in practice.
- Many organisations struggling to digitise
- Some organisations reluctant to change where their system is working well.
- We have amended the language to say

the PURPOSE T risk assessment tool or other risk assessment tool that as a minimum contains the same items

Theoretical schema of proposed causal pathway for PU development



Coleman et al 2014 b JAN

PURPOSE

PURPOSE T Pathways

- If you do not use PURPOSE T – the colour coded pathways are generic and still applicable
- The guidance should still be followed

No pressure ulcer, not currently at risk

No pressure ulcer but **at risk**

PU Category 1 or above or scarring from previous pressure ulcers.

Reassessment intervals

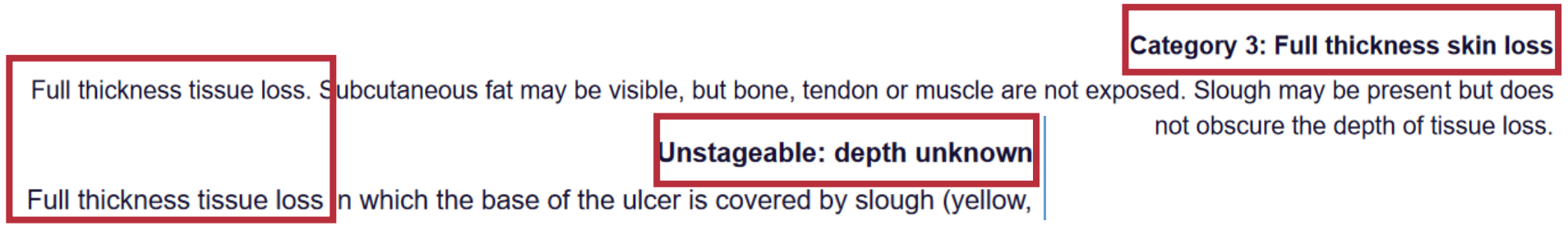
- It was felt that there was some conflict between differing statements about reassessment
  - If condition changes
  - At the preplanned interval
  - At regular intervals (and what is regular)

Reassessment intervals

- This is a hierarchical process
- Priority is:
  - reassess if there is a change in that individual's condition, circumstances or environment
- If there is no change, reassess at the preplanned interval
- Our recommendation for the minimum of what this should be is:
  - At least once a week in acute settings
  - At least once a month in community or care homes
- But the preplanned interval is very dependent on the risk and risk indicators so should be individualised to that patient

Categories

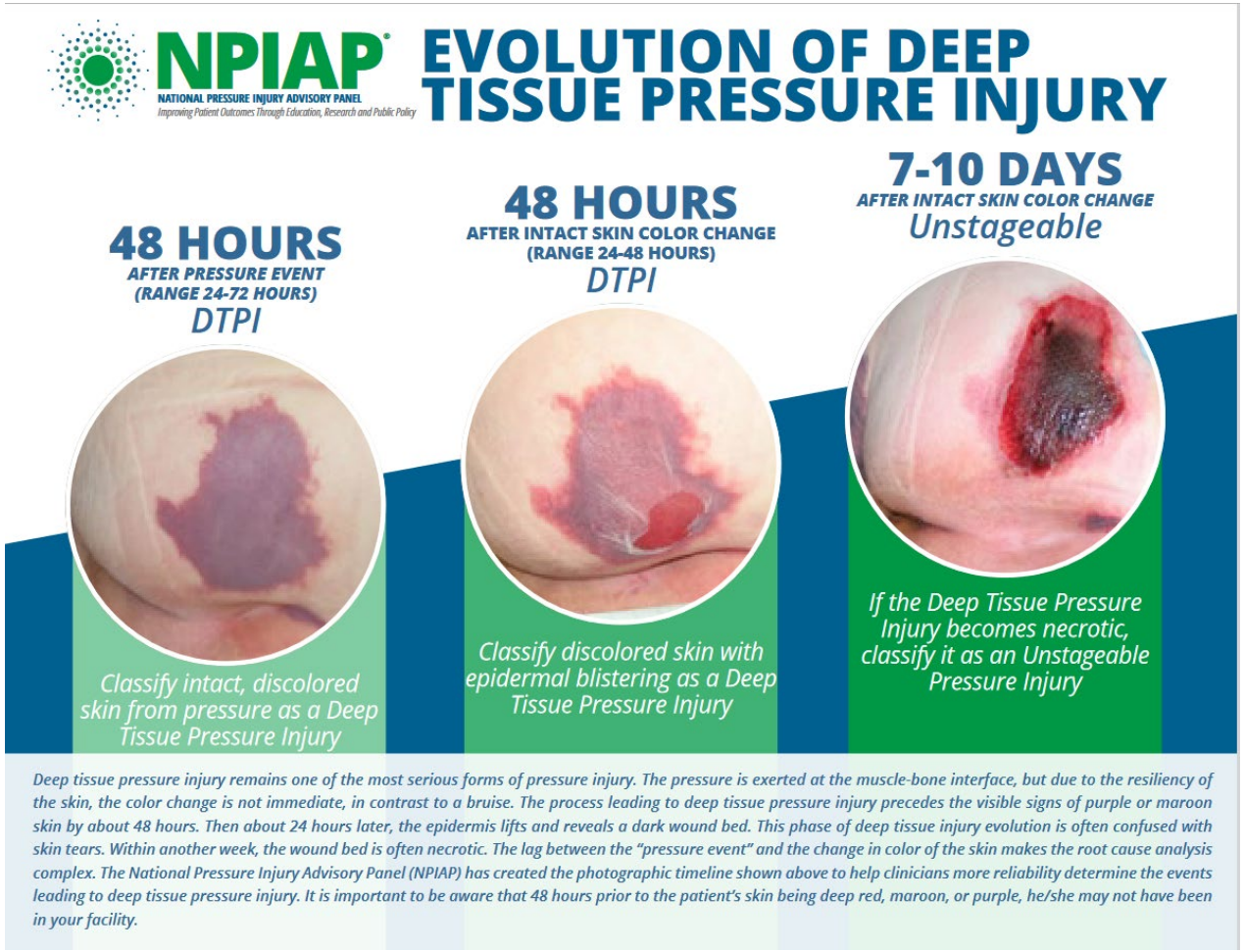
- Unstagable is as a minimum a category 3



- Do not use DTI
  - Full thickness tissue loss can be expected in only 9–14% of DTI cases (Wynn 2021)

DTI

- Our understanding of DTI is poor
- True DTI occurs in the muscle
- Most of what is reported as DTI does not!
- In some ‘DTI’ you may never see skin breakdown due to the resilience of the skin

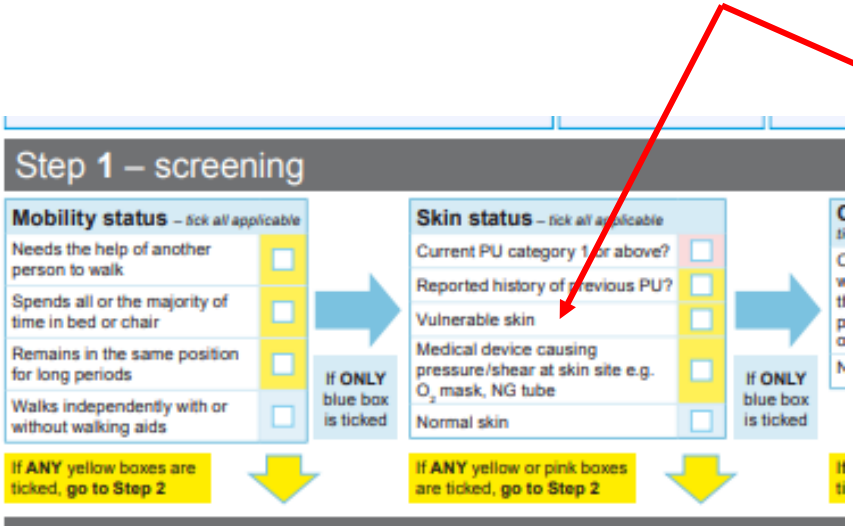


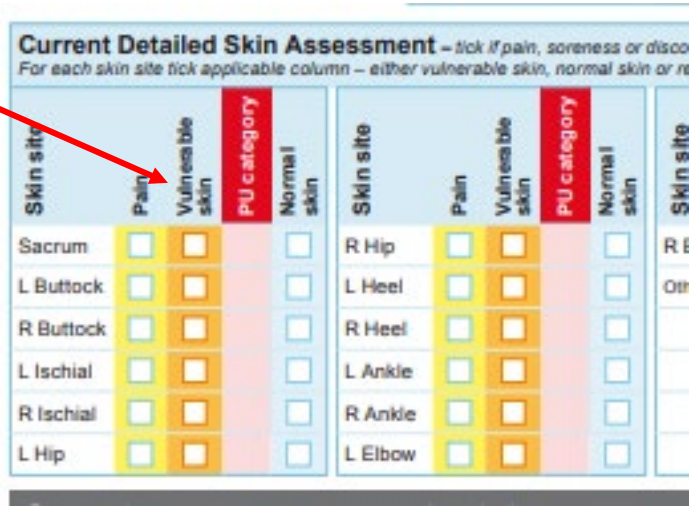
This involves multiple episodes of reclassification

- DTI
- Unstageable
- Then whatever evolves…

Deep Tissue Injury

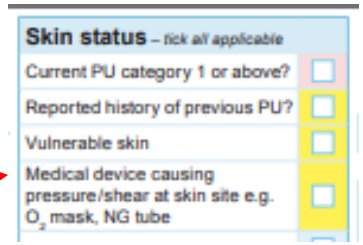
- Concern re lack of care provision if not identified as a DTI
- Should be classified as vulnerable skin





DRPU vs MDRPU

- This has been an issue for a long time
  - Many reports in the literature of patients developing PU from items such as TV remote controls
- In this context we are
  - Discussing assessment of risk
  - Identifying if this could reasonably have



Medical device

- A medical device is
  - Something that is used intentionally
  - Something where risk can be predicted
- We cannot say this for the myriad other things that may cause a PU such as TV remote controls
- You cannot control for everything

PSIRF and PU

- More information can be found here: https://soundcloud.com/nhsengland/considering-pressure-ulcers-in-psirf-planning

Levels of harm and PU

- **2. Can category of pressure ulcer be matched to a LFPSE degree of harm?**

- No, the degree of harm depends on the actual impact for this patient as a result of the patient safety incident and does not corelate with the category of pressure ulcer. For example, a patient with a category 3 pressure ulcer could fall into moderate harm because they needed additional healthcare for 3 months.
- However, if the same ulcer was on the heel and expected to affect mobility even after healing, then that would be graded as severe harm. Each pressure ulcer must be assessed for degree of harm, using category of pressure ulcer only as a guide and the reason for the level of harm selected should be demonstrated in the free text description of the incident.
- If a patient has multiple pressure ulcers that developed by the same mechanism, then only one incident need be recorded. The harm associated with this incident would be the actual level of harm to the patient (i.e., the highest level of harm the patient has incurred from any or all of the pressure ulcers).
- If a patient has multiple pressure ulcers which developed due to different mechanisms (i.e, one develops due to a monitoring device, and the other is related to profiling bed equipment), two distinct incidents have occurred and should be recorded as such

Society of Tissue Viability

National Wound Care Strategy Programme

STOP THE PRESSURE WEEK

Monday 13th to Friday 17th November 2023

EVERY CONTACT COUNTS TO STOP THE PRESSURE

STOP THE PRESSURE 13 -17 NOVEMBER 2023

Stop the pressure week

Our theme for the week

‘Every contact counts’

- **Every contact** with a clinician, healthcare professional or carer can help prevent pressure ulcers
- **Every contact** with a bed, chair or other surface can help prevent pressure ulcers
- **Every contact** with leaders in healthcare can help prevent pressure ulcers
- **Every contact** on social media or traditional media can help prevent pressure ulcers

Stop the Pressure

C-O-N-T-A-C-T

C – START THE CONVERSATION, CONNECT, COMMUNICATE, SHOW THAT YOU CARE

O – CONSIDER OPTIONS, OBSERVE, DISCUSS, AGREE

N – BE NEEDS LED, NOTICE WHAT'S IMPORTANT

T – TEAMWORK, TALKING TO PEOPLE, LISTENING, ENGAGING AND TEACHING

A – ASK QUESTIONS, ADJUST AND ADAPT TREATMENT PLANS

C – BE CLINICALLY CURIOUS – ADJUST, CHALLENGE, CHANGE

T – TAKE ACTION, BE THE CHANGE THAT IS NEEDED

20 Questions – pressure ulcer quiz

Test your knowlege in our quick quiz

Word search

Online version

How quickly can you complete our on-line Every Contact Counts word search?

Take a screen shot of your time and post on one of our social platforms (you must use the tag #everycontactcountswordsearch) for the chance to win a £25 Amazon voucher (prize only available to practicing UK healthcare professionals).

Online word search

Paper version

Or here's a traditional pdf version if you'd prefer to print and complete whilst you have a cuppa 🙂

Paper word search

Win a conference place

Competition

We are offering the opportunity for you to win registration and a travel bursary to the joint EWMA and Society of Tissue Viability 2024 conference being held on 1-3 May in London

Submit your Every Contact Counts learning resource via hello@societyoftissueviability.org

Closing date – 24 November 2023

Terms & Conditions

- Conference registrations and travel bursaries are non-transferrable and cannot be exchanged for their monetary value or similar
- Reimbursement of any travel expenses of up to £100 will be payable upon receipt of proof of purchase
- It is not the responsibility of the Society to organise and purchase travel insurance. If needed, this is to be arranged by the individual

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NatWoundStrat

NatWoundStrat@yhahsn.com

How does everyone feel about the removal of DTI and classing these areas vulnerable skin?

What is the consensus? How will Hospices be capturing this data?

Faith Slater
Tissue Viability Lead
St Wilfred's Hospice

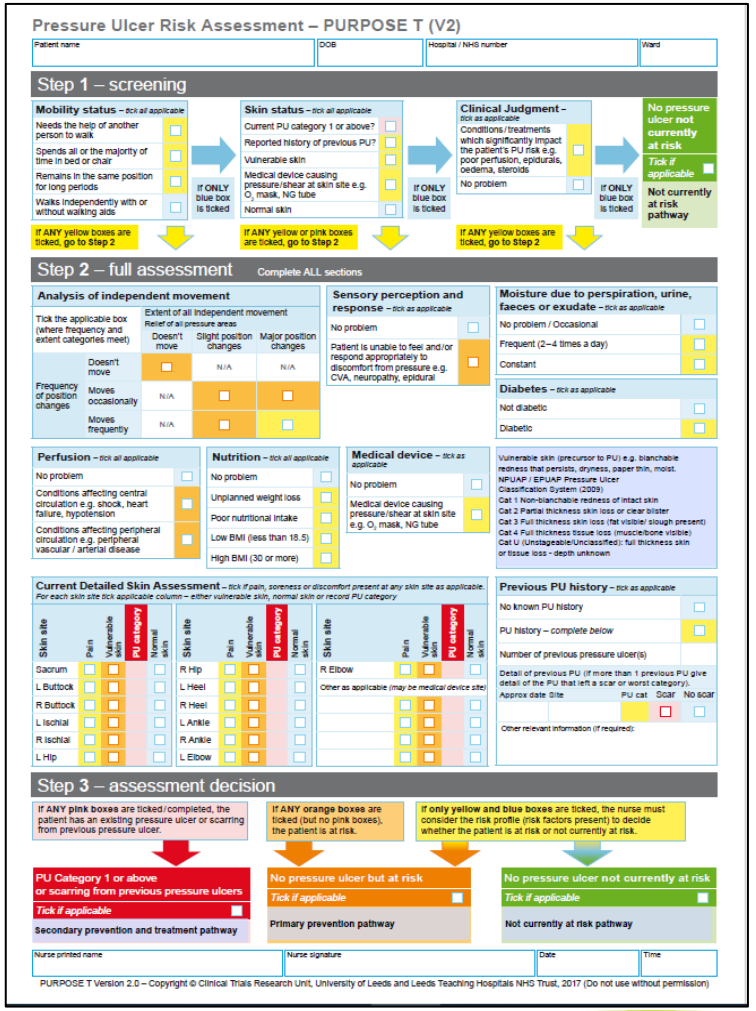
St Wilfrid's Hospice
Making a difference to local lives

PURPOSE T Risk Assessment & how we use it at St Wilfrid's Hospice

By Faith Slater – Clinical Practice and Quality Improvement Nurse

St Wilfrid's Hospice
Making a difference to local lives

- Purpose T is an evidenced based pressure ulcer (PU) risk assessment developed by Leeds university.
- It identifies adults at risk of developing a PU and supports the nurses decision making to reduce the risk (primary prevention).
- It also identifies those with existing pressure ulcers that require secondary prevention and treatment.
- The use of colour indicates the most important risk factors and forms a three step assessment process.
- Permission for use needs to be gained from [PURPOSE-T Registration • CTRU Leeds Research Portal]



What is Purpose T?

St Wilfrid's Hospice
Making a difference to local lives

Why did we move to Purpose T ?

- We moved over to Purpose T from the Waterlow risk assessment in 2021.
- We had used Waterlow for years on the ward. The primary aim of the Waterlow was looking at patients at risk rather than looking at patients with pressure ulcers or scars from previous pressure ulcers.
- We recognised that Waterlow didn't work for our patients at the hospice. They would all score high and there was an element of 'so what'.
- We recognised that by moving over to this risk assessment this would enable us to identify patients at risk and aim to prevent them by:
  - Identifying those with existing pressure ulcers that needed management and treatment.
  - Aiding a clearer assessment of patients at the end of life and facilitating a plan of care that was suitable to meet their needs.
  - Enabling the nurses clinical judgement to be utilised.

St Wilfrid's Hospice
Making a difference to local lives

- I put together some pressure ulcer prevention training and as part of this we introduced Purpose T and explained what it was, why we were changing and completed it using some case studies.
- A Purpose T care plan was added to S1 but at this point we were still completing paper copies and then uploading to the patients notes.
- We set a date for the change over and let everyone know.
- I moved every patient over to Purpose T so there was a baseline to start with.
- Following the change over date I made sure I was on duty over a period of shifts and went through it with each member of the nursing team.
- It was tough as there was a delay from the training to implementing due to COVID.
- The team worked hard and kept going with it.
- We ensured we supported them through this change and process.

How did we implement it?

St Wilfrid's Hospice
Making a difference to local lives

- We complete Purpose T risk assessment within 6hrs of admission (NICE, 2015)
- Our nursing team have grown in confidence.
- We are now completing Purpose T digitally on S1.
- We are recognizing and reporting pressure ulcers consistently.
- We continue to develop and improve the our Purpose T and aSSKINg care plans for our patients.
- We have developed a digital way in which to document the repositioning of our patients.
- We continue to learn from incidents and drive forward quality improvement .

How we have developed and moved forward since 2021?

St Wilfrid's Hospice
Making a difference to local lives

- Over the next few slides we will complete a Purpose T risk assessment for a patient with a pseudonym of Mary.
- I have used red ticks to highlight and be clear where we are ticking

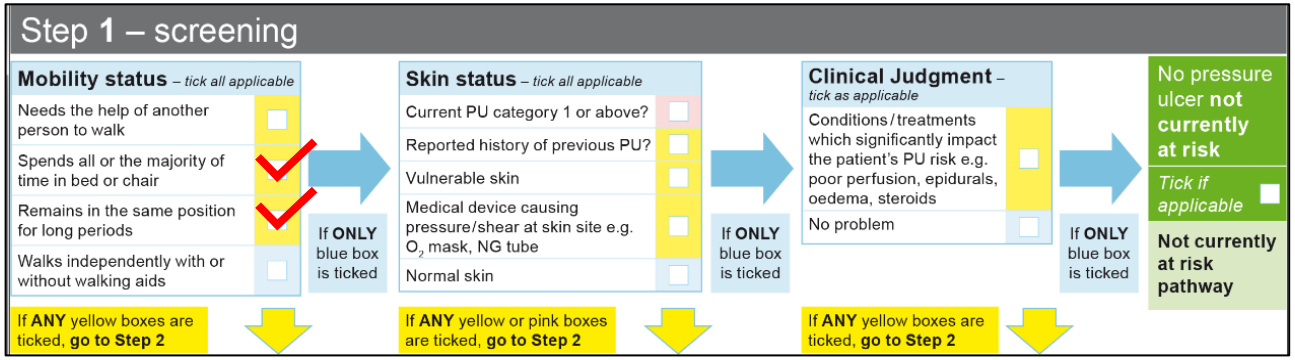
Case Study

St Wilfrid's Hospice
Making a difference to local lives

Mary is immobile and in bed 95% of the time- ticks yellow in two of the mobility status

Due to this we can go straight to our full assessment.

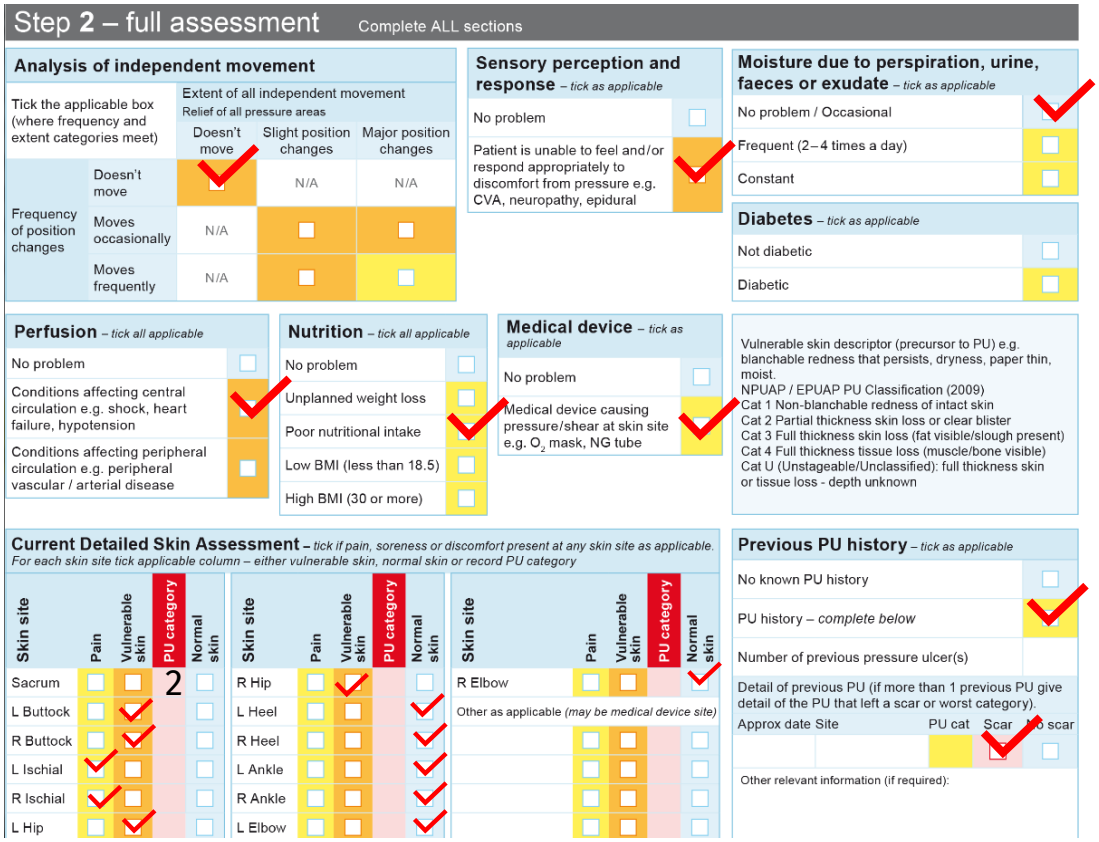
If she had ticked blue we would have gone to the skin status and so on



Step 1 - screening

St Wilfrid's Hospice
Making a difference to local lives

- Mary is immobile and in bed 95% of the time
- Cannot reposition herself independently
- She can communicate and ask for help but unable to respond appropriately to pain or discomfort on the skin
- Type 2 diabetic
- She has poor nutrition
- Has heart failure
- Has a catheter and a syringe driver
- Has previous scarring from a pressure ulcer
- Mary has a category 2 pressure ulcer to sacrum



Step 2 – full assessment

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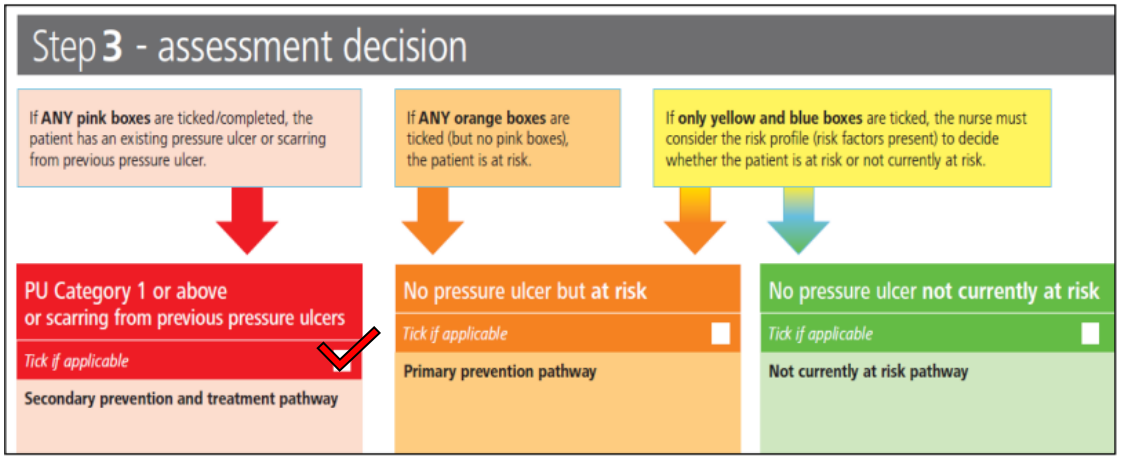
Making a difference to local lives

- Mary would be RED as she has a existing category 2 pressure ulcer.
- She would then require a plan of care to manage the current pressure ulcer, reduce further deterioration and prevent further pressure ulcers to other areas of her body.



Step 3 – Assessment decision

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- Red – We complete the Purpose T risk assessment, aSSKINg care plan and wound assessment every 3 days.
- Amber – We complete the Purpose T risk assessment, aSSKINg care plan and wound assessment every every 4 days
- Green – We complete the Purpose T risk assessment, aSSKINg care plan and wound assessment every every 7 days (we hardly ever have a green patient)

- We complete and update the traffic light system in the patient room.
- We put in a plan of care.

What do we do after our assessment decision?

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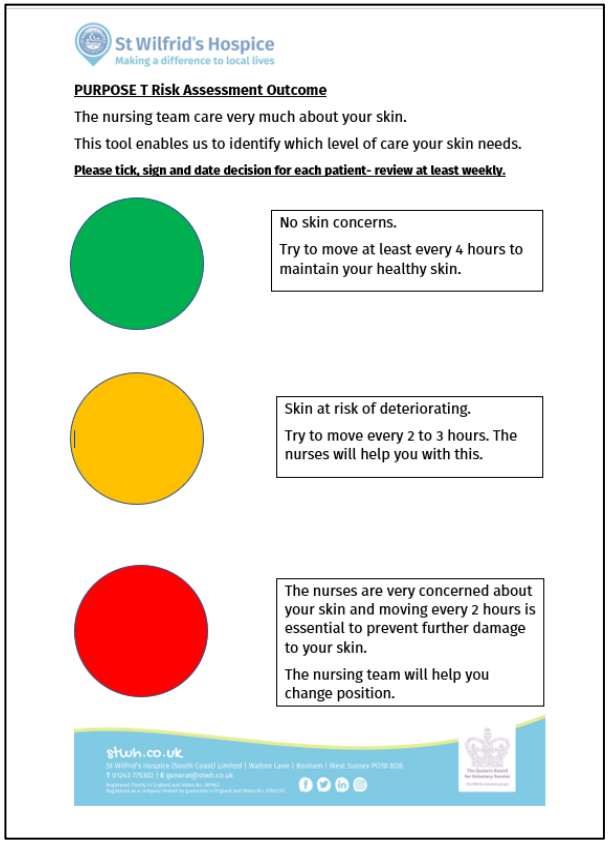
Making a difference to local lives



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PURPOSE T Risk Assessment Outcome

The nursing team care very much about your skin.

This tool enables us to identify which level of care your skin needs.

Please tick, sign and date decision for each patient- review at least weekly.

No skin concerns.

Try to move at least every 4 hours to maintain your healthy skin.

Skin at risk of deteriorating.

Try to move every 2 to 3 hours. The nurses will help you with this.

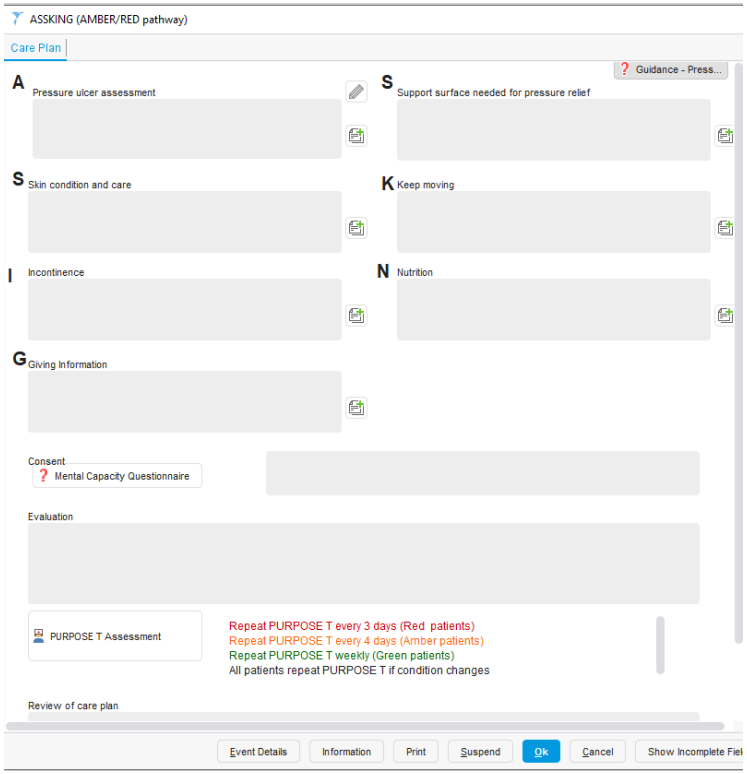
The nurses are very concerned about your skin and moving every 2 hours is essential to prevent further damage to your skin.

The nursing team will help you change position.

stwh.co.uk

Traffic Light System for patients rooms

St Wilfrid's Hospice
Making a difference to local lives



[The aSSKINg Framework (nationalwoundcarestrategy.net)]

aSSKINg framework on SystmOne

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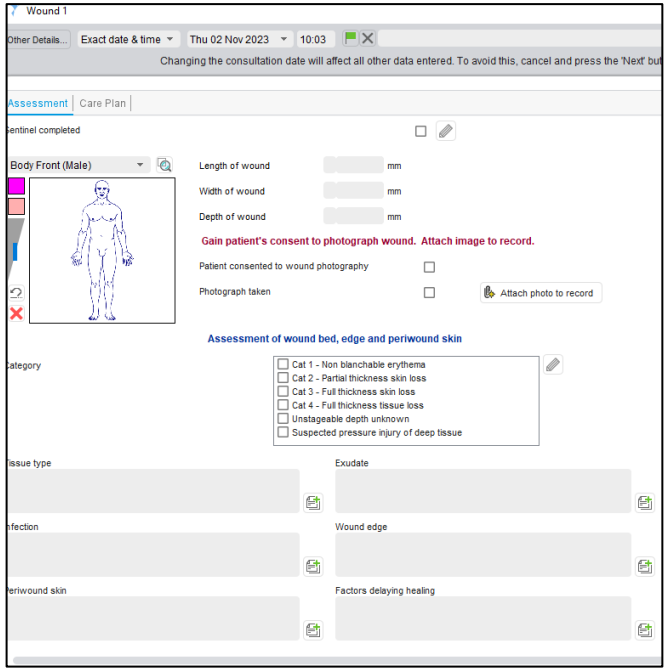
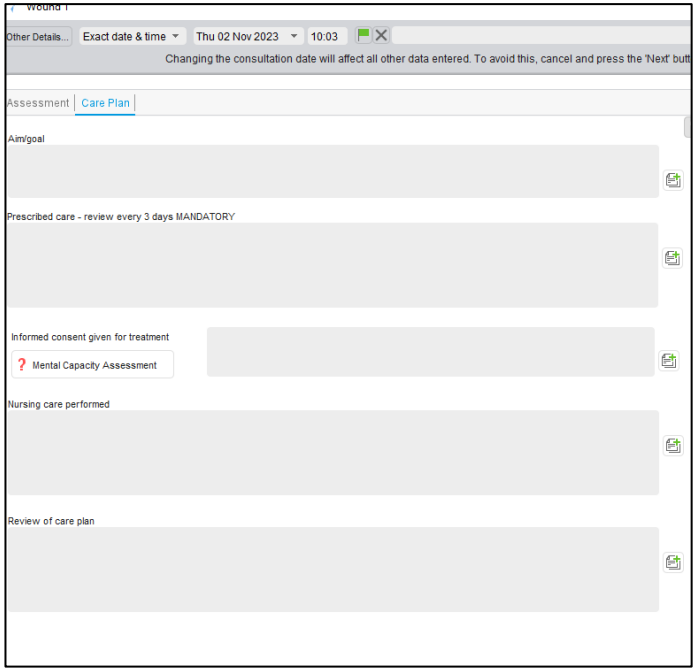
- Follow the TIMES (Wounds Uk 2017) model to complete our pressure ulcer wound assessment.
- Photograph wound as shows improvement and deterioration.
- I am currently writing a wound care formulary to aid the assessment and plan for the patients.





Wound Care plan on SystmOne

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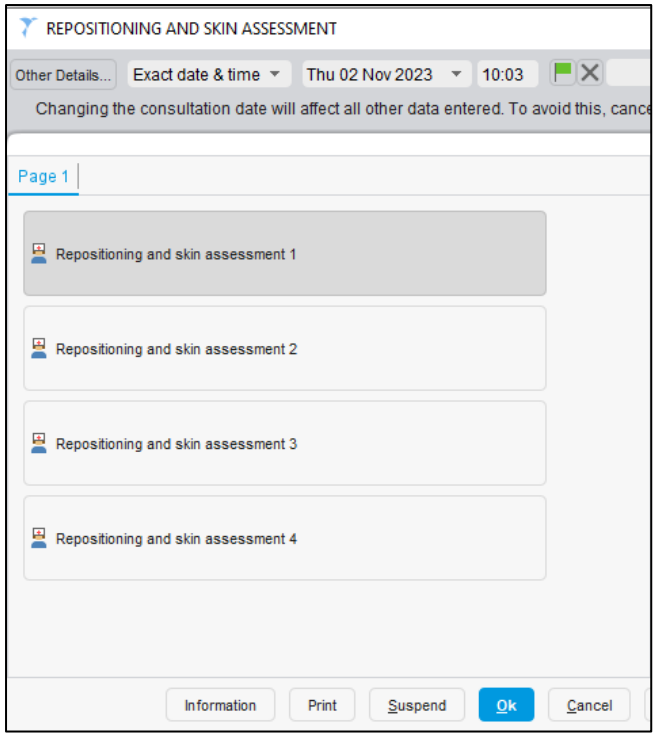
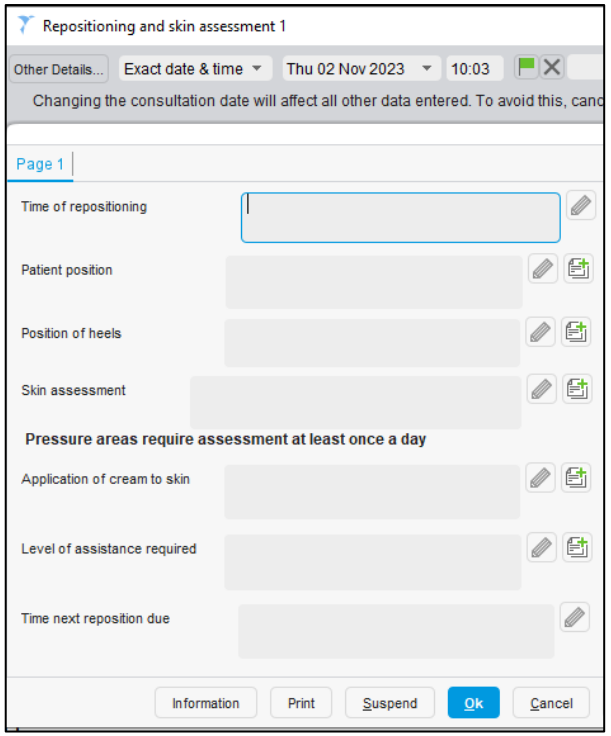
- We needed to document our repositioning more accurately.
- I worked with the IPU, and community teams across days and nights to identify a way we could do this.
- I listened to their worries and what they needed that would work for them.
- They did not want more paperwork.
- Its working well!
- The team like using it and find it easy to use.
- Always room for improvement but documentation is far better than it was.





Documenting repositioning on SystmOne

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Thank you,
any questions?

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Making a difference to local lives

References

- Coleman S, Smith IL, McGinnis E,et al. Clinical evaluation of a new pressure ulcer riskassessment instrument, the Pressure Ulcer Risk Primary orSecondary Evaluation Tool (PURPOSE T).J Adv Nurs.2018;74:407–424.https://doi.org/10.1111/jan.13444COLEMANET AL.|423
- NICE (2015) Quality statement 1: Pressure ulcer risk assessment in hospitals and care homes with nursing | Pressure ulcers | Quality standards |
- Wounds UK (2017) 'Quick Guide: Times Model of wound bed preparation' Available at: https://wounds-uk.com/quick-guides/quick-guide-times-model-of-wound-bed-preparation/

Lynn Cornish
MSc Wound Healing & Tissue Repair, BSc Hons,
Tissue Viability Lead
St. Margaret's Hospice Care

Reducing Pressure Injuries within a hospice In-Patient-Unit

Bringing about permanent change

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Somerset.
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Background

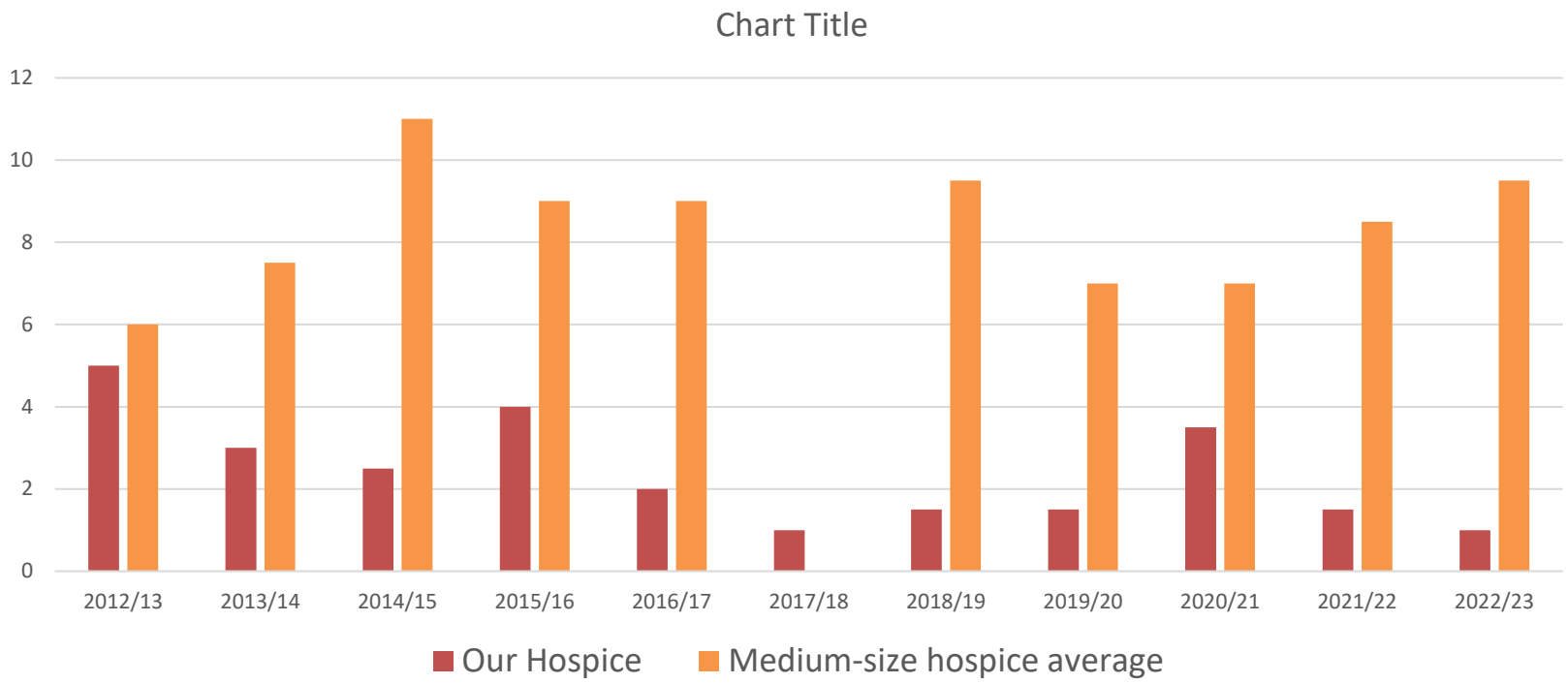
- Over 700,000 patients in the UK are affected with a pressure injury each year [1].
- It is estimated that the incidence within palliative care is 11.7% [2].
- Evidence demonstrates that education can reduce the incidence of new pressure ulcers [3].
- Improvements made will only be temporary without cultural change [4].

Programme for improvement 2013

Induction day + annual update TV training days	Whole team engagement with all decisions: Developing new formulary. Equipment Documentation	Emphasis on prevention - use of prophylactic dressings	Tissue Viability Lead presence on the IPU for support/guidance	Feedback/reflection On what we have achieved, and how to continue with encouraging results.

St Margaret's Hospice Care

Pressure injuries acquired at hospice per 1000 OBDs



Conclusion

- Healthcare assistants have proven to be indispensable in the prevention and management of pressure ulcers.
- Regular education/training at the same level for all staff has shown to bring about consistent excellent long-term results.
- Cultural change has been maintained and embraced.
- Feedback demonstrates that patients, relatives and staff alike have benefitted from the changes.

References

1. Wood J, Brown B, Bartley A et al (2019). Reducing pressure ulcers across multiple care settings using a collaborative approach. **BMJ** Open Quality 8

2. Ferris A, Price A, Harding K (2019). Pressure ulcers in patients receiving palliative care: a systematic review. **Palliative medicine** 33(7)

3. Park M, Kim G, Kim K (2020). The effect of pressure injury training for nurses: a systematic review and meta-analysis. **Advances in skin and wound care** 33(3): 1-11

4. Yan B, Dandan H, Xiangli M (2022). Effect of training on nurses' ability to care for subjects with pressure injuries: a meta-analysis. **International wound journal** 19(2): 262-271

St Margaret's Hospice Care

Thank you

QUESTIONS?

Nichola Smith and Georgia Wood
Katherine House Hospice

katharine house hospice
embracing life and living

Falls – Audits and Quality Indictors

Senior Hospice Manager- Nichola Smith
Senior Staff Nurse- Georgia Wood
Occupational Therapist- Shona

Our Vision...
"People live well and die with dignity in a place of their choice"

Falls: Audits and Quality Indictors

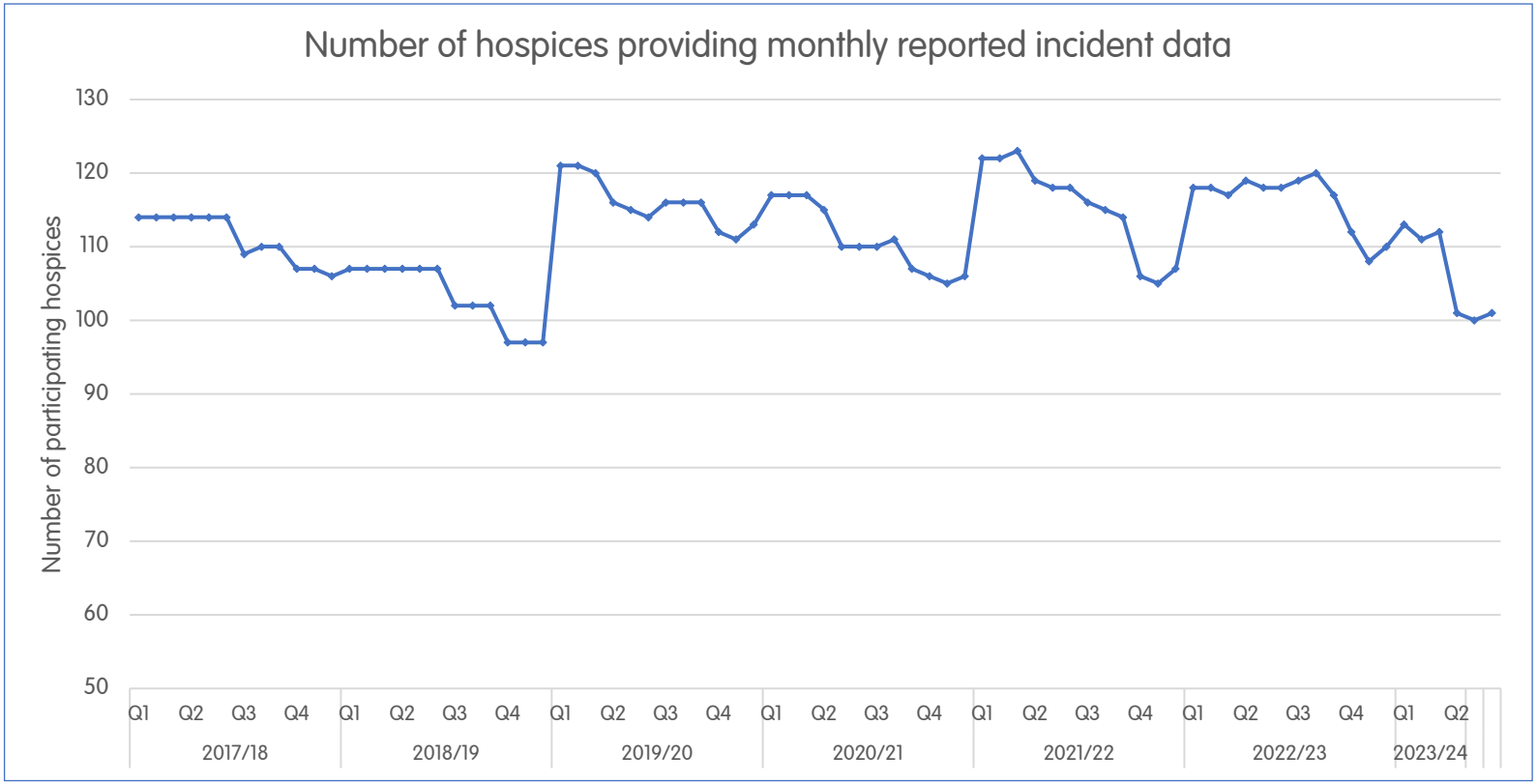
Discussion:

Now we are moving away from bench marking-

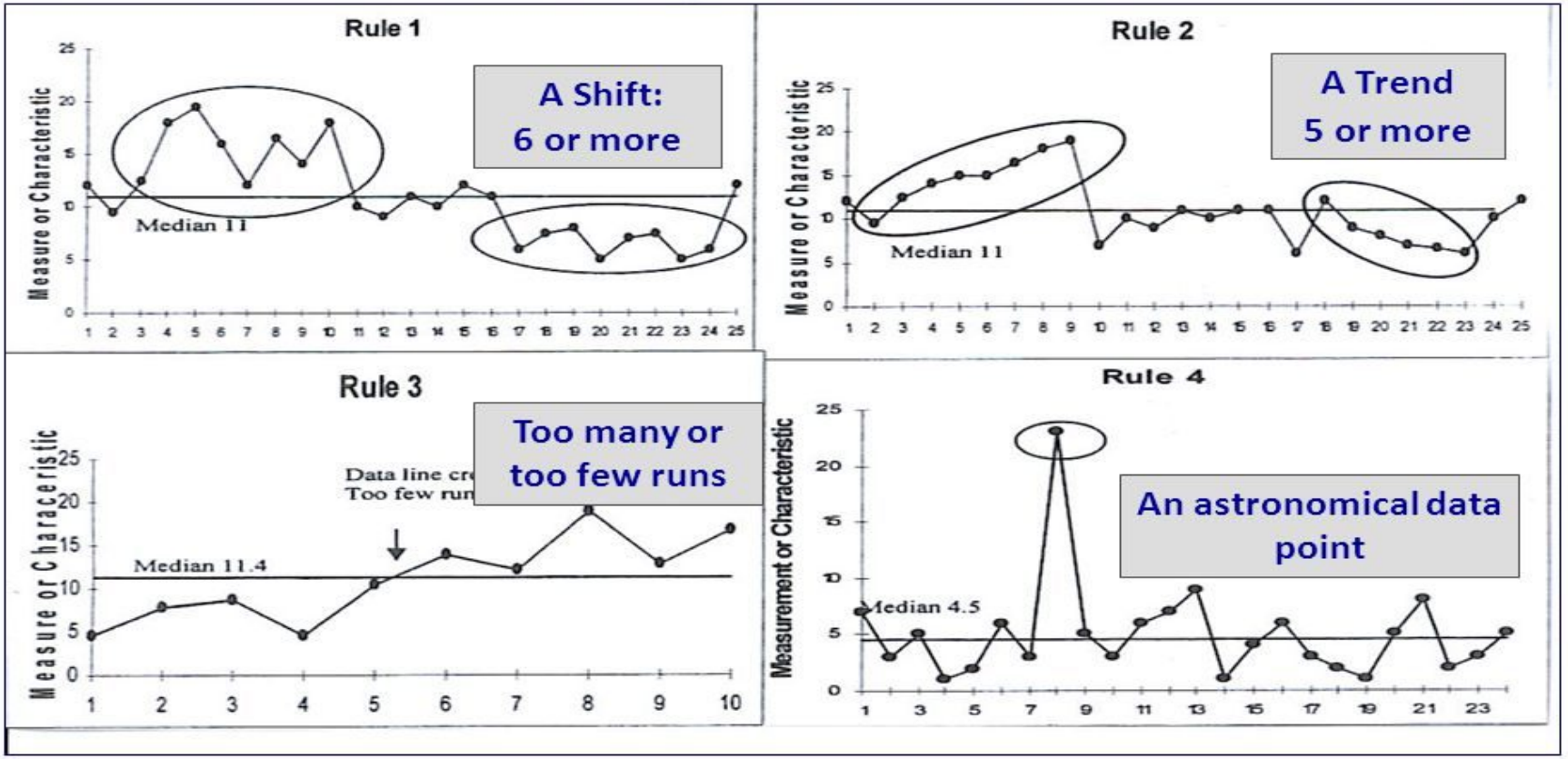
how can we identify trends from incidents and ensure that the quality indicators we have in place are effective

Patient Safety Incident Data self-reported by Adult Hospices

Data Submissions: Years and Quarters



Non-Random Signals on Run Charts

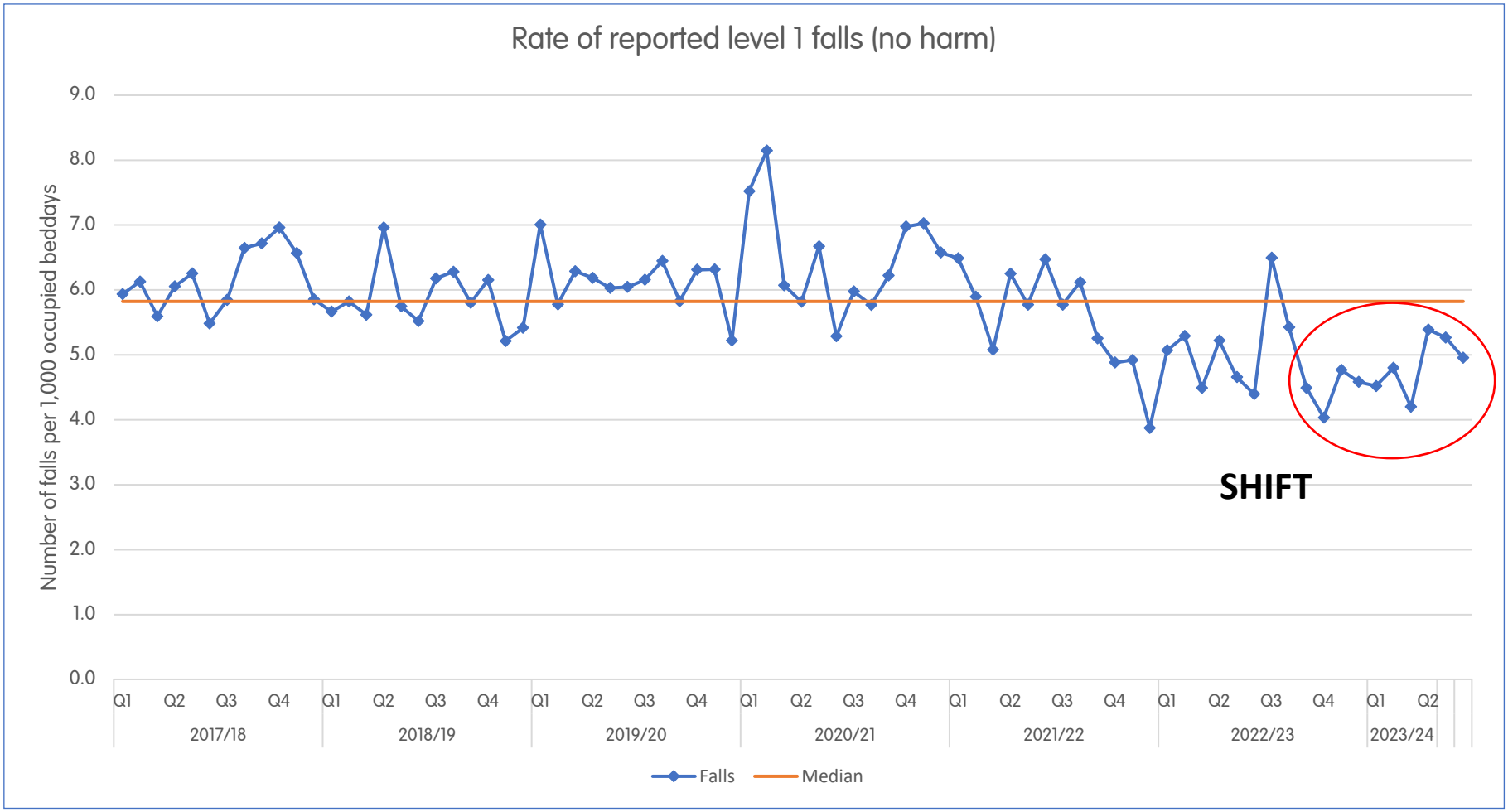


Evidence of a non-random signal if one or more of the circumstances depicted by these four rules are on the run chart. The first three rules are violations of random patterns and are based on a probability of less than 5% chance of occurring just by chance with no change.

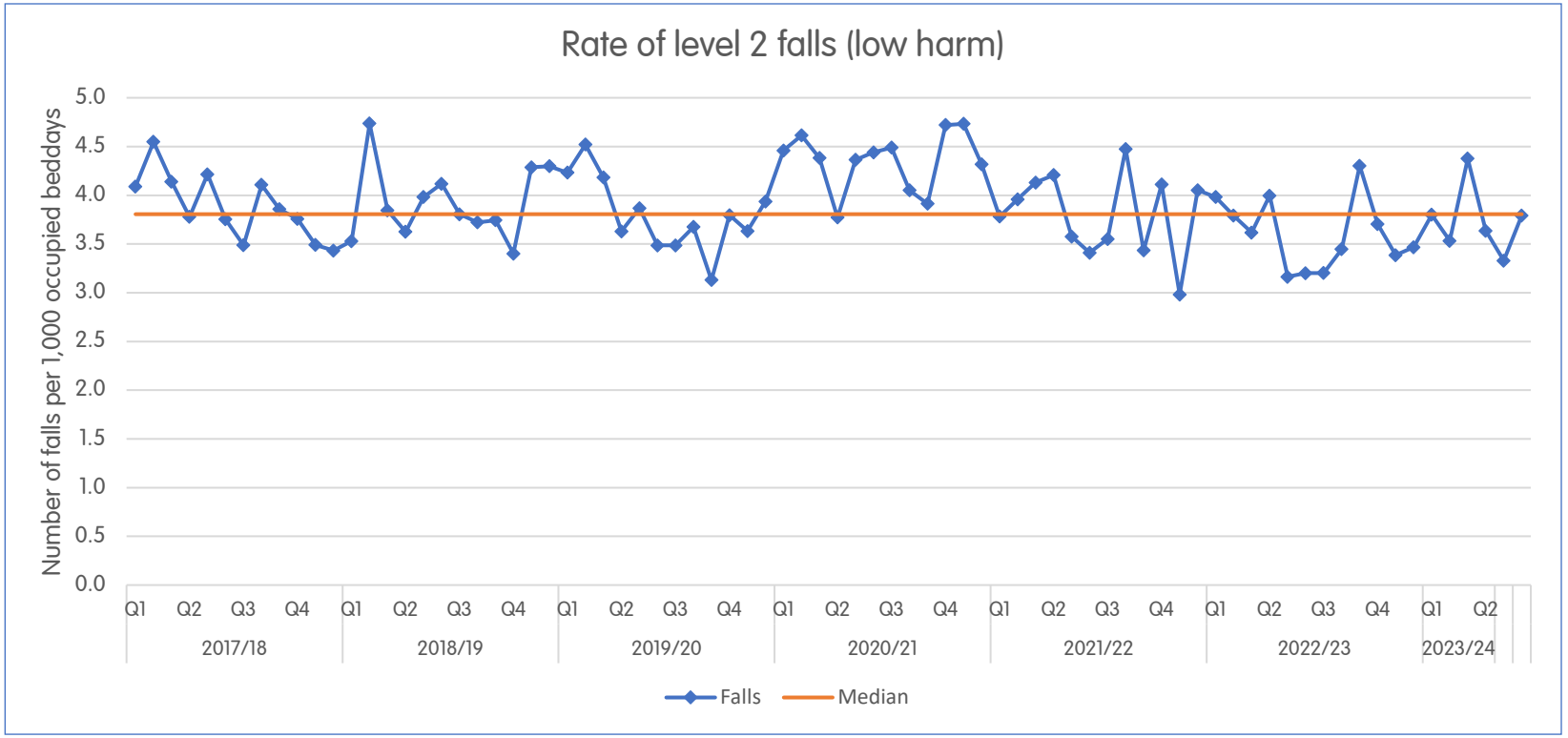
The Data Guide, p 3-11

FALLS

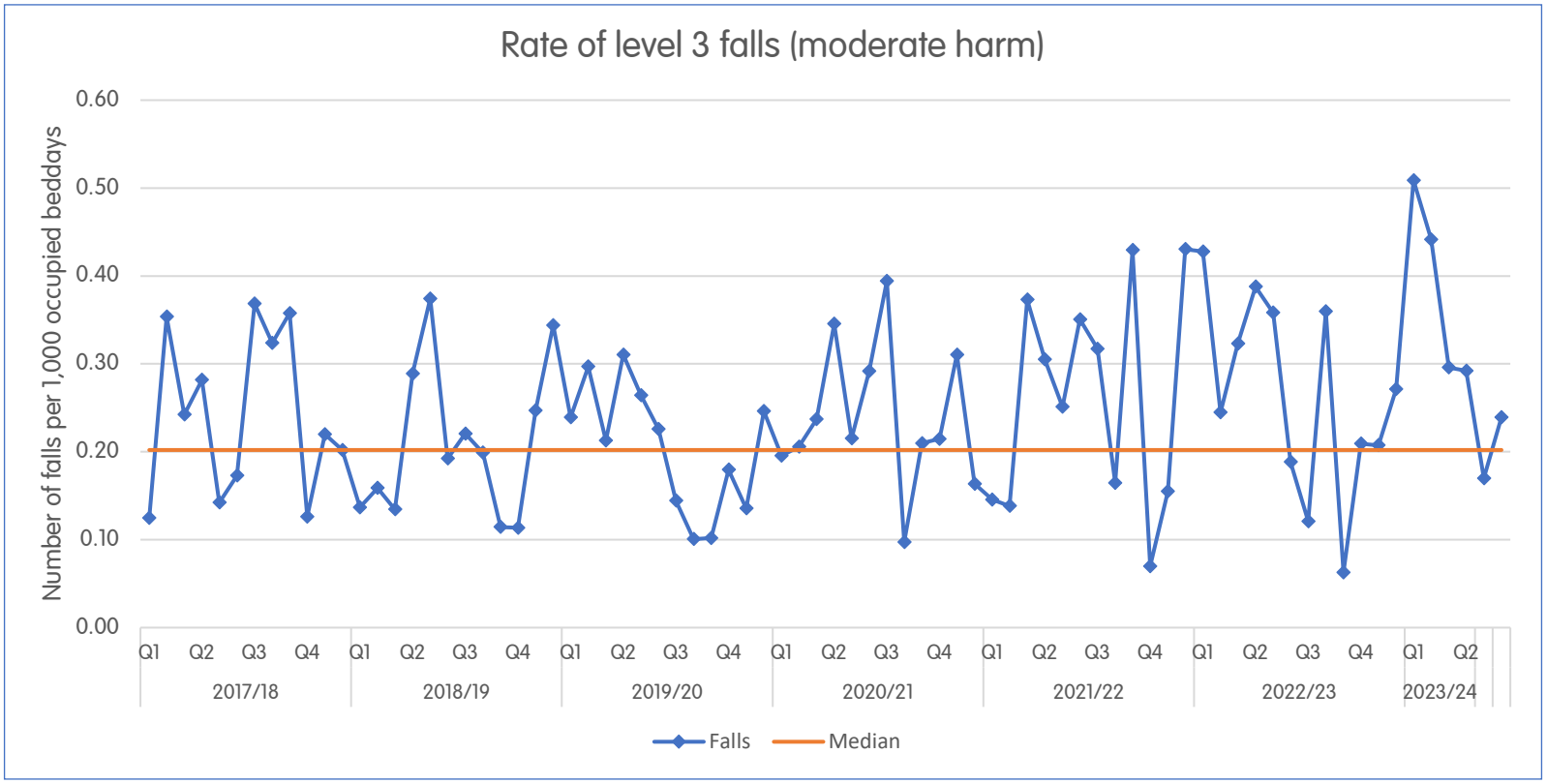
Level 1 falls over time



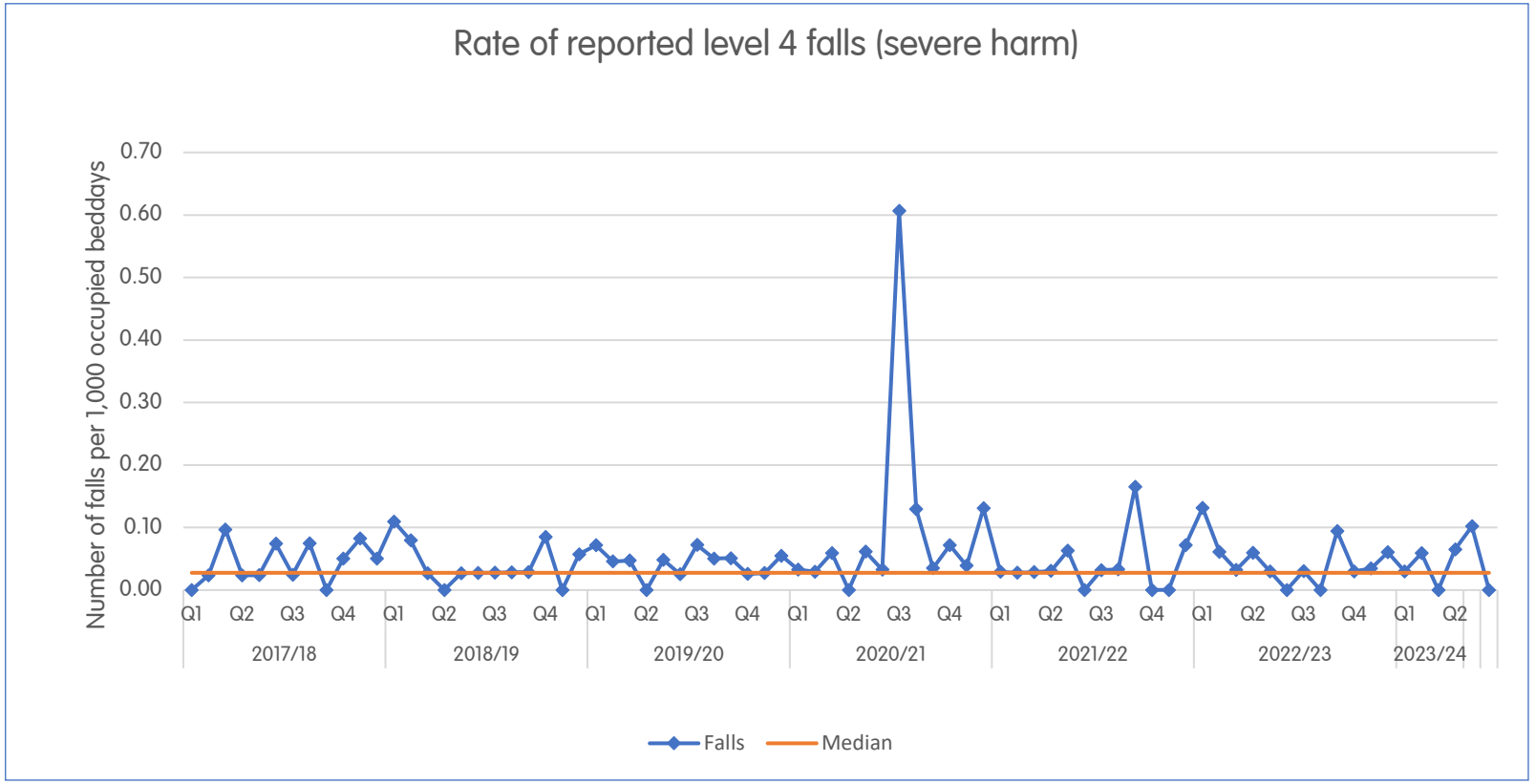
Level 2 falls (low harm) over time



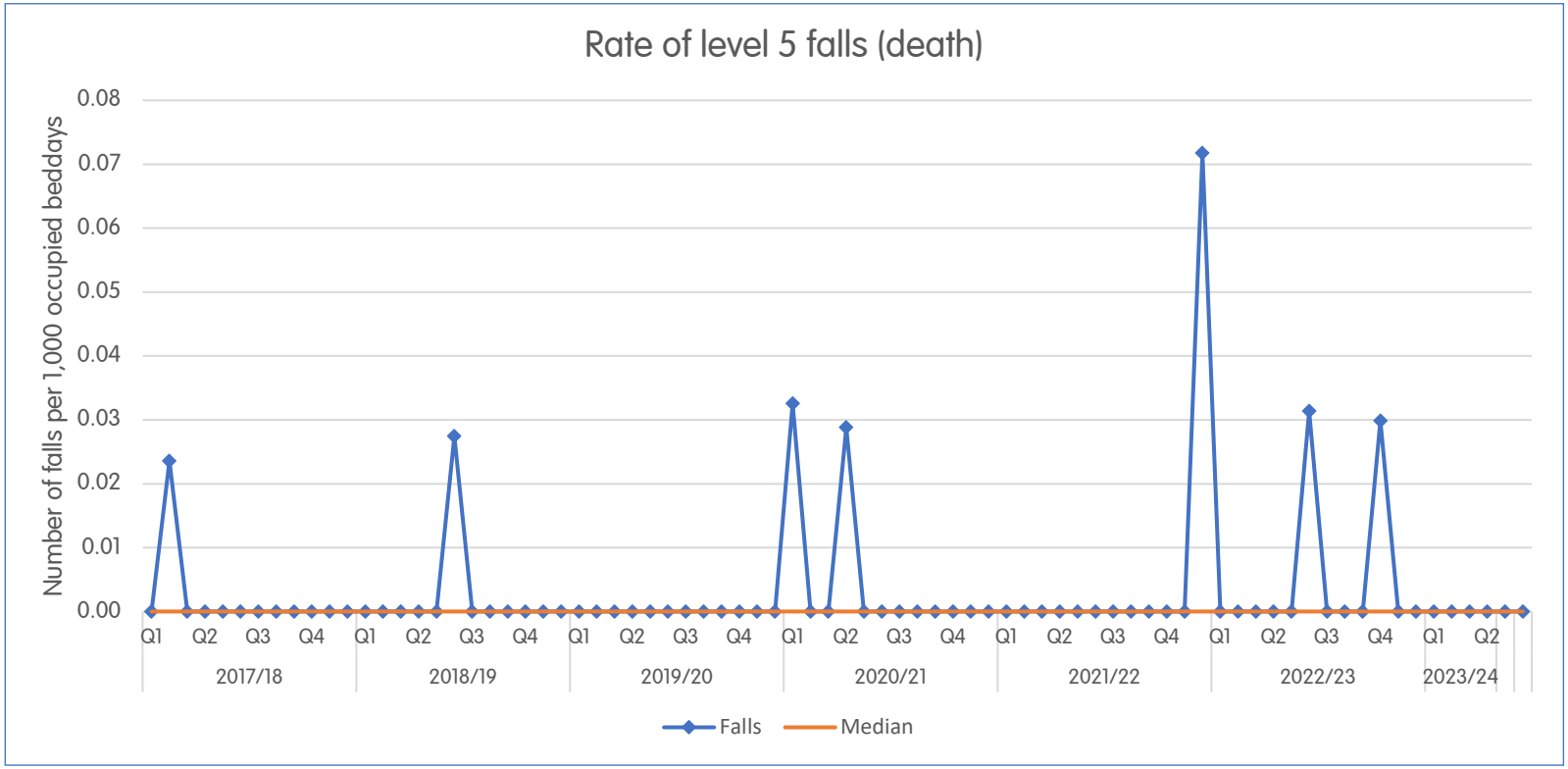
Level 3 falls (moderate harm)over time



Level 4 (severe harm) falls over time

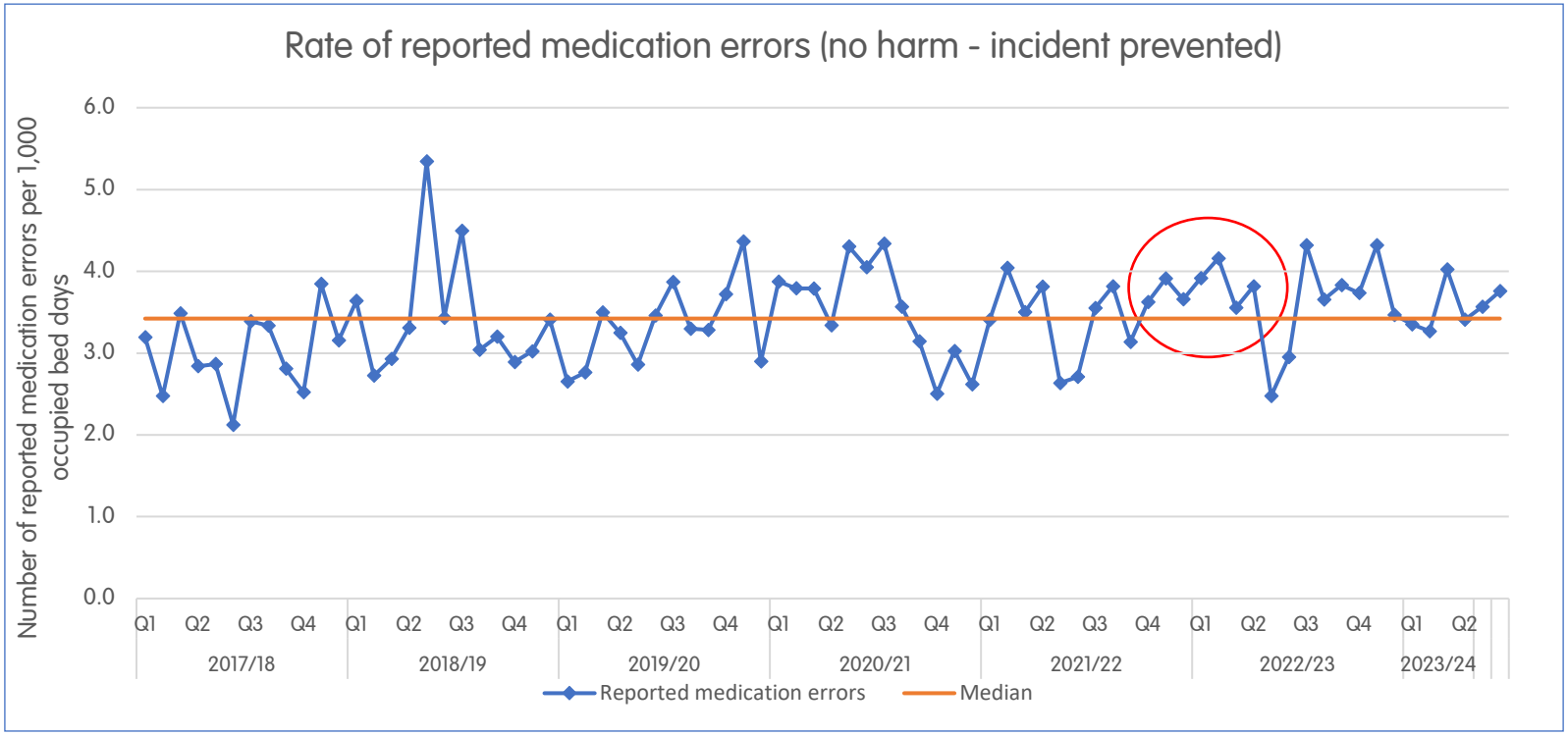


Level 5 (death) falls over falls over time

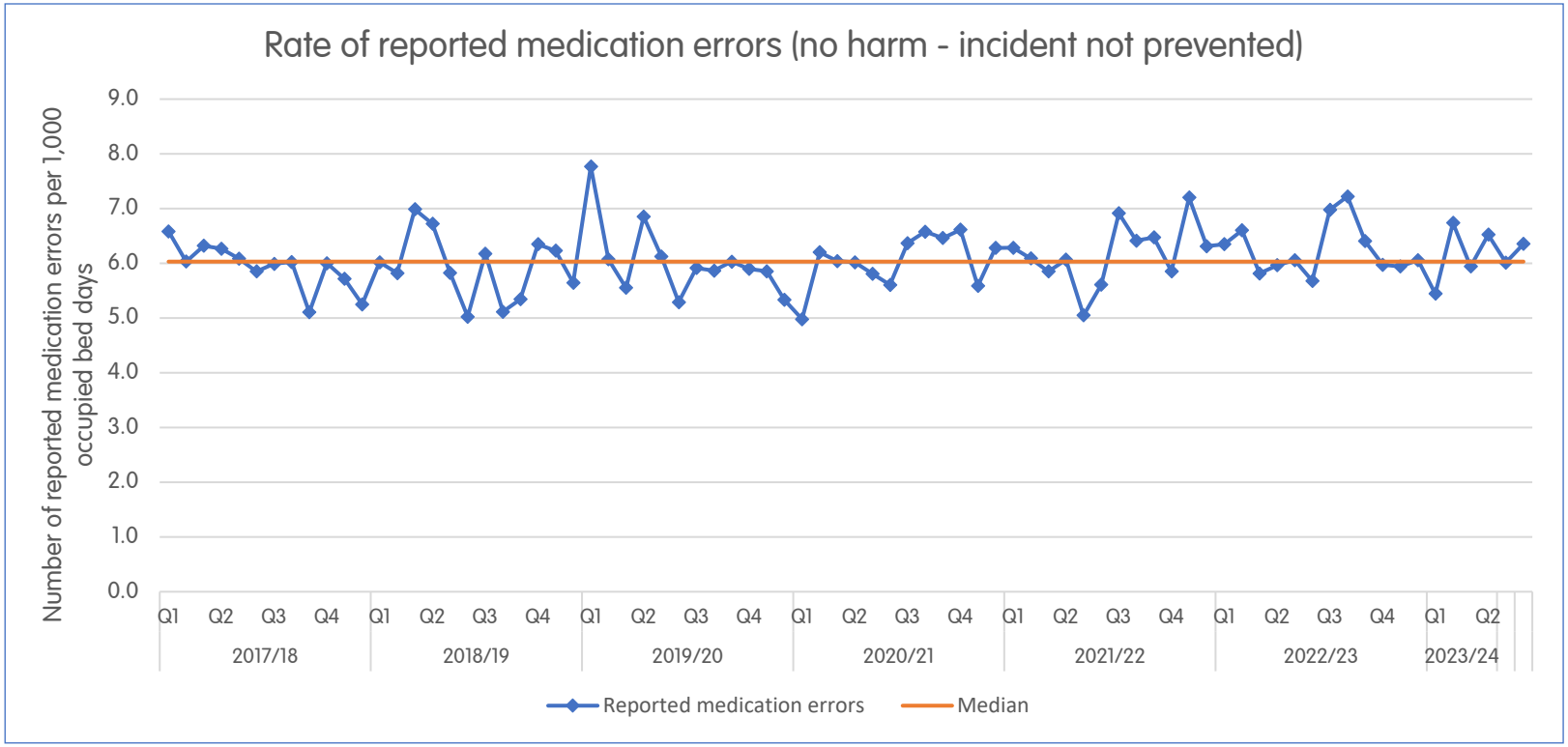


MEDICATION

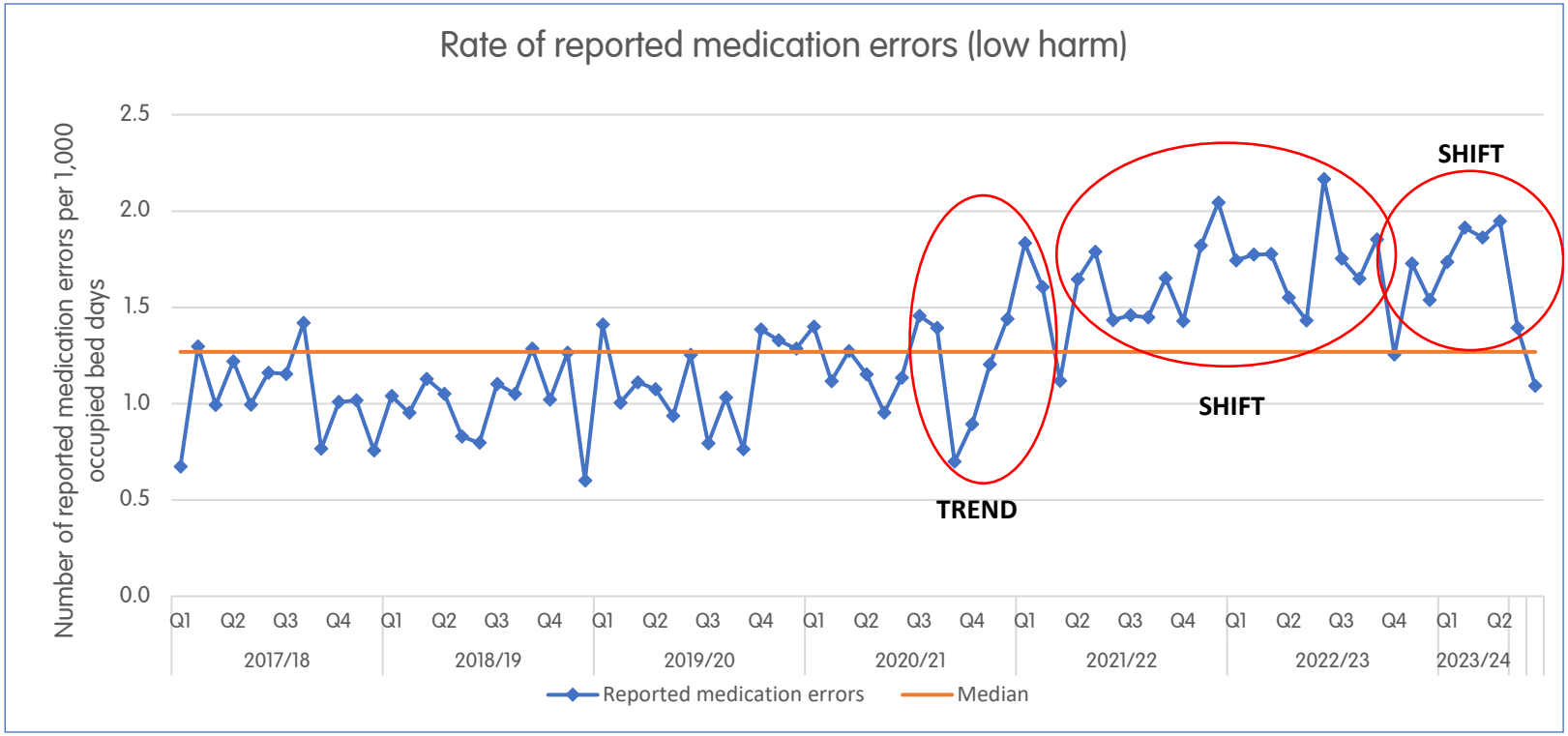
Rate of medication incidents; no harm – incident prevented (adults)



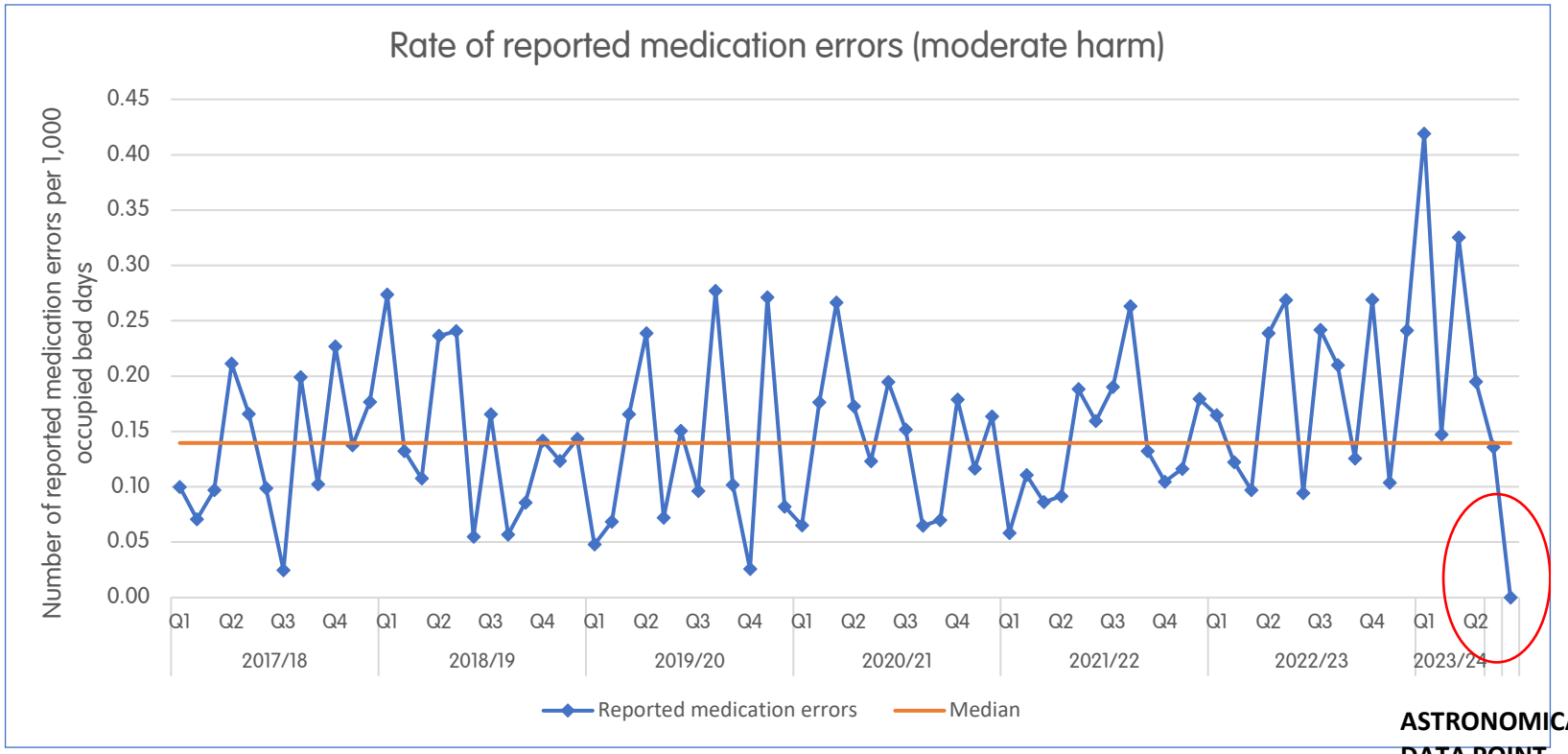
Rate of medication incidents; no harm (incident not prevented)



Rate of medication incidents; low harm

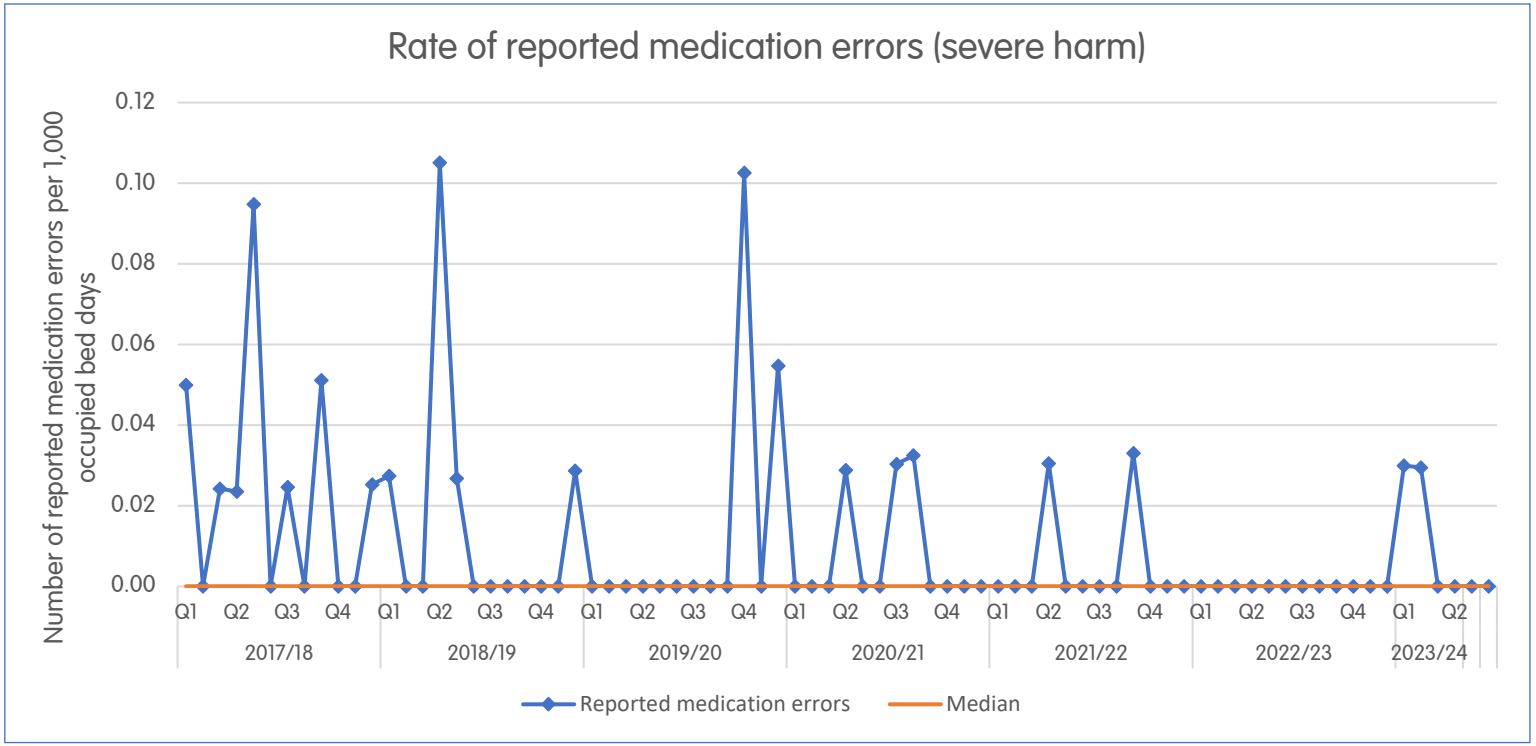


Rate of medication incidents; moderate harm

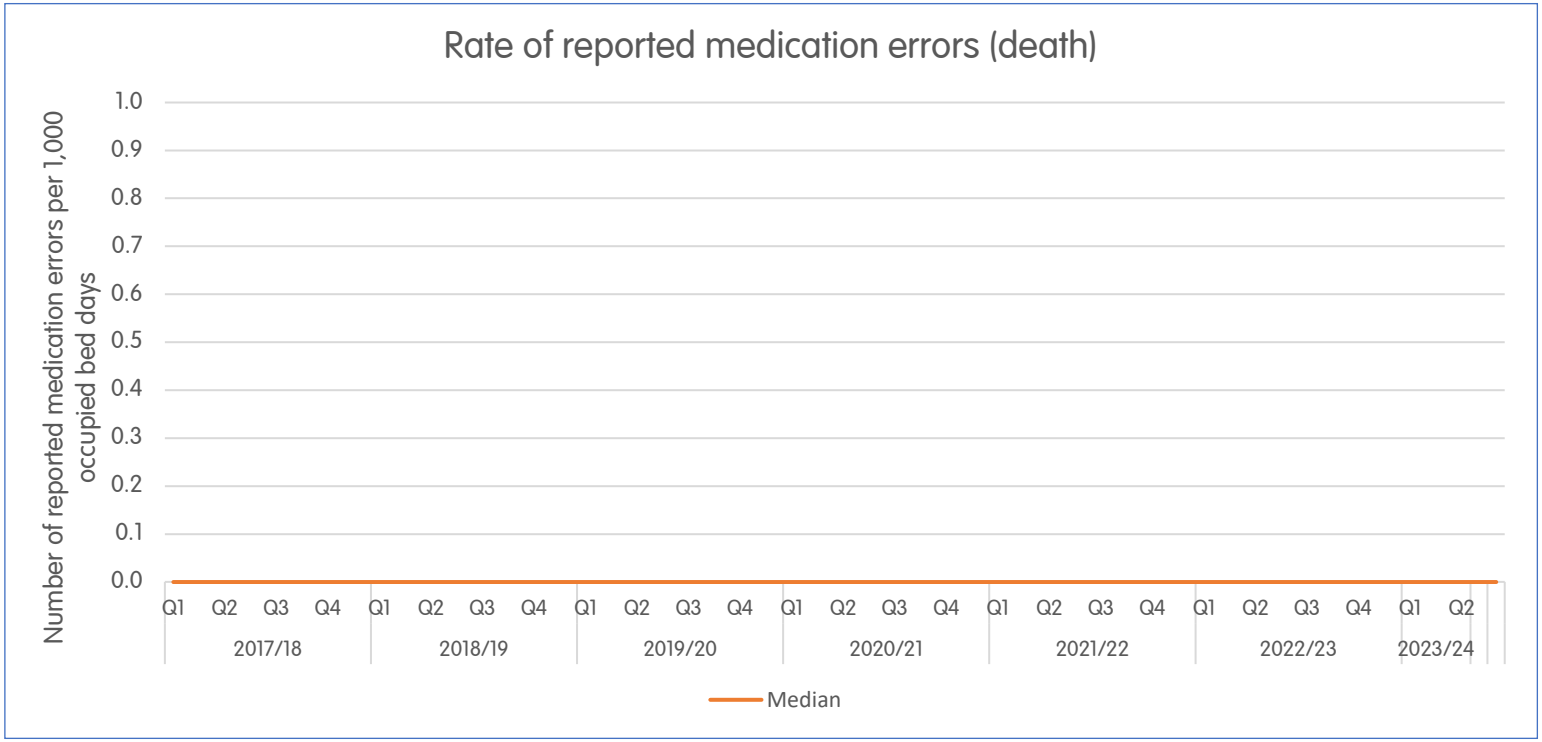


ASTRONOMICAL DATA POINT

Rate of medication incidents; severe harm



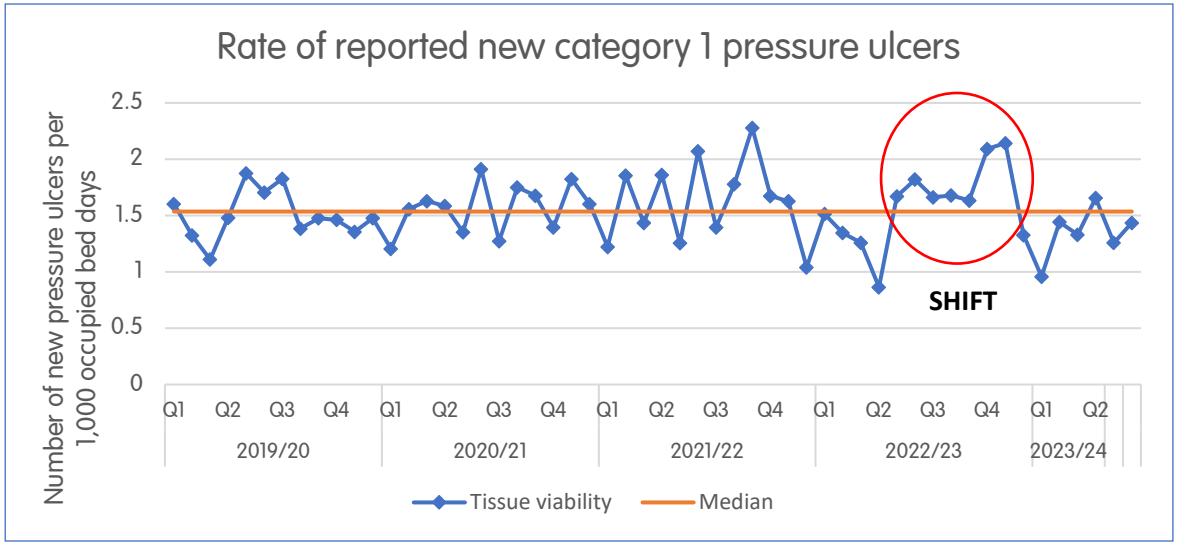
Rate of medication incidents; death

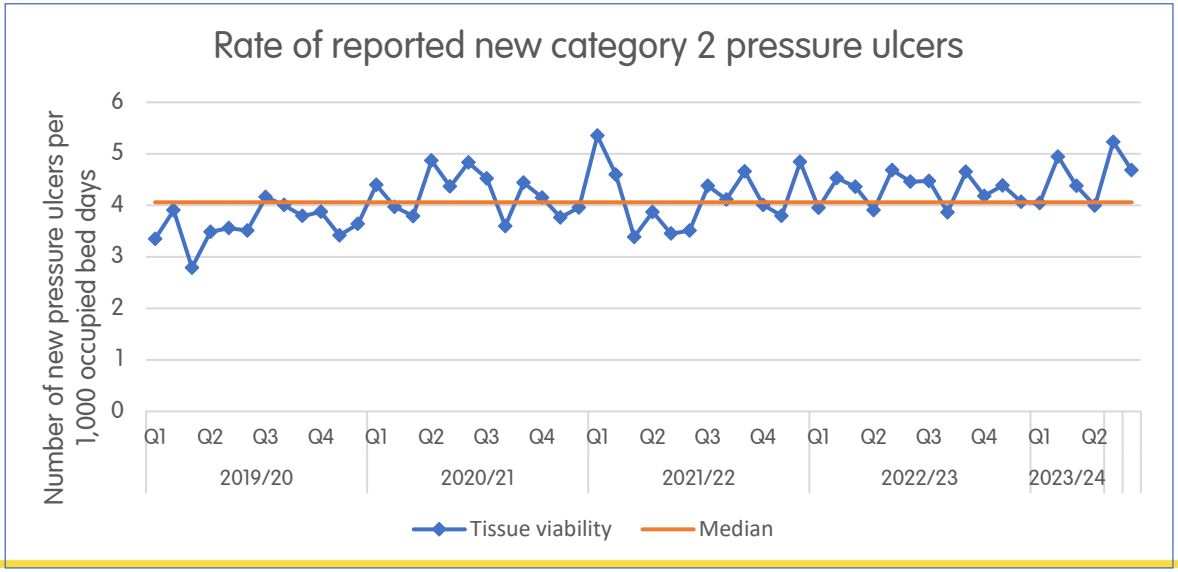


TISSUE VIABILITY

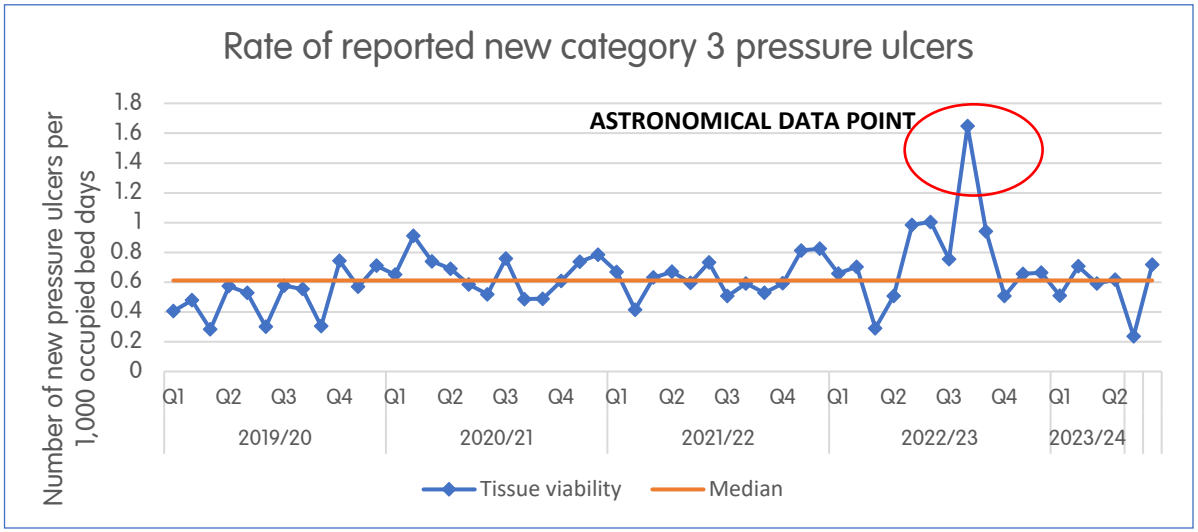
New Pressure Ulcers

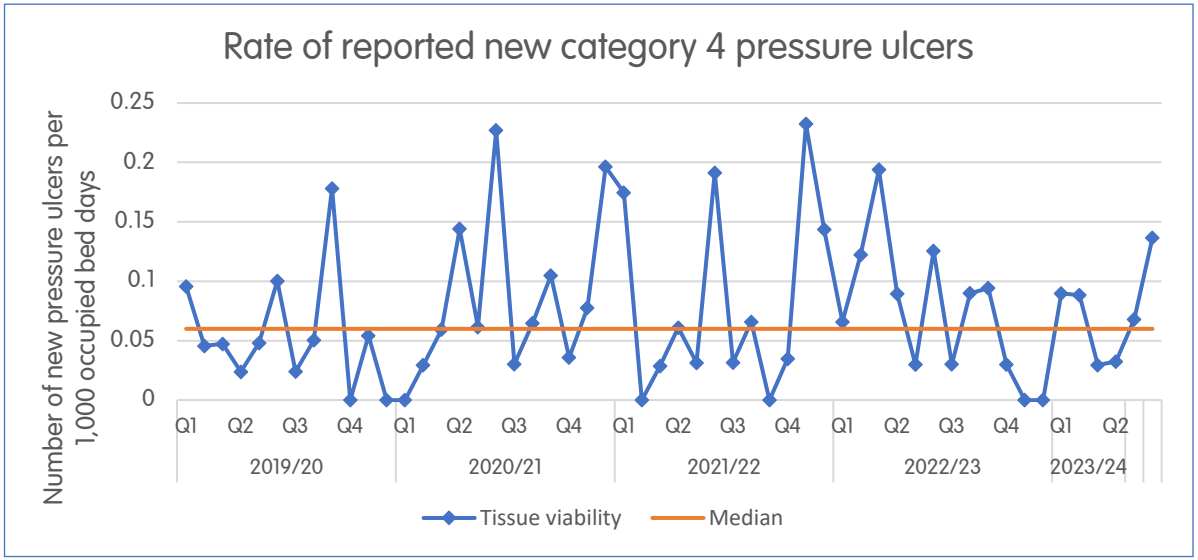
Rate of new Cat 1 & Cat 2 Pressure ulcers



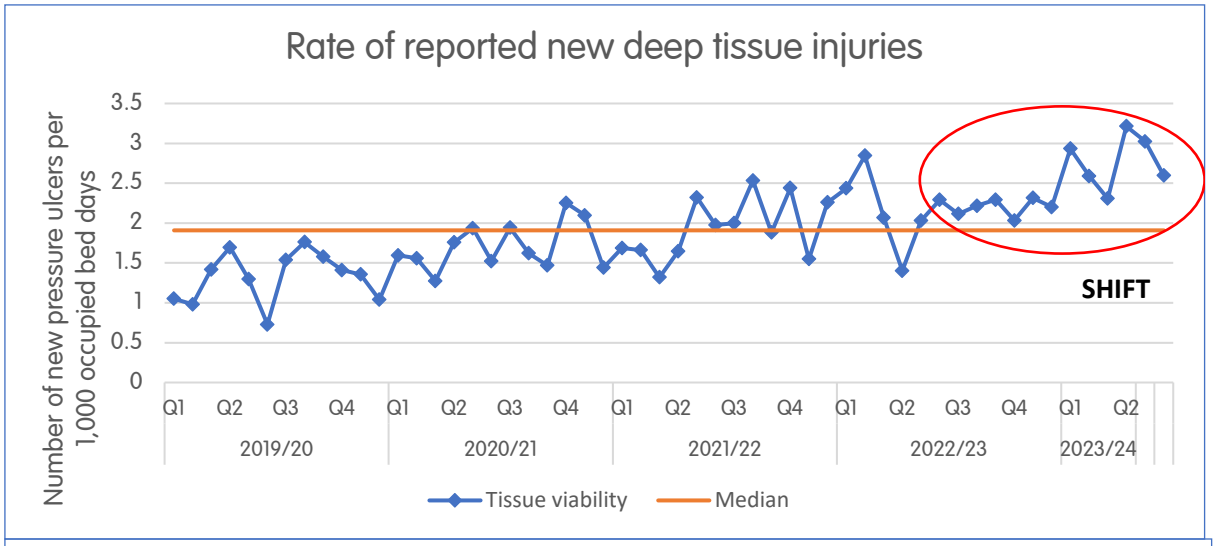


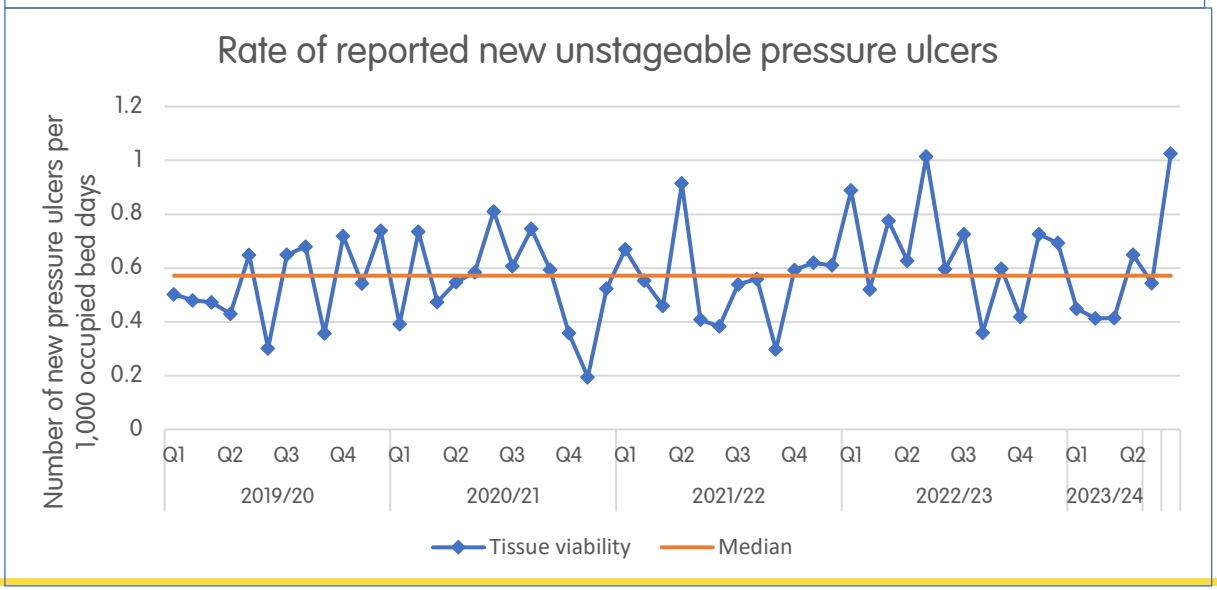
Rate of new Cat 3 & Cat 4 Pressure ulcers



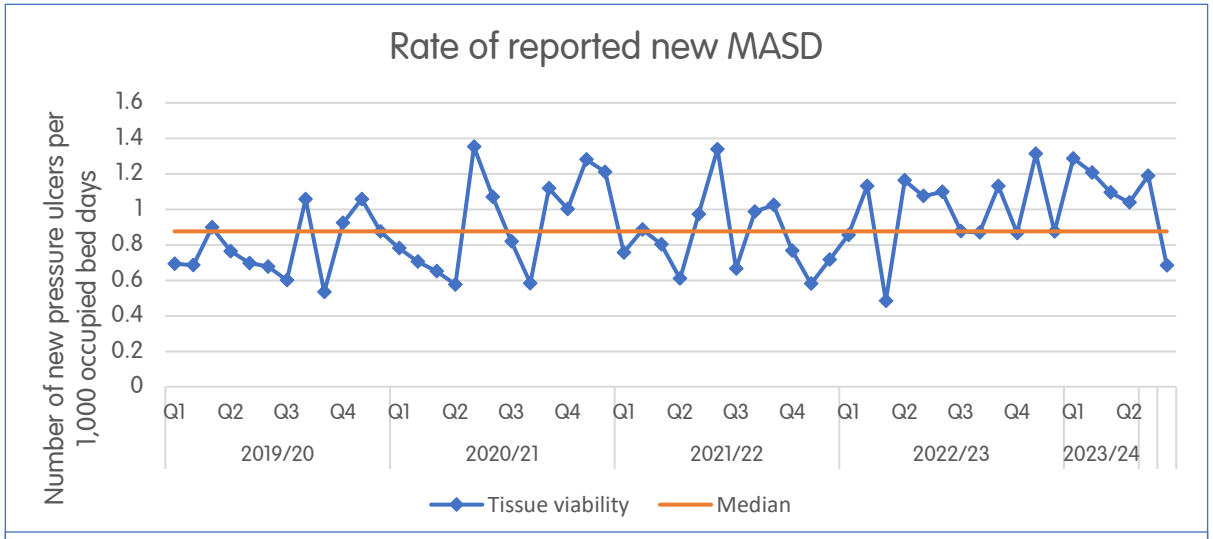


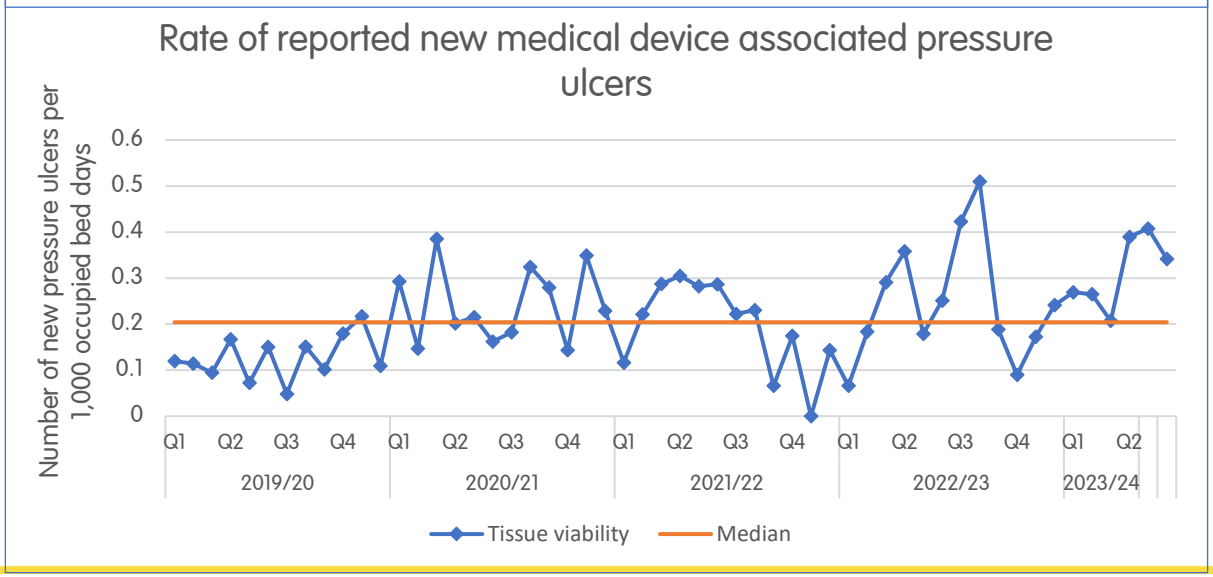
Rate of new DTI's & US Pressure ulcers





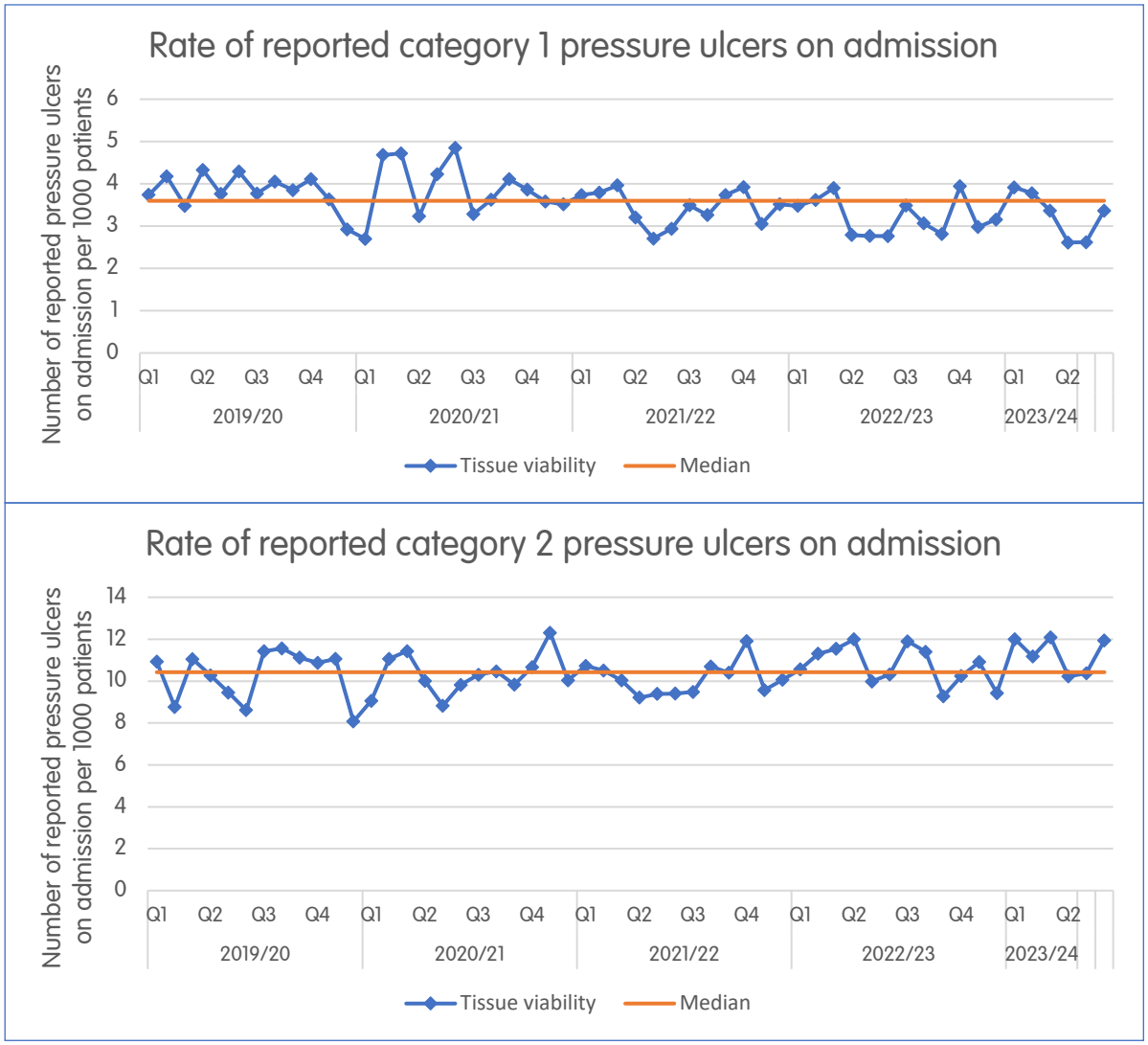
Rate of new MASD & MDA Pressure ulcers



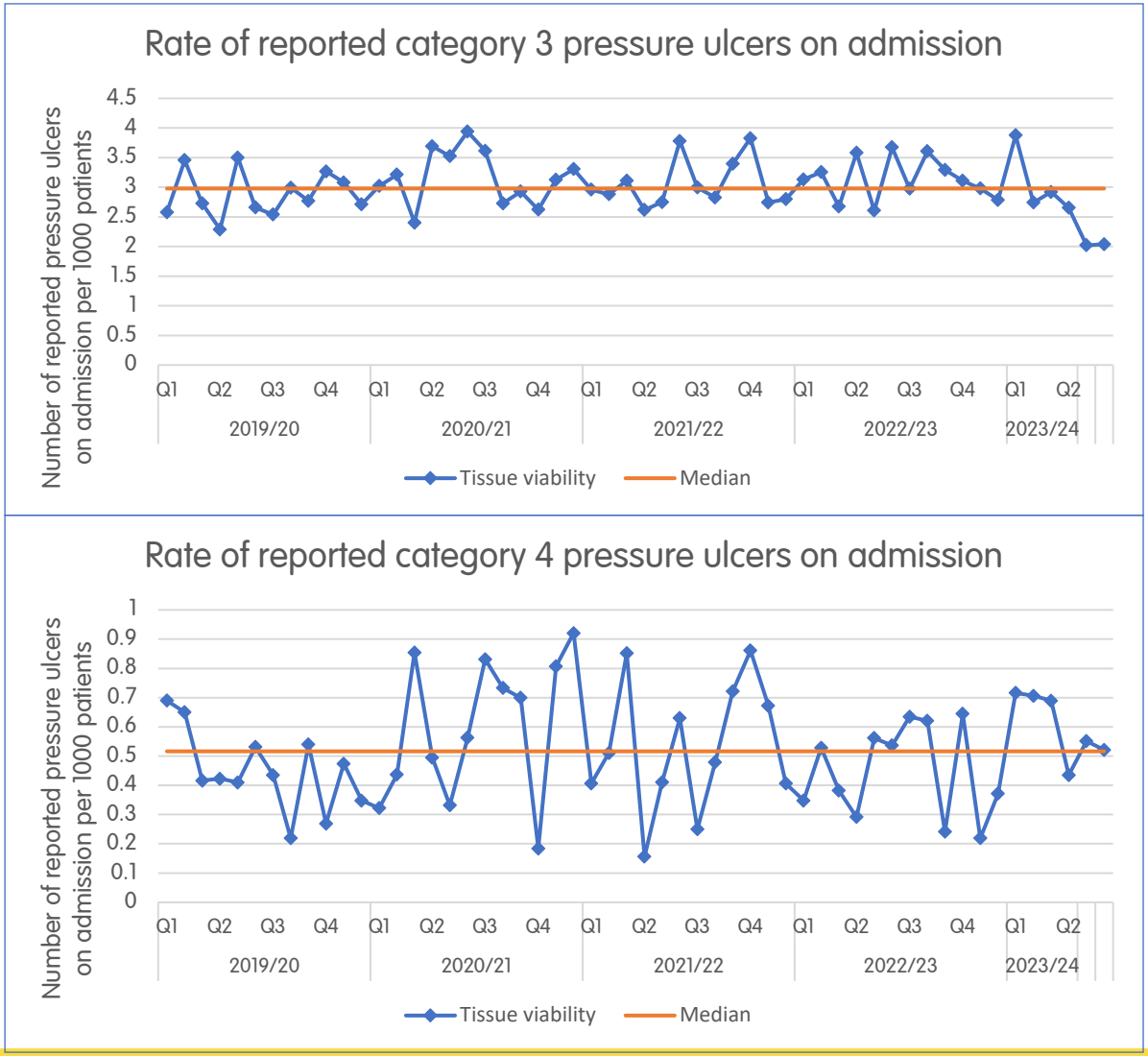


Pressure Ulcers on Admission

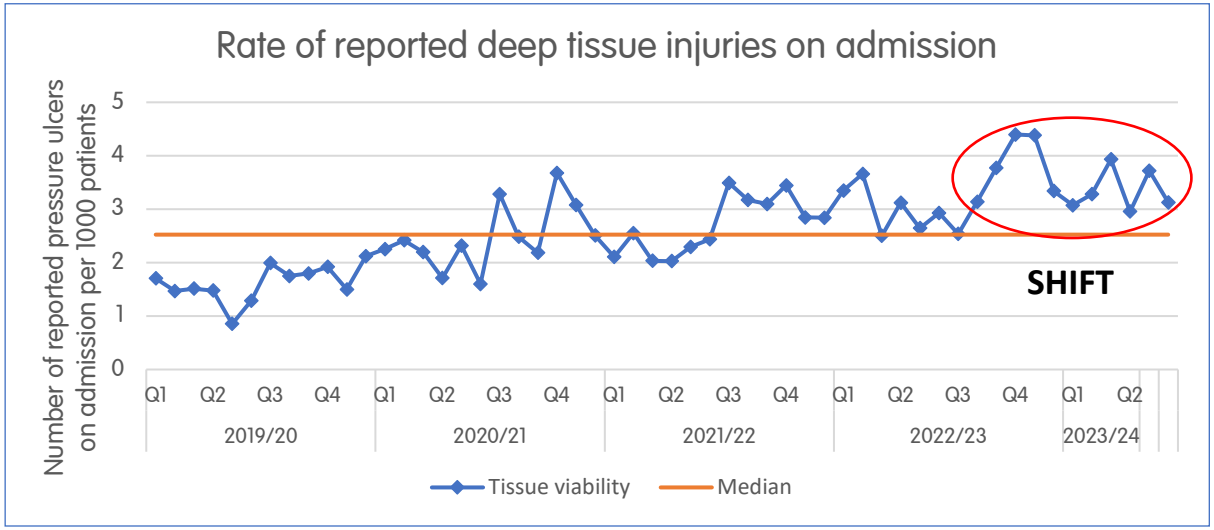
Rate of Cat 1 & Cat 2 Pressure ulcers

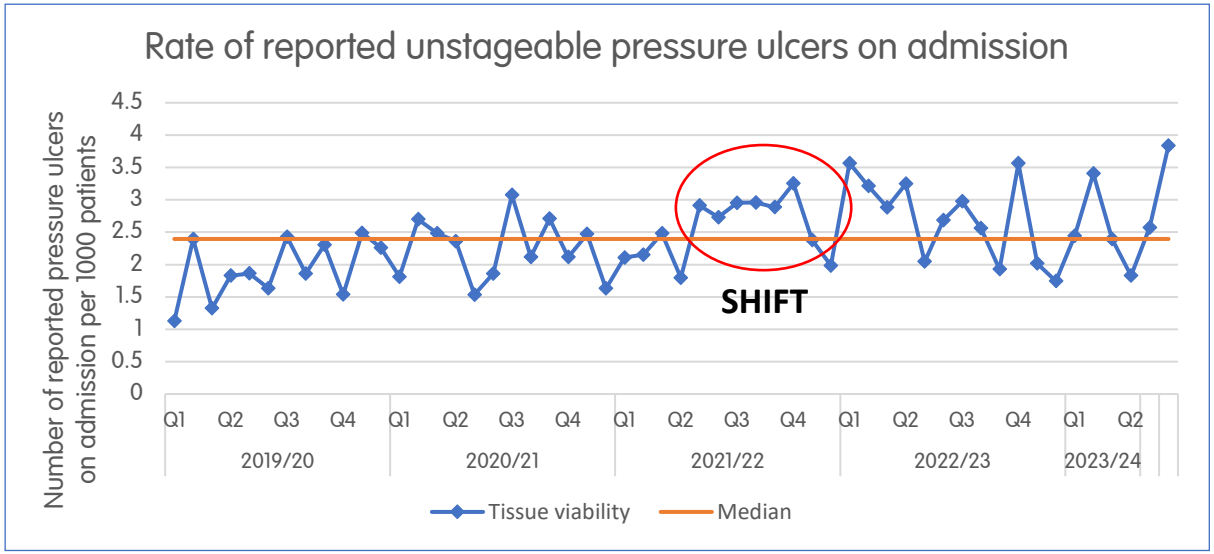


Rate of Cat 3 & Cat 4 Pressure ulcers

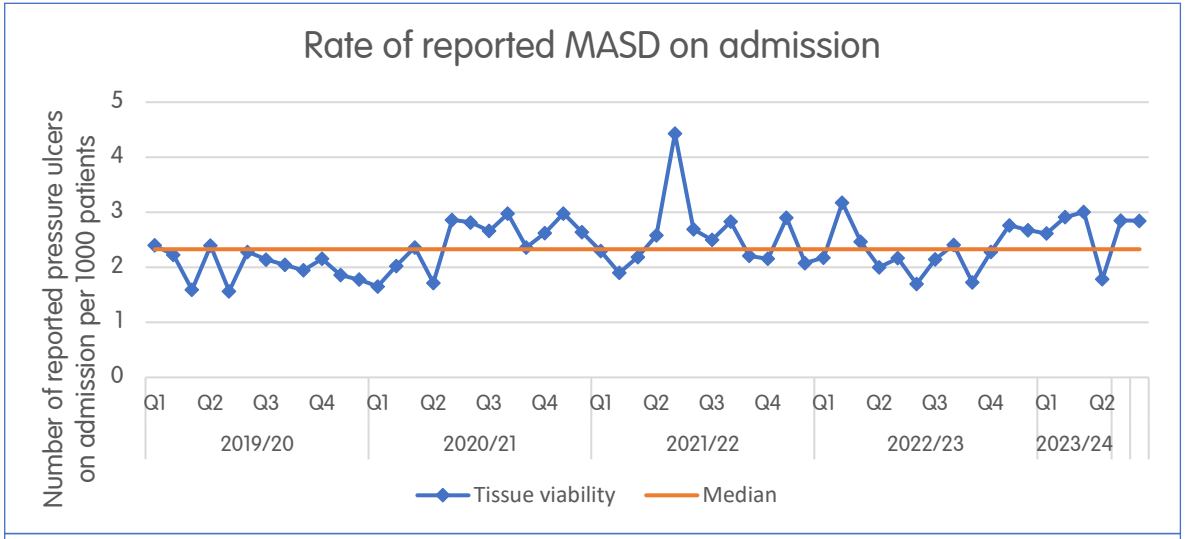


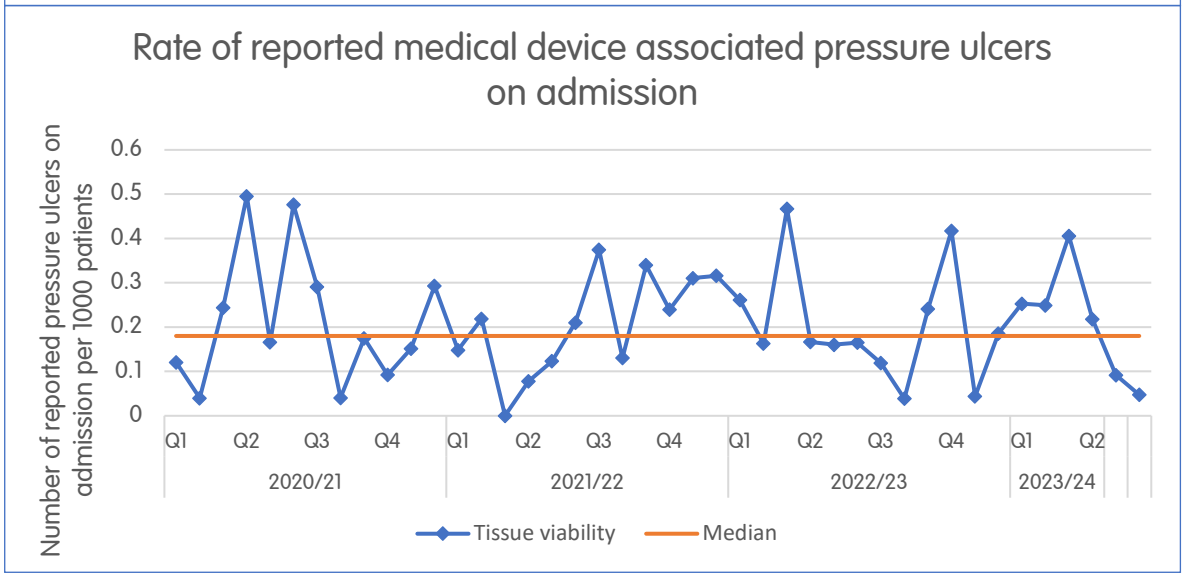
Rate of DTI & US Pressure ulcers





Rate of MASD & MDA Pressure ulcers





PSIRF TEAMS CHANNEL

Please contact Julia if you'd like to join.

How to get involved:

Follow MHRA social media channels during the week – repost, retweet, share new patient safety messages encouraging Yellow Card reporting

Organise local events to raise awareness about the importance of reporting suspected problems with healthcare products to the Yellow Card scheme.

Yellow Card website resources section contains downloadable materials to help you raise awareness locally and encourage reporting, such as:

- Banners (email, Facebook, Twitter, Linkedin)
- A4 downloadable poster to **print and put up in waiting areas or exhibition stands**
- Digital screen advert to **display on TVs or screensavers**.
- **Encourage colleagues to complete CPD accredited Yellow Card training** courses: e-learning modules

Childrens Hospices:

SteriFeed Colostrum Collection device and risk of choking due to infant airway occlusion, DSI/2023/010

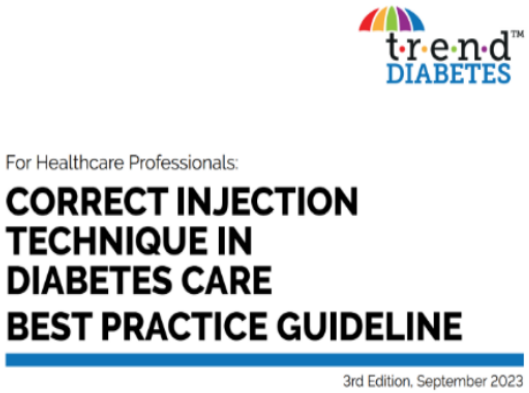
The SteriFeed colostrum collection device is intended to be used only to collect and store colostrum. It should not be used as an infant feeding device as the cap, if not removed, can easily get dislodged and become stuck in the baby's throat.

- Remove the cap before using the device.
- When instructing parents on using the device, remind them to always remove the cap from the tip of the syringe prior to use.
- Advise parents on how to feed the collected colostrum to the baby.

SteriFeed Colostrum Collection device and risk of choking due to infant airway occlusion, DSI/2023/010 - GOV.UK (www.gov.uk)

Insulin pen safety needles updates and resources from TREND

- TREND have recently produced a useful document as part of their Injection Technique Matters resources.
- Whilst there are many manufacturer resources for how to use both active and passive devices safely, there may be under-recognition for access to active insulin pen safety needles as these are possibly considered second generation when compared to passive devices that were initially introduced after the implementation of the EU Directive 2010/32/EU *Prevention from sharp injuries in the hospital and healthcare sector.*
- Both types of safety engineered needle devices (SENDs) have different modes of action with regards to mechanism of use, which with regards to usability, should be considered when purchasing to ensure staff awareness of how they are used to support accurate dosing.
- Use of any device for insulin administration must consider wider system factors in who is performing administration and the impact that frequent staff changes or reliance on transient staff may have on education and training in use.
- If there are supply disruptions with one type of SEND it must be recognised that an alternative may have a different mechanism of action. Failure to understand this prior to accepting alternatives for use, may result in patient harm unless supported by education and training.
- Education and training in use of both active and passive insulin pen needles is of utmost importance to ensure accurate insulin dosing and appropriate management of diabetes care.

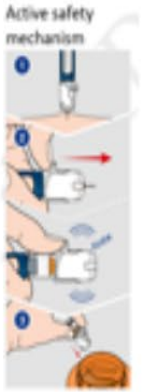


Insulin pen safety needles updates and resources from TREND

Passive insulin pen safety needles: consistent pressure has to be applied on contact with the skin (to puncture the skin) and throughout delivery of the medication. Once pressure is reduced the safety mechanism deploys and contact with the patient is lost, meaning any undelivered medication will sit either in the device or on the patient's skin.

UPDATE

Active insulin pen safety needles: mechanism for skin puncture and delivery is similar to the technique for insulin pen delivery via a conventional (non-safety) pen needle. However, reliance is on the user to activate the safety device to protect the user and promote safe management of sharps.



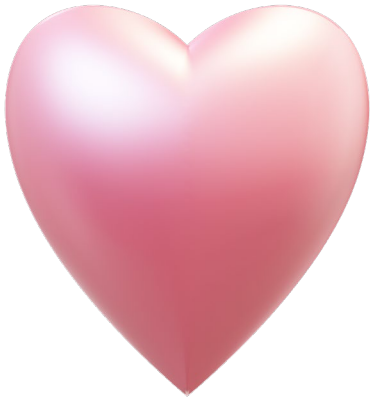
hospiceUK

Sharing Current Scottish Practice

The SPPC Autumn Season 2022 featured an online poster exhibition of 55 posters, sharing work and research underway across Scotland. Each month, our blog highlights a few of these posters. This month, we're highlighting:

- **Views of Care at End of Life:** An action research study exploring the best ways of eliciting patient and family views of end of life care and giving real time feedback in acute hospitals
- **Views of Care at End of Life:** Using Care Opinion to explore end of life experiences
- **When Sage and Thyme met Zoom**
- **Working as a true multi-disciplinary team**

The SPPC blog is a space to share practice currently underway in Scotland. If you have practice you'd like to share, please get in touch.



Next Meeting:

14 February

Please get in touch if you would like the opportunity to present on medication safety or would like to suggest guests to join us.

Submit

https://www.hospiceuk.org/innovation-hub/clinical-care-support/quality-improvement/patient-safety

Quarter	Months	Submission deadline	Final reports circulated
Q1	Apr, May, Jun	14 July 2023	28 July 2023
Q2	Jul, Aug, Sep	13 Oct 2023	27 Oct 2023
Q3	Oct, Nov, Dec	12 Jan 2024	26 Jan 2024
Q4	Jan, Feb, Mar	12 Apr 2024	26 April 2024

request a copy of the submission links:

https://www.hospiceuk.org/professionals/clinical-and-care-support/quality-improvement/patient-safety-project/request-submission-links

Thank you