Why do we make things so complicated?

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Just when I thought things seem to be sorted out, it feels like we are adding another layer of complication. We finally reached agreement on the categories with the publication of the Revised Pressure Ulcer (PU) Definition and Measurement Framework in June 2018 (NHS Improvement, 2018) — and even have some standard posters on the way. However, now we have to decide what to call a PU that had healed but has opened up again. Is it the *same* PU — so the same category it had been— or is it a *new* PU — so whatever category it now presents itself as? The Americans, of course, have already had this discussion and have offered a variety of definitions, such as: closed PU, healed PU, mature resolved PU, reopened PU, recurrent PU and new PU (Tew et al, 2014).

But isn't it complicated enough already? We are struggling to get staff to allocate the existing six categories without adding even more. However, it is important that we all do the same, so we need to look at how we can reach a consensus on this. If we are to improve the care patients with wounds receive, we need to have a clear vision of how to make and measure those improvements — and sometimes it needs to be made clear that this means to stop doing certain things.

MAKING SURE THAT WE ARE IMPROVING THE QUALITY OF CARE

The Lower Limb work stream (of the National Wound Care Strategy Programme) is proposing the implementation of care in a streamlined way for all patients with lower limb wounds (yes, including heel pressure ulcers) and surgical wounds as well as PUs, simplifying treatments and referral pathways, identifying red flags early. No doubt that all of this will need to be measured and counted, but let's learn from the complexities of what has gone before and be sure that we are counting and measuring for good reason. We need to make sure it stimulates quality improvement and is not just used to compare us to others and potentially become a stick with which to beat us.

It's important to remember quality improvement is about exactly that: *improving quality*. Yet on so many occasions, it is used to compare and judge nurses. We seem to be bogged down doing the same thing over and over again. It takes a brave person to stand up and say: *"let's not do this anymore, we have learned what we can and now we are just doing the same things over and over again without any learning — let's do something different"*. I guess it goes back to the old saying *"if you always do what you always did, you will get what you always got!"* Just imagine how much time could be saved if we didn't have to categorise pressure ulcers — with no impact on the delivery of care. I know this is my personal utopia and that we've just voted on keeping the category numbers and so are the new NPUAP, EPUAP and PPPIA guidelines, but I dream of simplification.

There is such emphasis now on improving the quality of lives of patients with wounds, yet there are so many other areas we need to tackle (e.g. identification of patients with wounds, prompt access to care etc) that we need to be sure that resources are used wisely and implement change not just for the sake of it but to achieve improvements. Perhaps more importantly, we need to consider *what* we need to change. Does changing from product A to product B really make a difference? Or does a proper assessment and timely referral to an appropriate clinician make the actual difference?

FAIL FAST, SUCCEED FASTER

Best quality improvement occurs where there is good leadership, encouragement to nurture and grow staff but also support to fail fast, i.e. early recognition when something is just not going to work and deciding to loose it — conserving effort, energy and enthusiasm and move on.

We also need to identify how much data we already have and use it wisely rather than creating new data sets that are an additional burden for clinicians to use. This is a really strong message from the Data and Information Work Stream, so hopefully it will be carried through into practice. WUK

REFERENCES

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