

REPOSITIONING PATIENTS TO PREVENT PRESSURE ULCER FORMATION: THE 30° TILT

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Regular repositioning of patients who are unable to move themselves and are at a high-risk of pressure ulcer formation is essential. The 30° tilt has become widely recommended as an optimal position for the dissipation of applied pressure. In this guide the position is described in detail along with the reasons why it should be employed.

Pressure ulcers are areas of localised tissue damage caused by pressure, friction, shear, or a combination of these (European Pressure Ulcer Advisory Panel, 1998). Patients with chronic disease tend to be more at risk of the development of pressure ulcers (Kosiak, 1959; Banks, 1992) and these vulnerable patients must therefore be nursed with pressure ulcer prevention in mind.

The use of a pressure ulcer risk assessment tool should be undertaken to first identify the patients who are at most risk of ulcer development and to help the healthcare professional make the appropriate choice of pressure-reducing interventions. Among these interventions is the use of specialist equipment such as static or dynamic mattresses in conjunction with regular repositioning and turning. National and local pressure ulcer guidelines support the manual repositioning of patients. NHS Quality Improvement Scotland's best practice statement

about pressure ulcer care (2005) prompts healthcare professionals to remember that individuals must be repositioned to minimise pressure, friction and shear. As the two main contributory factors leading to ulcer development are thought to be intensity and duration of pressure the manual repositioning of patients by nursing staff has become a recognised technique in the prevention of ulceration (Young, 2004).

Repositioning can range from small shifts in position undertaken by the patient with encouragement, to full lateral repositioning/turning by the healthcare staff on behalf of the patient. There are various positions that have been recommended including the 90° laterally inclined, prone, and the 30° tilt (Colin et al, 1996). The 30° tilt has recently become more widely recommended by tissue viability and wound care nurses as it is thought to dissipate any applied pressure by redistributing pressure from bony prominences to areas of

larger tissue mass (Young, 2004). However, the evidence for the use of the 30° tilt tends to be anecdotal and the National Institute for Clinical Excellence guidelines (2005) do not specify a preferred position when repositioning an individual who is at risk of pressure ulcer development.

The position is achieved by placing a pillow under one buttock/small of back with the aim of tilting the pelvis forward by 30° while aiding patient comfort (*Figure 1*). Another pillow may then be situated lengthways under the legs (*Figure 2*). If undertaken correctly the outcome of this position should be that there is no contact between the patient's heels and sacrum and the support surface (the mattress) (*Figure 3*).

When considering the use of the 30° tilt position it is necessary to consider patient comfort and be aware that this position may not be suitable for all. Individuals with a fractured neck of femur and those who have suffered a cerebral vascular attack require specific

nursing care and positioning to reduce the risk of pressure damage and the 30° tilt position would be unsuitable for them (Preston, 1988). It is also very important to remember patient choice when undertaking repositioning and the need to consider that some individuals may be encouraged to reposition themselves with appropriate guidance. This may require reassessment of the patient and any equipment in use. If, for example, a patient has the ability to reposition themselves while on a static mattress but feels unable to do so while using a dynamic mattress, a simple change of equipment may mean the difference between dependant and independent repositioning. **WE**

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Figure 1. Pillows are placed under the patient's head to support the head and neck with a further pillow used to support the lumbar region and shoulder.



Figure 2. The patient's legs being supported by pillows.



Figure 3. The full recumbent 30° tilt position.

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