Summary of Recommended Guideline

Pressure Ulcers: Prevention

Key Highlights:
- Formally assess all in-patients within six hours of admission for risk of developing pressure ulcers.
- Remove or minimize these risk factors: Pressure, Shearing, Friction.
- Inspect skin regularly.
- Encourage and educate patients who are willing and able to inspect their own skin.
- Do NOT use as pressure relieving aids: water filled gloves; synthetic or genuine sheepskins and doughnut-type devices.
- Reposition patients at risk of pressure ulcer development. Determine the frequency of repositioning based on skin inspection and individual needs.

Scope: This guideline is directed at medical and nursing staff in acute and chronic institutional care.

1. General Assessment

- Formally assess all in-patients within six hours of admission for risk of developing pressure ulcers. Document the assessment in a manner which is available to all members of the health care team. CONSENSUS
- This assessment should be performed by personnel trained to recognize risk factors for pressure ulcers and preventive measures. CONSENSUS
- Re-assess those considered not at risk if there is a change in condition. CONSENSUS
- Risk assessment scales should not replace clinical judgment but should be memory aids only. GOOD EVIDENCE There is not enough evidence to recommend any one scale over another.
- Consider the following risk factors when assessing risk: FAIR EVIDENCE
  - Reduced mobility/immobility
  - Sensory impairment
  - Acute illness
  - Decreased level of consciousness
  - Age <5 or >65 years
  - Previous history of pressure damage
  - Vascular disease
  - Severe chronic or terminal illness
  - Malnutrition and Dehydration
  - Medications
  - Moisture to the skin

- Remove or minimize these risk factors: FAIR EVIDENCE
  - Pressure
  - Shearing occurs when the skeleton and deep fascia slide downwards with gravity, while the skin and upper fascia remain in the original position. Shearing most often occurs when individuals slide down or are dragged up a bed or chair.
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2. Skin Inspection  CONSENSUS

- Inspect skin regularly (the frequency should be determined in response to changes in the individual’s condition) and document changes immediately. The inspection should be based on an assessment of the most vulnerable areas of risk, typically:
  - Heels;
  - Sacrum;
  - Ischial tuberosities;
  - Parts of the body affected by anti-embolic stockings;
  - Femoral trochanters;
  - Parts of the body where activities of daily living cause pressure, friction and shear;
  - Parts of the body where equipment and clothing cause external forces
    - Elbows;
    - Temporal region of skull;
    - Shoulders;
    - Back of head;
    - Toes.

- Encourage and educate patients who are willing and able to inspect their own skin.
- Wheelchair users should use a mirror to inspect the areas that they cannot see easily or get other to inspect them.
- The following signs may indicate pressure ulcer development: persistent erythema; non blanching erythema; blisters; discolouration; localised heat; localised oedema and localised induration.
- In those with darkly pigmented skin, look for: purplish/bluish localised areas of skin; localised heat which, if tissue becomes damaged, is replaced by coolness; localised edema and localised induration.
- The guideline makes no recommendation on the use of pressure-relieving devices, as the developers could not do a full assessment of their cost-effectiveness.
- Do NOT use as pressure relieving aids: water filled gloves; synthetic or genuine sheepskins and doughnut-type devices. CONSENSUS

3. Positioning  CONSENSUS

- Reposition patients at risk of pressure ulcer development, ensuring that:
  - prolonged pressure on bony prominences is minimized,
  - bony prominences are kept from direct contact with one another, and
  - friction and shear damage is minimized.
- Determine the frequency of repositioning based on skin inspection and individual needs. Establish and record a re-positioning schedule, after agreement with the patient.
- In individuals acutely at risk of developing pressure ulcers, restrict chair sitting to less than 2 hours until general condition improves.
- Teach patients or caregivers, who are willing and able, how to redistribute weight.
- Ensure proper use of manual handling devices correctly in order to minimize shear and friction damage. After maneuvering, do not leave slings, sleeves or other parts of the handling equipment under individuals.
4. Seating

**CONSENSUS**

- Trained assessors should perform seating assessments for aids and equipment and advise on correct seating positions.
- Positioning of individuals who spend substantial periods of time in a chair or wheelchair should take into account: distribution of weight; postural alignment and support of feet.
- No seat cushion has been shown to perform better than another, so this guideline makes no recommendation about which type to use.

4. Education and Training

- All health care professionals should receive relevant training or education in pressure ulcer risk assessment and prevention. *FAIR EVIDENCE*

Patient/caregiver education should include information on: *CONSENSUS*

- the risk factors associated with developing pressure ulcers;
- the sites that are of the greatest risk of pressure damage;
- how to inspect skin and recognize skin changes;
- how to care for skin; methods for pressure relief/reduction;
- where to find further advice and assistance should they need it;
- the need for immediate visits to a health care professional should signs of damage be noticed

### Levels of Evidence

<table>
<thead>
<tr>
<th>Good Evidence</th>
<th>Generally consistent finding in a majority of multiple acceptable studies</th>
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<tbody>
<tr>
<td>Fair Evidence</td>
<td>Either based on a single acceptable study, or a weak or inconsistent finding in multiple acceptable studies</td>
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<tr>
<td>Consensus</td>
<td>Limited scientific evidence which does not meet all the criteria of acceptable studies or absence of directly applicable studies of good quality. This includes expert opinion.</td>
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### Additional Material:


The above recommendations were derived from the following GAC endorsed guideline(s):

