Pressure Ulcer
Prevention and Wellness Practice Guideline

Overview of the Condition/Disease

Definition: Also known as a decubitus or a bed sore; a disruption of the normal structure and function of the skin with its associated underlying soft tissue structures.

Pathophysiology: Pressure ulcers can develop in areas of the skin where soft tissues are compressed between bony prominences and external surfaces (such as a bed or wheelchair) for an extended period of time, resulting in decreased blood flow to the affected areas, as well as exposure to friction and/or shearing forces with movements of the body. These same factors that contribute to skin breakdown can also set up conditions for the development of infections, involving not only the skin, but potentially of the blood as well. (Infections of the blood [i.e., sepsis], can be life-threatening). Common areas affected include the lower spine (sacrum), shoulder blades, hips (trochanter), heels, ankles, and the back of the head.

Best Practice Standards for Prevention and Management

Education: Proper skin care and pressure relief are key in preventing pressure injuries. Encourage a routine bathing schedule with the use of warm water and mild soap as well as repositioning every two hours with padding under bony prominences when unable to offload pressure. An assessment of vulnerable areas of the skin should be completed at least weekly and more frequently if the individual already has a pressure injury or has signs of one developing.

Interventions: Assessing the member's risk of developing a pressure ulcer is key in determining strategies for pressure ulcer prevention. The Braden Scale is an evidenced based tool used to predict the risk by assessing six categories including: sensory perception, moisture, activity, mobility, nutrition and friction/shear, where each category is scored individually and then totaled together to determine the individuals risk.

- Very High Risk: Total score of 9 or less
- High Risk: Total score of 10-12
- Moderate Risk: Total Score of 13-14
- Mild Risk: Total Score 15-18
- No Risk: 19-23

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Anticipating, Recognizing, and Responding to Symptoms

Seek timely medical attention when current interventions and/or medications are not managing symptoms.

Potential symptoms: Tender, non-blanchable areas of redness on the skin in areas where increased pressure, friction and/or shearing may be occurring. These areas will appear differently in darker pigmented skin. Refer to the Wound Terminology Quick Reference to learn more about stages of pressure ulcers and specific symptoms to watch for in those stages such as drainage, odor and necrotic (i.e., dying) tissue.

Manifestation of symptoms: Pressure ulcers can open exposing underlying tissue and bone. If left untreated, the open pressure ulcer can become infected and lead to muscle loss, bone loss, pain, limited mobility, sepsis, and even death.

Interventions to prevent pressure sores, and to manage those that have already developed:

- Manage comorbid conditions to ensure optimal heart and lung functioning
- Assure adequate nutrition and hydration with protein, calorie-dense meals, vitamin supplements when indicated, unless contraindicated
- Maintain the skin's moisture balance
- Treat pain
- Provide appropriate support surface (gel overlay, alternating pressure mattress)
- Reposition every two hours in bed or every hour when in a chair
- Off-load heels by using pillows or positioning boot
- Use pillow between legs when side lying
- Do not position directly on the hip bone
- For people with diabetes, maintain blood sugar control
- Use draw sheets for repositioning or encourage the use of a trapeze bar
- Elevate head of bed at least 30 degrees if tolerated
- Manage incontinence to ensure skin is clean, dry, and remains intact
- Cleanse and treat the wound as directed by a licensed healthcare professional
- Prevent and manage infection

Risk Factors for Impaired Wound Healing

• Infection	• Impaired mobility
• Smoking	• Use of systemic steroids
• Advance aging	• Vascular disease
• Malnutrition/Dehydration	• Immunosuppressive therapy
• Incontinence	• Diabetes
• Changes in Mental Status • Impaired mobility + Neurocognitive disorders that impair executive functioning (ability to monitor health status and/or perform ADLs and IADLs)	• Morbid obesity or • Significant weight loss

Guidelines and Process for Interdisciplinary Team

- For Family Care and Partnership: Care team nurse will assess member's skin and risks for skin breakdown at least annually and document the assessment in the appropriate electronic health record.
- For members with an active wound, the care teams will add wound management interventions to the member's care plan, including recommendations for wound treatment plan (i.e., frequency of dressing changes, provider for wound supplies, when to seek out medical attention), repositioning schedules, nutrition/hydration recommendations, proper skin techniques and recommended hygiene schedules.
- For members with an active wound, the care team will document their wound measurements monthly in the appropriate electronic health record to track the wound healing process and re-evaluate the effectiveness of the wound treatment interventions in use.

Cultural Considerations

- In general: ethnic and cultural minority groups have continued to experience a disproportionate burden of disease, injury, premature death, and disability when compared to the white population.
- Health disparities can mean lower life expectancy, decreased quality of life, and loss of economic opportunities, as well as perceptions of injustice.
- Health disparities are reflected in decreased productivity, increased health care costs, and social inequities.
- Contributing factors to ethnic, cultural, and gender disparities:
    - Mistrust in the health care system (stemming from historical mistreatment or neglect)
    - Personal and group experiences of discrimination

- Varying degrees of health literacy
- Provider prejudice or unconscious bias
- Low cultural competency and clinical humility among health care providers
- Discordance in patient-provider gender, race and/or ethnic background
- Under representation of minority health care providers (only 19% of RNs in the workforce are from a minority background)

All ethnicities and genders are at risk for pressure ulcers, but research shows some are at higher risk. Please be considerate of members at higher risk and make sure to provide education when necessary.

- Ethnic groups with darker skin pigmentation are at higher risk for under-identification of pressure ulcers at early stages due to poor recognition of signs in the darker pigmented skin.
- The prevalence of pressure ulcers in general is 4-30% for those in hospitals, 2.4-23% for those in long-term care facilities and 4% for in home care patients.
- Pressure ulcers are also more likely in adults aged 65 years of age or older due to increasing prevalence of impaired mobility and increasing risk for cognitive decline.

Quality Assurance Monitoring

Internal file reviews are completed by internal staff to monitor members with documented wounds. The internal file review monitors the member has appropriate wound management interventions documented in their care plan including coordination and follow-up of member visits to their primary care physician or wound management specialist.

Additional Resources

Specialty Mattress Quick Reference

Wound Terminology Quick Reference

Wound Treatment Quick Reference

Wound Vac Quick Reference

References

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