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Case study; Management of a Pressure Sore This essay analyses the assessment tools used and care given to a patient with a grade 2 pressure ulcer on the lower part of the sacrum, and at potential risk of further skin breakdown. The essay begins with an overview of what pressure ulcers are and the prevalence and incidence of pressure ulcers. The paper goes on to evaluate the assessment tools used and the care plan that was implemented for the patient , the essay then discusses the impact of the pressure ulcer on the patient and his wife and concludes with a reflection on the validity and reliability of the assessment tools used. The name of the patient has been changed to maintain confidentiality. Pressure ulcers also known as debucutis ulcers, are an area of localized injury to the skin and underlying tissue, they are caused when the affected area of skin is placed under too much pressure, shear or friction or a combination of these. (Wright et al 2007). When sustained pressure is placed on a particular part of the body the blood supply to that part of the body is interrupted. Blood contains oxygen and other nutrients that are essential to help keep tissue healthy and without a constant blood supply, tissue damage occurs and the tissue will eventually die. The lack of blood supply means that the skin no longer receives infection-fighting white blood cells resulting in the development of a pressure ulcer. Pressure ulcers can range in severity from areas of discoloured skin to open wounds that expose the underlying bone or muscle. Pressure ulcers are a serious problem in health care systems, they cause pain and suffering and can lead to infection, and if not prevented or managed effectively can result in fatality. (Nazarko 2005). The presence of a pressure ulcer creates a number of significant difficulties, psychologically, physically and clinically, to

patients, carers and their families, they are a widespread and often under - estimated health problem in the UK. (RCN, 2005). Current research suggests that prevalence rates in the UK are between 5. 1 percent and 32. 1 percent across a range of care settings. It is estimated that approximately half a million people in the UK will develop a new pressure ulcer in any given year. This is usually people with an underlying health condition. The most consistently associated factors contributing to pressure ulcer development include inactivity, restricted mobility, sensory impairment, incontinence and nutritional status. (Russell 2000). The groups identified as most at risk of pressure ulcers include those who are seriously ill, neurologically compromised, have impaired mobility or who are immobile, those who suffer from impaired nutrition, obesity and older people. (NICE, 2005) The financial cost to the NHS is considered to be substantial, recent financial estimates put the total cost of pressure ulcer care in the UK between 1999 and 2000 as £1. 4 to 2. 1 billion (Dougherty et al 2008). The causes of pressure ulcers are split into two groups, intrinsic- that which is within the body and cannot be influenced and extrinsic- that which is external to the body and can be influenced. Intrinsic factors include; disease, medication. malnutrition, age, dehydration/fluid status, lack of mobility, incontinence, skin condition, weight. Extrinsic causes are; pressure, shearing forces, friction, moisture. (Waterlow, 2011) Mr Elliot is a 77 year old man who has advanced stage Alzheimer’s disease and double incontinence. He has a grade 2 pressure ulcer on his sacrum. The ulcer is superficial and presents as a blister, with whitening of the skin, whereas before it was red. The area around the wound is red and irritated and the skin also appears cracked and broken (EPUAP

2009). Informal and formal assessments were adopted to fully ascertain Mr Elliot's level of risk of pressure ulcers. The assessments are also integral in planning care for management of his current pressure ulcer and any care needs that may hinder prevention and management of pressure ulcers. Nice guidelines for The Management and Prevention of Pressure Ulcers in Primary and Secondary Care (2005), advises that an assessment of the ulcer together with an initial and ongoing holistic assessment is the foundation for commencing, developing, maintaining and evaluating the plan of care for an individual with a pressure ulcer. Mr Elliot's holistic assessment was based on his ability to carry out Activities of Daily Living (ADL's), such as eating and drinking, dressing, bathing, mobilising and continence, this was used as a guide establish his care needs and the level of intervention necessary to plan his care. Holistic assessments have been associated with improvement in patient outcomes; they provide a baseline for planning and monitoring care identify problems and promote continuity and communication as well as education (Hayes, 2006). The Waterlow risk assessment tool was used to assess Mr Elliot's risk in regards to the development of pressure ulcers. His age, gender, continence status, nutritional status, cognitive ability, skin integrity and the presence of an existing pressure ulcer were assessed and evaluated to establish his risk of pressure ulcers. Assessing and planning Mr Elliot's care involved liaising with the multidisciplinary team such as his Community psychiatric nurse (Cpn) , occupational therapists, dietician, district nurse, tissue viability nurse and not least his wife, Elizabeth. Elizabeth was integral to the assessment and the plan care implemented for Mr Elliot, she is his wife of 55 years and his main carer, she advised the

district nurse team and occupational therapist of his day to day routine habits , capabilities and medication,. Efforts were made to engage Mr Elliott in conversation about his health, however due to his impaired cognition and restricted communication he was unable to participate in assessments and plan for his care. On assessment of Mr Elliot it was established that he is completely dependent in activities of daily living concerning communication, mobility bathing, dressing, continence and feeding, he has gradually lost the ability to walk and is wheelchair bound. Mr Elliot's only form of communication is to shout the word ' Please', He routinely wakes up through the night, and can no longer remember the names of his children, however he occasionally remembers the name of his wife. Mr Elliot is on medication of 50mg Trazodone twice a day to abate his agitation low mood and sleep disturbances. (Aisen 1993). Mr Elliot has complex health problems affecting wound healing and further risk of skin breakdown as well as intrinsic and extrinsic factors that have repercussions for compliance with treatment. Advanced stage Alzheimer's is characterized by a loss of ability to remember communicate or process information. A person with this level of cognitive impairment will generally be incapacitated with severe to total loss of verbal skills, mobility and continence (Ouldred et al, 2008). When a person with Alzheimer's is bedridden or wheel chair bound, their skin will bruise, tear and become infected more easily. (Morrison, 2000). Alzheimer's disease is one of several medical conditions that are significantly associated with the development of a pressure ulcer (Margolis, 2003). Dementia, confusion or decreased mental awareness prevents a person responding to bodily discomfort and pain in a normal way making them potentially unaware of the

discomfort and consequences associated with prolonged pressure on the skin (NICE, 2006). Mr Elliot's impaired cognition also means he is no longer able to recognise the need to empty his bladder or rectum; hold on until it's appropriate to release waste; find and recognise the toilet and remove his clothes and use the toilet correctly (Price, 2011). Mr Elliot's double incontinence is a major factor in the breakdown of his skin and any potential healing. The potential long-standing problems of continually being incontinent include pressure sores, malodour and associated psychological effects. (Price, 2011) Both urine and faeces are alkaline in nature in contrast to the skin which is slightly acidic, with each incident of incontinence there is an instant chemical reaction taking place at the skins surface in addition ammonia is also produced when microorganisms discharge urea from the urine, this increases the pH of the skin causing further irritation. Prolonged contact of the skin with faeces and urine together increase the irritant effect causing excoriation and skin breakdown (Cooper, 2002). Urinary and faecal incontinence are more prevalent and more severe in the elderly and are highly prevalent in people with dementia due to deterioration in their mental and physical abilities, (Price, 2011.) Mr Elliot's impaired cognition and physical health status lends itself to non-compliance to the necessary interventions needed to manage and prevent further skin breakdown. interventions to mange Mr Eliot's immobility and incontinence are essential to the management of his pressure ulcer and prevention of further skin breakdown, however interventions such as frequent repositioning to optimise blood circulation and the use of behavioural techniques to anticipate toileting require committed and consistent participation of the patient , Mr. Elliot's

restricted communication, altered cognition and memory problems would make such interventions difficult to implement and evaluate, which could result in him receiving substandard care. Consistent and coherent liaison between the different health professionals involved with Mr Elliot's care as well as continued support and education for Elizabeth is crucial for effective patient care, (Gilmartin, 2003). Establishing a care plan for Mr. Elliot was multifaceted not least because of the complex legal and ethical considerations surrounding care and treatment of the dementia patient in regards to informed consent to treatment or care. It was deemed by all the professionals involved in Mr Elliot's care that due to his impaired cognition he is incapable of consenting to care or treatment concerning his pressure ulcer. Although Elizabeth was Mr Eliot's next of kin she has no legal entitlement to consent to treatment on his behalf. However case law permits health professionals to liaise with a patient's next of kin when considering whether treatment would be in the patient's best interests. (Rogers, 1997). This was particular relevant to Mr Eliot who is not yet at the point that necessitates palliative care but is in the final stage of a degenerative disease. Mr Eliot's plan of care was guided by information gained from the holistic assessment and the Waterlow assessment, on evaluation of the Waterlow assessment, Mr Eliot's age alongside his incontinence, restricted mobility skin integrity and dementia placed him in the high risk group of people at risk of pressure ulcers. , the aim of the care plan was to determine the interventions necessary to help prevent pressure ulcers forming, manage the current pressure ulcer and to address his other care needs that have potential to negatively impact on wound prevention and healing The care

plan implemented to manage and prevent further breakdown of Mr Elliot’s skin primarily focused on pressure relieving strategies. Pressure relieving interventions underpin prevention and treatment and aim to lessen the magnitude and duration of any pressure that the patient is exposed to (NICE, 2005). Mr Elliot’s immobility put him at high risk of developing pressure ulcers Interventions to manage his immobility included; educating Elizabeth about the risks of pressure ulcers to people who are immobile, referral to the physiotherapist, the use of pressure relieving equipment and a 2 hourly repositioning schedule. Evaluations of these interventions would be assessed weekly. Interventions regarding Mr Elliot’s continence included; a routine skin inspection after each episode of incontinence to identify excoriation cleansing of skin with a foam cleanser after each incontinence incident; regular toileting and ensuring that Mr Elliott was using good quality and well fitting continence pants. (Cooper2002) In regards to managing Mr Elliot’s existing pressure ulcer, interventions included: inspection of the wound daily or more, if the wound dressing needs changing or there are episodes of incontinence, at such times a wound assessment is also required which involves assessing and documenting the ulcers duration, site, pain, size, assessing wound bed for necrotic tissue granulation and infection , assessing odour and exudate as well as assessing the surrounding skin for any inflammation or indication of infection. (Young, 1997) Ensuring that the correct dressing was used at each dressing change was imperative, the dressing used on Mr Elliot's ulcer is a hydrocolloid dressing; these dressings have the ability to manage wound fluid as well as provide a moist environment, the dressings contain a special gel that promotes the growth of

new skin cells in the ulcer while keeping dry the surrounding healthy area of skin (Butcher 2005). Mr Elliot was also referred to the dietician in regards to potential malnutrition. Mr Elliot and Elizabeth were supported with twice daily visits from the district nurse team, weekly visits from Mr Elliot's Cpn, the physiotherapist and dietician and 3 visits daily from the social carers, who were also educated on the care plan implemented for Mr Elliot. The impact of Mr Elliot's pressure ulcer and the ultimate care required to manage and prevent further skin breakdown was psychologically, physically and clinically challenging for both him and Elizabeth and had restricted their lives, causing Elizabeth additional work and worry.(Challenger et al, 1998). Whilst reflecting on this case study, I have realised the importance of effective collaboration between differing health professionals in providing and managing best practice, patient care. I have also gained knowledge about consent and its implications in regards to incapable adults, What I gained most from the cases study was an enhanced admiration for family carers, Mr Eliot's wife Elizabeth was completely dedicated in her care for her husband and was open to education in regards to preventing and managing skin breakdown . Butcher M. 2005. Prevention and management of superficial pressure ulcers. 10 (6 suppl) s16-s20. British Journal of Community Nursing. Cooper, P. 2002. Incontinence induced pressure ulcers. 4 (5) 216- 220. Nursing and Residential Care. Challenger J. Hardy B. 1998. Dementia: the difficulties experienced by carers. 3 (4) 166-171 British Journal of Community Nursing. Dougherty, L and Lister, S. (Eds.) (2008). Royal Marsden Hospital Manual of Clinical Nursing Procedures: Student Edition. Oxford: Wiley- Blackwell. European Pressure Ulcer Advisory Panel (2009)

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