

Summary of Recommendations

RECOMMENDATION		*LEVEL OF EVIDENCE
Practice Recommendations		
Assessment	1.1 A head-to-toe skin assessment should be carried out with all clients at admission, and daily thereafter for those identified at risk for skin breakdown. Particular attention should be paid to vulnerable areas, especially over bony prominences.	IV
	1.2 The client's risk for pressure ulcer development is determined by the combination of clinical judgment and the use of a reliable risk assessment tool. The use of a tool that has been tested for validity and reliability, such as the <i>Braden Scale for Predicting Pressure Sore Risk</i> , is recommended. Interventions should be based on identified intrinsic and extrinsic risk factors and those identified by a risk assessment tool, such as Braden's categories of sensory perception, mobility, activity, moisture, nutrition, friction and shear. Risk assessment tools are useful as an aid to structure assessment.	IV
	1.3 Clients who are restricted to bed and/or chair, or those experiencing surgical intervention, should be assessed for pressure, friction and shear in all positions and during lifting, turning and repositioning.	IV
	1.4a All pressure ulcers are identified and staged using the National Pressure Ulcer Advisory Panel (NPUAP) criteria.	IV
	1.4b If pressure ulcers are identified, utilization of the RNAO best practice guideline <i>Assessment and Management of Stage I to IV Pressure Ulcers</i> is recommended.	IV
	1.5 All data should be documented at the time of assessment and reassessment.	IV
Planning	2.1 An individualized plan of care is based on assessment data, identified risk factors and the client's goals. The plan is developed in collaboration with the client, significant others and health care professionals.	IV
	2.2 The nurse uses clinical judgment to interpret risk in the context of the entire client profile, including the client's goals.	IV
Interventions	3.1 For clients with an identified risk for pressure ulcer development, minimize pressure through the immediate use of a positioning schedule.	IV
	3.2 Use proper positioning, transferring, and turning techniques. Consult Occupational Therapy/Physiotherapy (OT/PT) regarding transfer and positioning techniques and devices to reduce friction and shear and to optimize client independence.	IV
	3.3a Consider the impact of pain. Pain may decrease mobility and activity. Pain control measures may include effective medication, therapeutic positioning, support surfaces, and other non-pharmacological interventions. Monitor level of pain on an on-going basis, using a valid pain assessment tool.	IV
	3.3b Consider the client's risk for skin breakdown related to the loss of protective sensation or the ability to perceive pain and to respond in an effective manner (e.g., impact of analgesics, sedatives, neuropathy, etc.).	IV
	3.3c Consider the impact of pain on local tissue perfusion.	IV

*See page 14 for an Interpretation of Evidence.

Risk Assessment & Prevention of Pressure Ulcers

	RECOMMENDATION	LEVEL OF EVIDENCE
	3.4 Avoid massage over bony prominences.	IIb
	3.5 Clients at risk of developing a pressure ulcer should not remain on a standard mattress. A replacement mattress with low interface pressure, such as high-density foam, should be used.	Ia
	3.6 For high risk clients experiencing surgical intervention, the use of pressure-relieving surfaces intraoperatively should be considered.	Ia
	<p>3.7 For individuals restricted to bed:</p> <ul style="list-style-type: none"> ■ Utilize an interdisciplinary approach to plan care. ■ Use devices to enable independent positioning, lifting and transfers (e.g., trapeze, transfer board, bed rails). ■ Reposition at least every 2 hours or sooner if at high risk. ■ Use pillows or foam wedges to avoid contact between bony prominences. ■ Use devices to totally relieve pressure on the heels and bony prominences of the feet. ■ A 30° turn to either side is recommended to avoid positioning directly on the trochanter. ■ Reduce shearing forces by maintaining the head of the bed at the lowest elevation consistent with medical conditions and restrictions. A 30° elevation or lower is recommended. ■ Use lifting devices to avoid dragging clients during transfer and position changes. ■ Do not use donut type devices or products that localize pressure to other areas. 	IV
	<p>3.8 For individuals restricted to chair:</p> <ul style="list-style-type: none"> ■ Utilize an interdisciplinary approach to plan care. ■ Have the client shift weight every 15 minutes, if able. ■ Reposition at least every hour if unable to shift weight. ■ Use pressure-reducing devices for seating surfaces. ■ Do not use donut type devices or products that localize pressure to other areas. ■ Consider postural alignment, distribution of weight, balance, stability, support of feet and pressure reduction when positioning individuals in chairs or wheelchairs. ■ Refer to Occupational Therapy/Physiotherapy (OT/PT) for seating assessment and adaptations for special needs. 	IV
	<p>3.9 Protect and promote skin integrity:</p> <ul style="list-style-type: none"> ■ Ensure hydration through adequate fluid intake. ■ Individualize the bathing schedule. ■ Avoid hot water and use a pH balanced, non-sensitizing skin cleanser. ■ Minimize force and friction on the skin during cleansing. ■ Maintain skin hydration by applying non-sensitizing, pH balanced, lubricating moisturizers and creams with minimal alcohol content. ■ Use protective barriers (e.g., liquid barrier films, transparent films, hydrocolloids) or protective padding to reduce friction injuries. 	IV

	RECOMMENDATION	LEVEL OF EVIDENCE
	<p>3.10 Protect skin from excessive moisture and incontinence:</p> <ul style="list-style-type: none"> ■ Assess and manage excessive moisture related to body fluids (e.g., urine, feces, perspiration, wound exudate, saliva, etc.). ■ Gently cleanse skin at time of soiling. Avoid friction during care with the use of a spray perineal cleanser or soft wipe. ■ Minimize skin exposure to excess moisture. When moisture cannot be controlled, use absorbent pads, dressings or briefs that wick moisture away from the skin. Replace pads and linens when damp. ■ Use topical agents that provide protective barriers to moisture. ■ If unresolved skin irritation exists in a moist area, consult with the physician for evaluation and topical treatment. ■ Establish a bowel and bladder program. <p>3.11 A nutritional assessment with appropriate interventions should be implemented on entry to any new health care environment and when the client's condition changes. If a nutritional deficit is suspected:</p> <ul style="list-style-type: none"> ■ Consult with a registered dietitian. – Level IV ■ Investigate factors that compromise an apparently well nourished individual's dietary intake (especially protein or calories) and offer him or her support with eating. – Level IV ■ Plan and implement a nutritional support and/or supplementation program for nutritionally compromised individuals. – Level IV ■ If dietary intake remains inadequate, consider alternative nutritional interventions. – Level IV ■ Nutritional supplementation for critically ill older clients should be considered. – Level Ib <p>3.12 Institute a rehabilitation program, if consistent with the overall goals of care and the potential exists for improving the individual's mobility and activity status. Consult the care team regarding a rehabilitation program.</p>	<p>IV</p> <p>IV</p> <p>IV</p>
<p>Discharge/Transfer of Care Arrangements</p>	<p>4.1 Advance notice should be given when transferring a client between settings (e.g., hospital to home/long-term care facility/hospice/residential care) if pressure reducing/relieving equipment is required to be in place at time of transfer (e.g., pressure relieving mattresses, seating, special transfer equipment). Transfer to another setting may require a site visit, client/family conference, and/or assessment for funding of resources to prevent the development of pressure ulcers.</p> <p>4.2 Clients moving between care settings should have the following information provided:</p> <ul style="list-style-type: none"> ■ Risk factors identified; ■ Details of pressure points and skin condition prior to discharge; ■ Type of bed/mattress the client requires; ■ Type of seating the client requires; ■ Details of healed ulcers; ■ Stage, site and size of existing ulcers; ■ History of ulcers, previous treatments and products used; ■ Type of dressing currently used and frequency of change; ■ Adverse reactions to wound care products; ■ Summary of relevant laboratory results; and ■ Need for on-going nutritional support. 	<p>IV</p> <p>IV</p>

RECOMMENDATION		LEVEL OF EVIDENCE
Education Recommendations		
	<p>5.1 Educational programs for the prevention of pressure ulcers should be structured, organized, and comprehensive and should be updated on a regular basis to incorporate new evidence and technologies. Programs should be directed at all levels of health care providers including clients, family or caregivers.</p>	III
	<p>5.2 The educational program for prevention of pressure ulcers should be based on the principles of adult learning, the level of information provided and the mode of delivery. Programs must be evaluated for their effectiveness in preventing pressure ulcers through such mechanisms as quality assurance standards and audits. Information on the following areas should be included:</p> <ul style="list-style-type: none"> ■ The etiology and risk factors predisposing to pressure ulcer development. ■ Use of risk assessment tools, such as the <i>Braden Scale for Predicting Pressure Sore Risk</i>. Categories of the risk assessment should also be utilized to identify specific risks and ensure effective care planning. ■ Skin assessment. ■ Staging of pressure ulcers. ■ Selection and/or use of support surfaces. ■ Development and implementation of an individualized skin care program. ■ Demonstration of positioning/transferring techniques to decrease risk of tissue breakdown. ■ Instruction on accurate documentation of pertinent data. ■ Roles and responsibilities of team members in relation to pressure ulcer risk assessment and prevention. 	III
Organization & Policy Recommendations		
	<p>6.1 Organizations need a policy with respect to providing and requesting advance notice when transferring or admitting clients between practice settings when special needs (e.g., surfaces) are required.</p>	IV
	<p>6.2 Guidelines are more likely to be effective if they take into account local circumstances and are disseminated by ongoing educational and training programs.</p>	IV

	RECOMMENDATION	LEVEL OF EVIDENCE
	<p>6.3 Nursing best practice guidelines can be successfully implemented only when there is adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:</p> <ul style="list-style-type: none"> ■ An assessment of organizational readiness and barriers to education. ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. ■ Dedication of a qualified individual to provide the support needed for the education and implementation process. ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices. ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. <p>In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the <i>Toolkit: Implementation of Clinical Practice Guidelines</i> based on available evidence, theoretical perspectives and consensus. The <i>Toolkit</i> is recommended for guiding the implementation of the RNAO guideline <i>Risk Assessment and Prevention of Pressure Ulcers</i>.</p>	IV
	<p>6.4 Organizations need to ensure that resources are available to clients and staff. These resources include, but are not limited to, appropriate moisturizers, skin barriers, access to equipment (therapeutic surfaces) and relevant consultants (OT, PT, ET, wound specialists, etc.).</p>	IV
	<p>6.5 Interventions and outcomes should be monitored and documented using prevalence and incidence studies, surveys and focused audits.</p>	IV

Interpretation of Evidence

Levels of Evidence

Ia Evidence obtained from meta-analysis or systematic review of randomized controlled trials.

Ib Evidence obtained from at least one randomized controlled trial.

IIa Evidence obtained from at least one well-designed controlled study without randomization.

IIb Evidence obtained from at least one other type of well-designed quasi-experimental study without randomization.

III Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.

IV Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

