Preventing Pressure Injuries

Promoting Healthy Skin

www.disabilityimages.com

Be good to your skin. You'll wear it everyday for the rest of your life.
-Renee' Rouleau

Preventing Pressure Injuries
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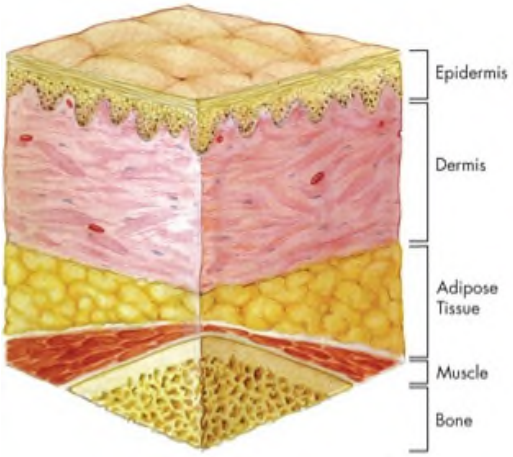
Disclaimer: The information, suggestions, and guidelines presented in this resource are consistent with best practices for maintaining good skin integrity. This information is not all-inclusive and should not be used to replace medical advice or detailed information and/or instructions from a health care provider. This resource is not intended to replace the policies and procedures of any agency.

Skin Anatomy and Function

The skin is the largest organ of the body and its primary job is protection — keeping good things in and harmful things out. Additional functions of skin are to help prevent dehydration, to regulate body temperature, and to provide a barrier from infection. Skin performs best when it is free of irritations, injury or open areas. Health professionals refer to this state as being “intact.” It is a primary goal to maintain good integrity of the skin over a lifetime.



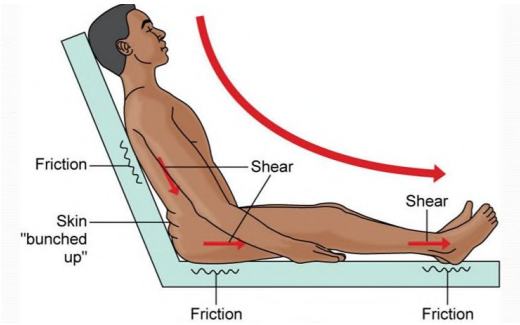
http://sci.washington.edu/info/pamphlets/msktc-stages.asp

The illustration above shows a cross-section of skin along with underlying tissue and bone. Note the layers: the epidermis layer, the dermis layer, the underlying tissue, muscle and bone. Pressure injuries can damage all layers.

What are Pressure Injuries?

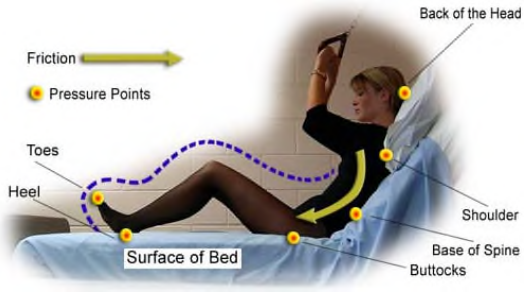
Pressure Injuries, also known as “bed sores” or “decubitus ulcers,” are areas of injury to the skin and the tissue under the skin due to damage from sitting or lying in one position too long. Friction and shearing (*a combination of friction and pressure*) occur when the body is in contact with services like bed linens, incontinence briefs, beds, chairs, wheelchairs, etc. Prolonged pressure is most problematic for those areas of the body where the bony parts of the skeleton are prominent because there is very little tissue, or flesh, between the bony prominence and the skin. Prolonged pressure in these areas forces blood out of the tissue that is under pressure. **Because blood carries vital oxygen to all the body’s cells, when oxygen is cut off, the oxygen-deprived tissue becomes damaged and a pressure ulcer begins.** The forces of pressure and shearing are the two main causes of pressure injuries.

http://www.arjohuntleigh.fi/products/therapeutic-support-systems/long-term-care/active-therapy-range/



https://slideplayer.com/slide/6861134/
Slideshow: Lisa M. Dunn MSN/ED/RN/CCRN/CNE

The one other ingredient that leads to trouble is *time*. Spending too much time in the same position without relieving pressure doesn't give the body a chance to let blood flow back into an area. Reestablishing blood flow to the area returns precious oxygen that keeps body tissue healthy. Prevention of prolonged pressure and early detection are key to keeping the skin intact.



https://www.myvmc.com/diseases/pressure-ulcers/

Who Gets Pressure Injuries?

Anyone who has to sit or lie in one position for a long time could get a pressure injury. Those with very poor nutrition and hydration are at an extreme risk because their body lacks the necessary fuel to repair itself. An otherwise healthy person who is immobilized due to illness or injury is at risk. People who cannot move themselves are at the greatest risk such as those who have strokes, paralysis, and nerve damage. Chronic diseases such as

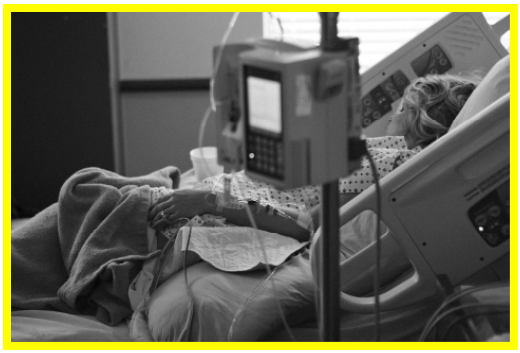
https://pixabay.com/en/hospice-care-patient-elderly-old-1821429/

diabetes, cancer, cerebral palsy, and problems with circulation are more risk factors. Elderly people are more prone to develop pressure injuries because the layers of their skin are less dense than their younger counterparts. Those with bowel and bladder incontinence also are prone to skin breakdown because this leaves the skin damp and more likely to break down.

https://www.pexels.com/search/elder/

Are Pressure Injuries Serious?

Pressure Injuries are absolutely serious and are a significant threat to health and safety. Complications from Pressure Injuries can lead to serious infections and even death. Pressure Injuries develop quickly, progress rapidly, and are often difficult to heal. In fact, pressure injuries are so costly to treat and heal that insurance companies question payment for new injuries that develop during hospital stays. With good monitoring and care, however, they can be prevented.



https://pixabay.com

Treating Pressure Injuries

Treatment focuses on preventing pressure injuries from getting worse and on restoring healthy skin. Three things help pressure injuries heal:

1. Relieving the pressure that caused the injury.
2. Treating the injury itself.
3. Improving nutrition and other conditions to help the injury heal.

Once the damage to skin has progressed beyond redness, then special medicated dressings, antibiotics and pain medication may need to be ordered. Improved nutrition and hydration also play important roles in healing.

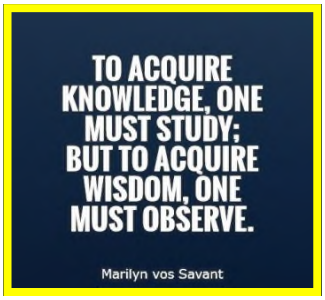
At times, pressure injuries are so deep and have such damage that surgical procedures may be necessary to remove all materials that promote infection and interfere with healing. Treatment is impacted by the person's general health, immune system, level of immobility, chronic illness, age and nutritional intake- especially protein and vitamin C. The individual's physician should be notified as soon as you see redness over an area and it does not fade after pressure is removed. The treatment plan begins at this stage of redness.

https://www.pexels.com/photo/two-person-doing-surgery-inside-room-1250655/

Skin Assessment and Observation

Be Observant

Your value to someone with a disability cannot be underestimated. Taking a few moments a day to observe for skin breakdown is vital to promoting and maintaining good skin health for the person you support. This can spare someone in your care the experience of significant pain and dramatically reduce the risk for serious complications stemming from skin breakdown. A good time to examine skin thoroughly each day is at bath time.

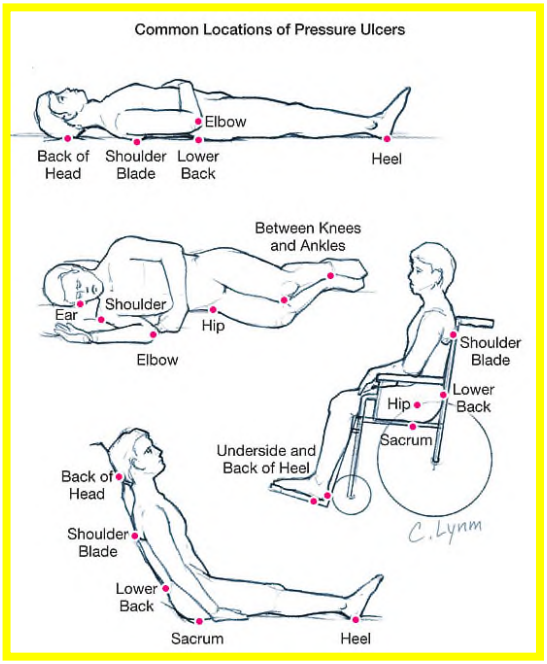


Observing is an Ongoing Process

A total body assessment is usually completed as part of many admission processes. This also is frequently done when a person is first admitted to a provider agency and to their new residence. This is often completed by a licensed medical professional at the agency or by someone who is designated to complete a basic skin assessment form. We have included a sample skin assessment form on page 24 of this manual. You may copy and use this form or choose another form that best suits your needs.

A skin care assessment should be completed before and after someone is in the hospital or nursing home. We would recommend using a skin assessment form just prior to a person being hospitalized, and just after they return from the hospital.

Common Locations of Pressure Injuries

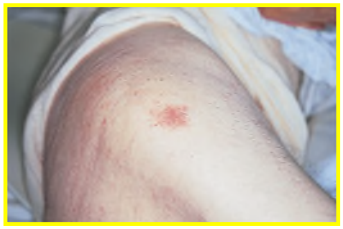


https://jamanetwork.com/journals/jama/fullarticle/203224

There are typically common locations for ulcer development depending on the person's degree of mobility and their position preference. 70% occur below the waist. If someone spends a lot of time in a wheelchair, usually areas over the tailbone, buttocks, and shoulder blades get significant pressure. It is also important not to overlook skin covering the spine, behind the bended knee or the elbows. If someone spends a lot of time in bed, the areas over the tailbone and hips are very vulnerable to pressure. Other areas include the back of the head, ears, shoulder blades, lower back and the back and sides of the legs. Remember that if anyone is incontinent of bladder or bowel, the dampness from waste products helps break skin down and provides a major source of infection.

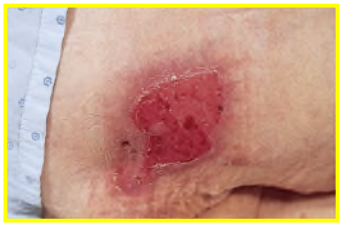
Stages of Pressure Injuries

If someone is unable to feel pain due to nerve damage, injury or chronic illness, then they are unable to communicate this important signal of alarm. If the pressure is not relieved, the damage to the tissues "digs" deeper and deeper into the skin. The skin on the surface opens and becomes a wound, which can become infected with drainage, fever, etc. The stages of pressure injuries can be recognized by the following descriptions and illustrations.



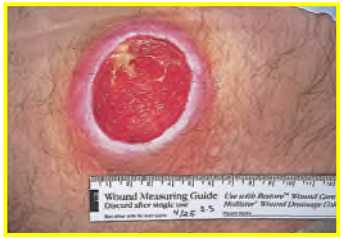
Stage 1

Skin is not broken but is red or discolored. The redness or change in color does not fade within 15 minutes after pressure is removed.



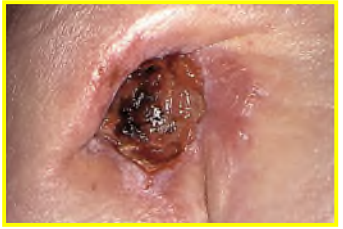
Stage 2

The epidermis, or topmost layer of skin is broken, creating a shallow open sore. Drainage may or may not be present.



Stage 3

The break in skin extends through the dermis (second skin layer) into the subcutaneous and fat tissue. The wound is deeper than in Stage Two.



Stage 4

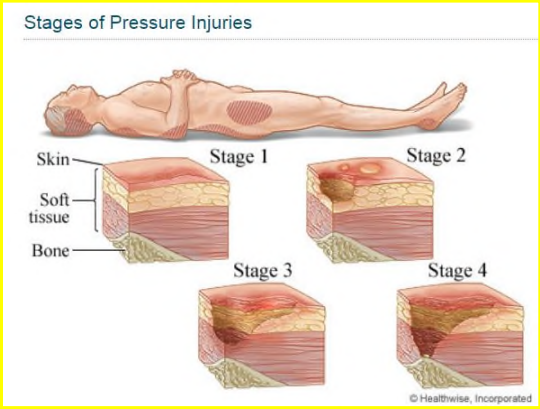
The breakdown extends into the muscle and can extend as far down as the bone. Usually much dead tissue and drainage are present.

Photos Credit: Hollister Incorporated
http://consumerjusticegroup.com/singhomeabuse/bedsores2.html

Stages of Pressure Injuries

The staging of pressure injuries is done by a physician or licensed nurse. The physician or nurse will categorize the ulcer into one of four stages depending on the level of tissue damage or depth of the injury. The tissue being referred to includes the skin and underlying dermis, fat, muscle, bone and joint. Knowing the stage helps guide the prognosis and management of the ulcer.

Once a pressure injury has been staged it remains at its highest level of staging from that point forward. For example, if someone had a stage 3 pressure injury and it later healed, it would be referred to as a “Healed Stage 3”.



The first sign of a pressure injury is a redness over a pressure point that does not fade within 15 minutes after pressure has been removed. Pressure damage to tissue begins deep. Once you see redness on the skin surface that does not fade after 15 minutes, there is already damage beneath the skin surface. These red areas can develop very quickly, sometimes in a matter of hours especially in a debilitated individual. A person who is unable to turn in bed could easily develop a reddened area overnight and be at risk for a pressure injury. These injuries are painful and uncomfortable, often leading the person to ask for help.

Preventing Pressure Injuries

Constant pressure over a long period of time causes injuries; reposition the person frequently. **No more than two hours should elapse before changing position**, whether in a wheelchair or in bed. Physicians or nurses may recommend special bedding, cushions or other products that can help relieve pressure. Even so, nothing is as effective as getting pressure off the affected area by turning, moving, or changing position. The following, excerpted from Mayo Clinic's website, provides many useful recommendations.

Repositioning in a wheelchair

www.disabilityimages.com

Repositioning in a wheelchair includes the following recommendations:

⇒**Frequency.** People using a wheelchair should change position as much as possible on their own every 15 minutes and should have assistance with changes in position every hour.

⇒ **Self-care.** If [the person has] enough strength in [his/her] upper body, [they] can do wheelchair push-ups — raising [their] body off the seat by pushing on the arms of the chair.

⇒ **Specialized wheelchairs.** Pressure-release wheelchairs, which tilt to redistribute pressure, provide some assistance in repositioning and pressure relief.

⇒ **Cushions.** Various cushions including foam, gel, and water or air-filled cushions can relieve pressure and help ensure that the body is appropriately positioned in the chair. A physical therapist can advise on the appropriate placement of cushions and their role in regular repositioning.

https://drift-away-beds.myshopify.com/products/copy-of-deluxe-cool-blue-memory-mattress

Repositioning in a bed

Repositioning for a person confined to a bed includes the following recommendations:

⇒ **Frequency.** Repositioning should occur every two hours.

⇒ **Repositioning devices.** People with enough upper body strength may be able to reposition themselves with the assistance of a device such as a trapeze bar. Using bed linens to help lift and reposition a person can reduce friction and shearing. Caution should be exercised not to "drag" skin across linens.

http://elderlycaresystems.com/best-trapeze-bar-bed-mobility/

⇒ **Special mattresses and support surfaces.** Special cushions, foam mattress pads, air-filled mattresses and water-filled mattresses can help a person lie in an appropriate position, relieve pressure and protect vulnerable areas from damage. Your doctor or other care team member can recommend an appropriate mattress or surface.

https://medmartonline.com

⇒ **Turning mattress.** Turning mattress, also known as a lateral rotation therapy mattress, provides regular lateral movement of the user through the use of air pressure to create an angled plane that causes the body to turn.

⇒ **Bed elevation.** Hospital beds that can be elevated at the head should be raised no more than 30 degrees to prevent shearing.

⇒ **Protecting bony areas.** Bony areas can be protected with proper positioning and cushioning. Rather than lying directly on a hip, it's best to lie at an angle with cushions supporting the back or front. Cushions should also be used to relieve pressure against and between the knees and ankles. Heels can be cushioned or "floated" with cushions below the calves.

https://www.restorationspt.com/blog/sleep-positioning-101/

Skin care

Protecting and monitoring the condition of the skin is important for preventing pressure injuries and identifying stage I injuries before they worsen.

⇒ **Bathing.** Skin should be cleaned with mild soap and warm water and gently patted dry. Or a no-rinse cleanser can be used.

⇒ **Protecting skin.** Dry skin should have lotion applied.

⇒ **Inspecting skin.** Daily skin inspection is important for identifying vulnerable areas of skin or early signs of pressure injuries. Care providers usually need to help with a thorough skin inspection, but people with more mobility may be able to inspect their skin with the use of a mirror.

www.pexels.com

Managing incontinence

Urinary or bowel incontinence should be managed to prevent moisture and bacterial exposure to skin. Care may include frequently scheduled assistance with urinating, frequent diaper changes, protective lotions on healthy skin, urinary catheters or rectal tubes.

Nutrition

Your doctor, dietitian or other members of the care team can recommend dietary changes that can help improve the health of your skin.

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⇒ **Diet.** You may need to increase the amount of calories, protein, vitamins and minerals in your diet. Your doctor may also prescribe dietary supplements, such as vitamin C and zinc.

⇒ **Fluids.** Adequate hydration is important for maintaining healthy skin. Your care team can advise on how much fluid to drink and signs of poor hydration, such as decreased urine output, darker urine, dry or sticky mouth, thirst, dry skin, or constipation.

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⇒ **Feeding assistance.** Some people with limited mobility or significant weakness may need assistance with eating in order to get adequate nutrition.

Other strategies

Other strategies that can help decrease the risk of pressures injuries include the following:

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⇒ **Quit smoking.** If you smoke, quit. Talk to your doctor if you need assistance quitting.

⇒ **Stay active.** Limited mobility is a key factor in causing pressure injuries. However, daily exercise that is appropriately matched to a person's abilities is an important step in maintaining healthy skin. A physical therapist can recommend an appropriate exercise program that improves circulation, builds up vital muscle tissue, stimulates appetite and strengthens the body overall.


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Observing is an Ongoing Process: Other Considerations:

People who spend most of their time in a wheelchair or in bed need their skin checked frequently, at least every two hours when their position is changed.

⇒ People who are incontinent of bladder and/or bowel should have their skin assessed several time a day, even if they do not have limited mobility.

⇒ Remember those who are not able to voice their discomfort. They also need their skin assessed several time a day.

⇒ If you can stop pressure damage in the ***redness*** stage, it is possible to prevent further complications.

⇒ Protect an affected area from any more pressure, but do not attempt to provide treatment without the orders of a medical professional.

http://health.sunnybrook.ca/navigator/share-hospital-room-opposite-sex/

⇒ Please be mindful of long fingernails. Not only can long nails scratch the person in your care, but they can harbor and transmit harmful germs.

⇒ Remember to respect the person's sense of modesty. Always ask permission to do an assessment and then explain what you are doing and why. Providing privacy at all times maintains the person's dignity.

Risk Assessment

Identifying risk factors for the development of pressure ulcers is a good starting point to developing a plan of prevention to keep skin healthy.

Good Nutrition and Hydration

Having adequate nutrition and hydration is vital to health and safety, even for skin. These factors are also crucial to the prevention and healing of pressure injuries. Talk with a physician or nurse for guidelines to improving and correcting areas of concern. Consider asking the physician for a consult with a Registered Dietician to help develop a nutritionally balanced diet and support plan.

Risk Factors for Developing a Pressure Injury

- *Decreased mental status*
- *Exposure to moisture*
- *Incontinence*
- *Friction/shearing*
- *Immobility*
- *Inactivity*
- *Poor nutrition*
- *People who use tube feedings*
- *Poor hydration*
- *Chronic illness*

Adequate protein is essential for tissue building and wound healing. The physician may order multivitamin, or mineral supplements. The physician may also order vitamin C since recent studies show that vitamin C is helpful in wound healing as well as its ability to act as a skin protector. Offer glasses of water whenever you can, such as with position changes (every two hours), and meals.

Incontinence and Hygiene

When someone is incontinent, their skin must be checked several times during the day, for example:

First in the morning; each time adult briefs are changed; afternoon prior to evening meal; and bedtime. While it is important to use adult incontinence briefs that are absorbent, there is a great risk for skin breakdown if they are left on without being changed.

www.pexels.com

Skin care for people with incontinence includes cleanliness. Cleanse the person's skin at the time of soiling. If urine or fecal matter is left on the skin it will quickly cause the skin to break down. The physician or nurse may tell you to use a protective salve that is a moisture barrier as a further means of prevention and treatment. Use moisturizers liberally and use salves and ointments sparingly, applying only a thin coat.

Avoid Rubbing

www.pexels.com

You can cause damage to the skin tissues if you massage over pressured areas, so avoid this practice. Contrary to some beliefs, you are not "increasing circulation" to the area. Instead, you are adding compression and friction to the areas that are already damaged. If you need to use moisturizers or salves, apply them very gently without a lot of pressure.

Body Check Assessment (BCA)

When Should a BCA be Completed?

This is a policy determined by your agency. The following is a list of situations when it would be appropriate to complete a body check assessment:

- ✓ A new admission into the agency
- ✓ Upon changing residence from one home to another
- ✓ Prior to going to the hospital (admission)
- ✓ Returning from the hospital (from inpatient stay)
- ✓ Returning from a nursing or convalescent home
- ✓ Discharge from the agency
- ✓ Before and after there has been an unobserved leave of absence with family or friends

The following are situations when it would be appropriate to complete periodic assessments (i.e. daily, weekly, monthly). The frequency will be dictated by individual situations and needs.

- ✓ Bath time allows you to check the entire body, i.e. bony prominences such as ears, buttocks, heels, etc.
- ✓ Incontinence of bowel and/or bladder
- ✓ Immobility—bedbound or chair bound
- ✓ Chronic illness
- ✓ Long term injury
- ✓ Receiving tube feedings

The Body Check Assessment Sheet on page 22 includes important elements discussed in this manual and can help you record and communicate necessary information about a person's skin status.

You may copy the Body Check Assessment form for your use, or you may find another form that better suits your needs.

Body Check Assessment Sheet

Resident's name:_____

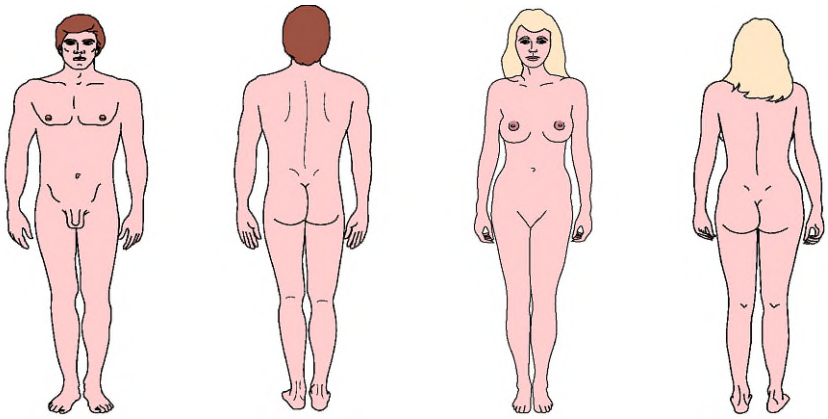
Date:_____ Time: _____Doctor:_____

Accurate weight: _____ Tube Fed? _____

Purpose (please check all that apply):

New Admission	Going to Hospital	Return from Hospital
New Residence	Going to Nursing Home	Return from Nursing Home
Incontinent	Bed Bound	Chair bound
Injury	Illness	Other

Bruise # Redness ✹ Open Area 0 Burn B Scrape /



Bruising	**Redness**	**Open Area**	**Burn**	**Scrape**
Yellow	Pink	Seeping	Red	Skin closed
Green	Red	Scabbed	Blister	Seeping
Purple	Soft	Dry	Seeping	Dry
Fading	Size	Swelling	Dry	Swelling

Draw symbol/s on the picture where mark is located on the person.
In the chart below, Initial what you observe:
Do red areas go away easily? _____

Can this person change their position independently? _____

Staff signature_____

Whom notified_____

Braden Scale For Predicting Pressure Injury Risk

The Braden Scale is a tool used to evaluate an individual's risk of developing a pressure injury. It examines six risk factors, and when completed, it provides a score that indicates a level of risk that is severe, high, moderate or mild. The six risk factors measured are: Sensory Perception, Moisture, Activity, Mobility, Nutrition, and Friction and Shear. You may easily locate a Braden Scale to view or print out by going online. *See page 24.*

Braden Scale For Predicting Pressure Injury Risk

BRADEN SCALE – For Predicting Pressure Sore Risk

SEVERE RISK: Total score ≤ 9 **HIGH RISK**: Total score 10-12
MODERATE RISK: Total score 13-14 **MILD RISK**: Total score 15-18

DATE OF ASSESS ➡

RISK FACTOR	SCORE/DESCRIPTION				1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. COMPLETELY LIMITED** – Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.	**2. VERY LIMITED** – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. SLIGHTLY LIMITED** – Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. NO IMPAIRMENT** – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE Degree to which skin is exposed to moisture	**1. CONSTANTLY MOIST**– Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. OFTEN MOIST** – Skin is often but not always moist. Linen must be changed at least once a shift.	**3. OCCASIONALLY MOIST** – Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. RARELY MOIST** – Skin is usually dry; linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity	**1. BEDFAST** – Confined to bed.	**2. CHAIRFAST** – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. WALKS OCCASIONALLY** – Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. WALKS FREQUENTLY**– Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body position	**1. COMPLETELY IMMOBILE** – Does not make even slight changes in body or extremity position without assistance.	**2. VERY LIMITED** – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. SLIGHTLY LIMITED** – Makes frequent though slight changes in body or extremity position independently.	**4. NO LIMITATIONS** – Makes major and frequent changes in position without assistance.				
NUTRITION Usual food intake pattern [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition.	**1. VERY POOR** – Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. PROBABLY INADEQUATE** – Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. ADEQUATE** – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. EXCELLENT** – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEAR	**1. PROBLEM**– Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. POTENTIAL PROBLEM**– Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. NO APPARENT PROBLEM** – Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					
TOTAL SCORE	**Total score of 12 or less represents HIGH RISK**							

ASSESS	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
1	/ /		3	/ /	
2	/ /		4	/ /	

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed

Form 3166P BRIGGS, Des Moines, IA 50306 (800) 247-2345 www.BriggsCorp.com
8304 PRINTED IN U.S.A

BRADEN SCALE

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Resources

Sometimes the pressure injury won't heal or becomes worse. You can ask your physician to refer you to a Wound Care Center to provide the latest treatments in wound care. If you are having trouble locating a Wound Care Center you can contact the Special Needs Unit (SNU) of your Health Care Insurance Company to assist you. A list of contacts for SNU's are available on page 27 in this manual.

Wound Care Center: A wound care center, or clinic, is a medical facility for treating wounds that do not heal.

Wound Care Nurse: Provides optimal care for patients dealing with complex wounds, ostomies or incontinence issues.

Resources: Special Needs Unit

Special Needs Unit — Units in all PA Medicaid Managed Care Organizations responsible specifically for helping patients with special healthcare needs coordinate care and obtain needed services

Health Choices Physical Health Plans	Member Services Phone Number	Special Needs Units Phone Number
Aetna Better Health	866-638-1232 TTY 711	855-346-9828 TTY 711
AmeriHealth Caritas PA	888-991-7200 TTY 888-987-5704	800-684-5503 TTY 888-987-5704
AmeriHealth Caritas Northeast	855-809-9200 TTY 855-859-4109	888-498-0766 TTY 855-859-4109
Gateway Health Plan Inc.	800-392-1147 TTY 711	800-642-3550 TTY 711
Geisinger Health Plan	855-227-1302 TTY 711	855-214-8100 TTY 711
Health Partners of Philadelphia Inc.	800-553-0784 TTY 877-454-8477	866-500-4571 TTY 215-849-1579
Keystone First Health Plan	800-521-6860 TTY 800-684-5505	800-573-4100 TTY 800-684-5505
United Healthcare Community Plan	800-414-9025 TTY 711	877-844-8844 TTY 711
UPMC for You, Inc.	800-286-4242 TTY 800-361-2629	866-463-1462 TTY 800-361-2629

Health Care Quality Units

Health Care Quality Units (HCQUs) work to support and improve the physical and mental health of people with intellectual disabilities. HCQUs can provide trainings on proper skin care and reducing or preventing pressure injuries, among many other topics. HCQUs can also help you locate resources in your community and make suggestions to enhance someone's wellbeing. For more about HCQUs, visit: www.myodp.org/mod/page/view.php?id=7699

HCQUs of Pennsylvania	Phone Number	Website
Central PA (Geisinger)	570-271-7240	https://www.geisinger.org/patient-care/for-professionals/about-healthcare-quality-unit
Eastern PA (Advocacy Alliance)	610-435-2700	www.easternpa-hcqu.org/
Northeastern PA (Advocacy Alliance)	570-558-3206	*www.nepa-hcqu.org*
Northwestern PA (Milestone HCQU Northwest)	814-728-9400	www.milestonepa.org/milestone-hcqu-northwest
South Central PA (Advocacy Alliance)	717-835-2270	www.southcentralpa-hcqu.org/
Southeastern PA (Philadelphia Coordinated Health Care)	215-546-0300	www.pchc.org/
Southwestern PA (KEPRO)	724-864-0715	www.hcqu.kepro.com/
Western PA (Milestone HCQU West)	724-283-0990	www.milestonepa.org/milestone-hcqu-west