Pressure Ulcers eCourse

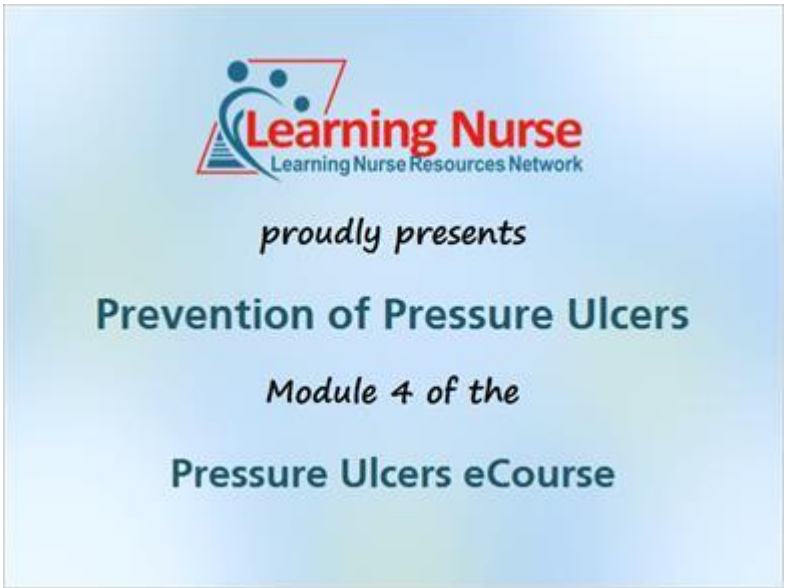
Module 4.1: Prevention of Pressure Ulcers

Handout

Prevention of Pressure Ulcers

1. PU Prevention

1.1 Welcome



Narration

No narration, only music.

1.2 Introduction

Narration

JILL: Hi … I'm Jill and with me is Mark. Welcome to Module 4 of this Pressure Ulcer course.

MARK: Hi Jill. In this module we going to discuss how to prevent pressure ulcers, right?

JILL: Yes, that is correct. In the previous module, we learned how to identify those patients and residents that may be at risk for developing pressure ulcers. We did this by doing a comprehensive skin assessment, using risk-assessment scales and using our best clinical judgment.

So now we are going to take a look at a step-by-step approach that will reduce the risks of our patients and residents developing pressure ulcers while in our care.

MARK: Sounds great. Let's get started!

1.3 Strategies

Narration

JILL: On this, and the next slide, is a list of the strategies that we will use to develop and implement our preventive pressure ulcer program. The first five include … daily skin inspection … at-risk visual reminder cues … documentation … nutritional intake and repositioning.

1.4 Strategies 2

Narration

JILL: The remaining four strategies are … pressure redistribution … managing moisture … dealing with incontinence and skin care supplies.

MARK: Knowing about the causes of pressure ulcers, those preventive strategies definitely make sense to me. I assume we are now going to discuss each in more detail?

JILL: Yes we are. Let's start with the daily skin inspection.

1.5 Skin Inspection

Narration

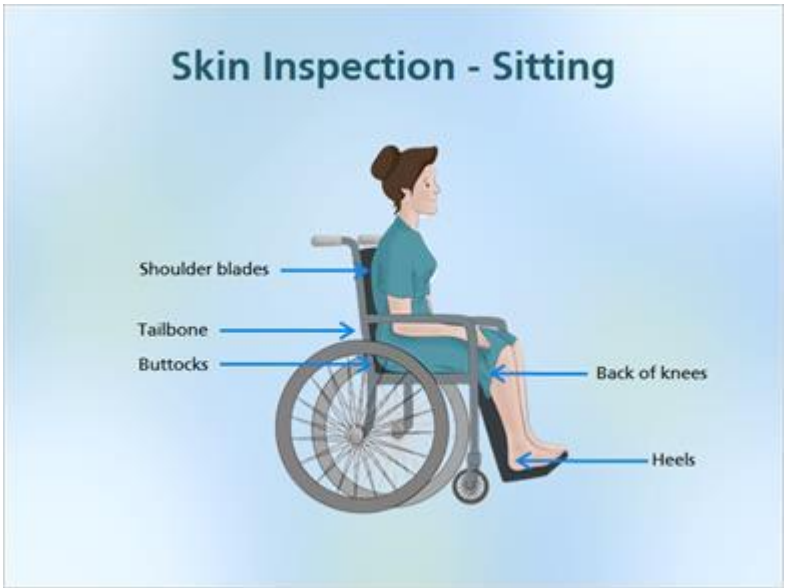
JILL: Daily skin inspection should be done on patients and residents at high risk for pressure ulcers. Skin inspections can be done while bathing, dressing, or assisting a patient or resident. Special attention should be given to specific, vulnerable pressure points for individuals who are bedridden or chair-bound.

MARK: And those vulnerable pressure points are … ?

JILL: We talked about them in our last module on risk assessment. But given how review reinforces learning, here they are again.

MARK: Okay … (chuckles)

1.6 Skin Inspection 2



Narration

JILL: For those patient and residents in a sitting position, here are the key pressure points. Pay particular attention to the sitting bones and coccyx in particular.

1.7 Skin Inspection 3

Narration

JILL: For patients and residents in the supine position, here are the places on the body to assess the skin.

1.8 Skin Inspection 4

Narration

JILL: And finally, for individuals lying on their side, here are the places where you should regularly inspect their skin for signs of developing pressure ulcers.

MARK: I would imagine that if these skin inspections are done as shown, they would become part of our daily routine with the patients.

JILL: Yes, and this would be an important step in preventing pressure ulcers and their early identification.

1.9 Reminders

Narration

MARK: What are at-risk reminders?

JILL: These are reminders to the care staff that a particular patient or resident is at high risk for pressure ulcer development. For example, one helpful technique is to place stickers on the patient's chart or door to alert staff that the patient is at-risk. This technique reminds staff to apply pressure ulcer prevention protocols, such as using draw sheets to transfer patients and to turn and reposition patients every few hours.

MARK: Hey, that's a great idea. Given how many patients we typically have under our care, it is easy to forget which ones are at-risk and which ones are not!

1.10 Documentation

Narration

JILL: The next prevention strategy is documentation. Documenting skin assessments is essential for the prevention and treatment of pressure ulcers.

MARK: What should we be documenting with these at-risk patients?

JILL: You should document evidence of assessment, risk status and plan of care. Of course you should document the development of any new pressure ulcers.

A bit more on care plans. Several studies on long term care residents have found that pressure ulcer prevention plans were poorly compiled and did not include any key points that clearly state the patient's care needs. Sometimes it was difficult to establish whether the residents' skin was intact or whether the individual had developed the pressure ulcers in care. So a complete pressure ulcer prevention care plan is very important!

MARK: When should this documenting be done?

JILL: On admission or initial identification of a hospital-acquired pressure ulcer. Documentation should also take place prior to any transition from one healthcare setting to another.

1.11 Nutrition

Narration

MARK: I see that the next prevention strategy is food … my favorite topic.

JILL: Yes Mark. It is recommended that we provide 30 to 35 calories/kg body weight for patients under stress with pressure ulcers.

MARK: Since a kilogram is 2.2 lbs, then a patient weighting 150 lbs should be getting between 2,000 and 2,400 calories each day.

JILL: Sound about right to me. However, this formula needs to be adjusted for weight loss, weight gain, or change in level of obesity. Patients who are underweight or have lost weight unintentionally will need additional calories.

MARK: And these calories are needed because …?

JILL: Severe protein deficiency renders soft tissue more susceptible to breakdown when exposed to local pressure.

1.12 Nutrition 2

Narration

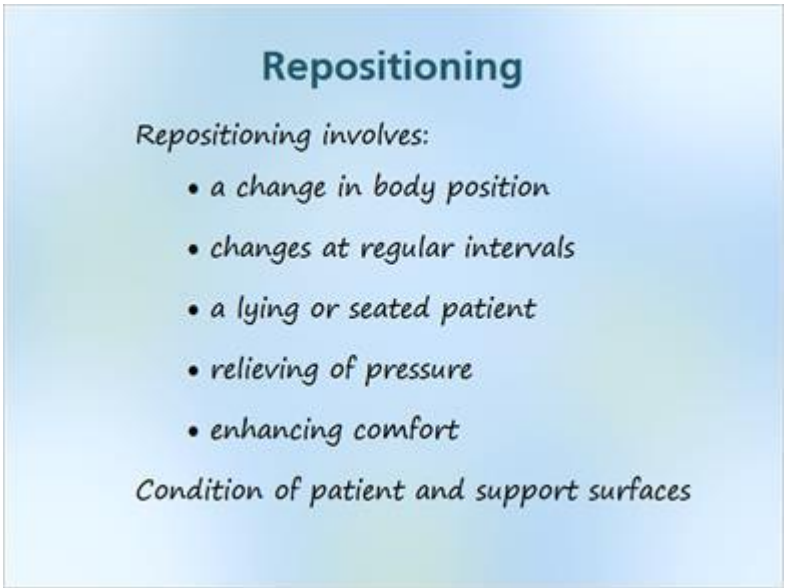
JILL: In addition, there is a decreased resistance to infection with low protein levels because of the effect on the immune system.

When a patient or resident has an inadequate dietary intake, you should attempt to discover the reasons why. Then offer support with eating and provide nutritional supplements as needed.

MARK: In summary, nutrients are important in keeping the body healthy and preventing pressure ulcers.

JILL: Right!

1.13 Repositioning



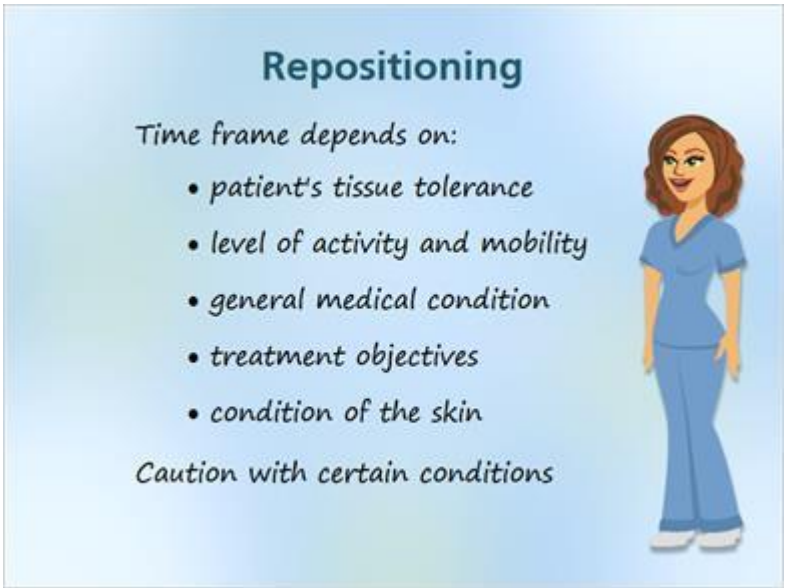
Narration

JILL: Our next strategy to prevent pressure ulcers from developing is repositioning. Remember that pressure ulcers are caused by continuous pressure on a part of the body, especially over bony prominences. So an important prevention strategy is to reposition the patient or resident regularly to relieve that pressure.

MARK: Repositioning involves a change of body position, undertaken at regular intervals, of the lying or seated patient, with the purpose of relieving or redistributing pressure, and enhancing comfort. The use of repositioning as a prevention strategy must take into account the condition of the patient and the support surfaces in use.

JILL: Yes, that is correct.

1.14 Repositioning 2



Narration

MARK: How often should we reposition an at-risk patient or resident?

JILL: The repositioning time frame is determined by the patient's tissue tolerance, his level of activity and mobility, general medical condition, treatment objectives and the condition of the skin. Also, certain medical conditions may affect positioning. For example, patients with respiratory or cardiac disorders may become unstable unless cared for in a particular position.

1.15 Repositioning 3

Narration

JILL: To answer your specific question Mark, the recommendation for regular and frequent turning and repositioning for bed- and chair-bound patients is every two to four hours.

MARK: Any other considerations when it comes to repositioning?

JILL: Yes there are! When repositioning, avoid the 90-degree side-by-side lying position. This position creates intensive pressure directly over the trochanter – the bony prominence on the upper part of the femur. Instead, the 30-degree lateral position should be used alternatively with the supine position. The head of the bed should be lowered to an angle of 30 degrees or less. This prevents shear and reduces pressure on the sacral region.

MARK: And I assume that we should maintain a written schedule for turning and repositioning a patient or resident.

JILL: Yes, we should.

1.16 Repositioning 4

Narration

JILL: A few more considerations about repositioning. If possible, use pressure-redistributing mattress and chair cushion surfaces. If the patient's condition allows, they should be encouraged to participate in a rehab program to maintain or improve their mobility and activity. Finally, reminders help nurses follow the repositioning schedules established for each patient or resident.

MARK: Good information. I now realize that repositioning is an important component in our pressure ulcer prevention program.

JILL: Yes, it sure is.

1.17 Redistribution

Narration

JILL: Our next strategy is pressure redistribution. Mark, why don't you do this one?

MARK: Okay. Pressure redistribution is the ability of a support surface to distribute load over the contact areas of the human body. You should try to relieve the pressure on areas near the pressure ulcer or vulnerable areas. Pressure redistribution can be achieved with repositioning and the use of support surfaces. It is important to use positioning devices, such as pillows and foam wedges, to avoid placing the patient on areas at-risk for pressure ulcers. Place the cushioning devices or pillows between the legs or ankles and other bony prominences to maintain alignment and prevent bony prominences from touching the surfaces.

JILL: Thanks for doing that Mark.

1.18 Moisture

Narration

JILL: Our next strategy is managing moisture. As we discussed previously, moisture is a contributing factor to the development of pressure ulcers. Mark, where do you think the moisture comes from?

MARK: I would think that the three main sources would be perspiration, wound drainage and incontinence.

1.19 Moisture 2

Narration

JILL: Yes, that's correct. Moisture from incontinence may contribute to pressure ulcer development by macerating the skin and increasing friction. Wet skin shows significant decreases in temperature and blood flow during pressure load. It is important to use a moisture barrier protectant on the skin. These can be creams, ointments, or film-forming skin protectants that will protect and maintain intact skin or treat non-intact skin.

MARK: So the rule is to keep the skin dry.

JILL: Uh-hum.

1.20 Incontinence

Narration

JILL: Speaking of moisture, our next topic is incontinence. Urinary incontinence has a harmful effect on the skin. The bacteria and ammonia cause undesirable alkaline skin conditions. Destructive enzymatic activity is also increased. Perineal skin damage caused by incontinence occurs in as many as a third of hospitalized patients and 40% of residents in long term care.

MARK: So I guess that, when dealing with an incontinent patient who is also at risk of developing pressure ulcers, the first step is to assess and treat the incontinence problem.

JILL: Right. This may involve adapting the patient's physical environment to include clothing that can easily be removed, physiotherapy, improved access to toilets, walking aids and assistance to access toilets, regular toileting or provision of commode, and regular cleansing and changing of soiled incontinence aids.

The skin should be kept clean, dry and well moisturized to maintain the best barrier possible against skin damage. Using specialized pH-balanced skin cleansers, avoiding damaging soaps, and protecting the skin with skin barriers, are also important.

1.21 Incontinence 2

Narration

JILL: Here are a few additional considerations when dealing with incontinence.

If patients or residents are incontinent, place them on moisture-control pads that provide quick-drying surfaces for the skin. Avoid use of diapers. Diapers tend to hold urine and fecal matter close to the skin. Implement a toileting schedule or bowel and bladder program as appropriate.

Prevent moisture from accumulating in skin folds. Use fecal-collecting devices such as pouches to collect loose or liquid stools from bedridden patients. For incontinent males, consider using external catheters to divert urine away from the skin.

MARK: Some more good ideas on keeping them dry.

1.22 Skin Care Supplies

Narration

JILL: Our final pressure ulcer prevention topic is skin care supplies. Keeping skin care supplies by the patient's bedside can reduce the workload for nurses. It is also a good reminder for them to provide skin care regularly. It may be useful to have information on the skin care products as well as their appropriate applications.

MARK: Yes, having skin care supplies available in the patient's or resident's room saves me time and is a good reminder.

1.23 Summary

Narration

JILL: This brings us to the end of this presentation on ways to prevent pressure ulcers. Mark, why don't you briefly summarize what we covered in this module?

MARK: Sure, I would be happy to do that. We discussed nine different prevention strategies for helping patients and residents at-risk of developing pressure ulcers. These were: daily skin inspections and staff reminders; documentation and nutrition; repositioning and redistribution of weight; moisture and incontinence; and, making skin care supplies readily available.

The main goal of any pressure ulcer prevention program is to significantly reduce the incidence of hospital-acquired pressure ulcers in patients and residents in our care facilities. Did I miss anything?

JILL: No Mark. Your summarization was excellent as usual. I'm Jill here will Mark saying goodbye for now. We will see you soon in the other modules of this pressure ulcers course.

MARK: Bye.

1.24 The End

Narration

No narration, only music.