

Improving skin care through prudent use of data – a pitch for patient safety incident reporting

Authors

Dr Ray Samuriwo PhD RN^{1, 2, 3}

¹ Primary Care Patient Safety (PISA) Research Group, Division of Population Medicine, School of Medicine, Cardiff University

² School of Healthcare Sciences, Cardiff University, UK

³ Cardiff Institute for Tissue Engineering and Repair (CITER), Cardiff University, UK

Dr Huw Williams MBBS¹

¹ Primary Care Patient Safety (PISA) Research Group, Division of Population Medicine, School of Medicine, Cardiff University

Dr Jennifer Cooper MB BCh¹

¹ Primary Care Patient Safety (PISA) Research Group, Division of Population Medicine, School of Medicine, Cardiff University

Dr Andrew Carson-Stevens MB BCh M Phil^{1, 4, 5, 6}

¹ Primary Care Patient Safety (PISA) Research Group Leader, Division of Population Medicine, School of Medicine, Cardiff University

⁴ Patient Safety Research Leader: Primary & Emergency Care Research (PRIME) Centre Wales, Cardiff University, UK

⁵ Visiting Professor of Healthcare Improvement, Department of Family Practice, University of British Columbia, Canada

⁶ Honorary Professor, Institute of Healthcare Policy and Practice, University of the West of Scotland, UK

Word Count:

381 words (Excluding reference list)

Conflict of Interest

None

Pressure ulcer prevention has been a major focus in quality improvement (QI) initiatives. Recent studies (1,2) have compared how several sources of pressure ulcer data can describe the frequency and burden of pressure ulcer-related harm in hospitals. Both papers show the usefulness of 'hard data', which is objective, numerical information. Determining whether changes being made during QI projects are resulting in improvement requires *hard data* about outcomes. However, successful QI leadership is also informed by 'soft data' which is qualitative, and sometimes rich contextual information often from the first-hand perspective of either a staff member or a patient (e.g. complaints data, staff culture surveys) (3,4).

Patient safety incident reporting systems exist in most healthcare organisations. Several national-level studies (5,6,7) show they contain valuable *soft data* to better understand the contributory issues that can give rise to specific actions or circumstances that increase the likelihood of unsafe care. Incident reports can describe how staff and patients interface with existing systems and processes (so called "human factors"), for example:

"...Care record indicates patient refused hygiene yesterday morning, no indication in records if this was reoffered later the day. Seen by TVN [Tissue Viability Nurse] last Tuesday for grade 4 pressure sores to sacrum and left heel. Prescription for dressings issued and nurse came to replace dressing 2 days later but could not find dressings, so rang TVN again [for a] second visit and second prescription issued. First prescription found today in nursing home, poor and inadequate care planning..."

An audit of patient care generating *hard data* might highlight that the TVN delivered evidence-based, timely care. However, the incident report's *soft data*, highlights failures in communication between community and specialist teams, and suggests issues for concern about the quality of fundamental nursing care. Each type of data, informed by a myriad of potential sources, can raise different albeit complementary opportunities to understand how, and in which contexts, wound care could be better designed / redesigned.

Healthcare leaders wishing to utilise learning from incident reporting systems at a local level must train and support their staff to provide good data, and make it clear to their staff how this data informs QI plans. In this way, incident reports can be used to drive the next generation of pressure ulcer reduction QI initiatives.

References

1. Smith IL, Nixon J, et al.. Pressure ulcer and wounds reporting in NHS hospitals in England part 1: Audit of monitoring systems. *Journal of Tissue Viability*. 2016; 25(1):3-15.
2. Coleman S, Smith IL, et al. Pressure ulcer and wounds reporting in NHS hospitals in England part 2: Survey of monitoring systems. *Journal of Tissue Viability*. 2016; 25(1):16-25.
3. Martin, G. P., L. McKee, et al. (2015). "Beyond metrics? Utilizing 'soft intelligence' for healthcare quality and safety." *Social Science & Medicine* 142: 19-26.
4. Martin, G. P. and M. Dixon-Woods (2014). "Can we tell whether hospital care is safe?" *British Journal of Hospital Medicine* 75(9): 484-485.
5. Rees P, Edwards A, Powell C, et al. Pediatric immunization-related safety incidents in primary care: A mixed methods analysis of a national database. *Vaccine*. 2015; 33(32):3873-3880.
6. Williams H, Edwards A, et al. Harms from discharge to primary care: mixed methods analysis of incident reports. *British Journal of General Practice*. 2015; 65(641):e829-e37.
7. Rees P, Edwards A, Panesar S, Powell C, Carter B, Williams H, et al. Safety incidents in the primary care office setting. *Pediatrics*. 2015; 135(6):1027-35.