Pressure ulcer risk assessment and prevention

RECOMMENDATIONS 2001
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The Department of Health commissioned the RCN Institute to develop a Pressure Ulcer Guideline prior to the establishment of the National Institute for Clinical Excellence. This is one of the inherited guidelines on the Institute's programme.

The guidance published by NICE (www.nice.org.uk) on pressure ulcer risk assessment and prevention is derived from this clinical guideline.

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**RISK ASSESSMENT AND PREVENTION OF PRESSURE ULCERS**
Introduction

“I had an operation on my gall bladder. I told the staff I was prone to getting pressure sores. They assured me I would not get any while in their care. Low and behold when I came around from the anaesthetic, they found a beauty...it is now six and a half years old”

(person with a spinal injury)

Background
Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and their carers (Franks et al, 1999). The financial costs to the NHS are also substantial (Cullum et al, 1995). It has been estimated that preventing and treating pressure ulcers in a 600-bed general hospital costs between £600,000 and £3 million a year (Touche Ross, 1993). Collier, 1999a, applying a similar formula to Hibbs, 1988, calculated the cost of treating a patient with a Grade IV pressure ulcer as £40,000.

Pressure ulcers, also known as pressure sores, decubitus ulcers and bedsores, are areas of localised damage to the skin and underlying tissue. They are thought to be caused by a combination of pressure, shear and friction (Allman, 1997). Collier, 1996, defines them as:

“...skin ulceration as a result of pressure in combination with the effects of other variables”

Acute illness/trauma and immobility are key variables but others identified in the proceeding recommendations, are also believed to play a part

Pressure ulcers usually occur over bony prominences and should be graded or staged to classify the degree of tissue damage observed. Unfortunately they are a common occurrence. A well-quoted study found new pressure ulcers occurring in 4 to 10% of patients admitted to a UK District General Hospital (Clark and Watts, 1994), dependent upon the patient case mix.

The human and financial cost of pressure ulcers, together with a variation in practice across the UK and a growing body of knowledge about effectiveness, have highlighted the need for recommendations for practice.

In response, the NHSE commissioned the Royal College of Nursing (RCN) to produce an evidence-linked clinical guideline on risk assessment and prevention of pressure ulcers. The guideline complements and builds on the work of others, such as the European Pressure Ulcer Prevention Guidelines (EPUAP, 1999).

The guidelines
The guidelines provide health care professionals with recommendations which:

✦ help early identification of patients at risk of developing pressure ulcers
✦ suggest preventive interventions
✦ point out practice that may be harmful or ineffective.

The guideline’s overall aim is to help reduce the occurrence of pressure ulcers. It comprises six sections:

✦ Quick reference guide and summary of recommendations
✦ Philosophy of care which makes suggestions about the environment within which the recommendations should be implemented
✦ Evidence-linked recommendations for:
  – identifying individuals at risk
  – use of risk assessment scales
  – recognising risk factors
  – skin inspection
  – pressure redistributing devices
  – use of aids
  – positioning
  – seating
  – education and training.
✦ Essentials of care which identifies the practice issues of nutrition, continence management and hygiene and their role in pressure ulcer development
✦ Quality improvement which includes a quality improvement cycle, monitoring, discharge planning, and audit information
✦ Glossary of terms
The guideline does not cover the epidemiology of pressure ulcers or make recommendations for wound care and/or the surgical management of pressure damage.
**Intended users of the guideline**

To provide a co-ordinated approach, risk assessment and prevention of pressure ulcers should be seen as an inter-disciplinary issue.

This guideline is intended to be used by all health care staff including: managers, professionals allied to medicine, nurses, doctors, equipment suppliers and academics. It could also be adapted for use by patients and carers.

**Patients and settings**

The recommendations are for patients (adults and children) who have no pressure ulcers, seen in hospital, nursing homes, supported accommodation and at home. They do not include treatment of existing pressure ulcers.

However, in cases where a patient has a pressure ulcer, they will be useful in preventing pressure ulcers on other areas of the body. Patients (adults and children) are referred to as individuals, persons or users throughout the guideline.

**Overview of guideline development method**

A project officer developed the guideline in collaboration with an inter-disciplinary group, including users and carers. See Appendix 1 for a brief overview of the method.

Full details about the development of the guideline can be found in the Technical Report (Rycroft-Malone and McInnes, 2001), the definitive document which includes method and recommendations (available at www.rcn.org.uk).

Evidence considered for this guideline has come from a number of sources:

- the Agency for Health Care Policy and Research (AHCPR, 1992) evidence-linked guideline Pressure ulcers in adults: prediction and prevention
- an update of sections of their research base (Rycroft-Malone and McInnes, 2000)
- the Effective Health Care Bulletin The prevention and treatment of pressure sores (EHCB, 1995)
- a systematic review of the effectiveness of pressure redistributing devices (Cullum et al, 2000)
- a systematic review of the effectiveness of risk assessment tools (McGough, 1999)
- the results of a formal consensus process (Rycroft-Malone, 2000).

As the above indicates, two clinical issues have recently been the subject of systematic review: risk assessment scales (McGough, 1999) and pressure redistributing devices (EHCB, 1995; Cullum et al, 2000). Their results provided some evidence that could be translated into recommendations. Both authors reported on the poor quality of the studies available for review and highlighted the need for good quality research in these areas.

The AHCPR guideline (1992) included a literature review of topics such as skin care, positioning and education. An updated literature review of these areas (1991-1998) revealed little good research evidence had emerged in the interim period (Rycroft-Malone and McInnes, 2000). In the light of this, a formal consensus development process was used to integrate the different evidence sources and, where there was a weak research base, agree recommendations based on current best practice.

**Evidence base**

The guideline is evidence-linked, rather than evidence-based. As there was insufficient evidence to guide all clinical decisions, a number of recommendations for practice were solely or partially based on consensus expert opinion. The recommendations were graded as follows:

**I Generally consistent finding in multiple acceptable studies**

**II Either based on a single acceptable study, or a weak or inconsistent finding in multiple acceptable studies**

**III Limited scientific evidence which does not meet all the criteria of acceptable studies or absence of directly applicable studies of good quality. This includes expert opinion.**

(‘acceptable’ for this guideline refers to those that have been subjected and approved by a process of critical appraisal, see Technical Report for more details).

Additionally, some recommendations have figures next to them. These show the results of the formal consensus process – for example: (m 9, iqr 1.25). They refer to the median (m) and inter-quartile range (iqr) calculated from the consensus ratings. In this example, 9 was median (or average) rating, and an inter-quartile range
of 1.25 tells us that not everyone rated 9 – that is there was a distribution of scores. If everyone rated 9 the inter-quartile range would be 0. The larger the inter-quartile range, the lower the level of agreement within the group. Although these are consensus-rating scores, the group did consider research evidence together with their clinical opinion/expertise to make these judgements.

The evidence grade shows the type of evidence supporting each recommendation though it does not indicate the strength of each recommendation. All recommendations are endorsed equally and none are regarded as optional.

Guidance is provided for local application for recommendations where there is little available research, or where a review of the research has been inconclusive in its findings. For example, because the systematic review of risk assessment scales suggested a limited use and did not identify the superiority of one scale over another for predicting pressure ulcer development, the choice whether or not to use one is left up to individual health care delivery services.

Disclaimer

As with any clinical guideline, recommendations may not be appropriate for use in all circumstances. Clearly a limitation of a guideline is that it simplifies clinical decision-making (Shiffman, 1997). Decisions to adopt any particular recommendations must be made by the practitioner in the light of:

✦ available resources
✦ local services, policies and protocols
✦ the patient’s circumstances and wishes
✦ available personnel and equipment
✦ clinical experience of the practitioner
✦ knowledge of more recent research findings.

Updating of the guideline

The guideline was completed in Spring 2000. Resources permitting, the guideline would be reviewed and updated on a two-yearly basis by the RCN. The first revision would therefore begin in 2002.

Audit

Simple audit criteria are included in the section on Quality Improvement. They have been developed from the recommendations and may help in developing a local audit tool. The criteria require further development work and piloting.
Quick reference guide

**Admission to episode of care**

1.0 Identify those ‘at risk’

*Trigger factors*

No | Yes
---|---
Currently not at risk | Informal risk assessment
Re-assess when change in condition | Formal risk assessment
Only use risk assessment scale as aide memoire

**Consideration of**

3.0 Risk factors

Intrinsic | Extrinsic | Exacerbating
---|---|---

4.0 Skin inspection

Regular but responsive to individual condition, individual’s most vulnerable area

5.0 Pressure redistributing device based on individualised assessment, comfort, risk, results of skin inspection

6.0 Do not use water filled gloves, doughnut-type devices or sheepskins as pressure relieving aids.

7.0 Positioning


8.0 Seating

Assessment and position – seek advice.

**Essentials of care:**

Nutrition | Hygiene | Continence management
---|---|---

**Quality improvement:**

Monitoring | Discharge planning | Audit
---|---|---

**Repositioning**

Change device in response to change of level of risk, results of skin inspection

**Figure 1. Quick Reference Guide**

Numbers refer to the recommendations that follow
Summary of recommendations

1.0 Identifying individuals ‘at risk’

1.1 Assessing an individual’s risk of developing pressure ulcers should involve both informal and formal assessment procedures.

1.2 Risk assessment should be carried out by personnel who have undergone appropriate and adequate training to recognise the risk factors that contribute to the development of pressure ulcers and how to initiate and maintain correct and suitable preventive measures.

1.3 The timing of risk assessment should be based on each individual case. However, it should take place in under six hours of the start of admission to the episode of care.

1.4 If considered not at risk on initial assessment, reassessment should occur if there is a change in an individual’s condition.

1.5 All formal assessments of risk should be documented/recorded and made accessible to all members of the inter-disciplinary team.

2.0 Use of risk assessment scales

2.1 Risk assessment tools should only be used as an aide memoire and should not replace clinical judgement.

2.2 If use of a risk assessment tool is preferred, it is recommended that a scale that has been tested for use in the same specialty is chosen.

3.0 Risk factors

3.1 An individual’s potential to develop pressure ulcers may be influenced by the following intrinsic risk factors which therefore should be considered when performing a risk assessment: reduced mobility or immobility; sensory impairment; acute illness; level of consciousness; extremes of age; vascular disease; severe chronic or terminal illness; previous history of pressure damage; malnutrition and dehydration.

3.2 The following extrinsic risk factors are involved in tissue damage and should be removed or diminished to prevent injury: pressure; shearing and friction.

3.3 An individual’s potential to develop pressure ulcers may be exacerbated by the following factors which therefore should be considered when performing a risk assessment: medication and moisture to the skin.

4.0 Skin inspection

4.1 Skin inspection should occur regularly and the frequency determined in response to changes in the individual’s condition in relation to both deterioration or recovery.

4.2 Skin inspection should be based on the individualised assessment of the most vulnerable areas of risk and therefore may include different or more areas which require inspection than those identified here: heels; sacrum; ischial tuberosities; parts of the body affected by anti-embolic stockings; parts of the body where pressure, friction and shear is exerted in the course of an individual’s daily living activities; parts of the body where there are external forces exerted by equipment and clothing; elbows; temporal region of skull; shoulders; back of head and toes.

4.3 Individuals who are willing and able should be encouraged, following education, to inspect their own skin.

4.4 Individuals who are wheelchair users should use a mirror to inspect the areas that they cannot see easily or get others to inspect them.
4.5 Health care professionals should be vigilant to the following signs which may indicate incipient pressure ulcer development: persistent erythema; non-blanching erythema; blisters; discolouration; localised heat; localised oedema and localised induration. In those with darkly pigmented skin: purplish/bluish localised areas of skin; localised heat which, if tissue becomes damaged, is replaced by coolness; localised oedema and localised induration.

4.6 Any skin changes should be documented/recorded immediately.

5.0 Pressure redistributing devices

5.1 Decisions about which pressure redistributing device to use should be based on an overall assessment of the individual and not solely on the basis of scores from risk assessment scales. Holistic assessment should include level of risk, comfort and general health state.

5.2 ‘At risk’ individuals should not be placed on standard foam mattresses.

5.3 Patients at very high risk of developing pressure ulcers should be placed on alternating pressure mattresses or other high-tech pressure redistributing systems.

5.4 Pressure redistributing overlays should be used on the operating table of individuals assessed to be at high risk of pressure ulcer development.

5.5 To ensure continuity of preventive care, post-operative management of at risk individuals should include the use of pressure redistributing mattresses.

5.6 Repositioning should occur when individuals are on pressure redistributing devices.

5.7 The benefits of a pressure redistributing device should not be undermined by prolonged chair sitting.

6.0 Use of aids

6.1 The following should not be used as pressure relieving aids: water filled gloves; synthetic sheepskins; genuine sheepskins and doughnut-type devices.

7.0 Positioning

7.1 Individuals who are ‘at risk’ of pressure ulcer development should be repositioned and the frequency of reposition determined by the results of skin inspection and individual needs not by a ritualistic schedule.

7.2 Repositioning should take into consideration other aspects of an individual’s condition – for example, medical condition, comfort, overall plan of care and support surface.

7.3 Individuals who are considered to be acutely ‘at risk’ of developing pressure ulcers should sit out of bed for less than two hours.

7.4 Positioning of patients should ensure that: prolonged pressure on bony prominences is minimised; bony prominences are kept from direct contact with one another and friction and shear damage is minimised.

7.5 A written/recorded re-positioning schedule agreed with the individual, should be established for each person ‘at risk’.

7.6 Individuals/carers who are willing and able should be taught to redistribute their own weight.

7.7 Manual handling devices should be used correctly in order to minimise shear and friction damage. After manoeuvring, slings, sleeves or other parts of the handling equipment should not be left underneath individuals.
8.0 Seating

8.1 Seating assessments for aids and equipment should be carried out by trained assessors who have the acquired specific knowledge and expertise (for example, physiotherapists/occupational therapists).

8.2 Advice from trained assessors with acquired specific knowledge and expertise should be sought about correct seating positions.

8.3 Positioning of individuals who spend substantial periods of time in a chair or wheelchair should take into account: distribution of weight; postural alignment and support of feet.

8.4 No seat cushion has been shown to out-perform another, therefore no recommendation can be made about which type to use for pressure redistribution purposes.

9.0 Education and training

9.1 Health care professionals should be trained/educated in pressure ulcer risk assessment and prevention.

9.2 Health care professionals with recognised training in pressure ulcer management should cascade their knowledge and skills to their local health care teams.

9.3 An inter-disciplinary approach to the training and education of health care professionals should be adopted.

9.4 Training and education programmes should include: risk factors for pressure ulcer development; pathophysiology of pressure ulcer development; the limitations and potential applications of risk assessment tools; skin assessment; skin care; selection of pressure redistributing equipment; use of pressure redistributing equipment; maintenance of pressure redistributing equipment; methods of documenting risk assessments and prevention activities; positioning to minimise pressure, shear and friction damage including the correct use of manual handling devices; roles and responsibilities of inter-disciplinary team members in pressure ulcer management; policies and procedures regarding transferring individuals between care settings; patient education and information giving.

9.5 Patients who are able and willing should be informed and educated about risk assessment and resulting prevention strategies. This strategy should include carers where appropriate.

9.6 Patient/carer education should include providing information on the following: the risk factors associated with them developing pressure ulcers; the sites that are of the greatest risk to them of pressure damage; how to inspect skin and recognise skin changes; how to care for skin; methods for pressure relief/reduction; where they can seek further advice and assistance should they need it; emphasise the need for immediate visits to a health care professional should signs of damage be noticed.
Philosophy of care

This philosophy of care describes the ideal context in which to implement the recommendations in this guideline.

**Person-centred care**
The rights of patients and their carers to be fully informed and share in decision-making is a central tenet of a number of recent policy documents – for example *The New NHS. Modern. Dependable* (DoH, 1997); *Our Healthier Nation* (DoH, 1999); and, specifically about the rights of the child, the United Nations convention (United Nations, 1991).

Involvement and partnership in care are central to the delivery of a service which responds to users’ individual needs.

✦ Users should be made aware of the guideline and its recommendations.
✦ Users should be involved in all aspects of pressure ulcer risk assessment and prevention, from involvement in assessment to shared decision-making about pressure redistributing devices.
✦ Health professionals are advised to respect and incorporate the knowledge and experience of people who have been at long-term risk of developing pressure ulcers and have been self-managing this risk.
✦ Users should be informed of their risk of developing pressure ulcers, especially when they are transferred between care settings or discharged home.

**A collaborative inter-disciplinary approach to care**
Pressure ulcer risk assessment and prevention should be seen as an inter-disciplinary issue. Adopting a team approach requires each member of the team to take responsibility for facilitating and improving communication, sharing care and responsibility for care. Such an approach requires health care professionals to understand and respect each other’s roles in the delivery of that care.

✦ All members of the inter-disciplinary team should be aware of the guideline and its recommendations.
✦ Health care teams need to articulate the role of each member in the management of risk assessment and prevention of pressure ulcers.

**Organisational issues**
Organisational issues influence the quality of pressure ulcer risk assessment and prevention. Health care service providers need to ensure:

✦ an integrated approach to pressure ulcer prevention with clear strategy and policy supported by management.
✦ care delivered in a context of continuous quality improvement where improvements to care following guideline implementation are the subject of regular feedback and audit.
✦ commitment to and availability of education and training to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge base and are able to implement the guideline recommendations.
✦ patients are cared for by trained staff, and that staffing levels and skill mix reflect the needs of patients.
Recommendations

1.0 Identifying individuals ‘at risk’

One of the first activities in preventing pressure ulcers is the early identification of individuals who are susceptible to developing them. If a person is identified as susceptible or ‘at risk’, it is the health care professional’s duty to ensure that preventive measures are implemented. The earliest phases of pressure ulcer development may show no outward visible signs of damage. Therefore it is important that individuals ‘at risk’ are given an immediate prevention plan.

1.1 Assessing an individual’s risk of developing pressure ulcers should involve both informal and formal assessment processes.

On initial contact with the health care system:
◆ all individuals should have an informal risk assessment, based on their clinical presentation and consideration of risk factors.

Trigger factors which identify a susceptible individual – for example immobility, acute illness or trauma, altered level of consciousness (see 3.0 Risk factors for further triggers) – will alert practitioners to conduct a full:
◆ formal assessment, where an individual’s risk is systematically and explicitly conducted via a structured risk assessment framework. Formal assessments should be routine for all in-patients (m 9, iqr 1.5) and all those seen on domiciliary visits (m 7, iqr 4.5).

1.2 Risk assessment should be carried out by personnel who have undergone appropriate and adequate training to recognise the risk factors that contribute to the development of pressure ulcers and how to initiate and maintain correct and suitable preventive measures.

Traditionally, the preferred member of the team to perform the risk assessment has been a trained nurse who has the acquired specific knowledge and expertise (m 9, iqr 0). However, if training has been completed, and knowledge and expertise acquired, risk assessment should also be carried out by doctors (m 9, iqr 2), ambulance personnel (m 9, iqr 3), therapists (m 8.5, iqr 3.75), health care assistants (m 8.5, iqr 3.75) and/or carers.

1.3 The timing of risk assessment should be based on each individual case. However, it should take place in under six hours of the start of admission to the episode of care (m 9, iqr 1).

It should be recognised that in some situations – for example acute and critical care – risk assessment should be carried out immediately so as not to delay appropriate preventive measures.

1.4 If considered not at risk on initial assessment, reassessment should occur if there is a change in an individual’s condition (m 9, iqr 0.25).

Risk assessment should be regarded as a dynamic process. Individuals, regardless of their initial admission status, could become ‘at risk’ during their contact with the health care system – for example because of a general deterioration in condition or undergoing surgery.

1.5 All formal assessments of risk should be documented/recorded (m 9, iqr 0) and made accessible to all members of the inter-disciplinary team (m 9, iqr 0).

Good documentation provides an accurate record of an individual’s progress and risk status, and is key for accountability, responsibility, risk management and evaluation.

Strength of Evidence III
These recommendations are based on principles of good practice and the nominal group’s clinical experience and opinion.

2.0 Use of risk assessment scales

2.1 Risk assessment scales should only be used as an aide memoire and should not replace clinical judgement.

Various scales have been developed to identify individuals at risk of developing pressure ulcers. Most scales have been developed in an ad hoc fashion based on opinions of the relative importance of possible risk factors (EHCB, 1995).

A recently completed systematic review (McGough, 1999) revealed that only the Braden scale has been tested for its predictive validity in comparison to nursing clinical judgement (Salvadalena et al, 1992; VandenBosch et al, 1996, cited McGough, 1999). These two clinical trials did not demonstrate the scale to be of greater predictive value than clinical judgement.
There is insufficient evidence to recommend one risk assessment scale as unambiguously superior to another, or a scale that is appropriate for use in all care settings (McGough, 1999). As the predictive validity of the six risk assessment scales (Anderson, Braden, Knoll, Norton, Pressure Sore Prediction Scale and Waterlow) is variable, both in comparison with each other and in relation to assessments made of the same scale, on evidence to date it is not possible to make valid comparisons.

**Strength of Evidence I**

McGough (1999) selected 18 studies which met the criteria for inclusion in her systematic review of the effectiveness of risk assessment tools. Findings from prospective cohort studies led her to conclude risk assessment scales may be useful ‘aide memoires’ for staff but should not replace clinical judgement (see Appendix 2 for table of included studies). McGough found:

- 61% of the scales that have been the subject of study are modifications of original scales, where the risk factors included in the original versions have never been questioned
- 86% of the scales had not been tested for their reliability and validity
- many of the studies reviewed were of poor quality in respect of methodological rigour, sample sizes and populations, and outcome measurement, resulting in them being susceptible to bias.

2.2 If use of a risk assessment tool is preferred, it is recommended that a scale that has been tested for use in the same specialty is chosen.

If a risk assessment tool is to be used to assist with clinical judgement, McGough suggests that local testing should establish an appropriate cut-off point to indicate risk (‘threshold’), that is, the score at which an individual falls into the ‘at risk’ category.

**Strength of Evidence III**

This recommendation is based on the opinion of the systematic review author (McGough, 1999).

**3.0 Risk factors**

3.1 An individual’s potential to develop pressure ulcers may be influenced by the following intrinsic risk factors which therefore should be considered when performing a risk assessment:

- Reduced mobility or immobility (m 8, iqr 2.5) A key factor in the development of pressure ulcers is reduced mobility or immobility. A number of studies have identified reduced mobility as an independent risk factor in pressure ulcer development.

In a prospective inception cohort study of patients fulfilling certain criteria admitted to a US tertiary university teaching hospital, Allman et al, 1995, found that a significant risk factor in patients who went on to develop sores was immobility.

- Sensory impairment (m 9, iqr 0) For example neurological disease results in reduced sensation and thus insensitivity to pain or discomfort. This results in a reduced (or lacking) stimulus to move to relieve pressure. There are certain groups of individuals that may suffer from sensory neuropathy, for example those with diabetes and spinal injuries.

- Acute illness (m 9, iqr 1) Clinical experience, observation and emerging research suggests that acutely ill patients are vulnerable to developing pressure ulcers. This is because of heart failure, vasomotor failure, vasoconstriction due to shock, pain, low blood pressure (Bliss, 1990) and temperature change – for example during and after anaesthesia (Scott, 2000).

- Level of consciousness (m 8, iqr 2) A reduced level of consciousness may reduce an individual’s awareness of the need to relieve pressure. Likewise an anaesthetised person has no independence to reposition themselves.

- Extremes of age (up to 65, less than 5 years of age) (m 7, iqr 3.25) Advancing age is associated with an increase in cardiovascular and neurological disease, and changes to the resilience and elasticity of the skin. Individuals over 65 years of age are at greater risk than the general population of developing pressure ulcers (Verluysen, 1986; Bergstrom et al, 1996; Bergstrom, Braden 1992).

Neonates and very young children are also at a greater risk. Their skin is still maturing and their head-to-body weight is disproportionate. It is currently thought that the factors that place children (m 8, iqr 3) and neonates (m 7, iqr 3.5) at risk are the same that place adults at risk, but the sites of greatest risk for pressure damage and the nature of the injury may differ. For example, there is greater risk of pressure damage to points on the head, on the ears from repeated oxygen saturation measurement, from repeated heel pricks for blood monitoring and an increased risk from extravasation.
Previous history of pressure damage (m 9, iqr 2) places individuals at a greater risk of developing further ulcers than previously pressure ulcer free patients (Berlowitz and Wilking, 1990; Bergstrom and Braden, 1992; Clark and Watts, 1994).

Vascular disease (m 8.5, iqr 2) reduces total blood flow and impairs micro circulation potentially making patients more vulnerable to pressure necrosis.

Severe chronic or terminal illness (m 8, iqr 2.25) places individuals at greater risk because of, for example, multi-organ failure, poor perfusion and immobility.

Malnutrition (m 7.5, iqr 3.5) and dehydration (m 8.5, iqr 2.25), while not directly linked to pressure ulcer development, malnutrition may increase an individual’s risk of organ failure and serious illness. Related to this is body weight, both emaciated (Allman et al, 1995) and obese individuals may be more vulnerable to pressure damage. Dehydration may reduce the elasticity of tissues and thus increase tissue deformability under pressure or friction (see Essentials of Care section).

3.2 The following extrinsic risk factors are involved in tissue damage and should be removed or diminished to prevent injury:

Pressure which causes compression and possible capillary occlusion, which if prolonged can lead to ischaemia. How high the pressure must be and how long it must be exerted to cause damage depends on the individual’s tissue tolerance. The key factors are intensity and duration of pressure.

Shearing occurs when the skeleton and deep fascia slide downwards with gravity, whilst the skin and upper fascia remain in the original position. Deep necrosis can occur when the shearing between two layers of tissue leads to stretching, kinking and tearing of vessels in the subcutaneous tissues. Shearing forces should not be considered separately from pressure: they are an integral part of the effect of pressure. Shearing most often occurs when individuals slide down or are dragged up a bed or chair.

Friction occurs when two surfaces move across each other. It often removes superficial layers of skin. Friction damage often occurs as a result of poor lifting techniques (Defloor, 1999).

Medication (m 7.5, iqr 2.5) – for example:

- sedatives and hypnotics may make an individual excessively sleepy and thus reduce mobility
- analgesics may reduce normal stimulus to relieve pressure
- inotropes cause peripheral vasoconstriction and tissue hypoxia
- non-steroidal anti-inflammatory drugs impair inflammatory responses to pressure injury.

This medication list is not exhaustive, practitioners should refer to pharmacists for specialist advice.

Moisture to the skin (m 7, iqr 1.75) – for example urinary and faecal incontinence, wound drainage and sweat (see section on Essentials of Care) are potential irritants to the skin.

Strength of Evidence II

These recommendations have been identified from cohort studies (Bergstrom and Braden, 1992; Papantonio et al, 1994; Bradeis et al, 1994; Allman et al, 1995; Bergstrom et al, 1996), the logic and principles of physiology, and are supported by opinion and experience. There is a need for further epidemiological research to improve our understanding of risk factors and the relative contribution they make to the development of pressure ulcers (McGough, 1999).

4.0 Skin inspection

Skin inspection provides essential information for both assessment and prevention. Although the precise role that skin inspection plays in decreasing the incidence of pressure ulcers has not been determined, regular assessment of the most vulnerable parts of the body will enable early detection of incipient pressure damage.

4.1 Skin inspection should occur regularly and the frequency determined in response to changes in the individual’s condition in relation to both deterioration or recovery (m 9, iqr 0).

4.2 Skin inspection should be based on the individualised assessment of the most vulnerable areas of risk and therefore may include different or more areas which require inspection than the examples identified below.

4.3 Individuals who are willing and able should be encouraged, following education, to inspect their own skin (m 9, iqr 0).
4.4 Individuals who are wheelchair users should use a mirror to inspect the areas that they cannot see easily (m 9, iqr 0) or get others to inspect them.

4.5 Health care professionals should be vigilant to the following signs which may indicate incipient pressure ulcer development:

- Heels (m 9, iqr 0)
- Sacrum (m 9, iqr 0)
- Ischial tuberosities (m 9, iqr 0)
- Parts of the body that are affected by the wearing of anti-embolic stockings (m 9, iqr 0)
- Trochanter (m 9, iqr 0)
- Parts of the body where pressure, friction or shear is exerted in the course of an individual’s daily living activities e.g. on the hands of wheelchair users (m 9, iqr 1)
- Part of the body where external forces exerted by equipment and clothing e.g. endotracheal tubes, intravenous lines, sites of pulse oximetry, catheters, shoes, elastic clothing (m 9, iqr 1)
- Elbows (m 7, iqr 1)
- Temporal region of the skull (m 7, iqr 1.25)
- Shoulders (m 7, iqr 2.25)
- Back of head (m 7, iqr 1.75)
- Toes (m 7, iqr 2.5)

It may not be possible to see the redness/erythema associated with tissue damage in people with darkly pigmented skin. Health care professionals need to be vigilant to the following signs, which may indicate incipient pressure ulcer development in people with darkly pigmented skin (Bennett, 1995):

- Persistent erythema (m 9, iqr 0.25)
- Non-blanching hyperaemia (m 8, iqr 3.25)
- Blisters (m 8, iqr 3.25)
- Discolouration (m 7.5, iqr 4)
- Localised heat (m 7, iqr 2.5)
- Localised oedema (m 7, iqr 1.5)
- Localised induration (m 7.5, iqr 2)

4.6 Any skin changes should be documented/recorded immediately (m 9, iqr 0) including a detailed description of what is observed and any action taken.

Strength of Evidence III

These recommendations are supported by principles of best practice and the nominal group’s clinical experience and opinion.

5.0 Pressure redistributing devices

5.1 Decisions about which pressure redistributing device to use should be based on an overall assessment of the individual and not solely on the basis of scores from risk assessment scales.

A recent systematic review (McGough, 1999) concluded that there was insufficient evidence to recommend using risk assessment scale scores on which to base or support decisions about choices of pressure redistributing surfaces. It follows that if risk assessment scales should not be used in isolation to identify individuals at risk, they should not be used in isolation to instigate prevention strategies.

Decisions about support surfaces should be influenced by holistic assessment of an individual’s risk (m 9, iqr 4), his/her comfort (m 8, iqr 2.25) and general health state (m 8.5, iqr 1.25). Interface pressure measurements should not be used to make decisions about pressure redistributing devices (m 8.5, iqr 5.25) because they have not been demonstrated to predict reliably the performance of support surfaces (Cullum et al, 2000). Assessment should be on-going throughout an individual’s episode of care and the type of pressure relief support changed to suit any alteration in risk (m 7, iqr 5.5).

Strength of evidence I

Findings from prospective cohort studies led the reviewer to conclude that staff should not rely solely on risk assessment scale scores (McGough, 1999).

*previously identified as ‘non-blanching erythema’ – see glossary.
**Strength of evidence III**

This recommendation and suggested decision-making practice regarding choice of pressure redistributing devices is also supported by the nominal group's clinical experience and opinion.

5.2 ‘At risk’ individuals should not be placed on standard foam mattresses.

A recently completed systematic review (Cullum et al, 2000) concluded that standard foam mattresses have been consistently outperformed by a range of foam-based, low pressure mattresses and overlays, and also by ‘higher-tech’ pressure redistributing beds and mattresses. The results from four trials comparing foam alternatives with the standard hospital foam mattress (Gray and Campbell, 1994; Hofman, 1994; Santy, 1994 and Collier 1996, cited Cullum et al, 2000) were pooled to reveal that various foam alternatives can reduce the incidence of pressure ulcer development in ‘at risk’ patients. Another randomised, controlled trial (RCT) (Andersen, 1982, cited Cullum et al, 2000) comparing alternating pressure surfaces to standard foam mattresses, also reported a reduction in the incidence of pressure ulcers. Cullum et al, 2000, note that ‘standard’ was poorly described in many of the studies included in their review. ‘Standard’ varies by country, setting and over time.

Other studies comparing alternating pressure devices with a variety of constant low-pressure devices have not shown significant benefits to using one device over another. At present the clearest recommendation is that ‘at risk’ individuals should be placed on an alternative to the standard foam mattress.

**Strength of evidence I**

This recommendation is supported by the findings of a systematic review including 29 RCTs of support surfaces for pressure ulcer prevention (Cullum et al, 2000).

5.3 Patients at very high risk of developing pressure ulcers should be placed on alternating pressure mattresses or other high-tech pressure redistributing systems.

The EHCB (1995) advises that in the absence of clear evidence for an optimal strategy, patients at high risk such as those in intensive care, orthopaedic units or with neurological deficits should be placed on higher-tech surfaces. Cullum et al, 2000, report that the relative merits of alternating and constant low pressure, and of different alternating pressure devices are unclear. Many of the studies which compared devices did not adequately describe the equipment being used, and were small and thus under-powered to detect clinically important differences, even when studies were pooled. There is limited evidence to suggest that low air loss beds (compared to standard ICU beds) reduce the incidence of pressure ulcers in intensive care (Inman, 1993, cited Cullum et al, 2000).

**Strength of evidence II**

Advice from EHCB (1995) and one controlled trial.

**Individuals undergoing surgery**

5.4 Pressure redistributing mattresses/overlays should be used on the operating table of individuals assessed to be at high risk of pressure ulcer development.

Three RCTs have evaluated different methods of pressure relief on the operating table (Nixon et al, 1998; Aronovitch, 1998; Dunlop, 1998, cited Cullum et al, 2000). Their results suggest that a reduction in post-operative pressure ulcers can be achieved using an alternative support surface to a standard operating table.

The three RCTs evaluated different methods of pressure relief, however, it is currently unclear which type is the most effective (Cullum et al, 2000). Nixon et al, 1998, found dry visco-elastic polymer pads (Action Products Inc.) to be more effective than a standard table. Whilst Aronovitch, 1998, and Dunlop, 1998, reported in favour of the Micropulse system (an alternating pressure overlay) in comparison to gel pads during surgery and a standard mattress post-operatively.

Some laboratory research has suggested that the ‘standard’ operating table mattress may be difficult to define and that any pressure redistributing properties are dependent on each product’s construction (Scott et al, 1999). Individuals that may be at a high risk are those undergoing vascular surgery (m 8, iqr 2.25), orthopaedic surgery (m 9, iqr 3.25), surgery classed as major (m 8.5, iqr 1.5) and those with one or more risk factors (m 7.5, iqr 3.25).

**Strength of evidence I**

This recommendation is supported by the findings of a systematic review (Cullum et al, 2000) including three RCTs that evaluated support surfaces for pressure ulcer prevention on the operating table.
Strength of evidence III
Identified individuals based on the nominal group’s clinical experience and opinion.

Post-operative care
5.5 To ensure continuity of preventive care, post-operative management of ‘at risk’ individuals should include the use of pressure redistributing mattresses (m 9, iqr 1.25).

Strength of evidence III
This recommendation for practice is supported by the nominal group’s clinical experience.

General issues
5.6 Repositioning should occur when individuals are on pressure redistributing devices (m 8.5, iqr 0.25). Frequency of repositioning should be determined by the results of skin inspection (m 9, iqr 1.25), patient comfort (m 8, iqr 1.25) and general state (m 8, iqr 1.25). A change of support surface and/or a change in the frequency of repositioning may be necessary.

5.7 The benefits of a pressure redistributing device should not be undermined by prolonged chair sitting (m 8.5, iqr 6.5) (EHCB, 1995)

Strength of evidence III
These recommendations for practice are supported by the nominal group’s clinical experience and opinion, and the EHCB (1995).

6.0 Use of aids
6.1 The following should not be used as pressure relieving aids:
- water-filled gloves (m 9 iqr 0)
- synthetic sheepskins (m 9, iqr 2)
- genuine sheepskins (m 5, iqr 2.25)
- doughnut-type devices.

Doughnut-type devices are believed to adversely affect lymphatic drainage and circulation, and thus are likely to cause rather than prevent pressure ulcers (AHCPR, 1992). Water-filled gloves under heels are not effective because the small surface area of the heel means it is not possible to redistribute pressure by this localised method.

Sheepskins do provide comfort to some individuals, but they are not pressure relieving or redistributing aids. If sheepskins are used for comfort rather than perceived pressure relief, care is needed with regard to cross-infection and correct laundering processes.

Strength of Evidence III
This recommendation is based on the nominal group’s clinical experience and opinion, AHCPR recommendations (1992 M9 p26) and one trial. Cullum et al, 2000, reviewed one small trial of a standard hospital mattress with and without sheepskin overlays (Ewing et al, 1964). The trial was of poor quality and the results inconclusive.

7.0 Positioning
7.1 Individuals who are ‘at risk’ of pressure ulcer development should be repositioned (m 9, iqr 0.25). The frequency of repositioning should be determined by the results of skin inspection and individual needs (m 9, iqr 1.25) not by a ritualistic schedule. This will help to determine and ensure a responsiveness to the time it takes for an individual to show signs of incipient damage.

Repositioning should entail adequate position changes avoiding an individual’s vulnerable areas. In cases where individuals have determined their own routine to prevent the development of pressure ulcers, for example those with spinal injury, their knowledge and routine should be respected by health care professionals.

7.2 Repositioning should take into consideration other aspects of an individual’s condition – for example breathing and medical condition (m 9, iqr 0.25), their comfort (m 9, iqr 1.25), how it fits into their overall plan of care (for example in relation to other activities such as physiotherapy or occupational therapy, meal times, attending to personal hygiene) (m 8, iqr 2.25) and the surface they may be lying or sitting on.

7.3 Individuals who are considered to be acutely ‘at risk’ of developing pressure ulcers should restrict chair sitting to less than two hours (m 8.5, iqr 0.5) until their general condition improves.

7.4 Positioning of patients should ensure that:
- prolonged pressure on bony prominences is minimised (m 8, iqr 1.25)
- bony prominences are kept from direct contact with one another (m 9, iqr 0.25)
friction and shear damage is minimised.

7.5 A written/recorded re-positioning schedule agreed with the individual should be established for each person at risk (m 9, iqr 1.25). This record should also include actual position changes.

7.6 Individuals/carers who are willing and able should be taught to redistribute their own weight (m 9, iqr 1).

7.7 Manual handling devices should be used correctly in order to minimise shear and friction damage. After manoeuvring, slings, sleeves or other parts of the handling equipment should not be left underneath individuals (m 8, iqr 4), as this practice may result in tissue damage. Correct lifting and handling techniques will also reduce the risk to carers’ backs.

**Strength of Evidence III**

These recommendations are supported by the nominal group’s clinical experience and opinion and some of the AHCPR (1992) guideline recommendations (M1 p22, M6 p24, M11 p27).

While manual repositioning is an established part of pressure ulcer prevention practice, there is little research demonstrating its effectiveness or the optimal frequency for manual repositioning (EHCB, 1995). However, the nominal group felt that repositioning where appropriate, should form part of pressure relieving practice and should incorporate the principles identified in the above recommendations.

Additionally, a study conducted by Gebhardt and Bliss (1994) compared the outcomes of two groups of elderly orthopaedic patients – one group sat out for unlimited periods and the other sat out for no more than two hours. They found a positive correlation between pressure ulcer development and length of time sitting in a chair.

There is an increasing body of knowledge about the use of the 30 degree lateral tilt (Defloor, 1997; Colin et al, 1996). A study of a small sample of healthy volunteers (n=20) found an impairment of oxygen supply to the skin in the 90 degree laterally inclined individuals but not in the 30 degree laterally inclined position (Colin et al, 1996).

This is a promising approach to positioning that requires further systematic evaluation before it can be recommended as ‘standard’ practice. However, it is a lying position that could be used for individuals who find it comfortable.

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**8.0 Seating**

8.1 Seating assessments for aids and equipment should be carried out by trained assessors who have the acquired specific knowledge and expertise (for example, physiotherapists/occupational therapists) (m 9, iqr 1.25).

8.2 Advice from trained assessors with acquired specific knowledge and expertise should be sought about correct seating positions (m 8, iqr 2).

8.3 Positioning of individuals who spend substantial periods of time in a chair or wheelchair should take into account:

- distribution of weight (m 9, iqr 1.25)
- postural alignment (m 9, iqr 1)
- support of feet (m 9, iqr 1).

8.4 No seat cushion has been shown to out-perform another, therefore no recommendation can be made about which type to use for pressure redistribution purposes.

**Strength of Evidence III**

These recommendations are supported by the nominal group’s clinical experience and opinion.

Cullum et al, 2000, reviewed two RCTs that compared different types of seating cushions. Lim et al, 1988, compared a slab with a bespoke contoured foam cushion and found no difference in pressure ulcer incidence. The other trial (Conine et al, 1994) compared Jay gel and foam wheelchair cushion with a foam cushion. Although they reported a reduced incidence of pressure ulcer development, this was not found to be statistically significant.

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**9.0 Education and training**

Education of staff and users should be an integral part of any pressure ulcer prevention strategy (Dealey, 1997).

The training and education of users and health care professionals should be tailored to the needs and requirements of the individual and particular professional group. However, there are generic components that should be included in all training programmes.
For all health care professionals

9.1 Health care professionals should be trained/educated in pressure ulcer risk assessment and prevention.

9.2 Health care professionals with recognised training in pressure ulcer management should cascade their knowledge and skills to their local health care teams (m 9, iqr 0).

9.3 An inter-disciplinary approach to the training and education of health care professionals should be adopted (m 9, iqr 0).

9.4 Training and education programmes should include the following:

- risk factors for pressure ulcer development (m 9, iqr 2.25)
- pathophysiology of pressure ulcer development (m 9, iqr 0.5)
- the limitations and potential applications of risk assessment tools (m 9, iqr 2.25)
- skin assessment (m 9, iqr 0.5)
- skin care (m 9, iqr 2.25)
- selection of pressure redistributing equipment (m 9, iqr 0.25)
- use of pressure redistributing equipment (m 9, iqr 1)
- maintenance of pressure redistributing equipment (m 8.5, iqr 1.25)
- methods of documenting risk assessments and prevention activities (m 9, iqr 1)
- positioning to minimise pressure, shear and friction damage, including the correct use of manual handling devices (m 9, iqr 0.25)
- roles and responsibilities of inter-disciplinary team members in pressure ulcer management (m 9, iqr 1.25)
- policies and procedures regarding transferring individuals between care settings (m 9, iqr 1)
- patient education and information giving (m 9, iqr 1)

Strength of Evidence II

Findings from observational studies by Bergstrom et al, 1995, and Moody et al, 1988, citing McGough systematic review, 1999, suggest that education programmes may reduce incidence and prevalence of pressure ulcer development. A continuous quality assurance approach would advocate that increasing people’s awareness about pressure ulcer risk assessment and prevention, via a co-ordinated and structured educational programme, is more likely to result in benefits for patients than providing no programme, although the effectiveness of educational programmes and what they consist of is currently lacking a reliable research base. These recommendations are supported by AHCPR guideline recommendations (1992, E2:p28), consensus opinion and principles of patient education.

For users and carers

9.5 Patients who are able and willing should be informed and educated about risk assessment and resulting prevention strategies. This strategy, where appropriate, should include carers. This information should be tailored to individual requirements. Written information can enhance verbal explanation. The education process should be two way, and patients’/carers’ previous knowledge and experience respected.

9.6 Patient/carer education should include providing information on the following:

- risk factors that are associated with developing pressure ulcers (m 9, iqr 1)
- sites that are of the greatest risk of pressure damage (m 9, iqr 1)
- how to inspect skin and recognise skin changes (m 9, iqr 0.25)
- how to care for skin (m 9, iqr 0.25)
- methods for pressure relief/reduction (m 9, iqr 0.25)
- where they can seek further advice and assistance should they need it (m 9, iqr 0)
- emphasis on the need for immediate visits to a health care professional should signs of skin damage be noticed.

Strength of Evidence III

These recommendations are supported by AHCPR guideline recommendations (E1:p27, 1992), consensus opinion, principles of patient education and one survey which found that individuals who waited longer to go to a clinic presented with more severe pressure damage (Garber et al, 1996).
Essentials of care

Nutritional status, continence management and hygiene are essential aspects of care. Their association with pressure ulcer risk assessment and prevention is well documented but not fully understood from the current evidence base, including consensus opinion. Therefore separate recommendations about these issues have not been devised, but in recognition that they are key to raising standards of care (RCN, 1999), this section outlines some principles for practitioners to consider.

Nutritional status

Malnutrition is frequently cited as a risk factor for the presence, development and non-healing of pressure ulcers. Nutritional status influences the integrity of the skin and support structures, and a lack of vitamins and trace elements may predispose the patient to increased risk of pressure damage (Cullum and Clark, 1992). Emaciated and obese people have also been associated with being at a higher risk (Allman et al, 1995; Pope, 1999).

However the relationship between nutritional status and pressure ulcers is complex. For example, the poor nutritional status of a person with pressure ulcers may be as much a marker of poor overall health status than as a result of poor nutritional intake. In which case, improving nutritional status per se would not improve the outcome for the patient (Finucane, 1995).

Despite a general belief among health care professionals that there is a link between pressure ulcer development and nutritional status, there is currently no research evidence to make this causative association.

Best practice entails monitoring the nutritional status of individuals as part of a holistic assessment procedure and as an ongoing process throughout an individual’s episode of care. Initially, this assessment should include documentation and monitoring of the following factors:

✦ current weight and height
✦ recent weight loss
✦ usual eating habits
✦ recent changes in eating habits and intake.

If nutritional risk is suspected, practitioners should undertake more detailed screening. A formal nutritional risk assessment scale may be preferred to help with this and nutritionally compromised individuals should be referred to a dietitian.

Continence management

Incontinence is often said to increase the risk of developing pressure ulcers. As with nutritional status, the relationship between incontinence and pressure ulcers is not as obvious as is presumed (Defloor, 1999). Some studies have supported the role of incontinence as a risk factor (Goldstone and Goldstone, 1982) and others have not (Berlowitz and Wilking, 1989).

The key factor is moisture to the skin, which puts it at greater risk from maceration, friction and shearing forces. Therefore the key practice issue is the presence or absence of wet skin (Defloor, 1999). As such, effective management of incontinence is an essential part of skin care and fundamental to maintaining a person’s dignity and comfort.

Where the source of moisture cannot be controlled, the use of moisture-absorbing or continence aids could be considered. The use of such aids should not interfere with any pressure redistributing surface an individual may be placed on. Referral to a continence advisor should also be considered on an individual basis.

Hygiene

An individual’s skin may be exposed to a variety of moist substances – urine, faeces, perspiration and wound drainage – which may make it more susceptible to injury. The AHCPR (1992) guideline recommends that: skin cleansing should occur at the time of soiling; mild detergents should be used and warm (rather than hot) water to minimise irritation and drying; and moisturisers should be applied to areas of dry skin. Skin rubbing and massage, particularly over bony prominences should be avoided (Dyson, 1978).
Quality improvement

Quality improvement is about constantly looking for ways to do things better (Morrell and Harvey, 1999). It is an iterative process, and requires the commitment of the whole organisation and its stakeholders to work effectively. Figure 2 offers an example of a quality improvement cycle and related activities for pressure ulcer prevention.

**Evaluation**
- Reduce occurrence of pressure ulcers
  - audit data
  - outcome indicators
  - patient/carer feedback

**Implementation and change**
- communication strategy
- education/training
- facilitators/facilitation
- charge strategy

**Research**
- questions arising from evaluation and change processes

**Problem identification**
- prevalence and incidence results
- patient feedback

**Examination of current practice**
- identifying those at risk, use of risk assessment scales, allocation of redistributing devices

**Evidence**
- find, critically appraise and synthesise research on risk assessment, prevention practices, patient experiences/preferences, education and training, or:
  - evaluate suitability of national guideline for local adaptation into a protocol. This will still require the collection of research, information and patient preferences

**Inter-disciplinary collaboration**

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### Monitoring pressure ulcers

The presence or absence of pressure sores is often seen as an indicator of quality of care and as such is high on the political agenda (Benchmarking DoH, 2000; Pressure sores: a key quality indicator DoH, 1993; and Health of the Nation, DoH, 1992).

Incidence and prevalence are the two ways to measure pressure ulcer frequency.

Prevalence is the proportion of people with pressure ulcers in a defined period of time. This is affected by, for example, people admitted with existing ulcers, patient healing rates, rates of discharge and successful treatment.

Incidence is the rate at which people initially admitted without an ulcer develop one during a specific period of time. This may be determined by the type of patients admitted (for example those at high risk) and the effectiveness of preventive care.

Comparisons of prevalence between and within care settings are difficult to interpret because they are affected by incidence, healing rates, admission and discharge policies. The measurement of incidence gives a more accurate picture of the success and effectiveness of risk assessment and prevention policies because it identifies those people who have developed ulcers over time and in a particular place of care. Measures of incidence need to be adjusted in the light of the type and number of ‘at risk’ patients admitted into the particular care settings.

The Benchmarking Fundamental Aspects of Nursing Care project (NHSE, 2000) will also provide a staged approach for practitioners to facilitate the development of practice in pressure area care. Benchmarks are being developed based on opinion about best practice, with the intention that practitioners use them to score their own current practice and compare this with ‘best practice’, by sharing examples and networking with others.
Discharge planning

Effective, successful discharge depends on the setting up of care packages based on the needs of the individual. When transferring an ‘at risk’ patient between care settings and/or to their home, the following factors need to be addressed and communicated:

- Identification of a specific professional who will be responsible for the management of the patient following discharge
- Assessment and indication of level of risk, including date of last assessment – if a risk assessment scale has been used, then the name of the scale should be documented not the score, as scores on one scale mean a different thing on another
- A description of the condition of the person’s pressure areas
- Details of any tissue damage, including size, grade, position and treatment
- Preventive measures the person has required, including the type of pressure re-distributing device(s) used
- Ensuring appropriate measures and equipment are in place prior to transfer or discharge
- Written and verbal information for users/carers about assessment and prevention should be provided.

Audit criteria

Clinical audit should form an integral of organisations’ clinical effectiveness activities. The principles and process of clinical audit are well documented (for greater detail see Morrell and Harvey, 1999). It has been defined as:

“...a clinically led initiative which seeks to improve the quality and outcome of patient care through clinicians examining and modifying their practices according to standards of what could be achieved, based on best evidence available or authoritative expert opinion where no objective research-based evidence exists.” (Mann, 1996)

Clinical audit should be based on the best available evidence and where national guidelines exist they should be used as a basis for audit activity. The following table provides some evaluative and descriptive statements derived from the recommendations, which could be incorporated into an audit tool.

Those developing measurement tools need to consider and adapt these into structure, process and outcome criteria (see Morrell and Harvey, 1999). Any tools or frameworks developed from the guideline should suit the particular characteristics of the clinical environment and patient caseload(s), and be piloted.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Audit criteria</th>
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<tbody>
<tr>
<td>Identifying ‘at risk’ individuals</td>
<td>✦ Has level of risk been assessed? On initial contact with the health care system:</td>
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<tr>
<td>Assess and record individuals’ level of risk of developing pressure ulcers</td>
<td>✦ Has an informal risk assessment on all individuals been conducted?</td>
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<td></td>
<td>✦ Has a formal assessment of risk been conducted on those people whose initial assessment highlighted factors (triggers) which place them at risk?</td>
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<td></td>
<td>✦ Has a formal assessment of risk been conducted routinely for in-patients and those visited on domiciliary visits?</td>
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<td></td>
<td>✦ Is the timing of risk assessment suitable for the patient’s condition?</td>
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<td></td>
<td>✦ In other cases has it taken place in under six hours of admission to the episode of care?</td>
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<td></td>
<td>✦ Are the results of the assessment recorded документирован?</td>
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<td></td>
<td>✦ Is an individual’s level of risk accessible to all members of the inter-disciplinary team?</td>
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<td></td>
<td>✦ Does reassessment of risk occur when an individual’s condition alters?</td>
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</tbody>
</table>

How to audit

Documentation/recording of process and results of risk assessment: time, date, personnel. If individual’s condition alters, is there a record of reassessment?

Is the documentation/records held in a place accessible to all members of the inter-disciplinary team?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Who carries out risk assessment</td>
<td>Has a suitably trained member of staff carried out the risk assessment(s)?</td>
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<tr>
<td>Risk assessment scales</td>
<td>How has risk assessment been performed?</td>
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<td></td>
<td>– Is there evidence that clinical judgement has also been involved in risk assessment activities?</td>
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<tr>
<td></td>
<td>– If a risk assessment tool is used – is it appropriate to the clinical speciality in which it is being used?</td>
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<tr>
<td>Skin inspection</td>
<td>Does skin inspection occur regularly and frequently in response to changes in an individual’s condition?</td>
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<td></td>
<td>Does skin inspection focus on areas of known vulnerability and also on areas of the body that are susceptible based on individualised assessment?</td>
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<td></td>
<td>Are changes documented immediately?</td>
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<tr>
<td>Pressure redistributing devices</td>
<td>Is the choice of pressure redistributing device based on an overall assessment of the individual?</td>
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<tr>
<td></td>
<td>What other factors were taken into account?</td>
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<td></td>
<td>Are individuals assessed to be ‘at risk’ on an alternative to a standard mattress?</td>
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<td></td>
<td>Are individuals assessed to be at high risk on an alternating pressure mattress or other high-tech device?</td>
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<td></td>
<td>Are support surfaces changed to meet alterations in an individual’s condition?</td>
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<td></td>
<td>Are individuals at high risk placed on pressure redistributing overlays during surgical procedures?</td>
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<td></td>
<td>Does post-operative care for these individuals include similar support surfaces?</td>
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<tr>
<td></td>
<td>Are individuals repositioned whilst on pressure redistributing devices?</td>
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<tr>
<td>Aids</td>
<td>Is there any evidence to suggest that inappropriate aids such as:</td>
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<td></td>
<td>– water-filled gloves</td>
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<td></td>
<td>– synthetic/genuine sheepskins</td>
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<tr>
<td></td>
<td>– donut type devices are being used?</td>
</tr>
</tbody>
</table>

Documentation/records to identify personnel carrying out risk assessment.
Records of training and education/induction programmes reflect attendees carrying out risk assessment.

Documentation/records of risk –
– name of the scale?
– evidence of scores?
– evidence of consideration of broader issues/risk factors (intrinsic/extrinsic/exacerbating)?
Ask health care personnel how level of risk has been assessed

Documentation/records show times, dates and results of skin inspection. Also documentation/records of action taken.
Observation of practice.
Ask health care professionals how skin inspection is performed and what signs they look out for.
Ask patients if their skin was inspected.

Documentation/records to include decision trail and factors taken into account when making decisions about support surfaces, including documentation/recording of any organisational constraints.
Accurate recording of what support surfaces individuals are on (e.g. care plans, records of hiring or equipment library records).
Mattress and support surface audits.

Documentation/records and observation of practice.
Repositioning

- Is there evidence that individuals assessed to be 'at risk' are being repositioned?
- Are repositioning schedules being tailored to individual needs and results of skin inspection?
- Do individuals have written repositioning schedules?
- Are correct lifting and handling procedures being adhered to?
- Is repositioning avoiding pressure on bony prominences?

Seating

- Are seating assessments carried out by appropriately trained assessors?
- Does positioning take into account:
  - distribution of weight
  - postural alignment
  - support of feet?
- Is chair sitting limited to a maximum of two hours for those at risk of developing pressure ulcers?

Education and training

- Are health care professionals trained in pressure ulcer risk assessment and prevention?
- What is included in this training?
- How is competence assessed?
- How is competence maintained/knowledge updated?

- Are users a) informed and b) educated about a) pressure ulcer risk assessment and b) prevention strategies?
- What does this education include?
- How has understanding been assessed?

Documentation/records to reflect individualised repositioning schedules.
Observation of practice.
Ask users about their involvement in care.

Documentation/records to reflect advice and assessment by appropriate assessors?
Asking staff about their practice.
Observation of practice.

Induction/training and education records.
Ask trainers.
Ask health professionals about their training.

Ask users if they have received a) information and b) education. What did this entail?
Ask health care professionals about what information and education they gave users.
Glossary

**Alternating pressure device:** device that mechanically varies the pressure beneath the individual thus reducing the duration of applied pressure.

**Bias:** the deviation of results from 'the truth', due to systematic error(s) in the methods used.

**Cellulitis:** a spreading infection of connective tissue, especially subcutaneous tissue.

**Cochrane Collaboration:** an international organisation in which people retrieve, appraise and review available randomised controlled trials. The Cochrane Database of systematic reviews contains regularly updated reviews on a variety of issues. The Cochrane Library is the database for the collaboration, it is electronic and regularly updated.

**Constant low pressure devices:** devices that mould around the shape of the patient to distribute weight over a large area

**Critical appraisal:** the process of assessing the validity, results and relevance of evidence, often in conjunction with a structured framework/tool.

**Effectiveness:** the extent to which an intervention does more good than harm.

**Erythema:** non-specific redness of the skin which can either be localised or general in nature and which may be associated with cellulitis, infection, prolonged pressure or reactive hyperaemia. See Collier 1999b for more details.

- **Reactive hyperaemia:** the characteristic bright flush of the skin associated with an increased volume of the pulse on the release of an obstruction to the circulation, or a vascular flush following the release of an occlusion of the circulation which is a direct response to incoming arterial blood.
- **Blanching hyperaemia:** is the distinct erythema caused by reactive hyperaemia, when the skin blanches or whitens if light finger pressure is applied, indicating that the patient's micro-circulation is intact.
- **Non-blanching hyperaemia** (previously identified as non-blanching erythema): is indicated when there is no skin colour change of the erythema when light finger pressure is applied, indicating a degree of microcirculatory disruption often associated with other clinical signs, such as blistering, induration and oedema.

**Extrinsic:** not belonging, lying outside, in the case of pressure ulcer development, factors that are external to the individual

**Incipient:** initial stages, beginning to exist.

**Induration:** the abnormal hardening of tissue (or organ).

**Intrinsic:** inherent, thus in the case of pressure ulcer development, factors present within the individual.

**Maceration:** a softening or sogginess of the tissue caused by the retention of excessive moisture.

**Necrosis:** the local death of tissue, often black/brown in colour and leathery in texture.

**Oedema:** increase in fluid in inter-cellular space, swelling.

**Overlay:** term used to describe surfaces placed on top of a standard mattress or operating table.

**Predictive validity:** a risk assessment tool would have high predictive validity if the predictions it makes of pressure sore development in a sample largely became true i.e. it has both high sensitivity and high specificity.

**RCT:** randomised controlled trial – a trial in which subjects are randomly assigned to either a group receiving an intervention that is being tested or another group receiving an alternative or no intervention. The results compare the outcomes of the different groups.

**Search strategy:** the method used for searching for articles to answer particular questions.

**Sensitivity:** what percentage of those who developed pressure ulcers in the study were predicted to be at risk by the score.

**Specificity:** what percentage of participants were correctly predicted to be not at risk by the score (a specificity of 100% means that all the participants who did not develop ulcers had been predicted to be not at risk).

**Systematic review:** a review in which evidence on a topic has been systematically identified, appraised and summarised according to pre-determined criteria.

**Validity:** a study is valid if the way it is designed and carried out means that the results are unbiased.

**30 degree lateral tilt:** the patient is placed in the laterally inclined position, supported by pillows, with their back making a 30 degree angle with the support surface.

**95% confidence intervals:** while a study will give single values of sensitivity and specificity for a risk score, these are based on the experience of the handful of people in the study and are the best guesses as to what would happen if the study was to be repeated. Where sample sizes are small, there will be high imprecision in the estimates of sensitivity and specificity.

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Department of Health (2000) *Benchmarking the fundamental aspects of care*. In process


**Appendix 1**

**Outline of consensus method**


Figure 3 (right) summarises the consensus development process.

The formal consensus development process was based on a modified nominal group technique (see *Technical Report* for rationale and full details). Ten people, who reflected the full range of those to whom the guideline will apply, were recruited to the nominal group (see group membership in Appendix 5). Prior to a meeting, participants were asked to rate statements that had been devised from the AHCPR guideline recommendations, systematic reviews, other literature and current practice issues. They were asked to rate on a 1–9 scale (where 1 represented least agreement and 9 most agreement) their agreement with these statements taking into account the research evidence and their clinical expertise. The first rating was conducted by post.

The nominal group met in November 1999. The distribution of responses to each statement was presented to group members during the consensus meeting alongside each member’s response to that statement. This enabled participants to see the spread of views and how their response related to this.

At the nominal group meeting each statement was discussed and then re-rated privately by each participant. The median (measurement of central tendency or average) and inter-quartile range (measure of distribution) was calculated for each statement from the ratings of the second round.

The recommendations were drafted based on the panel’s level of agreement about issues. If a statement’s median was 7 – 9, it was developed into a practice recommendation.

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Santy JE, Butler MK, Whyman JD (1994) A comparison study of 6 types of hospital mattress to determine which most effectively reduces the incidence of pressure sores in elderly patients with hip fractures in a District General Hospital. *Report to Northern and Yorkshire Regional Health Authority*


Aims and scope of guideline

Collation of other pressure ulcer guidelines

Systematic search and review of literature re. topic areas

Choice of development method based on consideration

Critical appraisal of systematic reviews

Selection of expert

Critical appraisal of systematic reviews

Statement formulation

+ Rating round of the statements conducted via post
+ Scores aggregated

Expert panel meet

+ Statements discussed in turn
+ Statements re-rated
+ Post-meeting scores aggregated

Drafting of the guideline

Comments sought from a wider audience

Adjustments made in the light of comments

Figure 3. Consensus process for guidelines – summary
# Appendix 2

**McGough Systematic Review (1999)**

See Technical Report for table of excluded studies. Studies included in review

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andersen KE, Jensen O, Kvorning SA and Bach E</td>
<td>Prevention of pressure sores by identifying patients at risk</td>
<td>British Medical Journal 1982 284: 1370-1</td>
</tr>
<tr>
<td>Barnes D and Payton RG</td>
<td>Clinical application of the Braden scale in the acute care setting</td>
<td>Dermatology Nursing 1993 5 (5): 386-88</td>
</tr>
<tr>
<td>Bergstrom N, Braden BJ, Laguzza A and Holman V</td>
<td>The Braden scale for predicting pressure sore risk</td>
<td>Nursing Research July/August 1987 36 (4): 205-10</td>
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<td>Braden BJ and Bergstrom N</td>
<td>Predictive validity of the Braden scale for pressure sore risk in a nursing home population</td>
<td>Research in Nursing and Health 1994 17: 459-70</td>
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<tr>
<td>Capobianco ML and McDonald DD</td>
<td>Factors affecting the predictive validity of the Braden scale</td>
<td>Advances in Wound Care 1996 9 (6): 32-6</td>
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Appendix 3


See Technical Report for table of excluded studies. Studies included in review

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<th>Authors</th>
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<tbody>
<tr>
<td>Aronovitch SA</td>
<td>A comparative, randomized, controlled study to determine safety and efficacy of preventive pressure ulcer systems; preliminary analysis</td>
<td>Acquired Pressure Ulcers, Advances in Wound Care (Supplement) 1998</td>
</tr>
<tr>
<td>Caley L, Jones S, Freer J</td>
<td>Randomised prospective trial of two types of low air loss therapy</td>
<td>Unpublished conference paper</td>
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<td>Clark M and Donald IP</td>
<td>A randomised controlled trial comparing the healing of pressure sores upon two pressure-reducing seat cushions</td>
<td>Proceedings of the 7th European Conference on Advances in Wound Management, Harrogate 1999 London: Macmillan Magazines</td>
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<tr>
<td>Collier ME</td>
<td>Pressure-reducing mattresses</td>
<td>Journal of Wound Care 1996 5(6): 207-211</td>
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<tr>
<td>Conine TA, Daechsel D and Lau MS</td>
<td>The role of alternating air and silicone overlays in preventing decubitis ulcers</td>
<td>Journal of Rehabilitative Research 1990 13: 57-65</td>
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<tr>
<td>Conine TA, Hershler C, Daechsel D, Peel C, and Pearson A</td>
<td>A pressure sore prophylaxis in elderly patients using polyurethane foam or Jay wheelchair cushions</td>
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<tr>
<td>Cooper PJ, Gray DG and Mollison J</td>
<td>A randomised controlled trial of two pressure reducing surfaces</td>
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<tr>
<td>Daechsel D and Conine TA,</td>
<td>Special mattresses: effectiveness in preventing decubitus ulcers in chronic neurological patients</td>
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<tr>
<td>Devine B</td>
<td>Alternating pressure air mattresses in the management of established pressure sores</td>
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<tr>
<td>Dunlop V (1998) (Micropulse Inc. reference in original review)</td>
<td>Preliminary results of a randomised, controlled study of a pressure ulcer prevention system</td>
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<tr>
<td>Economides NG, Skoutakis VA, Carter CA and Smith VH</td>
<td>Evaluation of the effectiveness of two support surfaces following myocutaneous flap surgery</td>
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<td>Ewing MR, Garrow C, Presley TA, Ashley C and Kinsella NM</td>
<td>Further experiences in the use of sheep skins as an aid in nursing</td>
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<td>Exton-Smith AN, Overstall PW, Wedgewood J and Wallace G</td>
<td>Use of ‘air wave system’ to prevent pressure sores in hospital</td>
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<td>Ferrell BA, Osterweil D and Christenson P</td>
<td>A randomised controlled trial of low air loss beds for treatment of pressure ulcers</td>
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<td>Gebhardt K</td>
<td>A randomised trial of alternating pressure (AP) and constant low pressure (CLP) supports for the prevention of pressure sores</td>
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<td>Goldstone L, Norris M, O'Reilly M, White J</td>
<td>A clinical trial of a bead bed system for the prevention of pressure sores in elderly orthopaedic patients</td>
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<td>Gray DG and Campbell M</td>
<td>A randomised clinical trial of two types of foam mattresses</td>
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<td>Hampton S</td>
<td>Evaluation of new Cairwave Therapy System in one hospital trust</td>
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<td>Hofman A, Geelkerken RH Hamming JJ</td>
<td>Pressure sores and pressure-decreasing mattresses: controlled clinical trial</td>
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<td>Inman KJ Sibbald WJ and Rutledge FS</td>
<td>Clinical utility and cost-effectiveness of an air suspension bed in prevention of pressure ulcers</td>
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<tr>
<td>Kemp MG, Kopanke D, Tordecilla L et al</td>
<td>The role of support surfaces and patient attributes in preventing pressure ulcers in elderly patients</td>
<td>Research in Nursing and Health 1993 16: 89-96</td>
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<td>Laurent S</td>
<td>Effectiveness of pressure decreasing mattresses in cardiovascular surgery patients: a controlled clinical trial</td>
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<td>Lazzara DJ, Buschmann MBT</td>
<td>Prevention of pressure ulcers in elderly nursing home residents: are special support surfaces the answer?</td>
<td>Decubitus 1991 4: 42-26</td>
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<td>Santy JE, Butler MK, Whyman JD</td>
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<td>Report to Northern &amp; Yorkshire Regional Health Authority 1994</td>
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<td>Preventing pressure sores – an evaluation of three products</td>
<td>Geriatric Nursing 1986 6: 23-25</td>
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<td>Summer WR, Curry P, Haponikm EF, Nelson S, Elston R</td>
<td>Continuous mechanical turning of intensive care unit patients shortens length of stay in some diagnostic-related groups</td>
<td>Journal of Critical Care 1989 4: 45-53</td>
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<td>Vyhlidal SK, Moxness D, Bosak KS, Van Meter FG, Bergstrom N</td>
<td>Mattress replacement or foam overlay: a prospective study on the incidence of pressure ulcers</td>
<td>Allied Nursing Research 1997 10 (3): 111-20</td>
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</table>
### Appendix 4

**Studies included in update of AHCPR review**

*See Technical Report for table of excluded studies*

<table>
<thead>
<tr>
<th>Study</th>
<th>Design including sampling strategy</th>
<th>Results</th>
<th>Comments</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finucane (1995)</td>
<td>Literature review</td>
<td>Low serum albumin associated with the development or presence of sores in seven studies, in five others it was not</td>
<td>Not all available data captured</td>
<td>Data on relationship between malnutrition and pressure ulcers is incomplete and contradictory</td>
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<tr>
<td></td>
<td></td>
<td>Most measures of nutritional status were not associated with pressure sore outcomes</td>
<td></td>
<td>There is no real evidence that there is any association between malnutrition and development of pressure ulcers</td>
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<tr>
<td></td>
<td></td>
<td>Poor nutritional intake associated with poor pressure sore outcome in four out of seven studies</td>
<td></td>
<td>No evidence to suggest that correcting malnutrition reduces the likelihood of developing pressure ulcers</td>
</tr>
<tr>
<td>Garber et al (1996)</td>
<td>Survey via interviews assessing demographic, Spinal Chord Injury (SCI) and ulcer characteristics, detection method, immediacy and appropriateness of action, time from detection to clinic visits, number of prior ulcers and knowledge and practice of ulcer prevention techniques</td>
<td>Individuals who waited longer to go to the clinic presented with more severe ulcers</td>
<td>Small sample size</td>
<td>Education programmes should emphasise immediate visits to the physician on detection of an ulcer</td>
</tr>
<tr>
<td></td>
<td>Sampling: convenience</td>
<td></td>
<td></td>
<td>Individuals with SCI should be encouraged to have another person inspect their skin regularly – even if they are capable of doing it themselves</td>
</tr>
<tr>
<td>Study</td>
<td>Design including sampling strategy</td>
<td>Results</td>
<td>Comments</td>
<td>Conclusions</td>
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<tr>
<td>Brandeis et al (1994)</td>
<td>Longitudinal cohort study 4,232 nursing home residents in 78 homes, over 60 years of age, 73% women, admitted without pressure ulcers Homes divided up based on incident rates of pressure ulcer formation – high and low incidence homes Assessed at 3, 6 and 21 months for presence of pressure ulcers Data collected on variables such as age, gender, antipsychotic medications, Body Mass Index cognitive status, incontinence, mobility, and an Activity of Daily Living score Pooled logistic regression</td>
<td>In high incidence homes – faecal incontinence, difficulty with mobility, diabetes and difficulty feeding oneself were significant independent factors In low incidence homes – difficulty with mobility, difficulty feeding oneself and male sex were significant independent factors</td>
<td>The nursing homes themselves may play a greater role in pressure ulcer development than the characteristics of the residents because practice was not controlled for Not all potential risk factors were investigated Nursing home staff carried out measures with only intermittent checks on reliability</td>
<td>By identifying and controlling for specific risk factors within certain populations pressure, ulcer incidence may be reduced</td>
</tr>
<tr>
<td>Papantonio et al (1994)</td>
<td>Cohort study Convenience sample of 136 adult patients (66% male) undergoing elective surgery Measurement of pre-, intra-, and post-operative variables, such as demographics, BMI, pre-existing medical conditions, position on table, use of thermal under blankets, and skin condition 6 day follow up period</td>
<td>Variables such as diabetes, increasing age, transfer from another hospital, respiratory disease and haematocrit levels were found to be associated with pressure ulcer development</td>
<td>Assessments carried out by a number of different assessors No strict inclusion criteria of patients Size of ulcer not recorded and collapsed stage I and II damage may have overestimated damage Limited to cardiac surgery</td>
<td>People judged prior to surgery as being ‘healthy’ are at risk of developing pressure ulcers during cardiac surgery</td>
</tr>
</tbody>
</table>
Bergstrom and Braden (1992)

To determine if dietary intake, nutritional status, and other physical markers are risk factors for the development of pressure ulcers in the elderly

**Cohort study**
- 200 newly admitted patients, 70% female, over 65 years of age, to a 250 bedded nursing home
- Skin assessment, Braden Scale score, blood pressure, temperature, anthropometric measurements and dietary intake were studied weekly
- Serum zinc, albumin, iron, copper and vitamin C were studied weekly for 4 weeks and biweekly for 8 weeks
- Main outcome measure – the presence or absence of pressure ulcers

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Results</th>
<th>Comments</th>
<th>Conclusions</th>
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</thead>
<tbody>
<tr>
<td>Cohort study</td>
<td>Stage I pressure ulcers developed in 35% and stage II or worse in 38.5% of residents</td>
<td>Background of patients unclear in relation to UK populations</td>
<td>These are factors that practitioners need to be aware that may increase a person’s risk of developing pressure ulcers</td>
</tr>
<tr>
<td></td>
<td>Age, blood pressure, temperature, dietary protein, iron and Braden score emerged as significant predictors of pressure ulcer development in logistic regression analysis</td>
<td>Selection bias present</td>
<td>A formal, structured risk assessment should be undertaken on people admitted to nursing homes</td>
</tr>
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</table>

Results should be interpreted in the light of the pressure ulcer prevention practices of the nursing home in which the study took place.