This simplified leaflet is intended to give you information about pressure ulcer and aid your clinical practice

PRESSURE ULCER PREVENTION SIMPLIFIED

Pressure ulcer development has become an indicator of the quality of nursing care. Since July 2012 all NHS organisations were expected to collect data of patient harms, including pressure ulcer prevalence, using the NHS safety Thermometer (The NHS Information Centre, 2012).

In 2012 the Department of Health set targets of eliminating all avoidable pressure ulcers in 95% of patients through Quality, Innovation, Productivity and Prevention (QUIP).

Protection of the individual patient from pressure damage is a fundamental aspect of nursing care (Wounds UK, 2013).

All patients should have a pressure ulcer risk assessment undertaken within six hours of being admitted to an acute setting or on first home visit (NICE, 2005).

NICE, (2014) recommends that clinicians carry out and document an assessment of pressure ulcer risk for adults.

PRESSURE ULCER PREVENTION STRATERGIES

When a patient is admitted into the NHS secondary care or having care in the community, it is vital that the following are considered as key risks of a patient obtaining a pressure ulcer. It important to identify the following key factors:

- Significantly limited mobility (for example, people with a spinal cord injury)
- Significant loss of sensation
- A previous or current pressure ulcer
- Nutritional deficiency
- The inability to reposition themselves
- Significant cognitive impairment

RISK ASSESSMENT

Validated risk assessment tools:

- Waterlow Scale (1985)
- Norton Risk Assessment Scale
- Braden Scale
- PPURA (Preliminary Pressure Ulcer Risk Assessment) (NATVS, 2014)

A risk assessment will not predict if a patient will develop a pressure ulcer, it will only identify patients who are likely to be at a higher risk, based on the combination of existing factors. It is important to clearly document the risk assessment to ensure that the risk factors are recognised an and appropriate care plan implemented.

Patients who are assessed to be at high risk of developing pressure ulcers should also have a skin assessment undertaken.

SSKIN CARE BUNDLES

The SSKIN Bundle is a simple, holistic approach to ensuring that all patients receive the appropriate care to prevent pressure damage (Whitlock & Rowlands, Joy 2011).
A care bundle is a collection of interventions, (usually no more than five), that may be applied to the management of a particular condition, or as preventative measures to reduce the risks of complications (NHS Midlands and East, 2012).

The fundamental (PU) prevention strategy should always include all five elements of the SSKIN bundle:

- Surface
- Skin inspection
- Keep moving (repositioning)
- Incontinence and moisture management
- Nutrition and hydration assessment
(NHS Midlands and East, 2012).

Surface

The right surface can help to prevent damage to the skin. Select a pressure distribution mattress and cushion based on patients needs and comfort.

Skin fragility

Skin fragility and vulnerability must be identified at each assessment of the patients' at risk assessment. Regularly inspect the skin for early signs of damage, such as discolouration or breaks to the skin. Ensure the skin is clean, dry and well hydrated.

Keep moving

Encourage patients to move around as often as possible or reposition the patient at regular intervals. Consider the 30° tilt to position the patient (please see Figure 1). Any at risk patients need to have a re-positioning chart in place, which is regularly reviewed and assessed. Also encourage early mobility and regular movement, to relieve pressure over bony prominences.

Incontinence and moisture

The impact of incontinence or any form of extrinsic moisture can lead to the breakdown of vulnerable skin. The patients needs must be assessed and managed in the form of a care plan. It is important to manage sweat, exudate and excess moisture, whilst establishing a good skin care routine.

Nutrition and hydration

It is essential that the patients nutrition and hydration status is assessed. Poor nutritional intake puts patients at an increased risk of pressure damage. Provision of a healthy diet and encouragement with their intake of fluids can decrease the risk of pressure damage. Complete a nutritional risk assessment – MUST (Malnutrition Universal Screening Tool). The commencement of fluid charts can help maintain good nutritional care.

PRESSURE RELIEVING EQUIPMENT

Pressure must be relieved in order to restore the circulation so that healing can take place (Beldon, 2008 a).

- Pressure redistributing devices are widely accepted methods of trying to prevent the development of pressure areas for people assessed as being at risk
- The equipment works by redistributing the pressure over a greater area of the patient's body, so that each individual point supports less pressure, or by removing the pressure by alternating between inflation and deflation of the equipment (Beldon, 2008a)
- Pressure relief therefore, not only forms an important part of pressure ulcer prevention, but also treatment

These devices include different types of mattresses, overlays, cushions and seating. They may work by reducing or redistributing pressure, friction or shearing forces. Furthermore NICE (2014) recommend the use of high-specification foam mattresses for adults with a pressure ulcer. If this is not sufficient to redistribute pressure, consider the use of a dynamic support surface.

NICE (2014) recommend the use of high specification mattress for adults who are:

- Admitted to secondary care
- Assessed as being at a high risk of developing a pressure ulcer in primary and community care settings

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REPOSITIONING

NICE (2014) guidelines recommend that "Adults who have been assessed as being at risk of developing a pressure ulcer should be encouraged to change their position frequently at least every six hours or less depending on the needs of the patient. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed.

- Involves moving the patient into different positions in order to remove or re-distribute pressure from a particular part of the body (Krapfl & Gray, 2008)
- Repositioning can range from small shifts in position undertaken by the patient with encouragement, to full lateral repositioning/turning by the healthcare staff on behalf of the patient
- Any repositioning should be tailored to the individual clinical need using manual handling aids to avoid dragging skin
- It is import to maintain repositioning despite being on a dynamic pressure reducing mattress
- It is also a good idea to keep a turning record chart to provide a record in the patient's notes and show that interventions have been implemented
- Furthermore any time that the patient is repositioned, the skin and vulnerable areas such as heels, elbows and sacrum should be checked for areas of reddened skin (Vuolo, 2009)

(Figure 1)

30° tilt is a repositioning technique that can be achieved by placing a pillow under the buttocks or small of the back, with the aim of tilting the pelvis forward by 30°, whilst aiding patient comfort. Another pillow may then be situated lengthways under the legs. If undertaken correctly the outcome of this position should be that there is no contact between the patients heel or sacrum and the support surface (Figure 1).

SKIN CARE

The need to protect vulnerable areas of the skin and to prevent skin breakdown forms one of the cornerstones of professional care across all spheres of practice (Voegeli, 2008).

- Healthy skin acts as a barrier to the external environment
- Dry skin conditions typically reflect the disruption of the normal functioning of the skin barrier, so the use of moisturisers and emollients should be undertaken to prevent skin breakdown
- The mechanical properties of the stratum corneum are changed by the presence of moisture and as a function of temperature (EPUAP/NPUAP, 2009).

PATIENT EDUCATION

Any pressure ulcer prevention strategy needs to involve the patient family and carers. Provide appropriate education, knowledge and understanding can play a major part in pressure ulcer prevention. If patients refuse to allow a change in position, these circumstances must be documented clearly in the individuals medical and nursing notes.

CONCLUSION

Identifying and reacting to changes early by adopting the care plan is key to ongoing pressure ulcer prevention. The key principles of best practice ensure clinicians have an increased awareness to the prevention of pressure ulcers.

References:

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