NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Bristol, North Somerset and South Gloucestershire Multi Agency Strategy for the Prevention and Management of Pressure Injuries

Shaping better health

In partnership with:

Sirona care & health

Bristol City Council

Bristol Community Health

North Somerset Council

St Peter's Hospice

South Gloucestershire Council

North Bristol NHS Trust

NSCP

Weston Area Health NHS Trust

University Hospitals Bristol NHS Foundation Trust

Contents

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	
Responsible Executive Director:	Anne Morris
Author and Job Title:	Cecily Cook, Deputy Director of Nursing and Quality Susan Brown, Head of Quality and Governance
Date Approved:	5 February 2018
Approved by:	*BNSSG Pressure Ulcer Programme Board*
Date of next review:	1 September 2019

Foreword

BNSSG CCG Quality Team works to improve quality systems in conjunction with their provider organisations, including Care Homes to improve patient safety and quality and reduce safeguarding incidents. Close partnership working with other stakeholders, commissioners and regulators across the health and social care system has also supported quality and safeguarding improvements. This can be evidenced through the work achieved by the BNSSG Pressure Ulcer Steering group.

Avoidable pressure injuries are a key indicator of the quality and experience of patient care. Despite progress in recent years in the management of pressure injuries they remain a significant healthcare problem costing the NHS, as a whole, more than £3.8 million every day.

As BNSSG CCG Director of Nursing and Quality I established a BNSSG Pressure Ulcer Steering Group in 2015 to deliver a programme of action aimed at reducing the overall incidence of pressure injuries in hospital and community settings across the Bristol, North Somerset and South Gloucestershire area.

The Steering Group is multi-agency, comprising of members from the CCG, provider organisations and local authorities. Each organisation represented on the Steering Group reports to its relevant Board. The Steering Group aims to address skin integrity and management throughout the entire patient pathway through collaborative working across the health economy. The group provides expert leadership in the support of evidence based best practice.

The work undertaken to date by the steering group has resulted in the development of this Multi-Agency Strategy. The Strategy relates to the prevention and management of pressure injuries in all settings where people may be at risk or where pressure injuries are identified, including hospitals, hospices, care homes and the homes of individuals. Reflecting the recommendations of the National Institute for Health and Care Excellence, the Strategy has been developed with the expectation that it will influence a further reduction in pressure injury incidence across BNSSG.

Anne Morris
Director of Nursing and Quality
NHS Bristol, North Somerset & South Gloucestershire CCG
April 2018

1. Executive Summary

BNSSG Pressure Injury Prevention and Management Strategy on a Page			
Our Aim	**Our Objectives**	**How We Will Achieve Our Objectives**	**How We Will Measure Success**
We will reduce the overall incidence of avoidable pressure injuries within provider organisations across BNSSG	**Documentation** We will establish an agreed documentation framework across BNSSG	• We will agree a joint approach to risk assessment and the documentation of pressure injury prevention and management across BNSSG; • We will promote an RCA process which supports learning from serious incidents.	• Risk assessments will be completed within agreed timeframes; • There will be consistency in the documentation used across healthcare settings for recoding skin assessments and ongoing management plans.
	Education We will establish agreed pressure injury education and training frameworks across BNSGG	• We will identify best practice in relation to pressure injury prevention and management training; • We will agree a standardised minimum training content; • We will support flexibility in training delivery to suit the needs of each organisation; • We will promote the sharing of training resources across BNSSG; • Training competencies will be developed for selected staff groups.	• Training in pressure injury prevention and management will become mandatory for clinical staff; • Existing training will be recognised when staff move between BNSSG organisations; The frequency of training will be standardised; • Adequate resources will be available to support training; • Staff are competent and confident to deliver safe and high quality care.
	Patient / Carer Support We will support patients and carers to participate in the prevention and management of pressure injuries	• We will ensure that there is a broad range of information and tools available for patients and carers in order to encourage and support their participation in the prevention and	• Patients and their carers will understand why they are at risk and what they can do to prevent tissue damage from pressure.

		management of pressure injuries	
	Communication We will build a culture of partnership and collaboration to improve communication between healthcare settings relating to pressure injuries	• We will introduce standardised systems to manage and monitor the reporting of pressure injuries across all healthcare settings	• There will be accurate and up to date information on the incidence of pressure injuries across BNSSG.

2. Introduction and Purpose

2.1 Pressure injuries are caused when an area of skin and/or the tissues below are damaged as a result of being placed under sufficient pressure or distortion to impair its blood supply (NICE, 2014).

2.2 All people are potentially at risk of developing a pressure injury. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, poor posture or a deformity, compromised skin or who are malnourished. The use of equipment such as seating or beds that are not specifically designed to provide pressure relief can also contribute to the development of pressure injuries. As pressure injuries can arise in a number of ways, interventions for prevention and treatment need to be applied across a wide range of settings, including the community, care homes and hospitals.

2.3 Avoidable pressure injuries are a key indicator of the quality and experience of patient care. Despite progress since 2012 in the management of pressure injuries they remain a significant healthcare problem and 700,000 people are affected by pressure injuries each year. Treating pressure injuries costs the NHS more than £3.8 million every day (NHS Improvement: Stop the Pressure 2017 http://nhs.stopthepressure.co.uk/).

2.4 Many pressure injuries are preventable, however when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating (Moore et al 2009). The most serious can lead to life-threatening complications. Preventing them will improve care for all vulnerable patients.

2.5 The National Institute for Health and Care Excellence (NICE 2014) recommends that services should be commissioned from and coordinated across all relevant agencies encompassing the whole pressure injury care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with pressure injuries and to prevent the development of pressure injuries in people at risk.

2.6 Reflecting the recommendations of NICE, this strategy has been developed by the Bristol, North Somerset and South Gloucestershire (BNSSG) Pressure Injury Steering Group with the expectation that it will influence a reduction in avoidable grade 2, 3 and 4 pressure injury incidences across BNSSG.

3. Scope

3.1 The BNSSG strategy relates to the prevention and management of pressure injuries in all settings where people may be at risk, or where

pressure injuries are identified, including hospitals, hospices, care homes and people's own homes.

3.2 The strategy is relevant to all age groups and reflects a person-centred approach to the prevention and management of pressure injuries.

3.3 The strategy sets out clear standards and expectations for all agencies.

3.4 The strategy applies to all staff groups in health or social care settings who have patients or residents who may be at risk of developing a pressure injury.

3.5 The strategy should be applied by all providers. Local policies and guidance developed within provider organisations should be aligned to the principles of the strategy.

4. Background and Context

4.1 The publication of the Chief Nursing Officers High Impact Actions in 2009 established a clear direction for the reduction of pressure injuries acquired in healthcare with the aim of reducing incidence by 50% by 2014. A significant amount of work has taken place since then to determine organisational baselines for pressure injury incidence, agree definitions and strengthen the identification and reporting arrangements to meet this reduction target.

4.2 The South West Patient Safety and Quality Programme was extended in 2010 to incorporate community and mental health settings and included, for the first time, a focus on pressure injury reduction. The Programme developed an approach to proactively address patient safety issues through a package of change, including process and outcome measures to drive improvement and a driver diagram. The approach for pressure injuries outlined the key interventions required to achieve a reduction in incidence across all healthcare settings.

4.3 The NHS introduced the Safety Thermometer in 2011 so that organisations delivering healthcare could see where they needed to improve and take action from data collected in a series of 'temperature checks'. Following this, in 2013/14 a CQUIN (Commissioning for Quality and Innovation) scheme was established to incentivise demonstrable and sustained improvement in key safety indicators as measured by the NHS Safety Thermometer with particular focus on pressure ulcer reduction.

4.4 In October 2014, the NHS England Patient Safety Collaboratives were launched. This confirmed the position of the Safe Care South West (the five year South West Safety Collaborative) within the West of England Academic Health Science Network (WEAHSN). Sign up for Safety, a national safety initiative is working alongside the AHSN based Safety

Collaboratives to build a culture of safety and of quality improvement through the use of campaign approaches.

4.5 The Health and Social Care Act 2008 (Regulated Activities) Regulations also came into force in 2014 providing for safe care and treatment under regulation 12. The intention to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm is set out in legislation. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

5. Local Context

5.1 There was an improvement in all BNSSG community organisations against the previous year during 2016/17 but grade 3 and 4 pressure injuries remained the highest category of serious incidents reported to the Strategic Executive Information System (StEIS) by Community providers, accounting for up to 94% of all serious incidents.

5.2 Grade 3 and 4 pressure injuries accounted for up to 34% of serious incidents reported by the acute Trusts in 2016/17 with no improvement in overall numbers against the previous year.

5.3 The true extent of pressure injuries outside of acute and community care is not clear. As a result of concerns regarding the high number of pressure injuries within North Somerset, a comprehensive thematic review was undertaken that included a benchmark analysis and scrutiny of serious incident investigations undertaken by North Somerset Community Partnership and Weston Area Health Trust during 2014/15. The review identified that the numbers of patients admitted with grade 2 and above pressure injuries to the Acute Trusts across BNSSG was excessively high which was vastly different to the number reported by community providers. The review indicated, therefore, a high prevalence of pressure injuries for patients not in receipt of community services that included residents from Care Homes.

5.4 Approximately 60% of attendees at a Pressure Injury Prevention Event held by Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups (CCG) in conjunction with NHS England in July 2014 were from Care Homes. An objective of the event was to create a forum for staff working in Acute Trusts, Community Providers and Care Homes to enable them to come together to exchange ideas and examples of good practice. Discussion revealed that care home staff had not received training on pressure injuries and were being prevented from buying equipment due to cost, along with a lack of management support.

5.5 The BNSSG Pressure Injury Steering Group was subsequently established in 2015 to deliver a programme of action aimed at reducing the overall

incidence of pressure injuries in hospital and community settings across the Bristol, North Somerset and South Gloucestershire area. The Steering Group is multi-agency, comprising members of the three clinical commissioning groups, provider organisations and local authorities. The group aims to address skin integrity and management throughout the entire patient pathway through collaborative working across the health economy. The steering group provides expert leadership in the support of evidence based best practice. In April 2016, the West of England Academic Health Science Network hosted a workshop for the Steering Group. The workshop provided clear focus for the group and resulted in the progress of work streams based on 4 key areas:

- Communication;
- Patient and Carer Support;
- Documentation;
- Education and Training.

5.6 The BNSSG Multi-Agency Strategy for the Prevention and Management of Pressure Injuries sets out the recommendations, resulting from the work of the steering group to date, for adoption by all providers.

6. Definitions

6.1 The term **provider** refers to any agency that provides either personal or nursing care for people in hospitals, hospices, care homes or their own home.

6.2 Providers across BNSSG should adopt a standardised term for rating pressure injuries, referring to them by **grade** as opposed to **category**. The advantage of this will be seen when patients are moved between care settings.

6.3 In 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from pressure **ulcer** to pressure **injury**.

6.4 **A pressure injury** is localised damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open injury and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

6.5 **An avoidable pressure injury** is where the injury to the skin was caused by the care provider not undertaking any one of best practice standards of care in the prevention of pressure injury. These standards include evaluation of the individual's clinical condition and risk assessment for developing pressure injury. It includes the implementation and monitoring

of interventions consistent with the individuals care needs and risk and documentation of all this care.

6.6 An **unavoidable pressure injury** may develop even though the individual's condition and pressure injury risk had been evaluated and goals and recognised standards of practice that are consistent with individual needs had been implemented. The impact of these interventions would have been monitored, evaluated and recorded and approaches revised as appropriate (NHS Midlands and East, Pressure Ulcer Management & Reduction Programme Board, 2011). The agreement that a grade 3 or 4 pressure injury was unavoidable will be determined through the Serious Incident (SI) / Root Cause Analysis (RCA) process.

6.7 A **moisture lesion** is defined as damage to the skin caused by urine and / or faeces and perspiration which is in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft, skin folds and where skin is in contact with moisture. When skin is in contact with moisture as above for long periods of time it causes the skin to become irritated and erythematous, often being painful. Moisture damage can present as broken excoriated skin (moisture lesions) and non-broken skin (erythematous), but will differ from that of pressure damage as it will present as superficial red areas with likely either red and shiny periwound skin or white macerated skin. These areas tend to be uneven, with multiple areas; other common areas tend to be a linear wound to the natal cleft or 'kissing' wounds to either side of the buttock. (All Wales Tissue Viability Nurse Forum 2014).

6.8 The management of moisture lesions should be set out in locally developed guidance.

6.9 **A Kennedy Terminal Ulcer** is a pressure ulcer that some patients develop during the end-of-life stages. The ulcer is irregularly shaped and often resembles a pear, butterfly or horseshoe. Usually starting as a blister or an abrasion, the ulcer quickly gets deeper. It forms due to poor blood circulation on the pressure area, is red, yellow or black in colour and is usually located at the base of the spine.

6.10 The **SSKIN** bundle is a five step model developed by NHS Midlands and East in 2012 for pressure injury prevention that identifies the simple steps to aid early detection and care management to eliminate avoidable pressure injuries:

- **S**urface: What is in contact with the skin that could cause damage
- **S**kin inspection: show your patients & carers what to look for and how to look after their skin
- **K**eep your patients moving. Regular repositioning is required.
- **I**ncontinence/moisture: your patients need to be clean and dry and know how to manage if this is a problem

- **N**utrition/hydration: help your patients have the right diet and plenty of fluids to enable wound healing

7. Factors Causing Pressure Injuries

7.1 A pressure injury is a localised injury to the skin and / or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or compounding factors are also associated with pressure injuries; the significance of all these factors is yet to be elucidated (European Pressure Ulcer Advisory Panel – EPUAP 2014).

7.2 Pressure injuries can occur in anyone but are more likely in high risk groups, such as the elderly, people who are obese, malnourished or who have continence problems as well as people with certain skin types and those with particular underlying conditions (EPUAP 2014).

7.3 Injury occurs when the skin and underlying tissues are compressed for a period of time, between the bone and the surface, on which the patient is sitting or lying. Blood cannot circulate causing a lack of oxygen and nutrients to the tissue cells. Furthermore, the lymphatic system cannot function properly to remove waste products.

7.4 If the pressure continues, the cells die and the area of damaged tissue that results is called pressure damage. The amount of time this takes will vary, but may develop in as little as one hour in people at greatest risk.

7.5 The factors causing pressure injuries are divided into 2 groups:

- Intrinsic – including disease, medication, malnourishment, age, dehydration/fluid status, lack of mobility, incontinence, skin condition and weight;

- Extrinsic – external influences which cause skin distortion including pressure and shearing forces. Friction was removed as a direct cause of pressure injuries by EPUAP (2014) and a consensus document by Wounds UK (2010) cited that friction contributes to shear rather than a stand-alone cause.

8. Risk Assessment

8.1 It is the responsibility of each organisation to ensure that their organisational process includes the use of a formal documented assessment tool that complies with the NICE guidance (2014). It requires that a formal assessment of those identified as potentially vulnerable to developing a pressure injury is clearly documented along with a plan to reduce these risks.

8.2 The skin inspection, risk assessment findings, including any initial risk assessment decisions, must be fully documented within the care records. Where appropriate, a management plan should be discussed and agreed with the patient / service user before implementation.

8.3 The skin inspections and assessments, including re-assessments should be continuous and responsive to any change in the person's condition or environment. It is recommended that high risk patients / service users should have their assessment reviewed on each contact in an inpatient / care home setting and that a robust re-assessment plan is implemented and maintained.

8.4 Holistic Assessment of Care Needs must be taken into consideration that encompass the SSKIN bundle and includes:

- Clinical conditions
- Medication
- Skin integrity
- Mobility and repositioning
- Equipment required
- Continence
- Nutrition
- Pain
- Patient's wishes and needs

9. Specialist Equipment

9.1 Patients identified as at risk or those with existing pressure injuries should be cared for on a pressure reduction or pressure relieving surface for 24 hours a day. The need for pressure reducing devices must be based on a risk assessment combined with the professional judgement of the assessing nurse. The pressure reducing support surface must meet the individual's needs based on their level of immobility and inactivity. More effective pressure relief is required where the individual cannot be positioned off an existing pressure injury or is not able to be repositioned regularly.

9.2 NICE (2014) recommends that patients identified as having an elevated risk of developing a pressure injury and those patients who have a grade 1 or 2 pressure injury should be provided with a high specification foam mattress as minimum. For those patients who have a grade 3 or 4 pressure injury, the minimum provision will be an alternating pressure overlay. A repositioning plan should be in place and skin must be closely monitored.

9.3 Each organisation should provide access to an appropriate supply and range of specialist pressure reducing equipment. The supplier, maintenance and supply arrangements should be determined locally.

Pressure relieving cushions and heel lifts should also be available if identified as a need following risk assessment.

10. Grading

10.1 Grading should only be used when the wound has been caused by pressure. Pressure injuries are graded depending on the depth of tissue that has been damaged. There are 6 different grades for pressure injuries according to the National Pressure Ulcer Advisory Panel (NPUAP 2016). These are:

Grade 1: An area of red, non-blanching erythema where the skin remains unbroken. This does not include purple or maroon like colouring which would suggest another grading

Grade 2: Partial- thickness loss of tissue extending into the dermis layer only. May also be an intact or ruptured serous filled blister

Grade 3: Full thickness loss of tissue extending into the soft tissue layer. This layer may consist of the adipose (fat layer). The depth will depend on the location of the wound and the individual's anatomy. Slough / Necrosis may be present in the wound bed and undermining / tunnelling may also be present

Grade 4: Full thickness tissue loss where bone, tendon, muscle and any other structures are exposed. Depth also depends on the location and anatomy. Undermining and tunnelling are often common in these wounds

Ungradable Pressure Damage: This defines a wound that has been caused by pressure damage but the view of the wound bed is obscured by slough / necrosis / eschar and therefore the true depth of damage cannot be defined. These will often become a grade 3 or 4 pressure injury

Deep tissue injury: This is described as purple/maroon, non-blanching discoloration to the skin. It can be both intact and broken skin. This injury is present from intense pressure or shearing forces. The injury will do one of two things, resolve with no tissue loss or deteriorate showing the true extent of tissue damage.

11. Record Keeping

11.1 Pressure injury care bundles provide a plan of care that includes five care elements (e.g. SSKIN) in an easy to follow document structure, providing reminders to the care required. However, they are not necessarily individualised and whilst some versions provide a structured care strategy, they may not accurately define a problem or detail the specific care provided in response to an observation.

11.2 Effective record keeping underpins service delivery and provides an individualised record of the quality of care delivered. Pressure injury risk assessment, prevention strategy and pressure injury care provision are a key element in the nursing process. This is supported by both NPUAP 2014 and NICE, CG179 2014 guidance:

- patients have an individualised care plan that reflects their risk assessment and that it is regularly reviewed and adapted to accommodate changes in their medical condition or social situation;

- that pressure injury risk assessments are an ongoing process that should be undertaken at first patient contact and should be repeated regularly, if the patient moves between care facilities, including ward areas, or if their medical condition changes;

- deviations from local or national guidance or the agreed care plan should be clearly documented and the rationale for those actions noted;

11.3 Where patients do not wish to follow advice on pressure injury prevention strategies such as repositioning or use of pressure relieving equipment (defined as non-concordance) in spite of education regarding the consequences, this should be clearly documented, together with mental capacity to make an informed decision.

11.4 Pressure injury prevention documentation must allow individualised patient specific details to be recorded by the whole multidisciplinary team.

11.5 Record keeping is an essential element of care delivery ensuring pressure injury and wound healing is evaluated effectively. As a minimum, it is expected that the records of patients at risk of developing a pressure injury includes the following:

- evidence of skin checks;
- risk assessment;
- SSKIN assessment;
- Involvement of other agencies / multi-disciplinary team (MDT).

11.6 The following information should be documented in the care records for all pressure injuries:

- classification of wound bed, colour, odour and exudate;
- grade;
- site;
- size;
- wound management.

11.7 All pressure injuries should be measured at least weekly to provide information about the progression of the wound. A photograph should be

taken, particularly if the injury is difficult to measure or trace. Not all clinical areas have the facility to record digital images but where digital images are taken, this should only be undertaken in accordance with the consent policy of the organisation.

11.8 Medical photography of pressure damage is a useful communication tool and can assist in assuring consistent pressure injury grading and it can also help in patient communication.

11.9 Professional guidance on record keeping should be followed.

12. 72 Hour Rule

12.1 The 72 hour rule, whereby if a pressure injury is identified within 72 hours from entering an organisation's care then it would not be deemed attributable to that organisation has come under criticism as being misleading. It is recognised that the time from unrelieved pressure to observable pressure damage can vary from hours to days/weeks, depending upon the site of the body and the depth of skin/soft tissue covering that site. It is important that organisations undertake a joint investigation into the circumstances that led up to the development of pressure injury to ascertain when, how and why the pressure injury has occurred. This will ensure that the cause of the pressure injury is understood and attributed to the correct organisation.

13. Measures For Improvement

13.1 The prevalence of pressure injury is one of the four common harms recorded in the NHS Safety Thermometer, for measuring, monitoring and analysing patient harms across a range of settings, including care homes, community nursing and hospitals on a monthly basis.

13.2 Organisations should decide what outcome measures are most appropriate and relevant to their care settings and all relevant information should be produced to front line staff at team level in order to drive improvement.

13.3 The BNSSG strategy will measure improvements in the following outcomes and process measures:

- incidence of newly acquired grade 2 pressure injuries;
- incidence of newly acquired grade 3 pressure injuries;
- incidence of newly acquired grade 4 pressure injuries;
- rates of pressure injury newly acquired per 1000 bed days and community/ primary care organisations per 10,000 population;
- percent compliance with risk assessment completion - NICE standard;

13.4 Process Measures (compliance should be 95% or greater)

- percent compliance with risk assessment within six hours of admission in acute Trusts or during first visit for community organisations;

- percent compliance with SSKIN bundle or similar. This is an all or nothing measure which means that to be compliant; all aspects of the bundle must be delivered.

14. Measures For Improvement

14.1 Open and honest reporting of pressure injuries incidents is an essential component to reducing harm to patients, improving patient experience and reducing the associated financial costs to the NHS. All provider organisations should have local recording, reporting and learning systems in place that enable them to:

- learn from the incident and put actions in place such as training that prevent future recurrence and improve patient health and wellbeing;
- facilitate the identification of Serious Incidents (see Statutory Reporting);
- identify where resources should be focused to make improvements;
- establish baseline data;
- monitor improvements in performance;
- benchmark performance against other provider organisations.

14.2 The systems in place should ensure that all pressure injuries, irrespective of grade are reported within the patient/service user record.

14.3 Reporting of pressure injuries on local reporting systems should ensure that the following data is captured relevant to the provider organisation:

- number of pressure injuries;
- number of pressure injuries newly acquired;
- number of patients that have a pressure injury;

- rate of pressure injuries newly acquired per 1,000 bed days (acute) / per 10,000 population (community)
- location of patient when pressure injury was acquired;
- grade of pressure injury;
- compliance with risk assessment;
- compliance with SSKIN bundle.

14.4 Pressure injuries of grade 2 and above should be reported on the local incident reporting system and an investigation undertaken, to identify how and why the pressure injury developed and deteriorated, to support learning.

14.5 Monitoring of the incidence of pressure injuries across organisations will be undertaken by commissioners through the local quality performance groups

to identify any specific issues in relation to the incidence of pressure injuries and/or their management.

15. Statutory Reporting

15.1 Serious Incidents

15.1.1 In broad terms, serious incidents (SI) are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Acute, Mental Health and Community provider organisations are required to report all pressure injuries of grades 3 and 4 in line with the NHS England Serious Incident Framework 2015.

15.1.2 All serious incidents should be reported through the Strategic Executive Information System (StEIS). Reports received into this system are reviewed and monitored by NHS England and the relevant CCG.

15.1.3 As commissioning organisations, CCGs have a responsibility to ensure that the services commissioned for their patients are safe. While best endeavours are made to ensure patients do not come to any harm when utilising these services, inevitably there are times when something goes wrong and a serious incident or patient safety incident occurs.

15.1.4 The investigation tool recommended by the National Framework applies a root cause analysis (RCA) approach. Many organisations have developed and adapted their own root cause analysis form based upon the principles of SSKIN. It is important that the RCA framework implemented outlines the preventative strategies already in place. The real learning requires a more detailed understanding of why, given all of the evidence based initiatives, the pressure injury has occurred or why when considering the wider organisational pressure injury incidence, the overall prevalence of pressure injuries still appears to be increasing. The emphasis of the RCA will be to review each incident and understand where proven methodologies for prevention have failed, identify root causes and any lessons that can be learnt to prevent recurrence and inform future care provision

15.1.5 All serious incidents reported through the serious incident reporting system should be reviewed by the relevant CCG at a Serious Incident Panel to ensure that the final report and action plan meets the requirements for a robust investigation. Feedback should be provided to the organisation to promote learning prior to closure of the incident.

15.2 Duty of Candour

15.2.1 The Health and Social Care Act 2008 requires that when a notifiable safety incident has occurred, the relevant person must be informed as soon as

reasonably practicable after the incident has been identified. Providers of commissioned services to BNSSG CCGs are required to undertake this within 10 days of the incident being reported. In addition, providers are required to give a meaningful apology to those affected by the incident and to follow up verbal communication in writing.

15.3 National Reporting and Learning System

15.3.1 All NHS patient safety incidents should be reported to the National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports. Through the NRLS, the Patient Safety Division collects confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts help analyse these reports to identify common risks and opportunities to improve patient safety. Feedback and guidance are provided to healthcare organisations to improve patient safety.

15.4 Safeguarding

15.4.1 Pressure injuries should be considered as part of the safeguarding process. The development of a pressure injury may be significant in the identification of vulnerable patients. Each local Safeguarding Board has processes in place to ensure that people with pressure injuries are referred into the safeguarding process appropriately. Provider organisations must ensure that staff are aware of local safeguarding policies and that regular training reinforces associated procedures.

15.5 Care Quality Commission

15.5.1 Registered providers of independent healthcare and adult social care are required under current legislation to report serious injuries to the Care Quality Commission (CQC). This includes pressure injuries grade 3 and above. The notification is added to the CQC's knowledge of the provider's service and assists them in planning inspection activity.

16. NHS Safety Thermometer

16.1 The NHS Safety Thermometer, developed by the QIPP (Quality, Innovation, Productivity and Prevention) Safe Care team, the Health and Social Care Information Centre, and other partners, is a measurement tool to support patient safety improvement. It is used to record 4 key patient harms at the point of care (VTE, Falls, Catheter Associated UTIs and Pressure Ulcers), and to provide immediate information and analyses for teams to monitor their performance in delivering harm free care (at a provider and system level).

16.2 The NHS Safety Thermometer is used across a range of healthcare settings. All relevant patients are surveyed one day each month, acting as a snap shot of the harm in time (a 'temperature check' on the system). The presence or absence of pressure injuries is recorded, allowing teams to measure harm and the proportion of patients that are 'harm free' during their working day; for example, at shift handover or during ward rounds.

16.3 All NHS providers of inpatient care in BNSSG will continue to work with local commissioners to ensure that this tool is routinely embedded in practice.

17. Stop the Pressure Campaign

17.1 The 'Stop the Pressure' campaign was originally launched by NHS Midlands and East as part of their ambition to make life better for patients. The campaign is now managed by NHS Improvement and forms part of a key ambition to support the improvement of standards of safe care.

17.2 The first year of the campaign saw providers in the Midlands and East of England achieving a 50% reduction in pressure ulcers. This was delivered by raising awareness of the causes of pressure ulcers via an extensive communication strategy, understanding the early warning signs, taking preventative measures and utilising SSKIN and the NHS Safety Thermometer. Front line staff were motivated to drive improvement in patient care for patients in their care settings Subsequent years have seen the improvement sustained and the campaign expand across some other regions. The campaign is now being rolled out nationally to coordinate and support a sustained reduction in pressure ulcer prevalence over a period of 2 years. This will be an ambitious target that with the support of front line staff, patients and other colleagues is achievable.

17.3 It is recommended that the Stop the Pressure website is used as an improvement resource to access current information for the benefit of all at risk of pressure ulcers.

18. Education - Staff

18.1 Ensuring staff are competent and confident to deliver safe and high quality care remains a key requirement for all health and social care providers

18.2 Training in pressure injury prevention and management should become part of the mandatory training schedule for all clinical employees within each provider organisation. The key benefits of a consistent approach across BNSSG are that all healthcare employees will have up to date knowledge and understanding of approaches to the prevention of pressure injuries and that existing training will be recognised when staff move between BNSSG organisations both, of which, will lead to the improved quality of patient care.

18.3 The BNSSG strategy supports the requirement for both induction and on-going training in all provider organisations. The recommended frequency of refresher training is 2 – 3 yearly. The uptake of training will be monitored by each provider and should be one of the elements reviewed within the serious incident reporting process.

18.4 Training should be delivered by a healthcare professional trained or experienced in pressure injury prevention and management.

18.5 Training will be provided, at induction, to all healthcare staff on preventing a pressure injury, including:

- who is most likely to be at risk of developing a pressure injury;
- how to identify pressure damage;
- what steps to take to prevent new or further pressure damage;
- who to contact for further information and for further action.

18.6 Additional training will be provided to healthcare professionals who have contact with anyone who is at increased risk of developing a pressure injury. Training should include:

- how to carry out a risk and skin assessment;
- how to reposition;
- information on pressure redistributing devices;
- discussion of pressure injury prevention with patients and their carers including management of non-concordance;
- details of sources of advice and support (NICE Clinical Guideline CG179).

18.7 This training should be delivered as part of induction and update training.

18.8 Training in pressure injury management should be delivered to identified trained healthcare professionals.

18.9 The multi-agency steering group and strategy supports the use of standardised education tools based upon the principles set out within this strategy, using on-line or face to face training tools. Provider organisations are encouraged to share training resources as appropriate.

18.10 Each provider organisation will be responsible for the development of pressure injury prevention and management competencies.

19. Education – Patient/Carer

19.1 The education of the patient at risk and their significant carers is central to successful pressure injury prevention. The risk must be clearly communicated, using a variety of ways to ensure individuals understanding

of why they are at risk and what they can do to prevent tissue damage from pressure. Each organisation should have a portfolio of resources available for patients to aid their understanding depending on their situation and need.

19.2 It is recommended that the following information is available using pictorial and explanatory leaflets and in video form:

- what causes a pressure injury;
- how a pressure injury worsens stage by stage;
- what can be done to prevent pressure injuries;
- using the SSKIN care bundle to prevent pressure injuries;
- dedicated heel injury prevention;
- patient stories.

19.3 It is recommended that information is repeated to patients on a regular basis and in given in a variety of ways. They should be provided with the tools to help them assess their own vulnerability to development of pressure injuries, how to prevent them and who to contact should they be concerned. All information should be culture and language specific, at the appropriate literacy level and easily accessible.

20. Patient Involvement

20.1 Each BNSSG organisation should ensure that they have a broad range of information and tools available for the public in order to encourage and support their participation in the prevention and management of pressure injuries. It is recommended that organisations develop a web page that is accessible by the public with explanations of how pressure injuries develop and useful information in the prevention of pressure injuries. Patients should be engaged in the development of resources to ensure they are user friendly.

21. Communication

21.1 It is important for healthcare providers within the BNSSG locality to build a culture of partnership and collaboration in order to explore how communication pertaining to pressure injuries can be improved between different healthcare settings during transitions of care i.e. movement of patients from one healthcare setting to either another or to home (or vice versa).

21.2 Working collaboratively clear communication channels should be established in order to ensure there is timely, effective, and person-centred communication, documentation and transfer of information to ensure continuity of care. For example:

- enhancing the transfer process and continuity of care between acute and community settings by developing / utilising a standardised communication tool to effectively facilitate information sharing i.e. an electronic pressure injury passport for patients who have a pressure injury or are at risk for developing a pressure injury.

- It is essential that information documented in the patient's care record is handed over when people transfer between different service providers.

22. Summary

22.1 This multi-agency strategy has been developed by the Bristol, North Somerset and South Gloucestershire (BNSSG) Pressure Injury Steering Group and reflects the aspiration of the participating agencies to have a consistent approach to the prevention and management of pressure injuries in all health and social care settings and in service users' homes.

22.2 It is expected that the strategy will shape local policy and influence a reduction in avoidable grade 2, 3 and 4 pressure injury incidence across BNSSG.

22.3 It is intended that this strategy will be communicated to the wider health and social care services and the general public.

22.4 The BNSSG Pressure Injury Steering Group will continue to monitor compliance with this strategy to drive forward improvements to reduce pressure injury incidence across Bristol, North Somerset and South Gloucestershire.

23. References

All Wales Tissue Viability Nurse Forum (2014) Best Practice statement on the Prevention and Management of Moisture lesions Wounds UK London.

EUPAP (European Pressure Ulcer Advisory Panel) 2014 Prevention of Pressure Ulcers:
Quick Reference Guide
https://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf

Understanding the Kennedy Terminal Ulcer 2014
http://www.kennedyterminalulcer.com/

Moore et al; 2009 cited in NHS Improvement: Stop the Pressure
http://nhs.stopthepressure.co.uk/

National Pressure Ulcer Advisory Panel 2016 Pressure injury stages
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

NICE 2014 CG179 Pressure ulcers: Prevention and management
https://www.nice.org.uk/guidance/CG179/evidence

NICE Quality Standard QS89 2015; Pressure Ulcers
https://www.nice.org.uk/guidance/qs89

NHS Midlands and East, Pressure Ulcer Management & Reduction Programme Board
http://nhs.stopthepressure.co.uk/Path/docs/Definition%20unavoidable%20PU.pdf

Wounds UK 2010 http://www.wounds-uk.com/journal/issue

24. Associated Agencies

- Bristol Clinical Commissioning Group
- North Somerset Clinical Commissioning Group
- South Gloucestershire Clinical Commissioning Group
- University Hospitals Bristol NHS Foundation Trust
- Weston Area Health NHS Trust
- North Bristol NHS Trust
- Bristol Community Health
- North Somerset Community Partnership
- Sirona Care & Health
- St Peter's Hospice
- Bristol City Council
- North Somerset Council
- South Gloucestershire Council