AUTHORS: (2022)
Gemma Long, Specialist Support Worker Skin Integrity, Doncaster Teaching Hospitals NHS Foundation Trust.
Kelly Moore, Lead Nurse Skin Integrity, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.
The Skin Integrity Team, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Skin Integrity Specialist Support Worker Role Introduced to Contribute to the Hospital Acquired Pressure Ulcer reduction quality improvement strategy

Introduction

The Hospital Acquired Pressure Ulcer (HAPU) category 2 and above data at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) identified an increase in the trusts position since 2017. Several factors appear to have impacted on time such as; no verification of category 2 pressure ulcers by the Skin Integrity Team and deterioration of category 2 pressure ulcer to a category 3.

Moisture lesions are often mistaken for superficial pressure ulcers, especially when skin damage is located in the peri-anal and natal cleft region (Yates 2012). Characteristics of the two differ as do the management strategies. In some cases, combined lesions of both pressure and moisture damage may be present (Yates 2012). This is also highlighted in a study by Defloor et al (2006) and Beeckman et al (2007). Therefore it can be argued that superficial pressure ulcers and moisture lesions can be misdiagnosed. Yates (2012) states because of this both quality of care aspect and national data is affected.

In the aim to improve the verification and diagnosis of superficial pressure ulcers and moisture lesions (incontinence associated dermatitis and moisture associated skin damage) a new role within the Skin Integrity Team was created to enable capacity for category 2 pressure ulcers to be reviewed, verified and have an effective and appropriate prevention and treatment plan put in place.

Method

The Skin Integrity Team at DBTH developed and implemented a quality improvement (QI) strategy from April 2021 with the aim to reduce the number of HAPU category 2 and above by 20% by the end of March 2023 and a total of 50% reduction the end of March 2025 (based on data from 2020/2021).

The Skin Integrity Team began reviewing, verifying and commencing prevention and treatment plans for category 2 pressure ulcers in October 2021. However this was not sustainable due to the increased work load this added to the existing Skin Integrity Team. Therefore a new role within the Skin Integrity Team was created to enable capacity for category 2 pressure ulcer to be reviewed, verified and have an effective and appropriate prevention and treatment plan put in place. This role was a Band 3 Specialist Support Worker (SSW) that commenced in December 2021.

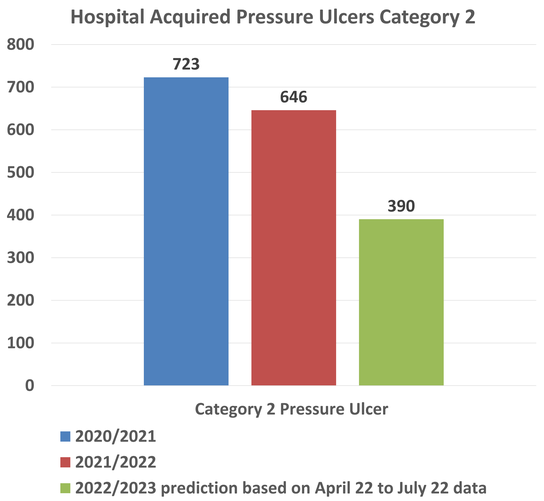
The Specialist Support Worker received education and training around pressure ulcer prevention and management, which included categorisation to enable them to hold their own caseload of patients that were referred to the Skin Integrity Team with category 2 pressure damage, both hospital acquired and present on admission.

Results

Data shows that since commencing the QI strategy and the Specialist Support Worker in July 2021 the following results have been seen:

- An 11% reduction in category 2 HAPU between April 2021 and March 2022.

This has continued to the over all category 2 and above hospital acquired pressure ulcer reduction of 13% . Therefore we are ahead of schedule to meet the 20% reduction of category 2 and above hospital acquired pressure ulcer reduction by the end of March 2023, with a predicated cat 2 end point of 390.



The reduction is multi factual due to the diagnosis now being verified and skin integrity resources being more visible on the ward with the specialist support worker providing hands on prevention support. Many previous category 2 pressure damage wounds are now being reassigned to Incontinence Associated Dermatitis , Moisture Associated Skin Damage or Trauma Injury.

Discussion

It is identified that one of the reasons the HAPU figures increased since 2017 is partly due to the fact that some staff are still not confident or competent in categorising pressure ulcers and often mistake Incontinence Associated Dermatitis (IAD) or Moisture Associated Skin Damage (MASD) a category 2 pressure ulcer.

Therefore the SSW are now able to verify the diagnosis (so the correct data is being reported), support and educate the staff to improve their confidence and/or competence around pressure ulcer categorisation and ensure the patient has the most effective and appropriate prevention and treatment plan in place.

Yates (2012) stated how the differentiation of superficial pressure ulcers and moisture lesions is a problem that cannot be ignored in clinical practice and therefore management strategies need to be addressed. Studies suggest that it is important to detect skin damage in the early stages, whatever the cause (pressure or moisture), as this allows for vital preventative (Yates 2012). However it has been highlighted and agued in studies whether the distinction between pressure ulcers and moisture lesions should be needed (Houwing et al 2007).

	Moisture Lesion	Pressure Ulcer
Causes	Moisture must be present (e.g. shining, wet skin caused by urinary incontinence or diarrhoea.	Pressure, Shear must be present.
Location	May occur over bony prominence perineum, buttocks inner thigh, groin, skin folds.	If not over a bony prominence then unlikely to be a pressure ulcer. Equipment related – under device/tube skin folds (combination)
Shape	Diffuse, different superficial spots, kissing ulcer. Anal cleft - linear	Circular wounds Regular shapes.
Depth	Superficial partial thickness skin loss Can enlarge if infection is present.	Dependent on category of pressure ulcer.
Necrosis	No necrosis	Dependent on category of ulcer
Edges	Diffuse and irregular edges	Raised edge (chronicity)
Colour	Non-uniform redness Pink/white surrounding skin (maceration) Peri-anal redness	Erythema. Slough, necrosis, granulation tissue, dressing residue, infection
Distribution	Confluent or patchy	Isolated individual lesions

Due to the need to identify the differences between superficial pressure ulcers and moisture lesions, the EPUAP issued a statement regarding pressure ulcer classification, differentiation between pressure ulcers and moisture lesions (Defloor et al, 2005). The characteristics are identified through cause, location, shape, depth, tissue types and wound edges. The Skin Integrity Team use the below table for education and support based on the work from Defloor et al (2005) to support the work of the Specialist Support Worker:

Conclusion

The Hospital Acquired Pressure Ulcer (HAPU) category 2 and above data at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) identified an increase in the trusts position since 2017. The main factor that impacted on this was misdiagnosis on reporting the pressure damage.

It is well established that moisture lesions are often mistaken for superficial pressure ulcers (Yates 2012). It has been argued that the distinction between the two (Houwing et al 2007) is not needed however, because the characteristics of the two differ they may required different management strategies(Yates 2012). The Skin Integrity Team were previously not reviewing and verifying category 2 pressure ulcers, therefore the data being reported was not accurate. In addition to this no personalised preventative and management plans were in place to prevent deterioration to a category 3 or 4 pressure ulcer.

The new role of a Band 3 Specialist Support Workers within the Skin Integrity Team was created to enable capacity for category 2 pressure ulcer to be reviewed, verified and have a prevention and treatment plan put in place. This has contributed to the Hospital Acquired Pressure Ulcer reduction quality improvement strategy achieving an 11% reduction in the first year.

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Statement of Interest

There is no statement of interest, this was done independently with the Team and organisation.