

The nursing supremacy myth in pressure ulcer prevention

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For years, medical staff have laboured under the impression that nurses are the ones who know about 'bed-sores', wounds, and the horrible things that a doctor does not want to bother about. There are times, of course, when doctors think it is good fun to infuriate nurses by insisting that a patient with an ischial pressure ulcer should be sitting out all day in order to help him/her get better more quickly, and consequently be discharged home sooner.

Come to think of it, lots of nurses seem to agree with that view as, after all, people in chairs are not as sick as patients in bed, are they? We therefore tend to concentrate on the latter, and let the others fend for themselves. The one proviso is that anyone who stands up unaided from a chair should be told to sit down again – to prevent them from falling. The other bit of fun for the surgeon is to demand paraffin gauze for the skin graft donor site, or to put proflavine (supposedly antiseptic) into a wound so it can dry out and cause maximum pain on removal.

But let us get back to pressure ulcer prevention. One of the most well-propagated myths is that nurses know better than doctors how to prevent and treat pressure ulcers. Unfortunately, this is not as true as nurses would like to believe. However, the news is not as bad as it seems. Let me explain.

Recently, I was analysing the results of a survey exploring knowledge and opinions of pressure ulcer prevention. It was a near replication of a questionnaire previously used as part of my PhD studies (Maylor and

Torrance, 1999a; Maylor, 2000a). The methodological differences were to adapt phrases such as 'have you used?' to 'have you seen used?' (in relation to pressure ulcer prevention equipment, etc.), so that medical staff could fill in the questionnaire as well as nurses.

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It included sections on how much education nurses and medics claimed to have had on the topic, either pre- or postregistration, and sources to which they attributed their knowledge. Further information was gathered on the extent of their agreement with expert consensus and the literature on the important contributors to pressure ulceration. Another section elucidated their views on when to use risk assessment, and what they would suggest for prevention in high-, medium-, and low-risk patients.

In the recent project, the response rate (from a population of 2543) was 46.2% (n=960) for nursing staff (which included 210 healthcare assistants), and 49% (n=228) for medical staff. Admittedly, this was not quite as high as one would have liked. Nonetheless, it involved large numbers of respondents, and the results were very similar to those of the previous survey (Maylor and Torrance, 1999a).

Returning to the 'myth' of whether or not nurses know more than doctors, it seems that they do, but only just! A knowledge/opinion score was computed so that the views of respondents could be compared with a standard derived from expert consensus and literature. For example, with 'do you strongly agree that prolonged high pressure on a bony prominence is an important contributor to pressure ulceration?', 1152 (97.9%) did agree. In short, if there was complete agreement between respondents and the standard, they scored maximum points.

Out of a possible score of 72, the median score for nursing staff was 56 (range=66), and for medics 55 (range=57). Believe it or not, this was statistically significant (Mann-Whitney U-test 88664.00, two-tailed $P = 0.002$). Hardly a resounding victory for nurses!

There is still more analysis to complete, but it looks as if the vast majority of staff, whether nursing or medical, are aware of risk assessment scales, and have seen them used. They also know about the various items of pressure ulcer prevention equipment, although they tend to describe them using the trade name, and are less familiar with generic descriptors of the same type of equipment. Therefore, overall knowledge of the main factors involved in recognising and preventing potential pressure damage does not seem to be lacking.

So why do patients continue to get pressure ulcers? My previous research concluded that it was not as a result of

lack of knowledge or equipment (over a period of 5 years every patient with a pressure ulcer had an appropriate piece of kit, although one patient had refused to use any) (Maylor, 2001a). Rather, I concluded that it was better explained in terms of locus of control and value of pressure ulcer prevention.

Paradoxically, the higher the proportion of sisters who believed they could not control pressure ulcers because it was largely down to fate, the lower the prevalence of patients with ulcers in their department. In other words, if they believed it was inevitable, then fewer patients suffered. A further paradox was that when sisters believed 'powerful others' controlled pressure ulcers (i.e. not themselves personally), then their knowledge score tended to be higher. This suggests that they felt they might have to answer to the doctor or the manager if their departmental prevalence of pressure ulcers was higher than elsewhere.

What I am suggesting is that it would be best to stop testing whether knowledge is adequate, and put more research effort into understanding why there is a theory/practice gap.

Data from a couple of other studies I am doing have shown significant correlations between the personality type of nursing students and their

preference for Waterlow rather than, for example, the Pressure Sore Prediction Score (Maylor and Roberts, 1999) as a perceived source of authority. The way people receive and use information is a function of personality type and learning style, and more account has to be taken of this factor if we are to maximise the benefit for both staff and patients alike.

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Earlier, I said that exploding the myth that nurses know better than doctors about the prevention of pressure ulcers might not be such a bad thing. By that I mean that it really does not matter who knows most, rather that someone decides to do something to protect the patient from harm. I would argue that such a responsibility should not be left to anyone in a junior position. Locus of control theory shows that if people believe they are personally able to control an outcome, i.e. the prevention of pressure ulcers, they must highlight its value to colleagues (Maylor and Torrance, 1999b; Maylor, 2001b). If they do not, and they are in a position of management, their staff may not view fundamental activities such as pressure ulcer prevention as a priority.

Therefore, medical staff should ask questions about the patient's pressure areas, and not assume that pressure ulcer prevention is a priority for all nurses (Maylor, 2000b). The majority of nurses think it of less interest and importance to them than other clinical practices (Maylor, 2000b). If knowledge is sufficient, let us turn our attention to promoting the value of pressure area care as the sexy thing to do! **WUK**

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