Dear Editors,

The article by Downie et al (Wounds UK 9(3): 16–22) is an important contribution to the topic of pressure ulcer (PU) avoidability. This topic is of the highest priority to tissue viability and the implications of the judgment of avoidable or unavoidable PUs and the consequences of non-adherence.

For clarity, if the investigation of the PU development clearly demonstrated that there was a lack of documentation, at any stage of the patients’ care, this would automatically put the PU into the “avoidable” category. Due to article word limitations, we were unable to discuss this in detail. However, the importance of PU documentation in the form of care bundles has been addressed elsewhere (Kiernan and Downie, 2011; Downie et al, 2013).

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REFERENCES

Dear Editors,

We welcome Professor White’s comments, and the opportunity to further expand on our methodology and working definitions.

The term “hospital-acquired” is a contentious issue within the literature, and a clear definition of hospital-acquired PUs has not been universally employed. However, all five organisations reporting in our article sit within NHS Midlands and East, and use the Safety Thermometer definition of “hospital-acquired”, which is any PU that develops within the organisation after 72 hours of admission (NHS Health and Social Care Information Centre, 2012). In addition, if a PU develops within 72 hours of admission and investigation clearly shows a local cause (e.g. prolonged theatre time), this PU is also reported as “hospital acquired”.

The criteria used to determine “avoidable” and “unavoidable” PUs. As part of the NHS Midlands and East initiative (2012) to eliminate avoidable grade 2–4 PUs, an “unavoidable” definition was produced based on the 2009 NPUAP definition. This definition was used by all five organisations reporting in the article. It should also be noted, as stated in the article, all grade 3–4 PUs included in the data presented had external review and validation of their avoidable/unavoidable status performed by the clinical commissioners, formerly the Primary Care Trusts.

For clarity, if the investigation of the PU development clearly demonstrated that there was a lack of documentation, at any stage of the patients’ care, this would automatically put the PU into the “avoidable” category. Due to article word limitations, we were unable to discuss this in great detail. However, the importance of PU documentation in the form of care bundles has been addressed elsewhere (Kiernan and Downie, 2011; Downie et al, 2013).

The Stojadinovic et al (2013) article is exactly the kind of refined evidence our community needs to become increasingly sophisticated with regard to defining avoidable/unavoidable PUs and, in particular, with regard to deep tissue injury (DTI). We suggest, and have previously written (Guy et al, 2013), that the topic of DTI requires further exploration, discussion, and monitoring. However, while articles such as Stojadinovic et al (2013) offer important scientific background, they are not easily transferable, at present, for clinicians to use at the bedside to inform diagnosis. Therefore, we would encourage healthcare professionals working in tissue viability to monitor the ongoing progression of these skin injuries. A recent paper by Sullivan (2013) reports a 2-year retrospective review of suspected DTIs and found that only 9.3% of these lesions went on to full thickness damage. Further studies of this kind may add to our understanding of this phenomenon.

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LETTERS TO THE EDITORS