

Improving patient education on pressure ulcers

Pressure damage is a commonly encountered harm that can have significant impact on patients, carers and healthcare providers. Preventing the occurrence of pressure damage requires a multipronged approach of which patient education should form an essential part. What kind of education takes place, who it is delivered by and at what level of detail, is a question of clinical judgement and the responsibility of qualified, experienced healthcare professionals. Overall, the emphasis should always be on delivering clear, meaningful and useful messages for patients and carers.

KEY WORDS

- ▶▶ Education and information
- ▶▶ Key messages
- ▶▶ Patient involvement

Pressure damage is a commonly encountered harm that impacts on all age ranges and specialities. Defined by the European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) as 'a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear' (EPUAP and NPUAP, 2009), studies suggest pressure ulcers affect around 18% of in-patients across Europe (Vanderwee et al, 2007) and approximately 21% in the UK specifically. In the community, studies in the UK have identified prevalence rates of 0.40–0.77 people per 1,000 adult population (Stevenson et al, 2013).

These time-consuming and often complex skin injuries also consume up to 4% of European health budgets (Posnett et al, 2009), which translates to an estimated £14,000 per person for a category IV pressure ulcer in the UK (Dealey et al, 2012). Most importantly, there is substantial evidence illustrating the impact of pressure ulcers on physical, social, psychological and financial aspects of health-related quality of life (Gorecki et al, 2009).

While talk of pressure ulcers is more common, it is important to recognise that ulceration is only one manifestation of the ischaemic tissue injury that characterises all pressure damage. In reality, the extent of injury can range from an intact area of non-blanching erythema, through to full-thickness skin loss with exposed bone, muscle or tendon (EPUAP and NPUAP, 2009). Blistering, necrotic eschar and deep tissue injury can all feature on this spectrum of harm

as well, making assessment of pressure damage severity an inexact science at best. However, regardless of whether there is a superficial damage to the microvasculature or deep tissue death and destruction, pressure damage in all its forms has the potential to impact negatively and should, therefore, be prevented at all costs. This imperative, alongside the prevention of other key harms, is articulated in the Department of Health's Commissioning for Quality and Innovation framework (Department of Health, 2012).

PATIENT EDUCATION

Many Trusts, and indeed whole regions, have undertaken major campaigns to reduce the amount of pressure ulcers (Acton, 2012; NHS, 2012; Bedo, 2013). Quality of care improvement initiatives — such as 'Intentional Rounding', which prescribes maximum times between patient contacts to ensure essential care needs are met, and the SSKIN bundle approach, which focuses on five key interventions to prevent pressure damage (surface, skin inspection, keep your patients moving, incontinence/moisture and nutrition/hydration) — have been used to great effect in many clinical settings. This especially applies when a multipronged approach is taken, incorporating a range of interventions, such as staff education, standardised risk assessment and better access to equipment. However, it is only by bringing patients and their carers into the picture as well that the potential to prevent pressure damage is fully realised.

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Box 1. Patient information should include:

- ▶ Causes of pressure ulcers
- ▶ Recognising the early signs of pressure ulcer development
- ▶ Ways to prevent pressure ulcers
- ▶ The consequences of developing pressure ulcers
- ▶ A demonstration of preventative techniques and equipment.

(National Institute for Care and Clinical Excellence, 2014)

Educating patients about their health and wellbeing — be it pressure-related or otherwise — gives them an important opportunity to have some control over what happens to them (Patient Information Forum, 2013). Patient information and advice has been shown to enhance health knowledge and recall, especially when it is personalised (Coulter and Ellins, 2006). The patient is usually best placed to decide how care should be carried out and when it is best to do so. However, first they need to know what the problem is and how they can prevent it happening. Just as patients are encouraged to remind staff to wash their hands, so too can they ask to have their skin checked. They can also ask for help to reposition or to stand up for a while to relieve the pressure.

Patients who recognise numbness and tingling as the early warning sign of pressure damage can alert staff to move them before the damage becomes irreversible. The patient who says “Please turn me, I think I may be getting a pressure ulcer,” is delivering a clear message that they need moving and promptly so. Patients can also make a difference in terms of what they eat when they know the right things to ask for and they can take in adequate fluids if they understand why it is important to do so.

Involving patients is not always easy, nor is it always appropriate. Some patients are simply too ill to fully digest the message, some will not want to be involved in their own care and others may be too anxious to understand the information they are given. Others will simply not be able to do the things required of them although it is their inability to move, to eat or to sense pain that puts them at risk of skin breakdown. It is a question of clinical judgement as to which patients are ready to receive information about their skin health and which can actively participate in their own care.

PATIENT INFORMATION

Clinical guidance stresses the importance of offering timely, bespoke information to people who have been assessed as being at high risk of developing pressure damage (*Box 1*) (National Institute for Care and Clinical Excellence [NICE], 2014). Information should include the causes of pressure ulcers, early signs of pressure ulcer development, ways to prevent pressure ulcers, the consequences of developing pressure ulcers and a demonstration of preventative techniques and equipment (NICE, 2014).

Information about pressure damage should be available in different formats to suit the diverse audience that is the pressure ulcer ‘at risk’ population. This diversity may encompass people with learning disabilities, dementia, hearing or sight impairments; children and teenagers; people with limited English literacy skills. The overall emphasis should be on delivering clear, easy to understand information in a way that is most suited for that person or group.

CONTENT

The clinician should consider the key messages they wish to get across and the purpose of doing it (i.e. is it just to give information or is it part of an education programme or plan). This will help the clinician decide the kind of format that is best suited to the purpose (e.g. written, visual or audio). Information should be presented in the form of short, simple statements with each statement containing just one or two key messages. The language should be easy to understand avoiding colloquialisms and healthcare jargon; where terminology is necessary, it should be clearly explained. It is also essential to consider cultural and language variances in the target audience.

DECIDING ON DETAIL

A patient at long-term risk of developing a pressure ulcer, such as somebody with a spinal injury, will need to understand more about their skin vulnerability because they will live with the risk day in and day out. A patient admitted for short stay surgery will need to know enough to keep them safe the few days that they are at risk. The minimum that patients need to know is what they have to do and why, what warning signs to look for and who to contact if they have a problem.

PRESENTATION

The layout for text-based information should be uncluttered with a mix of white space and text so the content is easy for the eye to focus on. The font should be sans serif (without any curly bits) and should be a minimum font size of 12 for legibility. Text should be black on a white background with judicious use of colour for illustrations (i.e. colour should enhance the content not distract from it). Diagrams or pictures should be used to illustrate important points, but overly graphic or complex illustrations should be avoided — the purpose is to inform not overwhelm or frighten the patient. If using a visual format, such

as a film clip, add in text sub-headings so that spoken messages are re-enforced visually. Whatever format is produced, the content must be accurate and relate to the intended purpose. Once the information has been drafted, user representatives should be asked to check it for readability, meaning and usefulness before the final version is produced. There are also various tools available to assess readability, although these should supplement not replace user involvement (Wilson and Williams, 2003).

DELIVERING THE MESSAGE

When talking to patients about the risk of pressure damage, it is important to ensure they are comfortable and pain free so they can concentrate on the information they are being given. Involving a carer or relative in the conversation will bring another perspective and will often raise different questions. Whoever is involved must be respectful of the patient's limits. The patient may be confused, tired, anxious or ill and too much information in this situation can be burdensome and worrying. If it is necessary to teach a skill, such as showing a carer how to re-position someone using the 30° tilt, then a suitable format for delivery should be selected and the clinician should be realistic about what can be achieved. The information may need to be relayed several times and diagrammatic and practical demonstrations may also be necessary to get the message across clearly.

In one London Trust, healthcare assistants (HCAs) provide pressure ulcer information to all patients on admission. HCAs are taught what to say using a written guide as a prompt and learn how to say it through facilitated role play. This helps them practise what to do when a patient says they are not interested or are too tired to listen. Qualified nurses then follow up the information with at risk patients. Peer support might be another useful approach, where a patient who has had a pressure ulcer teaches another about the importance of prevention. There is growing evidence about the value of patients teaching students (Spencer et al, 2011), but less about the benefits of patients teaching patients. However, the success of participative models like that offered by the Lindsay Leg Club® (Lindsay, 2004) suggest that social interaction, empathy and peer support can play an important part in helping patients to manage their own conditions effectively. However, where more

formal education is required it should be delivered by a qualified healthcare professional. This will ensure appropriate and accurate information is given and its effect properly evaluated. NICE guidance is clear that the overall responsibility for delivering pressure ulcer information should lie with a trained or experienced healthcare professional (NICE, 2014).

CONCLUSION

Pressure damage is a complex and impactful harm that should be prevented at all costs. Educating patients about the dangers of pressure damage is an essential part of any pressure damage prevention programme. A successful strategy for patient education needs planning and forethought and must involve patients and carers at every stage to be of maximum benefit.

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REFERENCES

- Acton C (2012) Reducing avoidable pressure ulcers: an online clinical ordering system. *Br J Nurs* 21(20):4,6–8
- Bedo J (2013) Reducing hospital-acquired pressure damage: an NHS acute trust initiative. *Br J Nurs* 22(20):20–23
- Coulter A, Ellins J (2006) *Patient-focused Interventions: A Review of the Evidence*. The Healthcare Foundation, London:1–277
- Dealey C, Posnett J, Walker A (2012) The cost of pressure ulcers in the United Kingdom. *J Wound Care* 21(6):261–6
- Department of Health (2012) *Delivering the NHS Safety Thermometer CQUIN 2012/13: A Preliminary Guide to Measuring Harm Free Care*. Available at: <http://bit.ly/1mCdQ8l> (accessed 14.07.2014)
- European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel (2009) *Prevention of Pressure Ulcers: Quick Reference Guide*. Available at: <http://bit.ly/1AOSFi> (accessed 14.07.2014)
- Gorecki C, Brown JM, Nelson EA et al (2009) Impact of pressure ulcers on quality of life in older patients: a systematic review. *J Am Geriatr Soc* 57(7):1175–83
- Lindsay E (2004) The Lindsay Leg Club® Model: a model for evidence based leg ulcer management. *Br J Community Nurs* 9(Suppl 2):S15–20
- National Institute of Health and Care Excellence (2014) *Pressure Ulcers: Prevention and Management of Pressure Ulcers [CG179]*. NICE, London
- NHS (2012) *NHS Midlands and East Launch ‘Stop the Pressure’ Campaign. Harm Free Care*. Available at: <http://bit.ly/1qAoefU> (accessed 14.07.2014)
- Patient Information Forum (2013) *Basic Principles. Producing Patient Information*. Available at: <http://bit.ly/1qYBop6> (accessed 14.07.2014)
- Posnett J, Gottrup F, Lundgren H, Saal G (2009) The resource impact of wounds on health-care providers in Europe. *J Wound Care* 18(4):154–61
- Spencer J, Godolphin W, Karpenko N, Towle A (2011) *Can Patients Be Teachers? Involving Patients and Service users in healthcare professionals' education*. <http://bit.ly/1pFOGpe> (accessed 8.08.2014)
- Stevenson R, Collinson M, Henderson V et al (2013) The prevalence of pressure ulcers in community settings: An observational study. *Int J Nurs Stud* 50(11):1550–7
- Vanderwee K, Clark M, Dealey C et al (2007) Pressure ulcer prevalence in Europe: a pilot study. *J Eval Clin Pract* 13(2):227–35
- Wilson FL, Williams B N (2003) Assessing the readability of skin care and pressure ulcer patient education materials. *J Wound Ostomy Continence Nurs* 30(4),224–30