Pressure Ulcer Management in Older Population

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The most common wounds among older population are :

- Pressure ulcers
- Vascular ulcers (arterial and venous)
- Neuropathic ulcers

Pressure Ulcers are defined as localized areas of tissue necrosis that develop when soft tissue is compressed between a bony prominence and an external surface for a prolonged period of time.

Most common causes of pressure ulcers among elderly are:

- Prolong the length of stay at hospital
- Increase health care costs
- Increase susceptibility to secondary infections
- Increase mortality rates
- Decrease quality of life

Why pressure ulcer management of older adults is important?

- Wound healing is delayed in older adults;
  - regeneration of healthy skin takes twice as long for an 80-year-old as it does for a 30-year-old
- Age-related changes affecting wound healing include
  - thinning dermal layer of skin; decreased subcutaneous tissue
- Signs of inflammation may be more subtle in older adults
- Diminished immune response from reduced T-lymphocyte cells predisposes older adults to wound infections

Approximately 70% of all pressure ulcers occur in the geriatric population

Most pressure ulcers occur within the first 2 weeks of hospitalization

Incidence	Prevelance
▪Acute care ▪2.8 -9 %	▪Acute care ▪11.9-15.8 %
▪ Long-term care ▪3.6–50 %	▪Long-term care ▪4.3-32 %
▪Home care settings ▪ 4.5-6.3 %	▪Home care settings ▪2.9-19.1 %

Prevention:

The best opportunity for management

The strategy for prevention includes;

I. Risk Assessment
II. Skin Care and Early Treatment
III. Mechanical Loading and Support Surfaces
IV. Education

Risk Assessment

1. Consider all bed- or chair-bound persons, or those whose ability to reposition is impaired, to be at risk for pressure ulcers.
2. Select and use a method of risk assessment.
3. Assess all at-risk patients at the time of admission to health care facilities and at regular intervals thereafter.
4. Identify all individual risk factors to direct specific preventive treatments.

Skin Care and Early Treatment

1. Inspect the skin at least daily, keeping the skin clean, dry and moisturized .
2. Use a mild cleansing agent. Avoid hot water, excessive friction.
3. Clean and dry the skin as soon as possible after each incontinent episode. Use a topical moisture barrier, and select underpads or briefs that are absorbent and provide a quick drying surface to the skin.
4. Use moisturizers for dry skin. Minimize environmental factors leading to dry skin such as low humidity and cold air.
5. Avoid massage over bony prominences

Mechanical Loading and Support Surfaces

1. Reposition bed-bound persons at least every 2 hours, chair bound persons every hour (check risk score)
2. Use a written repositioning schedule.
3. Place at-risk persons on a pressure-reducing mattress/chair cushion.
4. Teach chair-bound persons, who are able, to shift weight every 15 minutes.
5. Use lifting devices to move persons during transfers and position changes.
6. Use pillows or foam wedges to keep boney prominences such as knees and ankles from direct contact with each other.
7. Use devices that totally relieve pressure on the heels
8. Avoid positioning directly on the trochanter in side-lying position.
9. Elevate the head of the bed as little (max. 30°), for as short a time as possible.

Education

1. Etiology of and risk factors for pressure ulcers.
2. Risk assessment tools and their application.
3. Skin assessment.
4. Selection/use of support surfaces.
5. Demonstration of positioning to decrease risk of tissue breakdown.