

In this article...

- How to reposition patients safely and effectively
- Use of equipment, including manual-handling aids
- The importance of documentation in meeting patients' individual needs

Pressure ulcer education 5: keeping patients moving



Key points

Keeping patients moving is a key component of pressure ulcer prevention

Repositioning is important for patients who are unable to move around easily

Nurses need to be competent in the use of devices that help with repositioning

Patients need reviewing regularly to assess how often they need to be repositioned

A position that provides good offloading in one patient may not be effective for another

Author Jacqui Fletcher is chair, Pressure Ulcer Education Core Curriculum Group; senior clinical adviser, NHS Improvement and NHS England.

Abstract Patients who are immobile are at highest risk of developing pressure ulcers. Ensuring regular movement or using repositioning redistributes pressure and helps prevent pressure damage. This article, the fifth in an eight-part series on the development of a core education curriculum for pressure ulcer prevention and management, discusses techniques to keep patients moving that maintain the safety of patients and staff, and take individual patient needs into account.

Citation Fletcher J (2020) Pressure ulcer education 5: keeping patients moving. *Nursing Times* [online]; 116: 2, 28-30.

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. In healthy individuals, the application of unrelieved pressure results in a conscious or unconscious change of position to remove or redistribute the load; this is often referred to as the pressure-pain stimulus. Patients are at increased risk of pressure ulcers when they are unable to feel the pressure-pain stimulus or respond to it adequately by changing position. Fig 1 shows the areas at greatest risk of pressure damage.

The module on keeping patients moving in the new education framework, aSSKINg (NHS Improvement, 2018), described in part 1 of this series (Fletcher, 2019), helps nurses understand the importance of maintaining mobility and how this affects patients' independence. It looks at:

- Different levels of mobility;
- Risk factors associated with reduced mobility;
- Health professionals' knowledge of the range of equipment that is available,

including the mechanisms of action, benefits and associated risks;

- Use of formal tools to assess mobility, including falls risk and moving-and-handling risk assessments;
- Impact of reduced mobility on an individual's engagement in activities of daily living (ADL) and psychosocial functioning (mood, isolation, social engagement);
- Use of a range of equipment to promote safe mobilisation (hoists and slings, standing hoists and frames, appropriate seating and mobility aids) to promote an individualised plan of mobility and assisted transfers;
- Referral to appropriate members of the multiprofessional team throughout the patient journey, including discharge planning.

Current guidelines state that all patients at risk of pressure ulcers should be repositioned, unless otherwise contraindicated, following an individualised schedule (European Pressure Ulcer Advisory Panel et al, 2019; National Institute for Health and Care Excellence, 2014). When positioning patients, practitioners should remember that individual anatomy

Fig 1. Areas at greatest risk of pressure damage

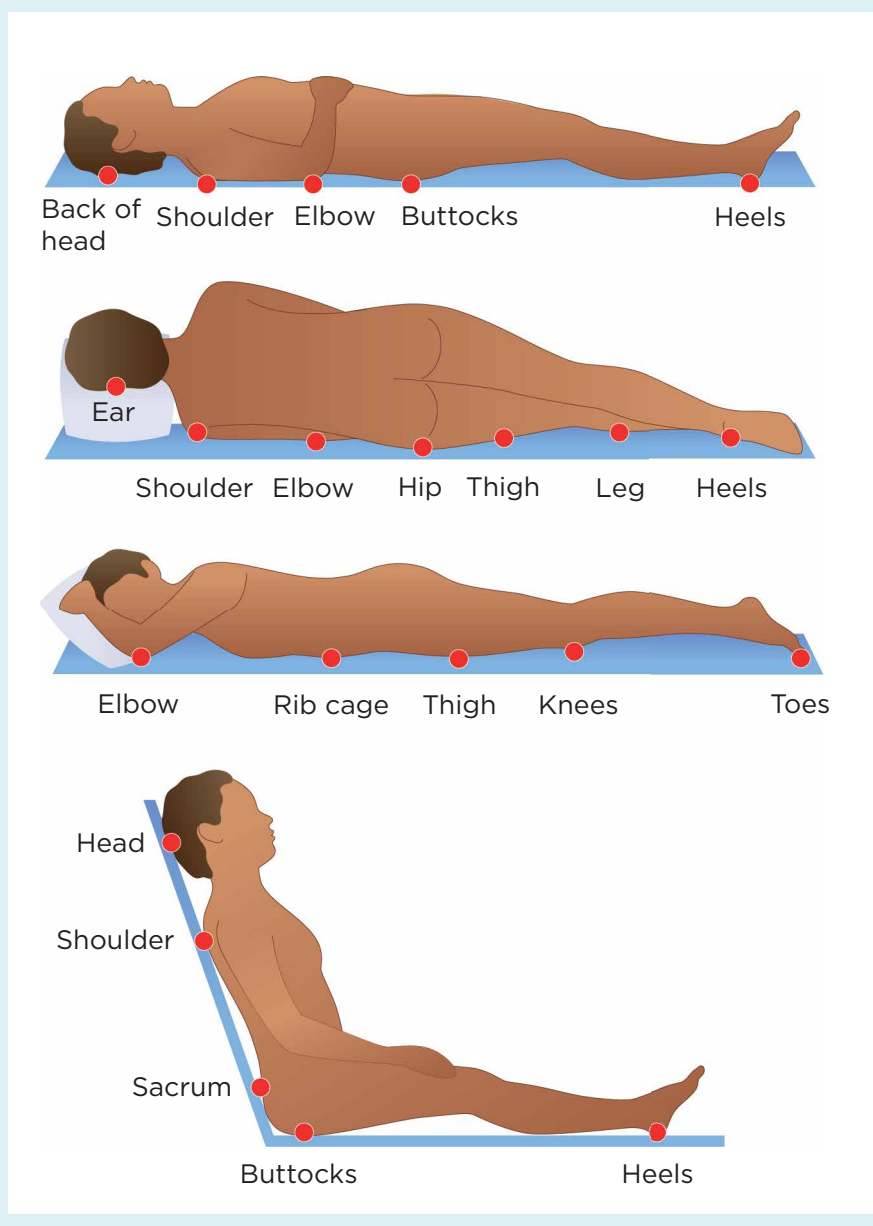
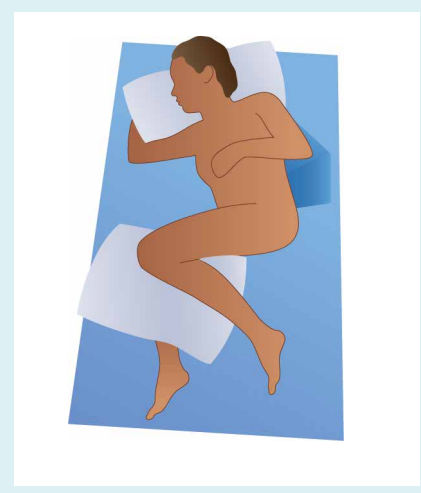


Fig 2. The 30-degree tilt



should be touching. Pillows or wedges should be used to maintain the position and ensure the patient is adequately supported (Fig 2).

For patients who are very large, the 30-degree tilt may not be sufficient to lift areas of the body away from the surface, and so alternative repositioning methods will be needed; these will vary depending on the individual patient's weight and body shape.

Electronic bed frames

Use of electronic bed frames is now common in hospital and community care settings. The profile function can be used to maximise the patient's position by keeping the headrest elevation below 30 degrees and using the knee break to minimise shear from the patient sliding down the bed (Fig 3). When sitting patients up using the backrest, it is important to use a slide sheet under the heels, as they are pushed about 15cm along the mattress (Fletcher, 2011).

Prone position

For patients who tolerate it, the prone position can be used; however, this can only be done for short periods as it exposes new areas of the body to pressure and increases the risk of medical devices becoming trapped. Nurses should check for uneven distribution of pressure and the location of medical devices once the patient is positioned. Areas requiring specific attention include:

- Breast region;
- Knees;
- Toes;
- Penis;
- Clavicles;

varies, and so what provides good off-loading (removal of pressure from the affected area) for one patient may not be effective for another. Any position used should also maintain the patient's dignity, hygiene and functional ability, as well as comfort. Failure to maintain comfort is one of the most common reasons for patients not tolerating the position in which they are placed.

Self-repositioning

Where possible, patients should be encouraged to self-reposition, for example, by doing arm lifts, or leaning when seated in a wheelchair. Movement needs to be sufficient to adequately relieve the pressure and

to do so for long enough to allow for reperfusion. Simple cues – such as moving at every commercial break when watching television at home, or setting an alarm – can be used to remind patients of the need to change position.

30-degree tilt

For patients in bed, the 30-degree tilt is widely recommended (Moore et al, 2011). Done correctly, this ensures the patient is not placed on any of the large bones; the sacrococcygeal area (at the base of the spine by the coccyx) and both trochanters (located by the hip) should be palpable, and if the legs are correctly supported, neither the knees nor malleoli (ankle bones)

Fig 3. Using an electronic bed frame to maximise pressure redistribution

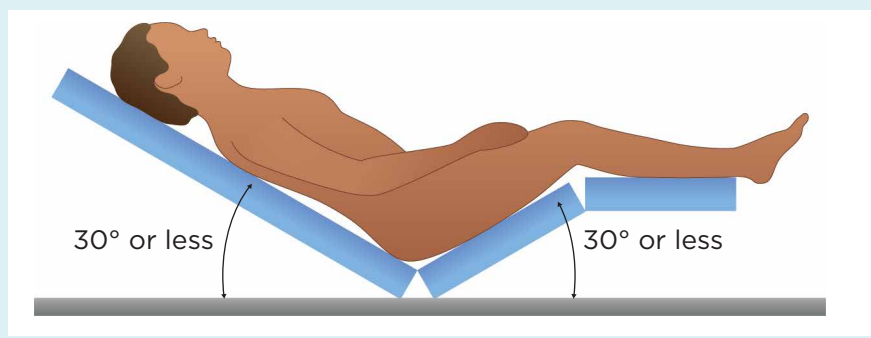
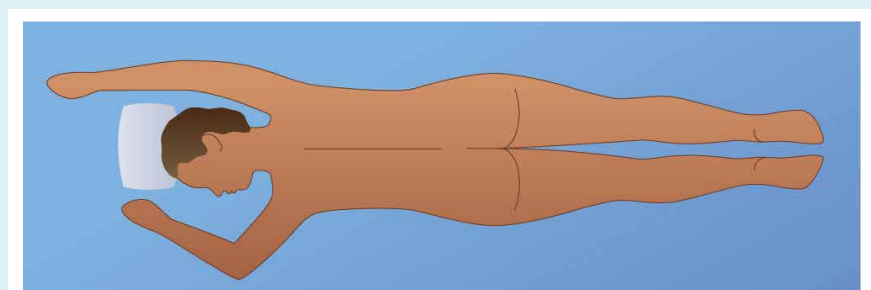


Fig 4. The prone 'swim' position



- Iliac crest;
- Symphysis pubis.

Use of additional pressure redistributing devices – for example, using prophylactic dressings over bony prominences such as the iliac crest, ribs and patella – should be considered.

The prone position is most commonly used in intensive and critical care areas; the prone 'swim' position – in which the patient is positioned with their head on one side, one arm lying straight alongside the back of the head and the other (near the face) slightly bent (Fig 4) – allows for smaller changes in position by changing the arm that is positioned alongside the head and turning the head.

Manual handling

Staff should use manual-handling aids when moving patients, as dragging a patient along the mattress can cause tissue damage (friction and shear). Types of equipment include:

- Slide sheets;
- Glide and lock sheets;
- Hoist slings;
- Lateral transfer boards;
- Electrical profiling beds.

It is important to know when and how to use such equipment to minimise the safety risk to staff and patients; nurses should follow manufacturers' instructions or local protocols for best practice.

Slide sheets should be removed where possible and should never be left in situ for more than the time taken to complete the reposition.

Regularly checking patients' skin over bony prominences when altering their position informs the length of time between position changes and helps identify early signs of pressure damage; for example, nurses should look out for:

- Areas of skin that appear reddened and/or do not blanch (turn white) when light finger pressure is applied;
- Changes in skin colour or texture.

Unstable patients

In some clinical areas – most notably, intensive and critical care – patients cannot be repositioned fully due to issues such as haemodynamic or spinal instability. In these cases, nurses should perform small but frequent movements to ensure sufficient offloading. Use of programmable repositioning devices, which move very slowly, may be better tolerated than manual repositioning; this should be discussed with the multidisciplinary team.

Documentation

Repositioning is not solely a nursing task; therapists should be engaged in the repositioning schedule and any activities that

promote rehabilitation should be considered integral to this. All activities must be fully documented to give a complete record of all position changes. This includes functional activities (such as the patient going to the toilet, sitting up for meals) or being repositioned for procedures such as dressing changes, as these may mean the patient is being moved frequently. Although frequent moving is beneficial for pressure-ulcer prevention, the patient's overall condition must be taken into account to make sure they do not become overly fatigued. Keeping patients moving should be tailored to their medical, physical and psychological needs; pain should be addressed and appropriate risk assessments performed.

Documentation should record the:

- Time the repositioning occurred;
- Position the patient was moved into.

Staff should also check regularly to see whether patients remain in position or move back into a position they find more comfortable within a short time. If this does occur, it should be documented and discussed carefully with the patient, as it may mean that changes to the planned schedule are required. **NT**

References

- European Pressure Ulcer Advisory Panel et al (2019) *Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide*. Bit.ly/EPUAPGuidance2019
- Fletcher J (2019) Pressure ulcer education 1: introducing a new core curriculum. *Nursing Times*; 115: 11, 18-19.
- Fletcher J (2015) Articulated bed frames and heel ulcer prevalence. *Wound Essentials*; 10: 1, 8-13.
- Moore Z et al (2011) A randomised controlled clinical trial of repositioning using the 30° tilt, for the prevention of pressure ulcers. *Journal of Clinical Nursing*; 20: 17-18, 2633-2644.
- National Institute for Health and Care Excellence (2014) *Pressure Ulcers: Prevention and Management*. nice.org.uk/cg179
- NHS Improvement (2018) *Pressure Ulcer Core Curriculum*. Bit.ly/aSSKING

CLINICAL SERIES

Pressure ulcer education

| | |
|--|----------|
| Part 1: Introducing the new curriculum | Nov |
| Bit.ly/UlcerEducation1 | |
| Part 2: Assessing risk | Nov |
| Bit.ly/UlcerEducation2 | |
| Part 3: Skin assessment and skin care | Dec |
| Bit.ly/UlcerEducation3 | |
| Part 4: Surface selection and use | Jan 2020 |
| Bit.ly/UlcerEducation4 | |
| Part 5: Keeping patients moving | Feb |
| Part 6: Incontinence assessment and care | Mar |
| Part 7: Nutrition and hydration assessment and support | Apr |
| Part 8: Giving information | May |