



PRESSURE INJURY PREVENTION SIMPLIFIED

This Simplified Guide is intended to give you information and answers to some questions you may have about pressure injuries.

Pressure ulcers/injuries (PU/PI) represent a major burden of illness and reduced quality of life for a person/patient and their caregivers. There is also an increase in morbidity and mortality associated with PU/PI development, alongside longer stays in hospital, readmission rates, and financial costs.

LEARNING OUTCOMES

- ✔ The significance of a full assessment of the skin
- ✔ Understand the key principles of pressure ulcer/injury prevention
- ✔ Identify the equipment and tools available to relieve pressure

The impact of living with the burden of a pressure ulcer/injury is the same as with a chronic wound, including pain, discomfort, stress, anxiety and depression. Having a pressure ulcer/injury can cause declines in independence, security, mental health, general wellbeing and social functioning. Individuals at risk of, or those having pressure ulcers/injuries, identify pain as one of their most significant concerns (EUPAP, 2019).

Prevention of pressure damage should be the primary aim of high risk patients. Successful prevention requires a comprehensive approach and can depend upon the identification and reduction of risk factors.

To prevent pressure ulcer/injury development, a person must be assessed to determine their risk. Assessment forms can be an integral part of the holistic management

and prevention of pressure damage. Pressure ulcer/injury assessment is generally enforced within care settings by a pressure prevention policy. There are clinical guidelines and policies available that should be applied to practice. They are designed to protect both the individual and the health care professional. It is essential that health care professionals are aware of the responsibility of care.

In England, NICE recommends that health care professionals carry out and document an assessment of pressure ulcer/injury risk within 6 hours of adults being admitted to secondary care (hospital) and community/nursing homes in which care is provided, or where a person is receiving care in other settings. (NICE, 2015; NICE, 2020)

RISK ASSESSMENT

Many healthcare settings use risk assessment tools. They will not predict if an individual develops a pressure ulcer/injury, only identify those who are likely to be at a higher risk based on the combination of existing factors. The risk level will change throughout the duration of the person/patient's care, and as such, assessments should be carried out regularly and any time there is a change in condition. It is essential to document and implement an appropriate care plan.

These tools are best utilised in conjunction with clinical judgment and used more as an aide-memoir (EPUAP, 2019).

VALIDATED RISK ASSESSMENT TOOLS:

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

PRESSURE RELIEVING EQUIPMENT

Pressure ulcers/injuries will not heal if they continue to be subjected to the forces that caused them (EPUAP, 2019).

Pressure redistributing devices are widely accepted methods of prevention for those assessed as at risk. Different types of devices include:

- ▶ Mattresses
- ▶ Seating
- ▶ Overlays
- ▶ Boots
- ▶ Cushions

Pressure injury risk factors vary from person to person. Choosing a support surface for an individual should take into account their specific needs such as:

- ▶ The person's level of mobility
- ▶ The site that is at risk
- ▶ The results of the skin assessment
- ▶ The person's weight
- ▶ The person's level of risk
- ▶ The person's general health

Comfort is crucial. If the surface is perceived otherwise it will often be rejected. This can be either overtly or by not using when health care professionals are not around.

Manufacturer's instructions for use must be followed and equipment regularly maintained and properly cleaned (Fletcher, 2020; Ovens, 2017).

aSSKINg CARE BUNDLE

The aSSKINg care bundle is a simple, holistic approach to ensure that all patients receive the appropriate care to prevent injury damage (*NHS Improvements, 2018*). The fundamental pressure ulcer/injury prevention strategy should always include all elements of the aSSKINg care bundle:

- a** ssessment risk
- S** kin inspection
- S** urface
- K** eep moving (repositioning)
- I** ncontinence and moisture management
- N** utrition and hydration
- g** iving information

ASSESSMENT RISK

Carry out an assessment of risk to understand and identify factors that could lead to the development of a pressure ulcer/injury. Use a validated risk assessment tool. Consider other factors that can affect risk, such as moving and handling by health care professionals and/or carers, (e.g. turning etc.) and pain. Reassess the risk if there is a change in clinical status e.g. after surgery, on worsening of an underlying condition, or with a change in mobility (*NICE, 2014*).

SKIN

Fragility and vulnerability must be identified at each assessment of the patient's 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.

SURFACE

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

KEEP MOVING

Where appropriate encourage moving around as often as possible or repositioning at regular intervals. Consider the 30° tilt to position (see Figure 1). At risk patients should have a repositioning chart in place that is regularly reviewed and assessed. Encourage early mobility and regular movement to relieve pressure over bony prominences.

INCONTINENCE AND MOISTURE

The impact of incontinence or any form of external moisture can lead to the breakdown of vulnerable skin. The individual's needs must be assessed and managed in the form of a care plan. The management of sweat, exudate and excess moisture is important whilst establishing a good skin care routine. Consider using emollients and, as prevention, barrier preparation to avoid skin damage.

NUTRITION AND HYDRATION

Assessment of the individual's nutrition and hydration status is essential. Poor nutritional intake puts a person at an increased risk of pressure damage. The provision of a healthy diet and encouraging fluids can decrease the risk of pressure damage. It is recommended that a nutritional risk assessment - MUST (Malnutrition Universal Screening Tool) is completed (*EPUAP, 2019*).

GIVING INFORMATION

Good communication and appropriate information ensure that the individual, their family and carers are prepared and fully aware of the next steps in their pathway. Involvement of the individual, their family and carers in their care improves overall experience (*ACT, 2018*).

It is essential when communicating with the multidisciplinary team that the information given is factual and imparts the relevant level of importance/urgency, and it is conveyed in a clear, structured way meeting the appropriate professional standards and guidance (*Fletcher, 2020*).

If aSSKINg bundle is being implemented, then the individual's risk of developing a pressure ulcer/injury will be identified and documented. Furthermore, care pathways will be put into place to prevent or reduce the risk of any further damage.

The aSSKINg bundle can also be used for the care of individuals who have developed pressure ulcers/injuries as part of their treatment pathway*.

SKIN CARE

Adequate skin care is key to preventing skin breakdown and improving tolerance. Healthy skin acts as a barrier to the external environment

- ✓ When cleansing the skin, use a pH-neutral agent.
- ✓ Excessive rubbing of the skin can cause damage when drying and may cause pain and damage to the tissue. The skin should be patted dry, and an emollient used to rehydrate the skin.
- ✓ Dry skin conditions typically reflect the disruption of the normal functioning of the skin barrier. The use of moisturisers and emollients should be applied to prevent skin breakdown.
- ✓ Each time the individual's clinical condition changes, a comprehensive skin and tissue assessment should be conducted to identify any alterations to skin characteristics or integrity and to identify any new pressure ulcer/injury risk factors. This should also be conducted on discharge to ensure that an appropriate pressure ulcer/injury prevention and treatment plan is in place.

REPOSITIONING

Repositioning involves moving the patient into different positions to remove or re-distribute pressure from a particular part of the body.

- ✓ Repositioning can range from small shifts in position undertaken by the patient, to full lateral repositioning/turning by the health care staff.
- ✓ Any repositioning should be tailored to the individual clinical need using manual handling aids to avoid dragging the skin.
- ✓ It is important to maintain repositioning despite being on a dynamic pressure-reducing mattress.
- ✓ It is also a good idea to document/record in the patient's notes and show that interventions have been implemented.



FIGURE 1 - 30° TILT

The 30° tilt is widely recommended (*EPUAP, 2019*), as it dissipates any applied pressure by redistributing from bony prominences to areas of larger tissue mass (*Young, 2004*).

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

No support surface provides complete pressure relief.

Pressure is always applied to some area of the skin. Repositioning for pressure redistribution must occur regularly.

The frequency may vary with the pressure redistribution capacity of the support surface; however, the individual's response to pressure should always guide the regularity. High-risk individuals with poor tissue tolerance may require more frequent turning.

REPOSITIONING

A Cochrane overview of support surfaces in 2020 suggests the following:

- ▶ A reactive air surface may be better than a foam surface for preventing and healing pressure ulcers.
- ▶ Alternating pressure air surfaces may be better than foam surfaces for preventing pressure ulcers. Alternating pressure air surfaces may cost less, overall, than foam surfaces in relation to their benefit in preventing ulcers.
- ▶ Reactive gel surfaces may be better than foam surfaces for preventing pressure ulcers. This type of surface is particularly relevant for people undergoing surgery that lasts several hours. (Shi et al., 2020)

NICE and EPUAP guidelines recommend adults who are at risk should be encouraged to change their position regularly, every six hours or less depending on the needs of the person. If they cannot move independently, assistance and moving and handling equipment may be required (NICE, 2014; EPUAP, 2019). Each time the person is repositioned, skin and vulnerable areas such as heels, elbows and sacrum should be checked (Norton, 2018).

CONCLUSION

Identifying and reacting to changes early by adopting a suitable care plan is key to ongoing pressure ulcer/injury prevention. The key principles of best practice ensure health care professionals have an increased awareness to the prevention of pressure ulcers/injuries.

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