Benefits to patients and practitioners in adopting the guidelines for the prediction and prevention of pressure ulcers

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Abstract

The aim of this article is to place the international array of clinical practice guidelines concerning the prediction and prevention of pressure ulcers into a patient and practitioner context. This requires a brief overview of the current major international pressure ulcer prevention guidelines, outlining the desirable attributes of these guidelines and discussing the weighing of research evidence used to develop guideline recommendations.

Further objectives include indicating the evidence for assessing guideline impact, guidelines in context – the benefits to patients and practitioners of clinical practice guidelines versus the role of litigation – and emphasising the role of education within a patient/practitioner environment.

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International guideline development

The first clinical practice guidelines were developed in the Netherlands in 1985 and in the USA in 1989 [1,2]. The CBO (The Dutch Institute for Health Care Improvement) and USA National Pressure Ulcer Advisory Panel (NPUAP) utilised open meetings and a multidisciplinary panel format to arrive at consensus guidelines.

At the same time, the US government established the Agency for Health Care Policy & Research (AHCPR) and pressure ulcer prevention guidelines; this was followed by treatment guidelines issued in 1992 and 1994 [3,4].

In 1998, the European Pressure Ulcer Advisory Panel (EPUAP), again utilising an open meeting, multidisciplinary panel, consensus evidence based approach, developed prevention followed by treatment guidelines for its 15 member (plus non European Union) countries [5].

Most recently, the Pressure Ulcer Interest Subcommittee of the Australian Wound Management Association (PUISC AWMA) presented the comprehensive *Clinical Practice Guidelines for the Prediction and Prevention of Pressure Ulcers*, again developed in similar circumstances, at the 1st World Wound Healing Congress in Melbourne 2000 [Prentice J, personal communication].

Desirable attributes of these guidelines

Clark [6] has outlined the desirable attributes of clinical guidelines (Table 1). Each of the major national/ international guidelines can be assessed against these desirable attributes.

Viability of the research evidence

The concept and introduction of research evidence based practice into wound care literature meant that this needed to be weighted for inclusion and transparency within developing guidelines. The EPUAP guidelines [5] utilised the following A, B, C system:

A Results of two or more randomised controlled clinical trials on pressure ulcers in humans provide support.

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B Results of two or more controlled clinical trials on pressure ulcers in humans provide support or, where appropriate, results of two or more controlled trials in an animal model provide indirect support.

C This rating requires one or more of the following:
- results of one controlled trial;
- results of at least two case series/descriptive series on pressure ulcers in humans; or
- expert opinion.

The reality of the evidence base within wound care is that the majority of the research work attracts B and C ratings [6,7].

Guideline impact and patients' guide

The Netherlands CBO prevention guidelines were critiqued for impact [8]. Of the 27 preventive interventions, only three activities were considered useful and were used by more than 80 per cent of nurses in acute care: clean, smooth and dry bedding; good hygiene; and palpating and inspecting the skin daily. It was considered that the Dutch prevention guidelines were "insufficiently incorporated into practice". A number of other impact assessments have been published [9-12].

A US [13] guide for patients concerning preventing pressure ulcers covered a number of areas (Table 2).

It is interesting and important to note that guidelines for patients do not indicate that the majority of pressure ulcers are preventable, should not have occurred, can constitute neglect and hence could form the basis for compensation [14].

Practice guidelines in context

In health care settings around the world, institutions and clinicians should be encouraged to foster a culture of clinical audit, clinical pathways, quality assurance and evidence based practice, especially within wound care [15]. It is known that guidelines can change process and outcome [16] and hence should be available (but relevant) to all practitioners. This availability needs to be linked into the developing environment of life-long learning for practitioners.

Table 1. Desirable attributes of clinical guidelines.

- validity
- cost effectiveness
- reproducibility
- representative development
- clinical applicability
- clinical flexibility
- clarity
- meticulous documentation
- scheduled review
- utilisation review

Table 2. Preventing pressure ulcers: a patients' guide.

- purpose of the guide
- what are pressure ulcers
- where pressure ulcers form
- your risk
- key steps
  - take care of your skin
  - protect family from injury
  - if you are confined to bed
  - if you are in a chair or wheelchair
- be active in your care
- additional resources

The development of guidelines for patients and carers needs to reflect the new transparency culture which invites comments, compliments and complaints, challenging individuals and corporate communication skills. I am convinced that the honest approach, stressing team responsibility within prevention guidelines, will result in greater true awareness of the problems amongst clinicians and patients.

More rigid programmes such as the use of risk management tools to identify key risk areas (clinical audit, near-miss review, publicise incidence and prevalence data 'name and shame') can improve standards, though may raise the profile of litigation led changes rather than via educational guideline development. The risk management approach can use practice guidelines as part of insurance criteria imposing clinical governance criteria rather than evolving them.

Education

Pressure ulcer prevention guidelines form part of a complex net of tools used to educate clinicians. The context of their use, described above, illustrates the battleground – will education initiatives or the backlash following litigation be the driver for change? In the era of computer assisted learning, guidelines can be incorporated into interactive CD-ROM study guides [16].

A full review of education initiatives is beyond the scope of this article; however, education *per se* is the generic basis of developing and then disseminating any knowledge base. To this end, we must view ourselves as perpetual students and teachers – remembering Benjamin Franklin's words; "Tell me and I forget, teach me and I remember, involve me and I learn".

References

1. Jacquerye A. Bedsore Prevention and Treatment as a Topic for Quality Assurance in Hospital. Brussels: COMAC/HSR CBO.
2. National Pressure Ulcer Advisory Panel. Pressure ulcers: incidence, economics, risk assessment. Consensus development conference statement. Decubitus 1989; **2**:24-28.
3. Bergstrom N, Allman RM, Carlson CE *et al.* Pressure Ulcers in Adults: Prediction and Prevention (Clinical Practice Guideline No 3). AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services, 1992.
4. Bergstrom N, Allman R, Alvarez O *et al.* Treatment of Pressure Ulcers (Clinical Practice Guidelines No 15). AHCPR No. 95-0652. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services, 1994.
5. European Pressure Ulcer Advisory Panel (EPUAP). A policy statement on the prevention of pressure ulcers from the EPUAP. BJN 1998; **7(15)**:888-890.
6. Clark M. Developing guidelines for pressure ulcer prevention and management. J Wound Care 1999; **8(7)**:357-9.
7. Nice Guidelines – National Institute for Clinical Excellence. Inherited Clinical Guideline B. Pressure Ulcer Risk Assessment and Prevention. London: DOH, 2001.
8. Halfens RJG *et al.* Knowledge, beliefs and use of nursing methods in preventing pressure sores in Dutch hospitals. Inter J Nurs Stud 1995; **32(1)**:16-26.
9. Regan MB, Beyers PH & Mayrovitz HN. Efficacy of a comprehensive pressure ulcer prevalence program in an extended care facility. Adv Wound Care 1995; **8(3)**:51-55.
10. Xakellis GC, Frantz RA, Lewis A & Harvey P. Cost effectiveness of an intensive pressure ulcer prevention protocol in long-term care. Adv Wound Care 1998; **11(1)**:22-29.
11. Harrison MB, Wells G, Fisher A & Prince M. Practice guidelines for the prediction and prevention of pressure ulcers: evaluating the evidence. App Nurs Res 1996; **9**:1,9-17.
12. Sunkten G *et al.* Implementation of a comprehensive skin care programme across care settings using the AHCPR pressure ulcer prevention and treatment across care settings using the AHCPR pressure ulcer prevention and treatment guidelines. Ostomy & Wound Management 1996; **42(2)**:20-30.
13. US Department of Health and Social Sciences, AHCPR. Preventing pressure ulcers: a patient's guide. Decubitus 1992; **5(3)**:34-40.
14. Bennett GCJ. How we keep the truth from patients the NICE way. J Wound Care 2001; **10(6)**:193.
15. Bliss M & Bennett GCJ. Pressure Ulcers. In: Tallis & Filit (Eds). Brocklehurst's Textbook of Geriatric Medicine and Gerontology (6th edition). Churchill Livingstone. In-press 2002.
16. Hopkins A *et al.* Educational CD-ROM. Poster presentation. First World Wound Healing Congress, Melbourne, Australia, September 2000.