

Pressure Ulcers

Contributing Factors

Major: Braden score of less than 18, serum albumin level of less than 3, fecal and/or urine incontinence, fragile skin, and bed bound

Less prominent: poor circulation, diabetes, edema, obesity, multisystem failure, chair bound, contracted, and enteral feeding

Cost-effective treatment

- High quality care with advanced dressings is more expensive upfront
- But the decreased number of changes, time until healing, and staff time makes this method more economical

Prevention

1. Conduct a PrU admission assessment for all patients (e.g. Braden Scale). Educate staff and keep information about scale at Nurse's stations.
2. Reassess risk for all patients daily (at every shift). Include Braden score on visible patient information.
3. Inspect skin every shift. Document both pressure and non-pressure skin problems.
4. Manage moisture. Check incontinent patients every hour; use moisture-barrier ointment, absorbent powder, and under-pad.
5. Optimize nutrition and hydration. Perform a nutritional assessment on every patient upon admission. All patients with stage II PrU's or greater should receive a dietary consultation.
6. Minimize pressure with frequent repositioning and foam padding to oxygen tubing around ears.

Repositioning

Goal: To reduce duration and magnitude of pressure over bony prominences.
FOR ALL AT-RISK PATIENTS.

Positioning frequency depends on: tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, assessments of skin condition, and the type of support surface.

During repositioning, you must: avoid shear and pressure forces, use transfer aids to reduce friction and shear, lift—don't drag, avoid positioning onto tubes or drainage systems, avoid positioning on bony prominences with existing non-blanchable erythema, and maintain patient dignity.

Use 30° side-lying position. Alternate right side, back, left side, and prone if the patient and his/her medical condition tolerates prone.

AVOID 90° sidelying, semi-recumbent position, and head-of-bed elevation sitting/slouching.

In sitting, use a footstool or footrest to position the legs with slight hip flexion so that the thighs are slightly lower than horizontal to prevent the body from sliding forward. Relieve pressure every 15 minutes since there is a lot of force over a small area (ischial tuberosities).

Document repositioning regimes, frequency, position, and evaluate outcomes of regime. Educate all care providers and significant others. Consider appropriate equipment such as foam wedges and specialty mattresses.

FREQUENCY

Patient Variables:

- Tissue tolerance
- Level of activity/mobility
- Medical Condition
- Treatment Objectives
- Skin Condition

Support Surface Variables:

- Non-pressure redistributing mattress=>requires greater frequency
- Viscoelastic foam mattress=>requires less frequency



Staging

I– Non-blanchable redness

II– Partial thickness loss of dermis

III– Full thickness tissue loss

IV– Full thickness tissue loss with exposed bone, tendon, or muscle

Unstageable– Full thickness tissue loss with bed completely obscured by eschar and/or slough

Suspected Deep Tissue Injury– Purple localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear

