Reflections on ritualistic care in tissue viability

Lilian Bradley

Recently I found myself on the other side of the healthcare divide as a patient in a 24-hour medical assessment unit (MAU). The care I received was excellent. With the day stretching ahead, and inspired by the nurses carrying out their routine observations, I decided to pass the time by reflecting on tissue viability practice and the ritualistic things we do that are throwbacks from the past.

The two-hourly turns carried out on the most vulnerable patients immediately came to mind. When I trained as a registered general nurse with an orthopaedic certificate, it was the two-hourly back round that took precedence. I certainly don't remember being taught about using skin tolerance to create an individualised repositioning schedule and we did use some questionable procedures like vigorously rubbing the sacral area with an astringent soap. The area was rigorously dried and women were dusted with talc and men rubbed with methylated spirit. Despite what today would be viewed as questionable practice, if a patient developed a pressure ulcer it merited a visit from matron and was the talk of the hospital. At least patients were repositioned even when they were nursed on a standard Kings' Fund mattress. There did seem to be fewer pressure ulcers back then, but was this a benefit of ritualistic practice or did older people have less comorbidities than we see today?

Lilian Bradley is Tissue Viability Nurse Specialist, Ulster Community and Hospitals Trust, Belfast

This then led me to reflect on the care of patients with fractured neck of femur. I thought about the Department of Health's decision to regionalise three centres in Northern Ireland. In my time, a fractured neck of femur was a surgical emergency with patients often having their hip pinned in the early hours of the morning. Yes, maybe the patients were younger then and with less comorbidities than today's older population, but anaesthetics have never been safer. So why is it now necessary to have vulnerable patients waiting up to 10 days for surgery, putting them at risk of deep venous thrombosis or pressure ulcers, the incidence of which are on the increase?

Part of the problem is that nurses' views are not always listened to. My employing trust have just launched their joint strategy for clinical governance in an attempt to get the voice of nurses heard. When the Department of Health decided to have patients with fractured neck of femur treated in three large hospitals — two in Belfast and one in Londonderry — it involved massive financial savings and the decision was therefore seen as penny-pinching rather than an attempt to improve care. This was something that nurses would have been more than able to point out, had they been consulted.

A case-control study or randomised controlled trial comparing outcomes in terms of rehabilitation or returning to independent living is needed for those patients with a fractured neck of femur treated with what is now standard treatment *vs* emergency surgery.

Several months ago, I was reviewing an A&E care pathway when I came across the following statement: 'if Braden score is below 18, please complete Braden risk assessment tool', so I spoke to a senior nurse in the department and asked her to explain. She said, with a twinkle in her eye as she looked me up and down, 'oh that will be the glance!' I knew exactly what she meant. As experienced nurses we begin our assessment of the patient the minute they come into our care. Yet we are often required to carry out ritualised formal assessments because legally it would be impossible to argue in favour of clinical judgement over formal assessment.

This leads to questions about responsibility. Who should support junior nurses when carrying out risk assessments on vulnerable groups? Who makes the decision on repositioning and mattress type? I believe that we can reduce the incidence of pressure ulcers, while still more frequently repositioning individualised care plans according to best practice.

In actual fact I had good reason to put my faith into the routine observation round when on one occasion it revealed I had a pulse rate of 150 and was in atrial fibrillation! Therein lies the dilemma. Ritualistic practice does have its uses in busy clinical areas but a nurses' judgement should not be underestimated. Nurses are wonderful. WUK