Hello Everyone;

Continuing with our theme on pressure ulcers, here is a brief summary of the points we have covered in the last few months. These recommendations on pressure ulcer prevention were made by the National Pressure Ulcer Advisory Panel. For now this will end our pressure ulcer series (we will be back!), and in two weeks we will begin to cover a different topic.

Whilst the article can be read on a handheld mobile device (i.e. a smart phone), to view the tables in detail you may need to open it on a desktop device.
This material can be used in multiple ways: For example, treatment nurses are encouraged to read the emailed documents and discuss any questions they may have with the rounding staff from ASWC. Another approach would for the DON/charge nurses to discuss the articles(s) with the treatment nurses and encourage group participation on the topic of interest.

If you would like to add your colleague(s) to the email list please visit www.advantagewoundcare.org and on the left-hand margin you will see "subscribe to our mailing list". This is an evolving platform; with time we will add other useful features to facilitate continuing education.

Sincerely;

G.S. Dhillon MD PhD

Pressure Ulcer Prevention Points

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NATIONAL PRESSURE ULCER ADVISORY PANEL

I. Risk Assessment

1. Consider all bed-bound and chair-bound persons, or those whose ability to reposition is impaired, to be at risk for pressure ulcers.
2. Use a valid, reliable and age appropriate method of risk assessment that ensures systematic evaluation of individual risk factors.
3. Assess all at-risk patients/residents at the time of admission to health care facilities, at regular intervals thereafter and with a change in condition. A schedule is helpful and should be based on individual acuity and the patient care setting.
   - Acute care: assess on admission, reassess at least every 24 hours or sooner if the patient's condition changes
   - Long-term care: assess on admission, weekly for four weeks, then quarterly and whenever the resident's condition changes
   - Home care: assess on admission and at every nurse visit.
4. Identify all individual risk factors (decreased mental status, exposure to moisture, incontinence, device related pressure, friction, shear, immobility, inactivity, nutritional deficits) to guide specific preventive treatments. Modify care according to the individual factors.
5. Document risk assessment subscale scores and total scores and implement a risk-based prevention plan.

II. Skin Care

1. Perform a head to toe skin assessment at least daily, especially checking pressure points such as sacrum, ischium, trochanters, heels, elbows, and the back of the head.
2. Individualize bathing frequency. Use a mild cleansing agent. Avoid hot water and excessive rubbing. Use lotion after bathing. For neonates and infants follow evidence-based institutional protocols
3. Establish a bowel and bladder program for patients with incontinence. When incontinence cannot be controlled, cleanse skin at time of soiling, and use a topical barrier to protect the skin. Select under pads or briefs that are absorbent and provide a quick drying surface to the skin. Consider a pouching system or collection device to contain stool and to protect the skin.
4. Use moisturizers for dry skin. Minimize environmental factors leading to dry skin such as low humidity and cold air. For neonates and infants follow evidence-based institutional protocols
5. Avoid massage over bony prominences.

III. Nutrition

1. Identify and correct factors compromising protein/calorie intake consistent with overall goals of care.
2. Consider nutritional supplementation/support for nutritionally compromised persons consistent with overall goals of care.
3. If appropriate offer a glass of water when turning to keep patient/resident hydrated.
4. Multivitamins with minerals per physician's order.

IV. Mechanical Loading and Support Surfaces

1. Reposition bed-bound persons at least every two hours and chair-bound persons every hour consistent with overall goals of care.
2. Consider postural alignment, distribution of weight, balance and stability, and pressure redistribution when positioning persons in chairs or wheelchairs.
3. Teach chair-bound persons, who are able, to shift weight every 15 minutes.
4. Use a written repositioning schedule.
5. Place at-risk persons on pressure-redistributing mattress and chair cushion surfaces.
6. Avoid using donut-type devices and sheepskin for pressure redistribution.
7. Use pressure-redistributing devices in the operating room for individuals assessed to be at high risk for pressure ulcer development.
8. Use lifting devices (e.g., trapeze or bed linen) to move persons rather than drag them during transfers and position changes.
9. Use pillows or foam wedges to keep bony prominences, such as knees and ankles, from direct contact with each other. Pad skin subjected to device related pressure and inspect regularly.
10. Use devices that eliminate pressure on the heels. For short-term use with cooperative patients, place pillows under the calf to raise the heels off the bed. Place heel suspension boots for long-term use.
11. Avoid positioning directly on the trochanter when using the side-lying position; use the 30° lateral inclined position.
12. Maintain the head of the bed at or below 30° or at the lowest degree of elevation consistent with the patient's/resident's medical condition.
13. Institute a rehabilitation program to maintain or improve mobility/activity status.

V. Education

1. Implement pressure ulcer prevention educational programs that are structured, organized, comprehensive, and directed at all levels of health care providers, patients, family, and caregivers.
2. Include information on:
   a. etiology of and risk factors for pressure ulcers
   b. risk assessment tools and their application
   c. skin assessment
   d. selection and use of support surfaces
   e. nutritional support
   f. program for bowel and bladder management
   g. development and implement individualized programs of skin care
   h. demonstration of positioning to decrease risk of tissue breakdown
   i. accurate documentation of pertinent data
3. Include mechanisms to evaluate program effectiveness in preventing pressure ulcers.

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