

ELIMINATING AVOIDABLE PRESSURE ULCERS: NICE QUALITY STANDARD 89

Pressure ulcers are the most frequently occurring harm to patients according to incidents reported to the National Reporting and Learning System in 2011–12, however, the majority of pressure ulcers could be avoided. This article provides a guide to eliminating avoidable pressure ulcers by following NICE quality standard 89 in both community and acute care settings.

It has been estimated that the mean cost of treating a pressure ulcer varies from £1,214 (Category I) to £14,108 (Category IV) (Dealey, 2012). The estimated overall cost of pressure ulcer management is £2.3 billion–£3.1 billion per year in the UK; this equates to 3% of the annual NHS expenditure at 2005/6 levels (Posnett and Franks, 2007). The majority of the costs are due to nursing time, and more severe pressure ulcers have higher costs that relate to higher complication rates (e.g. infections or longer hospital stay). As well as having a financial cost, pressure ulcers have a massive impact upon health-related quality of life; their presence and treatment have been found to affect people's lives emotionally, mentally, physically and socially (Spilsbury, 2007; Gorecki, 2009). It is, therefore, not surprising that pressure ulcer prevention is a key quality improvement target in the NHS (Harm Free Care, 2013).

Over time, as our knowledge of how and why pressure ulcers develop has expanded, it has become acknowledged that the majority of pressure ulcers are avoidable: estimates have been made that up to 80–95% of all pressure ulcers are

avoidable (www.nhs.stopthepressure.co.uk). The Department of Health gives the following definition of an 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 recognise standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate' (National Patient Safety Agency, 2010).

It is therefore not surprising that accurate and timely assessment of a person's pressure ulcer risk, and acting upon this level of risk, is key when looking to eliminate avoidable pressure ulcers. The new National Institute for Health and Care Excellence (NICE) quality standard for pressure ulcers (NICE, 2015) is mainly focused around timely and accurate assessment and reassessment of a person's pressure ulcer risk.

NICE quality standards contain a concise set of prioritised

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statements designed to drive measurable quality improvements in the three dimensions of quality; patient safety and experience; and clinical effectiveness. In June 2015, a new NICE quality standard was published regarding the prevention, and assessment of pressure ulcers in all care settings. It consists of nine quality statements that, if followed, would be expected to contribute to improvements in the following outcomes (NICE, 2015):

- ▶▶ Incidence of Category II–IV pressure ulcers
- ▶▶ Health-related quality of life
- ▶▶ Length of hospital stay
- ▶▶ Discharge destination (such as a patient's home or care home).

By following NICE quality standard 89, along with evidencing that care has been provided as defined in the Department of Health avoidable pressure ulcer statement, we can work towards eliminating all avoidable pressure ulcers.

Risk assessment

There is not one single factor that has been found to explain pressure ulcer risk; it is usually an interplay of different factors that increases a person's susceptibility to the effects of pressure (Coleman et al, 2014). Research has shown that the three most frequently occurring risk factors are mobility, perfusion and skin/pressure ulcer status (Coleman et al, 2014). An improved understanding of the relative contribution risk factors make to the development of pressure ulcers and an improved ability to identify patients at high risk of pressure ulcer development would enable us to better target resources in practice. This will allow for the identification of patients at risk of developing pressure ulcers, and trigger the implementation of preventative treatment at an early stage of the patient's journey.

NICE quality standard 89 recommends that all patients

should have a risk assessment within 6 hours of admission to a hospital or a care home with a nursing facility. Patients with at least one risk factor — defined as significantly limited mobility (e.g. people with a spinal cord injury), significant loss of sensation, a previous or current pressure ulcer, malnutrition, the inability to reposition themselves or patients with significant cognitive impairment — require a pressure ulcer risk assessment at their first face-to-face visit with community nursing services.

A patient's pressure ulcer risk is likely to change as his or her condition changes. It is, therefore, important that the risk assessment should be repeated if there is a change in a person's clinical status. As it is not always easy to recognise a change in clinical status, a reassessment should be carried out after a surgical or interventional procedure in hospital, and after a person's care environment changes following a transfer in any setting. Good practice would also recommend weekly reassessment in an acute care environment.

There are numerous different risk assessment tools available, such as the Braden Scale, Waterlow Score and PURPOSE T (Pressure Ulcer Risk Primary Or Secondary Evaluation Tool), and there is no single tool that has been recommended over the others, however they are designed to aid a nurse's clinical judgement and not to replace it (NICE, 2014). It is the responsibility of service providers to ensure that all staff are sufficiently trained in pressure ulcer prevention and risk assessment, and for the individual practitioner to ensure that he or she is aware of pressure ulcer risk factors and how to assess a patient's risk.

Skin assessment

NICE quality standard 89 recommends that if a patient is

identified as being at high risk of developing a pressure ulcer, he or she should have a skin assessment. As part of the skin assessment, pain over pressure areas should also be taken into account. The results of the skin assessment should be used to inform care in the form of suitable preventative interventions.

Skin assessment has long been seen as a separate assessment to risk assessment. The new PURPOSE-T risk assessment tool is the first that incorporates a skin check, as research has shown that there is a strong association between Category I pressure ulcers and subsequent Category II pressure ulcers (Coleman et al, 2013).

NICE quality standard 89 recommends that a skin assessment should be carried out every time a patient is identified as high risk following an assessment or reassessment of pressure ulcer risk. In an acute care setting, a high-risk patient whose condition is not changing might only require a weekly risk assessment, but the patient's skin should be checked more frequently — in the author's experience, a minimum of once per day should be recommended.

Patient and carer education

Where appropriate, patients and carers should receive education and information about how to prevent pressure ulcers and they should be encouraged to take ownership of their care. Patient education should include how to check skin and the benefits of and how to achieve effective repositioning. Resources such as the Stop the Pressure website (www.nhs.stopthepressure.co.uk) and NICE (2014) have information specifically designed for patients and carers.

Repositioning

People at risk of developing pressure ulcers, who are unable

to reposition themselves, must be helped to change position. There is a lack of evidence with regards to the frequency and degree of repositioning that is sufficient for preventing pressure ulcers (Gillespie et al, 2014). NICE recommends repositioning at least every 6 hours for adult patients at risk, and every 4 hours for patients at high risk (NICE, 2015). If, however, a patient is showing signs of pressure damage, repositioning should be more frequent than this. The recommended frequency of repositioning is higher for children and young people.

Equipment

All patients who have been identified as being at risk should be provided with a pressure-redistributing surface that will meet their needs. Examples of factors that should be taken into consideration when choosing a pressure-redistributing surface include:

- ▶▶ The person's level of mobility
- ▶▶ The results of the skin assessment
- ▶▶ The person's level of risk
- ▶▶ The site that is at risk
- ▶▶ The person's weight
- ▶▶ The person's general health.

In the community it is also essential to find equipment that will compliment a patient's lifestyle and abilities, rather than restrict him or her, and that will allow for safe transfers if appropriate.

Devices include high-specification mattresses, pressure-redistribution cushions and equipment that off-loads heel pressure. Despite there being numerous randomised-controlled trials looking at pressure-redistributing surfaces, there is a lack of good quality evidence with regards to which surfaces are the most effective. The only evidence-based recommendations are that high-

specification foam mattresses should be used for at-risk patients over standard hospital mattresses, and there could be a benefit from the use of natural, not synthetic, sheepskin overlays (McInnes et al, 2011).

Medical device-related pressure ulcers

The 2015 NICE quality standard includes a placeholder statement for the prevention of medical device-related pressure ulcers. This means that it is acknowledged that there is no current guidance to base the standard on, and it demonstrates the need for evidence-based guidance in this area. If patients have a medical device *in situ*, such as oxygen masks, splints, casts or endotracheal tubes, the skin should be checked around these devices as part of the patient's skin check. Devices should be repositioned where possible to alleviate the pressure.

Maintaining skin integrity

The maintenance of skin integrity is not included in NICE quality statement 89, but is an essential factor in preventing pressure ulcers and is included in the SSKIN bundle (stop the pressure, 2015) and the NICE pressure ulcer guidelines (NICE, 2014). Moisture, especially from urinary and faecal incontinence, has been found to be a risk factor for pressure ulcer development (Coleman et al, 2013). Although incontinence-associated dermatitis (IAD) is not the same as a pressure ulcer and, therefore, should not be reported and investigated in the same way, a person with IAD is at higher risk of developing a pressure ulcer and can also develop a combined pressure-IAD lesion. The maintenance of skin integrity through the appropriate management of incontinence, skin cleansing and use of emollients

and/or barrier creams is therefore required in the prevention of avoidable pressure ulcers.

Nutrition

Nutrition is another area not included in NICE quality statement 89, but it is an essential factor in preventing pressure ulcers and is included in the SSKIN bundle (stop the pressure, 2015). There is limited evidence-based research on nutrition in the prevention of pressure ulcers, but general consensus indicates that nutrition is an important aspect of a comprehensive care plan (Dorner et al, 2009), and is a risk factor in a number of different risk assessments. Helping the patient have the right nutrition and hydration will improve his or her skin integrity, along with his or her ability to heal.

Conclusions

Pressure ulcers cause patients unnecessary suffering and harm in the majority of cases. In order to eliminate avoidable pressure ulcers, a multidisciplinary care approach is required, along with a thorough understanding of the individual risk factors for our patients. Adherence to NICE quality standard 89 will demonstrate that high quality, safe care is being provided and should contribute to the reduction in avoidable pressure ulcers. **WE**

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