

Pressure Ulcer Treatment Guidelines

INTRODUCTION

Pressure damage is common in many healthcare settings across Europe, affecting all age groups, and is costly both in terms of human suffering and use of resources. With an ageing population, and changes in patterns of sickness, this problem will increase unless action is taken. In all care settings the risk of pressure damage should be highlighted.

Most pressure damage could be prevented and it is important to have prevention and educational strategies in place. These should be based on the best available evidence.

All interventions and outcomes should be monitored and documented.

Guidelines are based on the following evidence:

[A] Results of two or more randomised controlled clinical trials on pressure ulcers in humans provide support.

[B] Results of two or more controlled clinical trials on pressure ulcers in humans provide support, or where appropriate, results of two or more controlled trials in an animal model provide indirect support.

[C] This rating requires one or more of the following:

1. results of one controlled trial,
 2. results of a least two case series/descriptive studies on pressure ulcers in humans,
- or
3. expert opinion.

RISK ASSESSMENT TOOLS AND RISK FACTORS

1. **Goal:** Identify 'at risk' individuals needing prevention and the specific factors placing them at risk

We believe that there are a number of issues associated with risk assessment tools. Risk assessment should be used as an adjunct to clinical judgement and not as a tool in isolation from other clinical features. **[C]**

There should be clarification of a full risk assessment in patients to include: General medical condition, skin assessment, mobility, moistness and incontinence, nutrition and pain. **[C]**

All strategies related to pressure damage should always be based on the best available evidence.

Assessment of risk should be more than just the use of an appropriate risk assessment tool and should not lead to a prescriptive and inflexible approach to patient care. **[C]**

Whilst risk assessment should be performed immediately on entry into an episode of care, this assessment may take time to fully complete if information is not readily available. **[C]**

Assessment should also be ongoing and frequency of re-assessment should be dependent on change in the patient's condition with the environment.

2. **Goal:** Maintain and improve tissue tolerance to pressure in order to prevent injury
Skin condition should be inspected and documented daily and any changes should be recorded as soon as they are observed. Inspection must be documented.

Initial skin assessment should take into account the following:

- I. Bony prominences (sacrum, heels, hips, ankles, elbows, occiput) to identify early signs of pressure damage.
- II. Identify the condition of skin - dryness, cracking, ery-thema, maceration, fragility, heat and induration. **[C]**

Every effort should be made to optimise the condition of the patient's skin.

Assessment of patients with dark or tanned skin is especially difficult. **[C]**

Avoid excessive rubbing over bony prominences as this does not prevent pressure damage and may cause additional damage. **[C]**

Find the source of excess moisture due to incontinence, perspiration, or wound drainage and eliminate this, where possible. When moisture cannot be controlled

interventions that can assist in preventing skin damage should be used. [C]
Skin injury due to friction and shear forces should be minimised through correct positioning, transferring and repositioning techniques. [C]
Following assessment nutritionally compromised individuals should have a plan of appropriate support and/or supplementation that meets individual needs and is consistent with overall goals of therapy. [C]
As the patient's condition improves the potential for improving mobility and activity status exists, rehabilitation efforts may be instituted if consistent with the overall goals of therapy. Maintaining activity level, mobility, and range of movement is an appropriate goal for most individuals. [C]
All interventions and outcomes should be monitored and documented. [C]

EXTERNAL PRESSURE AND SUPPORT SURFACES

3. **Goal:** Protect against the adverse effects of external mechanical forces; pressure, friction and shear
Any individual who is assessed to be at risk of developing pressure ulcers should be repositioned if it is medically safe to do so. [B] Frequency of repositioning should be consistent with overall goals. [C] Documentation to record repositioning should be completed. Correct positioning and support is important to minimise friction and shear in both bed and chair. [C]
Correct positioning or devices such as pillows or foam wedges should be used to keep bony prominences (for example knees, heels or ankles) from direct contact with one another in accordance with a written plan. [C] Care should be taken to ensure that these do not interfere with the action of any other pressure relieving support surfaces in use. [C]
When repositioning patients do so in such a way as to minimise the impact on bony prominences. [C]
Devices to assist manual handling should be used during transfer and positioning of patients to minimise shear forces for those patients who require assistance in movement in accordance with EU manual handling regulations.
In all care settings individuals considered to be at risk of developing pressure ulcers should have a personalised written prevention plan which may include a pressure redistributing device. [C]
Patients at risk of developing pressure ulcers because of the time spent sitting in a chair should be allocated a chair of the correct height in addition to a pressure relieving device. [C]
Any person who is acutely ill and is at risk of developing a pressure ulcer should avoid uninterrupted sitting out of bed. [B] The period of time should be defined in the individualised care plan but generally will not be more than two hours. [B] Individuals, where appropriate, should be encouraged to reposition themselves if this is possible. [C]
Individuals at risk from pressure ulcers who are likely to spend substantial periods of time in a chair or wheel chair should generally be provided with a pressure redistributing device. [C]
Individuals who are able should be taught to redistribute weight every fifteen minutes. [C]

EDUCATION

4. **Goal:** To improve the outcome for patients at risk of pressure damage through educational programmes.
Educational programmes for the prevention of pressure damage should be structured, organised and comprehensive, and made available at all levels of health care providers, patients and family or caregivers. [C]
The educational programme for prevention of pressure damage should include information on the following items:
- Pathophysiology and risk factors for pressure damage.
 - Risk assessment tools and their application.

- Skin assessment.
- Selection and instruction in the use of pressure redistributing and other devices.
- Development and implementation of individualised programmes of care.
- Principles of positioning to decrease risk of pressure damage.
- Documentation of processes and patient outcome data.
- Clarification of responsibilities for all concerned with this problem.
- Health promotion.
- Development and implementation of guidelines.

The educational programme should be updated on a regular basis based on the best available evidence. The content of the programme should be modified according to the audience. **[C]**

Further information on the European Pressure Ulcer Advisory Panel may be obtained from:
EPUAP Business Office, Wound Healing Unit
Department of Dermatology, Churchill Hospital
Old Road, Headington, Oxford, OX3 7LJ, UK
Tel: +44 (0)1865 228269
Fax: +44 (0)1865 228233
E-mail address: EuropeanPressureUlcerAdvisPanel@compuserve.com
Website: <http://www.epuap.org/>