Thursday, 03 February 2022

FAQ for the CQUIN for Pressure Ulcer Risk Assessment (CCG15)

If you can't find the answer to your question, please email: NatWoundStrat@yhahsn.com

Which services does this CQUIN apply to?

1. **Can organisations choose if they want to do the pressure ulcer risk assessment CQUIN?**

   The CQUIN Guidance page 8 states that "all providers commissioned to deliver the services to which these indicators apply will be required (as mandated by NHS Digital through information standards notices and/or approved collections) to report their performance via the national collection".

2. **Is the CQUIN just for community hospital in-patient services? Does it apply to community nursing services, acute hospital services or GP practices?**

   This CQUIN is just for community hospital in-patient services. Other services have different levers for quality improvement.

Which patients should be included?

3. **Do we have to include every patient within our service?**

   Yes, all patients who have a length of stay more than 24 hours within the dates specified should be included. The specification document states "all community hospital spells (including those starting before 1 April 2022 and those unfinished by 31 March 2023), for patients aged 18+ with length of stay greater than 24 hours".

4. **What is a 'patient spell'?**

   A patient spell is the **total continuous stay of a PATIENT** using a Hospital Bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more Nursing Episodes (https://datadictionary.nhs.uk/nhs_business_definitions/hospital_provider_spell.html).

5. **Can you clarify the exclusion criteria?**

   The exclusions are listed as "hospital spells where the admission/initial community nursing contact was before 1 April 2022, and the discharge was before 1 June 2022". Please could you clarify:

   - whether any patient admitted on 31 March 2022 (one day before 1 April 2022) and discharged on 1 June 2022 would be excluded, and
   - a patient admitted on 1 April 2022 and discharged on 31 May 2022 (day before 1 June 2022) would also be excluded.
   - Please also clarify whether this is one single exclusion criteria (i.e., patients admitted and/or discharged before 1 April and/or 1 June 2022) or
   - they are two distinct exclusion criteria (i.e., patients admitted before 1 April 2022 OR discharged before 1 June 2022)?

A patient discharged on 1 June 2022 would be included (the exclusion refers to patients discharged *before* 1 June).
A patient admitted on 1 April and discharged on 31 May would be also included, as patients admitted to community hospital on or after 1 April should have their first pressure ulcer risk assessment within 24 hours.

The exclusion criterion "where the admission was before 1 April 2022, and the discharge was before 1 June 2022" is a single exclusion criterion. The purpose is to ensure that patients already under community care do not miss out on these valuable interventions, whilst allowing providers extra time to "catch up" on providing this care for existing patients if they are not already doing so.

Risk Assessment

6. **Our organisation uses the Braden scale which does not include skin status. Does that mean we are not required to capture this information?**

   Skin status is a key element of risk assessment. If your chosen risk assessment scale does not assess skin status, it must be assessed and documented separately.

Care Planning

7. **Should every patient have an individualised care plan to identify how risk will be managed?**

   No, only patients who are at risk should have a care plan. However, those assessed as not at risk should have documentation that records their risk assessment, the rationale for that risk status and a review date.

8. **Should there be a care plan for all comorbidities, or should comorbidities be noted in the Pressure Ulcer Prevention care plan?**

   Where patients have comorbidities that contribute to risk and are modifiable, they should be noted in the Pressure Ulcer Prevention care plan.

9. **In relation to the minimum criteria to include in the pressure ulcer care for the CQUIN, why have those elements been included?**

   Where the patient is deemed to be at risk, the items to be considered within the plan of care are based on the NICE Guidelines key priorities for implementation.

10. **When developing the individualised care plan, do we have to meet the NHS England and Improvement five criteria for a personalised care plan ?**

    While it is recommended that an individualised care plan should meet these criteria, this is not part of the requirement for this CQUIN.

How to collect the data for the CQUIN audit

11. Can we select a sample of 100 patients from the specified time span?

The CQUIN Indicator Specification describes how quarterly data should be collected (Section 13 p 4 and 5).

> a. Where a list of records matching both the denominator and the numerator can be identified and extracted from systems (eg PAS, EPR or other local systems), and performance assessed without the need for case note auditing then all records must be used to calculate performance for each quarter in scope.
>
> b. Where a list of records (broadly or exactly) matching the denominator can be identified (e.g., from PAS, EPR or other local systems), but not the numerator, then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and random sampling should be used to obtain this sample from case notes.
>
> b. In exceptional circumstances, where neither the denominator nor the numerator can be readily identified then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and quota sampling should be used to obtain this sample from case notes.

For the Pressure Ulcer CQUIN, organisations that use point of care electronic systems (such as Wound Management Digital Systems), may want to work with their system supplier to ensure their system is capable of collecting the required CQUIN data as part of routine clinical practice (based on the criteria listed in the Data Collection Tool) - so they can report on every patient. Organisations using electronic patient record systems (such as SystmOne, EMIS or RIO) may want to develop templates to support the electronic collection of the CQUIN data as part of routine clinical practice and be able to report from these systems either on an all patient or sampling basis.

If, however, your organisation is still using a paper-based patient record, you will have to collect data manually by printing off the Data Collection Tool.

Clear instructions on how to undertake random sampling and quota sampling are described on p 5 - 7 of the CQUIN Indicator Specification

12. Does every element of the pressure ulcer risk assessment criteria need to be recorded to be compliant?

The assessment criteria are based on a minimum data set so all elements must be met to achieve the CQUIN. Therefore, the assessment should indicate a response for each element, even if that response simply confirms the absence of an element. (For example, if there is no deficit in mobility then recording 'No' indicates that the assessment has included consideration of this element and demonstrates that the assessment has considered all the minimum criteria.)

13. To meet the 40% – 60% target, do you have to meet all four sections of the Numerator?

To achieve the CQUIN, 40 – 60% of patients audited must have achieved ALL the clinically relevant steps described within the indicator specification. Missing any one of these constitutes a failure.

The following examples may be helpful:

a. If a patient has had:
- A CQUIN compliant pressure ulcer risk assessment (TICK 1), *and*
- They are deemed to be at risk they have a CQUIN compliant care plan (TICK 2) *and*
- Actions as described in the care plan have been documented (TICK 3), *and*
- Their length of stay is more than 30 days and they have had a review of all of these (TICK 4)

then this audit is fully compliant and receives a **PASS** rating.

b. If a patient has had:
- A CQUIN compliant risk assessment plan (TICK 1), *but*
- They are not at risk but do have a documented risk score, skin assessment and if they have not been in for more than 30 days, a date set for review or if they have been in for 30 days a review has taken place (TICK 2)

They do not require a prevention care plan, so this audit is fully compliant and receives a **PASS** rating.

c. If a patient has had:
- A CQUIN compliant pressure ulcer risk assessment (TICK 1), *and*
- They are at risk, but their skin assessment is not documented (FAIL 1) *but*
- They do have a CQUIN compliant care plan (TICK 2),

then this audit is not fully compliant and receives a **FAIL** rating.

So, to achieve the CQUIN, 40 - 60% of cases must be 100% compliant (rather than achieving 40 – 60% for each of the three requirements, independent of each other).

To translate this into provider quarterly results, they might look like this:
- Provider A reviewed 100 cases and found that 45 had received a satisfactory risk assessment, an appropriate care plan AND actions were documented and where the patient had been present more than 30 days risk had been re- evaluated. Therefore, this provider achieved **45%**

- Provider B reviewed 100 cases and found that whilst 100 had received a satisfactory risk assessment, and 60 had a compliant care plan with evidence of actions, only 20% of patients who had a length of stay of greater than 30 days had had a reassessment of risk. Therefore, this provider achieved **20%**

14. Is there a proforma for data collection for the CQUIN data capture?

A data collection pro-forma can be found on the National Wound Care Strategy Programme website.

15. How should we address the issue that as the CQUIN requires a quarterly data capture, it won't be possible to report on the first quarter until the second quarter to allow for the 30 days? (For example, if the quarter ends on the 30th of June, it would only be possible to review those with an inpatient stay up to the 2nd of June, otherwise they would not have had a length of stay greater than 30 days to audit against.)

The end of Q1 is 30th June. Therefore, in order to audit the care of patients admitted from 2nd June onwards, the audit for Q1 should not commence until 31st July.