Safety Indicators – Pressure Damage & Medication Errors

Final Internal Audit Report

April 2023

Hywel Dda University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

Review reference:	HDUHB-2223-16
Report status:	Final
Fieldwork commencement:	9 December 2022
Fieldwork completion:	2 March 2023
Draft report issued:	7 March 2023
Management response received:	2 April 2023
Final report issued:	5 April 2023
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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The purpose of the audit is to review the arrangements for the prevention, management and learning from pressure damage and medication error incidents.

Overview

The Health Board has current and comprehensive policies and procedures relating to pressure damage and medication errors. Appropriate governance structures are in place for the monitoring and reporting of related incidents and identified learning.

We have concluded **Reasonable** assurance overall with one high priority matter arising due to the considerable proportion of open incidents, delays in undertaking management review and completing incident investigations, and instances where a pressure damage 'focussed review' had not been completed.

We have also identified two medium priority matters arising relating to:

- Delays in the completion of pressure damage risk assessments (Purpose T's) and in some cases no evidence of care plans in place.
- Infrequent Scrutiny & Assurance meetings within the Unscheduled Care directorate due to operational pressures.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	n/a

Assurance summary[1]

Objectives		Assurance
1	Policies & Procedures	Substantial
2	Pressure Damage Risk Assessments	Reasonable
3	Incident Investigations	Limited
4	Monitoring and analysis of Incidents	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Pressure Ulcer Risk assessments & Care Plans	2	Operation	Medium
2	Incident Investigation	3	Operation	High
3	Monitoring and analysis of Incidents	4	Operation	Medium

1. Introduction

1.1 Pressure damage and medication errors are among the most frequently reported adult inpatient forms of clinical harm and are considered to be key indicators of the quality and safety of patient care.

1.2 Pressure ulcers are a localised injury to the skin and/or underlying tissue as a result of pressure, whilst the Health Board's Medicines Policy defines a medication error as "a preventable error that may cause or lead to inappropriate medication use or patient harm while medication is in the control of the health care professional or patient".

1.3 Both are a high priority for the Health Board due to the risk of patient harm and associated potential financial and reputational damage implications arising from associated incidents.

1.4 There have been 3956 pressure damage and 1207 medication error incidents reported on Datix during the 15-month period April 2021 to June 2022.

1.5 Whilst the majority of these were reported as resulting in low or no harm to patients, pressure damage and medication errors feature in the top three patient safety incidents reported within the Health Board, along with patient falls which has been subject to separate audit review earlier in 2022/23.

1.6 The associated potential risks are:

- patient harm;
- reputational damage to the Health Board; and
- financial loss to the Health Board

2. Detailed Audit Findings

Objective 1: Policies and procedures have been developed and implemented

2.1 Health Board Policy 024 'Prevention and Management of Pressure Ulcer Policy' outlines the management of pressure ulcer prevention and treatment in the Health Board. The policy is consistent with national guidelines including National Institute of Health & Care Excellence (NICE) and All Wales Guidance 'The Essential Elements of Pressure Ulcer Prevention and Management (2017). It sets out the process for preventing pressure ulcers, including the requirement to complete risk assessments and care plans, and the arrangements for reporting and investigation of pressure damage incidents.

2.2 The Health Board's Policy 558 'Management of Nursing and Midwifery Medication Errors/Near Misses Policy' has been developed to support staff in the management of decision making following an error or near miss. The policy sets out the process to be followed on identification of a medication error or near miss, including incident reporting, investigation and learning from events.

2.3 We confirmed that the policies provide sufficient guidance, were up to date and accessible to staff via the intranet.

Conclusion:

2.4 Noting the above, we have concluded **Substantial** assurance for this objective.

Objective 2: Risk assessments have been completed where required, and appropriate action taken to reduce the risk of pressure damage

2.5 Key to the prevention of pressure ulcers is the identification of those at risk of developing pressure ulcers and then developing an appropriate prevention care plan, when required. In line with *NICE Guideline CG179(2014)* the Health Board's *Prevention and Management of Pressure Ulcer Policy* requires that pressure ulcer risk assessments be performed on all patients being admitted to secondary care, with the first assessment for adult inpatients being done within the first six hours following intention made to admit the patient and weekly thereafter or more frequently if their condition changes.

2.6 All risk assessment outcomes must be recorded in the patient record of care. For those patients deemed at risk of pressure ulcers after completion of the risk assessments (or 'Purpose Ts') and for those with an existing pressure ulcer, a plan of care (the All-Wales Pressure Ulcer Prevention/Management plan) needs to be commenced.

2.7 We sampled 40 inpatients across the four acute sites and sought to establish whether a Purpose T had been completed on admission and periodically thereafter, and if a care plan had been commenced for those considered at risk. We reviewed 66 Purpose Ts in total - the initial and most recent assessment (where subsequent assessment was due, depending on length of stay) for each of the 40 patients

sampled. All patients had a fully completed Purpose T on admission, although for six patients we identified delays of up to eight days in completing these. A further six had no evidence of a care plan in place following initial assessment, and three had no evidence of a care plan following the most recent assessment. **[Matter Arising 1]**

Conclusion:

2.8 The Health Board's policies clearly set out the processes for preventing pressure ulcers, however the systems are not always being complied with at ward level. Whilst a risk assessment had been completed for each patient we reviewed, we noted some delays in completion of the initial assessment, and instances where there was no evidence of a care plan in place. Accordingly, we have concluded **Reasonable** assurance for this objective.

Objective 3: Comprehensive investigations are undertaken for all incidents, identifying the root cause with appropriate measures taken to prevent recurrence

At a Glance: Pressure Damage Incidents – 1 April 2021 to 30 November 2022

Incident Status

- 2602 incidents reported during the period
- 54% remained open at November 2022
- 93% of the 'new incidents' were more than one month old, with 27% dating back to 2021
- 86% of incidents under 'management review' or 'investigation' were more than 60 days old

Chart 1: Pressure Damage - Incident Status

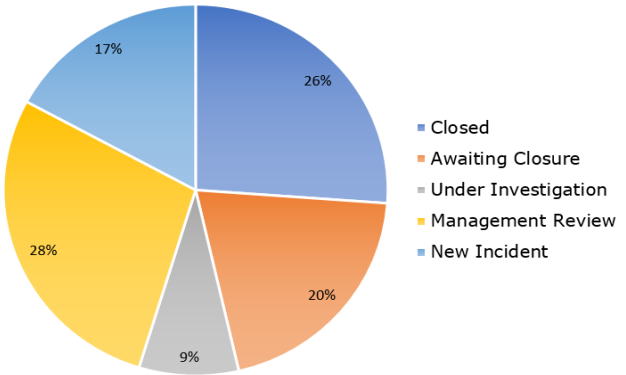
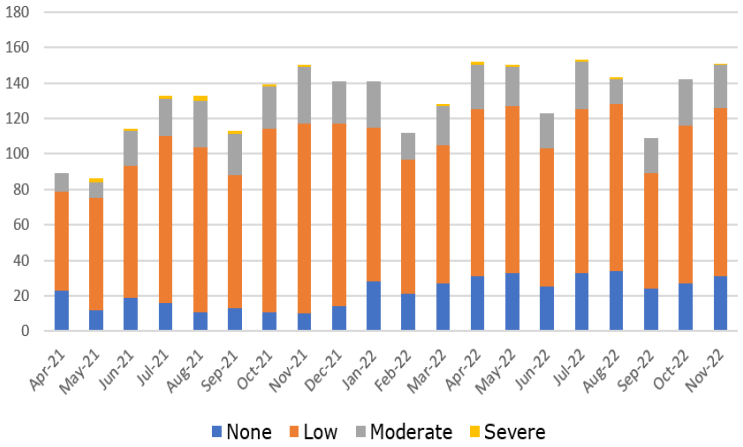


Chart 2: Pressure Damage - Incident Harm



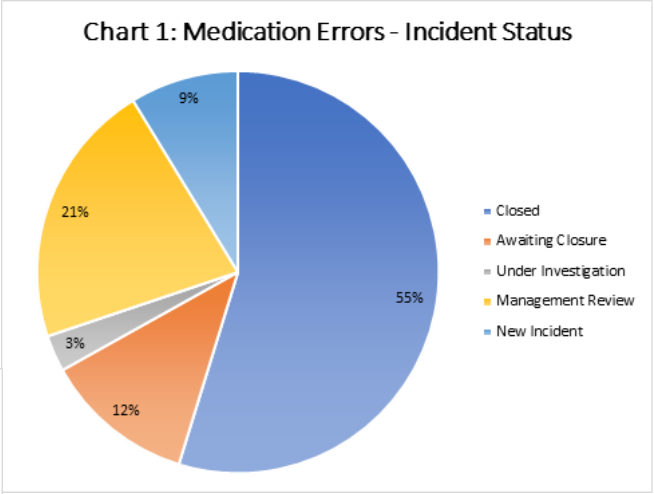
Incident Harm

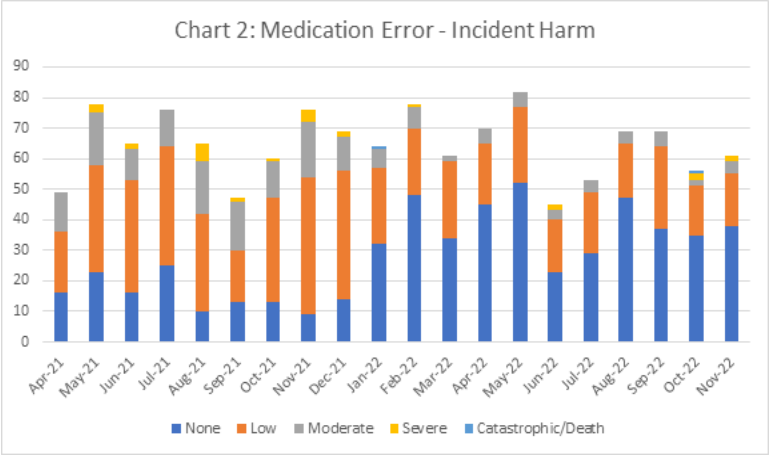
- Most incidents (83%) were assessed as resulting in 'no' or 'low' harm
- 17% resulting in 'moderate' or 'severe' harm

At a Glance: Medication Error Incidents – 1 April 2021 to 30 November 2022

Incident Status

- 1293 incidents
- 33% remained open at November 2022
- 88% of 'new incidents' were more than one month old, with 30% dating back to 2021
- 83% of incidents under 'management review' or 'investigation' were more than 60 days old





Incident Harm

- Most incidents (84%) were assessed as resulting in 'no' or 'low' harm
- 16% resulting in 'moderate' or 'Severe' harm
- There were two incidents assessed as 'Catastrophic/death' during the period

Incident Investigation

2.8 We sampled 15 medication error and 15 pressure damage incidents reported on Datix during the period July 2021 to November 2022. We sought to establish whether the incident had been investigated to identify points of failure and lessons for learning.

2.9 According to the patient safety flow chart, a management review should be undertaken within 72 hours of identifying an incident. Only three of the 15 pressure damage, and five of the 15 medication error incidents sampled had a management review undertaken within this timescale, with some cases taking up to 130 days. **[Matter Arising 2]**

2.10 Incident investigation should be concluded within 30 or 60 days, depending on the nature of the incident. Investigation of four of the sampled medication error incidents exceeded 60 days, with one taking 119 days. Six pressure damage incidents exceeded 60 days, with two in excess of 120 days. **[Matter Arising 2]**

2.11 The *All-Wales Guidance on Pressure Ulcer Reporting & Investigation (2018)* stipulates that completion of a 'focussed review' is required for pressure damage incidents. This includes checking that there is documented evidence of a risk assessment completed on admission and correctly scored, and a care plan detailing prevention interventions. Focussed review had not been completed for four of the 15 sampled pressure damage incidents. **[Matter Arising 2]**

2.12 Investigations recorded on Datix were otherwise generally comprehensive and identified, where appropriate, any further actions required, learning and the outcomes of scrutiny meetings.

Conclusion:

2.13 Data analysis indicates that incidents are not being investigated promptly. Our sample testing corroborates this, with examples of substantial delays identified in the completion of management review and investigation. We also identified some instances of non-compliance with the *All-Wales Guidance on Pressure Ulcer Reporting & Investigation* due to the absence of a focussed review. Failure to undertake prompt review of incidents may delay corrective action and learning, potentially resulting in incident recurrence. Accordingly, we have concluded **Limited** assurance for this objective.

Objective 4: The monitoring and analysis of all incidents is used to inform and drive improvement throughout the organisation

Monitoring & Reporting at Directorate/Service Level

2.14 Clinical Team *Scrutiny & Assurance* meetings are held for each acute site to scrutinise incidents including medication errors and pressure damage, identifying causal factors and sharing learning to prevent recurrence. The outcomes of these meetings feed into the *Directorate Quality, Safety & Experience Groups (QSEGs)*.

2.15 Meetings within the Scheduled Care directorate are generally held monthly. For Unscheduled Care meetings are more sporadic with many cancelled in late 2022 due to operational pressures. In Bronglais, medication error and pressure damage incidents have not been discussed since June & August 2022 respectively. **[Matter Arising 3]**

2.16 The bi-monthly *QSEG* meetings receive incidents reports which are produced monthly by the Quality Assurance & Safety Team. This report provides detail which is designed to allow identification of themes and trends of the top five reported incidents which include pressure damage and medication errors. The detail includes analysis by service area of the number of incidents and concerns reported within the year by incident type and how many remain open.

2.17 Review of recent *QSEG* papers for the Scheduled and Unscheduled Care Directorates at the four acute sites confirmed that incidents are discussed to identify and share best practice and monitor actions. Directorate QSE Groups report by exception to the *Operational Quality, Safety & Experience Committee (OQSEC)*.

2.18 *Medicine Error Review Group (MERG)* meetings are held bimonthly and review errors and incidents that involve medicines in detail with a view to sharing lessons learnt and taking action to reduce the likelihood of errors occurring in future.

Medication incident reports produced by the Assurance, Safety and Improvement team are submitted to the MERG for review. Senior Nurse Managers report medication error incidents discussed at their respective Scrutiny & Assurance meetings in to MERG, which reports to the *Medicines Management Operational Group*.

Monitoring & Reporting to Board

2.19 The *Quality, Safety & Experience Committee (QSEC)* is responsible for providing assurance to the Board that lessons are learned from patient safety incidents. Patient safety incident statistics are reported to QSEC via the Quality and Safety Assurance (QS&A) reports on a bi-monthly basis.

2.20 The QS&A reports show the number of medication errors and pressure damage incidents reported on Datix during the preceding year as part of the graph showing month by month the top 5 reported patient safety incidents.

Conclusion:

2.21 Governance structures and processes are in place for the reporting, scrutiny and monitoring of pressure damage and medication error incidents at directorate/service level, with onward assurance reporting to the Board via the Quality, Safety & Experience Committee. Scrutiny & Assurance meetings play a key role in the sharing and implementation of learning in order to prevent incident recurrence, but meetings within Unscheduled Care directorate have been sporadic throughout 2022. We have therefore concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Pressure Ulcer Risk Assessments & Care Plans (Operation)	**Impact**
We sampled 40 inpatients across the four acute sites and sought to establish whether a Purpose T had been completed on admission and periodically thereafter, and if a care plan had been commenced for those considered at risk. We reviewed 66 Purpose Ts in total - the initial and most recent assessment (where subsequent assessment was due, depending on length of stay) for each of the 40 patients sampled. All patients had a fully completed Purpose T on admission, although for six patients we identified delays of up to eight days in completing these. A further six had no evidence of a care plan in place following initial assessment, and three had no evidence of a care plan following the most recent assessment.	Non-compliance with NICE guidance and Health Board policy, potentially resulting in patient harm and/or reputational damage

	Recommendations	**Priority**
1.1	Ward level checks should be undertaken to ensure compliance with NICE guidance and the Health Board's Prevention & Management of Pressure Ulcer policy, specifically that: • Purpose T risk assessments are completed for all inpatients, on admission and weekly thereafter. • Where a patient is assessed as being at risk of pressure damage, a care plan is developed and implemented.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1.1	All Heads of Nursing to discuss at Professional Nurse Forums (PNF) the importance of timely completion of Purpose T risk assessments and completion of associated care plans.	30th April 2023	Assistant Director of Nursing
	Professional Practice Development Nurses to undertake spot check audit across all sites in relation to both completion of Purpose T assessment and development of Care plans and feedback findings to the PNF.	31st May 2023	Head of Quality and Improvement/Practice Development. Heads of Nursing

	Spot check audits in relation to Purpose T Risk Assessment and associated Care plans to be undertaken as part of the agreed standardised Audit development framework plan.	30th June 2023	Heads/Deputy Heads of Nursing
	Individual improvement monitoring plans to be formulated by Heads of Nursing and monitored through the PNF.	31st July 2023	Heads of Nursing

Matter Arising 2: Incident Investigation (Operation)	**Impact**
There is a significant proportion of open incidents for pressure damage (72%) and medication errors (45%) which indicates that incidents are not being investigated promptly. We sampled 15 medication error and 15 pressure damage incidents reported on Datix during the period July 2021 to November 2022. We sought to establish whether the incident had been investigated to identify points of failure and lessons for learning. • a management review should be undertaken within 72 hours of identifying an incident. Only three of the 15 pressure damage, and five of the 15 medication error incidents sampled had a management review undertaken within this timescale, with some cases taking up to 130 days. • investigation of four of the sampled medication error incidents exceeded 60 days, with one taking 119 days. Six pressure damage incidents exceeded 60 days, with two in excess of 120 days. • focussed review had not been completed for four of the 15 sampled pressure damage incidents.	Potential risk of: • Patient harm • Reputational damage

Recommendations		**Priority**
2.1a	Investigation and closure of open incidents should be prioritised, with a timescale for completion.	**High**
2.1b	In line with the patient safety flow chart: • Management review of incidents must be undertaken within 72 hours. If this is not feasible in the short term due to service pressures, an improvement plan should be developed to support achievement. • Incident investigation must be completed within 30/60 days • Investigation of pressure damage incidents must include completion of the focussed review	

Agreed Management Action	**Target Date**	**Responsible Officer**

2.1a	All staff need to be reminded of the importance of timely investigation of incidents in line with Patient Safety flow chart.	30th April 2023	Heads of Nursing
2.1b	All areas to develop improvement plans as to how the 72 hour target is to be met with target dates, this will need to be monitored via the Improving Together Meetings	30th July 2023	General Managers/Head of Nursing

Matter Arising 3: Scrutiny & Assurance Meetings (Operation)	**Impact**
Clinical Team *Scrutiny & Assurance* meetings are held for each acute site to scrutinise incidents including medication errors and pressure damage, identifying causal factors and sharing learning to prevent recurrence. Meetings within the Unscheduled Care directorate are sporadic with many cancelled in late 2022 due to operational pressures. In Bronglais, medication error and pressure damage incidents have not been discussed since June & August 2022 respectively.	Potential risk of: • Patient Harm

	Recommendations	**Priority**
3.1	Scrutiny & Assurance meetings to be held monthly at all four sites in line with the terms of reference, with regular review of pressure damage and medication error incidents.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3.1	All sites to be reminded of the importance of undertaking scrutiny meetings monthly and audits to be undertaken in relation to monitoring compliance against this standard	30th May 2023	Heads of Nursing

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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