Why doesn't knowledge of skin care translate into nursing actions for patients?

The title of this debate is clearly contentious. Is it true that we are not caring for patients' skin or is this an unfair generalisation? My response to my own question is that we are not seeing the care of patients' skin as a core, routine component of nursing patients with vulnerable skin and wounds. I am basing my response on clinical observations, a series of conference papers, and conversations with a number of well-known nurses working in the field of tissue viability. They say the following: 'we are not getting the basics right'. I have observed patients being nursed on pressure-relieving devices who have pressure ulcers together with continence problems, and whose skin across the buttocks is damaged to the point where the clinicians caring for them believe the situation is irreversible; septicaemia is predicted. An alternative opinion has been proposed that the skin damage is due to maceration and a set of nursing actions taken (barrier products, wound debridement, selection of moisture wicking dressings, diversion of faeces and urine into collection devices and so forth). The maceration has quickly resolved and the wounds have progressed to healing. These patients were dying of their underlying conditions, but death from septicaemia is clearly not acceptable. The purpose of this debate is to raise questions as to why experienced nurses are saying: 'we are not getting the basics right', and to find solutions. **PG**

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Are we getting the basics right when it comes to caring for patients with vulnerable skin and wounds?

DV: Traditionally, skin care is seen as one of the cornerstones of professional nursing care, and the incidence of skin breakdown as a measure of the quality of that care (Department of Health [DoH], 2003). Unfortunately, in the UK there appears to be a problem with distinguishing skin care provided for social and hygiene purposes from that provided as a specific therapeutic nursing intervention. Thus, it is still not uncommon for care to concentrate on keeping a patient's skin clean and dry by using soap and water and towel drying, with little regard for the evidence suggesting that this may not be best practice, or adequate consideration given to the wide range of factors that may predispose the individual to skin breakdown (Voegeli, 2008). This aspect of 'basic' care is made more complex by the sheer variety of patients who are at risk of skin breakdown, and therefore require skin care regimens. Skin care often means different things to different people. In this context there is much we could learn from our North American colleagues, where interventions to reduce the risk of skin breakdown are clearly articulated and form the basis of nationally agreed protocols.

JB: It is important to recognise that in some healthcare settings we are absolutely getting it right. There are many examples of excellent care being provided to patients/clients. At a recent meeting of the Wound Management Association of Ireland, Zena Moore commented on the excellent care she had observed in care settings while undertaking her PhD. Unfortunately, this is not happening across all healthcare settings.

TY: For me the argument starts at an earlier point, are we assessing patients' skin. In 2004 I took part in an observational study along with members of the North Wales tissue viability team, Clare Morris, Menna Lloyd-Jones and Barbara Pritchard (Young et al, 2004). Our aim was to establish what constituted pressure ulcer prevention in clinical practice. This had arisen due to concerns that clinical guidelines, best practice and education were not being reflected in care delivery at the bedside. We sat observing nurses caring for patients in medical wards of all three district general hospitals for over 100 hours, covering the patient's day from 7.00AM–11.00PM. Unfortunately, we saw little pressure ulcer prevention taking place, the basis of which has to be inspection of the patient's skin. We concluded that pressure ulcer prevention had become subsumed into general nursing care, and, as such, was no longer seen as a specific element of care delivery.

TY: *I would like to see the term skin failure used more often and given the same precedence as the failure of other organs such as the liver, kidney, heart and lung.*

JB: *Raising the profile of tissue viability to the highest level of management is also essential to succeed in implementing change.*

TH: Unfortunately, this answer is not as straightforward as the question. The focus of the nursing profession has changed dramatically since I was in training (note the change from profession to training right there!). Medical technology, nursing education (I cannot imagine when I was in training there would have been such a thing as a doctorate of nursing) and nursing autonomy has grown, as well as the actual scope of nursing practice. This has made it difficult to care for our patients in the same way as we did 30–40 years ago. In many countries, particularly in North America, nurses have a greater scope of practice and education, and the focus has changed from basics such as skin care to an advanced nursing practice (nursing consultant) role. As our independence and scope has broadened, perhaps we have moved away, so to speak, from the actual bedside or basic nursing.

More importantly, we need to be proactive and do what we are doing now and see how that is affecting the patients and the profession as a whole. Invariably, skin, nutrition and the very basics of how we care for patients will be impacted if we continue to move away from this practice.

If not, can you pinpoint some explanations as to why this is happening?

DV: The reasons why we are not getting the basics right are fairly complex. Despite the general acknowledgement of the importance of good skin care, it is an area that has become neglected in the curriculum and one that is often delegated to those with the least training or experience. Problems occur during the process of assessing the patient's skin. Although risk assessment tools have become universally used, the assessments tend to be poorly done, and reassessment often lacking. In many areas assessment has become rooted in a 'tickbox' culture, lacking any real thought or judgement. This is not helped by the suggestions that there is no real evidence that adoption of formalised risk assessment tools has had any real impact on the incidence of pressure ulcers (Pancorbo-Hidalgo et al, 2006). Also, we have become too reliant on the technological advances, particularly in the area of pressure-relieving devices, and forgotten the huge difference that basic nursing care makes. It is not uncommon to see patients being nursed on an increasingly complex variety of beds, mattresses and overlays, and the basics of repositioning, skin care and continence care being missed. We need to remember that these devices are only a small part of preventing skin breakdown, and there is limited evidence as to their effectiveness (McInnes et al, 2008), so the basics are still needed. Interestingly, there is a growing body of evidence, although not perfect in research terms, highlighting the apparent remarkable outcomes that can be achieved when concerted effort is made to reinforce and re-evaluate basic skin care (Bales and Padwojski, 2009). Finally, we need more investment in high quality research into the mechanisms of skin breakdown and the most effective interventions. Sadly, this has never been a glamorous or high priority area, making attracting funding exceptionally difficult.

JB: Let's start with education. We should be providing high quality tissue viability education to student nurses, medical students, healthcare support workers, carers and anyone else who is involved in delivering care to patients/individuals, and this education should be tailored to the particular group it is being delivered to. We also need to consider qualified staff providing regular updates and post registration education.

Again, much of this education is currently available but access may be limited.

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TY: Were our findings (Young et al 2004) due to a lack of knowledge and training or was it more to do with nurses' attitudes, which was initially highlighted by Miles Maylor's work into the locus of control and its influence on pressure ulcer care (Maylor, 2000). In a recent presentation, Samuriwo (2009) investigated the value that nurses placed on pressure ulcer prevention and found that they valued this aspect of care highly. Unfortunately, a slightly less promising reality was presented by Demarre et al (2009), who found that in nursing home settings there was a lack of knowledge about pressure ulcers and the attitude to the subject was rather negative. When a more positive attitude was displayed, the care provided improved in quality. Therefore, is the key to providing skin care linked to an attitude shift in the nursing population?

TH: There are many areas of practice where healthcare aids or care-aids are doing the actual bedside care and the nurse is delegating these tasks and not actually performing. The patient has also changed; we have much sicker and more complex patients to care for than ever before. These patients are even more vulnerable with our not having the diligence that we had time and focus for probably 25 years or more ago. The nurse is now often involved in ethical decisions, advocacy, technology advancements, research, prescribing drugs, giving drugs by advanced technique, independent assessments and making clinical as well as holistic decisions. When all the changes and variables are considered, we could not help but move from what we defined as the basics of nursing (therefore not getting them right) to what we would now perceive as an advancement in the profession.

How can we make a sea change in nursing care with the care of patients' skin a core nursing action? a. More training in skin and wound care? b. Higher staff to patient ratio? c. More supervision of nurses from lead tissue viability nurses, nurse managers and nurse consultants? d. Routine clinical outcome measurements and audits? e. Inclusion of skin care as a Quality Outcomes Framework Indicator?

DV: We are already seeing pressure ulcer incidence rates being monitored and linked to quality outcomes, and many trusts have set themselves ambitious targets, although have given little thought to how these might be achieved. However, given the severe reduction in the health economy that will inevitably impact over the next few years, whatever measures are taken will have to be cost-effective and achievable, without increasing overall staff costs. Considering this, it is unlikely that increasing staff/patient ratios will be an option, and if we cannot get it right now with what we have, more of the same will not necessarily make any difference. Within these constraints, increasing the emphasis on education and training is one way forward, both within pre-registration training and post-qualifying. Similarly, the whole healthcare team needs to take ownership of the problem, and experience good, strong, clinical leadership. Experience from areas where clinicians have a clear voice, which is heard and supported by management, shows real improvements can be made. Overall, the problem has to become an organisational one, and not just left to an increasingly shrinking body of nurse specialists.

JB: All of the above are important, again we have initiatives which incorporate many of these points. An example of this is the ongoing project that Quality Improvement Scotland (QIS) are currently undertaking. The groups involved in this work include the National Association of Tissue Viability Nurses Scotland, academics, the Care Commission, nursing leads, GP representatives, procurement leads, care home representatives, NHS Education for Scotland and, importantly, patient representatives. The project has produced a tool kit which contains among other items, educational modules, best practice statements, wound grading tools, excoriation tools, and audit tools. Currently, wound and risk assessment are being explored. The aim is to get the basics right and ultimately to have high quality and equitable care across all settings in Scotland. The website can be accessed at: www.tissueviabilityonline.com.

Similar work is currently underway in Ireland with the recent launch of the *National best practice and evidence-based guidelines for wound management* (Health Service Executive [HSE], 2008).

As you can see from these examples, there is a great deal of excellent work being undertaken, our challenge is to make sure it gets to the people who are delivering care.

TY: I would like to see the term skin failure used more often and given the same precedence as the failure of other organs such as the liver, kidney, heart and lung. This may help to raise awareness and treat the skin with the reverence it requires to prevent institution-induced skin failure in the form of pressure ulceration.

We have excellent training resources, not least the free on-line resource, the European Pressure Ulcer Advisory Panel's (EPUAP) pressure ulcer classification educational tool, PUCLAS2 (www.puclas.ugent.be/), which teaches people how to inspect for signs of pressure damage. However, education alone does not always have an impact on practice. It should be part of a wider change implementation strategy that incorporates raising

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awareness and emphasising the importance of skin care.

The issues of staff/patient ratios and the suggestion of supervision by tissue viability nurses I think are detracting from the situation. However, the responsibility of the healthcare system to ensure safe and effective resources within the working environment is a necessity. The lead has to come from the directors of nursing along with the ward sisters who should ultimately guide skin care practice in their clinical areas.

The situation has not been helped by guidelines for pressure ulcer prevention (Royal College of Nursing [RCN], 2005; NHS Quality Improvement Scotland, 2009). They do not specify a minimum frequency for skin inspection; this, unfortunately, has also been omitted in the imminent publication of the international pressure ulcer prevention and treatment guidelines (www.pressureulcerguidelines.org).

If it was specified that an individual's skin had to be assessed at least daily in a hospital or care home setting, and weekly in the patient's own home, this might have given more emphasis to the importance of this task and provide a baseline for audit purposes. However, I acknowledge the problems with being so prescriptive and the burden this can place on resources, as demonstrated by the edict that all individuals with healed venous leg ulcer should have a Doppler ultrasound examination every three months giving most clinicians an unattainable target, and, according to Vowden in 2003, an unnecessary one.

TH: All these aspects will help to focus nurses on caring for patients' skin. Nursing leaders need to put patients' skin on the radar for overall organisational performance. The skin, wounds and the actual complexity of a patient with a wound should not be underestimated and often an advanced practice nurse or a whole interdisciplinary team will be required. In the past 25 years, we have moved significantly in technology, yet, to this day, we still have patients dying of avoidable wounds such as pressure ulcers. We have to motivate and make the profession accountable through the use of audits, as not getting the basics right can ultimately lead to a patient's death. Finally, organisations need to put wounds such as pressure ulcers under their patient safety guidelines.

Will the advent of an all-graduate nursing workforce improve the delivery of 'the basics' or make it worse?

DV: Critics of the move to an all-graduate profession will no doubt claim it will make things worse, using the 'too posh to wash' argument. However, the students of the future will be no different to those of today, who in most cases want to be 'good' nurses, able to deliver the basics. The outcome will depend to a large extent on the curricula taught and the role models they encounter in practice. This provides an excellent opportunity to ensure that the 'basics' are clearly defined and presented in an evidence-based manner, to encourage a more critical practitioner. A personal (tongue-in-cheek) view, and perhaps controversial one, is that it would be good to see nursing once more take centre stage in UK schools of nursing. Raising the academic level of nursing, and bringing it in line with other healthcare professionals, will have the knock-on effect of increasing research. If handled correctly, this will increase our ability to analyse and formulate the key clinical questions, and with the emergence of incentives such as the clinical academic career pathways, robust patient-outcome intervention-based research can be delivered. Nursing research can produce real results, as evidenced by the general success of the last research assessment exercise (RAE.) However, we still need to work at ensuring results are incorporated into current teaching and practice. Both of which requires greater partnership working between academics and clinicians.

JB: If skin care is viewed as being fundamental when caring for patients, it will improve the delivery of 'the basics'. Additionally, as we produce more high quality evidence in tissue viability, we will engage students. From my personal experience as a lecturer in wound management to student nurses in the honours year of their BSc, I have found that this optional module is always fully subscribed. The students undertake it because they recognise that wound care is a hugely important part of a nurse's role.

TY: That is impossible to predict, as a nurse educator I have a strong view that knowledge is the key to

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JB: *When pressure-redistributing surfaces were first introduced there was a misconception that patients no longer needed to be repositioned. Reversing this trend has been, and remains in some areas, a huge challenge...*

service improvements and individual development. However, perhaps we need to be learning from the patients and the carers, not just the text books. A fine example is the lesson we all can discover by reading the report 'patients not numbers, people not statistics' from the Patients Association (www.patients-association.com/DBIMGS/file/Patients%20not%20numbers,%20people%20not%20statistics(1).pdf).

TH: Having done graduate work for many years, I feel I can safely say that the answer is no. In my experience, the level of education will not make a difference to the actual bedside care of the patient.

Can technologies help?

DV: In short, I believe they can, but only if technology is viewed in its widest context and developed in response to a clearly identified clinical need. At the moment technological developments have tended to focus on a narrow area of skin care; namely, the prevention of pressure ulcers. There has been an enormous investment in the development of products all aimed at reducing skin breakdown due to pressure damage, leading to a bewildering choice of products, and with limited evidence as to their effectiveness. However, with the huge leaps that have been made in materials, science, electronics and engineering, there are exciting new opportunities. The emergence of so-called 'smart textiles' has led to the development of clothing that can monitor an individual's vital signs and transmit them to a central monitoring facility. These techniques can be adapted to monitoring pressure damage, and the rapidly changing physiology of the skin, potentially alerting clinicians to impending problems before the current visible clinical indicators occur. Before we go too far down this path, I believe that we need to ensure that technology is used to help us fully understand what we are dealing with, that is to say, what exactly are the physiological mechanisms of skin damage. Once we really know what we are looking for, then we can develop the technology to help manipulate and monitor these.

JB: Technologies can help a great deal, but they cannot replace the fundamentals of good skin care. When pressure-redistributing surfaces were first introduced there was a misconception that patients no longer needed to be repositioned. Reversing this trend has been, and remains in some areas, a huge challenge for tissue viability specialists. We now know that these surfaces are of value in patients at risk and those who already have pressure ulcers, in conjunction with a repositioning regimen.

TY: Technologies that help to detect early skin damage will be a boon to the practitioner and hopefully prevent institution-induced skin failure in the form of pressure ulceration. Nevertheless, any aspect of technology is only as good as the person who uses it, and the issues surrounding education, user-friendliness, cost and availability will surely influence the uptake of any enabling technology. In addition, we have to ensure that the technology delivers in the form of a valid and reliable instrument. To do this, it must be subjected to a rigorous research and development process.

TH: Technology can help, but again, I do not believe there is only one answer. The problems are multifactorial, requiring many different solutions. For example, a top of the range pressure relief surface will not replace nursing, it will certainly help, but never replace the care that the nurse brings to the bedside. On the other hand, in our busy environments, technology can make both patients' and nurses' lives easier, leading to better care when used appropriately.

Is the suggestion that we need technologies to assist in the delivery of skin care an admission of failure?

DV: Far from being an admission of failure, it is an acknowledgement that skin breakdown is not a simple process. Rather, it is a poorly understood, complex interplay of factors. In most cases we are dealing with a problem that we do not fully understand, the development of pressure ulcers being the classic example. There is a real need for some joined-up thinking and adopting a multidisciplinary approach to answering the many questions that remain, and encouraging new ways of thinking. Part of our failure is down to the fact that we have not gone back to basics in our research, or in exploring why the basic simple interventions are so important.

JB: No! We cannot stand still. We do need to get the basics right but

as new technologies are developed we need to decide whether they can benefit our patients/clients. Versajet® (Smith and Nephew) is a new technology being used by tissue viability nurses and podiatrists. This technology means that we can remove debris and sloughy/necrotic tissue from the wound bed quickly and efficiently, to enhance the wound healing process. In some instances this has led to a shorter length of stay in hospital, a huge benefit to the patient that also results in cost-savings for the NHS.

TY: The content of the previously mentioned report (Patients Association) is an example of an admission of failure; the evidence is there with or without advancing technologies.

TH: No, it is an admission that both nurses and the profession have changed. We integrate technology into our every day practice, so integrating skin care as well would be logical.

Is the suggestion of developing technologies to assist patient assessment, monitoring and decision-making a pragmatic proposal given the rapid, and not always observable, skin breakdown in response to stressors such as excessive moisture, pressure, friction and shear in vulnerable patients?

DV: It is for these very reasons that it is a pragmatic approach. Current assessment techniques are based on visual clues that are not always easy to spot, or where it is difficult to actually agree what signs are important. Developing technologies based on a firm understanding of the critical risk factors and physiological changes will take the guess work out of patient assessment and possibly enable continuous monitoring of the condition of the patient's skin. However, even with state-of-the-art monitoring, the outcomes will only be as good as the actions of the nurse interpreting the information and providing the basic care. We are still a long way off having robots providing basic nursing care, or are we?

JB: Pragmatism means common sense. Any technologies, provided that they do not compromise clinical skills and decision-making, and that they assist us in caring for patients/clients with vulnerable skin, should be considered.

TY: I have seen many prototypes of instruments that hope to detect early, non-visible pressure damage. I hope the advent of such technologies is imminent and that they can provide a pragmatic tool to aid in pressure ulcer prevention and the detection of skin failure.

TH: I might be showing my age here, but I believe that this suggestion would be too pragmatic. A nurse or clinician should ultimately be the one who is there to observe when rapid changes happen. As said before, the complexity of a patient's skin, particularly those at risk of developing pressure ulcers, should never be underestimated. **WUK**

References

Bales I, Padwojski A (2009) Reaching for the moon: achieving zero pressure ulcer prevalence. *J Wound Care* **18(4)**: 137–44

Department of Health (2003) *Essence of Care: Patient-focused benchmarks for clinical governance*. DoH, London

Health Service Executive (2008) *National best practice and evidence-based guidelines for wound management*. HSE, Dublin. Available online at: www.irishpracticenurses.ie/img/imguploadsfile/Wound%20Management%20-%20FULL%20DOCUMENT.pd

Maylor ME (2000) Investigating the value of pressure sore prevention. *Br J Nurs* **9(12)**: S50–S51

McInnes E, CullumNA, Bell-Syer SEM, Dumville JC (2008) Support surfaces for pressure ulcer prevention. Cochrane Database of Systematic Reviews Issue 4. Art. No: D001735. DOI: 10.1002/14651858. CD001735.pub3

NHS Quality Improvement Scotland (2009) *Best Practice Statement: prevention and management of pressure ulcers*. NHS Quality Improvement, Scotland

Pancorbo-Hidalgo PL, Garcia-Fernandez FP, Lopez-Medina IM, Alvarez-Nieto C (2006) Risk assessment scales for pressure ulcer prevention: A systematic review. *J Adv Nurs* **54(1)**: 94–110

Royal College of Nursing (2005) *The management of pressure ulcers in primary and secondary care A Clinical Practice Guideline*. National Institute for Clinical Excellence, London

Samuriwo R (2009) The value that nurses attribute to pressure ulcer prevention. Conference proceedings of the twelfth annual European Pressure Ulcer Advisory Panel Open Meeting, The Netherlands

Voegeli D (2008) The effect of washing and drying practices on skin barrier function. *J Wound Ostomy Continence Nurs* **35(1)**: 84–90

Vowden K (2003) Doppler ultrasound for healed ulcers. *J Wound Care* **12(1)**: 12

Young T, Lloyd-Jones M, Williams C, Pritchard B (2004) A multi-centre qualitative observational study to define the nursing practices that constitute pressure ulcer prevention and treatment. *European Pressure Ulcer Advisory Panel Rev* **6(1)**: 11–13