



Preventing Pressure Ulcers

Evidence-based clinical practice guidelines that offer the latest in the management of pressure ulcers emphasize an interdisciplinary team approach.

HAVING AN EVIDENCE-BASED pressure ulcer prevention and treatment program is essential to all long term care facilities, says Jacqueline Vance, RNC, CDONA/LTC, director of clinical affairs and industry relations for the American Medical Directors Association (AMDA), Columbia, Md.

But implementing an effective program in the absence of good data is challenging, at best. That is why AMDA developed and recently updated its evidence-based clinical practice guidelines (CPGs) on pressure ulcers.

Beyond Standard Assessments

The 64-page document, developed by an interdisciplinary work group comprised of physicians, nurses, wound care experts, dietitians, and nurse practitioners, addresses a number of practice areas, including interdisciplinary development of care plans, patient assessments, use of wound care protocols by all caregivers, and evaluation of a patient's "tissue tolerance" before determining the turning and positioning schedule.

The CPGs emphasize going beyond standard assessment scales to determine a patient's risk of developing a pressure ulcer and individualizing approaches to care, among other topics.

The fact that the AMDA pressure ulcer guidelines are evidence-based, says Vance, is something that's sorely needed to better inform facilities in their efforts to prevent and treat pressure ulcers. "People have tended to do things that have no evidence just

■ Many issues can play a role in the formation of pressure ulcers or can impede their healing.

Table 1

RISK FACTORS FOR DEVELOPING PRESSURE ULCERS

- Comorbid conditions, such as diabetes mellitus, end-stage renal disease, or thyroid disease;
- Drugs that may affect ulcer healing, such as steroids;
- Exposure of the skin to urinary or fecal incontinence;
- History of a healed Stage III or IV pressure ulcer;
- Impaired diffuse or localized blood flow, such as generalized atherosclerosis or lower-extremity arterial insufficiency;
- Impaired or decreased mobility and functional ability;
- Increase in friction or shear;
- Moderate to severe cognitive impairment;
- Resident refuses some aspects of care and treatment; and
- Undernutrition, malnutrition, and hydration deficits.

Source: AMDA's Pressure Ulcer Clinical Practice Guidelines, as adapted from CMS 2007



because "This is how we've done things before," she says.

One example is that many facilities have a policy to turn and reposition all patients with pressure ulcers every two hours, but the evidence shows that the need to do that is dependent on the patient's tissue tolerance. "There's evidence that shows that [two-hour turning] is not [necessarily] efficacious," says Vance.

Team Approach

According to the guidelines, the use of an interdisciplinary wound care team may help to ensure the implementation of a consistent, appropriate management process for ulcer prevention and treatment based on objective protocols. Such a team may include a designated wound care nurse, a nurse assistant, a dietitian, a physical or occupational therapist, a nurse practitioner, and one team member who is trained in wound care.

In addition, the team should have access to a wound care specialist.

The reason is that many issues—from comorbidities to nutritional factors—can play a role in the formation of pressure ulcers or can impede their healing.

KATHLEEN LOURDE is a freelance writer based in Dacoma, Okla.

Patient assessment should “include consideration of functional and clinical status and coexisting diagnoses that contribute to the risk of tissue injury as well as the likelihood of ulcer healing,” the guidelines say.

The use of wound care protocols should allow caregivers who are not wound care specialists to perform tasks correctly, although basic training in wound care for at least some staff is important, the guidelines recommend. All nursing staff should be competent at examining pressure ulcers and at changing pressure ulcer dressings.

Pressure ulcers should be examined and the status documented by a licensed practical nurse under the supervision of a registered nurse at least weekly.

Table 2

PRESSURE ULCER PREVENTION MEASURES

- Create a turning and positioning schedule that is based on the patient's individual risk factors.
- Do not massage reddened areas over bony prominences.
- Evaluate and manage urinary and fecal incontinence.
- Initiate a plan to prevent or manage a contracture.
- Inspect skin during bathing or daily personal care.
- Maintain adequate nutrition and hydration if possible.
- Maintain the lowest possible head elevation to reduce the impact of shear.
- Position the patient to minimize pressure over bony prominences and shearing forces over the heels and elbows, base of head, and ears.
- Use appropriate offloading or pressure-redistribution devices.
- Use lifting devices such as draw sheets or a trapeze.
- Use proper transferring techniques.

Source: AMDA's Pressure Ulcer Clinical Practice Guidelines.

Assessing Risk

Evaluating an individual's risk for pressure ulcers is also addressed in the CPGs (see Table 1, page 33). “It's important to go beyond the [assessment] scales to look at a person's risk,” says

■ We need to step back and really look at the whole person, says Vance.

Vance. “The current scales don't necessarily capture everybody's risk.” The guidelines examine indications that are not on the scales but could show that a person is at higher risk for getting a pressure ulcer. “We need to step back and really look at the whole person,” says Vance.

Facilities tend to have a one-size-fits-all approach to caring for pressure ulcers. Directors of wound care management tend to say “for anybody at risk—we're going to do all this canned care plan list of things,” says Vance, whereas patients with varying conditions may not respond to treatments and preventive efforts that aren't individualized. “We have to really individualize care to make a difference.”

Individualizing care will also free up staff from performing treatments that won't work, thereby spending precious time ineffectively.

Although both the Braden Scale and the Norton Score have been shown to have good sensitivity and specificity, they have been known to produce poor positive predictive value, the CPGs point out.

A meta-analysis of 33 studies (*Journal of Advanced Nursing*, 2006) concluded that while there is no evidence that use of risk assessment scales decreases pressure ulcer incidence, it does increase the intensity and effectiveness of preventive interventions.

Communication

Communication with the family is another topic addressed in the CPGs. One time this is critically important is at the end of life—an area where facilities need more direction about how to handle pressure ulcers, Vance says.

If a physician knows that a patient is at an end-stage of life and is actively dying, pressure ulcers may well develop. “The skin is the largest organ of the body,” says Vance. “The organs are going to shut down; you have to be prepared that the skin's going to shut down. The family's going to have to be prepared for this” and that the facility's caregivers will do their best to prevent and treat pressure ulcers, but that “skin breakdown is likely going to happen,” she says.

“We're trying to help people see that sometimes no matter what you do

Table 3

RECOMMENDED COMPONENTS OF PRESSURE ULCER DOCUMENTATION

Although no consensus exists on documentation content, most recommendations include the following components:

- Type of ulcer, how long it has been present, and in what setting it occurred;
- Size of ulcer measured as length x width x depth in centimeters (areas of the wound-bed that is deepest, without a tract);
- Color, as percentage with red, indicating amount of granulation tissue; yellow, indicating the amount of slough present; and black, indicating necrotic tissue or eschar;
- Description of exudates, such as serous, serosanguineous, sanguineous, or purulent;
- Presence or absence of odor in the wound, determined after the wound is thoroughly cleaned; and
- Evidence of wound undermining, tunneling, or sinus tracts.

Source: AMDA's Pressure Ulcer Clinical Practice Guidelines.

pressure ulcers are unavoidable. You still have to do everything you can to prevent or heal an ulcer, but it doesn't mean you're going to be successful," says Vance.

"There is definitely a relationship between some certain intrinsic factors going on inside the patient and their increased risk—certain factors that are not modifiable to prevent a pressure ulcer." Facilities need to know how to document these situations, she says.

Infection Management

The guidelines include a number of steps that facilities can take to improve their pressure ulcer prevention and treatment programs, such as how and when to examine a patient's skin, assessing a patient's overall physical and psychosocial health, characterizing

pressure ulcers, and monitoring the progress of the patient and of the ulcer.

Detailed in the guidelines are suggestions for effectively managing infections. The presence of odor, necrosis, or purulent drainage does not always indicate the need for systemic antibiotics, the CPGs say. Instead, local cleansing, topical antibiotics, or chemical or surgical debridement may be indicated.

The rationale for a decision to use systemic antibiotics or more limited interventions should be documented in the medical record, the guidelines say. Such treatment should be explained to the patient and the family.

Pressure ulcer healing may be delayed by the presence of necrotic tissue, the guidelines say. Saline irrigation

is a safe cleansing method for most pressure ulcers, while the use of cytotoxic antiseptic solutions, such as povidone iodine, acetic acid, or Dakin's solution, are discouraged because they may retard ulcer healing and increase resistance to subsequent antibiotic treatments. Commercial ulcer cleansers that do not contain harmful chemicals may be used at the practitioner's discretion.

In addition, the guidelines suggest that discussions with the patient and family about debridement should communicate that ulcers usually measure larger after debridement of nonviable tissue than they did before. ■

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Collaboration Paves Way To Prevent Pressure Ulcers

Wisconsin state and private health leaders have announced a new collaboration to double the number of pressure ulcer care specialists in the state. Eleven organizations, including the Wisconsin Department of Health and Family Services, the Wisconsin Health Care Association, and the Wound Care Institute, aim to certify 200 Wisconsin registered nurses who work in long term care as certified pressure ulcer specialists.

"Pressure ulcers are preventable afflictions, and we as leaders in health and long term care must do all we can to reduce their occurrence," said Department of Health and Family Services Secretary Karen Timberlake.

The goal of the collaborative is to train an additional 200 registered nurses to become certified in the prevention and treatment of pressure ulcers.

"Wisconsin is already one of the top states in the nation in successful treatment outcomes," said Tom Moore,

executive director of the Wisconsin Health Care Association. "But this program is going to take our state from good to great in preventing and treating pressure ulcers."

■ Caring for a severe pressure ulcer can range from \$38,000 to \$55,000.

The federal goal is to reduce the number of residents in nursing facilities who develop pressure ulcers to 8.5 percent.

Although Wisconsin has consistently performed better than federal goals for both the nation and the state, with an average holding steady at around 6.9 percent, the collaborative aims to

reduce the state average even further.

The National Pressure Ulcer Advisory Panel reports that caring for a severe pressure ulcer can range from \$38,000 to \$55,000. Costs include specialized treatment materials such as bandages and ointments and increased use of staffing resources, including labor, charting, and physician oversight.

The collaborative believes that while pressure ulcer education and certification will increase the quality of care for nursing facility residents, it could also save Wisconsin's health care system millions of dollars annually.

Week-long certification courses will be offered this fall in four different locations in the state for 200 nurses. Wisconsin long term care facilities will have the opportunity to send nurses for the cost of \$1,000. The remaining course costs—approximately \$2,500—will be defrayed by the sponsors of the initiative.

—Joanne Erickson