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# Pressure ulcers: understanding the challenges of promoting quality

Karen Ousey

Pressure ulcers represent a notable burden of sickness and reduced quality of life for patients, and create significant difficulties for patients, their carers and families (NHS Institute for Innovation and Improvement, 2009). Clark et al (2004) estimated that new pressure ulcers occur in 4–10% of patients admitted to acute hospitals in the UK, with Posnett and Franks (2007) estimating the cost of wound care to the NHS at between £2.3 billion and £3.1 billion per year (2005/06 prices); costs in one trust were estimated to be £9.89 million (Vowden et al, 2009). As well as the financial burden to health care, pressure ulcers are a significant cause of morbidity and mortality for patients (Posnett et al, 2009).

The Department of Health (DH) (2009a) set out to reduce the amount that an average district general hospital spends on treating pressure ulcers, which is currently estimated at £600 000–£3 million each year. This suggests that the majority of pressure ulcers are entirely preventable through risk assessment and the implementation of pressure-relieving measures. However, the National Pressure Ulcer Advisory Panel (NPUAP) (2010a) issued a statement on unavoidable pressure ulcers, agreeing that patients who choose not to participate in their own pressure ulcer prevention could develop unavoidable pressure ulcers. The panel issued the revised definition of unavoidable pressure ulcers as:

**‘Unavoidable—means that the individual developed a pressure ulcer even though the provider had evaluated the individual’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with individual needs goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.’**

The annual budget for the NHS has more than doubled in the last decade, and is now in excess of £102 billion. Today, £1 of every £13 produced by the UK economy is spent on health care (DH, 2010a). The DH (2010a) stated that the NHS needs to concentrate on improving productivity and eliminating waste, while focusing on quality and making cost-efficiency savings. The target for these savings is £15–£20 billion by the end of the 2013/14 period. Savings are to be reinvested in the service to deliver year-on-year quality improvements (DH, 2010a).

## Abstract

**Pressure ulcers affect quality of life and general wellbeing, and create significant difficulties for patients, their carers and families. Pressure ulcers are associated with morbidity and mortality, and prove costly for healthcare providers. This article identifies the Government’s quality agenda and the importance of maintaining, developing and delivering quality care for the prevention of pressure ulceration.**

**Key words:** ■ Pressure ulcers ■ Quality ■ Risk assessment ■ Guidelines

## Quality agenda

The DH (2008) states that ‘it is imperative that in order to achieve high quality care for all we must build on existing local governance’. It identifies seven necessary steps to achieve this:

- Bring clarity to quality
- Measure quality
- Publish quality
- Raise quality performance
- Recognize standards
- Raise standards
- Safeguard quality and staying ahead.

To support quality measurement for improvement, the DH (2010b) produced the Nursing Roadmap for Quality that aims to help nurses and their teams understand the elements of the quality framework with regard to nursing practice. These documents indicate that every health professional caring for a patient with a wound will be accountable for ensuring that all patients are offered consistently high quality care (Ousey and Shorney, 2009). Indeed, the DH (2008) add that health professionals will improve their performance against ‘quality at the heart of everything we do’ and identified the following domains as being important:

- Patient safety
- Patient experience
- Effectiveness of care.

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According to *NHS 2010–2015: From Good to Great* (DH, 2009b), there will be ‘safer care for patients who could be confident that they would be protected from avoidable harm’, and pressure ulcers are identified as an area that needs to be addressed. Dame Christine Beasley, Chief Nursing Officer for England, and the strategic health authorities (SHAs), have agreed the first three national nursing outcome indicators that measure performance:

- Pressure ulcers
- Falls
- Urinary tract infections.

Dowsett and White (2010) comment that services should ensure they are delivering high quality, safe and effective care that will need to be monitored against the agreed quality indicators.

Kennedy (2009) suggests that nurses increasingly report the difficulties of trying to provide high quality care when factors such as staffing levels and skill-mix of the available staff are inadequate. However, frontline practitioners are paramount to ensure evidence-based, effective and quality care is both delivered and evaluated. The NHS National Quality Board was charged to champion quality and ensure alignment in quality throughout the NHS (DH, 2009c) and to clarify quality in nursing, how it can be measured, and how it can be demonstrated and measured confidently. The collection of patient-reported outcome measures (PROMs) will allow trusts and health professionals to assess the level of quality care in healthcare arenas, and will be submitted as part of the trusts’ quality accounts.

High Impact Actions (HIA) (NHS Institute for Innovation and Improvement, 2009) published eight actions, including

‘Your Skin Matters: preventing avoidable pressure ulcers in NHS provided care’. The tissue viability service at NHS Newham appointed an additional member of the tissue viability team to focus on pressure ulcer prevention and management in the local nursing home population to achieve this action. Evaluation of this initiative has seen the service able to demonstrate a 50% reduction in hospital admissions for pressure ulcer management over a 5-month period. A £59 100 cost saving has been witnessed based on the highest number of admissions at costs of £199 per bed, per night (Dowsett, 2010).

### Impact of pressure ulcers on quality of life

A systematic review of the literature focusing on the impact of pressure ulcers on quality of life in older patients was undertaken by Gorecki et al (2009). The review highlights 31 studies which reported the impact of pressure ulcers and pressure ulcer interventions on health-related quality of life (HRQoL). The authors found that pressure ulcers significantly affected physical, social, psychological, and financial aspects of HRQoL. Pain was identified as a significant concern, and patients felt they were a burden to others, causing anxiety and worry. They also believed their pressure ulcers had resulted from inadequate health care and a lack of knowledge with regard to the prevention of pressure ulceration from healthcare providers.

Gottrup (2009) highlights that the European Wound Management Association (EWMA) patient outcome group suggested that, as well as ‘wound healing’, other outcome measures such as quality of life, infection rates, and cost-effectiveness should be considered when planning both patient care and future research.

### Using guidelines to promote quality

Local, national and international guidelines are available for practitioners to access support and guide their care interventions. These should be accessed by all practitioners involved in pressure area management and treatment. The NPUAP (2010) state that pressure ulcers are assigned a stage or category once the wound has been assessed, diagnosed or determined to be a pressure ulcer. Their guidance maintains that the wound classification system is for use in classifying pressure ulcers, and was not designed for use in any other wound type. They promote the integration of a team approach in the prevention and management of pressure ulceration, remarking that the information to determine the stage of a pressure ulcer is not exclusively held by any one profession.

The European Pressure Ulcer Advisory Panel (EPUAP) (2009) updated their guidance in 2009. Dealey (2009) provides an overview of the prevention statement available, as shown in *Table 1*.

### The value of risk-assessment tools

Malnutrition and prolonged immobilization are the most significant risk factors for pressure ulcer development according to Hofman et al (1994). The National Institute for Health and Clinical Excellence (NICE) (2005) suggested that when assessing a patient’s ‘at-risk status’ of

**Table 1. European Pressure Ulcer Advisory Panel Prevention Statements**

Use a structured approach to risk assessment that includes assessment of activity and mobility
Ask individuals to identify any areas of discomfort or pain that could be attributed to pressure damage
Offer high-protein mixed oral nutritional supplements and/or tube feeding, in addition to the usual diet, to individuals with nutritional risk and pressure ulcer risk because of acute or chronic diseases, or following a surgical intervention
Repositioning frequency will be determined by the individual’s tissue tolerance, his/her level of activity and mobility, his/her general medical condition, the overall treatment objectives, and an assessment of the individual’s skin condition
Assess the individual’s skin condition and general comfort. If the individual is not responding as expected to the repositioning regimen, reconsider the frequency and method of repositioning. Do not base the selection of a support surface solely on the perceived level of risk or the category (grade) of pressure ulcer
Refine risk assessment of individuals undergoing surgery by examining other factors that are likely to occur and will increase risk of pressure ulcer development, including: <ul style="list-style-type: none"> <li>• Length of the operation</li> <li>• Increased hypotensive episodes intraoperatively</li> <li>• Low core temperature during surgery</li> <li>• Reduced mobility on day 1 postoperatively</li> </ul>

From: Dealey (2009); European Pressure Ulcer Advisory Panel (2009)

**Table 2. Assessment of the 'at-risk' patient**

- Health status
- Acute, chronic and terminal illness
- Comorbidity (e.g. diabetes)
- Mobility status
- Posture
- Sensory impairment
- Level of consciousness
- Systematic signs of infection
- Nutritional status
- Previous pressure damage
- Pain status
- Psychological factors
- Social factors
- Continence status
- Medication
- Cognitive status
- Blood flow

From: National Institute for Health and Clinical Excellence (2005)

developing a pressure ulcer, there are a variety of areas that require assessment on initial contact, and thereafter on an individual basis (Table 2). To be able to promote and maintain quality of life, it is important that all patients are assessed for their at-risk status of potential pressure ulcer development. There are a number of pressure ulcer risk assessment strategies available for health professionals to use, but they must be used in conjunction with professional judgement and as an aide memoir. NICE (2005) guidance on pressure ulcer prevention highlights that management approaches and techniques are constantly developing and as such, there is no overall consensus as to how to prevent and manage them. However, NICE (2005) has suggested that the documentation of a risk-assessment score will provide a useful starting point for investigating clinical areas with regard to standards.

Webster et al (2010) published the findings of their study that assessed the validity of the Waterlow at-risk tool, with medical patients to identify factors that contribute to pressure injury. A prospective cohort observational study design was used to investigate the effect of using the Waterlow scale on pressure ulceration prevention. They conclude that there was limited evidence with regard to the predictive efficacy of the Waterlow screening tool in acute hospital settings, and that their results concurred with Pancorbo-Hidalgo et al's (2006) results of a review of risk-assessment scales. However, they argue that although the Waterlow screening tool was effective in identifying those who would remain ulcer-free, the tool as a whole was unable to effectively discriminate between those who did or did not develop a pressure ulcer at a later stage (Webster et al, 2010).

Benbow (2009) advises that until there is an alternative means of assessing risk, the existing pressure ulcer risk-assessment tools should be used (despite limited research evidence of their effectiveness), appropriately acted on, and any interventions clearly documented in line with nurses' professional responsibilities and accountability.

## Conclusions

Prevention of pressure ulcers is multifactorial and it is the responsibility of each health professional to ensure that patient care is based on the best available evidence to promote a quality service. Recent government documents have identified the importance of quantifying quality and have set out clear outcomes for health care. For 2010/11, the DH (2010c) has identified that contracts require commissioners to make 1.5% of contract value available for providers to earn if they achieve locally agreed quality improvement and innovation goals, and for acute providers, this will be two national goals.

EPUAP, NPUAP and EWMA provide guidance on preventing and managing pressure ulceration in addition to local guidelines, and it is paramount that these are used to plan, implement and evaluate patient care. The introduction of PROMs will be a vehicle to assess the effectiveness of interventions.

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## KEY POINTS

- Pressure ulcers represent a significant burden of sickness and reduced quality of life for patients, and create significant difficulties for patients, their carers and families
- The annual budget for the NHS has more than doubled over the past decade to over £102 billion; £1 of every £13 produced by the UK economy is spent on health care
- The Nursing Roadmap for Quality aims to help nurses and their teams to understand the elements of the quality framework with regard to nursing practice
- Local, national and international guidelines are available for practitioners to access to support and guide their care interventions, and should be accessed by all practitioners involved in pressure area management and treatment
- Until there is an alternative means of assessing risk, the existing pressure ulcer risk-assessment tools should be used
- Patients who choose not to participate in their own pressure ulcer prevention could develop unavoidable pressure ulcers

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