Campaign Intervention Fact Sheet

Pressure Ulcer Prevention

A pressure ulcer is defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed. Because muscle and subcutaneous tissue are more susceptible to pressure-induced injury than skin, pressure ulcers are often worse than their initial appearance. Pressure ulcers are also called decubitus ulcers or bed sores and range in severity from mild to severe.

Although pressure ulcers are preventable in most cases, the prevalence of pressure ulcers in health care facilities is increasing. It is estimated that 2.5 million patients are treated for pressure ulcers in US health acute-care facilities each year. Pressure ulcers cause considerable harm to patients, hindering functional recovery, frequently causing pain and the development of serious infections. Nearly 60,000 US hospital patients are estimated to die each year from complications due to hospital-acquired pressure ulcers. The estimated cost of managing a single full-thickness pressure ulcer is as high as $70,000, and the total cost for treatment of pressure ulcers in the US is estimated at $11 billion per year.

Six Essential Elements of Pressure Ulcer Prevention:

1. Conduct a Pressure Ulcer Admission Assessment for All Patients
The admission assessment should include both a risk assessment (to evaluate risk of developing a pressure ulcer) and a skin assessment (to detect existing pressure ulcers).

2. Reassess Risk for All Patients Daily
The complexity and acuity of hospitalized patients require daily reassessment of the potential and degree of risk of pressure ulcer development. Assessing risk daily provides caregivers the opportunity to adjust prevention strategies according to the changing needs of the patient.

3. Inspect Skin Daily
Skin integrity may deteriorate in a matter of hours in hospitalized patients. Patients identified as being at risk need a daily inspection of all skin surfaces. Ideally, staff should incorporate a skin inspection into their work, every time they assess the patient.

4. Manage Moisture: Keep the Patient Dry and Moisturize Skin
Wet skin is conducive to the development of rashes, is softer, and tends to break down more easily. Skin should be cleansed at time of soiling and at routine intervals.

5. Optimize Nutrition and Hydration
Assessment of the patient for possible risk of pressure ulcer development should include a review of nutritional factors and an assessment of hydration.

6. Minimize Pressure
Relieving pressure, especially over bony prominences, is of primary concern. Patients with limited mobility are especially at risk for the development of pressure ulcers. Every effort should be made to redistribute the pressure on the skin, either by repositioning or by utilizing pressure-relieving surfaces.

Highly Informative Tips (HITs) for Implementation

Pressure Ulcer Prevention

Create a multidisciplinary team approach and start small. Narrow focus to two or three activities and start with small tests of change in those areas before spreading.

Use a business case to engage leaders. Pressure ulcer prevention champions should have no trouble making the business case for purchasing special pressure relieving equipment. One Stage IV pressure ulcer can cost an estimated $100,000 to treat.

Admission Assessment:

- Improve processes so that risk assessment is conducted within four hours of admission for all patients.
- Include a visual cue on each admission documentation record for the completion of a total skin assessment and risk assessment.
- Agree on the use of a standard risk assessment tool (for example, Braden Scale). Facilities may wish to adapt the tool to allow using check-boxes and short phrases for easy completion.
- Utilize multiple methods to visually cue staff as to which patients are at risk. For example, consider using stickers in the patient chart or on the patient's door.

Daily Risk Reassessment:

- Adapt documentation tools to prompt daily risk assessment, document findings, and initiate prevention strategies as needed. For example, include this information in daily clinical notes.
- Educate all levels of staff about potential risk factors of pressure ulcer development and the process for implementing prevention strategies.
- Use validated risk assessment tools to easily identify degree of risk and potential prevention strategies.

Daily Skin Inspection of High Risk Patients:

- Adapt documentation tools to prompt daily skin inspection, document findings, and initiate prevention strategies as needed.
- Educate all levels of staff to inspect the skin anytime they are assisting the patient. For example, have staff check when assisting patient to the chair, moving from one area to the other, and while bathing.

Moisture Management of High Risk Patients:

- Design a process for periodic activities such as repositioning, assessing for wet skin, applying barrier agents, offering toileting opportunity, and offering fluids. By combining routine activities staff can complete multiple tasks while in the room every two hours and document them all at once.
- Provide supplies at the bedside of each patient who is incontinent. This provides the supplies the staff needs to immediately clean, dry, and protect the patient's skin after each episode of incontinence.
- Provide underpads that pull the moisture away from the skin, and limit the use of disposable briefs or containment garments if at all possible.
- Provide pre-moistened, disposable barrier wipes to help cleanse, moisturize, deodorize, and protect patients from perineal dermatitis due to incontinence.

Optimizing Nutrition and Hydration of High Risk Patients:

- Assist patient with meals, snacks, and hydration. Every effort should be made to allow patient preferences when medically appropriate.
- Document the amount of nutritional intake, and notify the dietitian or physician if the patient does not have adequate intake.
- Offer water to every patient who is scheduled to be turned and offer toileting, assess for needs of cleanliness, and change wet surfaces.

Minimizing Pressure of High Risk Patients:

- Use tools inside the patient room to remind caregivers to turn/reposition the patient every two hours.
- Utilize unit- or hospital-wide "musical" cues (for example, setting caregiver beepers to sound every two hours) to remind staff to turn/reposition all at-risk patients at two-hour intervals.
- Utilize positioning, transferring, and turning techniques to minimize friction/shear injury.
- Use pressure redistribution mattresses/overlays to assist with minimizing pressure.