

Pressure ulcer on sacrum

Food & Diet



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BUSTER**

The purpose of this assignment is to identify a patient, under the care of the district nursing team, with a Grade 1 pressure ulcer, to their sacral area. To begin with, it will give a brief overview of the patient and their clinical history. Throughout the assignment the patient will be referred to as Mrs A, in order to protect the patients identity and maintain confidentiality, in accordance with the guidelines set out by the Nursing and Midwifery Council (NMC 2008). A brief description of a Grade 1 pressure ulcer will be given, along with a description of the steps taken in assessing the wound, using The Waterlow Scale (1985). This assignment will discuss the literature review that was carried out, along with other methods of research used, to gather vital information on wound care , such as the different classifications of wounds and the different risk assessment tools available. This assignment, will include brief overviews, of some the other commonly used pressure ulcer risk assessment tools, that are put to use by practitioners and how they compare to the Waterlow Scale. This assignment will also seek to highlight the importance of using a combination of clinical judgement, by carefully monitoring the patients physical and psychological conditions, alongside the ‘ at risk’ score calculated from the Waterlow Scale, in order to deliver holistic care to the patient.

Mrs A is a 84 year old lady who has been referred to the district nurses by her General Practitioner, as he has concerns regarding her pressure areas . Following a recent fall she lost her confidence and is now house bound. She now spends more time in her chair as she has become nervous when mobilising around the house and in her garden. She has a history of high blood pressure and occasional angina for which she currently takes

Nicorandil 30mg b. d. as prescribed by her General Practitioner , Nicorandil has been recognised as an aetiological aspect of non – healing ulcers and wounds (Watson, 2002), this has to be taken into consideration during the assessment and throughout the management of her wound. Mrs A has no history of previous falls or problems with her balance. She has always been a confident and independent lady, with no current issues surrounding continence or diet. She has always enjoyed a large network of friends who visit her regularly. It is recommended by National Institute for Health and Clinical Excellence (NICE) that patients should receive an Initial assessment (within the first 6 hours of inpatient care) and ongoing risk assessments and so referrals of this nature are seen on the day, if it is received if not within 24 hrs. In order to establish Mrs A's current risk of developing a pressure area, an assessment must take place. An initial holistic assessment, looking at all contributing factors such as mobility, continence and nutrition will provide a baseline that will identify her level of risk as well as identifying any existing pressure damage.

A pressure ulcer is defined as, a localised injury to the skin and / or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing, or confounding factors, are also associated with pressure ulcers. According to the European Pressure Ulcer Advisory Panel (EPUAP 2009), the significance of these factors, is yet to be elucidated.

Mrs A is more vulnerable to pressure damage, as her skin has become more fragile and thinner with age (NICE 2005). There are risk factors associated to the integrity of the patient's skin and also to the patients general health.

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Skin that is already damaged, has a higher incidence of developing a pressure ulcer, than that of healthy skin. Skin that becomes too dry, or is more moist due to possible incontinence, is also at higher risk of developing a pressure ulcer than healthy skin. An elderly person's skin is at increased risk, because it is more fragile and thinner than the skin of a younger person. Boore et al (1987) identified the following principles in caring for the skin to prevent pressure damage, skin should be kept clean and dry and not left to remain wet. The skin should also not be left to dry out to prevent any accidental damage . Due to Mrs A spending more time sitting in her chair, she has become at a higher risk of developing a pressure sore, as she is less mobile. The reason being It becomes difficult for the blood to circulate causing a lack of oxygen and nutrients to the tissue cells. Furthermore, the lymphatic system also begins to suffer and becomes unable, to properly remove waste products. If the pressure continues to increase and is not relieved by equipment or movement. The cells can begin to die, leaving an area of dead tissue resulting in pressure damage. Nelson et al (2009) states, pressure ulcers can cause patients functional limitations, emotional distress, and pain for persons affected. The development of pressure ulcers, in various healthcare settings, is often seen as a reflection of the quality of care which is being provided (Nakrem 2009). Pressure ulcer prevention is very important in everyday clinical practise, as pressure ulcer treatment is expensive and factors such as legal issues have become more important. EPAUP (2009) have recommended strategies, which include frequent repositioning the use of special support surfaces, or providing nutritional support to be included in the prevention.

In order to gather evidence based research, to support my assignment. I undertook a literature review of the Waterlow Scale and Classifications of Grade 1 pressure sores. The databases used were the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and OpenAthens. I used a variety of search terms including ‘pressure sores’, ‘Grade 1 classification’, ‘Waterlow Scale’, and ‘How pressure sore risk assessment tools compare’. Throughout the literature review the information was gathered from sources using a date range between the years of 2000 – 2011, although some references were found from sources of information that are from a much later date. This method of research ensured a plethora of articles and guidelines were collated and analysed. The trust guidelines in wound care were used, to show how we implement theory into practise in the community, using the wound care formulary. There was a vast amount of information available, as pressure area care is such a broad subject. The search criteria had to be narrowed down, in some cases to ensure the information gathered was relevant and not beyond the scope of the assignment. The evidence used throughout this assignment, is based on guidelines and recommendations given by NICE (2001), EPUAP (2001) and articles sourced from The Journal of Community Nursing (JCN). This was the most accurate information and guidance on pressure ulcer classifications and assessment although, some articles may not have been the most recent.

The assessment tool used throughout my area of work, is the Waterlow Scale. The Waterlow Scale was developed by Judy Waterlow in 1985, while working as a clinical nurse teacher. It was originally designed for use by her student and is used to measure a patient’s risk of developing a pressure

sore. It can also be used as a guide, for the ordering of effective pressure relieving equipment. All National Health Service (NHS) trusts have their own pressure ulcer prevention policy, or guidelines and practitioners are expected to use the risk assessment tool, specified in their trust's policy. NICE (2003), guidance states, that all trusts should have a pressure ulcer policy, which should include a pressure ulcer risk assessment tool. However, it reminds practitioners that the use of risk assessment tools, should be thought of as an aid to the clinical judgement of the practitioner. The use of the Waterlow tool enables, the nurse to assess each patient according to their individual risk of developing pressure sores (Pancorbo-Hidalgo et al 2006). The scale illustrates a risk assessment scoring system and on the reverse side, provides information and guidance on wound assessment, dressings and preventative aids. There is information regarding pressure relieving equipment surrounding, the three levels of risk highlighted on the scale, and also provides guidance, concerning the nursing care given to patients. Although the Waterlow score is used in the community setting, when calculating the risk assessment score, it is vital that the nurse is aware of the difference in environment the tool was originally developed for.

The tool uses a combination of core and external risk factors that contribute to the development of pressure ulcers. These are used to determine the risk level for an individual patient. The fundamental factors include disease, medication, malnourishment, age, dehydration / fluid status, lack of mobility, incontinence, skin condition and weight. The external factors, which refer to external influences which can cause skin distortion, include pressure, shearing forces, friction, and moisture. There is also a special risk section of

the tool, which can be used if the patient is on certain medication or recently had surgery. This contributes to a holistic assessment of a patient and enables the practitioner to provide the most effective care and appropriate pressure relieving equipment. The score is calculated, by counting the scores given in each category, which apply to your patient's current condition. Once these have been added up, you will have your 'at risk' score. This will then indicate the steps that need to be taken, in order to provide the appropriate level of care to the patient. Identification of a patient's risk of developing a pressure sore is often considered the most important stage in pressure sore prevention (Davis 1994).

During the assessment a skin inspection takes place of the most vulnerable areas of risk, typically these are heels, sacrum and parts of the body, where shear or friction could take place. Elbows, shoulders, back of head and toes are also considered to be more vulnerable areas (NICE 2001). When using the Waterlow tool to assess Mrs A's pressure risk, I found she had a score of 9. According to the Waterlow scoring system she is not considered as being at risk as her score is less than 10. As I had identified in my assessment, she had a score of 2, for her skin condition due to Grade 1 pressure ulcer to her sacrum. I felt it necessary, to highlight her as being at risk. A grade 1 pressure ulcer on her sacral area, maybe due to her recent loss of confidence and reduced mobility which has left Mrs A spending more time in her chair.

Pressure ulcers are assessed and graded, according to the degree of damage to the

tissue. The National Pressure Ulcer Advisory Panel (NPUAP), classifies pressure ulcers based on the depth of the wound. There are four classifications (Category/Stage I through IV) of pressure damage. In addition to these, two other categories have been defined, unstageable pressure ulcers and deep tissue injury (EPUAP, 2009) Grade 1 pressure damage is defined, as a non-blanchable erythema of intact skin. Indicators can be, discolouration of the skin, warmth, oedema, induration or hardness, particularly in people with darker pigmentation (EPUAP, 2003). It is believed by some practitioners, that blanching erythema indicates Grade 1 pressure damage (Hitch 1995) although others suggest that, Grade 1 pressure damage is present, when there is non-blanching erythema (Maklebust and Margolis, 1995; Yarkony et al, 1990). The majority of practitioners, agree that temperature and colour play an important role, in identifying grade 1 pressure ulcers (EPUAP, 1999) and erythema, is a factor in almost all classifications (Lyder, 1991). The pressure damage usually occurs, over bony prominences (Barton and Barton 1981). The skin in a Grade 1 pressure ulcer, is not broken, but it requires protection and monitoring.

At this stage, it will not be known how deep the pressure damage is, regular monitoring and assessment is essential. The pressure ulcer may fade, but if the

damage is deeper than the superficial layers of the skin, this wound could eventually

develop into a much deeper pressure ulcer over, the following days or weeks.

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A Grade 1 pressure ulcer, is classed as a wound and so I have commenced a wound care plan and also a pressure area care plan. I will also ensure, Mrs A has

regular pressure area checks in order to prevent the area breaking down.

The

pressure area checks will take place weekly until the pressure relieving equipment

arrives, this will then be reduced to 3 monthly checks. Dressings can be applied to

a Grade 1 pressure ulcer. They should be simple and offer some level of protection.

Also, to prevent any further skin damage a film dressing is often used, or a

hydrocolloid to protect the wound area (EPAUP, 2009) . These dressings will assist in

reducing further friction, or shearing, if these factors are involved. It is considered

the best way to treat a wound, is to prevent it from ever occurring.

Removing the

existing external pressure, reducing any moisture, which can occur if the patient is

incontinent and employing pressure relief devices, may contribute to wound healing.

Along with adequate nutrition, hydration and addressing any underlying medical conditions.

The advice given to practitioners, on the reverse of the Waterlow tool is to provide a

100mm foam cushion, if a patients risk score is above 10. As Mrs

A has an 'at risk' score of 9, with a Grade 1 pressure sore evident, I feel it appropriate to provide the pressure relieving mattress and cushion to prevent any

further pressure damage developing. All individuals, assessed as being vulnerable to

pressure ulcers should, as a minimum provision, be placed on a high specification

foam mattress with pressure relieving properties (NICE, 2001). As I am providing a

cushion and a mattress, it is not felt necessary to apply a dressing at this point.

However, the area will need regular monitoring, as at this stage it is unknown how

deep the pressure damage is. If proactive care is given in the prevention and treatment of pressure ulcers, with the use of risk assessments and providing pressure relieving resources, the pressure area may resolve. Pressure ulcers can be

costly for the NHS, debilitating and painful for the patient. With basic and effective

nursing care offered to the patients, this can often be the key to success.

Bliss (2000) suggests that the majority of Grade I ulcers heal, or resolve without

breaking down if pressure relief is put into place immediately. However, experiences

in a clinical settings supports observations, that non-blanching erythema can often

result in irreversible damage (James, 1998; Dailey, 1992).

McGough (1999) during a literature search, highlighted 40 pressure ulcer risk assessment tools, but not all have be considered suitable, or reliable for all clinical

environments. As there are many different patient groups this often results in a wide

spectrum of different patient needs. The three most commonly used tools in the United Kingdom (U. K.) are, The Norton scale, The Braden Scale and The Waterlow Scale.

The first pressure ulcer risk assessment tool was the Norton scale. It was devised by Doreen Norton in 1962. The tool was used for estimating a patient's risk for developing pressure ulcers by giving the patient a rating from 1 to 4 on five different factors. A patients with a score of 14 or more, was identified as being at high risk. Initially, this tool was aimed at elderly patients and there is little evidence from research gathered over the years, to support its use outside of an elderly care setting. Due to increased research over the years, concerning the identification and risk of developing pressure ulcers, a modified version of the Norton scale was created in 1987.

The Braden Scale was created in the mid 1980's, in America and based on a conceptual schema of aetiological factors. Tissue tolerance and pressure where identified, as being significant factors in pressure ulcer development. However, the validity of the Braden Scale is not considered to be high in all clinical areas (Capobianco and McDonald, 1996). However, EPAUP (2003) state The Braden

Risk Assessment Scale is considered by many, to be the most valid and reliable

scoring system for a wide age range of patients.

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The Waterlow Scale, first devised in 1987, identifies more risk factors than the Braden and the Norton Scale. However, even though it is used widely across the U. K., it has still be criticised for its ability to over predict risk and ultimately result in the misuse of resources (Edwards 1995; McGough, 1999).

Although there are various tools, which have been developed to identify a patients individual risk, of developing pressure sores. The majority of scales have been developed, based on ad hoc opinions, of the importance of possible risk factors, according to the Effective Healthcare Bulletins (EHCB, 1995). The predictive validity of these tools, has also been challenged (Franks et al, 2003; Nixon and Mc Gough, 2001) suggesting they may over predict the risk, incurring expensive cost implications, as preventative equipment is put in place, when it may not always be necessary. Or they may under predict risk, so that someone assessed as not being at high risk develops a pressure ulcer. Although The Waterlow scoring system, now includes more objective measurements such as Body Mass Index (BMI) and weight loss after a recent update. It is still unknown, due to no published information, whether the inter-rater reliability of the tool, has been improved by these changes. It has been acknowledged, that this is a fundamental flaw of these tools and due to this clinical judgement, must always support the decisions made by the results, of the risk assessment. This is clearly recognised by NICE, as they advise their use as an aide-mémoire (2001). The aim of Pressure ulcer risk assessment tools, is to measure and quantify pressure ulcer risk. To determine the quality of these measurements the evaluation of validity and reliability would usually take place. The validity and reliability limitations, of pressure ulcer risk tools are widely

acknowledged. To overcome these problems, the solution that is recommended is to combine the scores of pressure ulcer risk tools, with clinical judgment (EPAUP 2009). This recommendation, which is often seen in the literature, unfortunately is inconsistent as Papanikolaou et al (2007) states: “ If pressure ulcer risk assessment tools have such limitations, what contribution can they make to our confidence in clinical judgment, other than prompting us about the items, which should be considered when making such judgments?”. Investigations of the validity and reliability, of pressure ulcer risk tools are important, in evaluating the quality, but they are not sufficient to judge their clinical value. In the research of pressure ulcer tools, there have been few attempts made to compare, the different pressure ulcer risk assessment strategies. Referring to literature until 2003, Pancorbo – Hidalgo et al (2006) identified three studies, investigating the Norton scale compared to clinical judgment and the impact on pressure ulcer incidence. From these studies, it was concluded that there was no evidence, that the risk of pressure ulcer incidence was reduced by the use of the risk assessment tools. The Cochrane review (2008), set out to determine, whether the use of pressure ulcer risk assessment , in all health care settings , reduced the incidence of pressure ulcers. As no studies met the criteria, the authors have been unable to answer the review question. At present there is only weak evidence to support the validity, of pressure ulcer risk assessment scale tools and obtained scores contain varying amounts of measurement error.

To improve our clinical practise, it is suggested that although tools such as the

Waterlow Scale are used to distinguish a patient's pressure ulcer risk, other investigations and tests, may need to be carried out to ensure an effective assessment is taking place. Practitioners may consider, various blood tests and more

in depth history taking, including previous pressure damage and medications. Patients

lifestyle and diet should also be taken into consideration and where appropriate, a

nutritional assessment should be done if recent weight loss, or reduced appetite is

evident. Nutritional assessment and screening tools are being used more readily and appear to be becoming more relevant in managing patients who are at risk of or have a pressure ulcer. The assessment tools should be reliable and valid, and as discussed previously with other risk assessment tools they should not replace clinical judgement. However, the use of nutritional assessment tools can help to bring the nutritional status of the patient to the attention of the practitioner, they should then consider nutrition when assessing the patient's vulnerability to pressure ulcer development. The nutritional status of the patient should be updated and re-assessed at regular intervals following an assessment plan which is individual to the patient and includes an evaluation date. The condition of the individual will then allow the practitioner to decide how frequent the assessments will occur. The EPUAP (2003) recommends that as a minimum, <https://assignbuster.com/pressure-ulcer-on-sacrum/>

assessment of nutritional status should include regular weighing of patients, skin assessment, documentation of food and fluid intake.

As Mrs A currently has a balanced diet, it is not felt necessary to undertake, a

nutritional assessment at this point. Her weight can be updated on each review visit,

to assess any weight loss during each visit. If there is any deterioration in her condition, an assessment can be done when required. Continence should also be

taken into consideration and where necessary a continence assessment should take

place. Incontinence and pressure ulcers are common and often occur together.

Patients who are incontinent are generally more likely to have difficulties with their

mobility and elderly, both of which have a strong association with the development

of pressure ulcers (Lyder, 2003).

The education of staff, surrounding pressure ulcer management and prevention, is

also very important. NICE (2001) suggest, that all health care professionals, should

receive relevant training and education, in pressure ulcer risk assessment and

prevention. The information, skills and knowledge, gained from these training

sessions, should then be cascaded down, to other members of the team. The

training and education sessions, which are provided by the trust, are expected to

cover a number of topics. These should include, risk factors for pressure ulcer

development, skin assessment, and the selection of pressure equipment.

Staff are

also updated on policies, guidelines and the latest patient educational information

(NICE 2001).

Education of the patient, carers and family, is essential in order to achieve optimum

pressure area care. Mrs A is encouraged to mobilise regularly, in order to relieve

the pressure as a Grade 1 pressure sore has been identified, she is at a significant

risk of developing a more severe ulcer. Interventions to prevent deterioration, are

crucial at this point. It is thought, that this could prevent the pressure sore from

developing into a Grade 2 or worse. NICE (2001) have suggested, that individuals

vulnerable to or at elevated risk of developing pressure ulcers, who are able and

willing, should be informed and educated about the risk assessment and resulting

prevention strategies. NICE have devised a booklet for patients and relatives, called

Pressure Ulcers – Prevention and Treatment (NICE Clinical Guidance 29), which gives

information and guidance on the treatment of pressure ulcers. It encourages patients

to check their skin and change their position regularly. As a part of good practise,

this booklet is given to Mrs A at the time of assessment, in order for her to
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develop some understanding of her pressure sore. This booklet is also given to the

care givers or relatives so they can also gain understanding, regarding the care and

prevention, of her pressure ulcer. An essential part of nursing documentation, is care

planning. It demonstrates the care, that the individual patient requires and can be

used to include patients and carers or relatives in the patients care.

Involvement of

the patient and their relative, or carer is advisable, as this could be invaluable, to

the nurse planning the patient's care. The National Health Service Modernisation

Agency (NHSMA 2005) states clearly that person – centred care is vital and that care planning

involves negotiation, discussion and shared decision – making, between the nurse and

the patient.

There were a number of improvements that I feel could have been made to the holistic care of Mrs A. I feel that one of the fundamental factors that

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needed to be considered, were the social needs of the patient. As I feel they are a large contributing factor, towards why the patient may have developed her pressure sore. The patient was previously known to be a very sociable lady, who gradually lost her confidence, resulting in her not leaving the house. There are various schemes and services available, which are provided by the local council or volunteer services, to enable the elderly or people unable to get around. For example, an option which could of been suggested to Mrs A are services such as Ring and Ride, or Werneth Communicare. Using these services or being involved in these types of schemes, may have empowered Mrs A to leave the house on a more regular basis. This would enable her to build up the confidence, she lost following her fall. This would have also led to positive impact on the patient's psychological care, as Mrs A would have been able to overcome her fears of leaving the house, enabling her to see friends and gain communications lost. As previously mentioned in this assignment, although Mrs A had a score of 9, which is not considered an 'at risk' score. I still felt it necessary to act on this score, even though the wound was a not considered to be critical. If it is felt the patient is at a higher risk than that shown on the assessment tool, the practitioner should use their clinical judgement, to make crucial care decisions. It should also be considered, by the practitioner that risk assessment tools such as The Waterlow scale, may not have been developed, for their area of practise. Throughout the duration of Mrs A's wound healing process, a holistic assessment of her pressure areas and general health assessment were carried and all relevant factors, were taken into consideration. The assessment tool used to assess her pressure areas, is the most common tool used currently in practise and the tool recommended by the Trust.

To conclude, there is evidence prove that pressure ulcer risk assessment tools are useful, when used as a guide for the procurement of equipment. However, they cannot be relied upon solely to provide holistic care to a patient. It has been highlighted, that to ensure a holistic assessment of patients, it is necessary to complete a variety of assessments, to create a complete picture. Although The Waterlow scale covers a number of factors that need to be considered, throughout the assessment, it has become evident that the ' at risk' score, can often be over or under scored depending on the practitioner. Clinical judgement has proved to be, a very important aspect of pressure ulcer prevention and treatment. The education of the patient, carer and relatives has also been highlighted, as an important aspect of care. Empowering the patient with information regarding their illness, may decrease the healing time and help prevent has further issues.