What's the harm?

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I am increasingly starting to wonder if we are too busy to ask the really difficult questions that may challenge our accepted norms.

I feel like I am constantly chasing my tail, still doing the same things – particularly in pressure ulcer prevention, where it seems everything is driven by data that is, let us face it, often pretty meaningless. What category of pressure ulcer did they get? What level of harm occurred? Why not link the category to the harm? No, let us not!

Patient safety is defined by the World Health Organization (2023) as: "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum." Within the broader health system context, it is "a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur" (WHO, 2023).

When we look at the definition, are we systematically failing, are we blinded by focusing on the one thing we have always considered important or a particular data set, so that we miss the real questions about what is happening?

It is really important that we have a clear picture of harm being caused to our patients, but it must mean something. It should be something that leads to learning and a change in practice, so it does not continue to happen and patients' lives are improved. Despite the move to the Patient Safety Incident Response Framework, which has improved the way we handle the reporting of patient safety incidents, I don't believe we are looking at the right things.

Is the occurrence of a pressure ulcer in our care always a harm? Sometimes it is an inevitability, sometimes it is a risk-based choice whereby we save their life and limb, but they may develop a pressure ulcer. Sometimes patients come to us with pressure ulcers, sometimes they have risk-inducing lifestyles, but we incident report them all nonetheless. But then what? What about once they have developed a pressure ulcer? In most instances, we do not know what happens to them. Many patients have pressure ulcers for month – or even years. Some die with them. But why? Do they die because they developed the pressure ulcer? Or did they get the pressure ulcer because they were dying? If they have still got a pressure ulcer 6 months later, especially if it is not progressing, what is going on? Should we be calling this out as harm? Are we failing to provide that patient with evidence-based care because of cost, because of challenges of implementing new technologies, because we do not do proper reassessment and review, or because we do not have proper escalation pathways or access to interested and engaged multidisciplinary teams. None of those things are acceptable.

What about patients who develop incontinence-associated dermatitis – doesn't that fit the definition of harm? They were clearly at risk and we failed to prevent it, although prevention in most cases is pretty straightforward. So why is that not reported as harm?

What about medical adhesive-related skin injury (MARSI)? Again, very predictable. Someone, usually a healthcare professional, has stuck something to the patient's skin and now it is going to be removed. What preventative care took place? What thought went into if it was necessary, who is considering how many times it has been stuck and removed?

As an aside, why can't we just agree on one ECG pad connection? I had a relative travelling through the acute care system who had four different sets of pads applied because the ambulance, A&E, theatre and ICU all had different sticky pads for their various machines. How difficult can it be to standardise pads with a connector that works for any machine?

MARSI can be predicted and mainly prevented, so why is it such a low priority? Even when I was with my relative saying repeatedly "they have very very fragile skin", clinicians were still using strong adhesives and sharp-edged tapes, especially after taking blood **[Figure 1]**.

In another example, *Wounds UK* recently convened a group to update the skin tones document. I asked the group: "Have we been misled by the research and by acceptance of what was made sense then, but doesn't now? By just blindly continuing 'doing the same,' are we missing the real reason why something happens?"

The literature from the late 80s and early 90s clearly indicates that people with black

or Hispanic skin get more category 3 and 4 pressure ulcers, but those papers all suggest that the reason for this is because we miss the early signs of damage. Erythema is difficult to detect on dark skin, so it gets missed so the individual develops a category 4 ulcer. I am less sure about that.

The current international guidelines suggest that superficial pressure ulcers (categories 1 and 2) occur in a different way to categories 3 and 4, stating: "PIs do not progress from Category/Stage 1 through 4" (National Pressure Injury Advisory Panel et al, 2025).

In which case, does a category 1 become a 2, then a 3, and then a 4? I do not think that is how it happens, but I don't have any data to say it does. But the important point is, if it is not this that is happening, what is is it? Because we have accepted that it is because we miss the redness, so we are not looking for what else it might be. There are distinct differences between black and white skin, does it relate to those? Or is it something else? We will not know if we just accept it is because we miss erythema.

So if any of you have any data on the progress of your patients with superficial pressure ulcers, please do let me know – because it is bugging me! ●

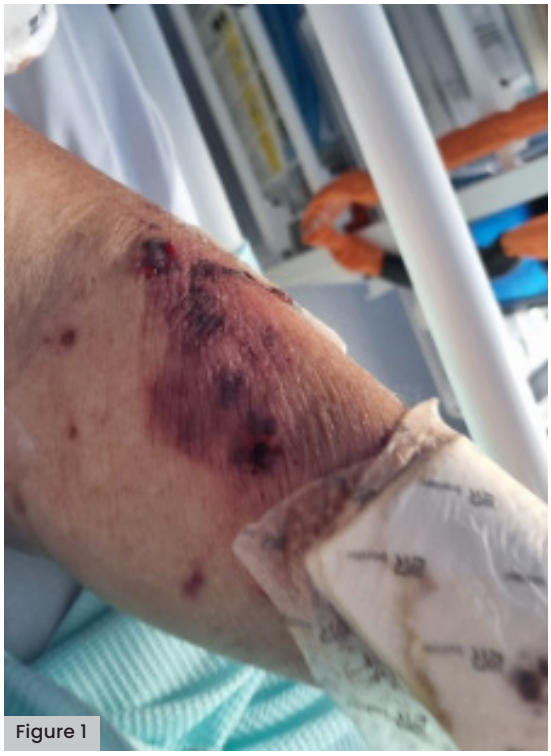

Figure 1

Figure 1. Medical adhesive-related skin injury due to inappropriate tape use.

References

National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (2025) Classification. In: Prevention and treatment of pressure ulcers/injuries: clinical practice guideline. The International Guideline: Fourth Edition. Emily Haesler (Ed). https://internationalguideline.com/classification (accessed 14.09.2026)

World Health Organization (2023) Patient Safety. https://www.who.int/news-room/fact-sheets/detail/patient-safety (accessed 14.09.2026)