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Sustained pressure ulcer reduction through validation of incidents

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Background

Pressure ulcers are a key indicator for quality and safety within NHS hospitals; recognised as an avoidable harm that can cause increased pain and suffering for vulnerable patients (NHS England, 2018). Reporting of pressure ulcer harms through the Datix system plays a vital role in measurement of incidents, as it allows for continuous monitoring and analysis. Data obtained through reporting can support in successfully implementing targeted and effective quality improvement initiatives. However, it should be highlighted that pressure ulcer reporting can often be inaccurate (Ho *et al*., 2017), which in turn could reflect negatively on an organisation (Coleman *et al.*, 2016). It is also crucial to avoid underreporting of serious harms such as category 3 or 4 pressure ulcers (Macdonald *et al.*, 2021), to avoid risk of further harm to the patient and to correctly identify opportunities to improve through shared learning.

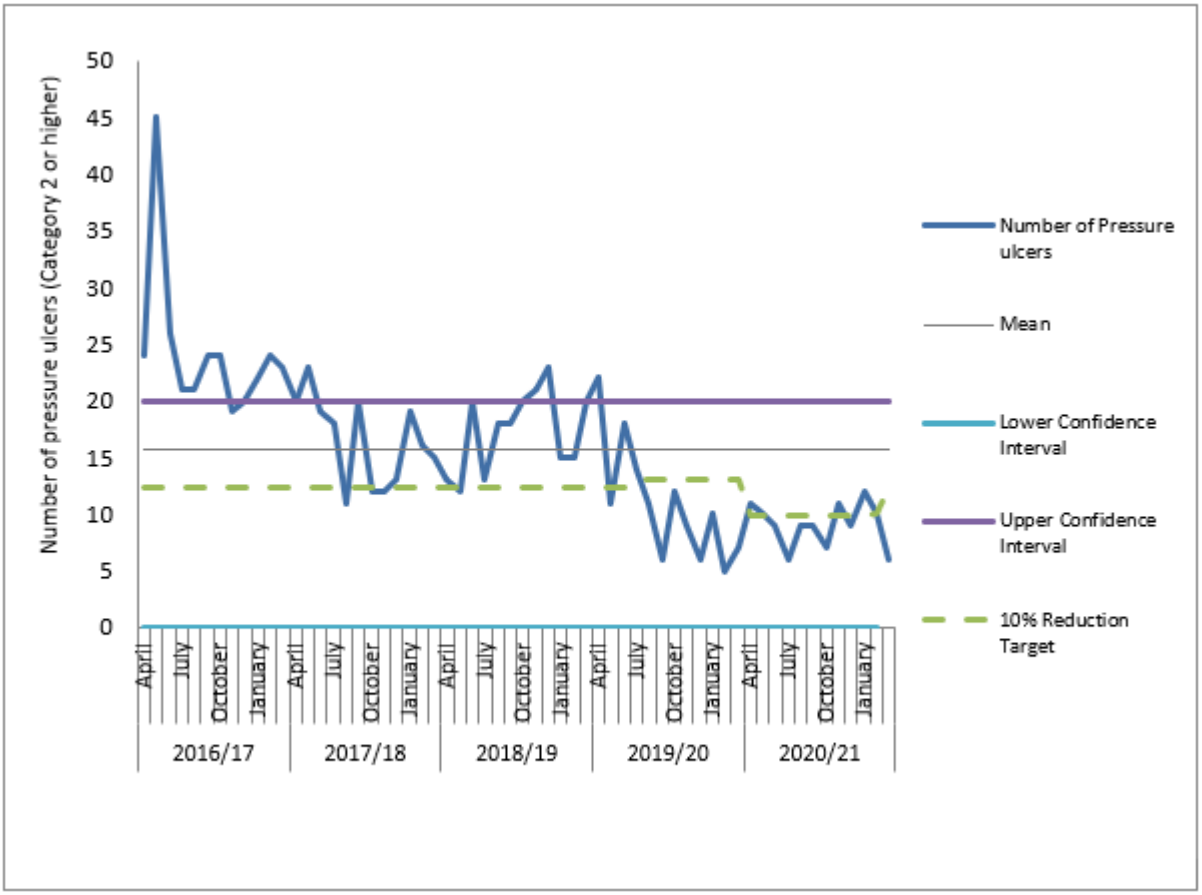
Evidence implementation

The Tissue Viability (TV) team at the Royal Cornwall Hospital have undertaken quality improvement projects to transform pressure ulcer practice. Following successful Plan, Do, Study, Act (PDSA) cycles (NHS Improvement, 2018) and dedication from the team, a robust validation process was implemented. The TV Assistant Practitioner (TVAP) plays a crucial role; undertaking a clinical assessment of the patient, a review of care needs, root cause analysis investigation, and providing education and support for staff in practice. Themes are then reviewed by the TV Clinical Nurse Specialist through monthly pressure ulcer reports. Clinical areas that have reported pressure ulcer harms are invited to monthly meetings to share learning and provide support where required (Ho *et al*., 2017).

Results

Following implementation of a focused validation process, pressure ulcer harms were reduced by 50%, meeting the reduction target set by the trust. The target was lowered in April 2020 by a further 10% which has been sustained (Table 1), apart from two winter months in 2020 where incidents went slightly over target.

Table 1:



Conclusion

A robust and conclusive approach to pressure ulcer validation has enabled a sustained reduction in reported pressure ulcers. A true representation of incidence enables support and shared learning where it is most required promoting safe, evidenced-based, patient-centred care (NHS England, 2016). The role of the TVAP has enforced this focused approach to harms reduction and culture change within the trust. Within the current NHS climate and drive for change agents (NHS England, 2016), it should be put forward that innovation and improvement can and should be a part of everyday clinical practice, to shape the future of health care and safeguard our most vulnerable patients from harm (The Kings Fund, 2017).

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