Spending time to categorise and report pressure ulcers and moisture-associated skin damage — is it worth it?

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This debate focuses on the complexities of categorising and reporting pressure ulcers (PUs) and moisture-associated skin damage (MASD), which are frequent topics of discussions among the Tissue Viability Nurse (TVN) community (Ousey et al, 2017; Fletcher, 2019). In recent years, great efforts have been made to assess the extent of patient harm and demonstrate improvement, in particular, PUs occurrence and severity. Efforts to improve the quality of care led to the development of a number of data collection systems and quality metrics, including the NHS Safety Thermometer (NHS, 2011), where NHS organisations in England input their prevalence data (of categories 2–4 PUs) on one given day each month, and the National Reporting and Learning System (NRLS) (NHS Improvement, 2019), where new PU incidents are recorded continuously based on the degree of harm they cause. There are five NRLS codes for the degree of harm (NHS Improvement, 2018a):

- **No harm**: a situation where no harm occurred: either a prevented patient safety incident or a no harm incident
- **Low harm**: any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons
- **Moderate harm**: any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons
- **Severe harm**: any unexpected or unintended incident that caused permanent or long-term harm to one or more persons
- **Death**: any unexpected or unintended event that caused the death of one or more persons.

Typically, front-line NHS staff will categorise and record the incident — a pre-existing or newly acquired PU — and then a TVN or designated other will approve the uploaded data. The debate about the utility of categorising PUs and the impact it has on the quality of care has been under scrutiny for almost a decade (Fletcher et al, 2011, Fletcher, 2019).

Suspicions of inaccuracies when recording PUs were supported by data from an audit by Smith et al (2016). They found high levels of under-reporting both via the NHS Safety Thermometer and the NRLS. That same year, Coleman et al (2016) reported that different organisations were using different PU classification systems and it was clear that there was confusion in differentiating between a PU and MASD. Yet despite these limitations, challenges and variations, different types of data were used to compare and evaluate hospital Trusts, leading, in some cases, to financial penalties.

It had become clear that those current systems used locally, regionally and nationally to monitor PU patient harm needed standardisation and in January 2017, the English national Stop the Pressure programme set up a small working group to tackle this challenge (Fletcher, 2018). Their efforts to harmonise and homogenise PU reporting, culminated in the publication of an agreed set of standards to define and measure PUs: 'Pressure Ulcers: Revised Definition and Measurement Summary and Recommendations', which was published in June 2018 (NHS Improvement, 2018b). This document advises organisations to follow the system recommended in the current international guidelines (National Pressure Ulcer Advisory Panel [NPUAP], European Pressure Ulcer Advisory Panel [EPUAP] and Pan Pacific Pressure Injury Alliance [PPPIA], 2014) and to categorise PUs as 1–4, Unstageable, Suspected Deep Tissue Injury (DTI), including those caused by a medical device. The terms avoidable/unavoidable were to be discontinued and the reporting of MASD is expected. Unfortunately, mucosal PUs have not been included in any of the recent guidelines and so remain locally reported using the above categories, despite the EPUAP recommending to include but not to categorise/stage them (NPUAP, EPUAP, PPIA, 2014). The impact of these recommendations on individual organisations varied, depending on their former PU reporting practices.

Overall, these recommendations are helping to create more clarity in reporting PUs both locally and nationally. However, Recommendation 2 of Table 1 gives way to some confusion (NHS Improvement, 2018b):

- Recommendation 2: A PU should be defined as: *"A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".*

The root of frustration stems from the addition of 'other' device. There are clear examples where a non-medical device, such as a pen that had fallen out of a clinician's pocket and caused a PU, can be considered a harm to a patient from which learning can occur and practice can change. However, there are other examples, such as a PU caused by a patient sitting on a remote control in their own home, which may seem more complex. What could a healthcare professional reasonably do to prevent this? Is there learning associated with it? There are aspects around patient education and engagement in their own preventative care, but how much can we control this? Given the amount of time and effort put into reporting PUs, there need to be boundaries. Perhaps a significantly reduced investigation if it is abundantly clear there will be no learning?

Following the 'Pressure Ulcers: Revised Definition and Measurement Summary and Recommendations' document, NHS Improvement published the 'Implementing the Pressure Ulcer Framework in Local Reporting Systems and Reporting to NRLS' guidelines in 2019. They describe 28 different subcategories of PUs and MASD to be captured on the NRLS (NHS Improvement, 2019). However, they also clearly state that the degree of harm, i.e. low/moderate/severe harm/death, attributed to a PU incident does not necessarily correlate to the category of a PU. Each PU must be assessed for degree of harm for the patient, using the category of the PU as a guide only. Clear definitions on what constitutes a 'low/moderate/severe' harm PU remain elusive, in parts as the degree of harm is specific to that individual patient — what constitutes low harm for one could be moderate of high for another.

With TVN across the country spending considerable amounts of time categorising, reporting and validating each PU and MASD incident, we must question whether the increased burden on an already time- and resource-poor NHS staff is worth it? TVNs are spending more and more time away from their clinical tasks to meet bureaucratic ones, but to help whom? Our national organisations? Our patients? This is an ongoing debate and by asking the following questions, I would like to draw attention to some of the recent discussions within the TVN Network.

Jenni MacDonald

1. Who validates the category of PU/MASD in your organisation? Over one working week, what % of their time is spent validating PU/MASD incidents?

EN: We have a PU Review Group (PURG) which meets one afternoon a week to review all the Datix incident reports for Category 3, 4, unstageable and DTI incidents. The group is comprised of a TVN, Adult Safeguarding Lead and the Lead for Community Nursing. Our purpose is to ensure all incidents are correctly categorised, and that all relevant reporting to Adult Safeguarding and/or STEIS for Serious Incidents is met. The group also monitors all unstageable PUs until they are able to be categorised. The category 2 PUs and MASD are validated separately by the TVNs. Validation is done from a review of the patient's records, and photographs as it is not possible for the TVNs to visit every patient in person at home to validate. There also needs to be trust and confidence in the nursing staff to make correct assessments on the back of the training and education provided by the TVNs.

LM: In our Trust, initial validation may be undertaken by a registered nurse who has received training on PU prevention and management, which includes MASD recognition and differentiation from PUs. Many of our registered nurses have completed PU competencies which include the categorisation of PUs. During team handover, the severity of a PU/MASD is discussed and photographs will be reviewed. If needed, a more senior nurse will undertake a follow-up visit within 24 hours to confirm diagnosis/severity. Community Nursing teams have recently been provided with Tablet devices, which can be used to take photographs and can enable prompt upload of images to the patient electronic records system. If there is any uncertainty over the identification or management of a lesion, they can seek telephone advice from the Tissue Viability team, who would be able to review the recently uploaded photographs. Patients with category 3, 4 or unstageable PU should be referred to Tissue Viability, who will see the patient within 5 working days and validate the PU. The approximate time that the Tissue Viability Team spend validating PUs varies, but is around 30–35% of their time.

GH: PU/moisture lesions are verified by the lead nurse for the acute and community trust, as this is an integrated Trust. They spend around 20 minutes per patient assessment to include verification (and preparing the patient for the assessment), so, therefore, I suggest a worst-case scenario of 6.25%.

EB: PUs — the Tissue Viability team; MASD — the Tissue Viability team and/or ward staff; severe MASD — the Tissue Viability team get involved. We spend around 10 hours (we are a small Trust – an Elective Specialised Orthopaedic Service).

2. Do you find staff have difficulty differentiating between PU and MASD? And what approaches have been most successful in overcoming this?

EN: The number of incidents we have had to reclassify has reduced over the year, probably as a result of increasing awareness and education. The reporter will provide a rationale in the Datix report to explain

his/her decision with regards to the classification. Some confusion remains around skin damage that is caused by incontinence where there is the presence of sloughy tissue. Slough is a natural by-product of the inflammatory phase of healing, and yet all classification tools list the absence of slough in moisture lesions as a differentiating factor. Where these are not sited over bony prominences, it may not always be accurate to label these as PUs. Differentiation between PU and MASD is addressed in all our in-house PU training and we have also introduced a skin protection pathway supporting the appropriate use of barrier products for different stages of skin damage. Where uncertainty remains, a conversation between the nurse and TVN usually reaches an agreement on the classification.

LM: Differentiation of PUs from Incontinence-associated dermatitis (IAD) is a challenge at times, particularly if the IAD has been severe and extended to cover a bony prominence. This has evoked suspicion as to whether the patient had been exposed to sustained pressure. There have been cases where patients have developed necrotic lesions with irregular wound edges, but it has not been immediately apparent as the anatomical location was that of a bony prominence due to how the patient had been positioned during the nurse review. Training sessions on differentiating PUs from MASD include review of photographs, during which nursing staff are asked to identify the conditions and categories, and provide rationales for their decisions. These answers appear to be fairly accurate during sessions undertaken over the last 6 months.

GH: Generally, yes they do. Education, training and pocket/diary-sized information cards for staff have been extremely useful. So have Learning-from-Incidence sessions held in Trust. All PU and MASD are photographed and, where there are concerns, reviewed by the Tissue Viability team.

EB: Yes difficulties when on the buttocks and sacrum. Helpful approaches include using apples to demonstrate PU categories and extra React-to-Red training for HCAs, Tissue Viability Link Nurses and registered staff. Pictures on Ulysses. The Moisture or Pressure Tool (MOPT) in the Tissue Viability folder as well as the Tissue Viability newsletters.

3. We know that the degree of harm attributed to a PU/MASD incident should not be directly correlated to the PU category but assessed on an individual basis. How and by whom is this decision made in your organisation?

EN: The degree of harm is a mandatory field in the Datix incident form and, therefore, is initially decided by the person completing the Datix. All category 3, 4, unstageable, suspected DTI and multiple 2s are discussed in our weekly PURG meeting to agree on the level of harm and whether they meet Serious Incident criteria and require root cause analysis (RCA).

LM: The Team Leader or designated deputy can make this decision, but will consult members of the team during handover or at a roundtable review of an incident to ensure that an accurate reflection of the impact is recorded. The decision of this specific patient incident is then entered on the electronic reporting system (Datix). Advice can be sought from a variety of sources, including the Matron, Risk Management Team, Tissue Viability, Safeguarding Team, Patient Experience and Freedom to Speak Up Guardian.

GH: We hold an Serious Incident meeting with the Patient Safety team, Deputy chief nurse, staff involved with patient care and Tissue Viability for each serious incident, so it is a team decision.

EB: The TV team initially assess the patient. The report on Ulysses is then discussed at the relevant Divisional Governance meeting, where a decision on the degree of harm attributed to the PU is made.

4. How many incidents of PUs have you seen caused by non-medical devices within the last year? Did you feel there was learning from these events?

EN: We did not have any reported incidents of PUs caused by non-medical devices over the last year, and only three device-related incidents, of which two were in patients not known to community services at the time.

LM: Birmingham Community Healthcare NHS Trust is one of the largest community Trusts in the country, hence our total PU numbers for 12 months are high, but have reduced significantly since the PU initiative in 2012. In the community setting, we have had around 1,182 new PUs (all reportable categories) and 972 PUs on admission (all reportable categories). In our in-patient settings, we have had 88 new PUs (all reportable categories) and 88 PUs on admission (all reportable categories). The introduction of the NHS Improvement recommendations have made an impact on our total PU numbers as we previously did not report DTIs and MASD. MASD incident data has been included with our PU data, therefore, this alone has contributed to around a 45% increase to our PU data. With all PU and MASD incidents, the management section of the incident reporting system requires the incident handler to identify if anything could have been done differently and what teams have learnt from the individual incidents, which triggers reflection on

practice. However, analysis of themes from our RCA investigations does indicate recurrence of key contributory factors, which does suggest some fragmentation in learning from these events.

GH: From April 1st 2019, we have reported 132 cases across the acute and community but none of these were reported as Serious Incidents following an investigation. Every reported incident has documented learning, which are discussed in the clinical area/Trust.

EB: Ten and, yes, we did learn from them. Staff on the High Dependency Unit are now repositioning patients more frequently overnight.

5. Do you think that by collecting this data, quantifiable quality improvements are being made and PU/MASD incidences are decreasing?

EN: The data alone cannot demonstrate improvements or otherwise in care but is nevertheless a helpful tool if interpreted in context. Compared with a year ago, we have seen a rise in overall numbers for a variety of reasons, but a large part is due to improvements in reporting practice. This is seen particularly in the rise of category 2 PUs, often very tiny in size and which heal within a few days. The real benefit has been in the work of the PURG group, which has enabled the focus of investigations to be on cases where the greatest improvement from learning can be made.

LM: We do see small scale quantifiable quality improvements, despite the overall change in our PU data following the introduction of the NHS Improvement PU recommendations. Each month, PU data is analysed in divisional and Trust forums and triangulated with dashboard quality audit data to identify potential hotspots. Where these emerge, support is provided to understand the underpinning reasons for this and facilitate actions to enable resolution. The outcomes from this are monitored month-on-month through these forums.

GH: I think that collecting the data makes us more aware of the problem, however, the actions taken from the data should lead organisations to address any identified issues with education, training and appropriate availability/use of resources.

EB: With regards to PUs, yes. However, we are still collecting data about MASD — we only really collected MASD due to incontinence before. Intertriginous dermatitis seems surprisingly high in patients admitted to the Royal Orthopaedic Hospital. Our medical device-related PU incidence rate appeared to be increasing at first as a result of educating staff because they were no longer reporting PUs under casts, braces and automated external defibrillators as bruises. However, PU/MASD incidences are now decreasing due to increased awareness.

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