Policy Critique + Policy document: Pressure Ulcer Prevention

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Both, the ulcers caused by pressures and injuries inflicted by bed, have had profound effect on people since ages. People are still vulnerable to such kind of injuries or ulcers. It has become a prime responsibility of National Healthcare to deal with ulcers caused by pressures and injuries inflicted by beds. Albeit, considerable number of developments in drug, medical procedure, nursing care have been beheld, the ulcers caused by pressures is still considered responsible for the number of deaths. Injuries inflicted by bed and ulcers caused by pressure are a typical issue among elderly folks and the individuals who are restrained or show partial movement following surgery or operation and other confined to bed patients. It can be witnessed by numerous investigations that older people are more vulnerable to ulcers caused by pressure all over the world and it has raised many eyebrows and turning into a critical subject. Patients who are weak and older will in general have co-morbidities owing to the maturing formula, which can once in a while abandon them with constrained portability or confined them to bed and this can make them more vulnerable to the ulcers caused by pressure. Owing to developing older populace it has become indispensable to address such a critical issue i.e. ulcers caused by pressure. Such kind of ulcers do not owe any specific setting, as they have become an apprehension in all environments where societal upkeep is being delivered, curative drugs are over – with secluded homes. This work will inspect contemporary practice standard for averting such kind of ulcers amid facilities deal explicitly with elderly folks concerning their upkeep.

# Overview of Current Policy

stresses and the appropriation of worldwide measures for the preclusion of such kind of ulcers delineated by clinical standards, the number of ulcer patients keep increasing rapidly while in intense consideration. Ulcers caused by pressure are a typical condition towards the demise for individuals in inhabited facilities concerning aged care(Sharp et al., 2000).

The reason for the NSW Government's arrangement order on the preclusion of injuries inflicted by pressure is to provide direction for a steady training procedure in order to curb the ulcers. So as to Minimize the occurrence of wounds inflicted by pressure to the patients of NSW through satisfactory hazard appraisal, hazard administration and suitable handling, and Institute a steady, efficient exercise to deal effectively with the damage caused by pressure and to carry out administration the crossways NSW Health .As indicated by the rule standard, Preclusion systems that incorporates: a) Rearrangement and additionally rallying daily practice, together with apt manual undertaking procedures b) individual carers/edification of the people bearing such kind of ulcers on conventional transposing and soothing techniques concerning pressure c) Supervision and observing of inflicted aching, with finest practice preclusion approaches executed as a primacy amid two hours of the appraisal(Lyder, 2003). Conﬂicting results with respect to real transposing repetitions, have been delivered by the research followed. However, the intonation of 2-hourly tries is still a relic of typical leitmotif, albeit, there is little proof to render this regularity. Regardless of a little clinical advantage such practice i.e. to turn the side of a bedridden patient every two hours, the expense was ominously more and this out-maneuvered the advantage(CEC, 2014).

The evident reveals that if the emergency clinic was to considerably lessen its rate of clinical PUs it would require them to move past empowering preeminent ways dependent on the utilization of clinical rules(Allman, 1989). There was presently vibrant proof of where we expected to mend clinical consideration and observance to rules.

# Consultation Activities

People involved in health care i.e. doctors and nursing staff need to work eagerly to think about their patients in an inexorably unpredictable, wasteful, and upsetting condition. Notwithstanding, the pay scale, bonus structures, and overall style of the framework in which they work are more often than not inadequately adjusted to help their endeavors to react to patients' needs as their fundamental primacy. Perceiving the imperious to fixate on the patient, the framework of healthcare concerning learning is that where patients and their families are key teamsters of the plan and task of the procedure which concerns learning. Whenever carers, patients, and the public at large are fully active in healthcare facility, wellbeing of the patients, the overall experience concerning the care of the patients, and financial results can be significantly improved.

If patients are well-versed concerning their health coupled with their effective participation in the development in the overall framework regarding health care then the learning framework might get improved.(Black et al., 2015). Patients are the key players so far as their own healthcare and synchronization and collaboration amid different features of overall healthcare framework are concerned.

Effective partnerships rely on shared information and when the consumers and communities are supported throughout the engagement and collaboration process. Delivering care that is based on partnerships provides many benefits for the health consumer, provider, organization and system.

Persistent Safety Group – is in charge of accepting a quarterly report from the Lead Nurse for Tissue Viability on all issues identifying with the Trust's Pressure Ulcer Prevention Strategy together with fitting danger control measures to dispose of or diminish any distinguished dangers. The gathering will make any move it feels proper on receipt of information.

Ulcer inflicted by pressure Steering and Panel Group – are responsible to the Committee concerning the safety and quality of patient. Pressure Ulcer Steering Group is in charge of the advancement of the Pressure Ulcer Prevention motivation in accordance with national and nearby rules. The gathering is additionally in charge of the progressing observing of all weight ulcers announced inside MEHT. This incorporates guaranteeing that the results of episodes and exercises educated are shared adequately(Niederhauser et al., 2012).

Every single enlisted medical caretaker, maternity specialists and Healthcare bolster laborers will get weight ulcer counteractive action preparing on acceptance. Directed preparing will happen as the need decides. HCSW are given with an extra examination day actualized in 2018(De Laat, Schoonhoven, Pickkers, Verbeek, & Van Achterberg, 2005). This tends to weight ulcer avoidance, wound consideration and dressing strategies. All inpatient HCSW are required to finish this preparation.

Referrals ought to be made to a District Nursing group for twisted administration preceding release. The area of body inflicted by ulcer, classification and measurements will be reported on the nursing and restorative release synopsis(De Laat, Schoonhoven, Pickkers, Verbeek, & Van Achterberg, 2005). Deliberation will be given for progressing hardware needs upon release and gear will be set up before release to the patient’s normal spot of living arrangement.

# Literature Review

There are two studies which, which evaluate the effectiveness of air mattress policy for the patients suffering with ulcers caused by pressures. One of the two approaches is alternating pressure air mattress (APAM’s) that hinges upon the air mattress and the other one is alternating pressure air overlays (APAO’s). Research on the APAM’s are quasi-experimental work. The conclusion of APAM study reveals that the development of ulcer inflicted by pressure was nearly about 12.41 cases out of 1000. The results clearly conclude that APAM is less harmful so far as the use so APAM is concerned in health care facilities owing to the indication of squat hazard of ulcer inflicted by pressure when APAMs are being in use by the patients. Another study on the subject also revealed that APAM makes patient less vulnerable to such ulcers i.e. 3.6% in comparison with APAO(Fletcher, 2017).

Another technique, which is randomized control technique (RCT) comparatively the above mentioned, also revealed that APAM is effective while nursing patients with ulcer caused by pressure. It revealed that APAM as opposed to standard preclusion technique (foam mattress and four hour transposing) (N=447). Amid the examination time frame 15.3% of the samples (patients) in the trial grouping 15.6% of samples (patients) in control bunch showed ulcer caused by their body weight. The contrast between the gathering was not factually noteworthy (p=1).Be that as it may, in this investigation, samples which were study under trial bunch were not transposed(Armstrong et al., 2008). This is not quite the same as suggested by the first study mentioned earlier in the start of this section. In that study patients were transposed on the basis of ordinary decorum regardless of being taken care of on an APAM. This could clarify the variance in results.

Another researcher who led the RCT in 2005, directed a writing audit examining the usage of APAM’s as a measure for precluding ulcers caused by pressure. The after effects of 15 RCT’s which were incorporated into the audit propose that APAM is more advantageous than a standard bed in the clinic. This was likewise obvious from checking on the above examination, wherein the usage of an APAM was observed to be more helpful than an APAO or standard counteractive action in the aversion of ulcers inflicted by pressure.

A randomized clinical preliminary by Manzano et al. (2014) analyzed the viability of transposition plans (two and four hourly) in an attempt to preclude ulcers caused by pressure. All

patients (N=329) in the preliminary were taken care of on an APAM. Patients were transposed either two hourly (2-h grouping) or four hourlies (4-h grouping). Albeit 10.3% of samples (patients) in the 2-h grouping and 13.4% in the 4-h bunch built up a ulcer by pressure, the thing that matters was definitely not factually critical (p=0.73). Along these lines, a two hourly relocation timetable in contrast with four hourlies can't be viewed as advantageous for people being nursed. The researcher ponders yielded comparable outcomes with 16.4% of samples (patients) in the trial gathering (2-h) and 21.2% in the control gathering (4-h) showing ulcere caused by pressure. Once more, the contrast was not meaningfully extraordinary (p=0.40)(Allman, Goode, Patrick, Burst, & Bartolucci, 1995).

The relationship between successive relocation (2-h) and weight ulcer occurrence was

researched by Rich et al. (2011). Notwithstanding, in this examination the patient's (N=269) chance status (according to the Braden RAS) was thought about. Discoveries uncovered that high-hazard samples (patients) had a lower frequency of such ulcers, when moved 2-h, while lower chance patients had a higher occurrence of such ulcers when transposed all the more regularly than for those moved less as often as possible(Sullivan, 2013). These outcomes recommend that the recurrence of moving the patients ought to be founded on the patient's dimension of hazard (utilizing a RAS). As the examinations another researcher did not go for broke status into thought, this may clarify why a noteworthy contrast was not noted between the two gatherings in their investigations.

An RCT led by Moore et al. (2011) in Ireland analyzed rate of ulcer caused by pressure

among patients (N=213) utilizing two distinctive repositioning routines – three hourly with 30° tilt (exploratory grouping); and six hourly with 90° parallel revolution (routine preclusion regulator grouping). Amid the examination, 3% of patients in the exploratory grouping and 11% in the control bunch showed ulcer caused by pressure, which was observed to be huge (p=0.038). The aftereffects of this investigation propose that standard repositioning is exceptionally viable in the aversion of ulcers inflicted by pressure(Bluestein & Javaheri, 2008).

# Implementing the Policy

Implementation of policy delineates distinct set of rules which are inexorable to be followed in their letter and spirit in order to make the policy successful.

## Prevention practices

All staff must cling to the accompanying standards of training to guarantee care is conveyed as per the best accessible proof.

All patients will be surveyed for their danger of ulcer improvement, utilizing the enlisted attendant's clinical judgment within the time domain of 4hours of admission to medical clinic, when their condition changes, and on exchange or release(Sharp et al., 2000). This will be reported in the confirmation nursing care record (CHA 3831) and conveyed as a feature of the nursing handover.

All patients must go through skin evaluation done within the specified time domain i.e. four hours of affirmation, and all through their stay as per the RCHT clinical pathway. The SSKIN pack device subtleties explicit markers which may build a patient's danger of weight ulcers. Staff are then guided relying upon the hazard class, Red, Amber or Green to actualize the fitting dimension of skin evaluations(Bluestein & Javaheri, 2008). The recurrence of re appraisal will be archived on the SSKIN pack evaluation apparatus together with the skin appraisal.

Any ulcer caused by pressure that are available on affirmation must be archived on the confirmation nursing care record and SSKIN pack appraisal device and gave an account of Datix as weight ulcer on confirmation. An injury care plan must be set up to mirror the injury the board(De Laat et al., 2005).

Where a patient creates weight ulceration amid their emergency clinic remain this must be accounted for as a clinical occurrence on the Datix framework as a New weight ulcer. In the event that the weight ulcer falls apart amid their stay the Datix must be refreshed. In the event that a Category 3 or 4 weight ulcer builds up a 48 hour account must be finished for thought as a grave happening(de Laat et al., 2007).

## Categorizing the damage inflicted by ulcers

Pressure harm is classified by seriousness and profundity as pursues:

Classification One: Uninjured skin with non-whitening redness of a confined area of the body. The region might be agonizing, fixed, delicate, hotter or chiller.

Classification Two: Incomplete width skin misfortune including the epidermis and potentially the dermis. Displays as a shallow ulcer with red/pink injury bed.

Classification Three: Full thickness skin misfortune (noticeable fat) Full thickness skin misfortune including the epidermis, dermis and sub-cutaneous layer, however not stretching out into the belt.

Classification Four: Deep Ulcer Extensive obliteration of sash, muscle and bone, with or without skin misfortune Tissue corruption

Unstageable: Depth Unknown – Full thickness skin misfortune in which the base of the injury is secured with swamp and/or eschar. Until enough of this devitalized material is expelled the genuine profundity and in this way the categorization can't be resolved(Niederhauser et al., 2012).

Suspected profound tissue damage – Purple or maroon restricted zone of stained unblemished skin or blood-filled rankle because of harm of basic tissues structure weight and/or shear. Tissue might be boggy, soft, hotter, cooler contrasted with nearby tissue(Barker, 2013).

Holding up might be required. On occasion a time of watch and hold up might be required before deciding the precise class of skin harm. Careful debridement might be considered to evacuate the territory of putrefaction and bolster exactness of classification(Black et al., 2015).

## Reporting of Damage inflicted by Ulcers

* At the point when a weight ulcer happens or break down re-appraisal of the patient and the class, position and presence of weight harm must be archived by a Registered Nurse. Another consideration plan ought to reflect mediations to recuperate existing ulceration and forestall further harm.
* All weight ulcers must be accounted for on the Datix framework by a Registered Nurse as pursues:
* Class 1 and 2 – report on Datix. Occurrence to be examined at the earliest opportunity or inside 5 days to guarantee the records are accessible.
* Class 3 and 4 – on Datix. A 48-hour report is to be finished for all medical clinic gained Category 3 and 4 weight ulcers. A Serious Incident examination will be started on audit of the 48-hour report if the particular SI criteria is met. See Appendix 5 for SI process.

# Conclusion

The Resolution clinical and scholarly organization has been fruitful in creating and conveying a world-driving connected wellbeing research program in the field of weight ulcer aversion. The PURPOSE program has tended to central issues distinguished by patients and gives the establishment to the improvement of proof based, persistent focused practice in the field and a future clinical preliminaries collection.

Our commonness study concerning such pain has demonstrated that emergency clinic and network patients experience both weight territory related and weight ulcer agony and results from our partner ponder show that torment is freely prescient of classification 2 (or more) weight ulcer advancement. This is the principal companion concentrate to have investigated torment as a hazard factor and supports understanding reports from past subjective work9 that torment had gone before the clinical introduction of their weight ulcer(Bluestein & Javaheri, 2008).

The ulcer chance factor deliberate audit featured the requirement for excellent hazard consider look into the field, basic gauges for the meaning of key hazard factors and improved informational collections supported by a calculated model for the advancement and testing of expectation models. We along these lines built up a hazard factor Minimum Data Set and utilized this to shape the premise of a Risk Assessment Framework, the PURPOSE-T, utilizing accord techniques supported by the best accessible proof. Choices joined the perspectives on administration clients. The hazard appraisal work joined key discoveries from the torment and extreme weight ulcer work bundles, to be specific the incorporation of agony in the Risk Assessment Framework and planning the structure to recognize essential counteractive action and auxiliary aversion/treatment choice pathways.

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# Appendix A

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| **NAME OF DOCUMENT** | Pressure Ulcer Prevention in Aged Care |
| **TYPE OF DOCUMENT** | Policy |
| **DOCUMENT NUMBER** |  |
| **DATE OF PUBLICATION** | 14 May 2019 |
| **RISK RATING** |  |
| **REVIEW DATE**  *Documents are to be reviewed a maximum of* ***three*** *years from date of issue* | Three Years |
| **FORMER REFERENCE(S)**  *Documents that are replaced by this one* | NSW Health: Pressure Ulcer Prevention and Management Policy Directive |
| **EXECUTIVE SPONSOR or**  **EXECUTIVE CLINICAL SPONSOR** | NSW Health |
| **AUTHOR**  *Position responsible for the document including email address* | Gita Shah |
| **KEY TERMS** | Ulcer, pressure, mattress, repositioning, evidence-based policy, skin, appraisal |
| **SUMMARY**  *Brief summary of the contents of the document* | It has become a prime responsibility of National Healthcare to deal with ulcers caused by pressures and injuries inflicted by beds. The NSW Health has issued clear policy directives to manage pressure ulcer and its prevention in aged Care. However, the existing policy which calls for a 2-hour repositioning of patients is not grounded in evidence. Instead, alternating pressure air mattress are recommended as a key prevention measure which will replace the 2-hour positioning policy. Evidence to the efficacy of the suggested policy measure is provided. |

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| **Name of Policy** |

# 1. POLICY STATEMENT

The policy is design to compare the repositioning policy with air mattress policy and to determine whether or not this policy of using APAM will effectively deal with the prevention of pressure ulcer.

# 2. AIMS

To prevent pressure ulcers in a best possible way and to promote its management. To study the impact of air mattress on the prevention of ulcer cause by pressure. Another aim is to regulate the satisfaction level of patient’s family.

# 3. TARGET AUDIENCE Clinicians, Managers, Stakeholders, Health departments

# 4. RESPONSIBILITIES

Prevention practices for pressure ulcers, responsibilities include the role of all staff, standards and practices, risk assessment, skin assessment, categorizing the damage inflicted by ulcers, reporting of damage inflicted by ulcers

# 5. DEFINITIONS

Pressure Ulcers- A damage inflicted by pressure or sustained pressure which cause injury to skin or underlying tissues.

Pressure Ulcer Categories-Pressure ulcer is normally defined on the basis of category and it is comprised of 4 categories, DIT and unstageable.

Datix Framework- This framework represents the contract between government and suppliers. The registration of Datix is done under Cloud Software category.

APAM- Alternating pressure air mattress, is a bed inflated by alternating pressure of air and the most of the material used in its construction is PVC and nowadays being used for pressure ulcer patients.

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# 6. DOCUMENTATION

(<https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_007.pdf>)

This document was critically analysed while devising a policy of APAM for the prevention of pressure ulcer.

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# REVISION & APPROVAL HISTORY

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| Date | Revision No. | Author and Approval |
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