SNS COLLEGE OF NURSING

SARAVANAMPATTI,COIMBATORE

UNIT-IV

CARE OF PRESSURE POINTS IN NURSING FOUNDATION

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Professor

CARE OF PRESSURE POINTS

Bed Sores

DEFINITION:

- **A *Pressure Ulcer* or *Pressure Sore* or *Decubitus Ulcer* or *Bedsore* is localized injury to the skin and other underlying tissue, usually over a body prominence, as a result of prolonged unrelieved pressure.**

Risk Factors

1. Friction
2. Shear
3. Impaired Sensory Perception
4. Impaired Physical Mobility
5. Altered Level Of Consciousness
6. Fecal And Urinary Incontinence

Risk Factors

7. Malnutrition
8. Dehydration
9. Excessive Body Heat
10. Advanced Age
11. Chronic Medical Conditions- Diabetes, Cardiovascular Diseases.

Pathophysiology

Various risk factors act on areas of soft tissue overlying bony prominence

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When this pressure exceeds normal capillary pressure

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Occlusion & tearing of small blood vessels

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Reduced tissue perfusion

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Ischemic necrosis

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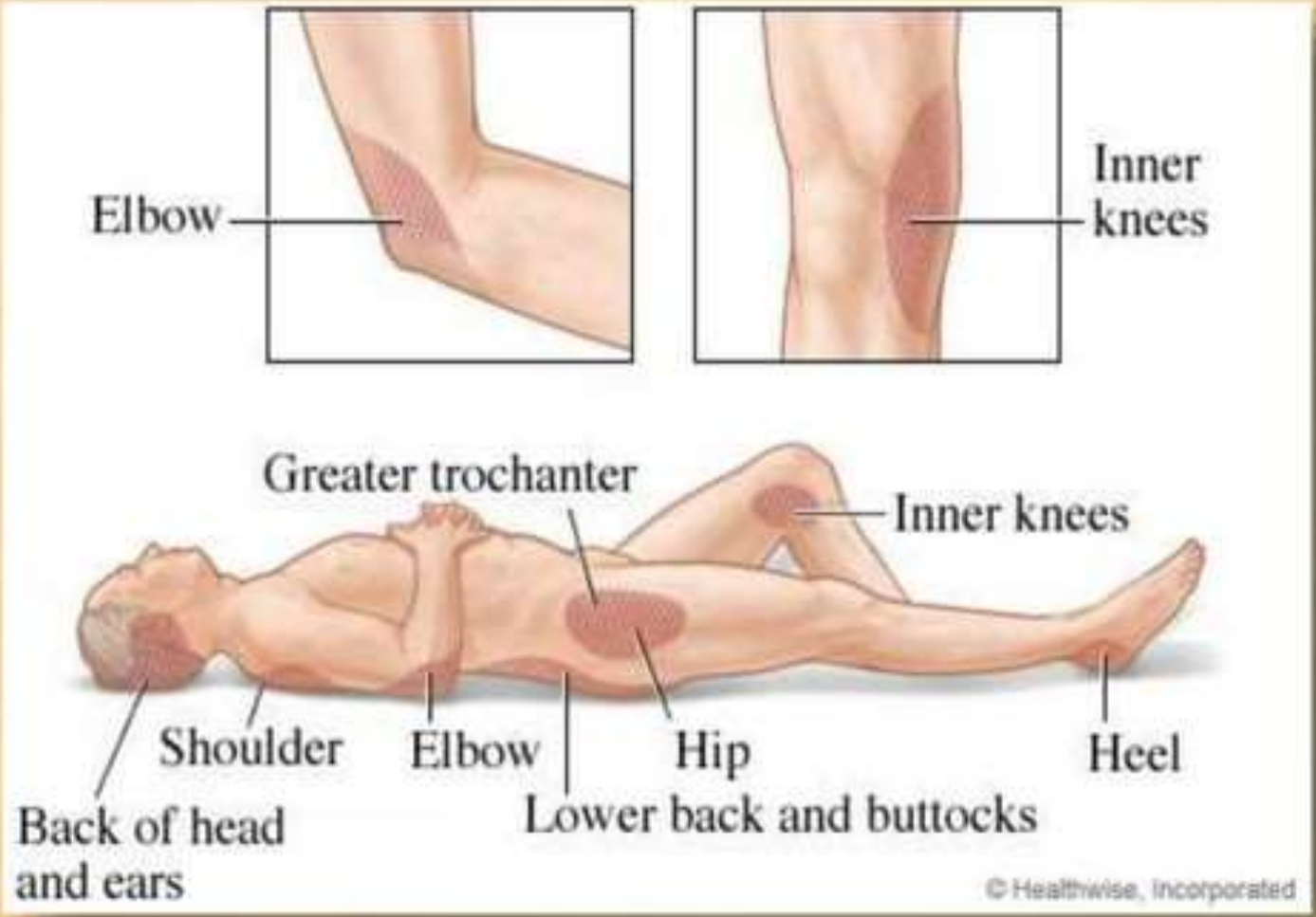
Pressure sore

Common Sites



Stages / Classification Of Bedsores

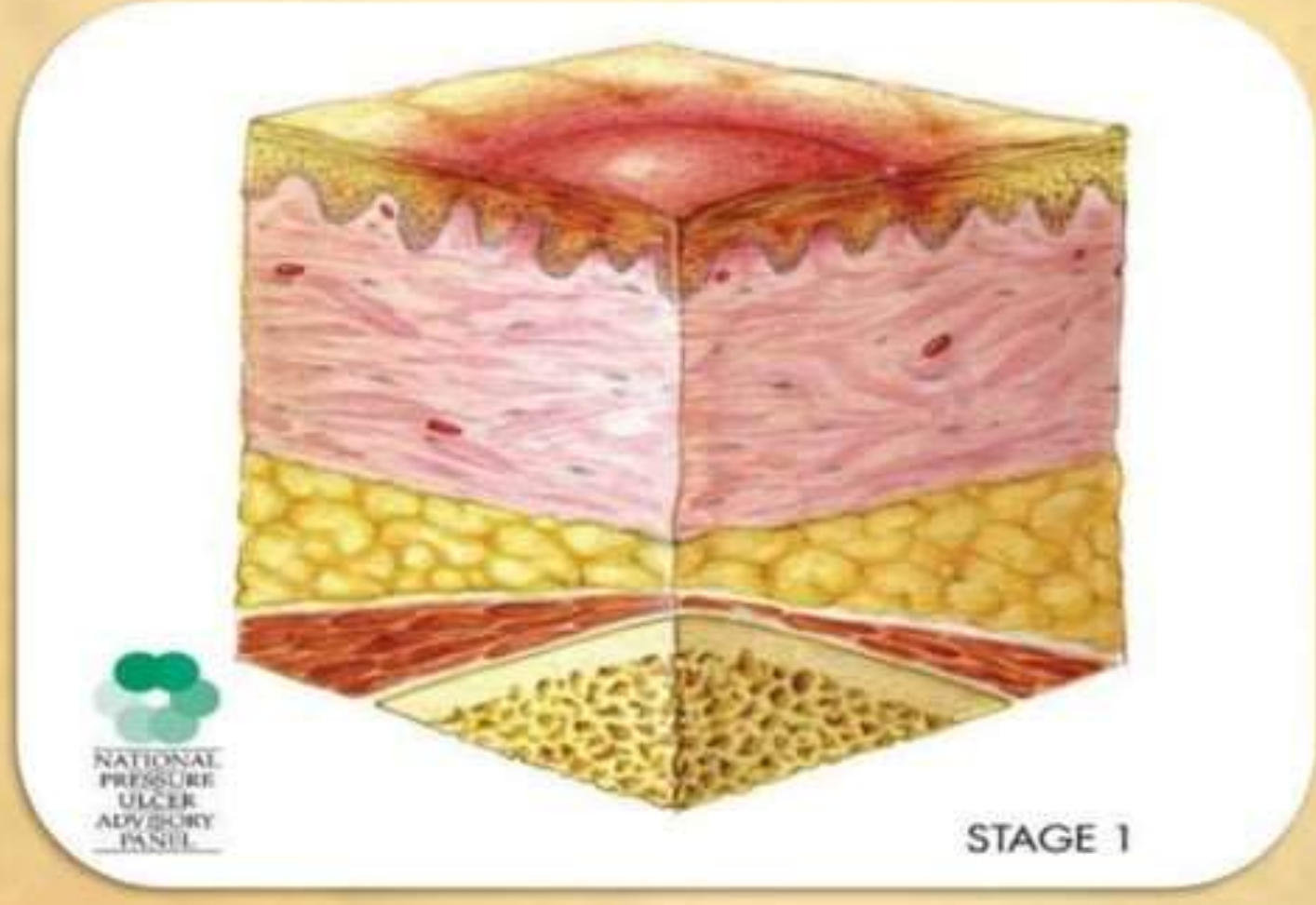
- **Staging systems for pressure ulcers are based on the depth of tissue destroyed.**
- **Based on the depth there are four stages of bedsores**

1. **Stage I**
2. **Stage II**
3. **Stage III**
4. **Stage IV**

Stage I: Nonblanchable Redness of Intact Skin

- Intact skin presents with nonblanchable erythema of a localized area usually over a bony prominence.
- Discoloration of the skin, warmth, edema or pain may also be present
- Stage I indicates "at-risk" persons.
- Involves only the epidermal layer of skin.

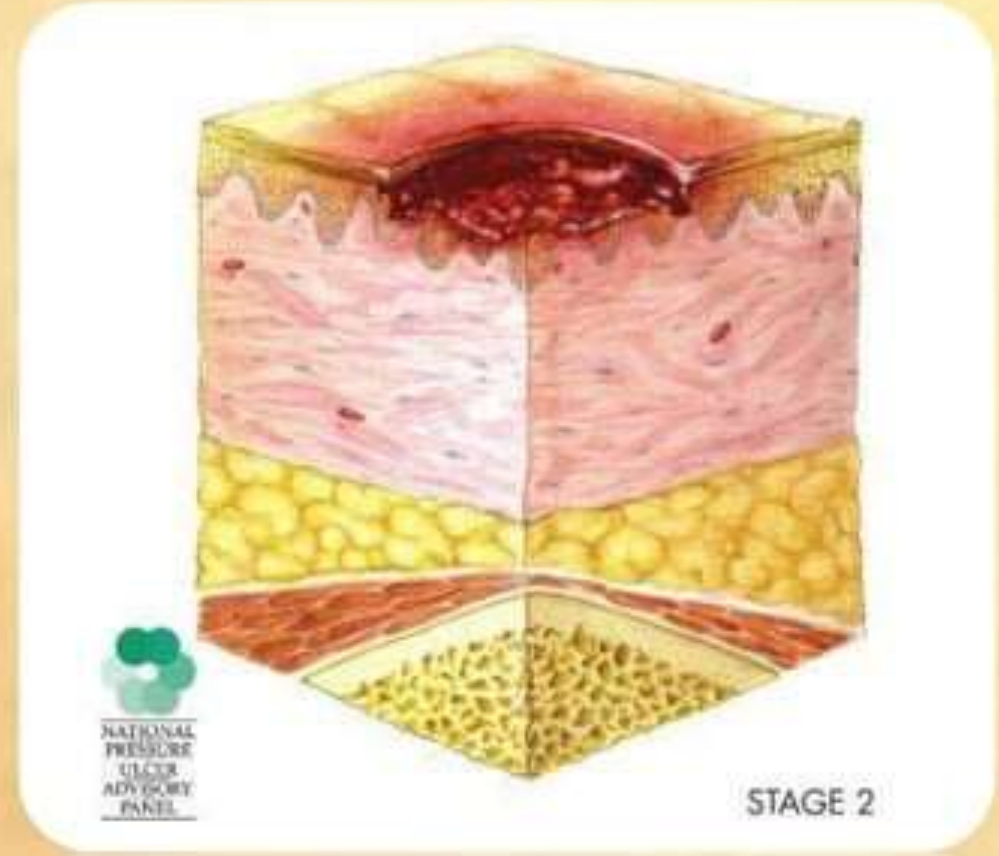
Stages / Classification Of Bedsores



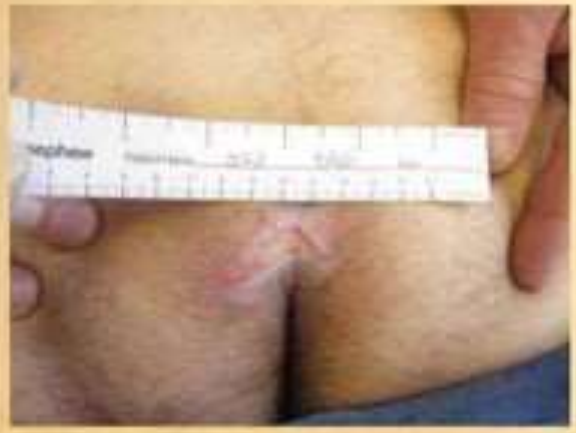
Stage II: Partial-thickness Skin Loss Or Blister.

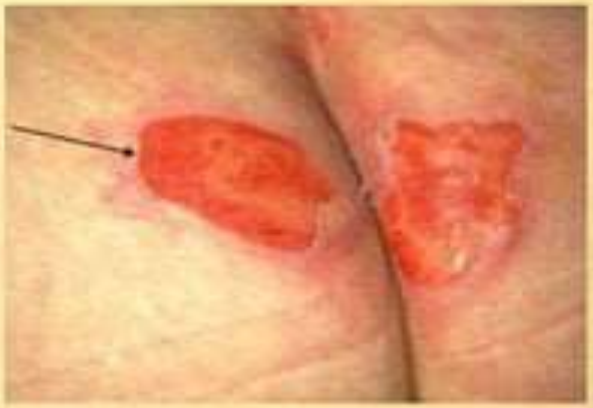
- A partial thickness loss of dermis presents as a shallow open ulcer with a red-pink wound bed without slough
- Stage II is damage to the epidermis and the dermis. In this stage, the ulcer may be referred to as a blister or abrasion.

STAGE II PRESSURE ULCER



STAGE II PRESSURE ULCER

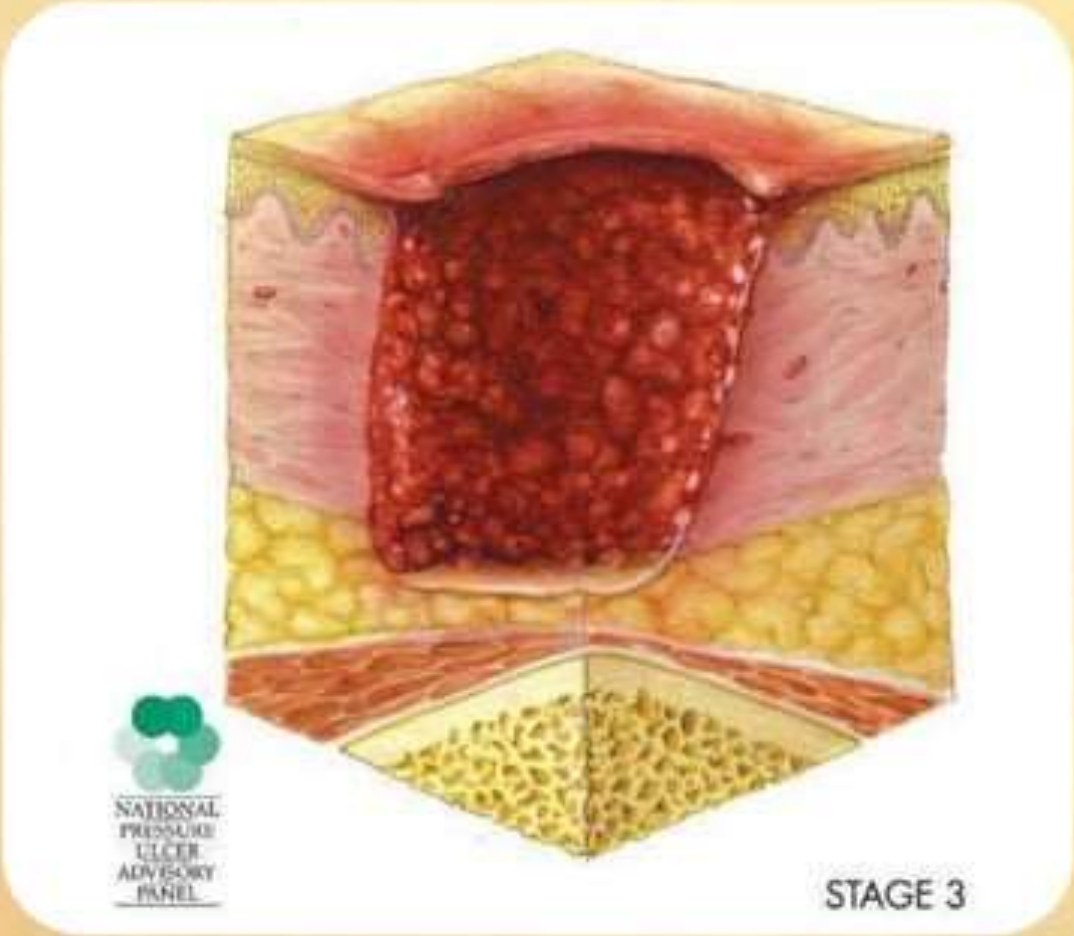




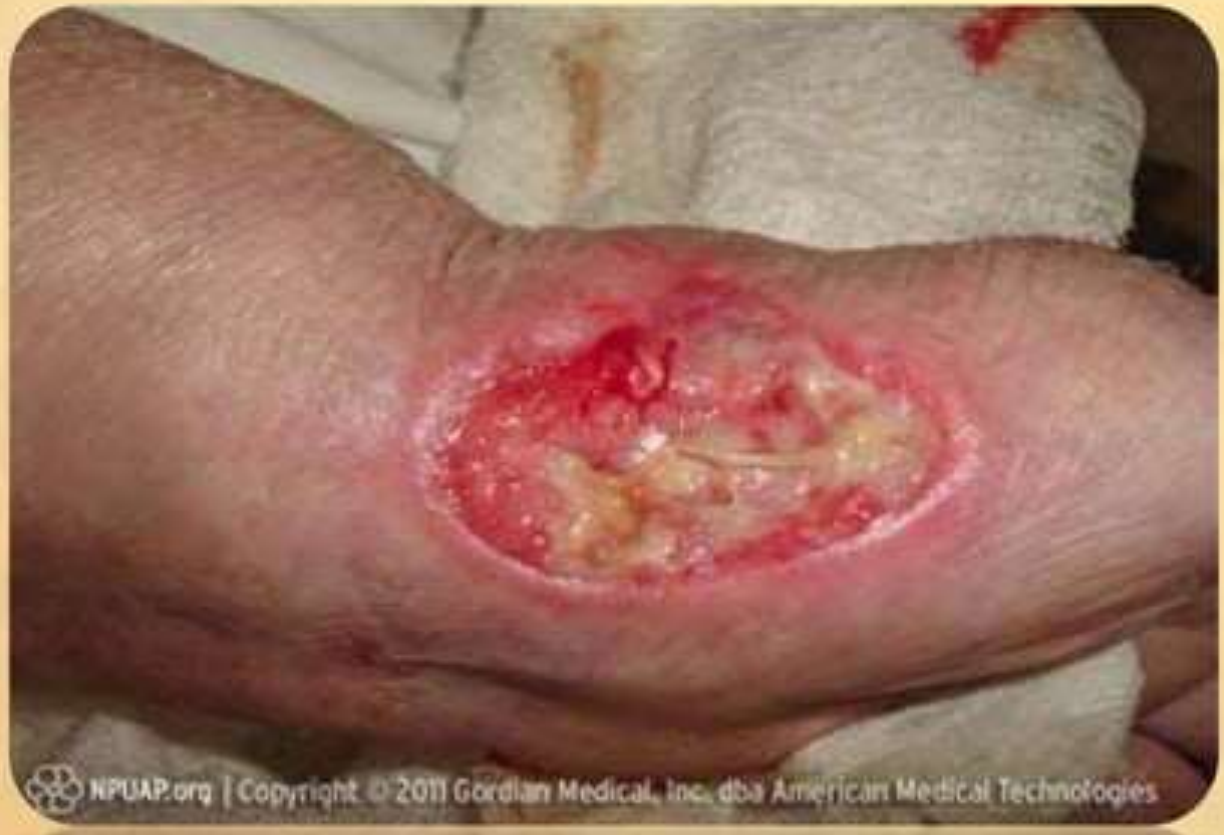
Stage III: Full-thickness Skin Loss (Fat Visible).

- A stage III ulcer is a full-thickness tissue loss. Subcutaneous fat may be visible; but bone, tendon, or muscle is *not exposed.*
- *Epidermis, dermis and subcutaneous tissues involved*
- subcutaneous layer has a relatively poor blood supply. So its difficult to heal.

STAGE III



STAGE III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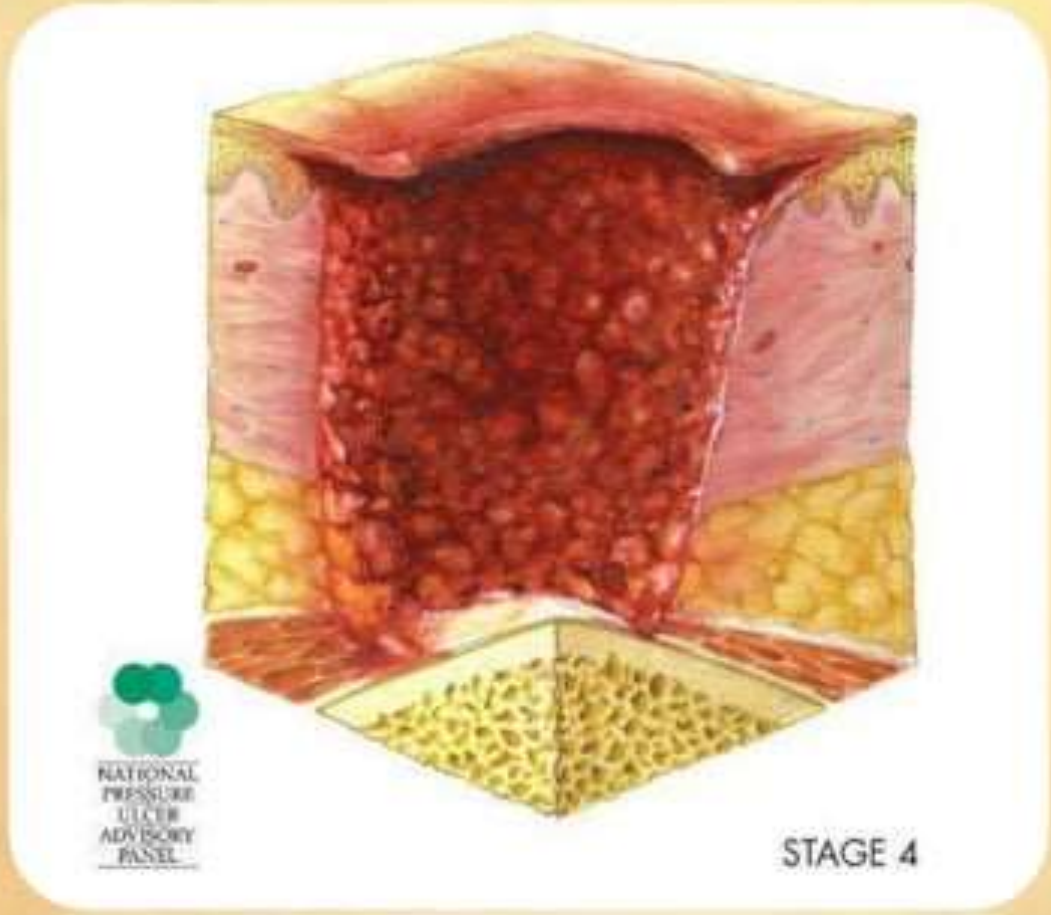
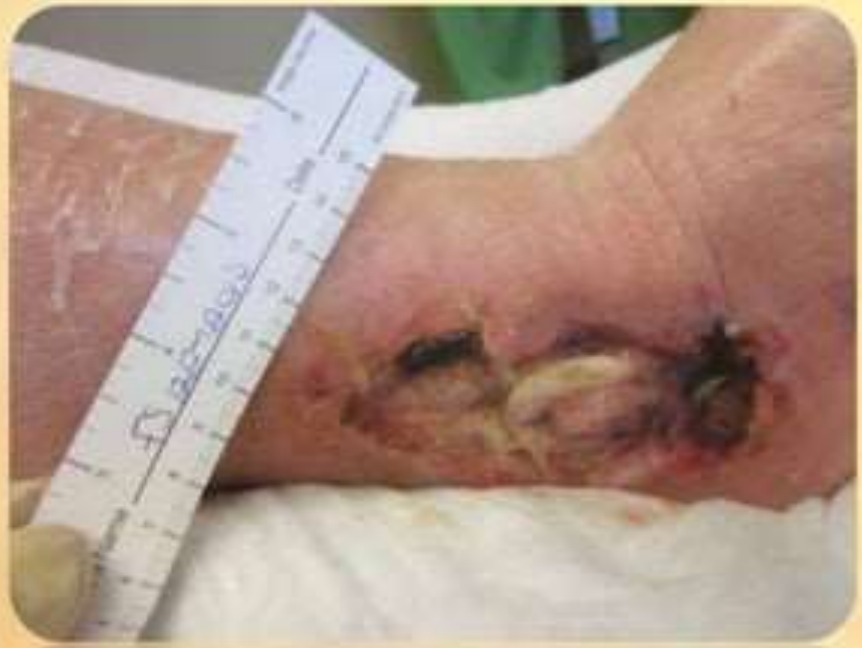
Stage IV: Full-thickness Tissue Loss

- A stage IV ulcer is is the deepest, extending into the muscle, tendon or even bone.
- Full thickness tissue loss with exposed bone, tendon or muscle.

Stage IV



Stage IV



Complications

- Cellulitis
- Bone and joint infections
- Sepsis
- Cancer

Prevention

- **Bedsores are easier to prevent than to treat. Although wounds can develop in spite of the most scrupulous care, it's possible to prevent them in many cases.**

Prevention

1. **Position changes**

   Changing position frequently and consistently is crucial to preventing bedsores. Experts advise shifting position about every 15 minutes that you're in a wheelchair and at least once every two hours, even during the night, if you spend most of your time in bed.

2. **Skin inspection**

   Daily skin inspections for pressure sores are an integral part of prevention

Prevention

3. Nutrition

A healthy diet is important in preventing skin breakdown and in aiding wound healing

Adequate hydration to maintain the skin integrity.

4. Lifestyle changes –

Quitting smoking

Exercise - Daily exercise improves circulation

5. **Use pressure-relieving devices** such as air mattress, water mattress.

Treatment

- **1. Changing positions often.** Carefully follow the schedule for turning and repositioning — approximately every 15 minutes if in a wheelchair and at least once every two hours when in bed. If unable to change position on own, a family member or other caregiver must be able to help.
- **2. Using support surfaces.** These are special cushions, pads, mattresses and beds that relieve pressure on an existing sore and help protect vulnerable areas from further breakdown.

Treatment

Treatment

- **3. Cleaning.** It's essential to keep wounds clean to prevent infection. A stage I wound can be gently washed with water and mild soap, but open sores should be cleaned with a saltwater (saline) solution each time the dressing is changed.
- **4. Controlling incontinence**

Treatment

- 5. Removal of damaged tissue (debridement). To heal properly, wounds need to be free of damaged, dead or infected tissue.
- 6. Dressings.
- 7. Oral antibiotics.
- 8. Healthy diet.
- 9. Educating the caregiver

Treatment

- Surgical repair
- Tissue flap.
- Plastic surgery may be required to replace the tissue.
- Other treatment options

  Researchers are searching for more effective bedsore treatments. Under investigation are hyperbaric oxygen and the topical use of human growth factors.

Role Of Nurse In Prevention & Management Of Bed Sores

- **The nurse should be continuingly assessing the client who are at risk for pressure ulcer development**

Assess the client for:

- **The predisposing factors for bed sore Development.**
- **Skin condition at least twice a day.**
- **Inspect each pressure sites.**
- **Palpate the skin for increased warmth.**

ROLE OF NURSE.....

- Inspect for dry skin, moist skin, breaks in skin
- Evaluate level of mobility.
- Evaluate circulatory status (eg. Peripheral pulses, edema).
- Assess neurovascular status.
- Determine presence of incontinence
- Evaluate nutritional and hydration status.
- Note present health problems.

ROLE OF NURSE.....

Interventions for a patient with Decreased sensory perception

- Assess pressure points for signs of bed sore development.
- Provide pressure-redistribution surface.

Interventions for a patient with incontinence

- Assess need for incontinence management.
- Following each incontinent episode, clean area and dry thoroughly.
- Protect skin with moisture-barrier ointment.

ROLE OF NURSE.....

Interventions to avoid Friction and shear

- Reposition patient using draw sheet and lifting off surface.
- Use proper positioning technique.
- Avoid dragging the patient in bed
- Use comfort devices appropriately.

ROLE OF NURSE.....

Interventions for a patient with Decreased activity/ mobility

- Establish individualized turning schedule.
- Change position at least once in two hours and more frequently for the high risk individuals.

Interventions for a patient with Poor nutrition

- Provide adequate nutritional and fluid intake
- Assist with intake as necessary.
- Consult dietitian for nutritional evaluation

ROLE OF NURSE.....

- Evaluate the ulcer progress every 4-6 days.
- Assist the physician or surgeon in debridement
- Educate the patient and family regarding the risk factors and prevention of bed sores.


Thank You