Pressure Reduction or Relief Mattresses (POC 13)

Effective Date: May 18, 2012

Purpose

This policy provides direction on devices (mattresses/overlays) used for the prevention and management of pressure ulcers for clients with significant limitations in mobility.

Policy

Definitions

1. Pressure Ulcer - a pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over a bony prominence and are staged to classify the degree of tissue damage observed.

2. Support Surface - a support surface is a generic term to describe all types of pressure reducing or pressure relieving devices that provide an environment to prevent or heal ulcers. Surfaces include mattresses, mattress overlays and other devices for elbows and feet. These include products such as heel, elbow and shin sleeves as well as soft boots.

3. Pressure reduction/relief support surfaces - pressure reduction/relief support surfaces are surfaces that reduce or relieve pressure by promoting an even distribution of body weight and reducing friction, shear and moisture.

4. Pressure reduction - is a surface which lowers pressure as compared to a standard hospital mattress or chair surface but does not consistently lower pressure to less than capillary closure levels over all bony prominences.

5. Pressure relief is a surface which consistently lowers pressure below capillary closure levels over all bony prominences.

Approval criteria

6. While this policy is largely focussed on interventions for the “treatment of” pressure ulcers, every effort should obviously be made at “preventing” pressure ulcers from developing in the first place, if at all possible. Where clients at risk are identified, an individualized care plan to address all risk factors should be implemented. Pressure reduction/relief support surfaces are not a substitute for nursing care, therefore turning and positioning schedules must be maintained whether or not the client is on a pressure reduction/relief surface.

7. Where care plans call for the use of pressure controlled surfaces, these may be considered for approval, as appropriate, not only when ulcers are present, but also when the client is at significant risk of developing ulcers, and where the use of a pressure controlled surface could avoid or lessen the development of the ulcer.

8. When considering approvals, VAC health care professionals should exercise their discretion guided by the criteria below.

9. Decisions to approve pressure reduction support surfaces (mattresses/overlays) as part of a comprehensive care plan should normally be guided by the following:

    a. Stage I or II ulcers are present; or

    b. The client’s Braden Scale (the Braden Scale may be accessed through VAC’s Electronic Forms) score is between 10 and 18; or

c. Indicated for the management of intractable chronic pain e.g. metastatic disease.

10. Decisions to approve pressure relief support surfaces (mattresses/overlays) as part of a comprehensive care plan should normally be guided by the following:

    a. Stage III or IV ulcers are present; or

    b. The client's Braden Scale score is between 6 and 14; or

    c. Indicated for the management of intractable chronic pain, e.g. metastatic disease.

11. Given the physical condition of clients requiring these items, the Department should ensure that, from a nursing perspective, the client is being cared for in the appropriate setting, e.g. if in a facility, it has the capacity to meet the care requirements.

Recovery

12. In accordance with policy, mattresses and/or overlays provided to the client are considered the client's property (unless rented or leased) and will not be recovered by the Department when no longer required by the client.

General

13. Predisposing factors causing the formation of pressure ulcers include:

    a. Limited mobility resulting in prolonged periods of lying or sitting;

    b. Compression of the deeper blood vessels against a bony prominence;

    c. Shearing/friction;

    d. Excessive moisture or incontinence;

    e. Poor nutritional status and low fluid intake;

    f. Physical frailty - chronic illness, advanced age, sensory impairment; and

    g. External trauma.

14. Pressure ulcers may be categorized into four progressive stages (as defined by the National Pressure Ulcer Advisory Panel (NPUAP, 1989):

    a. Stage I: Non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discolouration of the skin may be purplish/bluish or voilaceous (eggplant like colour) accompanied by localized heat, edema, induration or hardness.

    b. Stage II: Partial thickness skin loss involving epidermis, dermis or both. The ulcer is usually superficial and presents clinically as an abrasion, blister or shallow crater.

    c. Stage III: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

    d. Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures e.g. tendon joint capsule. Undermining and sinus tracts also may be associated with Stage IV ulcers.

15. The Braden Scale for Predicting Pressure Sore Risk should be used to identify clients at risk of developing ulcers. If the Braden scale is not available, other established scales such as the Norton may be used.

16. Decisions to purchase or rent should be based on policy on the purchase, rental or lease of treatment benefit items, and factor in considerations such as the cost and likelihood of long term use, as well as other relevant considerations.

References

Veterans Health Care Regulations, paragraph 4 (a)

Benefit Grids