# EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

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| REPORT TO: | **BOARD OF DIRECTORS** |
| DATE: | **27 MARCH 2015** |
| SUBJECT: | **PATIENT STORY** |
| REPORT FROM: | **CHIEF NURSE & DIRECTOR OF QUALITY & OPERATIONS, DEPUTY CHIEF EXECUTIVE** |
| PURPOSE: | **Discussion** |

## CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services.

Patient stories are a key feature of our ambition to revolutionise patient and customer experience. Capturing and triangulating intelligence pertaining to patient and carer experience from a variety of different sources will enable us to better understand the experiences of those who use our services.

Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

## SUMMARY

This month's story relates to the experiences of a 92 year old gentleman who developed deep pressure ulcers on both heels whilst in the Clinical Decision Unit at the William Harvey Hospital in July 2014. The root cause analysis investigation revealed that a number of significant lapses of care had occurred. Summarised these were inaccurate and poor assessments of skin integrity, a failure to follow the SKINS bundle, and a failure to document thoroughly. A number of actions were put in place on the ward to ensure that these events do not occur again. These actions have been progressed and the learning has been shared. Since these events, no further deep ulcers have been reported by the ward.

## RECOMMENDATIONS:

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence.

## NEXT STEPS:

None. The actions outlined in the story are being monitored by the Division and the Deep Pressure Ulcer Working Group.

**IMPACT ON TRUST'S STRATEGIC OBJECTIVES:**

Improving patient experience and satisfaction with the outcomes of care are essential elements of our strategic objectives.

**LINKS TO BOARD ASSURANCE FRAMEWORK:**

This story links to AO1 of the BAF: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

**IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:**

The risks identified in this story were around staff not following policy around pressure area care, thereby placing patients at risk.

**FINANCIAL AND RESOURCE IMPLICATIONS:**

None

**LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:**

None

**PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:**

None

**ACTION REQUIRED:**

**(a) Discuss**
**(b) To note**

**CONSEQUENCES OF NOT TAKING ACTION:**

If we do not learn from events such as these there is an increased risk of further occurrences which may adversely affect both patient experience and outcomes.

**Board of Directors**
**Patient Experience Story**
**March 2015**

## Introduction

This month's story relates to the experience of a 92 year old gentleman who developed deep pressure ulcers on both heels whilst in the Clinical Decision Unit (CDU) at the William Harvey Hospital (WHH)in July 2014. It describes the findings of the root cause analysis investigation that was undertaken and the learning that has been shared Trust wide as part of the pressure ulcer improvement work that is being progressed Trust wide.

## The Patient Story

A 92 year old gentleman was admitted to the CDU at the William Harvey Hospital with a two week history of falls, bilateral leg cellulitis, reduced mobility, feeling generally unwell and unable to weigh bear. The gentleman was treated for infected cellulitis with antibiotics. The gentleman also had pressure ulcers (category 2) on his sacrum. Members of the patient's family and Community Nurses confirmed that the category 2 ulcers on the patient's sacrum were present prior to admission to hospital.

On admission to the CDU he was assessed as 'medium risk' of developing pressure damage. This was an inaccurate assessment. As a consequence he was not placed on an air mattress, neither was there documentary evidence that a full assessment had taken place. Regrettably his existing dressings were not removed and the wounds not inspected. Furthermore the appropriate turning regime was not carried out as per best practice and policy.

Over the following days the gentleman became increasingly unwell and a decision was agreed with his family not to resuscitate him should he require it. Review of his care record showed a lack of accurate assessments of his skin, poor recording of his turning regime and a lack of preventative measures in place to protect his skin.

The gentleman was transferred to Cambridge L Ward where two category 3 heel ulcers were assessed. These were reported on STEIS as per normal procedures. On Cambridge L Ward a full skin inspection was undertaken and the patient was placed on to an airwave mattress. 'Prevlon' boots were also applied to prevent further skin damage.

## Care and Service Delivery Problems

There were a number of lapses in care with this gentleman. These are summarised below:

- Inaccurate and incomplete risk assessments;
- Inconsistent completion of SKINS bundle documentation;
- Lack of evidenced heel offloading;
- Airwave mattress was not provided in a timely manner;
- Inconsistently completed repositioning charts;
- Lack of compliance with the Trust's pressure ulcer policy in relation to pressure ulcer prevention and completion of Health Care Records resulting in a lack of appropriate preventative care.

Ward Manager Maria Linden returned from leave and was informed of this case plus two other cases on the ward. She commenced a full investigation which resulted in a number of actions, learning and consequences for those involved. The case was presented to the newly established Pressure Ulcer Panel enabling Trust wide sharing to be facilitated.

**Learning and Actions**

A number of actions were taken as a result of these events. These included:

- The standard of care on the ward required “deep dive” investigation. The deep dive looked at all aspects of pressure ulcer care as well as other factors including nutrition and safeguarding;
- All staff on CDU met on a 1 to 1 basis with the Ward Manager where their responsibilities for pressure area care were made clear. Each of them signed a record of the meeting which was placed on their personal files;
- All staff on CDU were required to undertake accurate and complete risk assessments and to follow the Trust policy regarding the SKINS bundle and preventative measures;
- All staff on CDU were re-taught how to recognise the risk of heel ulcers and the importance of appropriate offloading strategies;
- These interventions are now discussed regularly at the handover by the Nurse in Charge;
- All documentation on CDU and Cambridge M1 Ward has a pink sticker with an ‘S’ to evidence that the staff have assessed and looked after their patients’ skin on each shift. This acts as a prompt when handovers between staff or wards occur;
- The Named Nurse for each group of patients undertakes a daily SKINS Audit and reports their findings to the Nurse in Charge;
- The Nurse in Charge now completes daily spot checks following receipt of the audit results. These findings are documented on the Patient Safety Checklist;
- The Nurse in Charge escalates areas of non-compliance to the Ward Manager and Matron;
- Heel off loading signs are placed at the medium and high risk patients’ bedsides;
- Spot checks are also undertaken by the Ward Manager or Matron.

There are several improvement trajectories in place for pressure ulcer reduction across the Trust. Reported monthly are the number of pressure ulcers that have developed and the teams are working to a 25% reduction on category 2, 3 & 4 ulcers. The Pressure Ulcer Steering Group has also agreed an internal stretch target of a 50% reduction in avoidable deep ulcers (category 3 & 4) for 2014/15. Improvements are reported via the Safety Thermometer data and monthly in the Clinical Quality and Patient Safety Board Report. It is encouraging to see that that the reductions in avoidable pressure ulcers are being achieved.

The root cause analysis investigations showed a particular problem with heel ulcers and repositioning. The Tissue Viability Team have focussed on working with ward teams to reduce the incidence of heel ulcers. A number of events have taken place including taking part in the National ‘Stop the Pressure Day’, exhibitions and ward "trolley dash" visits on each acute site. Every ward/department was provided with a resource pack and a variety of staff were seen wearing their "STOP THE PRESSURE" T-shirts. The aim was to refresh our "Think Heel" campaign and introduce our "Keep Moving" theme for achieving compliance with repositioning. At the end of February we reported an 78% reduction of avoidable heel ulcers compared to this time last year, and a reduction of greater than 25% on all heel ulcers (avoidable and unavoidable). The Deep Ulcer Working Group continues to meet to review the action plan, share learning and check progress. It is important to note, that since this patient story occurred, there have no further deep ulcers developing on the CDU at WHH.

**Summary**

A 92 year old gentleman developed deep pressure ulcers on both heels whilst in the CDU at the William Harvey Hospital. The root cause analysis investigation revealed that a number of significant lapses of care had occurred. Summarised these were inaccurate and poor assessments of skin integrity, a failure to follow the SKINS bundle, a failure to document thoroughly. A number of actions were put in place on the ward to ensure that these events do not occur again. Since these events (July 2014), no further deep ulcers have been reported by the ward.