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**INDUSTRY STANDARD OF THE
PEOPLE'S REPUBLIC OF CHINA**

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**Pressure ulcer prevention for senior care organization
(English Translation)**

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Foreword

This standard was drafted in accordance with the rules given in GB/T 1.1-2009.

This standard was proposed by the Ministry of Civil Affairs of the People's Republic of China.

This standard is under the jurisdiction of the National Technical Committee for Social Welfare Services Standardization (SAC/TC 315).

This standard was drafted. Suzhou Social Welfare Institute, Social Welfare Center of the Ministry of Civil Affairs, Beijing First Social Welfare Institute, Beijing Chaoyang Yangcao Cuncao Chunhui Nursing Home, Tianjin Nursing Home, Guangzhou Nursing Home.

1 Scope

This standard specifies the assessment, prevention methods and management requirements for pressure ulcer prevention services in nursing homes.

This standard applies to the prevention of pressure ulcers in the service providers of the elderly institutions.

2 Terms and definitions

The following terms and definitions apply to this document.

Pressure ulcer

Due to the long-term compression of local human tissues, tissue damage, ulceration, and necrosis due to continuous ischemia and hypoxia occur.

3.1 Evaluation objects and parts

3.1.1

The service object of the elderly care institution shall be included in the evaluation object as long as it meets any of the following.

- Bedridden, unable to turn over independently or unable to be an active author;
- Advanced disease;
- Wasting or edema, severe malnutrition;
- People with impaired consciousness and restricted autonomy;
- Postoperative or fixed medical measures, restricted body position or mobility;
- Patients with sensory impairment or dysfunction caused by chronic diseases;
- Incontinence, local dampness;
- Elderly people with slow response and difficulty in autonomous movement;
- Fever.

3.1.2

Prone areas include compression, lack of adipose tissue protection, and skeletal eminence. The following areas should be evaluated.

- ? tail;
- Anteroposterior spines;
- Costal margin protrusions;
- Hip;
- At the spinal body;
- Scapular region;
- Occipital tuberosity;
- Pinna;
- Elbows;
- Medial and lateral knee joints;
- Medial and lateral ankles;
- Heel area;
- toe;

- The big toe joint protrusion.

3.2 Evaluation requirements

3.2.1

The assessment should be performed on the day when the service object enters the elderly care institution, and follow-up observation should be conducted within 7 days.

3.2.2

If any one of the conditions in 3.1.1 occurs, the pressure ulcer risk level assessment shall be performed, see Appendix A.

3.2.3

During the fever period, a risk level shall be increased based on the evaluation score.

3.2.4

The relevant third party should be notified in writing when there is a risk of pressure ulcers.

4.1 Changing body position

When the risk of pressure ulcers is assessed as low-risk and high-risk, the position should be changed. The requirements are as follows.

- Autonomous change, supervise, remind, and encourage bedridden clients to change their positions frequently to reduce the pressure on skeletal protuberances;
- Passive change, to help clients who do not have the ability to stand up, turn over at least once every 2 hours;
- The service object using the wheelchair should change its posture once every 0.5h;
- When turning over and moving, avoid dragging, pulling, pushing, etc. to prevent scratching the skin.

4.2 Aid protection

When the pressure ulcer risk assessment is moderate to high risk or above, assistive devices should be used, the requirements are as follows.

- When lying down, you can use anti-pressure ulcer mattresses, roll-over auxiliary pads and other assistive devices. Place soft cushions (pillows) in the body space to reduce skeletal muscle Pressure at the protrusion-When sitting, can be equipped with auxiliary cushions, soft cushions placed in the body space;
- You can use the protective frame according to the doctor's order, use the protective frame to raise the quilt and blanket to avoid local pressure;

-The position should be changed according to the provisions of the use of assistive devices, and replaced immediately after soaking.

4.3 Cleaning

During service.

- The beds should be kept dry, level and free of debris;
- The skin of all parts of the body should be kept dry;
- Bathing and wiping bath, the skin should be wiped clean after bathing;
- Clients who are not suitable for bathing, such as surgery, trauma, and disturbance of consciousness, should arrange scrubbing baths;
- Apply force evenly when wiping to avoid rubbing the skin;
- When the clothing is wet with wound secretions, it should be changed immediately;
- Dinner, incontinence, vomiting, sweating, etc., should be wiped clean immediately, changing diapers and quilts with wet; warm water should be used Wash and dry the perineum;
- Use a non-destructive toilet to avoid hard plugs and deadlifts; soft paper or cloth pads should be placed on the edge of the bedpan;
- The client should be prevented from lying directly on the rubber sheet or plastic cloth.

4.4 Nutrition intake

Clients should be provided with meals that enhance their resistance and tissue repair capacity, and encourage and help them to eat.

4.5 Primary disease treatment

The client should be arranged to seek medical treatment, treat the primary disease, return to the clinic on time, give medicine on time, and help complete the rehabilitation course.

4.6 Psychological support

Clients should be provided with psychological counselling.

4.7 Health education

The clients and their families should be informed about the prevention of pressure ulcers.