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PREVENT PRESSURE INJURY IN THE ER

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ASSESS AND TREAT ANY cABCDE[1]. ASSESS THE PATIENT'S SKIN CONDITION AND RISK OF PRESSURE INJURY AS SOON AS THE PATIENT HAS BEEN ADMITTED OR WITHIN MAXIMUM OF 8 HOURS. MAKE THE ASSESSMENT FOR BED PATIENTS, PATIENTS IN WHEELCHAIR, AND PATIENTS WHO MAY NEED FOLLOW-UP CARE.

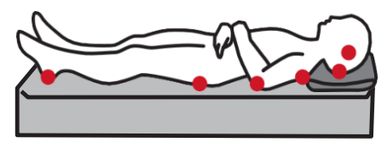
1 ASSESS THE RISK FOR PRESSURE INJURY

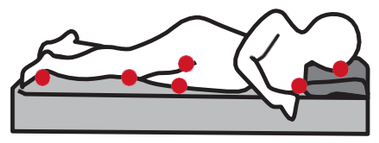
CHOOSE THE BEST MATTRESS[7] AND SEAT CUSHION

HIGH RISK	MODERATE RISK	LOW RISK
• Not able to change position • Poor circulation in legs • Mechanical ventilation • Spine support • Hip fracture or • A previous pressure injury	• Able to move with assistance • Often moist or fragile skin • Age over 75 years with several chronic diseases or one severe disease • Over 24 h stay in the ER • Low GCS[2] • High injury severity score • Significant under- or overweight • Acute infection, respiratory organ, urinary tract or circulatory disease	• No limitations in mobility and healthy skin

2 CHECK SKIN AND TISSUE OF AN AT-RISK PATIENT

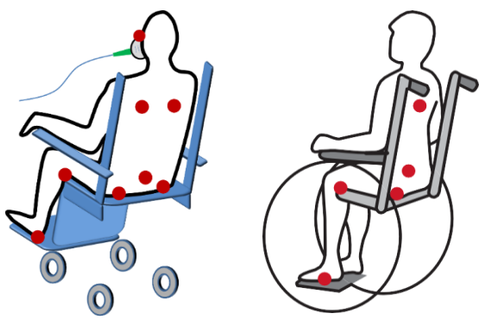
- **Check skin** once per shift.
- **Pay attention** to the risk areas (marked with red dots on the pictures).
- **Consider** the effect of medical devices on the skin (intubation tube, NIV[3], indwelling cathether, NG tube[4], nasal cannula, oxygen mask).
- **Check** for pain and skin colour. Pain or redness may be early symptoms of a pressure injury.
- **Estimate** the temperature of skin and tissue. Increased temperature and/or poor circulation are risk factors.
- **Compare** firmness of swollen tissue to the surrounding areas. Swelling is a risk factor.





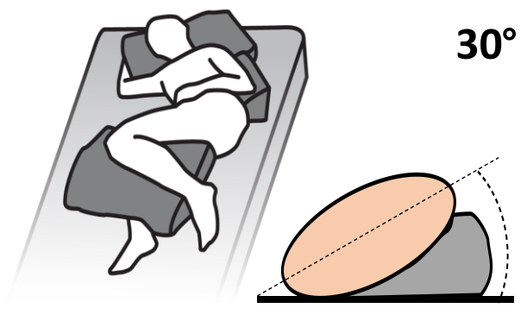
3 PROVIDE PREVENTIVE SKIN CARE

- **Prioritise** x-ray imaging of patients with spine support.
- **Keep** the skin clean and apply moisturizer on dry skin when necessary.
- **Change** moist bed linen and clothes.
- **Check** for incontinence, check diaper every 2 – 3 hours and apply protective skin care products.
- **Protect** the sensitive areas of at-risk patients with silicone multilayer foam dressing and check the skin under the dressing every 8 hours.



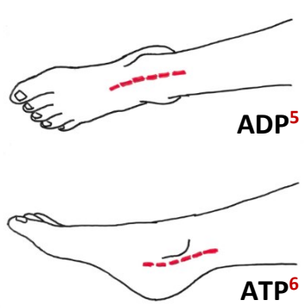
4 REPOSITION AND MOBILISE

- **Reposition** bed patients every 1 – 4 hours and seated patients every hour according to their personal needs.
- **Relieve** and redistribute pressure.
- **Avoid** friction and stretching when lifting and moving the patient – use assistive devices and correct lifting techniques.
- **Apply** the 30° tilt for bed patients when feasible.
- **Keep** the head of the bed in the lowest possible position, as permitted by the patient's condition.
- **Instruct** the patient to change their position personally.



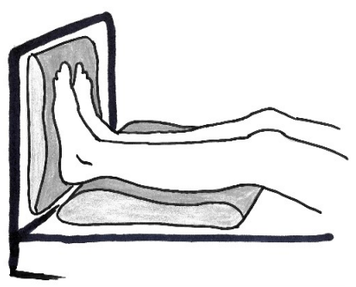
5 PREVENT PRESSURE INJURY TO HEELS AND FEET

- **Feel** for pulse in the feet. An undetectable pulse is a risk factor.
- **Estimate** the sense of touch and temperature. Cool and numb feet indicate a risk.
- **Protect** the heels and risk areas in the feet with silicone multilayer foam dressings.
- **When at risk**, lift heels off the bed with pillows or other relief device and support the ankles to a 90° angle.



6 NOURISHMENT

- **Make sure** the patient has enough fluids.
- **Provide** of good nourishment as applicable to the situation.
- **ENSURE DIABETES IS PROPERLY CARED FOR!**



7 DOCUMENTATION

- **Document:** - Pressure injury risk
  - Classification and location of a detected pressure injury
- **Report** your observations to the follow-up care unit.

[1] cABCDE = catastrophic hemorrhage, Airway, Breathing, Circulation, Disability, Exposure [2]GCS = Glascow Coma Scale [3]NIV = non-invasive ventilation [4]NG tube = nasogastric tube [5]ADP = Arteria dorsalis pedis [6]ATP = Arteria tibialis posterior [7] Consider possible contraindications to special mattress, such as unstable fractures or need for spine support. Measuring intracranial pressure can be a contraindication to alternating pressure mattress.