

Taking pressure ulcers out of the headlines

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Having a strong voice is incredibly important for nurses involved in tissue viability and wound care, especially as the media continues to bombard the public with headlines such as 'Hospitals "named and shamed" on bedsores record which costs NHS £4bn a year' (*The Telegraph*, 2011).

The Telegraph article reported that the 'sores, also known as pressure ulcers, cause hundreds of deaths a year, taking hold when bed-bound patients are not regularly turned over or given special mattresses by nurses'. The newspaper continued that most victims are elderly or long-term patients who need help with mobility.

The Telegraph interviewed Peter Walsh, Chief Executive of Action Against Medical Accidents, and he reported that pressure ulcer prevention was not 'rocket science', and is usually a result of inadequate nursing care.

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He went on to state that more initiative needs to be taken in pressure ulcer prevention, with the introduction of a zero tolerance policy.

While it is true that many pressure ulcers are preventable, in some cases they are unavoidable (*Figure 1*).

However, the development, implementation and evaluation of standards for pressure ulcer prevention should be made a priority if clinicians are going to be able to justify the care that they provide to patients and attempt to present a more balanced view of pressure ulcer treatment and prevention.

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Policy

The US Wound, Ostomy and Continence Nurses Society (2009) wrote a position paper which clearly states the definitions of avoidable and unavoidable pressure ulcers.

These definitions have been accepted for use by the Department of Health (DH) to develop outcome indicators that can be used by nurses and other clinicians. The modified definitions, which comply to UK terminology (DH, 2011a), are laid out in *Figure 1*.

The Government reforms to health services will continue through 2011.

The DH (2011b) has announced that it will accept the core recommendations of the NHS *Future Forum* report (DH, 2011b). However, it has identified several key changes to the original proposals, such as introducing new GP consortia (or governing bodies) called 'clinical commissioning groups', safeguards against privatisation and new ways of extending integrated care to NHS patients.

Each clinical commissioning group will include at least one nurse and one doctor. Clinical networks will support and advise the commissioning groups in individual areas of care, such as cardiovascular disease or cancer.

Also, clinical senates in each area of the UK will provide interprofessional advice on their community's commissioning.

It will be possible to highlight tissue viability and wound care as fields for development, where specialist clinicians can ensure that they have voices in all areas of the UK.

The DH (2011b) suggests that there should be stronger accountability for clinicians and that health and well-being boards should be a substantial part of local councils, with the authority to denote that local commissioning plans do not coincide with health and well-being strategies.

The DH is very clear that the new system must and will involve the public, patients and carers and that there will be stronger responsibilities

for commissioners. It will also be necessary to extend personal health budgets and joint health and social care budgets, as commissioners will have to promote care that meets the needs of users.

Until 2016, Monitor, the independent regulator for NHS foundation trusts, will have 'transitional powers to maintain high standards of governance' during these changes (DH, 2011b) and the NHS *Future Forum* report suggests that, rather than relying on GPs alone, nurses, specialist doctors and other clinicians must be involved in making local decisions about the commissioning of care (DH, 2011b).

The report also states that the NHS should avoid tokenism, or the creation of new bureaucracy.

What next?

These changes represent a great opportunity for tissue viability and wound care clinicians to stand up, be heard and to make a difference to healthcare provision in the UK.

However, to do this, nurses and other clinicians must be able to access appropriate educational opportunities.

The DH (2011b) recognises this, stating that it will:

- ▶ Ensure a safe and robust transition for education and training, taking action to put Health Education England in place quickly to provide national leadership and strong accountability, while moving towards provider-led networks in a phased process
- ▶ Ensure that, during the transition, deaneries will continue to oversee the training of junior doctors and dentists, and give them a clear place within the NHS framework
- ▶ Improve the quality of management and leadership, for example by retaining the best talent from primary care trusts and strategic health authorities and through the ongoing training and development of managers

- ▶ Further consider how best to ensure funding for education and training is protected and distributed fairly and transparently.

Pressure ulcer prevention should be made a priority in the UK, however, pressure ulcers are not always preventable, even according to the DH's own guidance. These new initiatives from the NHS Future Forum will begin to help clinicians provide appropriate care using clinical commissioning groups, stronger accountability and more support for patients.

These changes represent a great opportunity for tissue viability and wound care clinicians to stand up, be heard and to make a difference to healthcare provision in the UK.

As clinicians, we need to ensure that tissue viability and wound care become important topics in the local and regional commissioning groups to ensure that pressure ulcers are being cared for appropriately. This is the only way to deter negative media headlines in the future. **WUK**

References

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- Department of Health (2011a) *Defining Avoidable and Unavoidable Pressure Ulcers*. DH, London. Available online at: www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/PressureUlcers/Defining%20avoidable%20and%20unavoidable%20pressure%20ulcers.pdf [accessed 1 September, 2011]
- Department of Health (2011b) *Government response to NHS Future Forum*. DH, London. Available online at: <http://healthandcare.dh.gov.uk/government->

Figure 1

Definitions of avoidable and unavoidable pressure ulcers

Avoidable pressure ulcer:

'Avoidable' means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- ▶ Evaluate the person's clinical condition and pressure ulcer risk factors
- ▶ Plan and implement interventions that are consistent with the person's needs and goals, and recognised standards of practice
- ▶ Monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

Unavoidable pressure ulcer:

'Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care did the following:

- ▶ Evaluated the person's clinical condition and pressure ulcer risk factors
- ▶ Planned and implemented interventions that were consistent with the person's needs and goals
- ▶ Recognised standards of practice
- ▶ Monitored and evaluated the impact of the interventions
- ▶ Revised the approaches as appropriate
- ▶ Where the individual refused to adhere to prevention strategies despite being educated as to the consequences of non-adherence.

[response-to-nhs-future-forum](#) [accessed 1 September, 2011]

Wound, Ostomy and Continence Nurses Society (2009) *Position Paper: Avoidable and Unavoidable Pressure Ulcers*. Available online at: www.wocn.org/pdfs/About_Us/News/wocn-avoidable-unavoidable_position-3-25.pdf [accessed 1 September, 2011]