The role of the Pressure Ulcer Improvement Nurse (PUIN) in improving the adverse event review process of pressure ulcers

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Introduction

The Pressure Ulcer Improvement Nurses (PUIN) are managed within the Acute Quality Improvement team in NHS Ayrshire & Arran. The role consists of 2 members of staff (0.2/0.8 whole time equivalent). This was a planned 2 year seconded post currently extended with the aim to aid reduction of pressure ulcers (PU's) across the 2 acute hospital sites within the board.

The remit of the PUIN consists of monitoring, identification of hot spots/areas of high incidence, review of Grade 3 and above (inclusive of Grade 3, 4, Suspected Deep Tissue Injury and Ungradable) pressure damage with feedback to senior charge nurse (SCN), assistance in developing action plans & educational support.

Aim

As part of the role of the PUIN, they carry out reviews of hospital acquired pressure ulcers Grade 3 and above, which once agreed with the SCN would be escalated to the Adverse Event Review Group (AERG) for decision on further action.

The quality of the reviews was felt to be such that an agreement was reached and a combined pressure ulcer investigation tool was created which was hoped would result in more timeous escalation of events and appropriate decision making by the AERG.

This has overall resulted in a more timeous and streamlined process. (see Diagram 2 in results section).

Following review the event is concluded as either 'avoidable' or 'unavoidable' which also aids the AERG in deciding on next steps.

Method

Prior to PUIN in role, all Grade 3 and above pressure ulcers required a pressure ulcer review followed by an SBAR often resulting in lengthy delays in reaching the AERG. These SBARS often would not contain robust detail to allow the AERG to make an appropriate decision.

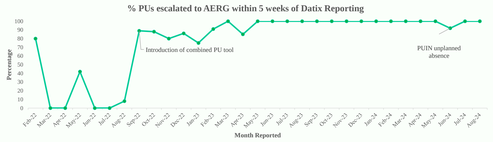
Testing of a new pressure ulcer investigation tool combining a decision making section , meant a separate SBAR from the Clinical Nurse Managers (CNMs) was not required.

The reviews now contain accurate and detailed information. This also helps to identify themes and findings for area concerned and assists in development of targeted improvement action plans.

Results

Data was collected which demonstrated how quickly SBARs reached AERG before and after implementation of new combined pressure ulcer investigation tool (September 2022 as indicated in graph below).

This revealed significant improvement in time to reach AERG allowing more efficient processing and decision making towards next steps.



The AERG members felt the quality and detail contained within the PUIN reviews was much more robust providing them with reassurance that learning needs/issues identified are being relayed back to ward managers timeously.

I see the PUIN post and involvement with AERG being very beneficial to the organisation and it is worth noting that we are now starting to see the benefits

The role has given the AERG confidence that PU development and improvement work is prioritised.

'The advice & reports of the PUIN have made a remarkable difference to the AERG which can only result in better patient care'

As the combined pressure ulcer tool was completed by the PUIN, this has resulted in overall reduction in workload for ward managers/clinical nurse managers assisting in releasing time for them to undertake other duties.

Conclusion

'This process is extremely valuable having the expert overview by the right people being a massive help'

The Introduction of the PUIN and involvement has resulted in a more timely decision making process which positively impacts on patient care, shared learning, identifying support and educational needs.

The AERG are confident in the reviews being undertaken and feedback being shared by the PUIN negating the need for further escalation and review of these events.

'This has been a massive improvement & allowed for a more timeous investigation of incidents & targeted action planning'