

# Implementing and evaluating a pressure sore policy

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## Rationale behind policy implementation.

Large amounts of much needed revenue are expended on the care of patients who sustain sores, an estimated hundred and fifty million in the United Kingdom(1). National bodies auditing health care outcomes regard pressure sore acquisition as a key target for quality improvement(2). Hibbs 1986(3) demonstrated that twenty six thousand was needed to cover the care of a patient with a grade four pressure sore. Much of this cost is immeasurable because it relates to patient suffering, and of course this figure does not allow for inflation.

However the message is clear: the patient studied by Hibbs spent time equivalent to sixteen uncomplicated patient admissions. Therefore opportunities lost to other patients must be

considered when a patient sustains a pressure sore. Furthermore the presence of a sore de-lays rehabilitation and the future care of the patient becomes complicated. Litigation awards are becoming increasingly common in this area of care, pressure sores are regarded as ninety five percent preventable(4) . Therefore litigation costs should be taken into account. A documented award of one hundred thousand pounds was judged adequate compensation for a pressure sore sustained during respite care(5). Many claims for compensation are settled out of court because responsibility lies indubitably at the hands of the hospital, unless extenuating circumstances are documented. Money awarded in litigation claims has to be directly subtracted from that which should be spent of patient care, it is a strong argument for directing resources into the area of prevention rather than treatment.

The United Kingdom Department of Health has issued guide lines on good practice in the prevention of pressure sores. Interest by Government departments must be sought and fostered. There is a tendency for pressure sores and tissue to be neglected as an unglamorous area of health care. Yet the problem is widespread, with around 6.7% of hospital patients sustaining pressure sores and 8% of district nurses patients reported as having sores in the United Kingdom(6), and therefore should be as a major area of importance.

## **Fundamentals of policy planning.**

Five stages have been outlined in policy formation(7). The most important first step is the formation of a multidisciplinary group. Pressure sore prevention involves all disciplines and it is important that medical, nursing and managerial staff are all unanimous in provision of resources and care directed at pressure sore prevention. Livesly also advocated collection and interpretation of baseline information.

An example of this may be:

1. How many patients are admitted to the studied hospital and diagnosed at risk by risk assessment, eg Norton, Waterlow. Prevalence surveys will supply this information.
2. Clients resident in the community thought to be at risk of pressure sore.
3. At which stage in the patient pathway are pressure sores being sustained, i.e. within two weeks of admission due to acute illness? Or after rehabilitation has started when prolonged periods are spent in a chair?

Once this information has been collected it has to be interpreted and formulated into a useful policy pertinent to tackle the problems found in the area.

## **What does a policy consist of?**

In the authors opinion a policy must consist of three parts which are interlinked and ongoing, supervised by a nurse who has an in depth body of knowledge upon which the policy can draw.

Omitting any stage in this flow chart will lead to a substandard policy. Staff education without the resources for equip,emt will lead to disillusioned frustrated staff, whereas resources for equipment without education will result in purchase of inappropriate equipment and lack of cost effective equipment use.

## **Deciding on an equipment policy.**

As early as the 1967 an extensive study was carried out by Norton, McLaren and Exton Smith(8). Patients were divided into three groups according to wards. In group one the patients were allocated the large cell ripple bed, the only alternating pressure mattress available at the time. The second groups were allocated simple turning on a ward which had an excellent standard of care in this respect. The third group were placed upon a mattress which is not made now. It was deemed unethical to continue the trial for the second and third group due to frequent development of pressured sores. This is a useful study, not only because it indicates that alternating pressure has a valuable preventive role, but also because it demonstrates that turning, even where nursing standards are deemed good, cannot be relied upon a sole method of pressure sore prevention. Patient survive extremes of illness to day which would have resulted in death thirty years ago. The skin, like other body systems, will show signs of strain during extreme illness. When the skin begins to fail in its protective function pressure sores will develop. It is important that therapy is offered to support skin function. Antibiotics would never be withheld in acute treatment, pressure relief must be regarded as comparably important. Just as dialysis would be given to support renal function, pressure relief must be given to support skin function. Having decided that equipment is essential, there is then the problem of how much, and what type!

## **Amount and nature of equipment.**

It has been calculated that around twenty percent of patients admitted to hospital will be at risk of pressure sores. Performing a prevalence survey on several occasions in your own hospital is a good idea to give you this base line information. Prevalence is a snapshot survey of the amount of pressure sores present at a specific point in time. Incidence is a more sensitive measurement of new pressure sores as they develop over a studied period of time. I will refer to this again in relationship to evaluation. Prevalence surveys in the community are likely to be less accurate and incidence is very difficult to calculate if the total population is often uncertain. However, studying the number of patients known to the district nurse needing pressure relief will give a base line indication of pressure relief need. Having decided upon the population of patients at risk of pressure sores, this information can roughly be used to judge the amount of pressure relief needed. This approach has been criticised by some workers(9) however our experience has shown this to be an acceptable method of calculating equipment needs(10) .

## **Evaluation of the success of your policy.**

Evaluation can be done in several ways. I would suggest that pressure sore incidence, financial expenditure and staff knowledge of the policy represent good areas to evaluate. Expenditure on pressure relief systems should be reviewed regularly to ensure that maximum cost effective use of the budget is being obtained. Research surrounding all equipment used should be carefully assessed before any commitment is made(11) . During my time as a nurse specialist, I was appointed at a time of great financial stringency, maintaining expenditure within budgetary limits was a major area of importance. The budget (in this case it was a

centralised budget, which gave greater scope for analysis) was greatly over spent in one of the hospitals within the scope of my position. The majority of this money was being spent on the minority of the patients who were receiving airfluidised or low airloss therapy. Thirty double celled alternating pressure units were owned, and this resulted in a considerable deficit between the amount of patients diagnosed at risk and the number of patients for whom pressure relieving units were available. Analysing the feelings of staff and their requests and looking at clinical case histories, it appeared that closing this gap may resolve the expenditure. The amount of alternating pressure units was increased and the number of high risk systems (Airfluidised and low airloss beds) fell dramatically shortly afterwards, as did monthly financial outlay. A greater number of patients benefited and incidence studies performed before and after the change of equipment policy revealed that the amount of patients sustaining sores was reduced, with statistical significance. Deciding whether these should be double or single celled units is an area which calls for further research. However as the problem was immediate, several single celled systems with a warranty were purchased plus the hire of further double celled units. Giving the purchased mattresses a two year life span, a cost of under eight pounds per week per patient was obtained. This must be contrasted to the price of a sheet of hydrocolloid (around three pounds which will be replaced several times a week if a severe sore arises. Now that the equipment policy has been well accepted it has been possible to buy the double celled units, and this has reduced financial outlay further.

Pressure sore incidence is a valuable way in which to audit the success of policy application. It is easier if this can be done on a computerised data base, however undertaking the audit by hand should be done if no other method is available. It is important that the same scale for grading sores is used by all concerned in reporting data for the incidence study. There are few national studies with which to compare your own results, however they are probably most valuable if they are done consistently and reviewed with the clinical staff from the areas concerned. Problem areas of pressure sore prevention may then become apparent. For example examining the point in a patient's pathway at which the sore was recorded can highlight specific problem areas. Examples of these may be a number of patients admitted with sores indicating inadequate equipment provision in the community, patients sustaining sores after prolonged casualty waiting times, or sores becoming apparent after operations indicating problems with pressure relief in theatre. Assessing staff knowledge of the pressure sore policy at regular intervals is also important. Areas to examine are appropriate use of equipment, documentation of risk assessment scoring and their understanding of pressure sore grading. Implementation of a link nurse scheme identifies interested staff who can help to raise the knowledge base of their colleagues by working with them to implement the policy. It is also valuable for nurse specialists to increase awareness of clinical problems, for example those which occur out of hours. The battle to prevent pressure sores is ongoing and policies must be continually reviewed to ensure that changing need is met. Community services should not be neglected, the nurse specialist can play a valuable role in bridging the gap and improving prevention in both acute and community patients. It is absolutely certain however, that as clinical staff we must take the lead in insisting that this area of care provision is brought to the attention of those with budgetary control. Careful documentation of all preventive care given to patients is essential, as is the need to study pressure sore acquisition

rates. In this way deficits, such as lack of finances to allow appropriate equipment provision, can be brought to the attention of those who decide upon budgetary allocation.

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