

NURSES' PERCEPTION ABOUT RESPONSIBILITY OF CARE IN DECUBITUS ULCER MANAGEMENT

I GEDE PUTU DARMA SUYASA
SEKOLAH TINGGI ILMU KESEHATAN (STIKES) BALI

ABSTRACT

This study was conducted in order to increase the understanding of issues around decubitus ulcer care in the Indonesian context. The study identified Indonesian nurses' perception regarding responsibility of care in the area of decubitus ulcer management. The choice of a qualitative research approach to elucidate the research questions provides the most appropriate way to fully appreciate and understand the uniqueness of the participants' view. In this study, eight nurses were interviewed using semi-structured interviews. Two themes arose from the study include nurses' responsibility and family involvement. In maintaining the quality of care in the decubitus ulcer area, the participants in this study emphasised the significance of the caring responsibility of both nurses and family. Appropriate education and adequate training for the family are essential in ensuring quality care when involving the family in giving any direct care to hospitalised patients.

Keywords:, family involvement , responsibility of care, decubitus ulcer

INTRODUCTION

Decubitus ulcers reduce patients' quality of life significantly. Moore (2004) observed that decubitus ulcers contribute to a reduction in comfort and the increase of morbidity. They also increase the length of hospitalisation which leads to other problems such as an increase in the financial burden for hospital and patients. In dealing with this situation, however, few are sufficiently aware that most decubitus ulcers can be prevented with vigilance and a heightened quality of care.

Pressure ulcer prevention and management is an integral part of nursing practice. The prevalence of decubitus ulcers in the health care setting becomes a quality indicator of nursing care (Lyder, 2003; Moore, 2001). Furthermore, the prevention of decubitus ulcers has been considered as a nursing responsibility (Gould et al., 2000). Although this responsibility is not solely in the hand of nurses, they have a 'unique opportunity' because they have traditionally taken the lead in pressure ulcer prevention and management among other health care team members (Moore, 2004, p. 30).

I Gede Putu Darma (email: putu_darma78@yahoo.com) Sekolah Tinggi ilmu Kesehatan, Prodi Keperawatan, Bali

After being discussed in some research paper around the globe (Gould et al., 2000; Lockhart, 2002; Lyder, 2003; Moore, 2001; Moore 2004), another study and discussion need to be conducted around nurses' perception of responsibility of care in decubitus ulcer area. However, there is limited

study indicating the issue especially in the Indonesian context. Therefore, it becomes important to address the issue through this study.

The aim of this study was to identify the Indonesian nurses' perception of caring responsibility in decubitus ulcer management. To achieve these outcomes, a qualitative approach with a case study design was adopted. This study provided an insight about Indonesian nurses' perception about caring in decubitus care area.

INSTRUMENT AND METHOD

Qualitative studies make a significant contribution in developing and integrating nursing knowledge into practice (Sandelowski, Docherty & Emden, 1997). They tend to be holistic, striving for understanding the human condition as a whole and it attempts to deal with the complexity and subjectivity of human nature through in-depth investigation into the human experiences (Patton, 1990; Polit & Beck, 2004; Roberts & Taylor, 2002).

A purposive sampling was used in this study to select suitable participants. Purposive sampling is 'hand-picking cases that will most benefit the study' (Polit & Beck, 2004, p. 306). The aim of this sampling is to select the participants that have a great deal of information regarding the study (Grbich, 1999).

Data was collected by in-depth interviews with eight nurses who are currently working in an Indonesian hospital. The interview was conducted by using a semi-structured question that is initially consisted of ten open-ended questions. Open-ended questions stimulate participants to give variety of responses. These types of questions also give opportunity for researcher to generate other questions which will be able to enrich the understanding of caring responsibility around decubitus ulcer care. The site and time allocation of data collection are important issues in any qualitative data collection. The site should be a quiet setting (Polit & Beck, 2004; Roberts & Taylor, 2002) and the time commitment should not be considered as a burden especially for participants. This provision ensures that in-depth and rich data is gathered from each participant's point of view. In this study, the allocation of time and place of interview depended on negotiations between the researcher and each of the participants.

Data was manually transcribed and before being analysed, the interview transcripts were sent to the participants to check for accuracy. All participants agreed to let the researcher use the data contained in the transcripts. Thematic analysis was conducted by coding and grouping the data according to the similarities and differences of the responses to questions.

RESULT

During interviews, each participant painted a different picture based on their particular perspectives. However, similarities and differences between them emerged. Two themes arose throughout the study. These themes were nurses' responsibility and family involvement. In maintaining the quality of care in the decubitus ulcer area, the participants in this study emphasised the significance of the responsibility of both nurses and family. Here, the participants will be identified by their pseudonyms, Siki, Kalih, Tiga, Papat, Lima, Kanem, Pitu, and Kutus. In presenting the themes, some important quotes will be included together with participant's pseudonym and the page number of the interview transcript to support the data.

Nurses' Responsibility

Decubitus ulcer care is a nursing domain. It is a caring responsibility of nurses. Nurses are the primary health care team members in relation to decubitus ulcer management. The nurses in this study were aware of this and highlighted that it is nurses who give direct constant care to patients. One participant, Kanem, stated that nurses are available for twenty four hours to provide care. Another participant, Kalih, also underlined this view by stating that nurses not only maintain continuous contact with patients, but they also have a significant chance to assess patients' skin condition regularly especially when attending to personal hygiene. She made the point:

...because nurses have more contact time with patients. Nurses are the ones who give attention to patients starting from giving a wash. When giving a wash we can assess a patient's condition...when the signs are starting to appear, we can prevent them [decubitus ulcers]. (Kalih, p. 2)

However, another participant, Pitu, had a different view about the nurse's role in the responsibility for care. He described that this is not solely a nursing responsibility but decubitus ulcer management is a collaborative process. In his view, other health care team members such as doctors, nutritionists, and physiotherapists also have a significant contribution to make in this area of practice. He stated:

The ones who are principally responsible in the practice area are nurses and it is done in connection with physiotherapists and doctors... (Pitu, p. 3)

Pitu's statement clarified the place of nurses in relation to the responsibility for care in decubitus ulcer practice among others in the health care team. Although nurses had a more obvious and more significant contribution, all participants believed that decubitus ulcer prevention and management require a multidisciplinary approach that included collaboration with other professionals. Some participants also highlighted that this multidisciplinary approach included family involvement.

Family Involvement

The place of the family in the management of decubitus ulcer care was also addressed by the participants. According to Lima, although the contribution of nurses and other health care team members was significant in decubitus ulcer management, the role of the family was also substantial. She stated:

I think all of the health care teams must be responsible in general...But with help from other parties such as doctors and more importantly from families...because support, motivation and cooperation from families or a patient's guardian are very important. (Lima, p. 4)

To these participants, family involvement in nursing care was perceived as mutually beneficial. This relationship was perceived by the interviewed participants as being very significant indeed and involved a kind of family empowerment in the ward because the family was seen to be able to help nurses in providing simple nursing care. Kanem alluded to the benefits of the family being knowledgeable about prevention strategies. She stated:

...as nurses we can't do that [decubitus ulcer care] alone...it is because patients are sometimes obese...besides we are educating families to prevent ulcers. Therefore, families understand about preventing decubitus ulcers. (Kanem, p. 5)

It was considered important for families to have adequate prevention knowledge because the family appeared to be criticised by nurses in this study if decubitus ulcers occurred in patients. Pitu described this situation as follows:

...because of lack of knowledge about decubitus ulcers among families. Therefore, patients are very susceptible to getting decubitus ulcers; besides with less knowledge comes less ability as well as less motivation from their families to prevent decubitus ulcers. (Pitu, p. 4)

Because of the perceived need for family involvement in decubitus ulcer care, especially in its prevention, family involvement was identified by these nurses as a risk factor in pressure ulcer development. Lima explained:

The main factor [in decubitus ulcer development], I think, is family involvement, because if we compare, for example, two patients who have the same degree of risk of getting decubitus ulcers, but one family is very cooperative and willing to help [compared to another situation where there is no family involvement]. We would suggest the family help with positioning patients left or right, but not all patients would actually be given a hand. It [family involvement] influences the incidence; therefore one patient [with family involvement] does not develop an ulcer whereas another one [without family involvement] does. (Lima, p. 5)

Participants in this study also emphasised the role of the family in terms of providing financial support. According to the nurses in this study, economic conditions impacted on maintaining the quality of

care. If financial difficulties existed, this impacted on the capacity of the patients or their families to afford hospitalisation. As a result, families tried to keep patients in home care as long as possible and then when patients were finally admitted to hospital they were often in a more advanced stage and some had already developed decubitus ulcers.

Lima stated:

I think it is a financial problem... the problem in Indonesia currently; people will not come to hospital if they are not in an obvious sick condition. If it is not thought to be a critical condition, families will not bring them to hospital...The problem is financial. [There is] less financial support. Finally after they arrive in hospital, the patients are really in a critical condition. (Lima, p. 4)

Furthermore, Lima, who had previous experience in a higher ward class, made a strong point about how the economic conditions of patients were very significant factors in being able to prevent decubitus ulcers. Patients or families with a higher income level could afford appropriate preventative equipments for decubitus ulcers. She said:

It really depends on access to appropriate equipment, for example, the patient who is able to afford a water mattress. That helps to prevent pressure ulcers. (Lima, p. 3)

Participants' comments on the responsibility for care suggested that preventing and managing decubitus ulcers were not only that of nurses. There were contextual considerations in the Indonesian setting. Although patients were being hospitalised, families were heavily involved in the maintenance of adequate care for patients with decubitus ulcers including positioning patients, giving a wash, assisting with food and applying massage.

DISCUSSION

The nurses in this study identified several factors in the responsibility for care in decubitus ulcer management, namely: nurses themselves, other health care professionals, the patient's family and the patient's circumstances. These will be used as a basis for the ensuing discussion.

Caring Responsibility of Nurses and Other Health Care Professionals

The findings under the theme of responsibility for care, demonstrated that nurses in this study were aware of the duty of care for nurses in decubitus ulcer care. These findings are in line with several previous studies which emphasise that decubitus ulcer care is a nursing domain (Gould et al., 2000; Lyder, 2003; Moore, 2001). However, careful interpretation and understanding are essential in handling this issue because patients and their families are often overlooked in this issue, being often viewed as a result of 'substandard nursing care' (Lockhart, 2002, p. 64). There are several factors,

known as pressure ulcer risk factors, which make a very significant contribution in the development of pressure ulcers. These factors include ageing, sensory perception, immobility, malnutrition, mental status, incontinence, moisture, friction, shear and smoking (Baranoski & Ayello 2004; Lueckenotte, 2000).

The findings in this study highlighted the ways in which the responsibility of care in decubitus ulcer management was not solely a nursing responsibility but it was also a collaborative process. Other health care team members have a significant contribution to this area of practice. Lueckenotte (2000) considers nurses as front-line providers and managers of care' in decubitus ulcer practice (p. 680). Nurses, in decubitus ulcer management, not only act independently when patients are identified as being at risk of the development of pressure ulcers, but also they collaborate with other health care team members in relation to providing adequate care for patients (Chambers, 1997).

Patient's Family and Patient's Circumstances

While these findings are in accord with several previous studies which emphasise the role of nurses and other health care teams in decubitus ulcer management, there are significant variations between them. According to the participants, nurses and other health care professionals such as doctors and physiotherapists are not the only team responsible for duty of care in decubitus ulcer prevention and management. In Asia, there is a general assumption that people rely on their families including their children and extended relatives, to provide substantial support (Kreager, 2003). This support includes physical, psychological and financial support. In Indonesia specifically, family issues in decision-making and also in caring for sick family members is very important (Nursasi, 1999; Sahar, Courtney & Edward, 2003).

This situation may differ from the Western perspective which has the concept of 'individualistic' rather than 'collective' care. Western people tend to be more individualistic in managing their diseases (McLaughlin & Braun, 1998). In Indonesia, the concept of 'collective' means the society and the family as a whole unit and is not just about the individual. The findings of this study suggested that preventing and managing decubitus ulcers also required family involvement. In the Indonesian context, even though patients were being hospitalised, families were heavily involved in the maintenance of adequate care for patients with decubitus ulcers.

The family as a care giver in a home care setting has been widely discussed as an acceptable approach to nursing intervention (Barusch, 1995; Boise, Congleton & Shannon, 2005; O'Brien et al., 1999; Sahar, Courtney & Edwards, 2003). Barusch (1995) names this as 'mandated family responsibility' (p. 316). However, there are limited studies addressing the issue of family involvement in hospitalised patients. The main role of family in chronic hospitalised wound care is to provide patients with psychological support (Chambers, 1997). The findings of this study suggested

that the role of family in hospitalised patients was not only in maintaining psychological and financial support, but also in providing direct care such as changing patients' position, sponging, massage and feeding patients - the practicalities of daily living activities.

Duty of care issues arise in regard to who is responsible for ensuring the safety of patients and the safety of families when families are giving direct care to hospitalised patients. Families possess less knowledge about mobilisation and patients' nutrition (Petrella et al., 2005). They are also often poorly educated and prepared (Sahar, Courtney & Edwards, 2003) and they may also have emotional difficulties related to their family members being ill (Eisenberger & Zeleznik, 2003). Therefore, their actions may produce harmful effects on patients and themselves. Inappropriate procedures for changing patients' positions and sponging may increase friction to patient's skin. Family also can endanger their own safety because of inadequate lifting and handling techniques (Brown & Mulley, 1997). According to a study by Brown & Mulley (1997), family members developed back injury as a result of repositioning their relatives. This is an important consideration for nurses when they involve family members in nursing care. Nurses therefore have a role in educating patients' relatives about safe handling techniques in mobilising patients and other 'mandated family responsibilities'.

The question of who is responsible in ensuring the safety of patients and the safety of families when families are giving direct care in hospitalised patients remains unresolved according to contemporary studies because of the limited number of studies that specifically address this issue. Considering it is a hospital based care, the responsibility appears to rest with health care team members, especially nurses. Therefore, appropriate education and adequate training for the family are essential in ensuring quality care when involving the family in giving any direct care to hospitalised patients.

Financial concerns are a crucial issue in managing decubitus ulcers in hospitalised patients. This study demonstrated the significance of family involvement in providing financial support. This is supported by a previous study which reveals that financial support from the family is an important issue in the Indonesian context (Nursasi, 1999). However, many Indonesians face financial constraints particularly in times of economic crisis. The low economic status of the patients or their families reduces the level of affordability of hospitalisation and impacts adversely on the hospital system's ability to provide adequate preventative equipment as well as treatment regimes.

The ward classification system in Indonesia demonstrates this situation clearly and providing a good example of how the classification of the health system in Indonesia works. A family with medium or low economic income can only afford hospitalisation in the economic class. In this class, such as the ward where this research was conducted, the facilities are usually very limited. For example, in this class, the bed is not adjustable, and the mattress is not a pressure-redistributing type

mattress. In the higher ward class, the bed is adjustable and the mattress is better for pressure area management.

However, there is no study reporting a higher incidence of decubitus ulcer in the economic class compared to higher class ward. The issue of whether the ward classification system and the economic level of patients or families affects the incidence and the treatment of decubitus ulcers needs further research and analysis beyond the scope of this study.

In summary, nurses, other health care team members and families were viewed to be responsible for decubitus ulcer management. The role of nurses and other health care team members were clearly and widely acceptable. Considering the critical role of family involvement identified by participants in this study, family involvement appeared to be viewed as one factor relevant to the development of pressure ulcers in hospitalised patients. Although family involvement is substantial in this area of nursing practice in Indonesia, further study and analyses are essential when involving family in giving direct care for hospitalised patients with pressure ulcers and especially with regard to consideration of the safety of patients and families.

CONCLUSION

Nurses, other health care team members and patients' families were identified by this study as being responsible for decubitus ulcer management in hospitalised patients. The role of nurses and other health care team members were clearly and widely accepted in maintaining a heightened quality of care in the area of decubitus ulcer management. Another interesting finding in this study was that nurses involved the family in providing direct care to patients in the hospital setting.

Based on the conclusion above, there are several recommendations. Firstly, nurses are required to deliver high quality care for patients; and therefore, they should have an adequate knowledge in the area of decubitus ulcers as a basis of their practice, secondly, family education and training is essential in ensuring family and patients' safety when involving the families and relatives in providing direct care for patients. These training needs should be incorporated directly and evaluated carefully in the patients' care plan on a regular basis.

REFERENCE

- Baranoski, S & Ayello, E.A. 2004. *Wound care essential: practice principles*. Philadelphia: Lippincott Williams & Wilkins.
- Barusch, A.S. 1995. Programming for family care of elderly dependents: mandates, incentives and service rationing. *Social Work*, 40 (3), 315-21.

- Boise, L, Congleton, L & Shannon, K. 2005. Empowering family caregivers: the powerful tools for caregiving program. *Educational Gerontology*, 31, 573-86.
- Brown, A.R & Mulley, G.P. 1997. Injuries sustained by caregivers of disabled elderly people. *Age and Ageing*, 26, 21-23.
- Chambers, N. 1997. The holistic management of pressure sores in terminal illness. *Journal of Wound Care*, 6 (8), 359-60.
- Eisenberger, A & Zeleznik, J. 2003. Pressure ulcer prevention and treatment in hospices: a qualitative analyses. *Journal of Palliative Care*, 19 (1), 9-14.
- Gould, D, James, T, Tarpey, A, Kelly, D, Pattison, D, & Fox, C. 2000. Intervention studies to reduce the prevalence and incidence of pressure sores: a literature review. *Journal of Clinical Nursing*, 9, 163-77.
- Grbich, C. 1999. *Qualitative research in health: an introduction*. Australia: Allen & Unwin.
- Kreager, P. 2003. Understanding elderly vulnerability in Indonesia. *IIAS Newsletter*, 32, 12.
- Lockhart, D.G. 2002. The legal implications of pressure ulcers in acute care. *Critical Care Nursing Quarterly*, 25 (1), 63-68.
- Lueckenotte, A.G. 2000. *Gerontologic nursing* (2nd edn). USA: Mosby.
- Lyder, C. 2003. Pressure ulcer prevention and management. *American Medical Association*, 289 (2), 223-4.
- Moore, Z. 2001. Improving pressure ulcer prevention through education. *Nursing Standard*, 16 (6), 64-70.
- Moore, Z. 2004. Pressure ulcer prevention: nurses' knowledge, attitudes and behaviour. *Journal of Wound Care*, 13 (8), 330-4.
- Nursasi, A. 1999. Case study: The contributing factors of patients' adherence to tuberculosis treatment in Jakarta, Indonesia., [Unpublished Masters Thesis]. Adelaide: Flinders University.
- O'Brien, SP, Gahtan, V, Wind, S & Kerstein, M.D. 1999. What is the paradigm: hospital or home health care for pressure ulcers? *The American Surgeon*, 65 (4), 303-6.
- Patton, M.Q. 1990. *Qualitative evaluation and research methods* (2nd edn). California: Sage Publication.
- Petrella, F, Nebbioso, G, Gallucci, A, Corona, G, Collin, A, Fiocco, S, Notarangelo, S & Maio, G. 2005. The importance of family and domiciliary treatment of immobile patients with chronic wounds. *EWMA Journal*, 5 (1), 16-21.
- Polit, D & Beck, C. 2004. *Nursing research: principles and methods* (7th ed). Philadelphia: J.B. Lippincott Company.

- Roberts, K & Taylor, B. 2002. *Nursing research process: an Australian perspective* (2nd edn). Australia: National Library of Australia.
- Sahar, J, Courtney, M & Edwards, H. 2003. Improvement of family carers' knowledge, skills and attitudes in caring for older people following the implementation of a family 'carers' training program in the community in Indonesia. *International Journal of Nursing Practice*, 9, 246-54.
- Sandelowski, M, Docherty, S & Emden, C. 1997. Qualitative metasynthesis: issues and techniques. *Research in Nursing & Health*, 20, 365-71.