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Scottish Patient Safety Programme Update
Implementation of Falls and Pressure Ulcers

Paper No: 14/55

1. Background

The Scottish Patient Safety Programme (SPSP) is one of the family of national improvement programmes, developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methods advocated by the Institute for Healthcare Improvement. SPSP now contains a number of distinctly identified programmes as follows:

- Acute Adult Care
- Primary Care
- Mental Health
- MCQIC (incorporating Paediatrics, Maternal Care & Neonates)

2. Purpose of Paper

The Acute Adult Programme contains a number of specific workstreams including work aimed at reducing the levels of patient falls and reducing the incidence of pressure ulcers. It has been agreed that SPSP implementation will be taken forward through Corporate Steering Groups for, Falls and Tissue Viability with strong links and support from the Clinical Governance Support Team and local services. This will enable the programmes to be integrated within current work streams.

In response to a previous paper providing a general update on SPSP a request for a deeper understanding of these two specific programmes was made at the NHS Board meeting. Therefore the purpose of this paper is to provide an update to the Board on the Scottish Patient Safety Programme workstreams for Falls and Pressure Ulcers.

The Board of NHS GG&C is asked to note:

- an update of the progress in improving Falls and Pressure Ulcer and in implementing the related SPSP workstreams

3. SPSP implementation of Falls Workstream

A patient fall is defined as 'a sudden unintentional change in position, causing one to land on a lower level, or on an object, the floor, or the ground' (Tinetti, 1987). The consequence of a fall can vary but in some patients, especially those who are already seriously ill, the outcome can be one of serious harm. There is evidence indicating certain falls can be prevented. Using approaches to create reliable clinical care processes, supplemented with tailored care plans reflecting each patients specific risk profile.

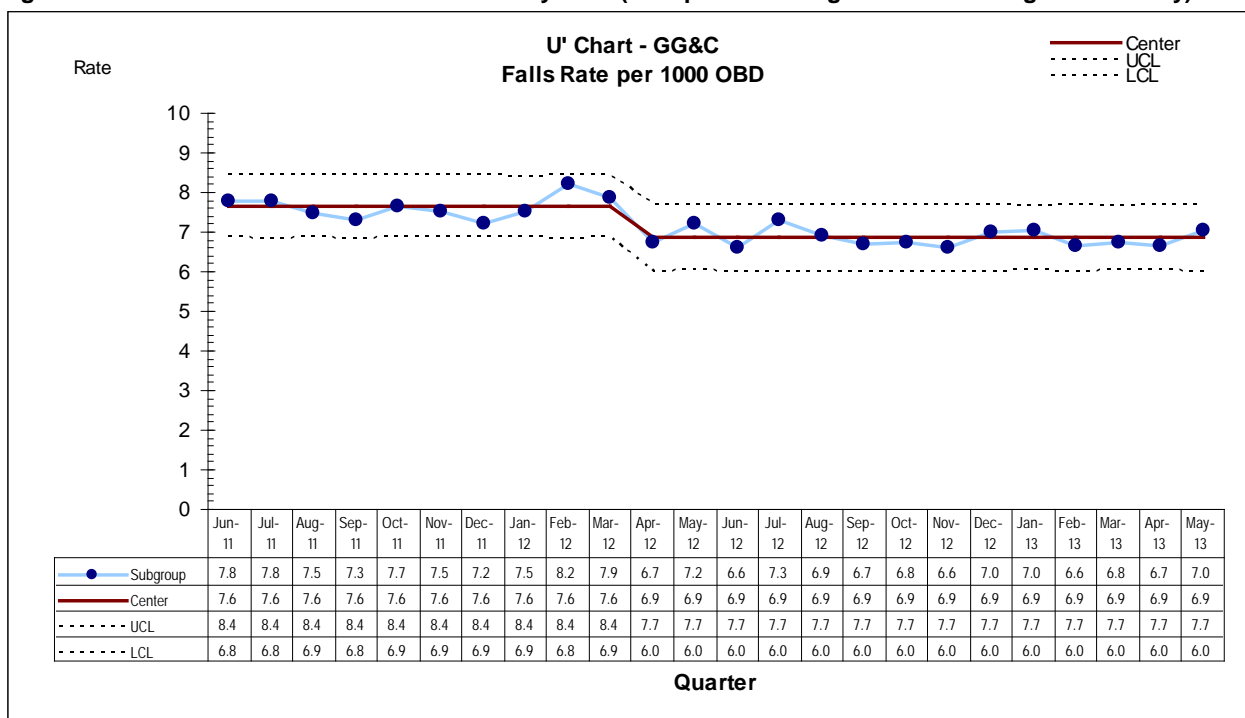
The existing approach to falls prevention is based on the clinical standards

- that all patients are assessed within 24 hours of admission to hospital using the Cannard Assessment Tool, a specialised assessment to measure their risk of falling
- that all patients have a risk based personalised care plan which may include greater supervision, walking aids, specialist seating.

These are complemented with standardised general safety precautions to minimise falls risks in clinical settings which may include monitors, observation, lowering bed heights.

To facilitate implementation of these standards there is an established governance structure for falls reduction and specialist posts, Falls Coordinators, to advice clinical teams. More recently the Cannard Assessment has been incorporated within the new nursing admission and assessment documentation to ensure patients are risk assessed on admission and minimising falls risk has been incorporated into the new Active Care documentation. We can see the positive impact of this work in reduction shown in figure one.

Figure 1: Board level Falls Rate June 2011 – May 2013 (as reported through Incident Management Policy)



SPSP pilot teams

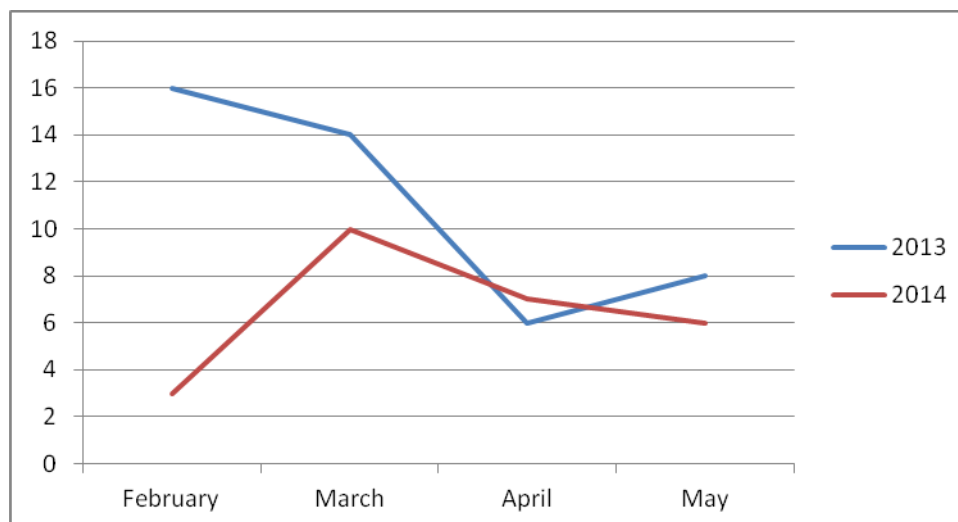
The structured application of improvement techniques is expected to augment the existing organisational approach. This is being developed in an initial cohort of nine clinical teams piloting the four national care bundles which are

- Falls Bundle, including risk assessment, for all patients,
- Safety Bundle for more vulnerable patients,
- Multi-disciplinary Assessment and Intervention Bundle for more vulnerable patients,
- Post Fall Bundle.

We have teams working in different areas across the four bundles and have observed success in nearly completing the tested development of a new risk assessment process and supporting documentation and good initial progress in the tested development of post falls review.

Measurement is a key aspect of the quality improvement process. We are working with 19 wards testing revisions to a visual monitoring tool for ward staff showing when and where falls occur and allowing wards to monitor incidence of falls i.e. Falls Safety Cross.

Figure 2 – reduction in falls in one ward after introduction of the falls safety cross



Challenges

A new risk assessment has been recommended through SPSP, and is being developed in pilot teams, but it is different from the current tool, the Cannard Assessment. It is much shorter and quicker for nursing staff to administer but Cannard is well established in our documents and training. The Cannard risk assessment is currently included in the NAD (nursing assessment document) and is a mandatory field. This means wards are required to do both assessments to ensure completeness of recording during early testing phase.

The falls rate is part of the national measurement plan linked to the Scottish Patient Safety Indicator. We are therefore required to aggregate falls rates in line with national descriptors. This requires development of Datix (the electronic incident reporting system) used to record falls.

3. SPSP implementation of Pressure Ulcers Workstream

The national programme uses the following definition of a pressure ulcer: 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. The prevailing literature suggests up to 95% of hospital acquired pressure damage is avoidable.

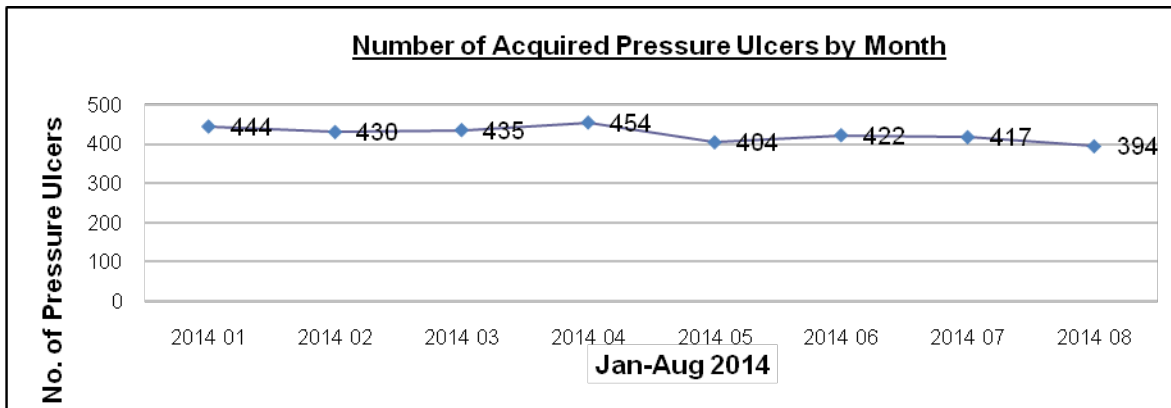
The existing approach to pressure ulcer prevention is based on the following clinical standards:

- All patients are assessed within 6 hours of admission to hospital using the Waterlow risk assessment tool to measure the risk of developing pressure damage.
- All patients have a risk based personalised care plan

These are complemented with standardised general safety precautions to minimise the risk of pressure damage for patients.

For instance NHSGGC developed and implemented the 'Top 10 Tools' for Pressure Ulcer Prevention and Management alongside promotion of a Zero Tolerance approach to avoidable pressure ulcer development. These tools are consistent with the SPSI change package, so for wards there is no change to current practice in terms of risk assessment tools etc.

The success of the current approach is suggested in the following chart showing a gradual but downward trajectory throughout this year.



SPSP pilot teams

The structured application of improvement techniques is expected to augment the existing organisational approach. This is being developed in an initial cohort of nine clinical teams with two key areas of focus; risk identification/assessment and implementation of the national SSKIN bundle (Note: the SSKIN bundle includes: Surface, Skin Inspection, Keep Moving, Incontinence (increased moisture), Nutrition)

There are currently 9 wards testing the measurement plan for the pressure ulcer change package. The major 'change' in implementing the pressure ulcer bundles is in ensuring that implementation is reliable and sustained within a whole team approach to prevention and management. The Tissue Viability Nurses have been provided with basic training in improvement techniques and are now working within pilot teams to coach on tested development as a means to create a reliable care process.

Given the long standing improvement work within NHS GG&C a key area is measurement to ensure we understand where outcomes and process reliability should be improved. We are currently working to implement the national measurement plan within the test wards. Significantly we have developed a model that allows our staff to determine whether a hospital acquired pressure ulcer was avoidable or unavoidable. This provides the basis for analysis which can target our tests of change in improving the clinical process.

Challenges

The pressure ulcer is part of the national measurement plan linked to the Scottish Patient Safety Indicator. We are therefore required to aggregate pressure ulcers rates in line with national descriptors. However we currently have two electronic systems used for collecting quality indicators data (Lanquips and Datix). Having to record the same information twice into two different systems is time consuming for front line staff and is known to reduce data quality, therefore we need to develop a single integrated data collection process.

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Date **01/10/2014**