THE PAST POLITICS OF PRESSURE SORES

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The NHS was four years old when I started nursing at Southampton Eye Hospital. I started my general nurse training at St Bartholomew's Hospital in 1954. We were trained to work in a very task oriented way, in a hierarchy of tasks becoming more complex as you became more senior. The wards were run with a rigid routine with an experienced sister at the helm, who never seemed to go off duty. We worked very long hours and, as student nurses, were the main work force. The major advantage of this time was the continuity of care for the patients: agency nurses were unheard of then and patient stays were much longer, so we knew them very well. The level of supervision meant that we had to work to a high standard and the wards were very clean because we did most of the cleaning.

The care of pressure areas was a major part of a junior nurse's job. Whatever was happening in the ward, the back trolley left the sluice door every two hours. One thing we quickly realised was that the development of a pressure sore was a disgrace and the only cause could be bad nursing care. The guilt that nurses were made to feel was a big obstacle for me to overcome in later years.

Patients were nursed on fixed height beds with a sprung base and a thick mattress. They had to endure thick rubber draw macs and twill draw sheets. Each patient was turned with two nurses, the sacral area was washed with water and soap, surgical spirit and talcum were applied and the draw sheet was pulled through. Although the patients were kept in bed far longer than they are today, I can remember very few pressure sores developing, but I do have a lasting memory of the row that one caused and the disgrace it was seen to be for the nursing staff. A much more frequent complication of care then was the sudden death from pulmonary embolus, not seen in any way to be related to care. During the sixties I was a ward sister on a busy surgical ward. I had acquired two dunlopillo mattresses which were placed on top of the existing mattress for any vulnerable patient. Apart from now allocating the total care of one patient to one nurse, nursing care and knowledge had not moved much further on.

My interest in finding solutions to pressure sore prevention started when I was appointed Divisional Nursing Officer for the group of hospitals in Hackney in the east end of London. I agreed to go for six months at first but stayed for eight years, and in many ways this was a very interesting and fulfiling part of my career. This group of hospitals and been very run down and was lacking in resources, in great contrast to the teaching hospital I had just left. It had only recently joined St Bartholomew's as part of the 1974 reorganisation and the unequal distribution of resources in health care was marked at this time. My constant request for more of everything alarmed my colleagues at Barts as they saw any success I had in gaining more as meaning less for them. We were to see many such tensions as health care spending was brought under control and the annual increases were capped and not allowed to automatically rise with demand.

At this time there were constant increases in technology, medical skills, new operations, new treatments for cancer and better anaesthetic and resuscitation techniques combined with the emergence of assertive patient groups. All this meant an increasing demand but also more survivors of care who were aging, with multiple pathology, many of whom would require continuing care. We started to see these numbers rise at this time. Hackney had over 400 elderly care beds, but there were also many elderly patients in the acute care beds and in 1976 it was very obvious that there was a serious problem with pressure sore prevention as over 20% had developed severe pressure sores. I had to persuade the nurses to let me see the patients for the first count as there was no record kept. The nurses thought it was strange that I was interested and in some wards were worried and anxious.

It became obvious that if there was to be any success in solving the problem, I would have to get rid of the blame culture and only offer help that was non judgmental and constructive. I had no idea myself how we would tackle the problem but put this as a partnership project to them. If they would let me know every week how many pressure sores there were on the wards I would feed back the results and try to obtain all the resources and materials they needed. The method of classification was worked out, a form was devised and ongoing surveillance commenced. Following time spent with nurses on the wards, it became apparent that staffing was such a problem that two hourly turning was not going to be a realistic goal and so it was dropped as a solution.

Interesting though the work was, there were many more managerial duties for me. In order to be able to do it all, Frances was appointed to lead the pressure sore project. she gained a great expertise and the work moved on at a great pace, my role was one as a coordinator and facilitator. Although the problem appeared to be a big one, I was unable to get any idea of any comparison with other like hospitals; it was never talked about at that time.

We did receive a great deal of help and support from many people though. The commercial firms in the business brought me materials and information from all over the country, that I was otherwise unaware of. Many gave me new aids to evaluate and try and provided most of the money for education. Rosemary Crow and her team helped us to make sense of the huge amount of data we collected and indicated where our first areas of research should be. Following this, we received our first research grant from the Goldsmith's Company and bigger grants from regional research funds. This enabled us to employ Margaret Versluysen who gave us valuable insight into the care needs of vulnerable patients, particularly the elderly patient who had sustained a fractured neck of femur. We also learned more about the causes of pressure damage: delays in care and high surface pressures were among them. Most of these causes were way beyond the control of nurses. Very few doctors took much interest, so we were all very pleased when Mary Bliss joined the staff and what a difference that made. Professor Livesley was also a great help to us, as it was clear that only with multi disciplinary effort would any progress be made. The Tissue Viability Society was a great source of knowledge and inspiration.

The plan of action for prevention meant that vulnerable patients were identified and part of the plan was to provide them with a suitable support system. We became aware of the problems with the King's Fund bed. This bed, designed in the sixties was an advance in the operation of hospitals. The bed moved around the different departments of the hospital, the solid base and tilting mechanism made resuscitation easy, the alternating height made nursing easier but the mattress was a big problem. The narrow foam lost it's body with continual use and may patients were therefore resting on the solid base. This was another factor and had to be remedied.

All the mattresses had to be replaced and a store of pressure relieving aids had to be available in all the hospitals throughout 24 hours, if the prevention plan was to be in operation within one hour. The cost was huge, some of it could be raised but not nearly enough. The Finance Director was alarmed and had to be convinced.

In a very labour intensive way we costed a patient who had sustained a grade 4 pressure sore over a 180 day stay. The cost came to £25,000 and using the Opportunity Costs financial model we worked out that if that patient had not sustained that pressure sore, 16 hip replacements could have passed through that bed. The 1985 general management reorganisation had taken place. Captains of industry were recruited to solve all the problems of the NHS and get the budgets under control, so as well as presenting the Opportunity Costs argument, I also showed them pictures of severe pressure sores, so they would know what I was talking about.

The good thing this reorganisation brought about was Quality Assurance. This gave us all an excellent chance to define the standards of care for our patients and start to work out outcomes of care. Tissue viability fitted in well and was given a big push forward during this time.

During the eighties another propaganda tool came to aid the promotion of the prevention plan. A patient had taken action against a Health Authority and won a big settlement. Many such cases were to follow and I found myself in court several times giving evidence for patients and in some sad cases for their relatives. These cases were brought with legal aid, but many more were settled out of court as the cost of taking them to court, as well as the bad publicity, was not good news for any Health Authority. Although there was hostility in court in one such case, this big teaching hospital later invited me back to talk to the staff and help them set up a prevention plan. The work in my own patch was progressing so well that I now felt able to visit other hospitals when requested to encourage them to set up prevention plans. I knew by now that most could be prevented and we published our own prevention plan in 1988. I was convinced then and I still am that 95% of all pressure sores could be prevented.

When the purchaser and provider split came it was not difficult to persuade authorities to place the incidence of pressure sores within the contracts, with an emphasis on improvement. We also started to see national guidelines being developed with the push for clinical effectiveness from the DOH. The King's fund also became involved. Pressure sores were one of the five clinical conditions where the research was reviewed, guidelines were produced and volunteers were sought to test them out. There has been a big debate about whether some research fails to bring the right answers as it does not ask the right questions and it is good to know that the drive for effective outcomes will provide more direction.

The drive for a pressure sore prevention strategy for all ill patients, wherever they are nursed has been a long hard struggle, but much has been achieved in recent years. For so many years nurses tried to find answers on their own. Many of us did become very knowledgeable about the importance of surface pressures and took what steps possible to ameliorate this. However, patients' problems are complex and there is no one discipline that knows all the answers. The very best of care and the quickest way of solving problems occurs when all the disciplines work together with a leader who has the leadership qualities that lead to good multidisciplinary effort. Although much has been learned, there is still a lot left to do. The constant turnover of staff means that education and updating of skills has to be a continuing process. I look forward to the time when pressure damage is a rare event.

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