Repositioning guide for therapy staff - patients with pressure damage

Leicestershire Partnership NHS Trust

Introduction

Pressure ulcers are caused by the application of sustained pressure on tissue, so keeping patients moving and the use of repositioning are important elements in pressure ulcer prevention and treatment. In healthy individuals the application of unrelieved pressure results in a conscious or unconscious change of position. Called the pressure-pain stimulus. Patients are at increased risk of pressure ulcers when they are unable to feel or respond to the pressure-pain stimulus adequately by changing position.

For rehabilitation

Usual practice will include progressive range of motion and remobilisation of patients.

Patients at high risk of developing pressure damage (high Waterlow scoring and/or poor mobility) or who already have pressure damage, and once their sitting balance has been established, can be transferred from surface to surface. These patients will require pressure relieving support surfaces and robust repositioning plans throughout the 24hr period to reduce the risk of further breakdown. A mixture of both sitting and lying **repositioning should be supported every 30mins - 2hrs** depending on the degree of damage, ideally pressure damaged areas will be offloaded as much as possible. For example, patients with sacral, buttock damage can be repositioned onto their left and right sides for 2 hours each side and then sat up for 30mins -1 hr for meals and fluids: the greater the tissue damage the less time on it.

If posture is playing a part in the development of pressure damage, for example patients with pelvic obliquity causing added pressure to the ischial tuberosity or, Kyphosis and damage to the spine, these areas will be more vulnerable to breaking down so pressure relief and the amount of time spent with pressure on these areas should be taken into consideration and limited.

For those patients with healing pressure damage, timings for sitting out can be increased by 15mins at a time as the pressure damage improves. It is **critical that pressure areas are checked** after each increase to ensure that the tissues are tolerating the increase and there is no deterioration to the ulcer. If the skin shows any sign of deterioration, then the timing must be decreased for a while until further healing has taken place and an increase can be tried again. Timings will vary from person to person and should include support for the feet to relieve the heels with consideration being given to the extra pressure exerted on the bottom when feet are raised.

Where possible patients should be encouraged to self-reposition: if safe, leaning from side to side in the chair ensuring the buttock is free of the support surface/restricting the amount of time spent in the chair to between 30 mins and 2 hrs dependent on the individual and the amount of damage or risk. Any movement needs to be sufficient to adequately relieve pressure and the patient needs to be able to do so long enough for the tissue to be reperfused. Patients should be **encouraged to stand to relieve pressure for 2 minutes**, by their hospital bed if safe to do so, for those able to, a **short walk** on the ward would be encouraged as this will allow tissues to fully reperfuse. These actions can both be timed to advert breaks if applicable.

For those with contracted limbs

The need for the patient to be moved regularly and not static in the same position is still advised. Any positional aids provided should, if possible, allow for repositioning. If the patient requires aids to keep them in one position for any length of time, this must be documented as a potential pressure ulcer risk and discussed with your patient so that they can make an informed choice.

For those patients in need of a tilt and space chair

These are usually provided with pressure relief integrated into the chair. However as with all pressure relieving equipment there is still a need for regular repositioning. The nature of the tilt and space chair allows for even small degrees of movement forward and backwards in the chair. This will change the pressure point on the skin and help prevent the skin from breaking down, but this needs to be done regularly and could be as often as every 30 minutes if the patient is marking.

To reable mobility for people with heel or planter ulcers

This is largely dependent on the patient's ability to walk or stand with suitable footwear, for example their footwear should be a good fit, not slipping on and off and offer good support. If the patient cannot wear appropriate footwear, consider offering a medical shoe (e.g. Jura, Kerraped or Darco) or refer patient to the orthotist to assess if specialist footwear is required. Consider referrals to podiatry, who may be able to offer sharp debridement, offloading casts or provide footwear to relieve pressure on foot ulcers, which will aid mobility and healing. Does your patient have adequate analgesia to allow for mobility if required? Timings should be minimal to start perhaps just standing or walking around the bed and increased slowly, and the feet should be offloaded once the period of rehabilitation has been completed. Exercises can be given to these patients to aid limb mobility whilst seated, if necessary.

My patient has a pressure ulcer: how long can they sit out/mobilise?

Category 1



Category 2



1-2 hours depending on tissue tolerance:

Check by blanch testing at the end of specified time/assessing temperature/texture if dark skin tones or if patient expresses pain/discomfort to the site.

Deep category 3



30mins deep -1 hour for superficial

Depending on the size and depth of the PU, pain levels and tolerance: check by blanch testing surrounding skin at the end of specified time/assessing temperature/texture if dark skin tones or if patient expresses pain/discomfort to the site.

Category 4



Deep tissue injury



30mins deep -1 hour for healing

Depending on the size and depth of the PU, pain levels and tolerance: Check by blanch testing surrounding skin at the end of specified time/assessing temperature/texture if dark skin tones or if patient expresses pain/discomfort to the site.

Key Points for consideration:

Remember! It's not what you put on the pressure ulcer it's what you put the pressure ulcer on that makes all the difference.

- What category of damage is the pressure ulcer: 1-4 depending on depth and underlying structures. The deeper and more extensive the damage (3-4 category) ulcers or for deep tissue damage the least time on the affected area the better.
- Does your patient understand their risk and what a pressure ulcer could mean to them personally?
- Can your patient give informed consent? If not an MCA is needed and potential best interests decision.
- Is your patient experiencing pain and discomfort to the area of damage? STOP, reposition to offload and inspect the area for deterioration.

Deep tissue injury



Rehabilitation for patients with foot ulceration:

- Before commencing ensure suitable footwear available and analgesia if required.
- Timings for rehabilitation minimal to start, if tolerated then increase timings slowly, if damage to the foot deteriorates then decrease timings.
- Consider referral to podiatry for specialist offloading footwear to aid mobility if required.
- Remove footwear once exercise completed and offload feet.