Title:
Description of Medical-Surgical Nurses' Care of Patients at Risk for Pressure Ulcers (PU)

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Session Title:
Global Practices for Pressure Ulcers
Slot:
M 07: Sunday, 30 July 2017: 10:15 AM-11:00 AM
Scheduled Time:
10:15 AM

Keywords:
Medical-Surgical Nurses, Practice Barriers and Pressure Ulcer Prevention

References:
Aydin, A., & Karadag, A. (2012). Assessment of nurses' knowledge and practice in prevention and management of deep tissue injury and stage I pressure ulcer. *Journal WOCN , 37* (5), 487-494.

Roberts, S., McInnes, E., Wallis, M., Bucknall, T., Banks, M., & Chaboyer, W. (2016). Nurses' perceptions of a pressure ulcer prevention care bundle: a qualitative descriptive study. *BMC Nursing.* Accessed December 6, 2016 at https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-016-0188-9

Samuriwo, R. (2011). The impact of nurses' values on the prevention of pressure ulcers: a Straussian grounded theory study (*unpublished doctoral dissertation)*. University of Glamorgan, Wales.

Sving, E., Gunningberg, L., Hogman, M., & Mamhidir, A. (2012). Registered nurses attention to and perceptions of pressure ulcer prevention in hospital settings. *Journal of Clinical Nursing , 21*, 1293-1303.

Waugh, S. (2014). Attitudes of nurses toward pressure ulcer prevention: A literature review. *Medsurg Nurs, 23 (5)*, 350-357.

Abstract Summary:
This session will provide insights into nurses' assessment and prevention of PU, articulate facilitators and barriers to the implementation of prevention measures, and describe several actions that could be taken to improve nurses' assessment of PU risk and implementation of prevention measures.
Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to assess their own practice environment for facilitators and barriers to implementation of pressure ulcer prevention measures.	I. Overview of Study A. Purpose B. Methods C. Findings 1. Nurses knowledge and understanding of PU development and prevention 2. How nurses identify patients at risk for development of PU 3. Perceptions of nurses' implementation of PU prevention measures 4. Factors facilitating

		implementation of PU prevention measures a) Nurses' personal beliefs b) Leadership support c) Treatment protocols d) Availability of expert consultants 5. Factors presenting barriers to implementation of PU prevention measures a) Prioritization b) Supplies and equipment c) Staffing d) Patient cooperation e) Families 6. Influence of regulatory mandates on nurses care of patients at risk for PU D. Implications for nursing practice E. Assessing your own practice environment
	The learner will be able to describe 3 actions that can be taken to improve nurses' assessment of pressure ulcer risk and implementation of prevention measures.	II. Implications for nursing practice A. Education and clinical experiences B. Using evidence-based protocols C. How clinical experts can help D. The role of organizational and nursing leadership
	The learner will be able to articulate 3 areas of research suggested by the study to further increase our understanding of PU risk assessment and implementation of prevention measures.	III. Future research A.Causes and implications of inconsistent interpretation of the Braden Scale B. Influence of family members on facilitating or impeding nursing care C. Types and extent of leadership behaviors and the effect on staff nurse motivations d. Nurse leader perceptions related to PU risk assessment and implementation of prevention measures

Abstract Text:

Purpose: The purpose of this qualitative study was to explore and describe the level of understanding of PU development and prevention and the perceptions of implementing PU prevention measures of nurses caring for patients in MS units.

Methods: The study was conducted in three (3) community hospitals in California within the same healthcare system using an interpretive description approach (Bertero, 2015). Purposive sampling was used to recruit medical surgical nurses. Six (6) focus groups were conducted including a total of thirty (30) participants. Participant comments were coded following each focus group session. Initial impressions and preliminary themes were explored in subsequent focus groups, allowing the investigator to refine and reorient the inquiry. Demographic information was collected to describe study participants.

Results: A total of 30 nurses working in MS units participated in six focus groups. A brief demographic questionnaire revealed the majority of participants were female (90%) and ranged in age between 26-61 years with a mean age of 41 years. Academic educational preparation included a Bachelor's degree in nursing (67%); pressure ulcer prevention continuing education within the last 12 months (83%), with 74% of classes attended by participants including instruction on evidence-based protocols. The majority of participants were employed full time (87%) and years of nursing experience ranged from 1 year to 38 years, with a mean of 12 years. Findings in this study are not dissimilar to those that have been reported elsewhere, but serve to orient us to today's environment in the wake of the 2008 CMS ruling. Four (4) major themes emerged from analysis of the data: 1) nurses' knowledge of PU prevention improved

following an educational activity and nurses' experience caring for patients at risk for development of PU was a significant factor in acquiring and maintaining their knowledge level; 2) an accurate risk assessment is essential in determining appropriate PU prevention measures. Risk was determined using a standardized assessment tool, the Braden Scale. However, participants related inconsistent use and interpretation of the scale, rendering patient scores suspect in determining risk. The presence of diagnoses and conditions known by participants, through previous experience, to be associated with patients at risk for PU development was more important in determining the level of patient risk for PU; 3) many factors were identified as influencing nurses' implementation of PU prevention measures. Factors identified as facilitating implementation of PU prevention measures were: nurses' personal motivations, the use of evidence-based treatment protocols to guide decision-making, the use of expert consultants, and leadership support. Factors identified as barriers to implementation of prevention measures were: staffing concerns, lack of equipment and supplies, patient cooperation; family influences, and balancing nurses' ethical need to provide safe, compassionate care with the desire to respect the wishes of the patient; and 4) regulatory mandates, specifically the 2008 CMS ruling on non-payment for hospital acquired PU, were perceived as having improved nurses' care of patients at risk for PU.

Conclusions: This study was undertaken to describe nurses' knowledge of PU development and prevention and to discover factors affecting nurses' ability to implement PU prevention measures. When interventions are omitted assumptions are often made that the nurse lacks the knowledge, skill or desire to provide quality care (Waugh, 2014). This study revealed that, in the case of PU development and prevention, nurses' knowledge was satisfactory, nurses understood the importance of PU prevention, and were motivated to carry out prevention measures. However, barriers and facilitators to implementation of prevention measures were identified. Because every hospital, shift, and patient encounter presents a unique set of circumstances, organizations must assess and identify contributing factors and implement improvements based on their own assessments to ensure quality care. Findings suggest several actions that could be taken to improve nurses' assessment of PU and implementation of prevention measures. Education promoting a common understanding and consistent use of the Braden Scale is essential to its effectiveness in guiding PU prevention measures. Methods within the practice setting to validate consistency should be implemented. Evidence-based protocols allow the nurse autonomy to implement measures aligned with the patient's individual risk factors. Protocols also remove the necessity of consulting the patient's physician, allowing timely implementation. The prudent organization should consider implementation of the wound care nurse role and/or expanding the involvement of wound care nurses in the direct provision of PU prevention measures, and provide regular formal and informal education regarding PU prevention for the RN as well as assistive staff such as the CNA. Finally, organizational recognition of the importance of PU prevention is required to facilitate consistent implementation of prevention measures. This includes providing adequate staff both in numbers and quality, leaders serving as role models, and public recognition of positive outcomes by leadership.