

The use of compression bandaging nursing essay



Using guidelines and research as well as prior knowledge that I had accumulated from previous practice placements about the subject, an evidence-based decision could be made. The patient was fully aware of all decisions made and given options regarding the type of dressings they would prefer along with leaflets that showed statistics of healing wounds. They were fully involved with their care by myself and my mentor. Valuing People (Department of Health, 2001) stresses the important role that person-centred planning can play in helping people take charge of their own lives. My personal reason for choosing this subject to explore is I have seen and been involved with a lot of leg ulceration and the long process of healing, however I feel by discussing and exploring the subject that I can develop my skills by looking at other literature around the subject and other trust policies for future reference. It will help me take a deeper look at the physiology of leg ulcers. Practitioners need to be aware of how different types of ulcers require different kinds of dressings to manage these. Therefore utilising up-to-date and pertinent literature I will look at the decision-making process as to why compression bandaging would be suitable and how it can be an effective treatment in healing leg ulcers.

The cost of treating specific wound types has been researched nationally and impacts on all trust budgets. Venous leg ulcers alone cost £240-400 million 15 years ago (Bosanquet 1992) although research-based treatments to improve healing rates using tissue viability specialist-led services have reduced some costs and improved patient outcomes (Ellison et al 2001). An estimated £373.4 million of the budget for medical consumables items is spent on wound dressings. Population prevalence rates generally fall in the

range of 1. 2-3. 2 per 1, 000 people (Graham et al, 2003), which means there are 70, 000-190, 000 individuals in the UK with a venous leg ulcer at any time. Prevalence increases markedly with age. A UK study examined the prevalence of venous ulceration in a local population (Moffatt et al, 2004). In those aged over 85, rates were 8. 29/1, 000 (men) and 8. 06/1, 000 (women). In this study, 55% of patients had had their ulcer for longer than a year.

The patient been cared for is a 63 year old women called Eve* who was admitted to the medical ward I was working on due to an exacerbation of her COPD, been a heavy smoker for best part of 40 years this patient was regularly been admitted to the ward. She has a family history of Deep vein thrombosis (DVT) and has type 2 diabetes which is caused to her been extremely overweight. She has very severe leg ulcers to both legs which she has only developed recently. Despite various wound dressings been applied the ulcers to her legs were not healing. Her mobility has decreased rapidly due to the ulcers.

On assessment of her ulcer, which was that the ulcer had no clinical signs of infection, I along with my mentor decided the first step would be to carry out a Doppler test. Before the Doppler test was carried out and through effective communication with Eve. I recorded Eve's full clinical history (ulcer history, medical history), physical examination (blood pressure, weight, urinalysis using a leg ulcer assessment tool. This assessment tool was used to support Eve's medical history and to identify possible health problems, which may have gone unrecognised. The decision was made to do the Doppler due to the fact that Eve had a family History of DVTs. A history of DVT is common in <https://assignbuster.com/the-use-of-compression-bandaging-nursing-essay/>

patients with leg ulcers, Elder & Veer (1995), and also because Eve has a history of leg ulcers. Knowing that after six weeks a chronic wound which remains unhealed becomes an ulcer. (Collins et al, 2002). After explaining the procedure to the patient and also making sure that Eve didn't have any of the contraindications to which she wouldn't be suitable for the procedure we carried out the Doppler assessment. Contraindications include: If the patient has cellulitis, because the procedure would be too painful or if the patient has severe ischemia, because there is a risk of further tissue damage. (Nursing Times 2003).

According to the RCN Guidelines (2008) all patients with chronic wounds should have access to the Doppler assessment to determine more thorough detection of arterial problems. An ankle brachial pressure index (ABPI) is a simple non-invasive method of identifying arterial insufficiency within a limb. An important factor determining the rate of healing of any wound is adequate arterial blood supply. In the management of leg ulcers, the ABPI forms a fundamental part of the assessment. The Doppler identified that Eve did not suffer from arterial disease; Callam et al (1987) suggest that compression bandaging is contraindicated in patients with significant arterial disease, as compression applied to a patient with ischemia might result in necrosis leading to amputation.

The ABPI is calculated by the highest ankle systolic pressure/ highest brachial systolic pressure, Eves readings were 1 and 1.15 for the right and left leg respectively. From these readings and following trust and national guidelines I and the nurse knew that Eve may be suitable for compression bandaging. However from previous experience of carrying out Doppler tests

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and compression bandaging alongside my mentor, I was aware that because the patient had type 2 diabetes this may give abnormal readings. There has been further research into whether a Doppler assessment would give accurate readings in a patient with diabetes, The result may be falsely elevated in patients with diabetes due to calcification of the medial layer of the artery, preventing the arteries from being compressed (Williams et al, 1999); An ABPI <0.8 usually suggests that the patient is not suitable for compression bandaging. There is little evidence for choosing this figure, however, and yet most practitioners use it as a guide for the safe application of compression bandaging (Marston and Vowden, 2003), because me and my mentor weren't experts in the field of Doppler tests and compression bandaging we were a little unsure because Eve had diabetes whether compression bandaging should be applied. The decision was made to ask advice from the tissue viability specialist nurse. The specialist nurse came to the ward to assess Eve's leg ulcers. She advised that compression bandaging would be suitable to use and that they should be changed every one to two weeks, I made the decision that Eve's dressings should be changed weekly due to a high amount of exudate, making them very wet and uncomfortable. Partsch, H (1991) advise that wet compression bandaging should be changed at least once weekly. As advised by the specialist nurse, I began with washing the ulcers and the surrounding skin with salt water and used atrauman as a primary dressing, the rationale for using this dressing is it is a low adherent dressing meaning that it aids healing, improves comfort, and controls exudate, this was appropriate because Eve's ulcers are very wet, their role in maintaining moisture facilitates autolytic debridement and promotes healing, Jones, et al, 2006. There is insufficient evidence to show

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that any wound dressing is better than simple low-adherent dressings for the healing of venous leg ulcer, Palfreyman et al, 2006.

I would not at this stage say that I was competent in choosing dressings for leg ulcers or competent in applying compression bandaging, however I know that you have to have had training to be able to complete compression bandaging safely and effectively. According to government policy application of compression bandaging can only be applied by a trained and qualified member of staff. The incorrect application can lead to the leg ulcer deteriorating further. (NHS Choices 2003). Therefore using Patricia Benner's novice to expert model (1984), I would put myself in the advanced beginner stage, the reason for this would be because I have observed Compression Bandaging been applied in the past and I do understand the physiology of why compression bandaging is applied to a venous leg ulcer and I do have an understanding of why the Doppler assessment is important, so I do believe I am further than a novice, but would not yet put myself in the competent stage.

Eve was on the ward for a significant period of time and it became obvious on her first dressing change that she was in a severe amount of pain and discomfort with her legs. Studies centred on chronic leg ulceration often find that health related quality-of-life issues are a major concern for patients, (Hopkins, 2004), and findings from these studies are generally well known to healthcare professionals. However, there have been limited changes in clinical practice; anecdotal evidence suggests that the assessment of patients with leg ulcers remains primarily focused on the ulcer(s) rather than on the patient. Although Eve was taking regular prescribed paracetamol on

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the ward it was obvious that these were not a strong enough analgesic. I decided that I would need to ask the doctor to prescribe a strong analgesic such as Oramorph as required. I firstly made sure that Eve did not have any known drug allergies.

On discharge from hospital Eve required a district nurse referral for dressing changes and to apply the compression bandaging. As a management student nurse who has completed two district nurse placements throughout my training I was aware that Patients who had leg ulcers would be referred to the leg ulcer specialist nurse by the district nurse in the community. Who would reassess Eve's leg ulcers on a weekly basis whether that was at Eve's home or if Eve was able to get out this would be at a clinic close to Eves home once a week. Many parts of the UK follow a nurse led leg ulcer clinic, rates of healing of leg ulcers due to these clinics have been shown to improve and costs have been reduced. (Moffatt et al, 1992).

Using my previous knowledge, local and national guidelines, the specialist nurse advice and also my mentor's knowledge we were able to make a multi disciplinary team holistic decision for my mentor to apply compression bandaging. This decision was the best option to take regarding the patient's ulcers and also the patient's quality of life, where Clinical experience is identified as being essential for effective clinical decision making (Benner (1987), cited in Jasper, 2006). Bakalis (2006) stressed that the experience level of the nurse has a profound effect on the decision-making process. He also made reference to (Benner (1987) experimental study examining differences in the way that novices and experts make decisions. The findings concluded that the experts often used less information in making a more

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accurate diagnosis and generated more alternative actions, were more specific in evaluating alternative actions and developed better nursing plans than novices. On the hand, Thompson et al (2004) emphasised that although Benner's work has provided insight into the nature of expert nursing practice, it fails to give details of how information is processed to inform accurate judgements. Throughout the decision making process the Situated Clinical-Decision Making Framework (Gillespie, 2009), could be used, She states how there is a well documented concern in the literature how novice nurses tend to make clinical decisions on limited knowledge and experience. There is evidence to suggest that novice nurses tend to follow documents and care plans to help make a decision (Radwin 1998). As they make decisions, their focus leans towards doing rather than on thinking and reflecting. Adair's (1999) five step decision making model could also be used the nurse will follow 5 defined steps to arrive at a decision. Comparing the two models I believe Adair's would be the best one to follow for a student nurse as it is easier to understand and makes it easier to relate to the main focus points. However, although this is a guide for nurses to make the best decision in practice it is important to note that for each individual patient with the same scenario a different outcome may be achieved because ultimately we are making the decision on what's best for the patient holistically. (Lewis et al, 1999) suggested that this approach follows values and outcomes to assist nurses in the decision making process. Myself and my mentor used our past knowledge and experience along with the expertise of the specialist nurse to use the best intervention for the patients leg ulcers. Eve's smoking and family history of DVT's contributed to the leg ulcers and also because she had diabetes we had to follow the specialists

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nurse advice on whether compression bandaging would be a safe and appropriate intervention for Eve. I believe the specialist nurse was expert in her field and without her we might have made the wrong decision for the patient I feel she played an important role in the clinical decision making process., Patricia Benner (1984) explained an expert as someone who has much more background knowledge on the subject, no longer relies on principles and guidelines to make the best decision, is highly proficient in their performance and has intuitive grasp of clinical situations. Moore (1996) suggests that it is not possible based on all opportunities and possible outcomes for nurses to make a rational approach to the decision. He also emphasises how the decision is limited by the decision makers knowledge, experience and intellectual capacity of the situation, myself and my mentor were able to use a rational approach as well as expert opinion to increase the reliability of the decision made to use compression bandaging.

Communication throughout the decision making process involving the patient is an important tool for nurses. Good documentation skills and communicating to all professionals involved achieves the best outcome for the patient involved. (Chapman 1994). When caring for a patient whose quality of life and lifestyle has been changed due to decreased mobility and pain it is essential to keep them informed of the decisions been made because lack of information will have a negative psychological impact on their ability to take part in the decision making process. (Moffatt et al 2006).

In conclusion, clinical decision making is a complex process. Nurses use a range of information to make judgements and these judgements can be challenge, whatever the outcome. Competency, knowledge and experiences

increase the cognitive resources available for interpretation of data resulting in more accurate decision making. Expert or novice practitioner, the patient's care and needs must always be paramount; I feel the care the patient received was ultimately the right decision made for the patient's best interest.