

REPOSITIONING: MAKE EFFECTIVE INTERVENTIONS!

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The most recent definition for Pressure Ulcer (also cited in the literature as “pressure sore”, “decubitus ulcer” or “bed Sores”, all these terms refer to the same problem) is the International NPUAP-EPUAP Pressure Ulcer Definition, defined as “A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.” (EPUAP & NPUAP, 2009). Pressure ulcers are an important problem on the healthcare systems all over the world, affecting millions of patients and requiring high costs, Hospital Managers and Administrators are giving now, more attention to this problem. Some numbers show the extent of this issue, Pressure Ulcers are a major cause of morbidity in the population (Franks, 2007) and increased mortality (Allman, 1997). Approximately 18% of hospitalised patients have a pressure ulcer (EPUAP, 2002). Professionals should be aware that, most pressure ulcers can be prevented, and the approach with objective preventive measures, may be cheaper than the concern to the treatment of this chronic wounds (Lyder, 2006, Hopkins B, 2000; Whitefield, 2000). It is known that the treatment and prevention of pressure ulcers is expensive for health services, yet there is little information on precise direct costs (Franks, 2007), we must not forget that the quality of life of patients is difficult, if not impossible, to quantify. How much will we pay to avoid a pressure ulcer? They can occur in all situations in which people are subjected to sustained mechanical loads, but are particularly common in subjects who are bedridden, wheelchair bound, or wearing a prosthesis or orthosis (Bouten, 2003). We must not forget that the concern of health professionals should not focus specifically on bedridden patients, but also in patients in sitting position, the evidence shows that chair-bound patients develop pressure ulcers more frequently than bedridden patients with the same degree of helplessness (Barbenel JC, 2007). A common but potentially severe problem afflicting permanent wheelchair users is pressure sores caused by elevated soft tissue strains and stresses over a critical prolonged period of time. There is lack of information regarding deep soft tissue strains and stresses in the buttocks of humans during sitting (Linder-Ganz, 2007, Gefen, 2008). The repositioning is the most important and most effective measure for prevention of Pressure Ulcers (Defloor, 2000). In all guidelines for the prevention and treatment of Pressure Ulcers, the repositioning is one of the interventions. International best practice advocates the use of repositioning as an integral component of a pressure ulcer management strategy (Zenna & Cowman, 2009). The repositioning cannot be seen as a preventative measure alone, but added a set of preventive measures, the overall

evaluation of the patient, associated risk factors, skin, nutritional status, as well as support surfaces to reduce pressure relief available and adjusted to the needs of patients. The combination with the pressure-reducing mattresses and cushions, is essential to the success of the prevention, adjusting frequencies according to various variables, such as position (bed or chair), posture, level of pressure and shearing forces, and the latest evidence related to tissue deformation and Deep Tissue Injury (DTI) (Gefen, 2008). Alternating the area of pressure, by regular repositioning the patients, in to different positions, alternates the contact area where the body is supported and if the position is modified frequently enough, the chance of developing pressure is limited (Defloor, 2006). The process of repositioning requires knowledge of certain principles to ensure that either the person to be positioned either to health professionals involved, a precursor of the technique without incident and the profitability of energy to expend (Malta, 2006). It will be suggested some approaches that should be considered, as repositioning frequency, different positions, restriction to certain positions, quantity and type of spontaneous movements, reposition schemes and reposition techniques in conjunction with others. It is worth considering a multiple approach, and establishes precise measures of repositioning the patients, taking into account that the variables associated with these interventions are numerous. These interventions should be adjusted according to individual patient needs, available resources in services and not according to habits and institutional routines.

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