



Elements of Pressure Ulcer Prevention: A Discussion and Evaluation

Pressure ulcers cause considerable harm to residents, hindering functional recovery and frequently causing pain and serious infections. Pressure ulcers have also been associated with an extended length of stay, sepsis and mortality. Most pressure ulcers are preventable. Below are listed some elements of pressure ulcer prevention. Please read, discuss and answer the questions; then, use your responses as part of a facility pressure ulcer prevention self-evaluation.

1. Perform a pressure ulcer/wound admission assessment for all residents.

Long-term care (LTC) residents are at considerable risk for developing pressure ulcers. Key factors include age, immobility, incontinence, poor nutrition, sensory deficiency, device-related pressure, comorbidities, circulatory abnormalities and dehydration. The prompt identification of at-risk patients using a validated assessment tool is essential for accurate identification and timely implementation of prevention strategies. An admission assessment should include use of the Braden or Norton scale to evaluate a patient's risk of developing a pressure ulcer. It should also use a facility skin assessment tool to detect existing pressure ulcers (arterial, venous, diabetes-related, surgical and cancerous lesions, abrasions, bruises, etc.) These two assessments should be thought of as a single step—a Pressure Ulcer/Wound Admission Assessment.

What processes can be put in place to ensure completion of the pressure ulcer assessment of all residents at admission?

What processes are in place currently ? Standing orders, canned careplans, pressure reduction w/c cushions, pressure reduction mattress, float heels?

2. Assess/reassess risk for all residents frequently

The complexity and acuity of nursing home residents require daily reassessment of the degree of risk of pressure ulcer development. For example, changes in mobility, incontinence or nutrition may change the resident's risk of developing pressure ulcers. Assessing risk frequently provides caregivers the opportunity to adjust prevention strategies to the changing needs of the resident. Assessing the degree of risk, as specified in several standardized risk assessments (Braden or Norton scale), allows nurses to implement targeted strategies for each resident. Frequent risk assessment also enables caregivers to quickly identify residents with a nutritional need and initiate an appropriate response, such as a dietary consult.

What processes can be put in place to ensure frequent reassessment of pressure ulcer risk?

Skin sweeps, review sig changes in IDT/morning meeting/assess during showers?

3. Inspect skin of high-risk residents daily.

Skin integrity of a nursing home resident may deteriorate in a matter of hours. Residents identified as being at risk need a daily inspection of all skin surfaces "from head to toe." Special attention should be given to areas at high risk for pressure ulcer development, such as the sacrum, back, buttocks, heels, elbows and areas subjected to device pressure. Ideally, staff members should incorporate a skin inspection in their work, every time they assess at-risk patients. Unlicensed assistive staff can perform this task.

What processes can be put in place to ensure daily inspection of the skin?

Feed to CNA charting? Task reminder to notify nurse. Wound care champion?

4. Manage moisture—keep the resident dry and moisturize skin.

Wet skin is favorable to the development of rashes, maceration and dermatitis, and tends to break down more easily. Skin should be cleansed at the time of soiling and at routine intervals. The process of cleaning the skin should include gentle use of a mild cleansing agent that minimizes irritation and dryness of the skin. Treating dry skin with moisturizers has been shown to be especially effective in preventing pressure ulcers. Care should be taken to minimize exposure of the skin to moisture due to incontinence, perspiration or wound drainage. Also use topical agents that act as moisture barriers and moisturize the skin.

What changes can we make to ensure effective management of moisture?

Barrier cream in all orders, utilize kind kept at bedside for CNA to apply, random brief fitting checks?

5. Optimize nutrition and hydration.

Assessment of residents for possible risk of pressure ulcer development should include a review of nutritional factors and an assessment of hydration. Residents who are assessed with deficits in nutritional intake and hydration may have muscle mass loss and weight loss, making the bones more prominent and making mobility more difficult. Often with nutrition deficits and fluid imbalance there may be edema and reduced blood flow to the skin, causing ischemic damage, which contributes to skin breakdown. Residents who are malnourished may be twice as likely to develop skin breakdown. Fluid, protein and caloric intake are important aspects of maintaining adequate general nutrition. Nutritional supplements or support may be needed if dietary intake is insufficient. If a resident is identified with significant nutritional needs, a registered clinical dietician should be consulted to assess and suggest feasible nutritional interventions.

What changes can we make to optimize nutrition and hydration?

Reviewed in IDT with RD or DM

6. Minimize pressure, friction and shearing.

Redistribution of pressure, especially over bony prominences is a primary concern. The reduction of friction and shearing also has a direct and positive effect in preventing pressure ulcers. Residents with limited mobility are especially at risk for the development of pressure ulcers. Every effort should be made to redistribute the pressure on the skin, either by repositioning or by utilizing pressure-redistribution surfaces. Two key components have proven especially effective in minimizing pressure:

- **Turn/reposition residents every two hours or more frequently as needed.**

The aim of repositioning is to redistribute pressure, thereby maintaining circulation to areas of the body at risk for pressure ulcers. Turning residents every two hours is a foundational element in most pressure ulcer prevention protocols. The turning, or repositioning, of at-risk residents temporarily shifts or relieves pressure on susceptible areas, diminishing the risk of pressure-ulcer development. Pillows and blankets are simple, readily available supplies that may be used to redistribute pressure. Staff should take care while actually turning the resident to protect the skin. Staff should consider using lift devices or “draw sheets” to move, rather than drag, individuals who are not able to assist during transfers and position changes.

- **Use pressure-redistribution surfaces.**

Specialized support surfaces (e.g., mattresses, beds and cushions) redistribute the pressure the resident's body weight exerts on the skin and subcutaneous tissues. If a resident's mobility is compromised and pressure is not redistributed, the pressure can lead to impaired circulation and ulcer formation. Many studies have noted the benefits demonstrated by pressure-redistribution surfaces in the prevention of pressure ulcers.

What changes can we make to minimize pressure?

Pressure reduction mattresses, facility audit for w/c cushions, initiate air loss for high risk, patients with impaired mobility, initiate pressure reduction boots for stroke/hip/knee repairs-standing orders

After you read and answer these questions, take a moment to evaluate your facility's Pressure Ulcer and Wound Prevention Plan/Protocol and make necessary improvements.

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