



Prevention – the best management

The prevention of pressure ulcers should be given the same priority as all other aspects of patient care, writes **Zena Moore**

THE DEVELOPMENT, implementation and evaluation of a care plan that is geared towards the individual needs of the patient, are the most fundamental aspects of pressure ulcer prevention at clinical level.

Success will not be measured by the ability to recognise those with pre-existing pressure ulcer damage. True achievement lies in recognising those at risk and providing adequate care to prevent problems arising.¹

Planning prevention

Pressure ulcer prevention should be offered to those at risk, at the point of first contact with the patient. It is often argued that other aspects of patient care may be more important initially,² however, this is a poor argument and may result in irreversible pressure ulcer damage occurring.

Furthermore, when the patient recovers from their initial illness, their rehabilitation may be severely hampered by the presence of a pressure ulcer.³ Therefore, pressure ulcer prevention should be given

the same priority as all other aspects of the patient's care.

Patients may develop pressure ulcers for many different reasons.⁴ Additionally, pressure ulcer prevention is based on the principle that prevention strategies are planned, based on the individual risk factors that the patient presents with.

Therefore, classifying the patient as high risk, medium risk or low risk is not helpful in guiding staff to the specific preventative strategies that are needed for the patient. It is of greater value to identify why the patient is at risk as this forms the basis for developing a prevention strategy.

Repositioning

It remains unclear from the literature, what is the optimum time frame for repositioning of individuals at risk of pressure ulceration.⁵

The two hourly turning regime has its origins in history rather than sound clinical research, none the less, it remains a popular method of pressure ulcer prevention.⁶ The 30-degree tilt offered an

alternative to complete repositioning of the patient. However, though interesting, it too lacks sound scientific evidence to support its use in practice.⁶

Despite the limitation of the current popular methods of repositioning, some basic factors remain important to consider. The physical act of repositioning must ensure that the patient remains protected from the adverse effects of shear and friction.

Therefore, it is imperative that all personnel involved in patient care are trained in manual handling techniques. Furthermore, those involved in this training must ensure that the methods they teach have due regard for patient safety and pressure ulcer prevention, as well as the health and safety of the staff.

The period between turning and repositioning must be based on the individual needs of the patient. Factors to consider are sleep requirements, pain management and the patient's individual tissue tolerance. It is therefore, unwise to be prescriptive about repositioning; rather

Practice points

- Pressure ulcer prevention should be offered to those at risk, at the point of first contact with the patient
- Each patient at risk of pressure ulcer damage should have an individualised care plan that addresses the factors that placed the individual at risk
- Care plans should be regularly evaluated and continued or discontinued as appropriate
- Adopt an individual approach to repositioning that is based on assessment and reassessment of the patient's tolerance to periods of immobility.
- Pressure redistributing/repositioning devices do not replace the need for repositioning of the patient
- Pressure ulcer prevention strategies should be offered to the individual when they are sitting out of bed as well as when they are in bed
- The nutritional status of the individual should be regularly monitored

it is better to adopt an individual approach that is based on assessment and reassessment of the patient's tolerance to periods of immobility.

Support surfaces

There are a wide variety of support surfaces currently available for use as part of a pressure ulcer prevention and management programme. Support surfaces can be classified as either pressure reducing or pressure relieving.⁷

Pressure reducing surfaces are static – commonly composed of foam or gel, or alternatively are air filled.⁷ Static surfaces work on the principle that pressure reduction will be achieved if the contact between the patient and the mattress is spread over the widest possible area.

This reduces the amount of pressure exerted over any one anatomical site. It is important to remember that pressure may not be evenly distributed and therefore, some parts of the body, for example the heels, will be more vulnerable to the adverse effects of pressure than others. Extra care is needed when nursing at risk patients and a repositioning regimen should be initiated along with use of the support system.

Pressure reducing systems are also commonly used, for example, alternating air overlays or mattresses. These systems operate by periodically removing pressure from varying anatomical sites of the body. This occurs through the cyclical inflation and deflation of cells within the mattress.⁷ Once again it remains important that the patient also has a repositioning schedule planned and implemented, even when nursed on these surfaces.

No support surface offers complete pressure relief, nor offer an alternative to normal body movements. All too often there is an over reliance on these beds and mattresses which increases the risk in an already vulnerable patient group.

For those patients who require pressure relief/redistribution whilst in bed, it must be remembered that they are also at risk of pressure ulcer development whilst sitting out of bed. Therefore, similar protection should be offered. This can be in the form of a pressure relieving/redistributing cushion, which should be selected based on the individual needs of the patient.

The patient should not be exposed to prolonged periods of sitting out as this also increases the risk of pressure ulcer development. Furthermore, it contributes to fatigue and may have a negative impact on rehabilitation.⁸ Patients with pre existing pressure ulcer damage should avoid direct weight bearing on the affected area.

Nutrition

The role of nutrition in the prevention and management of pressure ulcers cannot be overstated. There is an abundance of literature available addressing this aspect of patient care.

The European Pressure Ulcer Advisory Panel (EPUAP) has recently completed draft guidelines on the role of nutrition in pressure ulcer prevention and management.⁹

These guidelines recommend that all patients should have regular assessment of their nutritional status, which should include weight measurement, skin assess-

ment and recording of fluid and food intake.

Wherever possible, the individual should be encouraged to improve their intake of fluids and food. However, consideration needs to be given to the quality of this food and any barriers that may impede the individual's ability to achieve this goal.

EPUAP argue that only when the individual cannot increase their own consumption of food and fluids, should consideration be given to the use of supplements.⁹ It is important to highlight that if an individual nurse is in doubt, advice should be sought from a nutrition and dietetics expert.

Prevention is key

Pressure ulcer prevention is an essential component in the fight against the rising prevalence and incidence of pressure ulcers and as practicing nurses we all have a role to play in this aspect of patient care. It is essential that prevention begins on initial contact with the at risk patient.

It is important to pay attention to the risk factors presented by the patient. These factors form the basis for the development of prevention strategy, which is individualised to the needs of the specific patient.

Prevention strategies should be regularly monitored, and updated or discontinued as appropriate.

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