

SURVEYING NATIONAL PRESSURE ULCER OCCURRENCE

Abstract

In November 2011, a survey was carried out across England to determine how pressure ulcer occurrence data were collected and reported. An electronic survey tool was used to design the survey and it was circulated via the regional tissue viability groups. A total of 145 responses were received and the results demonstrated considerable differences in both what was collected and reported. These data were used to underpin a consensus meeting held in Birmingham where tissue viability nurses debated the issues.

KEY WORDS

- ▶ Pressure ulcers
- ▶ Reporting
- ▶ Incidence

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References

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The Bedfordshire and Hertfordshire Tissue Viability Nurses Forum (2010) Regional Round UP — BHTVNE. *Wounds UK* 6 (4): 24

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During 2011, the issue of pressure ulcers rose up the political and NHS agenda with several documents suggesting that they were a valid indicator of an organisation's general quality of care and that their occurrence should be monitored and prevented (Department of Health [DH] 2010; National Institute for Innovation and Improvement [NII], 2010).

However, many of the tissue viability nurses who were to be tasked with implementing any data collection, as well as enforcing a zero tolerance to pressure ulcer development, had grave concerns — namely that the data on pressure ulcer occurrence that were being used, both to illustrate the local picture and to compare the situation with other organisations, were not as straightforward or as easily comparable as NHS managers believed.

However, the author only had personal experience and anecdotal views to support this opinion, therefore, in February 2011, a survey was carried out among the 27 organisations within the then East of England Strategic Health Authority. Twenty-three from a possible 27 organisations completed the survey and results indicated that while most trusts collected prevalence data, there was no standard way of doing this. Nor were standard definitions used — for example, 14 of the trusts did not use a definition of 'unavoidable', two had a locally agreed definition and others used NPUAP/ Bedfordshire and Hertfordshire Tissue Viability Nurses Forum definitions.

These results provided the impetus for an all-England survey by illustrating to other areas of the country the discrepancies that had been highlighted — namely, that different organisations were counting and categorising pressure ulcers in different ways, which made it impossible to benchmark.

Minor changes were made to the electronic survey used in the East of England, for instance, increasing the number of descriptors available for a 'serious incident' (see *Table 1*) as it appeared that there were different versions in use around the country, and including a question about the respondents' location. The survey was then widely publicised via the regional tissue viability nurse networks and at the annual Wounds UK conference in Harrogate.

A tight deadline of two weeks was set for completion of the survey to encourage participation and it was launched at the 2011 Harrogate Wounds UK conference to ensure maximum exposure and encourage as many tissue viability nurses as possible to participate.

It was impossible to identify how many organisations within England had a tissue viability nurse in post as there is no reliable database and the numbers of nurses cannot simply be implied from the numbers of services — some organisations have as many as 12 tissue viability nurses, while others may have only one.

The timing of the survey also coincided with many organisations changing

Table 1

Questions that featured in the national pressure ulcer survey

- ▶▶ When collecting information on pressure ulcer occurrence which terms do you use? Please tick all that apply:
 - EPUAP 1–4 (old version)
 - EPUAP 1–4 (new version)
 - Deep tissue injury (DTI)
 - Unstageable
 - Moisture lesion
 - Other (please specify):

 - ▶▶ The EPUAP/NPUAP (2009) (categories 1–4) is the grading tool currently included in the National Nursing Quality Indicators. Do you believe the following terms should be included?
 - No changes required
 - Yes to unstageable
 - Yes to DTI
 - Yes to unstageable and DTI
 - Other (please specify):

 - ▶▶ Would you prefer to use a simpler grading system?
 - ▶▶ Do you measure pressure ulcer prevalence?
 - ▶▶ How often do you measure prevalence?
 - ▶▶ If you do collect prevalence, how do you collect the data?
 - ▶▶ Do you measure pressure ulcer incidents as serious incidents?
 - ▶▶ What grade/category do you report as a serious incident?
 - ▶▶ Which grades do you report to the SHA as serious incident requiring investigation/serious untoward incident (SiRi/SUI)?
 - ▶▶ Do you follow a root cause analysis (RCA) procedure to investigate the incident?
 - ▶▶ Which grade/category would you carry out an RCA for?

 - ▶▶ Are you required to raise a safeguarding alert if a patient has
 - Multiple grade 2s
 - A grade 3
 - Multiple Grade 3s
 - A grade 4
 - Multiple Grade 4s
 - DTI
 - Multiple ulcers of different stages
 - Other (please specify)

 - ▶▶ Do you have a standard definition to denote at which point it is said a pressure ulcer occurred in your care?
 - ▶▶ Do you use a standard definition of 'unavoidable' pressure ulcers?
- Three questions regarding the area of care:**
- ▶▶ What care setting do you work in?
 - ▶▶ What region are you based in?
 - ▶▶ How many beds do you have (acute)/what is your population size (primary care)?
(optional field allowed the respondent to name their organisation)

their boundaries and amalgamating or disengaging from each other, therefore, the sample size was uncertain. However, it was the author's belief that there were approximately 220 separate NHS organisations at the time (not all of which would have a tissue viability service) and in an attempt to capture as many as possible the survey information was sent out via regional tissue viability specialist groups.

THE SURVEY

The questions included in the survey can be seen in *Table 1*. All were presented as closed questions with a fixed number of options apart from the last question regarding population size in community. A total of 145 responses were received.

RESULTS

The areas that demonstrated the most

EPUAP/NPUAP (2009) *Pressure Ulcer Treatment*. Available at: http://www.epuap.org/guidelines/Final_Quick_Treatment.pdf (accessed 31 August, 2012)

NII (2010) *Harm Free Care*. Available at: http://www.institute.nhs.uk/safer_care/harm_free_care/harm_free_care_homepage.html (accessed 31 August, 2012)

NICE (2005) *Pressure ulcers: The management of pressure ulcers in primary and secondary care*. NICE, London

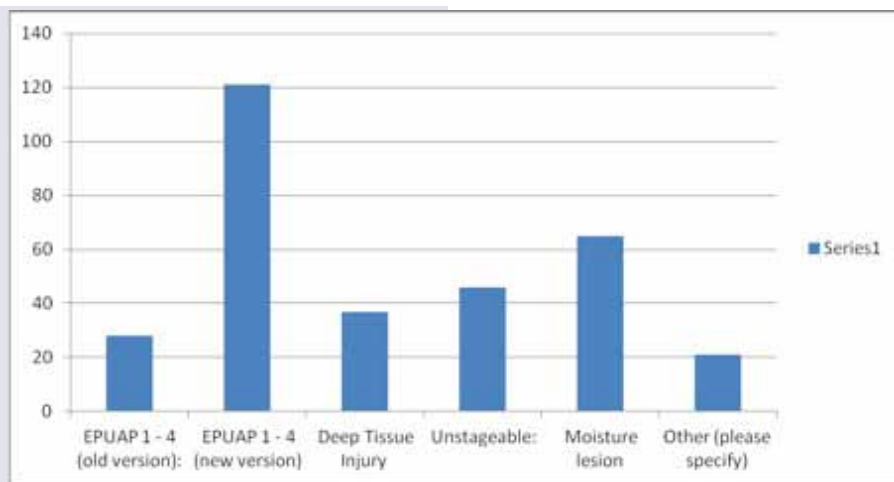


Figure 1: The various terms and systems used nationally to classify pressure ulceration.

discrepancy centred around grading, prevalence, definition of what constitutes unavoidable pressure ulcer and timescale for attribution of damage. Any of these alone could skew any information gathered, for example, it is possible to reduce the number of pressure ulcers deemed to have occurred in an organisation by broadening the parameters of what would be regarded as unavoidable. With the changes being made to how care is commissioned and reimbursed, defining where pressure damage occurred and, therefore, where to attribute the cost may have significant effects on funding.

Figure 1 shows the spread of different grading — while the majority of organisations were using one of the EPUAP systems, which use four different categories, some were counting up to seven categories in their prevalence surveys (additional categories included ‘deep tissue injury,’ ‘unstageable’ and ‘moisture lesion’).

It is apparent, therefore, that the percentage of pressure ulcers in any one category could vary considerably throughout different areas, depending on whether the local tissue viability nurses were using four, seven or a different number of classifications.

Almost three-quarters of organisations measured prevalence (70%), however, the frequency with which this was done and way in which data were collected varied considerably (Figure 2). Forty-six organisations collected prevalence data on an annual basis, however, thirty-two did not collect prevalence data at all. The frequency of collection varied from monthly to every three years.

The mechanism of data collection obviously has a significant impact on the thoroughness and reliability of any conclusions that can be drawn, however, only four organisations suggested that they cross-checked the data in any way.

There were also considerable discrepancies in the reporting of pressure ulcer occurrence again with organisations including ‘moisture lesions,’ ‘unstageable’ or ‘deep tissue injury’ in their serious incident reporting systems (Figure 3). Perhaps of greater concern in terms of workload for tissue viability teams was that some organisations required category 1 damage to be reported as a serious incident.

There was even greater disparity in how organisations attributed responsibility for where and when damage occurred, with time scales ranging from ‘damage not present on admission’ through to ‘damage not noted within the first 72 hours’ (Figure 4). Some organisations would only determine attribution after a root cause analysis had been carried out.

Almost two-thirds of organisations said they used a definition of ‘unavoidable’ when classifying pressure ulcers — although two standard definitions (NPUAP, 2011 [n=26]; The Bedfordshire and Hertfordshire Tissue Viability Nurses Forum, 2010 [n=22]) were in use — the remaining group of organisations who said they did use a standard definition (n=30) worked to a locally agreed definition (n=30) (Figure 5).

DISCUSSION

From the small amount of information

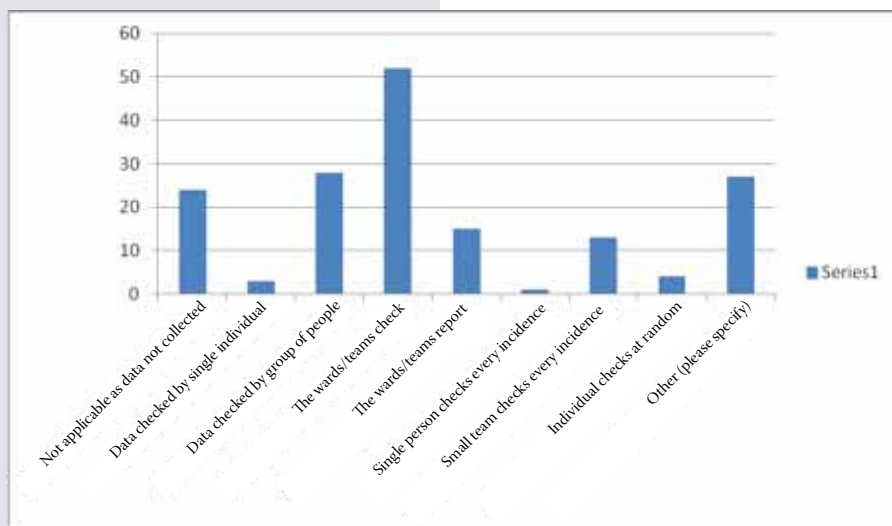


Figure 2: Variations in the way in which prevalence data was collected.

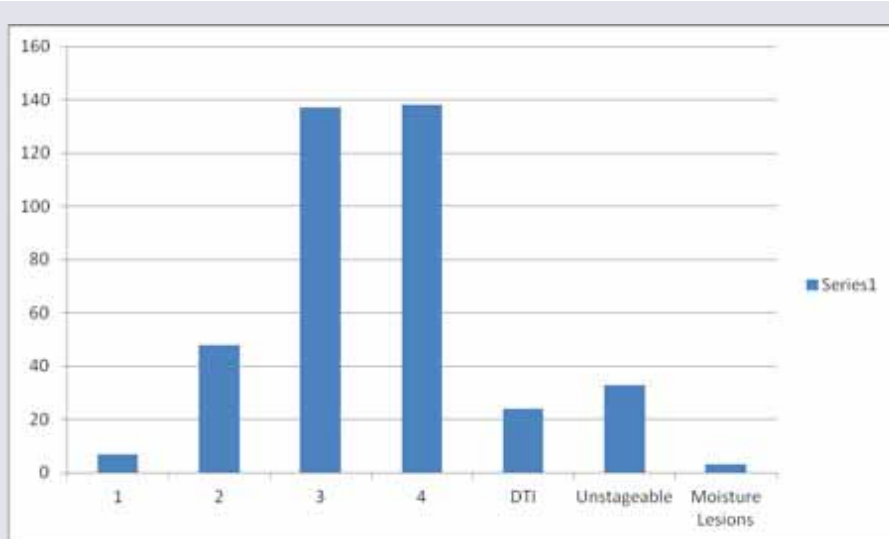


Figure 3: What grade/category is reported as an serious incident?

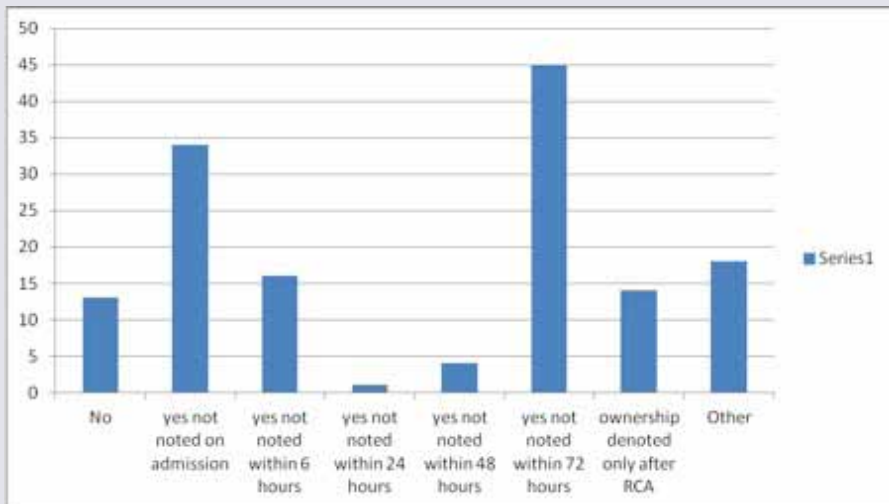


Figure 4: Do you have a standard definition to denote at which point it is accepted that a pressure ulcer occurred in your care?

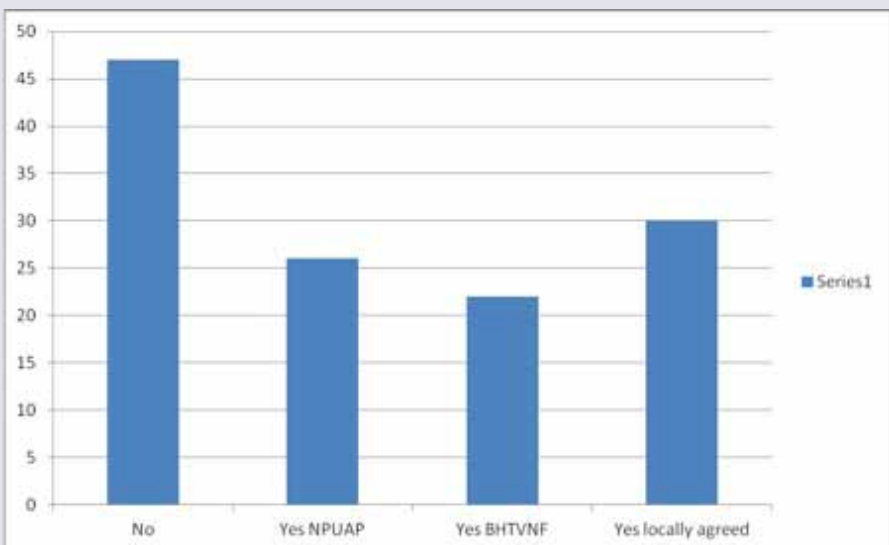


Figure 5: Do you use a standard definition of 'unavoidable' pressure ulcers?

presented here it can be seen that there are major inconsistencies in the information generated and collected around pressure ulcer occurrence. Therefore, attempting to make any comparisons between organisations is futile at present.

There is a large amount of work being carried out in an attempt to try to bring some standardisation to this data collection (for example www.stopthepressure.com), but again, there is no strategy to unify this, which is unfortunate.

It is hoped that the National Institute for Health and Clinical Excellence (NICE, 2005) guidance, which is currently being updated may help by agreeing standard terms and timescales, a workable definition of 'unavoidable', which grades/categories to use, and a standardised method for attributing responsibility. However this is unlikely as guidelines rarely contain this level of detail and even then it is unlikely to be available until 2014.

Until there is a system of standard definitions, confusion may result in tissue viability nurses being unfairly penalised or lauded for results based on non-uniform data and many are already experiencing significant increases in their workload in an attempt to reduce or eliminate pressure ulcers.

CONCLUSION

It seems it is necessary to continue to ask questions about methodologies when reading, interpreting and applying pressure ulcer occurrence data, otherwise the situation remains as confusing as it has always been.

Future policy needs to focus not just on collecting data, but also on what is collected and more importantly why it is collected. Only when the purpose for which the information will be used is clear, can we start to make informed choices about what we collect and how we collect it.

The triangulation of data using prevalence and incidence needs to be explored, to determine if it is beneficial. However, if there is no benefit, then prevalence should not be collected without a clear aim as it is wasteful of time and resources. Clinicians need to review why they are collecting information and what they are doing with it when they have it. [WUK](#)