



## Clinical study

# Pressure ulcer and wounds reporting in NHS hospitals in England part 1: Audit of monitoring systems

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**KEYWORDS**

Pressure ulcer;  
Prevalence;  
Sensitivity;  
Incident reporting;  
Adverse event;  
Patient safety

**Abstract** Internationally, health-care systems have attempted to assess the scale of and demonstrate improvement in patient harms. Pressure ulcer (PU) monitoring systems have been introduced across NHS in-patient facilities in England, including the Safety Thermometer (STh) (prevalence), Incident Reporting Systems (IRS) and the Strategic Executive Information System (STEIS) for serious incidents. This is the first of two related papers considering PU monitoring systems across NHS in-patient facilities in England and focusses on a Wound Audit (PUWA) to assess the accuracy of these systems. Part 2 of this work and recommendations are reported pp \*-\*.

The PUWA was undertaken in line with 'gold-standard' PU prevalence methods in a stratified random sample of NHS Trusts; 24/34 (72.7%) invited NHS Trusts participated, from which 121 randomly selected wards and 2239 patients agreed to participate.

*Prevalence of existing PUs:* The PUWA identified 160 (7.1%) patients with an existing PU, compared to 105 (4.7%) on STh. STh had a weighted sensitivity of 48.2% (95%CI 35.4%–56.7%) and weighted specificity of 99.0% (95%CI 98.99%–99.01%).

*Existing/healed PUs:* The PUWA identified 189 (8.4%) patients with an existing/healed PU compared to 135 (6.0%) on IRS. IRS had an unweighted sensitivity of 53.4% (95%CI 46.3%–60.4%) and unweighted specificity of 98.3% (95%CI 97.7%–98.8%). 83 patients had one or more potentially serious PU on PUWA and 8 (9.6%) of these patients were reported on STEIS.

*Abbreviations:* STh, Safety thermometer; STEIS, Strategic executive information system; SIs, Serious incidents; IRS, Incident reporting systems; PUWA, Pressure ulcer/wound audit; TVS, Tissue viability society; NHS, National health service; PU, Pressure ulcer; CQUIN, Commissioning for quality and innovation; NRLS, National reporting and learning system; CQC, Care quality commission; IAD, Incontinence associated dermatitis; POA, Present on admission; HA, Hospital acquired.

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<http://dx.doi.org/10.1016/j.jtv.2015.11.001>

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The results identified high levels of under-reporting for all systems and highlighted data capture challenges, including the use of clinical staff to inform national monitoring systems and the completeness of clinical records for PUs.

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## 1. Introduction

In efforts to minimise patient harm in health-care systems the measurement of adverse events including pressure ulcers has been undertaken to assess the burden and scale of patient harm and attempt to measure improvement [1–7].

In line with international debate and policy, a number of initiatives have been introduced throughout the NHS in England to facilitate improved care quality and patient safety. They are set against changes to the NHS structure in England, which encompasses two main functions; the first is to commission health services which deliver high quality patient care and improved outcomes and the second is to provide this care [8]. Therefore both commissioners and care providers are important stakeholders for PU monitoring.

The importance of collecting and learning from patient safety incident data was highlighted by ‘An organisation with a memory’ [9] and subsequent implementation publication ‘Building a Safer NHS for patients’ [10], providing the impetus for the National Patient Safety Agency and the National Reporting and Learning System (NRLS) established in 2003 to encourage national reporting of patient safety incidents to facilitate widespread learning and establish priorities for patient safety [11]. Subsequently, an NHS Outcomes Framework was developed to provide national-level accountability for the delivery of outcomes and facilitate quality improvement and includes PUs [12], with operationalization through the Commissioning for Quality and Innovation (CQUIN) framework [13,14] with local target setting for the reduction of avoidable harm.

The policy initiatives have led to the development of data collection systems and quality metrics including: the Safety Thermometer (STh) [15] which includes assessing PU prevalence monthly; Incident Reporting Systems (IRS) to facilitate data reporting to the NRLS [11], and NHS England’s web-based serious incident management system, the Strategic Executive Information System (STEIS) for the reporting of serious incidents (SIs) [16].

The Quality Observatory is an organisation that was set up to enable local benchmarking and the development of metrics [17]. The STh is a nationally co-ordinated measurement tool to support

patient safety improvement in the NHS [15]. While it is a voluntary scheme it is incentivised via CQUINs and most NHS Trusts participate. Data collection is undertaken locally on one specific day of each month by front line nursing teams, for all NHS funded patients. Anonymous data is then uploaded to the national database, providing a point prevalence of existing PUs, which is presented as the percentage of all in-patients with a PU on the STh census date.

IRS’s, using software packages including Datix [18] and Ulysses [19] are locally held databases capturing patient identifiable reported incidents of harm including PUs. Most Trusts routinely upload anonymised IRS data to the NRLS on a monthly basis, though direct reporting to the NRLS can be undertaken [11]. Locally the actual reporting of incidents is encouraged to be undertaken as near to the time of the incident as possible. Incident monitoring data provides either a simple count of the number of PU incidents per month, a measure of the incidence of PUs as a proportion of the number of patients admitted to hospital in that month, or a measure of the number of PUs per 1000 bed days in that month. For SIs there are additional requirements, including reporting the incident to STEIS (without patient or staff names) the NRLS, the Care Quality Commission (CQC) and other bodies as appropriate [16].

There has been a number of difficulties in the definitions (Table 1) and implementation of quality metrics including:

- Interchangeable use of the terms prevalence, incidence and incidents despite their differences.
- Poor coding of pressure ulcers in healthcare records.
- Lack of clear national guidance for the reporting of pressure ulcers (e.g. type of ulcer to be reported, classification system to be used) which has led to inconsistent reporting across the country [20].
- The introduction of the terms ‘Old’ and ‘New’ pressure ulcers in the STh methodology, whereby pressure ulcers present within 72 of admission are classified as ‘Old’.

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