

## Clinical Practices - Pressure Ulcer Prevention

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**Summary** Sets out the steps to prevent the occurrence of pressure ulcers.

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**Applies to** Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, NSW Dept of Health, Private Hospitals and Day Procedure Centres, Private Nursing Homes, Public Health Units, Public Hospitals

**Distributed to** Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Government Medical Officers, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Private Hospitals and Day Procedure Centres, Private Nursing Homes, Tertiary Education Institutes

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**CIRCULAR**

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**CLINICAL PRACTICES-  
PRESSURE ULCER PREVENTION**

The aim of this circular is to reduce the incidence of pressure ulcers in the New South Wales health system (both public and private sectors) by setting out the steps to prevent the occurrence of pressure ulcers. The health services included in this system range from community care and general practitioners through residential and aged care facilities to acute care facilities.

This circular should be used in conjunction with the appropriate clinical practice guideline. Clinical practice guidelines have been developed for acute care, rehabilitation and residential, community and transport settings.

**1. PURPOSE OF THIS CIRCULAR**

This circular has been developed for use by managers, health care workers (such as medical practitioners, nurses, assistants in nursing and allied health professionals), patients and their carers in a range of health care settings for the prevention of pressure ulcers.

The occurrence of pressure ulcers poses a significant burden to both patients and their carers, and the health system. Pressure ulcers can result in pain, disfigurement, reduced quality of life, and prolonged rehabilitation for the patient. Patient treatment costs have been estimated at about 2.5 times the costs of preventive measures (Xakellis et al, 1995, p20). In addition, the length of stay of a patient with a pressure ulcer is 3.5 times that of a patient without a pressure ulcer (Allman, et al, 1986, p340).

Adherence to this circular should reduce the occurrence of pressure ulcers by enhancing resource utilisation and providing directions in care for pressure ulcer prevention.

**2. DEFINITION OF A PRESSURE ULCER**

A **pressure ulcer** can be described as a lesion caused by unrelieved pressure, friction or shear. Pressure ulcers occur most commonly on the sacrum and heel but can develop anywhere on the body including the coccyx, occiput, clavicle, ear, and nose.

Other terms for a pressure ulcer are pressure sore, bed sore and decubitus ulcer.

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

### 3. STAGES OF A PRESSURE ULCER

Staging attempts to standardise the classification system for a pressure ulcer based on the depth of tissue destruction. The stage of a pressure ulcer should be documented to assist with the monitoring of strategies for the prevention of pressure ulcers.

There are four stages of a pressure ulcer. The stage should not be thought of as synonymous with the level of severity as extensive tissue damage may underlie even a stage one ulcer.

Stage	Definition	Explanatory Notes
One	Observable pressure-related alteration(s) of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain/itching)	The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue and purple hues.
Two	Partial thickness skin loss involving epidermis and/or dermis.	The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.  (Note that this superficial presentation can also be a non pressure related injury due to friction and excessive moisture eg incontinence, wound drainage, perspiration).
Three	Full thickness skin loss involving damage or necrosis to subcutaneous tissue and extending down to, but not through, the underlying fascia.	The ulcer presents clinically as a deep crater with or without undermining of the adjacent tissue.
Four	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (for example, tendon or joint capsule).	Undermining and sinus tracts may also be associated with Stage 4 pressure ulcers.

Reference: Stages of Pressure Ulcers (AWMA, 2001, pp6-7)

### 4. RISK ASSESSMENT

Most pressure ulcers are preventable. Prompt identification of people at risk of developing a pressure ulcer allows the health care worker and/or carer to initiate appropriate preventative strategies.

The trigger for the risk assessment of a person is **mobility**. Any person with a mobility deficit or a change in mobility status should undergo a risk assessment. Risk assessments should be routine for all inpatients and for those people seen on domiciliary visits.

Risk assessment involves the use of a risk assessment tool in conjunction with clinical judgement.

The **recommended** risk assessment tool is the Pressure Sore Prediction Score (PSPS) (Lowthian, 1987)

Pressure Sore Prediction Score (PSPS)				
	No	No, but	Yes, but	Yes
Sitting up?	0	1	2	3
Unconscious?	0	1	2	3
Poor general condition?	0	1	2	3
Incontinent?	0	1	2	3
	No	Yes & No	Yes	
Lifts up?	2	1	0	
Gets up and walks?	2	1	0	

### Explanatory Notes

<i>Sitting up?</i>	Sitting in a chair, wheelchair or resting in bed in a Fowlers or semi-Fowlers position for >2 hours means a definite "Yes" answer.
<i>Unconscious?</i>	Mental confusion may qualify as a "No but" answer.
<i>Poor general condition?</i>	This may be a severe/sudden illness, or a long standing medical condition eg cancer or diabetes, or a disability eg paralysis. A lack of response to pain suggests a poor condition. Also poor nutritional status, existing pressure ulcers or wound breakdown, etc may be indicative of a poor general condition.
<i>Incontinent?</i>	Is the patient is wet or soiled underneath (urine, faeces, perspiration, wound drainage).
<i>Lifts up?</i>	When possible, the patient is asked to try, without help from anyone else, to "Lift up". A "Yes" answer means that the patient does lift his/her pelvis clear of the bed or seat at the time of asking. Ensure that it is clinically appropriate to request the patient to lift themselves eg a patient following cardiac surgery may be advised not to lift him/herself using their arms.
<i>Gets up and walks?</i>	A "Yes" answer implies normal or nearly normal walking.

The risk level is then determined as follows.

Score	Level of Risk	
< 6	Not at risk	<i>If a pressure ulcer is present Assign a minimum score of 10</i>
6 – 9	Low	
10 – 11	Medium	
12 – 16	High	

The outcome of each risk assessment should be documented in the patient's notes and communicated to members of the teams involved in the patient's care and treatment.

## 5. PRESSURE ULCER PREVENTION

Care and treatment to reduce the risk of pressure ulcer development should be directed at reducing the degree and duration of pressure. Mobility of the person is the key to reducing the risk of pressure ulcer development.

The following procedures should be adopted -

- People at risk of developing a pressure ulcer should be repositioned to reduce the risk of pressure ulcer development. Repositioning should complement the use of appropriate support surfaces and/or specialised equipment. Refer to NSW Health Circular 01/111 – *Policy and Guidelines for the Prevention of Manual Handling Incidents in NSW Public Health Care Facilities* and to local guidelines for information on the prevention of manual handling incidents,
- People at risk of developing a pressure ulcer and people with an existing pressure ulcer should have appropriate support surfaces and/or specialised equipment, and
- Active rehabilitation and early ambulation should be encouraged consistent with the overall goals of the person's clinical care and treatment.

The care and treatment adopted for the prevention of pressure ulcers should be documented in the patients' notes.

## 6. MONITORING AND REPORTING

Systems should be put in place for the ongoing monitoring and reporting of data on pressure ulcers. Statewide key performance measures should be adopted to measure ongoing performance.

Data about the incidence and prevalence of pressure ulcers should be collected. Incidence data examines whether the prevention strategies are achieving what they are meant to achieve and prevalence data examines the burden of pressure ulcers to the health system. These data when reviewed in conjunction with the patient risk assessment data will allow for risk stratification of the data.

## 7. GOVERNANCE STRUCTURE

The following sets out the governance structure that should be adopted by public sector health services. It is recommended that the private sector have regard to this structure in the development of policies on pressure ulcer prevention.

### *Preventative Management by Clinicians*

Risk assessments for all inpatients and for those seen on domiciliary visits should be conducted at the time of admission or the first time they are seen, and again when there is any change in mobility status.

Health care workers are responsible for ensuring that the following information is documented in the patient's notes on entry to the health system, regularly during clinical care (or on each community visit) and on discharge -

- Evaluation of skin integrity
- Results of the risk assessment - score and risk category,
- Presence and stage of a pressure ulcer, if appropriate,
- Details of the actual prevention programs that were implemented for those patients assessed as at risk of developing a pressure ulcer, and
- Details of the actual prevention programs that were implemented for those patients documented as having a pressure ulcer.

The patient's risk status and prevention management should be **communicated** to the various members of the teams involved in the patient's care and treatment when transferred from one care setting to another, eg ward to operating theatre or radiology, transport to another care setting, and from acute setting to residential setting. Information to be communicated should include the current risk assessment, the presence of pressure ulcers if relevant, and the use of any support surfaces and specialised equipment so that there is continuity of care.

### *Education of Clinicians*

A comprehensive ongoing education program for the prevention of pressure ulcers should be provided to clinicians. This could cover issues such as risk assessment of the patient, skin assessment and skin care, use of contemporary wound management products, selection and

use of appropriate support surfaces and specialised equipment, and advice on support systems for consumers and carers.

### *Health Services*

Each health service should -

- Develop guidelines for the availability and maintenance of support surfaces and specialised equipment for the prevention of pressure ulcers,
- Develop pressure ulcer prevention strategies based on this circular and the clinical practice guidelines,
- Monitor, assess and evaluate these strategies,
- Collect, analyse and distribute data, and
- Report on pressure ulcer prevention strategies against targets and outcomes.

In the public health system this work should be overseen by the Area Quality Council and/or a committee that reports directly to the Area Quality Council (NSW Health, 1999, p47).

Robyn Kruk  
**Director-General**

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