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With a national focus on prevention, how well do we treat pressure ulcers?

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Pressure ulcers continue to challenge clinicians on a daily basis and there is a huge industry focussed on preventing their occurrence, with both national and international initiatives devoted to prevention. In England, an enormous data set (Safety Thermometer) on pressure ulcers is collected on a monthly basis that breaks pressure ulcer occurrences down into 'new' and 'old' (or pre-existing) ulcers across myriad healthcare settings. Quite rightly, many health improvement activities have been initiated to drive down the occurrence of new ulcers, as across the world the mantra of harm-free care has risen to the top of healthcare organisation's strategic objectives.

The failure to prevent a pressure ulcer is seen as patient harm, a reflection on the quality of care delivered, and will result in a discussion at the highest level about the impact on the patient's quality of life, the impact on length of stay and, therefore, on use of resources (Hauck et al, 2017). Whole teams devote time to identifying a number to allocate to the

damage (as if this makes any difference) and to pinpointing where the 'lapses in care' occurred. But in the midst of all of these activities, what happens to the poor patients who actually have the misfortune to develop a pressure ulcer? Does anyone know what happens to them? How much time and effort is devoted to ensure that that patients are on the right pathway of care and the appropriate resources are allocated to make sure the pressure ulcer heals in a timely manner? How often are patients followed up to see how long it takes for the pressure ulcer to heal or for someone to decide that they are not on a trajectory for healing? I would suspect that every tissue viability nurse in the country has a patient in his or her area that has had a pressure ulcer for more than 5 or even 10 years. Is this acceptable? It cannot all be about non-concordance or exacerbation of pathology. How often do these patients get brought to the front of a list, get seen by a multidisciplinary team, referred to a surgeon — or even get a thorough review of medication and/or nutrition? When they do, unsurprisingly, many of them make considerable progress and even go on to heal. Pressure ulcers cost the NHS a staggering amount of money (Guest et al, 2017) and whilst prevention should be the primary goal, shouldn't we also be as focussed on healing those that do occur in the most effective way possible? The profile of tissue viability in the UK is becoming higher. We are starting to see a high-level focus on the outcomes for patients with wounds generated in part to the woeful care described by Guest et al (2017) with patients not having appropriate assessments or a plan of care and failing to heal for many years. It would be wonderful to see the targets stretched to include not just prevention — but also healing.

Jacqui Fletcher

1. Do you think there is insufficient attention paid to the progress of patients once they actually develop a pressure ulcer as the focus is so firmly on prevention and recording of occurrence?

PV: Yes. Despite significant investment in pressure ulcer prevention and an increasing understanding of the mechanisms involved in tissue and cellular damage, there has been little progress in the treatment of pressure ulcers once they occur. As published studies (Hopkins et al, 2006; Bale et al, 2007) illustrate, pressure ulcers have a major impact on patients' daily life. The "Burden of Wounds" study (Guest et al, 2015; 2017) has highlighted both the long duration and cost of these wounds. These findings do not differ significantly from those reported in earlier studies by Dealey et al (2012) and Bennett et al (2004) and serve to illustrate how little has changed for the patient with a pressure ulcer in the last decade.

RS: I agree to a certain extent, as there is a great deal of focus on pressure ulcer prevention and the reporting of the occurrence of a pressure ulcer. On the other hand, there is also an emphasis on investigating pressure ulcer formation, the patient's status and pressure ulcer-related outcomes in different contexts. There are some things that can be improved, such as a greater focus on category/grade 2 pressure ulcers and the development of more intense pressure ulcer-related treatment plans.

SP: In my experience in primary care, I have not found this. I think there is **more** concern when a patient has developed a pressure ulcer than there used to be; especially if it is full thickness as the staff will be disappointed for the patient

concerned and that harm has occurred. They will also be questioning how this could have happened and whether the correct preventative plans had been in place. This might also be the result of knowing that there will be an investigation and a report, which will be reviewed by senior members of the organisation. Since 2012, when NHS Midlands and East started its ambition to reduce pressure ulcers to zero, they are reported much earlier, when they are still small or shallow. And although, initially, numbers of avoidable pressure ulcers were not reducing, we realised they were much less significant in terms of injury, as the preventative plans were improving and we were learning from our investigations. In addition, we measured healing rates for acquired full-thickness pressure ulcers for a CQUIN and this demonstrated that, unless the patients died, the majority were healing or had healed at checks at 40 and 80 days. The predominant theme now, resulting from investigations into full-thickness pressure ulcers last year, is failure to change care plans/equipment/reassess risk in response to patients' deteriorating conditions or not recognising subtle changes in patients' risk when they have chronic conditions — this is where insufficient attention seems to be paid. However, having worked in hospitals and with nursing homes, there is a danger that, if supplies are scarce — for example pressure-relieving equipment, and penalties or negative reports may result due to a new pressure ulcer — then specialist equipment might be moved from a patient with an existing pressure ulcer to an at-risk patient for prevention. However, this does contravene care recommendations and the NMC's code of conduct.

AV: The focus nationally is definitely on prevention of pressure ulcers, and this is justified as the elimination of avoidable pressure ulcers is essential. However in my opinion there will always be pressure ulcers developing as there will always

be the patient that collapses at home, not known to any services, who sadly lays on the floor waiting to be found and gets admitted to hospital with pressure damage. It is essential that healthcare staff are aware of the principles of wound assessment and management so they can deal with these wounds when they occur. In addition if a patient does develop a pressure ulcer whilst receiving care then the healthcare provider has a responsibility to ensure that staff know how to care for their skin integrity and improve it. It may be that a grade 2 pressure ulcer could be prevented from deterioration to a grade three if the right care and attention was paid to the patient.

2. Do you think there have been any significant new developments in the treatment of pressure ulcers?

PV: Many of the therapeutic tools necessary for successful pressure ulcer management already exist. It is not so much about developing new treatments as providing an effective service model that allows coordinated and integrated care delivery. Only in this way can appropriate patients benefit from the timely introduction of advanced wound care and regenerative tissue engineered products occur. There are basic questions we, as service providers need to address, if we are to improve patient outcomes. Can staff adequately assess wounds, correctly categorising pressure damage, develop appropriate treatment plans and recognise and respond to delayed healing? For example, Vowden and Vowden (2015) have demonstrated that patients with heel pressure ulcers rarely receive vascular assessment, appropriate foot care and orthotic support to help maintain their mobility and optimise healing potential.

RS: There have been some key developments in the treatment of pressure ulcers, such as novel medical devices and

research which informs treatment such as PURPOSE T and PRESSURE 2. However, it is too early at this point to establish their significance with regards to pressure ulcer prevention.

SP: In Nottingham, when patients developed a large stage 3 or 4 pressure ulcers, we would often use larvae for swift debridement followed by topical negative pressure, using bridging techniques on heels or sacral wounds where possible. We also investigated the use of novel wound treatments but nothing has been as effective as the aforementioned treatments, and so we did not pursue these further. Now we rarely see extensive pressure ulceration that requires such intensive treatment, which is why we were able to concentrate more on pressure mapping for prevention and treatment to ensure that the blood flow to the wound or skin is optimal. This new type of pressure-relieving equipment has become part our pressure ulcer management. Over the past few years, we have become much more vigilant in assessing patients for osteomyelitis, if their pressure ulcers are not healing, and requesting blood tests with X-rays. Nutritional assessment remains key to the treatment plan. In primary care, one need is to have offloading devices for heel ulcers that patients can safely mobilise in.

AV: There are a few things that are new in pressure ulcer prevention and management, namely the Scanning Electron Microscope (SEM) scanner that reports to be able to identify early skin changes on the patient's skin, this could be particularly helpful in emergency departments when patients are first admitted and could allow higher preventative care to be implemented if early signs of non-visible skin damage had been identified by the SEM scanner. There are some companies now who have developed casting techniques for heel pressure ulcer prevention and management. Formally only used in diabetic foot ulcer and fracture management, the technique involves

bespoke casts made to the exact shape of the patient's heel to provide pressure reduction.

We have effectively used Veraflo VAC therapy for the management of patients with grade 3 and 4 pressure ulcers with good effect. It is particularly helpful at removing some slough, managing exudate and facilitating granulation tissue. Lastly, the ToTo bed springs to mind when I think of developments in pressure ulcer prevention and management. This bed can assist the caregiver in repositioning and is reported to be helpful in patients who are in pain and struggling with repositioning. Colleagues have reported success in healing significant pressure damage when using this piece of equipment in community settings.

3. Do you believe we should set targets for delivering improved outcomes for patients once they have developed a pressure ulcer?

PV: Yes. The recently introduced CQUIN related to wound assessment, which has been highlighted in recent Wounds UK publications (White et al, 2016; Wounds UK, 2017), goes some way to do this but we need to improve patient and wound monitoring so that patients are not left languishing with non-healing wounds. Currently, no one person seems to be responsible for the care of these patients — who is held to account if a pressure ulcer has not healed at 6 months or a year?

RS: Yes, there should be some nationally set targets with realistic goals for improving clinical outcomes for patients with a pressure ulcer in acute and community settings. It is important that any nationally set targets are informed by the best available evidence, as well as the views of clinicians (who are expected to deliver these outcomes), other key stakeholders and patients. At present,

many clinicians are measured on their face-to-face contact, which gives no indication of the quality of care that patients receive and the impact of this care on patients' pressure ulcer-related outcomes. It is also important that any targets that are set at a national level for delivering improved pressure ulcer related outcomes are accompanied by an appropriate level of investment and resourcing to ensure that they can be consistently delivered.

SP: Yes I do. I think for any wound type, we should have pathways of care with expected outcomes at set time periods, actions to take following best practice guidance and processes to follow with rigorous reevaluation. Holistic assessment and reassessment is key and in primary care some patients will not heal well, if at all, meaning that maintenance and preventing deterioration may be the final goal. Every patient has the right to be treated in accordance with best practice standards of care and be referred to to specialists dependent on the pathway. If the pathway is not followed, justifications need to be made as to why, which must be non-discriminatory. Too much in healthcare is left to individuals to decide and the disparity in knowledge and experience between healthcare professionals is widely evident. Promoting patient involvement with treatment plans also needs to be included in such pathways and best interest assessment to provide care for patients who do not have the ability to decide for themselves.

AV: Yes. We should have an objective that the current wound improves and also that no new pressure ulcers develop whilst patients are in our care. The current national drive is elimination of pressure ulcers and focusses more on reporting of numbers, however this doesn't take into account the individual patient's objectives in regards

to their wound and may not consider their priorities.

4. How could we encourage a more multidisciplinary approach to treating patients with pressure ulcers?

PV: While financial and organisational barriers to appropriate referrals exist, it is impossible to allow a patient to move freely through the healthcare system to receive truly multidisciplinary and multi-professional care. If pressure ulcer development reflects care failure by institutions and their healthcare professionals, then patients with pressure ulcers should receive prioritised care aimed at rapidly restoring skin integrity and patient quality of life. This unfortunately is rarely the case as the healthcare system is not penalised in any way if healing is delayed.

RS: It would be good if there was more integration in health and social care teams across primary and secondary settings. This would help to foster greater multidisciplinary team working in relation to the care of patients that have pressure ulcers. In settings where integration has taken place, it has facilitated improved multidisciplinary team working, which has improved key element of patient care by expediting support for equipment/mobility etc.

SP: I think we have come quite far with this in our area, but perhaps not far enough. All our healthcare professionals — physio and occupational therapists, matrons, nurses, assistant practitioners and support workers for nursing and rehabilitation services — undertake pressure ulcer risk assessments and order pressure-relieving equipment to varying degrees, depending on their level of access to order. Competency training is in place for pressure risk assessment as

well as guidance for using the equipment. We developed many new services with different healthcare professionals, such as the independence pathway and urgent care teams. Some consist of only a few nurses and some include staff who initially did not think pressure ulcer prevention and skin checking was part of their role. This has been largely overcome now; however, non-nursing professionals, can be limited by their lack of experience when assessing skin, looking at skin damage, and understanding skin changes. As a general observation, they tend to underestimate the risks to patients, which has been evident in some root cause analysis investigations. Teams who look after patients in the short-term do not see the results of their treatment plans so cannot evaluate if they were successful or not. We have a multidisciplinary team with staff from tissue viability, infection control, physiotherapy, occupational therapy, dietetics and continence care. They have worked well together and have contributed to our *Pressure Ulcer Prevention Handbook* for staff. I think the roles of physiotherapist and occupational therapist are key to keep patients mobile, promote movement, facilitate specialist seating and functioning. However, restrictions due to contract specifications can limit progress, as referrals for patients without 'rehabilitation potential' need to be very specifically

described. We would like better links with the the Wheelchair Service, which is not part of our organisation, but is used by some of our patients. Other hospitals may have better access to their local service. Occasionally, we have case conferences with GPs, another important group of healthcare professionals who need to be involved as well, particularly when patients are not making progress or have multiple problems at home.

AV: I think we need a public campaign to raise awareness of the importance of identifying early skin changes and how to prevent pressure ulcers. This could allow the harder-to-reach disciplines and the general public to have a wider understanding of everyone's involvement. Discussions should already be occurring at board rounds, ward rounds and multidisciplinary meetings that should include pressure ulcer prevention and management.

In our Trust, we are just about to launch our latest campaign specifically designed to target the multidisciplinary team called 'Keep on ASKIN what YOU can do to PREVENT PRESSURE ULCERS'. This campaign will educate staff on the six moments of pressure ulcer prevention when they can ask what they can do to reduce the risk of patients developing tissue damage. 

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