Improving practice in pressure ulcer grading and the prevention of pressure ulcers
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CITATION
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Abstract
The study reflects upon introducing and managing change in order to improve the skills and knowledge around pressure ulcer grading and the prevention of pressure ulcers on a 20 bedded step up/step down (SUSD) unit based within an acute hospital. The report is based on a Masters dissertation submitted as part of the MSc in Advanced Practice in Health and Social Care, NMLB 7071.

Keywords
pressure ulcer; practice development; grading; prevention

Introduction
The full report on this piece of work (available from the author) overviews significant literature pertaining to pressure ulcer grading and prevention, offers a critical discussion of change management theories, and discusses time spent observing practice to identify where the problems lay and gain insight into the ability of nurses to accurately grade pressure ulcers. This brief report is a reflective article that considers the change processes that were important in engaging the systems and effecting positive outcomes. The report first identifies the change activities from the project, and then reflects on the change and evaluation processes that were important in the project.

The change activities
1. The first activity involved observing current practice and carrying out a pressure ulcer grading test in which nurses’ accuracy in grading pressure ulcers was established. Feedback on this was provided in the form of a report for managers and in clinical meetings with staff. Feedback provided an opportunity to report areas of good practice but also identify resisting and driving forces in order to facilitate moving forward (Lewin, 1951). By identifying and highlighting problem areas I hoped to empower people to take action that would improve practice (Patton, 1994).

2. The ward introduced the ‘safety cross’ which provides a monthly snapshot of pressure-ulcer-free days and pressure ulcers transferred or developed on the unit (Healthcare Improvement Scotland, 2011; Whitlock et al., 2011), the nursing staff took ownership of completing it daily.

3. I adapted the colour EPUAP (European Pressure Ulcer Advisory Panel) tool incorporating moisture lesions as well as pressure ulcers and this was trialled by a small focus group to identify any problems in the design that might need to be modified (Polit & Hungler, 1997). Inter-rater reliability was checked and, although only a small sample was assessed, the accuracy in grading was good compared with previous assessment of inter-rater reliability using the black and white EPUAP tool.

4. I condensed the National Institute for Health and Care Excellence (NICE; 2005b) guidance for patients on pressure ulcers so that it was easier for patients to understand, thus involving individuals in their own care is said to achieve a higher degree of concordance (James, 2010). The information was made into a booklet for staff across the Trust to give to patients/carers.

5. I conducted an audit of the SSKIN bundle tool looking specifically at the quality of the information on the tool. This provided objective evidence and supported the need for further training and education. Acknowledging that in the area of clinical audit I was a novice (Benner, 2001), I enrolled the support of the clinical audit team and attended a study day looking at all aspects of the clinical audit process. I put forward an audit proposal based on SMART (specific, measurable, achievable, realistic, and timely) objectives which was accepted by the clinical audit team. I devised an audit tool which aimed to assess the quality of the information documented on the SSKIN bundle. The audit was completed on all patients on the SUSD unit on a given day; the results corroborated my findings from
observation that the SSKIN bundles lack documented evidence to support the fact that effective strategies are in place to prevent avoidable pressure ulcers from occurring (Welford, 2006). The audit was identified as a priority audit within the locality, therefore, following analysis of the findings, recommendations/actions were made in conjunction with senior management, thus ensuring high-level support in making change happen.

The change process
In this section I reflect upon the processes involved in implementing change. In this I used ‘force field analysis’ (Lewin, 1951) which identifies forces that drive change and those that resist change, with the intention of working on both factors in developing the project.

A consideration of driving forces suggested that, while internal stakeholders such as the SUSD unit staff had considerable influence on the proposed change, external stakeholders were equally as important (Hayes, 2010). Through the report on observations of practice on the SUSD unit I was able to gain high-level support in driving change forward. National targets and processes such as Commission for Quality and Innovation (CQUIN) were also driving forces supporting this project, (NPSA, 2010). Another driving force was my desire to improve practice on the unit; as internal stakeholders, the unit staff also needed to share this desire as they were influential in the success or failure of the proposed change.

The initial feedback gave the staff an understanding of why practice needed to improve, however, there were still resisting forces that had to be overcome in order to push people in the desired direction (NHS Institute for Innovation and Improvement, 2005). Lewin (1951) advocates spending more time on driving forces as opposed to expending energy on the resisting forces, however, it was important from the outset to recognise areas of resistance in order to identify strategies to overcome them. Motivating the staff at a time when they felt vulnerable due to other organisational changes was a challenge (Bridges, 2009). Many of the staff had been working together within the same area for many years; the way things are done within teams are heavily influenced by shared unwritten rules which can be one of the most powerful parts of culture (NHS Modernisation Agency, 2005).

Discussions with staff members highlighted issues around roles and clarification of my place within the hierarchy. It was important not to be seen as a threat: my role was not that of a manager but of a clinical leader aiming to facilitate the development of best practice. Anderson and Ackerman Anderson (2001) argue that change agents sometimes need to look beyond external barriers to change and look internally at themselves. Self-awareness and advanced interpersonal skills were essential in helping me to recognise when I needed to modify my approach in order not to alienate individuals. On the other hand, working on the unit enabled day-to-day communication and embedding of my values and beliefs through my actions, reflecting the qualities of congruent leadership and being a role model for staff (Stanley, 2008).

Congruent leadership occurs where clinical leaders translate their values and beliefs about care and nursing into actions (Stanley, 2008); nursing clinical leadership involves working closely with other nurses, sharing their values and living them out in action. Cain (2005) maintains that leaders need to earn the right to lead, by being a visible presence, directly involved in not only providing quality clinical care but also inspiring others to improve their practice which brings respect and credibility and encourages others to follow. Congruent leadership is said to fill the gap for those nurses with leadership skills who want to stay by the bedside or in strong clinical posts as opposed to moving into traditional leadership that is affiliated with a leadership or management function (Stanley, 2008).

I saw my role as having a visible presence and was keen to share my values and beliefs but recognised that as a clinical leader it was important to empower and develop others. Rogers’ (2003) theory of diffusion describes how innovations diffuse through social systems; ideas are initially adopted by innovators before diffusing down to early adopters who then spread the idea to the early majority, then late majority, and finally to the laggards (Giddens & Walsh, 2010). I considered myself to be the innovator but required early adopters to help diffuse the idea through the rest of the team. One of the registered nurses, who took on the role of Tissue Viability Link Nurse, represented an early adopter (Rogers, 2003), and she was encouraged to attend the Tissue Viability Link Nurse Meeting which is an educational forum whereby link nurses can increase their knowledge then cascade to other members of their team. Supporting the link nurse by ensuring she was given the time out from the ward to attend the meeting was an important
Economic). Developmental evaluation tends to be viewed from one of four perspectives (Experimental, Developmental, Managerial, and Economic). Ovretveit (1998) argues that evaluation can be a resisting force (Rogers, 2003). Giddens and Walsh (2010) point out that adoption of innovation can be by degrees as opposed to an immediate response to an idea, and can therefore take time. This was certainly the case with some members of the team, thus unfreezing took longer for some individuals, highlighting that the human elements of change are not straightforward (Redfern & Christian, 2003).

Small group discussions and one-to-one supervision sessions involving the link nurse helped to reinforce the feedback already given, and facilitated discussion around current practice and the need for better documentation to provide evidence that effective pressure ulcer prevention is being provided. This helped to bring people on board and I felt I was able to reach out to the late majority; however, there were still the laggards who proved to be a resisting force (Rogers, 2003). Giddens and Walsh (2010) point out that adoption of innovation can be by degrees as opposed to an immediate response to an idea, and can therefore take time. This was certainly the case with some members of the team, thus unfreezing took longer for some individuals, highlighting that the human elements of change are not straightforward (Redfern & Christian, 2003).

The grading exercise proved to have an influential effect on the unit staff, it helped raise awareness of individual ability, moving the unconscious incompetent to conscious incompetent (Howell, 1982). Lewin (1951) claims that movement occurs through cognitive restructuring, thus putting people to the test highlighted gaps in knowledge. Although this could have resulted in individuals feeling vulnerable, the positive impact of the grading exercise served to bring on board the early majority (Rogers, 2003). This was more evident with the healthcare assistants and lower graded staff nurses who sought advice on changes in skin integrity and grading of pressure ulcers.

Evaluation

Ovretveit (1998) argues that evaluation can be viewed from one of four perspectives (Experimental, Developmental, Managerial, and Economic). Developmental evaluation tends to take a more flexible and inclusive approach to change, allowing those affected by the change to reflect on problems encountered and formulate actions to overcome them (Lazenbatt, 2002). It was felt to be the most appropriate type of evaluation to utilise within this project where my role as a clinical leader has been to motivate and innovate staff to learn and develop, exploring potential solutions with the team.

Evaluating improvement in practice is an ongoing process (Redfern & Christian, 2003). Ongoing evaluation was an important part of the change management strategy used within this study, as it provided a cyclical process of collecting information through observation, providing feedback, and making actions based on the latter. Formative feedback/evaluation was delivered through focus groups and clinical meetings. Bridges (2009) suggests that constant feedback and communication helps people through the transition and forms part of the ongoing cycle of evaluation. The feedback session provided impetus for the team to identify strategies for improvement.

Outcome evaluation was used to assess whether the interventions introduced within this project achieved the aims and objectives with regards to the ability of nursing staff on the SUSD unit to accurately grade pressure ulcers and determine whether current practice in respect of prevention and management of pressure ulcers reflect the recommendations of NICE (2005a). As identified through the SSKIN bundle audit, there was 100% compliance in the use of the tool, however, staff often failed to provide evidence of prevention and management strategies for those who had a pressure ulcer and those at risk of developing one. Lazenbatt (2002) suggests that as well as measuring the extent to which the intervention has achieved its objectives, other outcomes such as Effectiveness (does it work in everyday practice?), Efficiency (how well resources are used), Equity (the extent to which everyone, ideally, has a fair opportunity to attain full health potential), and Economy (costs such as staff, materials, facilities and the benefits of the intervention such as changes in attitudes and knowledge) are important; economy is threaded throughout the indicators so is not considered in isolation.

In order to monitor effectiveness of intervention, the safety cross was introduced. As well as supporting data collection, the safety cross acted as a visual tool to monitor monthly performance. It was also useful as
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a learning tool to discuss good/poor practice within teams and identify learning needs, as it generated discussion around whether an ulcer could be defined as avoidable or unavoidable, which is undoubtedly an important factor with regards to CQUIN targets (Black et al., 2011). Completing incident forms with the staff enabled us to look in more detail at why the pressure ulcer had developed and whether prevention strategies had been put in place in a timely manner. Recognising skin changes and accuracy of grading was highlighted to be extremely important; for example, if skin changes were documented stating 'reddened area', but not followed up as to whether it was 'blanching or non-blanching', indicating a grade 1 pressure ulcer, then skin integrity could deteriorate further (EPUAP/National Pressure Ulcer Advisory Panel (NPUAP), 2009). Initial feedback regarding the use of the adapted pressure ulcer grading tool is positive and inclusion of moisture lesions in the tool was said to be beneficial, as it increased awareness of the difference between moisture lesions and pressure ulcers (Bianchi, 2012). Local data show an increase in reported pressure ulcers from the unit, but, as highlighted in other studies, increasing awareness often leads to increased reporting (Phillips & Buttery, 2009).

Organisations tend to use data-gathering measures to evaluate and improve care, but also to identify compliance or variation from policies and procedures (Ovretveit, 1998). Locally, the Trust use the NCSIs to evaluate compliance with local and national guidelines (NICE, 2005). Conducting an audit of the quality of the information on the SSKIN bundle was a means of determining its efficiency. By completing the audit myself, extra resources were not required and it was, therefore, economical in terms of cost (Lazenbatt, 2002). A re-audit of the SSKIN bundles is planned for six months’ time, thus forming part of the ongoing evaluation process that is needed in order to achieve long-term sustainability of change (Lewin, 1951).

Equity is concerned with everyone having a fair opportunity to achieve the best care possible and receive evidence-based care with the aim of reducing risk of harm (Lazenbatt, 2002). Monitoring standards on the unit over time with regards to incidence of avoidable pressure ulcers will help determine whether change management strategies introduced within this project improve practice in terms of detection and prevention of avoidable pressure ulcers. Senior management support has influenced Trust-wide adoption of the adapted EPUAP tool, safety cross, and adapted NICE (2005b) guidance for patients booklet, thus sharing good practice across the wider locality.

Conclusions

Although progress to improve practice has been much slower than anticipated, I feel that my participation and input in facilitating change within the SUSD unit has been a success. Through the work I have been doing during the course of this project, there has been a substantial advancement in knowledge and understanding of non-qualified and qualified staff around the subject of pressure ulcer grading and prevention of pressure ulcers. Evaluation of the project so far has highlighted the benefits of using an action research approach as a means of identifying problems, and working closely with staff to find solutions and develop action plans to improve practice. Working on the SUSD unit has helped to create an environment where staff are encouraged to talk about pressure ulcers and consider strategies that are based on best practice and up-to-date evidence in order to prevent ulcers from occurring (Elliot, 2011). It is recognised that there are areas for improvement and, by observing practice so closely, other issues have emerged that have not necessarily been the focus of this study but are nonetheless important and have implications on the delivery of care (Polit & Hungler, 1997). Ongoing work is needed around reassessment of wounds and completion of wound care documentation in order to provide objective evidence of continuous management. Further discussion is also needed around the care of patients who are seated to address the issues highlighted around chair height, redistribution of weight, and pressure-relieving cushions.

Involving staff in the process of change has been challenging, however, education and congruent leadership has helped with the transition by motivating individuals to change and feel part of the change process. There are still those who will only change at their own pace (Rogers, 2003), nonetheless, they have a professional requirement to continually update after qualification and, through the influence of others, will recognise they have a part to play in improving their own knowledge and skills in order to improve practice (Nursing and Midwifery Council, 2008).

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