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**Pressure Ulcer Prevention & Repositioning**

Numerous older adults are at risk of developing pressure ulcers and long-term care providers must identify this risk and implement interventions to reduce this risk in those they serve. Repositioning is an intervention that is frequently used as a prevention strategy. However, is there a best practice to determine the frequency and methods used for repositioning? When researching pressure ulcers, I found a robust guide on several topics on patient repositioning including determining the frequency that someone should be repositioned given their overall condition as well as how individuals should be repositioned.

The National Pressure Injury Advisory Panel (NPIAP) offers a free online guidance document(s) on the multiple facets of pressure ulcer prevention, identification, and treatment. To prevent information overload, lets focus on one area at a time.

The NPIAP information outlines that pressure injuries cannot form without mechanical loading acting on the tissue which includes extended periods of lying or sitting on a particular part of the body without redistributing the pressure leads to tissue deformation and ultimately damages the tissue in the form of a pressure injury. Repositioning is an essential preventative measure to reduce the occurrence of pressure injuries. To reduce your burden in researching these, I've outlined some key considerations to implementing best practice in your community.

General Repositioning:

It is good practice to reposition patients at risk for pressure ulcers, regardless of the pressure redistribution support surface being used. However, you may consider the frequency of repositioning based on the support surface. It is good practice to reposition patients in a way that offloads pressure points and maximizes redistribution of the individual's weight. Implementation considerations include:

- The person's goals of care and priorities. For example, someone at the end of life may forego reducing the risk of pressure injury to not be disrupted by repositioning or to cause pain by repositioning. While pressure ulcers cause pain in and of themselves, the individual's goals may outline that a repositioning at a less frequent schedule is sufficient to both meet their preferences and not develop pressure ulcers.
- Look at the individual's repositioning needs over a 24-hour period. Are there times when the person will always be at meals that can be counted as a repositioning

time? Additionally, there may be considerations to their preference of repositioning location (such as a bed compared to a recliner). An interdisciplinary approach should be used when developing a schedule for the patient.

- Check all pressure points when you are redistributing their weight. Areas such as the gluteal cleft, elbows, malleolus, and wrist are vulnerable areas that are frequently overlooked.
- Assess the patient's pain before, during, and after repositioning. Consider the use of pain medication before repositioning occurs if the act of repositioning causes pain.
- Assess the patient's full body when repositioning. Evaluating the person's body alignment and posture to maximize comfort and offload pressure is necessary to pressure ulcer prevention. The use of additional repositioning supports or devices may be necessary to ensure proper alignment and pressure reduction.
- Use of positioning devices can be used to maintain position, elevate and support pressure injury prone areas, promote body symmetry, posture and comfort Ensure that the patient and/or staff are well educated on positioning devices intended anatomical areas for pressure relief (for example do not position a pillow directly against the sacrum when in a lateral position). Consider using specialized repositioning devices to support specific needs or body shape such as a Z-Flo or similar device that can be molded or conformed to the patient's position and won't flatten over time like towels or blankets.
- Ensure that objects and medical devices are moved out from underneath patients to prevent device-related pressure and friction.
- If a patient can self-reposition, encourage them to do so as often as possible and staff may need to remind them to regularly do so. Assess and monitor these individuals to ensure that their self-repositioning techniques are effectively offloading pressure points and they are avoiding friction and sheer as they reposition themselves.

When repositioning patients, it is good practice to use specialized equipment designed to reduce friction and shear. If manual handling is necessary, techniques that minimize the friction and shear should be applied. Implementation considerations include:

- Identifying individual's experiences with manual handling. Fear, pain and/or discomfort may lead to difficult transfers and repositioning.

- Specialized manual handling equipment shall be easily available and in good working order. Ensure that this equipment is also safe based on age, weight, and dimensions of the individual.
- Establish procedures to support safe and appropriate transfers such as lifting rather than dragging and consider use of assistive devices such as low friction fabric transfer sheets. Also pay close attention to patient's heels during repositioning and/or transfers.
- Minimize shear once repositioning by ensuring that surface materials are not pulling on skin. Examples of this can include loosening sheets.
- Manual handling equipment should not be left under the resident unless the equipment is specifically designed for this purpose.
- Consider implementing a dedicated repositioning team who are experts in manual handling to promote optimal repositioning, adherence to schedules, and reduction of staff injuries such as ComfortGlide Turning and Repositioning System by Medline.

When positioning in bed it is not necessary to use a 30-degree lateral positioning or maintaining a 30-degree head of bed elevation as there is low certainty of evidence supporting these recommendations.

- Avoiding laying in positions that increase pressure is recommended such as a 90-degree lateral position.
- When repositioning in a lateral position, offload the sacrococcygeal area without placing pressure on the trochanter. This can be possible by positioning the upper leg forward of the lower leg with support from a pillow to promote comfort and stability.
- Ensure bony prominences such as heels, knees, and ankles are offloaded.
- Consider use of a Leaf Sensor or similar device that the patient can wear and will tell the staff if the individual needs repositioned or if they are correctly positioned with offloading of pressure injury prone areas.
- The head of the bed should be as flat as possible considering the individual's clinical needs and preferences. When possible, maintain elevation at 30 degrees or lower.
- When elevating the head of the bed, ensure that the thighs are elevated to minimize shear by sliding.

- Investigate alternatives to sitting in bed such as sitting out of bed during meals.
- Avoid slouched positions which increase pressure and shear on the sacrum and coccyx.