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Pressure area care

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This snapshot learning feature raises awareness of the importance of pressure area care, which can present significant challenges to clinicians and patients, i.e. difficulties in categorising pressure ulcers, poor inter-agency working, the complex, deteriorating patient being looked after closer to home, sporadic equipment provision, patient monitoring, and pressure ulcer prevention awareness (Chamanga, 2016). Read the feature, then go online and complete the accompanying e-learning module and test to find out more about pressure area care — completion of this will count towards revalidation or CPD:
www.woundcare-today.com/learning-zone/pressure-area-care/module

Pressure ulcer prevention and incidence reduction is a priority for healthcare providers worldwide. Within the NHS, pressure ulcers are recognised as one of the most commonly occurring patient harms. Since 2014, the Department of Health (DH) has focused on reducing avoidable harms in an attempt to save 6,000 lives each year, while improving patient safety and saving money. More recently, the *NHS Outcomes Framework* (NHS OF; NHS Digital, 2020) and *Five Year Forward View* (NHS England, 2019) documents set out the expectation for the delivery of safe, effective, harm-free care to patients.

However, despite improvements in technology and medical advances, pressure ulcers continue to be a challenge and represent a significant economic and humanitarian burden globally. Prevalence

figures can vary significantly between different geographical and clinical settings, with worldwide figures ranging from 0–72.5% (Samaniego, 2003; Al Mutairi et al, 2018; Tubaishat et al, 2018). Within the UK, the *NHS Safety Thermometer* has shown that from March 2016 to March 2017, 106,675 patients were reported as having a pressure ulcer — prevalence range: 4.2–4.5% (NHS Digital, 2017).

To help tackle the challenge of pressure ulcer prevention and management, two key documents were launched by the NHS in 2018 to support a more consistent approach to the definition and management of pressure ulcers at both local and national levels (NHS Improvement, 2018a), and a core curriculum to guide education for nurses and other healthcare professionals on preventing pressure ulcers (NHS Improvement, 2018b). Internationally, the *Prevention and Treatment of Pressure Ulcers Clinical Practice Guideline* was updated in 2019 (European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Ulcer Injury Alliance [EPUAP, NPIAP, PPPIA], 2019).

Every pressure ulcer has a tangible effect on the patient. This includes pain, the need for additional nursing interventions, damage to their sense of self, leading to depression or social isolation, due to wound symptoms such as odour. The drive to prevent harm is at the forefront of the argument for investment of time and money in pressure ulcer prevention (National Institute for Health and Care Excellence [NICE], 2015; Ellis, 2017). Every setting where care is delivered, whether home, hospital or care home, faces challenges in delivering pressure ulcer prevention — pressure ulcers also affect the morale of clinical staff, because they are still considered to be an indicator of poor nursing care, affecting the quality of life of patients and their families (Chamanga, 2016; Tingle, 2016; Ellis, 2017).

WHO IS AT RISK?

Not every person is at risk of developing a pressure ulcer. Those at higher risk include the elderly, patients in intensive care, as well as stroke, postoperative orthopaedic, spinal cord injury, malnourished and cancer patients.

WHY DO THEY OCCUR?

Pressure ulcers develop because of pressure compromising local tissue blood supply, usually over bony prominences with the lower trunk (sacrum, coccyx, trochanter and ischial tuberosities) and heels being the most common anatomical locations (Vanderwee, 2007). They can range from superficial damage, involving little more than skin discolouration, to deep ulcers, which extend down to tendon and muscle or bone (Glasper et al, 2009). Pressure ulcers are influenced by intrinsic (internal) and extrinsic (external) factors. Intrinsic involve those relating to the patient's anatomy and physiology, such as age, impaired mobility, poor posture or deformity, underlying medical conditions, for example, neurological conditions such as cerebrovascular accident, or spinal cord injury, impaired nutrition and hydration, previous pressure damage, and incontinence (EPUAP et al, 2019). Pressure and shear are the two main extrinsic factors (Chamanga, 2016).

RISK ASSESSMENT

Risk assessment is a central component of clinical practice and the first step in identifying individuals susceptible to pressure ulcers (EPAUP et al, 2019). Within the UK, the assessment and documentation of pressure ulcer risk within community services and care homes is a key patient safety indicator for the Commissioning for Quality and Innovation (CQUIN) scheme 2020–2021, thus, highlighting the importance of this aspect of pressure area care.

There are several risk assessment tools to help staff identify those at greatest risk, but these must always be used in conjunction with sound professional judgement (Moore and Cowman, 2014; NICE, 2014; Qaseem et al, 2015).

The most commonly used tools in the UK are Waterlow (2005), Norton (Norton, et al, 1992), Braden (Bergstrom et al, 1987), and Purpose T (Nixon et al, 2015).

CATEGORISING/STAGING PRESSURE ULCERS

As well as comprehensive skin and wound care assessment, it is also important to categorise/stage pressure ulcers. The NPUAP/EPUAP (2014) classification system to categorise/stage pressure ulcers has been recommended as best practice by NICE (2015), NHS Improvement (2018a, b) and Healthcare Improvement Scotland (HIS, 2016), as this assesses and establishes the severity and depth of tissue damage, namely:

- Category/stage I pressure ulcer: non-blanchable erythema (intact skin)
- Category/stage II pressure ulcer: partial-thickness skin loss
- Category/stage III pressure ulcer: full-thickness skin loss
- Category/stage IV pressure ulcer: full-thickness tissue loss (exposed bone, tendon or muscle)
- Unstageable: depth unknown (full-thickness tissue loss in which the base of ulcer is covered by slough and/or eschar)
- Suspected deep tissue injury (SDTI): depth unknown (purple or maroon localised area of discolouration intact skin or blood-filled blister)

Accurate pressure ulcer categorising/staging has several benefits, in that it (Chamanga, 2016):

- Gives an objective assessment and understanding of the extent of tissue damage
- Assists in planning, implementing and evaluating preventative or treatment regimens
- Allows appropriate allocation of equipment (i.e. support surfaces)

Remember...

Since 2014, the Department of Health (DH) has focused on reducing avoidable harms in an attempt to save 6,000, lives while improving patient safety and saving money. As well as pressure ulcers being recognised by the DH as one of the 'classic' patient harms, further investment has been made with the introduction of the NHS Improvement 'Pressure ulcers: revised definition and measurement' and 'core curriculum' documents, which are aimed at supporting a more consistent approach to the definition and management of pressure ulcers and structured education in order to prevent them. The *Prevention and Treatment of Pressure Ulcers Clinical Practice International Guideline* was also updated in 2019 (EPUAP et al, 2019).

- Supports clinical incident reporting (Datix)
- Generates data which can be used to identify hotspots, tailor training sessions, design prevention and management strategies.

Deep pressure ulcers (category III and IV) represent a dramatic change in the skin and underlying tissue (Beldon, 2014). These patients are at risk of infection and complications and will need immediate treatment and/or referral to specialist services.

All pressure ulcers should be reported via local monitoring systems. This will ensure consistency and reduce variations in the reporting process and support timely identification of pressure damage and local quality improvement actions (NHS Improvement, 2018a). Those identified as serious incidents should be thoroughly investigated to ensure any problems in care are identified, understood and resolved to prevent the likelihood of future recurrence (NHS England, 2016).

MANAGEMENT OF PRESSURE ULCERS

Building on the existing NHS Improvement 5-step SSKIN model for pressure ulcer prevention, the ASSKING model (*Table 1*), which includes assessing patient risk and giving information, can now be used when planning and implementing pressure ulcer prevention and management care planning.

SSKIN represents the fundamental elements of care delivery (prevention and when necessary management), while the other elements (A and G) underpin and support successful implementation of care (NHS Improvement, 2018b).

Positioning and reduction of pressure and shear

Regardless of which support surface a person is using, mobilisation and effective repositioning are central activities for relieving pressure and reducing shear forces. Where possible, a person should be prompted to reposition independently. This is often achieved by combining an appropriate patient support surface with a patient-specific repositioning schedule, which is not based on ritualistic practice. It is also important that position is varied and that loading directly over any single bony prominence is limited over the course of the day.

Selection of support surfaces should be based on a person's level of mobility and inactivity, skin microclimate control and shear reduction, number, severity and location of existing pressure ulcers, and the risk of developing new pressure ulcers. (EPUAP et al, 2019). It is also important to consider patient comfort and user acceptance. Modern support surfaces are broadly categorised as:

- Reactive (static): providing a constant pressure to the skin and subcutaneous tissue, unless the patient moves or is repositioned
- Active (alternating): periodically redistributing the pressure beneath the body. These surfaces should be considered for a wide range of at-risk patients, particularly those with existing pressure ulcers (EPUAP et al, 2019).

Wound care

Category/stage I pressure ulcers, where the skin is intact, can be treated with simple barrier products, such as film dressings or barrier creams and then monitored regularly. Category/stage II pressure ulcers, where the skin is broken, will need a dressing. Film dressings are useful for wounds producing a low volume of exudate, as they offer a protective layer while still allowing the wound to be seen without removal (Royal College of Nursing [RCN], 2005). Category/stage III and IV pressure ulcers may need advanced wound dressings that support an optimum wound healing environment, e.g. hydrocolloids, hydrogels, foams, soft silicone dressings and hydrofiber-based dressings, and negative pressure wound therapy (NPWT) may be considered if the wound is large, deep and heavily exuding. These wounds should be referred to a specialist (NICE, 2015). It is essential that wound assessment guides dressing choice, e.g. exudate volume, wound size, location, odour and presence of infection.

Table 1: ASSKING model (NHS Improvement, 2018b)

Assess	Assess risk using a validated tool to support clinical judgement (NICE, 2014)
Skin	Skin assessment and skin care — early inspection means early detection. Continue with regular skin inspections. Show patients and carers what to look for
Surface	Ensure the provision of appropriate pressure-reducing or relieving devices. Make sure that the patient is repositioned at regular intervals, which meet with the individual patient's healthcare needs. Consider 30˚ tilt to position the patient, using pillows below the neck, back and legs
Keep moving	Encourage mobility and regular movement to relieve pressure over bony prominences. Assist those who are unable to do so independently
Incontinence	Keep skin clean and dry. This may include the use of barrier creams, incontinence products and or emollients
Nutrition	As part of pressure ulcer management or prevention, nutritional status must be assessed. Keep patients well hydrated and implement prescribed diet/nutritional supplements
Giving information	Communicate effectively and provide information to patients, carers and the multidisciplinary team regarding pressure ulcer prevention (i.e. repositioning, equipment, nutrition/hydration)

Skin care

Incontinence may lead to impaired skin integrity, making a person more vulnerable to pressure ulcer development (NPUAP et al, 2014). As outlined in the ASSKING bundle, effective continence management and prevention of incontinence-associated dermatitis (IAD) and other moisture-associated skin damage (MASD) are crucial for skin health.

Educating patients and their carers/family to follow a good hygiene regimen and keep the skin clean and dry can help to prevent pressure damage, or further skin breakdown. Carers should also be aware of the early signs of skin breakdown and regularly reassess the skin (Blenman, 2017).

Practice point

Categorising/staging pressure ulcers is not a way of monitoring their progress, as they do not proceed from one category/stage to the next (Defloor and Schoonhoven, 2004; Beldon 2014). Likewise, a stage IV ulcer does not become a stage III as it heals, but should be viewed as a healing category IV ulcer.

Nutrition

Guidelines from EPUAP et al (2019) highlight the essential role that nutrition management plays. Assessment of the person's nutritional state should ensure that they have sufficient energy for metabolism as well as protein, fluid and micronutrients to be able to maintain and repair tissue. When needed, nutritional supplements may help to achieve an adequate supply of nutrients (Taylor, 2017).

Psychosocial considerations

Pressure ulcers can also have a negative impact on patient quality of life and wellbeing. They can be painful, causing anxiety and frustration (NICE, 2015; Ellis, 2017). Discomfort, concerns about odour, as well as the practicalities of pressure-redistributing equipment can restrict patient lifestyle. To help patients develop coping skills, nurses should involve patients and their families/carers in pressure ulcer-related prevention and management decisions and develop a plan of care together.

CONCLUSION

Pressure ulcer prevention requires systematic care planning based on a sound understanding of risks. Only by regularly assessing individual patients is it possible to determine their needs. Care planned with the ASSKING model is more likely to cover the key components of good practice for pressure ulcer prevention.

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