# New year, new challenges: An abundance of opportunities for tissue viability

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Welcome to the first editorial of 2013 and a belated "Happy New Year" to everyone! We are sure that this year is going to be as exciting as 2012, in terms of changes to healthcare provision and education. Time will continue to be a valuable commodity for clinicians who want to undertake research, case studies, and study new evidence, but it is vital that we do find this time, to ensure that patients receive the most up-to-date interventions.

Higher education institutions are increasingly moving to online delivery of courses and modules that allow students the luxury to study at a time that suits their professional and personal demands. Industry is providing online education to support their products and the staff using them, and many publishing houses are providing readers with online learning opportunities. This often represents a new way of learning for many, unless, of course, degree courses were undertaken via the Open University.

It is important that we become flexible in our approach to education. This flexibility will provide everyone with the opportunity to learn new skills, develop knowledge, share best practice, and – potentially of great importance – it opens up the prospect of learning with international students as there are no geographical boundaries in online learning. Hopefully, we will see and act on these opportunities that tissue viability will be presented with, allowing us to further develop research and a strong evidence base to support interventions.

How often do we think about terminology when we are caring for patients, planning care, or writing research proposals and papers for publication? Karen had an interesting conversation with colleagues in Australia discussing the terms "pressure ulcer" and "pressure injury". It became apparent that the Australians are using the term pressure injury as opposed to ulcer. WoundsWest (2011) defines a "pressure injury" as:

"Occurring when vessels collapse under external pressure, blood supply to the cells is cut off, limiting oxygen supply and decreasing nutrients to the cells which results in tissue hypoxia, leading to the development of localized tissue ischemia, cellular death and tissue necrosis. A pressure injury can develop in as short as 30 minutes if there is high pressure in a small area. Increased pressure, over short periods of time and slight pressure for long periods of time, has been shown to cause equal damage."

Is this a more accurate term to use than "pressure ulcer"? Especially when, in the UK (European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, 2009), we define a Stage/Category I ulcers as:

"Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue."

Perhaps the use of terminology should be debated among clinicians? If you would like to be a part of the debate please let us know by writing to furtherinfo@wounds-uk.com. Here are a few terms to perhaps consider when discussing pressure ulcers:

- Aged/older/elderly
- Pressure ulcer/pressure injury
- Moisture lesion/moisture ulcer/incontinence-associated dermatitis
- Compliant/concordant/non-compliant/non-concordant
- Competency/competence/competencies

As part of Jacqui's new role as Ambition Lead for Midlands and East NHS, it is abundantly

clear that we do not have clear definitions in the UK. Jacqui spends much of her time debating where to place deep tissue injury in the grading system and far longer than is reasonable discussing what the NHS Safety Thermometer definition of a new pressure ulcer means. In some ways, I wonder how relevant this debate is – the aim of "harm free care" is to ensure our patients are free of harm, not any particular category of harm, just harm.

Perhaps we are wasting our efforts bickering about terminology when we could direct that time and energy into formulating effective preventative measures. It seems that so much time and effort is spent on deciding who we attribute the damage to, when that time could be better spent supporting and educating clinicians so pressure ulcers do not occur in the first place. If we do manage to prevent pressure ulcers then we should be looking at other "harms"; can we prevent patients with venous disease from developing leg ulcers, or those with diabetes losing a limb?

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It does seem that we have forgotten – or pushed to the periphery – every other type of wound that is not a pressure ulcer in recent months. Yet, pressure ulcers remain as challenging and numerous as ever.

In Midlands and East, we have invested a huge amount of time and effort in education and resources for training and developing our qualified staff, but this level of commitment in prequalification education appears to be lacking. Wound care is still a "squeeze-it-in-if-you're-lucky" subject (although this varies considerably around the country). It would be brilliant to see wound care increase in importance in prequalification curricula for nursing and other disciplines.

This year will see a huge focus on quality initiatives and it would be great to see wound care up there as one of them, but that will only happen if we pull together and start to focus on what the real issues are – rather than the ones that are easy to count! WUK

European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel (2009) *Treatment of Pressure Ulcers: Quick Reference Guide*. National Pressure Ulcer Advisory Panel, Washington DC. Available at: http://bit.ly/10cLro (accessed 06.02.2013)

Mulligan S, Prentice J, Scott L (2011) *WoundsWest Wound Prevalence Survey 2011 State-wide Overview Report*. Ambulatory Care Services, Department of Health, Perth, Western Australia. Available at: http://bit.ly/12sjDDA (accessed 06.02.2013)