

Pressure ulcer categorisation: time and money well spent?



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Pressure ulcer occurrence continues to challenge healthcare providers, despite intensive activity around prevention. Increasingly, organisations are focusing on specific areas where targeted activities may improve patient outcomes. These may be specific anatomical areas, such as heel or mask-related ulcers, or particularly vulnerable populations, such as wheelchair-bound patients or the frail elderly. Identifying such specific risks is complex but crucial, as the standard risk assessment tools may either over-predict risk or miss those at significant risk. Standard interventions, such as those utilised in a SSKIN bundle, may not trigger appropriate preventions, e.g. to avoid mask-related pressure ulcers.

Prompted by the appalling care identified by Operation Jasmine — the UK's biggest enquiry into alleged neglect in six homes — a review of the patients' and their families' experiences made strong recommendations for increasing the strength of reporting of category III and IV pressure ulcers, suggesting that they are notifiable incidents (Flynn, 2015). While perhaps extreme, this reflects how seriously such damage is taken. Such stringent reporting may help with triangulation of data on pressure ulcer occurrence — which current reporting mechanisms fail miserably to do, with many organisations having multiple mechanisms of reporting, none of which tally with one another (Coleman et al, 2015).

It seems that for every example of good care — delivery of targeted interventions, inclusion of groups not previously reviewed — there are still patients who suffer from avoidable harm. A key theme of the Operation Jasmine review was the importance of documentation, both in terms of recording care delivered and police review evidencing what had or had not happened. A consistent theme was a failure to identify early signs of skin damage or even to identify skin damage as a pressure ulcer.

However, despite the plethora of research that suggests it is virtually impossible to reach

consensus on the category of a pressure ulcer, organisations continue to expend a great deal of time and effort attempting to do just that. Tissue viability nurses (TVN) and university lecturers devote hours to teaching classification systems; in England, the TVN then wastes a considerable amount of time each month checking every Safety Thermometer capture, validating the category of damage reported, and ensuring that a wound is actually a pressure ulcer. In the rest of the UK, whilst the Safety Thermometer is not used, TVNs still validate the category of damage prior to any onward reporting via Serious Incident systems.

It has been proposed repeatedly that the categorisation of damage should be simplified to 'superficial' or 'deep' — yet this suggestion has not been taken up, despite the most recent guidelines clearly identifying differing histopathology. Numerical categorisation appears to be a distractor; it serves no purpose in planning care, and does not guide the treatment plan with regards to equipment used or dressing selected. In terms of audit, it is worse than useless: even where the category has been validated by an 'expert' such as a TVN, research indicates this categorisation will be inconsistent across a group of similar experts.

So, is this a wasteful activity? Could this resource be better spent identifying those most at risk, and implementing and documenting appropriate care? Could time spent teaching pressure ulcer categorisation be used instead to outline the mechanisms by which they occur, ensuring clinicians properly understand the impact of shear forces, particularly in the seated patient and the semi-recumbent patient in a bed?

The NHS has limited resources; it is of paramount importance that we use them wisely to deliver high quality harm-free care to patients. **WUK**

Coleman S, Smith I, Brown S, Wilson L and Nixon J (2015) Executive Summary: Pressure ulcer and wounds reporting in NHS Hospitals.

Flynn M (2015) *In Search of Accountability: A Review of The Neglect of Older People Living in Care Home Investigated in Operation Jasmine*. Available at: <http://gov.wales/docs/dhss/publications/150714ojreporten.pdf> (accessed on 26.08.2015)