Has anything changed?

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As we look forward to finally meeting again at Harrogate 2021, and in the bigger picture moving out from COVID-19 into the new world where we carry forward the many lessons that we learned (once we get through winter obviously!), it has made me reflect on how much has changed – or should that be how little has changed?

I recently gave a presentation about pressure ulcer prevention over the last 60 years, which required me to do quite a lot of research around the whole of tissue viability over the last 60 years – and it made me feel a little despondent. If we go back to the Norton score (circa 1962), we are still seeking the perfect risk assessment tool – by creating more risk assessment tools that work in the same way, identify key risk factors and then tick them off lists. It hasn't really been the golden bullet for 60 years, so why would it be any different now? Whilst systems such as PURPOSE T can say that the criteria they use are based on research, it doesn't make their implementation or daily use any better, and RCA regularly identify 'poor risk assessment practice' as key in the development of pressure ulcers (PUs). I did, however, finally find out why the Norton score has a lower score, meaning a higher risk! Doreen Norton later wrote that the descending score relates to the decline in the patient's condition (Norton, 1989). In the same paper, she expressed her horror at the increased shear forces through the sacrum when using a new type of backrest in beds she had seen in the USA (yes, we are once again looking at the importance of posture in relation to shear and deformation). When I trained as a nurse (not 60 years ago I might add, but in the 1980s), we had a small but very helpful selection of preventative equipment, overlays, (fibre filled or air filled) our big yellow Pegasus (alternating) mattresses, low air loss systems in intensive care and 'Clinitrons' for when the patient was in desperate need (air fluidised beds for those too young to remember). Our Director of Nursing was also implementing a total mattress replacement programme to remove our existing mattress stock, which included some made from horse hair. Nevertheless, the main problem was the delaminated, cracked and therefore heavily contaminated foam mattresses with the marble cover *(Figure 1)* that were being replaced with the first of the high density foam with stretch covers.

Whilst the technologies have improved and mattresses look better and have more bells and whistles – has there been any really significant changes? Maybe hybrids? They have helped reduce the need to move patients from one mattress to another which has been a real bonus, but in terms of new technologies – what has actually changed? Maybe it isn't about equipment – is it about the wider aspects of care? I dug out a copy of the first PU Prevention policy I wrote in the early 1990s, and looked at the 9 standards it was based on – it was easy to tie it in to the aSSKINg framework *(Figure 2)*, and although incontinence isn't specifically mentioned there was a whole segment in the skin care section.

Is it just pressure ulcers where it seems a bit same old same old? Let's look at venous leg ulcers. I can recall the excitement in 1992 at the publications by Christine Moffatt that identified that assessment of the vascular supply using hand held Doppler and then use of compression significantly improved the healing rate for patients with venous leg ulcers – but some 30 years later what is the focus of the lower limb clinical navigation tool – yes, vascular assessment and appropriate use of compression...

What about dressing products? Well, from memory, in the 1980s we had (forgive the naming of products!) Scherisorb hydrogel, Lyofoam, Varidase as a debrider, Granuflex for everything else, not 1 but 2 alginates; Kaltostat and Sorbsan, a superabsorber (made from tiny beads that escaped all over the place – and I'll give a bar of chocolate to the first person who can remind me of the name!) and various antiseptic products containing silver, iodine, chlorhexidine and, yes, honey. Although we have significantly more

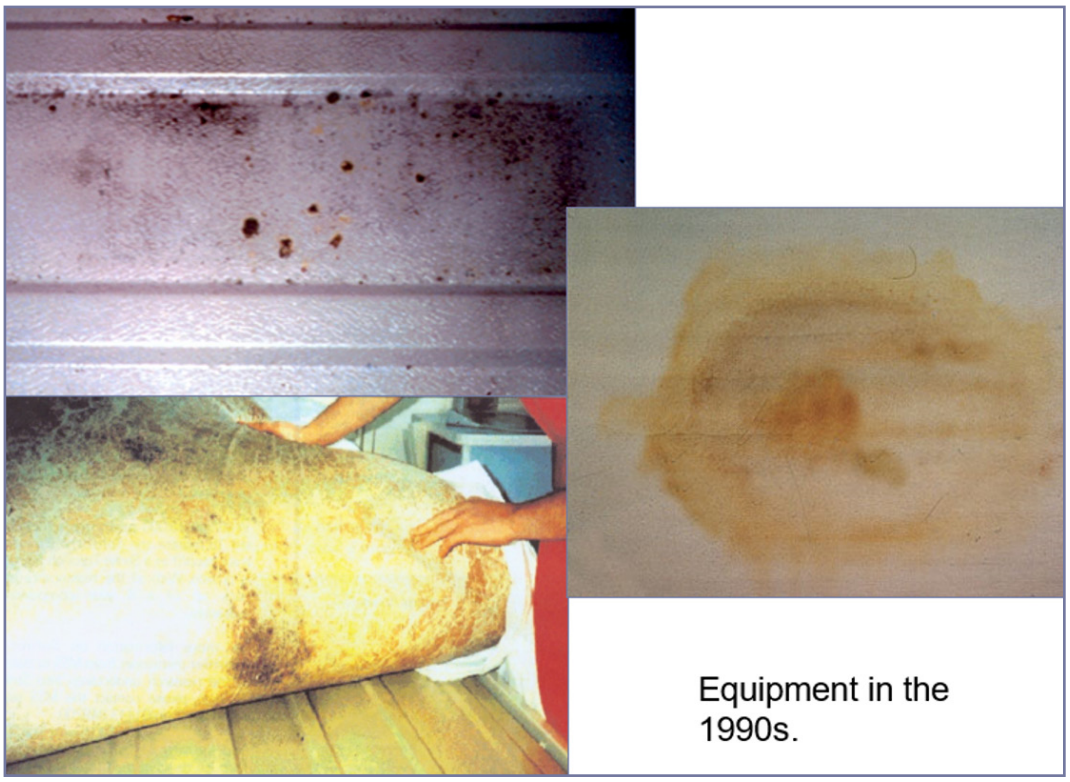


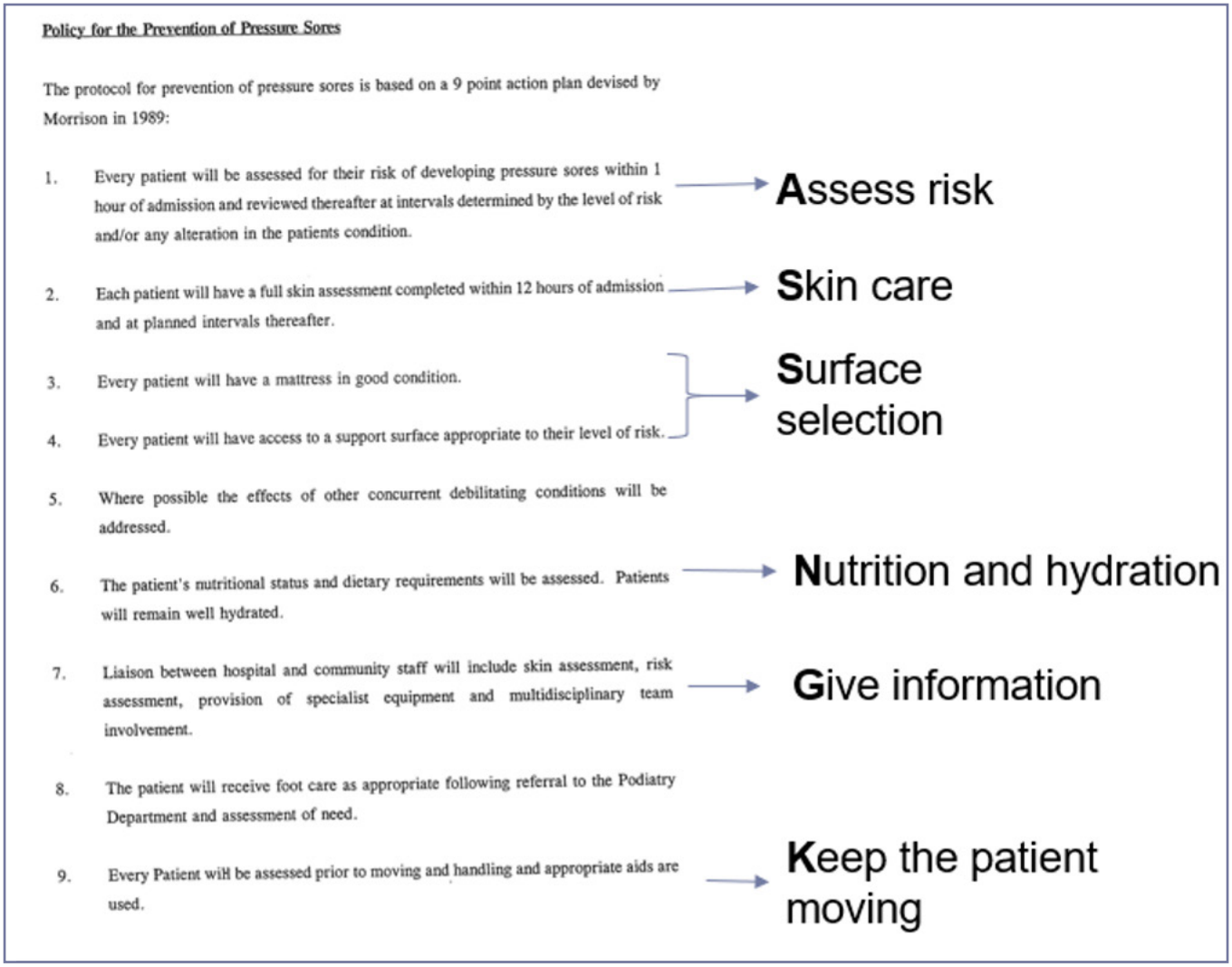
Figure 1. Equipment in the 1990

choice now, I couldn't even name all the foam dressings available let alone every product we have. Have we actually got any better choice? Have there been any really different technologies come along? Well, yes, negative pressure has been the biggest game changer, but aside from that – have the materials changed all that much? Foams are better yes, adhesives revolutionised by silicone, but could we still manage with a foam, a hydrogel, an antiseptic, a debrider, a form of hydrocolloid, a superabsorber and negative pressure – isn't that what most formularies contain? Please don't think I am dismissing some of the newer more active products that are available and that are the go to choices for patients with really complex wounds, but the majority of what is managed is managed with materials that have been around for 50 or 60 years with only small technological developments.

I would like to think that we are actually at quite a crucial turning point, our knowledge and understanding is changing significantly, for example, what we knew about the aetiology of PUs has changed significantly over the last 10 years as we begin, thanks to out bioengineering colleagues, to understand more about cellular deformation at a practice level.

What all the new innovations in the past have lacked is consistent application; implementation has always been down to local champions and local teams, which only ever sustains for as long as the champion remains. Maybe the big difference we have now is the national focus and drive that comes from having a nationally funded body making policies and having a plan for national implementation – perhaps this will be the game changer – the step change we need? Perhaps digitisation and improved communication and connectivity will be real drivers for change, certainly improved use of data so long a hurdle to overcome in the NHS will help us move forward.

It certainly isn't from lack of motivation or innovation from clinicians, clinicians in tissue viability have always been highly motivated and incredibly passionate and creative, never is this more apparent than in how services flexed and adapted over the last 18 months, embracing technology, running on reduced (or non-existent)



Policy for the Prevention of Pressure Sores

The protocol for prevention of pressure sores is based on a 9 point action plan devised by Morrison in 1989:

1. Every patient will be assessed for their risk of developing pressure sores within 1 hour of admission and reviewed thereafter at intervals determined by the level of risk and/or any alteration in the patients condition. → **Assess risk**
2. Each patient will have a full skin assessment completed within 12 hours of admission and at planned intervals thereafter. → **Skin care**
3. Every patient will have a mattress in good condition.
4. Every patient will have access to a support surface appropriate to their level of risk. → **Surface selection**
5. Where possible the effects of other concurrent debilitating conditions will be addressed.
6. The patient's nutritional status and dietary requirements will be assessed. Patients will remain well hydrated. → **Nutrition and hydration**
7. Liaison between hospital and community staff will include skin assessment, risk assessment, provision of specialist equipment and multidisciplinary team involvement. → **Give information**
8. The patient will receive foot care as appropriate following referral to the Podiatry Department and assessment of need.
9. Every Patient will be assessed prior to moving and handling and appropriate aids are used. → **Keep the patient moving**

Figure 2. How much has changed since 1989?

staffing, keeping activity up despite significantly increased acuity and a workforce that was overwhelmed. And that is why I am so looking forward to seeing everyone at Harrogate, to be re-engergised, to pick up the buzz of possibility, of moving forward and reigniting the joint passion to improve care for our patients. WUK

REFERENCE

Norton D (1989) Calculating the risk: reflections on the Norton scale. *Decubitus* 2(3): 24-31