

Using service improvement methodologies to reduce the prevalence of pressure ulcers in NW London

A Review of Pressure Ulcer Data Analysis Systems in use in North West London

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Background to the project

The aim of the North West London pressure ulcer project has been to build up and expand the work carried out by the Community Education Provider Network (CEPN) team in 2013/14. Imperial College Health Partners (IHP) are engaging with various stakeholders to explore the benefits of a single joined up approach across our partners in NW London to improve the prevention and management of pressure ulcers.

The overarching aim of this project has been to align the existing pressure ulcer initiatives into a harmonised and collaborative project to achieve improved capability in preventing and managing pressure ulcers across the health care providers in NW London.

The project reported on here, was funded and supported by Imperial College Patient Safety Centre and focused on one particular aspect of pressure ulcer prevention and management: the development of a joined up patient information system. However, the project team has been keen to learn and adopt best practice from other AHSNs and engage with subject matter experts nationally and internationally where this could be used to inform good practice in NW London.

Purpose of the Study:

The service improvement study reported here built on the earlier work undertaken in the Community Education Provider Network (CEPN) project (funded by Health Education NW London) into the prevention and management of pressure ulcers. The CEPN identified a number of issues which fell outside the remit of the CEPN project but which are important in informing strategies for pressure ulcer prevention and management. These are:

1. Lack of an agreed cross organisational methodology for validating the grading of pressure ulcers.
2. A focus on prevalence data which is suitable for monitoring trends over time but not detailed enough to inform service improvement activity.
3. Lack of statistical controls on prevalence data which makes interpretation with small numbers difficult.
4. The absence of an agreed process for measuring incidence of pressure ulcers across provider organisations leading to double and occasionally treble counting which adversely affects meeting the sector target.
5. The attribution of pressure ulcers acquired at home to community services even though the community services were not involved in the patient's care.
6. Grade 3 and 4 pressure ulcers are subject to mandatory reporting as a serious incident. All high grade pressure ulcers are investigated using root cause analysis (RCA) methodology. Currently there is no agreed and standardised methodology for undertaking RCAs with individuals and organisations conducting their own investigations according to local procedures. The lack of an agreed methodology makes comparative analysis difficult and reduces the systemic learning that could be achieved if the approach to RCAs was standardised across provider organisations in NW London.
7. Confusion about the roles and responsibilities of the non-registered workforce in assessing and preventing skin damage from pressure with NICE guidance recommending referral to a registered health care practitioner for assessment of all grades of pressure damage. This

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creates delays which often result in the development of a more serious pressure ulcer than would have occurred if the non-registered workforce had been enabled to instigate preventative actions based on principles of self-care.

In response to these findings Imperial College Patient Safety Centre provided funding for this further study to develop a coherent and integrated information system for the measurement of all grades of pressure ulcers across NW London.

Benefits and Risk

The benefit of this research is that it will help provider organisations to understand the capabilities of the current pressure ulcer data systems in place with recommendations for improvements across organisational boundaries. This will inform choice of reporting in the future in reducing risk of duplication and omission and increasing the efficiency of this aspect of practice.

We anticipated that we would uncover variable practice in relation to the collection of pressure ulcer data. The project was designed to provide answers to enable provider organisations across the system to address this variation in practice.

The goal is that provider organisations work together across NW London to develop a system where an individual patient can be tracked by all organisations they come into contact with across the system. The benefits of this are:

- improved patient care and management of the pressure ulcer
- reduction in duplication of data collection and reporting
- reduction in variation of reporting
- improved monitoring of care
- valid and reliable data that enables confidence in the effectiveness of improvement strategies

Continuing with the current system where patients cannot easily be identified; creates poor communication, increases workload on front line staff to assess and manage the patient without prior information, perpetuates excessive time spent by staff on attributing the pressure ulcer to an organisation for reporting purposes, perpetuates duplication of data reporting to central agencies such as Safety Thermometer (ST) and Strategic Executive Information System (STEIS) now the Serious Incident Framework see <https://www.england.nhs.uk/patientsafety/serious-incident/> Collectively this results in fragmentation in the patient experience and poor management of the pressure ulcer.

The aims of this study were to:

- Develop a validated, standardised and systematic approach to the collection of point prevalence data on pressure ulcers across NW London.
- Develop a validated, standardised and systematic approach to the collection of incidence data on pressure ulcers across NW London to inform service improvement strategies and to reduce prevalence.
- Develop a validated, standardised and systematic approach to the collection of RCA data across NW London to develop effective learning cycles contributing to service improvement and the reduction of prevalence.
- Improve the effective use of data currently collected on pressure ulcers across NW London.

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Process

A questionnaire was designed, with ethical approval given by Buckinghamshire New University ethics committee with the intention of understanding organisational pressure ulcer incidence and prevalence data collection systems across NW London.

To identify a common approach to the reporting of incidence and prevalence before embarking on designing a data collection system that could be used across the sector.

Participating Care Organisations

Two Secondary Care organisations; one of the organisations required two respondents to complete the questionnaire due to divisional differences in reporting

Two Primary Care organisations; one of the organisations with three divisions; the provision of care included General and Mental Health Care (Primary, Secondary and Care Homes)

One Mental Health Primary & Secondary Care organisation

Thirty Domiciliary Care staff across a wide spectrum of care providers

Two Care home organisations (one questionnaire completed by a large national care home provider and covered their national policies)

There were no Foundation Trusts respondents.

Methodology

A Total of nine NHS organisations in NW London, plus several multiagency domiciliary care agencies with a total of 30 respondents completed the survey.

The key NHS primary and secondary care organisations in NW London completed the questionnaire. The remaining participants included Mental Health, Care Home, and Domiciliary Care Organisations. Individual Care Home owners and Managers were contacted by the Safeguarding Adults Manager from CWHHE CCG but when followed up with telephone conversations were reticent to participate.

It was envisaged that the results from the survey would inform Imperial Patient Safety Centre and Imperial College Health Partners to identify the most appropriate way to develop an accessible integrated information system designed to overcome the problems identified.

The questionnaire was piloted prior to final implementation to ensure the validity of the content. Ethical approval was obtained prior to the start of the survey.

Each questionnaire was completed electronically and stored in a bespoke spreadsheet on a shared folder in Bucks New University site with approved access for members of the project team.

The questions were designed to answer the following:

- What data provider organisations currently collect on pressure ulcers
- How provider organisations collect data on pressure ulcers
- How provider organisations record data on pressure ulcers
- The electronic and paper systems used to record data on pressure ulcers
- Who receives the reports on pressure ulcers and what do they do with them

The survey questionnaire comprised of seven single and multiple response questions; with additional free text options (Appendix 1). The data was collected using either a structured face to face or telephone interview. The interview was recorded and used to populate the questionnaire.

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Once the questionnaire had been completed the recording of the interview was deleted. The interview was not transcribed. To note: not all organisations answered all questions.

To improve knowledge and understanding of current systems and processes in place for PU reporting other personnel were also consulted including the National Safety Thermometer Team (ST), Salford; two NHS safeguarding leads; the Director of Quality and Audit and two other quality managers working in three separate large care home organisations; two care home managers; three teams working in separate NHS organisations recruited by East Midlands Academic Health Science Network in NHS organisations to reduce PU damage; a senior trial co-ordinator, Clinical Trials Research Unit (CTRU), University of Leeds; a tissue viability consultant nurse and three tissue viability nurses; senior personnel working for the data reporting companies currently in use in NHS organisations. The following definitions are used throughout this report:

Point Prevalence	The number of people with a PU at a specific point in time as a percentage of the total or average total of the numbers at risk at that point in time within a reporting organisation	This information is uploaded by provider organisations to ST on one specified day each month and is designed to monitor the increase or decrease (trend) in PU numbers in the NHS provider organisation. It does not hold patient specific data so is open to multiple reporting of the same person over a period of time or even on the same day.
Incident reporting	Patient identifiable data on the occurrence of a PU on one individual. The reporting should include why the ulcer occurred/ serious incident information	The detail of the case can be used to improve knowledge on why the ulcer occurred in the specific care environment. This data can then be used to populate incidence data to show an increase/decrease in PU numbers it often takes the form of a root cause analysis (RCA).
Incidence reporting	The number of people newly diagnosed with a PU divided by the whole population at	Patient identifiable data that should be stored on a system that can be shared within an organisation or across

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	<p>risk in the organisation/care system or population</p>	<p>agencies to reduce duplication/ under reporting with people being lost in the care system. Comprehensive incidence data allows an analysis of the total number of pressure ulcers in a given population and enables trends to be monitored over time linked to service improvement strategies. This data can also be used to inform education & future practice within organisations and nationally</p>
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Results of Questionnaire

1a. Type of organisation?

There were nine NHS organisations who took part in the survey in NW London. The key NHS primary and secondary care organisations in NW London completed the questionnaire, including one mental health trust plus a collection of care home and domiciliary care agencies with a total of 30 respondents.

Non registered staffs working in domiciliary care are not required to report pressure ulcers. They will request advice from a registered nurse if they recognise the skin damage is a pressure ulcer and the treatment they are providing is not healing the ulcer. The registered nurse should then report via his or her NHS provider organisation. This can result in home acquired pressure ulcers being attributed as a serious incident to community care NHS organisations.

1b. What is the approximate number of beds/community case load of your organisation?

The approximate figures for the number of beds or community caseload were identified by all but two of the NHS organisations so it is possible to provide point prevalence or incidence rather than incident data if the reporting system allows. In domiciliary care the numbers were not known. The consequence is that pressure ulcers seen by domiciliary care workers are an unknown quantity. This also excludes any pressure ulcers being managed in the community by patients themselves or their family.

When identifying prevalence or incidence data of acquired pressure ulcers in an organisation it is essential to calculate per number of bed days or caseload to provide a valid benchmark when comparing the statistics with another organisation or population

1c. What is the ratio of registered nurses to care assistants?

Due to differing job roles within the NHS organisations not all respondents were aware of the detail. There is National guidance for NHS organisations in governance and safe practice for staffing levels. The document 'How to ensure the right people, with the right skills, are in the right place at the right

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time' emphasises monitoring the quality of care as being the key indicator.

<https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-guid.pdf>

One private organisation comprising of 288 care homes employ Quality Managers. Each manager links with 8-10 care homes. The manager is notified of patient harms and links causes to ratios of care staff when required.

In domiciliary care there was reportedly limited access to a registered nurse and access was only via a GP referral. Currently NICE and NPUAP/EPUAP (2014) recommend a registered nurse is required to assess risk and plan care for all grades of PU however increasingly health care assistants (HCA) are providing care at the bedside. There is a requirement for standardising training and competency in PU care for HCA's to empower and recognise the vital job role. Improving the communication pathways between domiciliary care and the NHS is also a priority. <http://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf>

1d. Is a tissue viability nurse (TVN) employed by your organisation?

All NHS organisations employed a tissue viability nurse. The number of TVN's employed was not related to the number of patients or population being served by the organisation. Two organisations had divisional TVN services and one had access to a retired TVN on a case by case basis via a service level agreement. Care home staffs were required to access a TVN via the district nurse or GP referral. Only one domiciliary care worker was aware they could access a TVN. Other domiciliary staff requesting a visit from any trained practitioner required a GP or nurse referral and one had to access NHS services via the social work team.

To access a TVN via a GP or community nurse is time consuming and may result in serious harm to a vulnerable patient so access should not be a postcode lottery. A grade 1 PU can deteriorate to a grade 3 or 4 in a matter of hours. It may not be feasible for NHS services to respond immediately so it is vital care services have an agreed plan of action to reduce the risk of deterioration for the patient.

2a. How is incidence data calculated?

Two NHS organisations reported total pressure ulcer numbers by the number of bed days (incidence). The other organisations reported each pressure ulcer incident but not all could confirm that every ulcer was reported due to lack of validation processes and one did not operate mandatory reporting so some clinical areas chose not to report. Two organisations reported each ulcer on the Datix system but one did not report Grade 1 ulcers. One organisation had the use of Datix but not for PU reporting and one used Datix only for reporting Grade 3 and 4 ulcers. One organisation used paper reporting, submitted on a weekly basis; the governance team transferring the data to an electronic system for each division to use. The IR1 system (an incident report form) was used in one organisation where the infection control nurse was responsible for analysing data and reporting trends.

Two organisations produced a Board report: one monthly and one quarterly. Most organisations held a quarterly quality meeting to discuss reporting trends.

Two of the organisations could not confirm robust action plans from the reporting trend analysis and two where divisional reporting was upheld did not share learning from previous incidents or between divisions.

One care home organisation reported incident data collection, analysed and acted upon internally by quality care managers working across the care homes within their remit. The method of collection was on paper as the incidents occurred, with a transfer of data to an electronic system once a

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month. The quality teams verified the monthly data and worked with individual care homes to monitor the response to change in practice and access to NHS services. Domiciliary care organisations were reporting pressure ulcers to NHS services but only when care staff felt the ulcers required nursing input unless a serious incident.

2b. Is incidence data collected on a 'live' system where data is collected across the whole organisation straight away?

Two NHS organisations were able to access data from their Datix system as the incident was reported. The others who used either Datix, IR1 or paper systems were reliant on either periodic reports or action reports generated by the Board for their organisation. In care homes the manager/owner was able to view each incident on paper. In domiciliary care there was no requirement to keep pressure ulcer data.

2c. How often is incidence data collected?

Only one NHS organisation used the data to provide incidence reporting within their organisation. One organisation reported the information systems and reporting tools were constantly changing. i.e. A finance company, recently employed, were planning to discontinue use of Qlikview and put another their system in its place. The company had been employed to save money and back office functions were one area they believed they could save money on. Qlikview can be used as an add-on to Datix reporting system and provides a live dashboard facility to show where PU's are occurring within the organisation. To lose the ability to track the occurrence of PU's will result in lost opportunities to learn from the incident.

In the remaining NHS, plus the care home organisations the data was either incident or prevalence (ST) reporting or retrospective data, shared with staff either electronically, on spreadsheets or in paper format.

Only population based incidence data can be used to benchmark performance between organisations and over time so currently it is not possible to monitor trends in the number of PU incidents in NW London.

Prevalence data reported to ST can provide trend data if care homes are encouraged to report.

2d. Can the incidence data be shared with other reporting systems?

In order to achieve population based incidence data reporting it would be necessary for each patient to have a unique identifier and be tracked across the system so that the same pressure ulcer is not reported multiple times as currently happens. The lack of unique patient identifiers means this is not currently possible on local or national reporting systems. Moreover local reporting systems such as Datix only capture information on patients using the provider organisation, they do not link up together to track patients across the system.

3a. How is prevalence data recorded?

All NHS organisations were using Safety Thermometer (ST) for collating prevalence data. ST reporting is required on one designated day each month. All new PU's seen on that day must be included but this only provides trend data for that organisation as care homes and domiciliary care are excluded from reporting.

The current use of the 72 hour rule when reporting ST data gives rise to the problem of attribution as the prevalence data has no patient identifier. The 72 hour rule refers to a PU that develops within

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72 hours of admission being attributable to the previous care environment. The time frame is regarded as misleading as observable pressure damage can vary from a few hours to days and sometimes weeks. If the attribution is challenged there is no way of making changes to the ST data once submitted. It also diverts front line staff time to resolving disputes over attribution rather than focusing on improving care pathways across the system.

<http://tvs.org.uk/wp-content/uploads/2013/05/TVSConsensusPUReporting.pdf>

Prevalence data reported to ST can provide trend data within each organisation provided the organisation provides bed days or caseload alongside the prevalence data. It is not however, possible to use this data to monitor performance of the organisation as the prevalence data will reflect variations in prevention and management of pressure ulcers in the local population using the NHS provider organisation. Prevalence data is only useful in monitoring NHS provider care if restricted to the measurement of pressure ulcers acquired while under the care of that organisation. If a patient is transferred between NHS organisations that creates problem of attribution and reduces the reliability of ST data to monitor organisational performance.

Only one care home could be found reporting to ST and this was infrequently. Domiciliary care is not required to report as the recommendation is for a registered practitioner to validate reporting. The PU would then be reported via the registered practitioner provider organisation but be attributed to domiciliary care if within the 72 hour rule.

There is a risk of random variation in reporting as some PU's may not be counted on the designated day as services may not be visiting on that day

3b. Is prevalence data collected on a 'live system' where data is collected across the whole organisation straight away?

In two of the organisations staff reported all PUs directly onto the ST dashboard. All other NHS organisations completed the reporting on paper and the details were uploaded by the quality or risk management teams.

There is limited opportunity for clinical staff to use ST for improvement or to inform future practice.

3c. Can the data be shared with other reporting systems?

Trends in the number of PU's identified in individual organisations can be viewed on the ST web site. However comparisons can be made without understanding the differences in reported patient population via the number of bed days/ caseload, so comparisons can be misleading due to the variation in the size of the organisation. .

3d. Do you collect ST data?

ST data was collected by all NHS organisations in the survey. The majority of care home staff had not heard of ST although it is possible for care homes to use the ST reporting system if they want to.

3e. What system for collating prevalence data information is in use?

Safety Thermometer was the only system in use for collating prevalence data across the sector.

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The positive news is it provides an opportunity to integrate the ST system into care organisations outside the remit of the NHS. This option for ST data collection will provide PU trend data across NW London.

Delivering the NHS Safety Thermometer CQUIN 2013/14

<http://harmfreecare.org/wp-content/uploads/2012/06/NHS-ST-CQUIN-2012.pdf>

3f. What information is the organisation prepared to stop collecting?

Four NHS organisations expressed preference for collecting patient identifiable (incident) data rather than prevalence.

Only one care home were reporting ST data and were unsure why.

3g. Is ST data used to inform practice?

All organisations were definite that the ST data was not used to inform practice and education. The general view was that ST data was retrospective and only monitored trends. Going forward there is a need to understand the purpose of reporting prevalence data as it cannot be used as a proxy for incidence or RCA type learning. Rather it can only be used for high level analysis of trends over time. When collected on an organisational basis as is the case with ST data, the information produced is undermined by the lack of information on bed days/case load data and the difficulties of attribution discussed earlier.

4a. Does your prevalence data collection tool link to any other systems?

The ST data collection system does not have the ability to link to any other reporting system. All other reporting systems in use monitor incident data. The current use of a variety of individual internal systems that do not share data means staffs are required to report the same information more than once internally and for national reporting requirements. This is time consuming and likely to increase inaccuracies in data reporting.

In the NHS serious incidents have to be reported within the organisation (IRS), to the Strategic Executive Information System (STEIS), to the National Reporting & Learning System (NRLS), to the local Clinical Commissioning Group (CCG) and to ST. The forms vary for each reporting system and they have differing time frames for completion and differing criteria for attribution.

<http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

4b. Does your incident collection tool link to any other organisation?

All NHS and care organisations reported that no system in use could be connected to another system in any other organisation.

Going forward there is a need to consider streamlining the number of reporting systems in use and what data is to be reported and to define the requirement for incidence, incident, prevalence data, RCA reporting and Serious Incident reporting and what the benefits are from each form of reporting.

4c. How is the information verified and corrected?

Organisations reported verification of the data in different ways. One verified Grade 2 ulcers and above by a TVN. One verified through the line manager with sporadic verification by a TVN. Two

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verified by a TVN only if the ulcers were not healing. Another verified ulcers through the governance team and the TVN by cross checking the ST data with the Datix reporting. ST data in another organisation was verified via an infection control nurse. Care home staff verified their own data with the District Nurses validating grade 3 and 4 ulcers only.

This variation in verification hierarchy can lead to reporting differences as the level of expertise and experience in grading ulcers may also differ.

4d. What else is the information used for?

Two organisations were using incident and RCA data to influence staff education. One was using evidence from the RCA's and reporting in a monthly newsletter and another for a yearly study day to encourage initiatives in lessons learnt and changes required in practice. No organisation used the ST data to inform education. ST data were used in one organisation to compare numbers of PU's to the numbers recorded in other organisations without understanding the influence on interpretation of the size of the caseload.

4e. Are staff provided with opportunities for education & learning using the incident data?

Five NHS organisations provided PU education. Two of the organisations also provided mandatory competency training. Of the two, one organisation included follow up yearly competency assessments.

Datix information was used to influence education and in one organisation it was linked to an education update if numbers of ulcers increased.

One care home organisation provided funding for 5 people to attend a wound management course at a local university.

Most care homes and domiciliary care agencies reported induction training but little ongoing training due to lack of trainers. Some organisations encouraged staff to obtain updates from external agencies but without funding attached.

The PU education in most organisations is modelled on the NPUAP/EPUAP (2014) best practice guidance. <http://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf>

Incident reporting and RCA findings are used to provide additional education opportunities when incidents occur. If a thematic analysis of RCA findings were to be shared nationally the findings could be beneficial to improving patient care.

4f. What patient details are collected when collating incident data?

All organisations reported patient details; name, NHS or organisational number, DOB, Grade, body location on their incident monitoring tool. This information can also be used to inform RCA reports, IRL and national statutory reporting systems.

Most organisations reported details of where the ulcer was acquired; acute or the community, not who was caring for the patient. i.e. domiciliary or NHS care or self/family care. By labelling an acquired PU as 'community acquired' when it was in fact acquired under domiciliary care or family/self-care is misleading and means that education may not be appropriately targeted. It also discredits statutory services if the patient received informal care from friends or relatives.

One NHS organisation requested information about specialist equipment required as the door ways into the wards were not wide enough to take a hospital bed.

One nursing home reported hostility when requesting details of the origin of the ulcer from the local NHS services. The concern about attribution and lack of formal pathways of communication

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between services results in a culture of blame rather than adoption of an improvement science model to support learning and improve patient outcomes.

Diagram 1. The arrows show the links are in the main only on a case by case basis between NHS nursing services and between primary and secondary commissioners. For care to improve, the formal links between NHS services, care homes and community need to be identified and made clear to staff, patients and carers as currently even the communication between nurses working in primary and secondary care can be reliant on individual personnel rather than from a formal operational system of communication agreed by all organisations.

To explain the layout of the diagram:

Beginning in the centre (deep pink circle) the patient and informal carer are at the heart of all services

Pale pink – Community funded direct services

Purple - Indirect support services for the community

Blue – Indirect hospital services

The outer green circle – Direct hospital funded services

To verify the detail in this diagram the data was collected through a series of multi-disciplinary workshops. The delegates included NHS staff, care home staff, patients and carers.

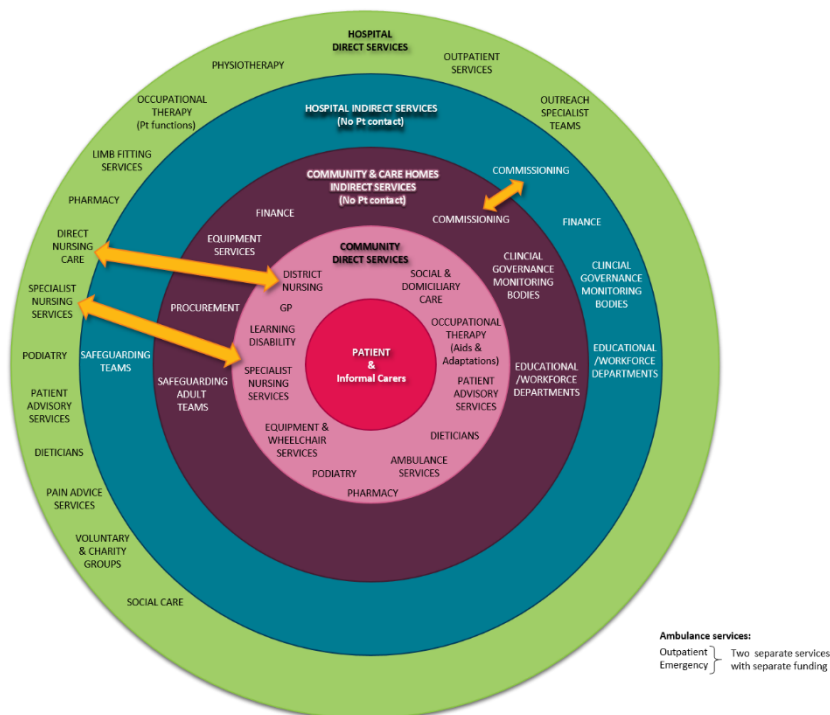


Diagram 1

4g. Is it possible to identify an individual who may already have been reported as a safeguarding incident (if so how)?

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Four NHS organisations reported access to information that will notify them if an individual has previously been reported for safeguarding; one via Datix, one via the safeguarding lead for the organisation, or by contacting the CCG safeguarding lead who will have received the information from organisations as they occur, one via SystemOne and another via Last Word, the data collection system operated in the individual organisation. In another organisation the infection control nurse had access to the information, another in-patient facility reportedly did not investigate harms acquired prior to admission, the onus being placed on the community NHS services or social services to carry out the investigation and in care homes staff were unaware if a previous safeguarding alert had been placed unless they communicated with social services.

It is not easy for clinical staff working at the bedside to access the information about established pressure ulcers on transferred patients without a delay. This leads to time consuming duplication of the same information due to time frames set for reporting.

4h. Does the collection have a start and end date which means chronic PU's will be recorded as new ulcers each year?

The majority of organisations provide ongoing reporting from year to year however one reported multiple reporting was likely and another that retrospective data could only be reviewed for one year (on a rolling programme) so multiple reporting was possible.

5a. Will the organisation share their RCA reporting tool with other organisations?

Five NHS organisations used adapted versions of the NHS England RCA reporting tool. One used the tool in one division while another division used an internal reporting tool. Care homes were not aware of the NHS reporting tool and are not required to complete RCA analysis of serious incidents. Adapting the tool has led to inconsistencies in the information collected. Going forward the data to be collected should be standardised to enable organisational learning and benchmarking from the national RCA reporting.

5b. What evidence does the organisation have to show learning from the root causes?

One NHS organisation reported the number of ulcers reported was dropping as a result of action plan learning from the RCA. The process involved implementation of actions with an audit of change in practice. It was noted the CQC were checking implementation of action plans.

Another NHS organisation reported a reduction of grade 3 and 4 ulcers but a rise in grade 2 reporting. This change was attributed to providing information on PU prevention, plus staff communicating with local care homes. It was noted the CQC inspections of care homes was not making an impact.

A third NHS organisation reported evaluation of the RCA's by a senior nurse panel but no evidence to show the results were used to inform practice. In the same organisation mandatory educational update sessions were run by the TVN if incidents of PU increased. Also a small group was formed in one clinical area to reduce PU numbers through learning.

All the NHS organisations involved senior nurses in the RCA report writing but only one stated Band 6 nurses working with the incident.

One care home had a system of reporting incidents on a risk register used to monitor events and outcomes.

Another care home organisation employed quality managers to monitor the number of ulcers reported by individual care homes. The data would be used to support staff to ensure the level of care required by the individual resident could be met.

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5c. Is the Safeguarding Decision Making Tool (SDMT) used to reduce the number of unrequired serious incident reports?

Only three NHS organisations reported using the SDMT (Refer to Appendix four for an explanation of SDMT) to decide if the ulcer was avoidable before completing the safeguarding referral. One reported all grade 2, 3 and 4 ulcers to safeguarding regardless of why they occurred rather than the grade 3 and 4 ulcers as required by STEISS. Three other NHS organisations did not use the tool either thereby reporting avoidable and non-avoidable ulcers, resulting in staff completing RCA reports that were not required. In one of these organisations the Director of Safety and Governance made the decision to report based on the information supplied.

Care home organisations did not complete the SDMT or RCA documentation. Each organisation had its own reporting paperwork. The CQC do not request an RCA. Social Services collate their own reporting timeline of events.

Use of the SDMT was endorsed through NHS London in 2013. It has not been widely adopted which leads to duplication of time consuming RCA reports. If care homes are also required to complete the SDMT it will also reduce unnecessary reports sent to social services and the CQC. It is mandatory for care homes to report serious incidents to the CQC but there is no framework for required actions. The CQC only visit following a report if requested by social services. This being the case why is more paperwork required for an agency that has no legal commitment to act.

6. How does the organisation access equipment?

Three NHS organisations had total bed management contracts to provide beds and specialist mattress/cushions. KPI delivery arrangements were 4 - 6 hours in secondary care. In primary care the time lapse was subject to clinical assessment; time frame could be same day, up to five days depending on assessed urgency. In another NHS organisation contracts were providing different items of equipment with more than one company. Another had divisional organisation contracts to supply equipment.

One care home organisation had an in house budget to ensure all homes had access to beds, mattresses and cushions. Other medical equipment had to be requested through social services. Other care homes relied on NHS provision by request to the local district nurses, GP's or social services. One care home reported that equipment provision had recently been stopped by the local services leaving a gap in provision. There was a consensus of opinion by the majority of care home and domiciliary delegates present that ordering equipment was a bureaucratic process and staff were not provided with the knowledge to make informed decisions.

NHS organisations seemed to have funds committed to an equipment budget however there is no standardisation for delivery times which can be confusing to the end users. The issue for care homes and domiciliary care seems to be twofold: lack of continuity as to which organisation will fund what items of equipment and inconsistencies in how to access the equipment for delivery. This can lead to increase risk and development of a PU.

7. Other comments obtained from the respondents

- The majority of domiciliary and care home staff were required to request PU assessment from a clinician via referral to the GP. A few were allowed direct access to the DN. The result was that individuals had to wait at least 24 – 48 hours for the initial assessment. This was described as very ineffective with the individual caught in the middle of a bureaucratic process that could lead to serious harm.

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- There is hope that the CCG will make the guidance clearer so all organisations report RCA's in a similar way. RCA reporting is currently carried out for avoidable and unavoidable ulcers. It has been stated in this questionnaire that reporting all ulcers may result in losing quality of reasons for reporting. For the future there is a wish to only report avoidable ulcers but organisations have not formally agreed to use the SDMT.
- There needs to be an agreed way forward for RCA reporting. There is currently a burden for senior nurses to complete an RCA report. It needs to be established 'what is the learning'?
- We are missing the point. i.e. There is a need to educate/ understand the risk to a patient who has been using hospital transport/ transport lounge waiting when identifying where an ulcer occurred.
- There is a need to educate domiciliary carers but there is currently no legal obligation to do so other than the Care Certificate which is not specific to training in the prevention of pressure ulcers.
- Raising awareness of a vulnerable individual living in the community so they can be identified immediately they enter the healthcare system. There are currently pilot triggers for GP identifiers in a pilot area of two NHS organisations – there are weekly meetings to highlight the vulnerable. How can these be linked to reducing risk.
- Direction is required so all organisations report the same data.
- There is a wish to standardise practice across all organisations.
- The organisations would like [standardised] mobile data collection tools
- Pressure ulcer accountability/ reduction in numbers are currently a work in progress. Likening the systems/ reporting is a 'Jack of all trades' that achieves little.
- There are no official lines of communication between organisations. One organisation set up a group to look at how services could reduce unnecessary harm but other organisations did not attend.
- One NHS organisation collated PU data and service provision by relying upon the good will of the person employed rather than in a job description for the post.
- ST data doesn't help in front line care as it does not provide patient specific data.
- Patient education is lacking so individuals can often be unaware of why they have a sore sacrum.
- The provision of an ageless service has introduced a need to work differently so there is a need for more training in PU care/equipment provision in mental health services.
- One organisation reported the adoption of a patient passport for use when a patient is transferred from one service to another. The passport advertised the Sign up to Safety initiative and pressure ulcer App to encourage self-learning. The development of a patient passport is a consideration for all frail at risk
- Communication on evaluation of PU's given to neighbouring Trusts where the ulcer originated. i.e. acute services to try to highlight requirement for training.
- One NHS organisation reported using the SSKIN care bundle and another using it in one division as there was no evidence to show a reduction in the numbers of ulcers occurring after its introduction. If introduced as a multi-organisational initiative it is important to

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establish a base line of PU incidents at the start. *NHS Wales (2010) 1000 lives Plus. Pressure Ulcer Safety Cross*

- A ward chart was in use in one organisation to show PU free days in an attempt to motivate staff with praise for effective care.
- One organisation was considering a new PU grading scheme that does not reflect NPUAP guidance. This will mean when patients are transferred between organisations the clarity will be further diluted.
- Care homes and domiciliary care reported not using SSKIN care bundle.

Discussion

The information obtained from the survey showed there is a significant variation within and between organisations when collecting and recording pressure ulcer incidents or prevalence data across NW London. The systems in use do not have design features to allow data to be shared between organisations, and two NHS Trusts which have merged in recent years are currently using different systems that are not designed to share data. Before an agreed data reporting system can be established it is important to decide what it will be designed to achieve; is it to know the scale of the problem, for organisations to benchmark or to improve patient care through learning. Currently the differences in reporting systems and the differences in the data captured mean that national reporting is not possible. A decision to collect incidence, incident or prevalence data should be agreed and the data questions and the system designed to be shared within and across organisations. If a national reporting system is adopted then all organisations can access the information to reduce duplication of reporting.

The reporting system of choice should allow for immediate access to detail of the incident to allow staff the opportunity to learn from the incident whilst still caring for the patient. Having instant access to PU data in the clinical area is crucial. It is important to monitor how a PU occurs. If the incident cannot be investigated in a timely manner the impact of events relating to the harm is lost, together with the opportunity for learning and change in practice.

To provide population based incidence data as against organisational incidence data it is imperative that care homes are required to use the same reporting systems as the NHS. Prevalence data reported to ST can also provide trend data if care homes were encouraged to report.

The feedback from the care home staff stressed the multifaceted role of the registered nurse (RN). The responsibilities include managing acute and chronic disease processes and balancing these conditions with optimising the residents functioning abilities and wellbeing. The RN also has to ensure the non-registered care assistants who are the predominant workforce are educated and supported to provide a service that causes no harm to an individual resident. Without knowledgeable and competent RN's there will be an increased number of NHS referrals and a poor standard in outcomes. *Ref. Supporting nursing in care homes Final Report 18.2.2015. Project Report for the RCN Foundation Patient Care and Professional Development for Nursing Staff in Care and Nursing Homes: A Research and Consultation Project*

The feedback from this questionnaire included the frustration of care managers and owners when trying to engage NHS staff. There is no agreed time frame from NHS referral to first assessment which means care staff and the patients' are left vulnerable and frustrated if there is deterioration in

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the skin condition. Reportedly the bureaucracy of who can refer can result in non-registered care staff being questioned or ignored and in some instances there are no clear referral pathways leading to time delays as the referral is passed from one service to another. If the care home staff recommends equipment this can be questioned or at worst another assessment will be required before the equipment is sanctioned. *Ref: The Cavendish Review an Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings July 2013* recognised how disjointed and disconnected the services were from each other. It recommended that nursing and social care assistants obtain a certificate of care to standardise and raise the level of care provided across the care sector. In April 2015 this recommendation came into effect but Cavendish is now calling for the certificate to be mandatory. The introduction of this much needed change to improve the knowledge of care assistants is welcomed but if the multi-disciplinary professional workforce does not recognise care workers as having knowledge and skills to make decisions about basic care needs then vulnerable individuals will continue to wait for the service they should expect, possibly resulting in unnecessary harm. For someone at risk, or who has already acquired a PU this can mean the difference between tissue damage at grade 1 or grade 4, resulting in serious harm.

The Care Act (2015) and related secondary legislation promotes a whole system approach. The recommendation is to form strong local partnership arrangements for working with clinical commissioning groups (CCGs) and health and wellbeing boards. This approach is central to effective commissioning. To provide harm free care in the future it is advisable for the current system of PU reporting to be reviewed.

Currently there are no systems in place that can be operated between organisations. The Datix system (Appendix 2) is designed for inter organisational use but the company has no plan to develop a platform for information sharing between organisations. Datix is a system designed for not less than 100 operators, so not accessible for individual care homes. In some areas of the country the patient safety collaborative within the local CCG has purchased the system for care home use and worked with the care homes to encourage and validate the data submitted. This provides the CCG with evidence to show where the PU's are occurring in the system rather than just a hospital or community identifiers. This approach still does not allow for identified ulcers occurring in domiciliary care but it is a step forward.

ST is an NHS reporting system. It can be accessed by anyone but relies on the data being validated by a registered practitioner. If domiciliary care workers report into ST there is further risk of duplication as the individual may also have been reported by the nursing services. Under reporting is also an issue if carers do not recognise skin damage as the individuals will not enter the NHS system either for reporting or for expert care. There is no patient identifier in ST so it is not possible to identify anyone who may have been previously reported so this system is not useful in plotting the patient pathway.

Summary of Current PU Reporting

Currently there is no IT system in place to show comparisons between one NHS organisation and another. Even ST allows for variations in the way the data is recorded.

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- The Datix system currently has different versions in use allowing different reporting practices. The information cannot be shared as the minimum data set is diverse. Even if the data collection were standardised Datix is not suitable for sharing data between organisations as there is no central dashboard. If there were to be a central database the information would have to be downloaded one individual spreadsheet at a time, making this a slow and time consuming way of downloading data. The Datix is not suitable for small organisations as it requires a minimum of 100 users in one organisation.
- SystmOne is not designed to share data between organisations.
- ST is for use by registered practitioners only. There is a risk of duplication or under reporting as individuals may not be known by the statutory services or known by more than one service.
- Large organisations are not all using the same internal reporting systems so shared learning is has limitations.
- RCA reporting may not be required in every case. The use of the Decision Making Tool reduces unnecessary reporting but has not been adopted for use by everyone.
- RCA templates vary. The result is the inability to benchmark or share action plans and outcomes. The Root Cause Analysis (RCA) reporting tool has to be completed with an action plan for learning. The original tool has been adapted by individual organisations which have led to difficulty in benchmarking across the sector. There is a case for streamlining the process, with a stronger emphasis on managing change as a result of lessons learned, rather than the repetitive process in place of describing the mistakes made. Going forward the learning from RCA reporting to STEIS could be considered for sharing with organisations nationally. The learning from incidents has a repetitive element in many cases so there is now duplication in reporting that is labour intensive. The individual events could now be submitted to include detailed action plans with proof the changes have made a difference rather than details of how the incident occurred.
- Care home organisations have differing templates for reporting from other care homes and the NHS. The staff advised the templates were embedded in paperwork designed to incorporate all aspects of the care provided making it difficult to identify individual reports.
- There are statutory requirements for care homes to report serious incidents to the CQC. Individual reports are only investigated if social services request.

Recommendations

Understanding the current diverse reporting shows there is a need for change if meaningful data is to be obtained. Susanne Coleman et al (2015) discussed findings of a national survey to compare PU monitoring systems in NHS in-patient facilities in England. The paper made five key recommendations for strategic change to reporting at national, regional and local levels. *Ref: Pressure ulcer and wounds reporting in NHS hospitals in England part2: Survey of monitoring systems. Journal of Tissue Viability (2015), <http://dx.doi.org/10.1016/j.jtv.2015.11.002>*

- Nationally a decision should be made as to why reporting is required. Is it to ensure best practice or to castigate services for poor care? Streamlining national reporting systems need

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not mean poor care will ensue. Rationalising reporting structures. i.e. ST, NRLS and STEIS as well as the CQC, CCG and social services maybe recommended as reporting the same ulcer to many organisations allows for duplication and adds to the burden of time consuming paperwork. The findings from organisations in North West London reflect and support the findings of Susanne Coleman's team.

Diagram 2 shows the plethora of different reporting pathways that currently exist.

This diagram depicts the patient and carer at its centre
 The Pale pink – Community funded direct services
 Purple - Indirect support services for the community
 Blue – Indirect hospital services
 The green circle – Direct hospital funded services
 The outer purple circle – National reporting systems

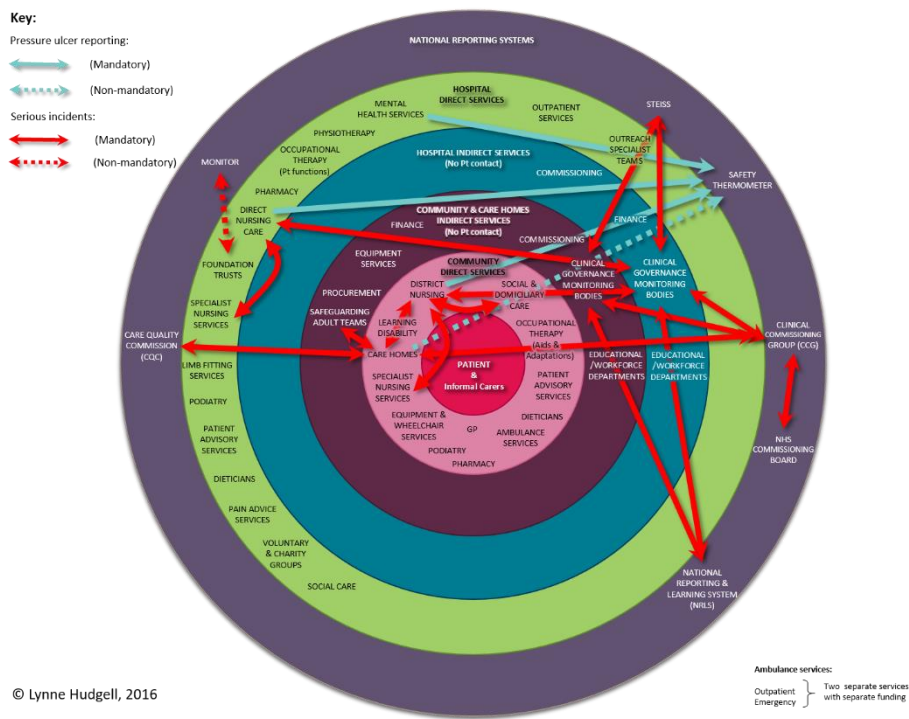


Diagram 2

Recommendations for Change in North West London

It is likely that national reporting structures will evolve over time in response to findings such as those produced by Coleman et.al (2015) as they did after the Serious Incident Framework (2015) however, this should not prevent action in NW London. Standardising data collection to improve communication and understanding in N. W. London can be achieved to compliment and improve national guidance.

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https://www.google.co.uk/?gfe_rd=cr&ei=ZwoqV9eFJPTS8AeztqPIAw&gws_rd=ssl#q=serious+incident+framework+2015

The recommendations are to:

- Appoint a specialist forum of multi-agency carers and professionals for agreeing standardised reporting and practice. The buy in to change current reporting practice from the Executive level in each provider organisation has to be established across the sector if the changes are to be meaningful.
- All organisations including NHS MDT, care homes and social services to agree to collaborative working for the benefit of patient care. This means addressing the issue of attribution to enable learning rather than allocation of blame.
- Standardise the minimum data set for reporting. If there is to be a sharing of data between organisations there are anomalies which will distort results.
- Standardisation of the PU grading system and definitions of what constitutes a PU is required. i.e. moisture lesions, diabetic foot ulcers, device related ulcers. There are organisations that are not using the up to date NPUAP/EPUAP (2014) reporting definitions. Also some do not report device related PU's and moisture skin lesions are known to be counted as PUs' through lack of education. Those who do separate moisture lesions from PU reporting are noticing a reduction in the numbers of PUs' they report. It is not a National requirement to report moisture skin lesions. However the incidents of moisture skin damage may be high so reduced PU incidents may not be in recognition of improved care.
- Decide on the importance of data collected and what it will be used for. Is it to understand numbers or compare one organisation with another or improve the patient journey? The decision to streamline reporting will reflect the rationale for reporting incidence, incident or prevalence monitoring. There is a need to share patient information to produce population based incidence data to enable accurate benchmarking and comparisons of origin of ulcer and deterioration of ulcer.
- Agree where to store incident reports in all organisations to enable staff swift access when asked for information. To record identifiable patient details in each incident report is to be commended however there needs to be reliable access to the record to establish previous reporting together with SI reporting history if applicable.
- Standardise the RCA reporting tool. Currently the national tool has been adapted within organisations. This has reduced the ability to share reliable data to inform education and learning.
- Agree a process for positive learning from RCA data to share best practice and to remove negative blame culture.
- Introduce a competency framework in PU grading and reporting across all organisations.
- A line of communication between the individual organisations to be formally recognised and adhered to with standardised communication documents; to include a definition of acceptable waiting times from referral to assessment, equipment access, recognition of the carer expertise.

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- Introduce a referral pathway for domiciliary carers and care home staff to access services when an individual is at risk or who has a PU. The pathway to include actions for non-registered workforce to implement immediately.
- Produce an option appraisal of the different systems and approaches that could be adopted to produce a standardised population based data set. This could include:
 1. All versions of Datix systems in use (see appendix 2). The limitations for using Datix is the lack of availability for a central dashboard
 2. Other systems in use such as SystemOne and Last Word
 3. United Lincolnshire Hospitals has a 10 year experience of developing an effective monitoring tool *Ref: The development & benefits of 10 years' experience with an electronic monitoring tool (PUNT) in a UK hospital trust. EWMA journal 2015. Vol 15.no2*. In approximately eighteen months from now there will be a licenced pilot version of PUNT made available and the final application ready eighteen months after that. This will be a wireless system and the hub will be located in Leeds.
 4. NW London CLAHRC is developing a generic web based patient safety dashboard which it might be possible to adapt to create a standardised population based information system. This approach will enable an agreed minimal data set to be collected by all organisations. The system of choice should promote live incident reporting and allow for a central dashboard to enable organisations to track individual patients across the system of care and link individual organisations to an overall picture of PU incidence. There may be an opportunity in the future to develop another bespoke data collection system for all organisations to use.
- Develop a central dashboard where organisations download agreed data set. The availability of this option will be dependent on which system is chosen and who agrees to purchase the system and support the upkeep. With patient identifier information stored on the dashboard data protection will be a key requirement.
- Patient Safety Collaborative to work with care homes to introduce ST data collection if this is the system of choice
- Provide a CCG supported training programme for the non-registered workforce for PU prevention including collection of ST data if this is to be collected across the system in NW London.
- To identify the number of beds/community caseload one TVN is responsible for is to be recommended so the role is accessible to all services /patients across the sector. A standardised competency framework for the role and responsibilities of a TVN is also required and made available to all.

Currently the financial implications plus the detriment to quality of life for individuals is not clear. If there is a requirement to understand the burden of care pressure ulcers create for patients, and in

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the care system as a whole then all services nationally and across the sector should be collecting and sharing meaningful pressure ulcer data. To achieve this there needs to be system changes.

Appendix 1 Questionnaire

Service Improvement methodologies to reduce the prevalence of Pressure Ulcers in NW London

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Data Collection - Suggested questions (Draft)

Phase 1 - Objectives

- Map pressure ulcer data collection points across the system linked to patient pathway
- Map verification of data across the system linked to patient pathway
- Map data collection tools across the system linked to patient pathway
- Map incidence and prevalence data collection tools across the system linked to patient pathway
- Map safety thermometer data collection points across the system

Suggested questions to identify the tools used in each organisation to collect data.

Role		Date	
Organisation / code			

1. Organisation information		
1a. Type of organisation		
<input type="checkbox"/> Secondary <input type="checkbox"/> Primary <input type="checkbox"/> Care home <input type="checkbox"/> Other, please state:		
1b. What is the approximate number of beds / community case load of your organisation?		
1c. What is the ratio of registered nurses to care assistants?	Nurses	Care assistants
1d. Is a tissue viability nurse employed by your organisation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If not, how do you access a tissue viability nurse:</i>		

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2. Incidence Data Tool: Recording of every pressure ulcer

2a. How is the incidence data calculated:

<input type="checkbox"/> Per number of bed days <input type="checkbox"/> Per 1,000 secondary care patients <input type="checkbox"/> Per 10,000 primary care patients <input type="checkbox"/> Other, please state:

2b. Is incidence data collected on a 'live' system, where data is collected across the whole organisation straight away?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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2c. How often is incidence data collected? Eg daily, weekly, monthly?	
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2d. Can the data be shared with other reporting systems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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3. Prevalence Data Tool (the proportion of people with pressure ulcers)

3a. How is prevalence data recorded (tick all that apply):

<input type="checkbox"/> Paper <input type="checkbox"/> Electronic system <input type="checkbox"/> In-house system <input type="checkbox"/> 'Live' system <input type="checkbox"/> Datix system <input type="checkbox"/> Other, please state:
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3b. Is prevalence data collected on a 'live' system, where data is collected across the whole organisation straight away?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3c. Can the data be shared with other reporting systems, eg patient systems such as Cerner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3d. Do you collect 'Safety Thermometer' data ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3e. What information is provided?		
3f. What information is the organisation prepared to stop collecting? i.e. prevalence or incidence		
3g. Is Safety Thermometer data used to inform practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please give details of how this data is used to inform practice:</i>		

4. Organisational systems		
4a. Does your collection tool link to any other systems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please give details:</i>		
4b. Does your collection tool link to any other organisation (e.g. primary/secondary/nursing homes or organisational groups such as Shelford)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please give details:</i>		

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4c. How is the information verified and corrected?		
4d. What else is the information used for (eg teaching and learning)?		
4e. Are staff provided with opportunities for education & learning using the data?		
<p><i>Please tick all that apply:</i></p> <p><input type="checkbox"/> Induction programmes</p> <p><input type="checkbox"/> Routine training: please state how often:</p> <p><input type="checkbox"/> Other, please state</p>		
4f. What patient details are collected?		
<p><input type="checkbox"/> Name</p> <p><input type="checkbox"/> NHS Number / Organisational number</p> <p><input type="checkbox"/> Waterlow risk assessment score</p> <p><input type="checkbox"/> Grade of pressure ulcer</p> <p><input type="checkbox"/> Origin of ulcer (more detail than just 'community')</p> <p><input type="checkbox"/> Body location</p> <p><input type="checkbox"/> Equipment usage</p> <p><input type="checkbox"/> Dressings</p> <p><input type="checkbox"/> Other, please state:</p>		
4g. Is it possible to identify an individual who may already have been reported as a Safeguarding Incident?(if so then how)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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4h. Does the collection have a start and end date (i.e. yearly which means chronic ulcers will be recorded as new ulcers each year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5. Root-Cause-Analysis		
5a. Will the organisation share the reporting tool with others organisations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5b. What evidence does the organisation have to show learning from the root causes		
5c. Is the safeguarding decision making tool used to reduce the number of unrequired serious incident reports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Equipment		
6a. How does the organisation access equipment		
<input type="checkbox"/> In-house NHS equipment loan contract <input type="checkbox"/> In-house NHS ownership <input type="checkbox"/> Private ownership <input type="checkbox"/> Loan to organisation from NHS <input type="checkbox"/> Time lapse to delivery <input type="checkbox"/> Other, please state:		

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7. Any other details or comments

Appendix 2 Datix Data Reporting System

Datix systems can be set up to ask any set of data questions an organisation wishes. This leads the way for development and agreement of a commissioning standard so that organisations in N.W. London could potentially capture the same pressure ulcer data. However if a whole system approach for data capture is required it is advisable for all organisations to be using the latest version of the system which was released last year (Version 14) as this will ensure the system can be designed to capture the same imputed data and be used on a tablet if required.

Once an organisation has purchased the initial system it becomes possible to design any data collection questions from within; so in effect organisations can upgrade themselves at no extra cost. The challenge is some organisations have old systems and have not continued to update their system.

There is a generic best practice Datix system that is used to demonstrate the system to a new client but it doesn't include specific questions on the topic of pressure ulcers. The rationale for not using specific questions included is that historically organisations have had a very varied requirement for many differing data questions so the basic system is purchased and the company configure a bespoke set of data for each client.

Datix is designed for use only within one organisation. It is not designed for sharing information between organisations. If multi organisational sharing is a goal then the data from each individual clinical area could be downloaded as a PDF file or excel spreadsheet, one file at a time, to a central location. Multi organisational data sharing and the tool of choice is a decision to be made by the Executive from each provider organisation.

There is a Datix module called Dashboards that can be purchased by individual organisations (some organisations in N.W. London do have this facility, others download into paper format). This will allow an organisation to create reports by location. There is another system called QlikView that provides a similar function. These dashboards are only for use in the individual organisation, not for sharing purposes between organisations.

The cost of a Datix system is dependent on the organisations' requirements. An organisational licence is purchased, not a licence for each user.

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There needs to be at least 100 people in the organisation who are going to use the system. Datix is not designed for small organisations. It is therefore not suitable for individual care homes to purchase.

It may be possible for a CCG to purchase a system for care homes (to ensure there are at least 100 people using the system) but this may still have limitations as not all small care homes have access to computer systems.

It is possible to use Datix version 14 on a tablet.

Not all CCG's use the Datix system.

Appendix 3 Safety Thermometer Data Collection System

Safety Thermometer data is currently collected in all NHS Trusts. In 2010 the national CQUIN scheme incentivised the use of either the NHS Safety Thermometer or achievement of a locally defined quality improvement goal. The reporting is still required in 2015 but any incentive offered is now authorised by each local CCG. It is considered to be a mandatory reporting system that is policed by each CCG not by NHS Safety Thermometer. It is deemed a breach of contract if NHS organisations do not report. The NHS Safety Thermometer is designed to collect data on patient harm by surveying all relevant patients in all relevant NHS providers in England on one day each month. CCG's are thought to use the data to monitor trends. The national guidance for the use of NHS Safety Thermometer is intended for all NHS funded providers across acute, community, mental health and residential and nursing care including NHS –funded independent sector providers to use the NHS Safety Thermometer to collect nationally standardised data. <http://harmfreecare.org/measurement/nhs-safety-thermometer/>

The NHS Safety Thermometer is a point estimate survey instrument. It is a measure of the proportion of people in a population who have one or more of the four harms (pressure ulcers, falls, catheter acquired infection and VTE) at a particular time and date. The survey is carried out on a given day once a month and data is submitted on-line to the NHS Information Centre. The NHS Information Centre is responsible for the collation and publication of data. Safety Thermometer data is publically accessible on-line for each organisation. In calculating point prevalence providers are asked to submit data on eligibility criteria in relation to bed numbers or contacts and total population of eligible patients in the survey on the day of data collection.

For pressure ulcers the respondents are asked to record the patients worst 'old' and worst 'new' pressure ulcer. The National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel, guidelines are used to define the grade of the worst pressure ulcer. Only pressure ulcers at grade 2 and above are reported. <http://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf>

An old pressure ulcer is defined as being a pressure ulcer that was present when the patient came under your care, or developed within 72 hours of admission to your organisation. A 'new' pressure

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ulcer is defined as being a pressure ulcer that developed 72 hours or more after the patient was admitted to your organisation. Given the short length of stay, high readmission rate and high transfer rate within and between organisations it is likely that this methodology lends itself to under reporting new pressure ulcers. A new pressure ulcer acquired in an NHS organisation between census dates will only be counted as new if the patient is in the same organisation on the day of the census (and this assumes good record keeping on the part of the organisation if the patient transfers to another ward, unit or team internally). If the patient transfers to another organisation or is discharged and readmitted to another organisation for the next census date then the pressure ulcer will be counted as old for that organisation.

Data reporting could be found for only one care home in N W London. The workforce in care homes and domiciliary care are predominantly not registered nurses. The NPUAP (2014) recommend individuals are assessed by a registered practitioner. As ST reporting is only carried out on one day each month it would not be possible for a registered nurse to visit every care home or domiciliary patient at risk in the time frame. The ST team report certain local authorities and patient safety collaborative teams across the country are working to encourage reporting from non NHS funded care homes.

There are three ways to report:

- ST data can be reported using a standalone spreadsheet. The data can then be manually transferred to the ST website.
- Direct input onto the web site
- The use of an app for use on cell phones or a tablet

ST data analysis is to monitor trends – showing a reduction or increase in numbers. The data does not show how many ulcers were found against the total patient population on the day of reporting so the trends can only be benchmarked against previous inter organisational reports, or another organisation with the same patient population.

Appendix 4 Safeguarding Decision Making Tool

In 2013 concerns were raised with NHS England (London region) that some organisations were reporting the occurrence of all grade 3 and 4 pressure ulcers as a safeguarding issue without establishing if the ulcers were avoidable. Different investigation processes and reporting. The issues raised at a stakeholder group of senior nurses were:

- Local Authority Safeguarding Leads do not have the expertise and capacity to undertake the safeguarding investigations for pressure ulcers.
- The investigation requires a Root Cause Analysis and a Safeguarding Investigation completed on different templates.
- No consensus pathway.
- Still significant number of Grade 3 /4 pressure ulcers being reported.
- The differing timescales for investigations for Safeguarding Incident Root Cause Analysis and Safeguarding Investigations.

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- Capacity of safeguarding leads / tissue viability nurses spent on investigations rather than implementing action plans and prevention.

Inappropriate referral to Safeguarding Adults places a considerable pressure on time and resources with NHS organisations, Local Authority safeguarding adult teams and Safeguarding Adult Boards. Stakeholders stated that clinician time and patient outcomes would be best served by time spent on prevention of pressure ulcers rather than duplication of Investigation of an RCA followed by investigations with the Local Authority that were at times inappropriate.

The response from NHS England (London Region) was to set up a group to take a closer look at the issue. The membership of the group reflected the key stakeholders, including Safeguarding Adults CCG leads, a Local Authority Safeguarding Adults lead, Tissue Viability Nurses, Commissioning Support Unit; Safeguarding Adults Board Chair and Provider Safeguarding Adults Lead.

The Group established that a much more unified approach to the reporting and investigation of pressure ulcers in relation to safeguarding was needed.

The group completed the following:

- Broad principals of Good practice in relation to Pressure ulcers and Adult Safeguarding
- A Decision pathway -pressure ulcers and safeguarding Adults. The pathway to be applied to those on the caseload of an NHS Professional who develop a pressure ulcer to facilitate decision making on when to refer to Safeguarding Adults as well as reporting a Serious Incident.

The response to this question was that only three organisations used the tool. This means unavoidable ulcers rather than those occurring through neglect or abuse are still being reported unnecessarily three years after the introduction of the tool.

It is up to each provider to endorse its use. Supports trust within partnerships. If endorsed by the Safeguarding Adults Board (SAB) it offers a whole-system approach to multi-agency working on prevention and reporting that integrates what is expected of local authorities, acute and community health services, care homes, home care services, commissioners and regulators

Making clinical decision transparent in a multi-agency context

The assessment must consider six key questions:

The six questions indicate a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the potential of neglectful care/management resulting in the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

The threshold for referral is 15 or above. However this should not replace professional judgement.

Using service improvement methodologies to reduce the prevalence of pressure ulcers in NW London