National Wound Care Strategy update: Pressure ulcers prevention and the PSIRF exemplar

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Pressure ulcers (PU) are in the top ten patient safety incidents reported in England. They can impact on patients of any age from premature babies to those at end of life and across all care settings and environments. PUs have a negative impact on patients' quality of life, causing pain, discomfort, and significant disruption to their lives and their families' lives. They increase the workload for those delivering care and may extend the length of hospital stay and increase the need for antibiotics, increasing organisational costs and may lead to litigation. The prevention of this common harm is therefore high on the NHS agenda.

The prevention of PUs falls within the remit of three different teams within NHS England:

- The National Wound Care Strategy Programme (NWCSP)
- The National Patient Safety Team (PST)
- The Nursing Directorate Safety and Innovation team

To ensure there is a consistent NHS England approach to prevention and management of PUs, these three teams are working together to align their work to give a consistent message.

The approach to the investigation of PUs currently takes a considerable amount of clinical time, resulting in little, if any, new insight. Typically, the recommendations made as a result of investigations are repetitive and not focused on underlying system issues; usually reports suggest that more education is required, documentation and communication need improving, and more pressure-redistributing equipment is needed. This suggests that either the true problem is not being found, or quality improvement activity does not follow, or the strategies implemented are ineffective, or a combination of the above. It has been suggested that the tissue viability teams responsible for the organisational oversight of PU prevention are spending so much time on investigation that they have little time left to focus their efforts on quality improvement to prevent further harm. The process of investigation has become a hamster wheel that it is impossible to get off!

In 2022, NHS England launched a new approach to patient safety. This includes the new Patient Safety Incident Response Framework (PSIRF) (https://www.england.nhs.uk/patient-safety/incident-response-framework/), which is a key part of the National Patient Safety Strategy (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/). PSIRF sets out NHS England's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF does not change any reporting requirements or expectations to record patient safety events; however, it should be noted that patient safety incident data cannot measure prevalence or incidence of PUs so other data sources are required for this purpose. This is important to consider when developing a measurement plan as part of an improvement project. The NWCSP is currently developing recommendations for reporting of PUs.

Under PSIRF, organisations working with their commissioners and other stakeholders, are required to develop a Patient safety incident response policy and plan. The plan will help to guide a more considered and proportionate response to patient safety incidents to allow resources to be invested in undertaking good quality systems-based learning responses where it matters most. As PUs are one of the most common types of patient safety incident, we know that there will be questions about how to apply the PSIRF principles in relation to responding to PUs. The NWCSP has therefore worked with the PSIRF team to develop a PSIRF planning aid.

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This aid demonstrates how data may be collected and collated from multiple sources (including complaints data, information from national surveillance and local surveillance audits, as well as patient safety incident recording) both retrospectively and prospectively to highlight where the most significant challenges and opportunities for improvement are, and how incident response methods can be selected to generate insight to inform quality improvement.

At the beginning of the patient safety incident response planning process, organisations are asked to understand what capacity is available for responding to incidents, and to map what services are provided to understand who needs to be engaged. Once this has been completed, teams and their stakeholders work through four key planning activities:

- Examining patient safety incident records and other data to gather and extract information about an organisation's patient safety incident profile (i.e., what are the incidents and issues affecting patient safety across the organisation?)
- Describing safety issues demonstrated by the data
- Identifying any existing improvement work underway
- Agreeing response methods and then completing the patient safety incident response plan template.

As a patient safety incident response plan is a living and responsive document, it should be reviewed regularly, and changes should be made if circumstances change.

Working corroboratively is allowing the National Patient Safety Team, the NWCSP team and the Nursing Directorate Safety and Innovation team to develop shared understanding about the patient safety issues for pressure ulceration to inform future advice and guidance. It is clear that the current approach, which encourages the investigation of all individual PUs of a certain category, is placing too great a burden on health professionals without achieving the necessary quality improvement. The new PSIRF offers a broader approach to addressing patient safety issues, such as pressure ulceration, taking the focus away from investigation and oversight of individual incidents to instead focus on quality improvement.