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Feature Article

# Pressure ulcer prevention in nursing homes: Nurse descriptions of individual and organization level factors

Mary Ellen Dellefield, PhD, RN [a,*], Jennifer L. Magnabosco, PhD [b,c]

[a] Department of Veterans Affairs, VA San Diego Healthcare System, 3350 La Jolla Village Drive, San Diego, CA 92161, USA
[b] Department of Veterans Affairs, Center for Implementation Practice & Research Support (CIPRS), VA Greater Los Angeles Healthcare System, Sepulveda, CA, USA
[c] Yo San University of Traditional Chinese Medicine, Los Angeles, CA, USA

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ABSTRACT

Sustaining pressure ulcer prevention (PUP) in nursing homes has been difficult to achieve. Implementation science researchers suggest that identification of individual staff and organizational factors influencing current practices is essential to the development of an effective and customized plan to implement practice changes in a specific setting. A mixed methods approach was used to describe nurses' perceptions of individual and organization-level factors influencing performance of PUP in two Veterans Health Administration (VHA) nursing homes prior to implementation of a national VHA initiative on Hospital Acquired Pressure Ulcers (HAPUs). Individual interviews of 16 nursing staff were conducted. Individual factors influencing practice were a personal sense of responsibility to Veterans and belief in the effectiveness and importance of preventive measures. Organizational factors were existence of cooperative practices between nursing assistants and licensed nurses in assessing risk; teamwork, communication, and a commitment to Veterans' well-being. Integration and reinforcement of such factors in the development and maintenance of customized plans of PUP initiatives is recommended.

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Globally, nursing home (NH) consumers and other stakeholders assume that the incidence and prevalence of pressure ulcers (PUs) are indicators of poor nursing care quality.[1,2] This is largely due to a longstanding rationale in the healthcare field that most PUs are preventable, especially if nurses routinely perform basic nursing responsibilities.[3]

Evidence-based guidelines for prevention of PUs have been widely disseminated in the United States (US) and European countries, including England, Germany, Italy, the Netherlands, Belgium, and Sweden.[4,5] The Joint Commission, as the accrediting agency for US healthcare facilities receiving federal healthcare funding, has included effective PU prevention (PUP) and treatment as a national safety goal for several years. In spite of these efforts, reducing the incidence of PU development for at-risk NH residents has been difficult to achieve.[6–9]

Difficulties in reducing the incidence of PU risk have been linked to multiple factors that may influence nurses' behaviors, including staff attitudes, beliefs, knowledge, clinical practice requirements, managerial behaviors, and unit infrastructure. Addressing these factors is key to formulating a plan to more easily and effectively implement evidence-based guidelines and practices for PUP care.[10] Researchers have found that prior to developing a plan to implement a practice change – such as the implementation of evidence-based guidelines – it is important to assess existing individual and organizational factors perceived by staff that may be positive and negative influences on the practices targeted for change.[11] This assessment is useful in tailoring a unit or facility specific approach to implementation of evidence-based practice changes.

Given the complexities of performing PUP care, and the variance in knowledge, attitudes, and beliefs that underlie clinical staff's delivery of such care, we explored individual and organizational factors associated with PUP using both qualitative and quantitative data. In order to gain a more comprehensive understanding of PUP care delivery, triangulation of these two data types allowed us to explore the multi-dimensional nature of PUP. Our purpose in asking open-ended (qualitative) and close-ended (quantitative) questions was to "get at" the "whats" and "hows" of PUP care delivery, and to be able to compare domains and dimensions of care that lent themselves best to qualitative and/or quantitative measurement.[12] While we were primarily interested in the uninfluenced descriptive expressions that nurses could provide (through answers to open-ended questions), we were also cognizant of the fact that nurses might conceal "real" knowledge, attitudes, and behaviors. Hence,

* Corresponding author. Tel.: +1 858 692 8553; fax: +1 858 552 1246.
*E-mail addresses:* mary.dellefield@va.gov, dellefield@aol.com (M.E. Dellefield).

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we created close-ended questions that were similar to the open-ended questions to provide an additional avenue for expression, and comparison among participants.

## Background

### *Study constructs*

Evidence-based guidelines and implementation science provided the conceptual foundations for this study.[4,13] Healthcare implementation is defined as a planned process and systematic introduction of a change in clinical practice that is evidence-based, and incremental.[11] The rigorous study of this process is termed implementation science (IS). IS seeks to establish greater understanding of how empirically based strategies are effectively used to improve healthcare practices, with special emphasis on how strategies are implemented to incorporate changes into routine and/or management practices.[11,14] One common exploratory goal of IS has been to determine how the adoption of evidence-based guidelines takes place, and to identify and describe which characteristics of care practices may be associated with the achievement of positive clinical outcomes.

### *Individual level factors and PUP*

Individual factors of nurses such as knowledge, attitudes, motivation, beliefs and values are known to influence behaviors of healthcare staff.[11] European nurse researchers have used qualitative methods to study relations between individual staff characteristics and PUP nurse performance.[15–21] For example, Beeckman et al and Samuriwo (2010) found that the variation in value placed by nursing staff on PUP care affected the delivery of their PUP practices.[2,19] In other words, nurses prioritized PU care by comparing it with other types of care that needed to be delivered. In a study of 9 NHs and 154 Belgian nurses, Demarre et al (2012) found that nurses had more positive attitudes toward PUP care than nursing assistants. A more positive attitude was a significant predictor of compliance with PU prevention practices.[20]

Globally, however, quantitative empirical evidence that links individual factors and actual compliance with PUP practice guidelines in NHs, is limited.[2,16,21] This is because individual factors have been understudied compared to organizational factors; few instruments have been developed; and existing instruments are not considered psychometrically rigorous.[18] However in 2010, Beeckman et al published a psychometric evaluation of a new instrument – the Attitude towards Pressure Ulcer Prevention (APuP). Testing of the APuP has shown that individual performance of PUP care delivery can be influenced by perceptions of personal competence and responsibility for PUP.[21]

### *Organization-level factors and PUP*

Although studies have been limited by small staff or facility sample sizes, trends are emerging about organizational factors reported as facilitators and barriers to performance of PUP care in NHs.[22–27] Factors related to effective organizational practices include use of standardized risk assessment forms and wound nurse specialists; consultation with interdisciplinary team members; ongoing staff education; use of higher specification foam mattresses to provide effective support; and use of 'turn schedules' or specific times at which at-risk residents are re-positioned, either in bed or in a chair, to relieve pressure.[22–27] Strategies consistently identified as important components of successful PUP programs in the US and Europe in a range of settings and across populations include administrative support; active involvement of direct care staff; bundling of care processes that are integrated into routine practice (e.g. performing risk assessment, repositioning, skin care, and skin inspections); using a systematic approach that is tailored to the unique features of a care setting; and ongoing staff education.[7,8,28]

Conversely, researchers have identified organization-level factors found to impede successful delivery of PUP care. These include under-utilization of risk assessment tools; lack of dissemination of clinical guidelines to all levels of clinical staff; lack of systematic approaches to guideline implementation[29]; use of documentation formats that do not record clinical data consistent with guideline content[30]; nursing staff perception of a lack of time for prevention,[19] absence of family advocacy; inadequate staffing; and lack of clinical supervision of nursing care associated with activities of daily living.[31]

In addition, Rosen et al (2005) found that when targeted performance feedback on preventive care and incentives were not sustained, the level of adherence to PUP guidelines declined.[32] Similarly, inadequate nurse staffing levels have been shown to impede performance of preventive nursing care. Horn et al (2005) found that increased PU incidence was associated with lower nursing staff of all skill levels and less direct care performed by registered nurses (RNs).[30] Niederhauser et al (2012) reported that program sustainability was reduced if too many changes were made at one time; staff was inadequately educated; resistance to new practices was not addressed; equipment was inadequate; and a supportive infrastructure was absent.[8]

## Methods

### *Study aim*

The purpose of this study was to describe nurses' perceptions of individual and organization-level factors influencing performance of pressure ulcer prevention (PUP) care in 2 VHA Nursing Home Community Living Centers (CLCs) to help identify existing factors perceived as facilitators and barriers to delivering PUP care. The study was conducted in concert with the beginning phases of the VHA's national Hospital Acquired Pressure Ulcer (HAPU) Initiative "Getting to Zero." Started in 2011, the Initiative's purpose was to implement updated and comprehensive evidence-based practices processes as defined in VHA Handbook 1180.02 "Prevention of Pressure Ulcers," to prevent PUs in all clinical settings, including 135 CLCs.[33] A national HAPU interdisciplinary workgroup was established and charged with "creating a culture of change, communication, and commitment to support eliminating HAPUs throughout VHA."[33]

### *Study design and sample*

The study employed an exploratory qualitative interview study design, triangulating qualitative and quantitative data to study individual and organization level factors associated with three domains of interest: nurses' general perceptions and feelings about PUP; PUP practices, including staff, residents, and family; and performance.[12]

A convenience sample of 2 VHA CLCs was selected because these facilities had the largest bed capacity of 5 VHA-operated CLCs in southern California. The sites were most representative of CLCs nationally in the types of services offered and nursing skill mix used. The study sites were comprised of 3 and 2 units, respectively, and provided a range of clinical services-palliative, dementia, rehabilitation, and traditional long-term care. The CLCs were staffed with 3.9–4.1 care hours per patient day (HPRD) that were at a higher level, on average, than non-governmental nursing homes.[34]

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