

# Outcomes of the implementation of the European & UK pressure ulcer guidelines and UK Government agenda across a UK primary Care Trust

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## Introduction

The research exploring the impact of living with a pressure ulcer (Hopkins et al 2006, Spilsbury et al 2007) identified endless pain and a restricted life. Pressure ulcers account for 3% of the annual United Kingdom National Health Service expenditure, which is estimated at £2.3–£3.1bn per year (Drew et al, 2007). Pressure ulcers have become increasingly high on the political agenda since the NICE 2005 (Nice 2005) and publication of the EPUAP (EPUAP 2009) guidelines. Clinical benchmarking (DoH 1999), The Quality, Innovation, Productivity and Prevention (QUIPP 2010) and High Impact Actions (DoH 2009) emphasise the importance of pressure ulcer prevention with the 7 main areas including:

- Aetiology Risk Assessment
- Nutrition Skin Assessment
- Positioning Support Surfaces
- Management

## Method

To reflect the national and government agenda a number of approaches have been utilised within the PCT to implement a strategy for the prevention, management and audit of pressure ulceration. The Tissue Viability Nurse consultant and Honorary tissue Viability nurse (TV Team) lead and assisted in conducting the pressure ulcer clinical benchmarking audit across the PCT. The TV team also reviewed the pressure ulcer nursing documentation as a subset of a much larger Wound assessment audit.

## References

- Callaghan, R. (2009) Unpublished PCT data
- DoH (1999) The Essence of Care. Clinical benchmarking. DoH London
- DoH (2008) Darzi, A. High Quality Care for All. DoH, London. [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh.digitalassets/@dh/en/documents/digitalasset/dh\\_085828.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/en/documents/digitalasset/dh_085828.pdf)
- DoH, (2009) Darzi, A. Transforming Community Services: Ambition, Action, Achievement. Transforming services for acute care closer to home. DoH, 24 June 2009. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_101425](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101425)
- DoH (2010) The NHS Quality, Innovation, Productivity and Prevention challenge: An introduction for clinicians. [www.dh.gov.uk/quality\\_and\\_productivity](http://www.dh.gov.uk/quality_and_productivity). Accessed 23.9.2010
- Drew P, Posnett J, Rusling L (2007) The cost of wound care for a local population in England. Int Wound J 4(2): 149–55
- EPUAP- NPUAP (2009) Quick version guide. OR [www.npuap.org](http://www.npuap.org) or [www.epuap.org](http://www.epuap.org)
- Hopkins, A. Dealey, C. Bale, S. Defloor, T. Worboys, F. (2006) Patient stories of living with a pressure ulcer. Journal of Advanced Nursing. Nov; 56(4):345-53
- Spilsbury, K. Nelson, A. Cullum, N. Iglesias, C. Nixon Mason, S. (2007) Pressure ulcers and their treatment and effects on quality of life: hospital inpatient perspectives. J Adv Nurs. 2007 Mar; 57(5):494-504

## Example of Audit questions

- 1.Has the patient been **assessed** for the presence of or risk of developing pressure ulcers at initial contact /5 contacts in District Nursing?
2. Is the assessor a registered health care practitioner?
3. Does the patient /carer have access to written information about their pressure ulcer or risk status?
4. Does the patients/carers consider the information that is supplied to them useful?
- 5.Does the patients/carers have an agreed individualised plan, which is documented?
6. Has the patients need for re-positioning been assessed and documented?
7. Does the patient have an appropriate pressure reducing mattress?  
(Using the equipment selection form for community hospitals/community)
8. Does the patient have the appropriate pressure reducing cushion?  
(Using the equipment selection form for community hospitals/community)
9. Is the plan fully implemented and in partnership with the multidisciplinary team/patients/clients/carers.
- 10 Has a date for reassessment been identified?

## Results :

- Clinical benchmarking audit identified:**
- 96% of patients had a pressure ulcer risk assessment completed by staff
  - 66% of staff provided patient information
  - 81% implemented a planned repositioning programme
  - 84% involved the multi-disciplinary team in care associated with the pressure ulcer
  - 73% documented the date for the next reassessment

## Outcomes

- The audit informed the development of:
- A bespoke educational programme to include risk assessment, categorisation of pressure ulcers, use of equipment and a database of all staff that had attended pressure ulcer study days
  - A tissue viability website linked to the PCT intranet making training, guidelines and resources available to all staff.

- Implementation of the public awareness “Your Turn” campaign. ([www.your-turn.com](http://www.your-turn.com))
- Updated patient information and pressure ulcer awareness reminder postcards.
- Standard recording of all category 3+ Pressure ulcers
- Annual audit of mattresses, beds and cushions across community hospitals
- On-going data collection on the incidence of pressure ulcers in Care homes are 7.9% (Callaghan 2009)





