

Type: EVIDENCE BASED PRACTICE

Subject: Issues in Nursing

Subject area: Nursing

Education Level: Masters

Length: 3 pages

Referencing style: APA

Preferred English: US English

Spacing Option: Double

Title: Evidence-Based Practice Project Proposal - Part E: Evaluation Plan

Instructions: in 750-1,000 words, discuss an evaluation plan to measure the effectiveness of your evidence-based practice project. provide the following criteria, making sure your evaluation plan is comprehensive and concise: propose evaluation methods to evaluate the implementation of your evidence-based intervention. describe the methods selected and provide rationale and support for why the proposed methods are best for the collection of outcome data. describe how the proposed evaluation methods will measure whether the project objectives are achieved. explain how the outcomes will be measured and evaluated based on the evidence. address validity, reliability, and applicability. describe strategies to take if outcomes do not provide positive results. discuss implications for practice and future research. upon receiving feedback from the instructor, refine "section e: evaluation" for your final submission. this will be a continuous process throughout the course for each section. prepare this assignment according to the apa guidelines found in the apa style guide, located in the student success center. an abstract is not required. this assignment uses a rubric. please review the rubric prior to beginning the assignment to become familiar with the expectations for successful completion.

### **Evidence-Based Practice Project Proposal - Part E: Evaluation Plan**

Name

Institutional Affiliation

Course

Instructor

Date

## **Introduction**

Prevention and treatment of acquired pressure ulcers is essential to every nursing care as identified by Florence Nightingale model two centuries ago. According to the National Ulcer Advisory Panel, pressure ulcers are identified as a localized injury either to the skin or underlying tissue over a bony prominence (Price & Reichert, 2017). Although there have been endless efforts meant to treat and prevent the development of pressure ulcers particularly in hospitalized patients, the rate of PU development has continued to increase gradually. For instance, report from the International Pressure Ulcer Preference Survey in the US between 2008 and 2018, the average prevalence rates of hospital acquired pressure ulcers in the acute care units was approximated to range between 5 and 15% (Talsma et al., 2016). Nonetheless, the prevalence rates of new acquired pressure ulcers in acute care units stands at about 8% with large variability between institutions.

## **Proposed Evaluation Pressure Ulcer Evaluation Methods**

Due to the sophistication underlying the prevention of pressure ulcers with many different evaluation methods, it may be difficult to consider how best practices should be put in place. The successful method is to consider a care package. A set of care methods provides the best methods that can lead to better results if combined (Gorecki et al., 2016). The methods of pressure ulcer evaluation described in this section include two key approaches for preventing pressure ulcers: a thorough skin evaluation and a controlled pressure ulcer risk evaluation.

## **Comprehensive Skin Evaluation**

A comprehensive skin evaluation is a process in which the patient's skin is evaluated for abnormalities. It requires the skin from head to toe to examine and touch with a special emphasis on the bony prominences. The goals and functions of a comprehensive skin evaluation method as an initial step towards the prevention of pressure ulcers is to identify the presence of any pressure ulcers, help in risk stratification given that a patient with underlying pressure ulcer might be at risk of developing other types of ulcers, identify other essential skin conditions, and to provide relevant data that can be used to evaluate the prevalence and incidence of pressure ulcer (Price & Reichert, 2017). A comprehensive skin assessment method has a number of unique elements like inspection and palpation which are considered to be essential. First the nurse professional is required to clearly explain to the patient and family that the patient's skin needs to be evaluated keenly in a private room. This method of pressure ulcer evaluation is not a one-time activity limited to hospitalization. It is important to repeat the activity on a regular basis to identify where there are changes in skin condition. Ideally, a single individual performs a daily comprehensive skin assessment on a standardized basis at a specific time. Comprehensive skin examination can also be integrated into normal care (Talsma et al., 2016). Patient caregivers can be taught to monitor the skin whenever they clean, bath or reposition the patient. In routine care, different parts of the skin can be scheduled to assess. Someone must then collect information regarding the skin evaluation from these distinct people.

The results of a thorough skin analysis must be noted in the patient's medical record and conveyed to the staff as an attempt to be most effective. Everyone should be aware that they should be notified when changes are observed from normal skin attributes. Patients should be empowered to report suspicious places on the skin and feel comfortable. Recovering new

defects, positive reinforcement will help nursing professionals to prevent or treat pressure ulcer. it is also important to consider keeping a separate unit log, in addition to medical records, which outlines the results of all complete skin tests (Gorecki et al., 2016). This document would record all patients on the unit with a pressure ulcer, the number of pressure ulcers and the highest level from the deepest ulcer. Healthcare specialists can readily identify whether a comprehensive skin evaluation is performed for each patient.

### **Standardized Pressure Ulcer Risk Assessment**

A comprehensive skin evaluation is aimed at identifying visible skin changes that signify an elevated risk of the developing pressure ulcer. In order to identify persons at risk for pressure ulcers, however, other criteria besides skin alterations must be examined. The best way to do this is to use a standardized risk assessment of pressure ulcers. Pressure ulcer risk evaluation is a standardized and recurring method to identify individuals at risk for pressure ulcer development in order to implement strategies for targeted preventive care for the risk indicated (Price & Reichert, 2017). This multi-faceted method has numerous components, including a tool or scale for established risk evaluation. Other risk factors not defined must be addressed in the evaluation tools. There is no identification of who develops a pressure ulcer in the risk assessment. It determines which people are more prone to develop a pressure ulcer, especially when there are no additional preventive actions. Furthermore, risk assessment can be utilized to determine various risk levels. More intensive procedures may be targeted towards more risky patients.

Risk assessment tools often examine various risk aspects, such as mobility, nutrition, and temperature, and allocate points depending on the degree of any deficit. Clinicians often feel that it is all they need to do to accomplish the risk assessment tool. Help workers realize that tools for

risk assessment are just a minor part of the risk assessment process (Gorecki et al., 2016). The risk assessment tools should be used in combination with a clinical evaluation, not to substitute for the clinical evaluation or judgment. Risk assessment tools or scales serve as a normal means of examining certain aspects which could put a person at risk for the development of a pressure ulcer. Research has shown that these methods are particularly useful for identifying persons with mild to moderate risks as nurses may identify those with a high risk or not (Talsma et al., 2016). All risk evaluation scales are intended to be used together with a consideration of the other risk factors of a person and strong clinical judgments. Although some organizations have developed their own instruments, the whole adult population has two risk assessment scales: Norton scale and Braden scale. Reliability and validity have been proven on both the Norton and Braden scales. They provide vital information for the planning process when used appropriately. Pressure ulcer risk documentation is crucial to make sure that all staff is aware of the pressure ulcer risk status of their patients. Documentation in the medical record may not be adequate alone to guarantee that all professionals are aware of risk levels. At shift changes or by reviewing written material in a medical record or patient safety worksheet, the risk state should be conveyed orally (Price & Reichert, 2017).

The clinical implications of these evaluation methods is that bedside nurses should always value pertinent and timely data for clinical decisions related to pressure ulcers and that both the standardized pressure ulcer risk assessment and comprehensive skin evaluation approaches were used to present data in actionable format for bedside nurses to help prevent pressure ulcers (Gorecki et al., 2016). Future application of these methods of pressure ulcer

evaluation includes advancing use of technology and maintaining a close relationship with the ultimate users for optimum implementation and utilization.

## References

- Gorecki, C., Brown, J. M., Cano, S., Lamping, D. L., Briggs, M., Coleman, S., ... & Nixon, J. (2016). Development and validation of a new patient-reported outcome measure for patients with pressure ulcers: the PU-QOL instrument. *Health and quality of life outcomes, 11*(1), 1-12.
- Price, S., & Reichert, C. (2017). The importance of continuing professional development to career satisfaction and patient care: meeting the needs of novice to mid-to late-career nurses throughout their career span. *Administrative Sciences, 7*(2), 17.
- Talsma, A., Tschannen, D., Guo, Y., & Kazemi, J. (2016). Evaluation of the pressure ulcer prevention clinical decision report for bedside nurses in acute care hospitals. *Applied clinical informatics, 2* (4) 508-21.