

Why are we making the same mistakes? And who will bring us forward?



JACQUI FLETCHER
Clinical Editor, Wounds UK

Pressure ulcers (PUs) remain high on the clinical and political agenda in the UK and also in the wider international arena. Their prevention and monitoring occupies a great deal of clinical time. This supplement identifies some of the outstanding difficulties in the identification and recording of pressure damage and also highlights the good practice undertaken in one area (Midlands and East Strategic Health Authority).

The development of an avoidable PU has, in more recent years been recognised as an avoidable harm (Department of Health [DH], 2010) and has, therefore, prompted a huge amount of interest. While data on PUs occurrence have been reported in the literature for many years, and specialists nurse presented business case after business case to help avoid their occurrence, it is only since the growth in the profile as a harm that PU prevention has attracted a more strategic interest and the associated funding to develop and deliver coherent strategies, supported by active implementation programmes.

While this strategic interest has been hugely beneficial in many ways, it has not been without problems. Many areas have been under considerable pressure to meet ill-conceived targets/key performance indicators, and tools to measure occurrence are in many cases identified as being significantly flawed. It appears that there is a belief that central data collection systems are 'good enough' yet there is no clarity on how 'good' this is or is not. However, these data are still widely being used for comparison and to measure key quality targets, such as Commissioning for Quality and Innovation (CQUIN) targets.

More recently, work has been initiated to identify the reality of how many PUs are being developed, with the Tissue Viability Society working with NHS England to map across a number of organisations how accurate Safety Thermometer is, by carrying out a proper prevalence survey concurrently. In this supplement, Karen Ousey identifies the confusion between moisture lesions and PUs.

However, this is not the only area of confusion, it seems that almost any wound, particularly if it is around the bottom area, can be counted as a PU. Some tissue viability nurses report that, had they not quality-checked their organisation's data, Safety Thermometer would include reports of wounds as PUs that were surgical, leg ulcers and/or a whole range of others. Equally, a source of conflict is the exclusion of a PU because of the lack of clarity on definition. Heel ulcers in patients with diabetes might get excluded as they are categorised as diabetic foot ulcers — there is no real clarity on how to determine where these should sit but it is clear organisations do different things. Some organisations also exclude PUs that they decide on the day are 'unavoidable' or are determined to be unclassified.

What is clear from the many route cause analysis (RCA) investigations carried out across the UK is that the root causes appear to be consistent and repeated. A lot of time and effort is put into the prevention of damage and then the investigation process when a PU occurs — is this reasonable? An RCA is supposed to trigger learning and change, yet time after time, the same issues are identified in PUs deemed to be avoidable. These include:

- ▶▶ Communication issues
- ▶▶ Lack of staff
- ▶▶ Issues related to access to equipment in a timely manner
- ▶▶ Education and training
- ▶▶ Multiple transfers.

In any other industry such as the airlines, rail or car manufacturing, this repeating of the same mistakes would not be tolerated, but it continues in PU prevention. So are we wasting our time, particularly with the investigations if all we do is identify the same issues?

NHS England has recently identified this as a problem and are intending to carry out a piece of work that does five or six deep-dive RCAs in the belief that we are not truly getting to the root cause with the investigations that are being done,

and that by selecting a small number of cases and carrying out an exhaustive investigation (facilitated by external experts) new issues may be identified. Hopefully, this will lead to some significant changes at both national and local levels.

A further area of interest is how organisations are ensuring care is delivered with many auditing documentation with no check on how documentation reflects practice. Anecdotally it is evident that because of the high priority of completing documents, such as SKINS bundles, staff can feel under undue pressure to ensure they are fully completed, whether or not the care has been delivered. Clinicians have been known to complete the whole morning's worth of documentation at the end of their shift – which may not be strictly accurate. There is no denying that the implementation of the bundles has been hugely influential in raising the profile of PU prevention, as Fiona Downie states in this supplement, and that in a majority of cases they do reflect practice – but in many cases they also do not. The only way to truly determine what is happening in practice is to observe practice – but this is not straightforward. There is little hard data to date to support that bundle implementation has actually improved PU prevention.

What is clear, is patient and public engagement has a large part to play in prevention, audit and investigation of PUs. A high percentage of patients are being admitted to acute services with pressure damage, yet they have had no contact with healthcare practitioners – or more specifically with nurses. Many patients may have seen their general practitioner or a therapist, but PU risk assessment and the implementation of basic prevention may be low on their agenda. Although some health professionals work very well with their multidisciplinary teams, and it would be unfair to say that they do not participate in risk assessment.


Most of the general public has no idea what a PU is – or certainly not how extensive and debilitating a PU can be. The Midlands and East market research clearly identified how people were shocked when they saw images of actual PUs (McIntyre, 2014).

It would be hugely helpful to have some guidance from the centre, yet the recent

National Institute for Health and Care Excellence (NICE) guideline update (NICE 2014) actually gave little guidance on some crucial points, avoiding the inclusion of better definitions and recommendations. Equally, the DH has stated that it should not be the one to define what PUs we do or don't count – or for that matter *how* we count them. Yet who else could ensure consensus? Individual groups, such as the Tissue Viability Society, are trying really hard to do this work, but they have limited funding and rely on the good will of their committee and general members; they also have no authority to enforce any findings. Much work is being done elsewhere, for example, in the United States, health professionals hold consensus meetings to determine what is meant by 'avoidable' and 'unavoidable' PUs. However, it is clear that much of what drives their definitions is litigation and insurance so these are not always relevant to the UK. We can learn from their work, but it is frequently not transferable.

It is abundantly clear from the three papers in this supplement that a huge amount of good work is being carried out and that we have made huge improvements in patient care in relation to preventing PUs. The three authors also identify the many challenges faced during the work already carried out and the work yet to be undertaken. Cost containment, prudent healthcare and minimal intervention seem to be the current 'in' phrases and, in all honesty, isn't that the right way to be practicing? We should be conscious of how we are spending NHS resources and we should do our best to deliver high-quality care – but we don't need to 'over egg the pudding'.

Our resources are precious and scarce, and we should use them wisely; not every patient needs a specialist mattress or 2-hourly turning, but some of them need extra special equipment and far more frequent turning, so we should focus on getting the balance right and working out what really does make a difference for individual patients, as well as groups of patients.

If we really are to deliver 'Harm Free Care', we need to realise that this journey has only just begun and that the route ahead is not going to be straightforward. However, I believe that taking the first steps is often the hardest, so hopefully progress should be easier from this point onwards. 

REFERENCES

- Department of Health (2010) *Equity and Excellence: Liberating the NHS*. Available at: <http://bit.ly/1g6YkNw> (accessed 03.06.2014)
- McIntyre L (2014) Implementing a regional strategy to reduce avoidable pressure ulcers *Wounds UK* 10(Suppl1)
- National Institute for Health and Care Excellence (2014) *Pressure Ulcers: prevention and management of pressure ulcers/Clinical Guideline 179* Available at: <http://bit.ly/1oHo88r> (accessed 18.06.2014)