Pressure ulcer assessment and management | reflection

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Description

The purpose of this reflection is to contemplate on the critical incident that brought to my attention regarding the pressure ulcer assessment and management of staffs in care home. Utilizing a critical incident as a way of reflecting involves the identification of comportment deemed to have been particularly subsidiary or unhelpful in a given situation (Hannigan, 2001).

I am working in a nursing home in unit catering elderly mentally ill clients. We have 25 residents most of them suffers from dementia. One incident happen to a 90 year old male client with dementia who was double incontinent and has been bed bound due to recent fall that have resulted him to have a fractured hip. He had a history of hypertension and angina 4 years ago. Throughout this essay I will referred the client to Mr. X to protect his identity and maintain confidentiality abiding the guidelines set by the Nursing and Midwifery Council (2014)

I observed redness on the sacral area of Mr. X while doing personal care for him with another staff. According to European Pressure Ulcer Advisory (EPUAP) guidelines, it was grade 1 pressure ulcer as there was intact skin with non-blanchable redness. He is more helpless against pressure damage, as his skin has ended up more delicate and more slender with age (NICE 2014). The nurse in charged was informed regarding our observation. She assessed the pressure area of Mr. X and told to staff that he needs to be assisted in changing his position every 2 hours and application of barrier cream during pad change.

The next day, it was reported in the hand over that Mr. X developed a grade 2 pressure sores, a partial thickness loss of dermis presenting as a shallow ulcer open ulcer with a red pink wound. (EPUAP 2014). It also conveyed that the night staffs have not turn him for more than 8 hours and never completed the positional chart. The worst was Mr. C was the fourth resident with pressure ulcer in the unit.

Feelings

I felt confident because I have prior knowledge regarding pressure sore management and can share this to other care staff for better care for residents with pressure ulcers. However, I was shocked with what I heard in the handover and felt sorry for Mr X that in less than a day he incurs grade 2 bedsores. The effect of pressure ulcer to him and the amount of pain he was dealing. Pressure ulcers can result in clients limited functions, emotional anguish, and agony from pain. (Nelson et al 2009). According to Purshotaman (2013), pressures to bony areas in a 1 to 6 hour period can result to pressure ulcer and shear and friction also act as a synergy to acquire wound in clients who are malnourished, incontinent, bedridden or mentally disturbed. And within 24 hours or it take up to 5 days for pressure ulcer to develop.

It was unacceptable that there are four residents who have pressure sore at the same time thus reflecting the quality of care rendered to clients. Pressure ulcer prevention involves an interdisciplinary approach to care. To achieve it, it requires coordination, organizational culture and operational practice that uphold teamwork and communication.

Evaluation

Pressure ulcers, otherwise called pressure or bed sore, are restricted areas of skin damage as a result of underlying destructed tissue brought on by excessive pressure stopping blood flow and bringing on an absence of oxygen and supplements to tissue cells. Eventually tissue cells die causing ulceration. The vital factors that leads to accumulation of pressure sore includes clients medical condition, medication, malnourishment, age, lack of fluid intakes or dehydration, incontinence, lack of mobility, skin condition and weight. The external influences that hasten its occurrence are pressure, shearing force, friction, moving and handling and moisture.

There are several risk assessment tools available to use to determine the level of client having pressure ulcer which I have been familiar during my learning process. These scales are the Norton scale, Braden Scale and Waterlow scale. The most common scale adopted in my work place was the Waterlow scale. It includes additional factors such as age, nutritional status, skin type and disease especially those affecting circulation. The score should be determined during admission of the client, but it is an on-going process and must be carried out whenever a significant changes arise from clients condition (L. Nazarko, 2009).

Even though the Waterlow scale identifies more risk factors than the other two assessment tools and widely used across the United Kingdom, it has still be criticised for its ability to over predict risk and ultimately result in the misuse of resource.(Edwards 1995; Mcgough, 1999).

Most of the scales used have been develop based on opinions of the importance of possible risk. It might get different scores from nurses assessing the same clients (L. Nazarko, 2009).

The predictability of these tools been challenged because it might over or under predict the risk of a person having pressure sore, gaining expensive cost of implications as preventive equipment is put into place that might not always be necessary.(Frank et al, 2003). Although the Waterlow scoring system includes more objective measurements like the Body Mass Index (BMI) and record of weight loss. It is still indefinite whether the reliability of the tool ratings has improved by these additions. It has been recognized that this is a fundamental defect of these tools and due to this clinical judgement must always support the conclusions made by the results. The aims of the Pressure ulcer risk assessment tools are to quantify and measure the risk of a person to have a pressure ulcer. To be able to determine the quality of the measurement, the evaluation of validity and reliability should always take place. However, the limitation of the validity and reliability of the pressure ulcer risk tools are generally recognized. According to EPUAP (2014), the solution to overcome these problems is to combine the scores of pressure ulcer risks tools with clinical judgement.

In the studies of pressure ulcer tools, there have been few endeavours made to analyse, the diverse pressure ulcer risk assessment strategies. Pancorbo – Hidalgo et al (2006) distinguished three studies, researching the Norton scale compared to clinical judgment and the effect on pressure ulcer frequency. From these studies, it was inferred that there was no confirmation, that the danger of pressure ulcer incidence was lessened by

the utilization of the risk assessment tools. The Cochrane audit (2008), set out to focus, whether the utilization of pressure ulcer risk assessment, in all health care settings, reduced the frequency of pressure ulcers. As no studies met the criteria, the authors have been not able to answer the survey question. At present there is just feeble proof to support the legitimacy of pressure ulcer risk assessment scale tools and obtained scores contain fluctuating measures of estimation lapse.

According to NICE (2014) guidelines, a client who is at risk having a pressure ulcer must be assessed within six hours of admission. However, Mr. X has been in the nursing home for years, his assessment should have been on-going as he was prone to develop it. During the assessment, a skin inspection must be completed on the most vulnerable areas the bony prominent part of the body like the sacrum, heels, elbows, shoulder, back of the head and toes and other parts of the body where shear or friction could take place. Pressure ulcers are assessed and graded according to the extent of damage of the tissue. The European and US National Pressure Ulcer Advisory panels (EPUAP and NPUAP) together with the Pan Pacific Pressure Injury Alliances (PPPIA) release the latest International Pressure Ulcer guidelines for pressure ulcer prevention and treatment. It’s an evidence based recommendation for the prevention and treatment that can be used throughout the world in any health care setting by health care professionals. Pressure sores are categories from stage I to IV depending on the tissue damage. Addition to these, are two other categories the unstageable pressure ulcers and suspected deep tissue injury (EPUAP-NPUAP-PPPIA International Pressure Ulcer Guidelines 2014)

The assessment implement used throughout my area of work, is the Waterlow Scale. The utilization of the Waterlow implement enables, the nurse to assess each patient according to their individual risk of developing pressure sores (Pancorbo-Hidalgo et al 2006)The tool uses an amalgamation of core and external risk factors that contribute to the development of pressure ulcers.. Nutritional assessment and screening tools like getting the Body Mass Index (BMI) are also utilized in the home for managing patients who are at risk of or have a pressure ulcer. The EPUAP (2014) recommends that as a minimum, assessment of nutritional status should include regular weighing of patients, skin assessment, documentation of food and fluid intake. Even so there are policies and procedures in place for management and prevention of pressure ulcer there were still a prevalent occurrence of pressure sores in the unit.

Analysis

The staffs' knowledge about pressure ulcer prevention and management plays a very vital role. However, the lack of health care staffs' education and trainings; and documentation resulted to numbers of patients having pressure ulcers in the unit. All health care professionals must receive relevant training and education regarding pressure ulcer risk prevention and management (NICE 2014). The information, skills and knowledge, gained from these training sessions, should then be shared down to other members of the team and embedded to practice. And all health care staffs involved in the care of clients with pressure ulcer needs to be updated on policies, guidelines and the latest patient educational information according to NICE guidelines (2014).

Effective communication between staffs in the care of Mr X could have played a major role to make his pressure sore healed quicker and not worsen. Pressure ulcer prevention and management is a collaborative effort. The nurses should have taken the lead and make sure that the information about the course of care actions towards pressure ulcer management of Mr X has been disseminated to all staffs during the shifts which can be done during the handover. The nurses as leaders of the unit must take other staffs to join on board towards the same direction on a certain goal of clients care.

As a student nurse, I have previous knowledge and experience about the pressure sore care and management before but the NMC(2014) oblige that I, to be a registered nurse in the United Kingdom, need to take an appropriate action to update my knowledge and skills to maintain and develop competence to safe practice. To be able to be competent, I need to acquire risk assessment skills while putting in my NMC code of conduct. I was able to assess and observe the redness of the sacral area of Mr X and have reported it immediately to the nurse in charge. Through this positive action of care, the nurse has provided immediate nursing care to Mr. X.

Conclusion

There is a proof that demonstrates that pressure ulcer risk assessment tools are valuable and useful when utilized as an aide for the obtainment of equipment. Then again, they can’t be depended upon solely to give a holistic care to clients. It has been highlighted, that to guarantee holistic assessment of clients, it is important to complete a combination of assessment to be able to create a complete picture client’s health. In spite of the fact that The

Waterlow scale covers various variables that need to be considered all through the assessment process, it has become apparent that the “ at risk” score, can frequently be over or under scored relying upon the health care practitioner’s clinical judgement. Clinical judgment has turned out to be, a vital part of pressure ulcer prevention and management. The education and effective communication of the patient, relatives, carers and nurses has likewise been highlighted, as a critical part of consideration. Enabling the patient with data in regards to their ailment, may diminish the mending time and prevents further concerns.

Action Plan

To prevent and minimize the number of pressure ulcer staffs must attend training regarding pressure ulcer prevention and management. They should be also familiarizing with the policies and procedures when pressure ulcer is noticed so that if the same experience occurs in the future they familiarize the actions to be follow.

In addition, health care staffs must be mindful that communication, teamwork, support and supervision have a big role to improve the quality of care of pressure ulcer management. Reporting, Supervision system and empowering staffs to confidently complete forms like positional charts, food and fluid charts and body map can be effective and a good way to improve communication between staff and for continuity of care of clients

As a catalyst of change, I should be a role model to other staffs by abiding with the standard of care rendered with clients and promote their best interest by educating my colleagues and having effective communication

between staffs and clients. However, not all staffs are willing for change. Change takes time but as long as there is a continuous education and system of good practice in place and staffs can see the results and benefits for clients, others and for themselves, more or less change can happen.

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