

Prevention and Management of Pressure Ulcers Evidence-Based Best Practice

Pressure ulcers can have a significant negative impact on the quality of life of older people. Aging increases the risk for the development of pressure ulcers, in part due to tissue changes such as reduced subcutaneous fat and decreased capillary blood flow. An interdisciplinary team approach with organizational commitment is imperative for an effective pressure ulcer prevention and management program.

Assessment:

Pressure ulcer risk assessments are completed within 6 hours of admission to the facility using a validated scale (Norton or Braden Scale)

Documentation includes:

- Comprehensive head-to-toe skin assessment
- Health history/diagnosis
- Nutrition and hydration
- Mobility/positioning and support surfaces
- Incontinence/moisture
- Pain status

If a pressure ulcer is present, an in-depth assessment should be conducted using a validated tool for measuring healing (PUSH Tool 3.0 or Bates-Jensen Wound Assessment Tool)

Documentation includes:

- Location and size (length, width and depth)
- Stage (2007 NPUAP staging system)
- Wound bed: granulation, odor, necrotic tissue, drainage/exudates, slough
- Undermining/tunneling/sinus tracts
- Peri-wound tissue – color, temperature, bogginess, fluctuation and edema
- Support surfaces
- Pain status

Reassessment should be repeated:

- Pressure ulcer risk assessment weekly for the first 4 weeks, then monthly for first quarter, then quarterly, and as clinical condition changes
- Individuals with a pressure ulcers should have an in-depth pressure ulcer assessment repeated depending on the individual's clinical condition and treatment plan

Care Plan:

A current care plan for actual or the risk of pressure ulcers includes:

- Measurable goals and time-frames
- Pressure ulcer interventions focused on individual risk factors, prevention, and/or effective treatment strategies including:
 - Education provided to individuals and/or family/surrogates
 - Individual's baseline information including risk factors
 - Specific treatment with timelines for pressure ulcer care
 - Frequency of pressure ulcer risk assessments and/or reevaluation of existing pressure ulcers
 - Process to notify the physician of changes in the pressure ulcer risk assessment and/or changes noted during assessments of existing pressure ulcers
 - Risk factors identified
- Process to review and update the care plan based on changes of condition or assessment process to review and update the care plan based on changes of condition or assessment
- Process for an interdisciplinary team (IDT) to develop the care plan

Outcomes:

- Individualized interventions identified in the care plan are implemented
- Effectiveness of the individualized interventions is monitored and evaluated