Supported decision-making tool for wound care :

Design and implementation in a community setting

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Purpose and Method

- Introduced PSIRF in January 2024
- Design a tool to support patient and clinicians, maintaining patient safety and providing clear clinical support
- Shift focus to support open communication and shared risk
- Pressure Ulcer Safeguarding risk assessment tool and launch of Livewell Southwest's Pressure Ulcer Strategy 2024/25
- Developed by professional and safeguarding leads, tissue viability and project manager with focus on supporting clinicians to escalate concerns

The current challenge

- Patient engagement and activation with their care plans impacting on wound management
- Lack of clear guidance for clinicians to support patients making clinically unwise decisions which leads to unmanaged risk and late escalation
- Challenges with openly communicating risk across the organisation and with wider stakeholders
- Prior to PSIRF, repeated SIRI's following did not allow for proactive management or engagement.

Perceived clinician and patient planning benefits

- Aids caseload supervision and supports case discussion
- Gives clinicians confidence to have open discussions with patients in a supportive and inclusive way
- Identification of themes and potential learning, promotes holistic assessments
- Provides a clear pathway for escalating concerns in a timely manner
- Allows patients' views and choices to be respected, whilst maintaining the safety and wellbeing of both patients and staff
- Provide information regarding the progress and outcome of wounds and the impact of decision making

GREEN	YELLOW	AMBER	RED	BLUE
All risks can be contained within the Support Plan. The person is involved and engaging with prescribed care plan.	A person is mostly compliant with care but not strictly aligned to care plan and has made some personal choices. A rationale for person choice has been adequately explored, including capacity. Risks can be managed but will require ongoing assessment, monitoring and incident reporting if appropriate.	A person's wound has deteriorated. Escalate to senior nurse/DNSP. Discuss risk within the team and person who is deemed to have capacity to understand the risks consider MDT and referral to Patient Safety team for presentation to sub-group for AAR. Incident report	A person's wound has significantly deteriorated and at risk of infection or is infected. Acquire with senior nurse/DNSP and incident report risks with manager, GP and Patient Safety Immediately. consider Risk Enablement Meeting. Update AAR. PSII may be necessary.	Potential sepsis, critical ischaemia. Risk to life or limb. Act immediately. Incident report escalation. Consider calling 999 ambulance and/or police. PSII.

Firgure 1- Excerpt from decision making escalation process within Electronic Health Record

"This is a really helpful tool, it will help us to feel more confident when supporting patients who may be making unwise decisions about their care" - Community Nurse

"We could really have benefitted from a tool like this with Patient A. It would have helped us make sure all teams involved were aware of the situation and managing his risk appropriately, whilst respecting his personal choice." - Community Sister

Example Scenario:

- Patient A admitted to caseload with existing Cat 3 pressure damage to sacrum. TVN recommend patient to be on bed rest and sit out for meals, however patient goes out shopping occasionally, spending 6-8 hours in their wheelchair. Support has been offered but declined, prefer not to change their routine. The wound is improving. Assess as YELLOW level of risk, patient not fully compliant but choices are not currently affecting care. Discuss risk with patient and continue to monitor closely.
- Patient A continues with same lifestyle choices, however wound has deteriorated. You discuss with patient and raise concerns that their routine is likely contributing to the deterioration. Patient understands but continues with current routine. Assess as AMBER level of risk and discuss with the patient. Raise incident and refer to relevant services, consider capacity. Undertake DNSP/senior review. Discuss care at Patient Safety group and raise After Action Review (AAR).
- Patient A continues with their preferred routine. The wound deteriorates further to a category 4 pressure ulcer. Consider risk of infection/sepsis and BLUE escalation process if required. Discuss RED risk with patient and explain concerns. Update incident form. Arrange Risk escalation or MDT meeting with relevant stakeholders. Update AAR and consider if Patient Safety Incident Investigation required.
- Patient A participated in an MDT to discuss their care and has agreed to comply with the recommendations made by health professionals. They have agreed to additional support at home and no longer go out all day on a regular basis. The wound has started to improve. Reassess as Green, the patient is fully engaging in their care and following clinical recommendations.

Route to implementation

- Revolutionary and vital tool in supporting both patients with wounds and the clinicians looking after them
- Adds security and back up to written notes
- Ensures appropriate and timely escalation
- Used daily for handover with colleagues, championed by key adopters
- Embed within patient electronic health record, aids identification and reporting
- Shared at Adult Social Care Safeguarding training and nursing Preceptorship programme
- Executive and Strategic oversight from Patient Safety Forum and Safety & Quality Programme
- Strategic and Practice Leads meeting

Next steps - opportunity to scale

- Scale within organisation/different pathways
- System-wide scaling/benefits, including adaptation in different services, such as Mental health and wellbeing services, adult social care
- Data analysis and review
- Share across the organisation with opportunity to diversify/modify in other areas of non-concordance

'Fantastic tool – even as a non-clinical person, I would find this tool very easy to follow.' - Community Service Manager.

'Brilliant piece of work'. - Patient Safety Specialist

References and contributors

- Patient Safety Incident Response Framework, 2022. NHS England
- Supporting Shared Decision-Making to achieve concordance: Strategies for shared decision-making. 2024, Sandoz et al.
- Pressure Ulcer Strategy 2024/2025 – Livewell Southwest
- Pressure Ulcer Safeguarding Risk Assessment Tool 2024 (Gov.UK)