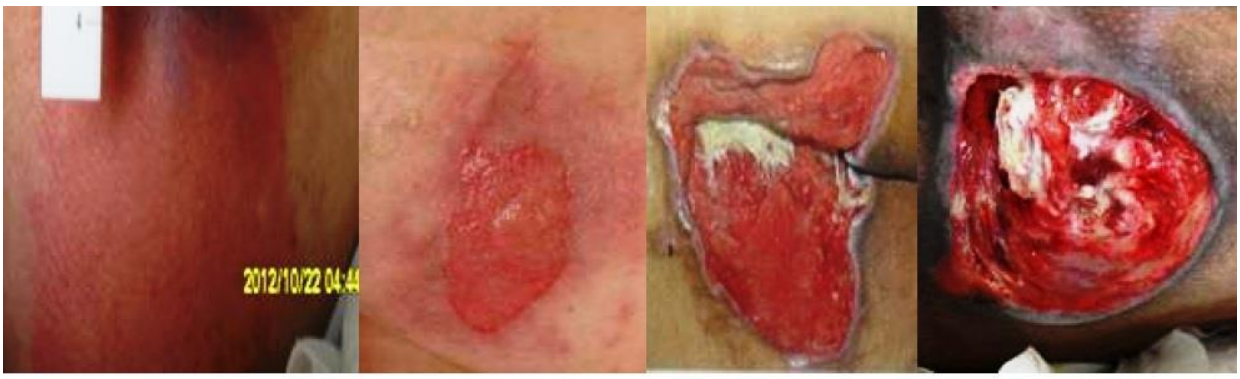
Pressure Ulcers

Prevention Strategies

Independent -Study Course



stage 1 stage 2 stage 3 stage 4

Idaho Department of Health & Welfare
Division of Licensing & Certification

Course Information

This course is a part of a series of courses produced by the Residential Care Assisted Living Facility (RALF) survey team. The courses were designed for direct care staff, nursing staff, administrative staff, and others who work in assisted living. While the courses will help you better understand the state rules, our primary goal in creating these courses is for you to gain knowledge and skills that you can apply in your community to safeguard and continually improve the safety, quality of care, dignity, and rights of the residents you serve.

The courses are designed to be useful either as a guide in delivering training to a group of caregivers, or as a self-study guide. It should take between one and two hours to complete a course. Each course includes a post-test. After reading the course and having any questions answered by your trainer, you're ready to take the post-test. The post-test is to be taken closed-book. A score of 80% or better should be considered passing. If you score lower than 80%, please review the course again and then re-take the test. If you are studying solo and do not have a trainer to ask questions, you can email your questions to us at **ralf@dhw.idaho.gov.** Please allow up to two working days for an answer.

Course Objectives

This self-study course was designed to provide basic information about pressure ulcers and prevention. When you complete this course, you will be able to:

- Describe the causes of pressure ulcers.
- Identify residents who are at risk for pressure ulcers.
- Explain the sites on the body where pressure ulcers commonly arise.
- List pressure ulcer prevention strategies.
- Illustrate the complications of pressure ulcers.
- Recognize the importance of team work when preventing and treating pressure ulcers.
- Lists important items that should be documented.

Terms

Anemia – Is a condition in which a person does not have enough red blood cells to carry adequate oxygen to the tissues.

Braden Scale – A universally accepted tool to help identify those at risk of developing pressure ulcers. A score of 12 or less indicates a high risk (see appendix).

Cognition – The mental process of knowing, which includes things such as awareness, judgment, perception and reasoning.

Edema – Swelling from fluid in your body's tissues, usually occurring in the legs, feet and ankles, but can occur throughout the body.

Eschar – Dead tissue (usually thick, dry and black) that is cast off from the surface of the skin.

Lesion – Any abnormality, involving any tissue.

Slough – A layer of dead tissue that is separated from the surrounding tissue.

Introduction

A pressure ulcer is a lesion caused by pressure, friction, shear or moisture. Pressure ulcers may be referred to as pressure sores, bedsores, or decubitus ulcers.

Pressure ulcers develop when there is constant pressure on a body part, especially over a bony area. This causes the skin to be compressed against another surface. This pressure causes less blood flow to that tissue, which leads to less oxygen delivery to the cells of the tissue. If this continues and pressure is not relieved, then the cells making up the tissue die, the skin breaks down and a pressure ulcer develops. A pressure ulcer may appear first as a red area on the skin or a blister or as an open sore. Pressure sores can be classified into stages, which will be covered later in this module. As a caregiver, it is important to recognize the first signs that a pressure ulcer may be developing. Pressure ulcers can lead to serious consequences and it is up to you, as a caregiver to help prevent these serious consequences from happening (Cateora, 2008; Oregon Department of Human Services, 2008).

The skin provides a barrier to protect the inner body. If the skin breaks open, then bacteria may enter causing a serious infection. An infection can cause significant harm to a vulnerable elderly resident. Pressure ulcers frequently cause pain and hinder a resident's functional ability. Two and one-half million patients are treated for pressure ulcers yearly, costing $11 billion per year. The cost of treating a single full-thickness pressure ulcer is estimated to be $70,000 (Campaign Intervention Fact Sheet, n.d.; Oregon Department of Human Services, 2008). Assisted Living Facilities may not retain residents with pressure ulcers greater than a Stage II. Therefore, it is important to prevent them, so that the residents you care for can remain in your facility. While these statistics may seem alarming, pressure ulcers are preventable and it starts with you!

In this module, we will cover in more detail the cause of pressure ulcers, the risk factors for developing pressure ulcers, the stages of pressure ulcers and prevention strategies you can implement at your facilities.

Course Content

Pressure Ulcers Explained

As you will recall, pressure ulcers can be caused from friction, shearing and skin moisture.

Friction – Friction can take place when a resident is pulled up or down in bed or is moved across the bed sheets or other surfaces. The friction that arises between the skin and a surface can lead to a friction burn because the top layer of the skin is actually scraped off. When a friction burn occurs, a pressure ulcer can result if the burn is combined with pressure and moisture. Proper moving techniques are vital to prevent pressure ulcers from forming.

Shearing – If a person's skin moves in one direction and the bones underneath move in another direction, small blood vessels are torn. Sliding down in a bed or chair for example, may cause shearing. Shearing may lead the skin to fold over itself, cutting off the blood supply to the skin in that area leading to pressure ulcers. For example, if a resident slides down in bed, after the head of his or her bed is raised the skin may fold over itself, leading to this type of shearing. Additionally, when blood vessels are torn, vital nutrients and oxygen cannot be delivered to the skin.

Skin moisture – The surface of the skin is damaged after being in long-term contact with moisture. This moisture could be due to perspiration, urine or feces. This moisture may also cause the skin to stick to things such as, a bed sheet. Damage then occurs when that bed sheet is pulled away from the skin. Excessive moisture is also irritating to the skin and can soften the skin contributing to the development of pressure ulcers (Cateora, 2008; Oregon Department of Human Services, 2008; Pressure Ulcer Awareness and Prevention, n.d.).

Pressure Ulcer Stages

Regardless of how pressure ulcers occur, they are categorized by severity from Stage I (first sign) to Stage IV (worst).

Stage I - In this stage, the skin is intact with non-blanchable (does not turn white when pressed) areas of redness. This usually occurs over a bony prominence. This stage may be difficult to detect in individuals with dark pigmented skin, but the area may appear discolored. Heat, swelling or firmness may also be present.

Stage II - In this stage, the outer skin will break open or wear away. The area becomes painful and tender. The sore may look like a shallow crater, a blister or an abrasion. Drainage may be present and the tissue around the wounds may be pale, red or swollen. The wound may expand to deeper tissues and tissue could die at this stage. However, with prompt attention**,** the ulcer can heal without a problem. **Residents are not allowed in assisted living if the ulcer is beyond a Stage II**.

Stage III - In this stage**,** damage to the tissue extends through the second skin layer into fat tissue. Slough (dying yellow or gray tissue) may be present. Additionally, foul smelling drainage may be evident. During this stage the risk for infection is high.

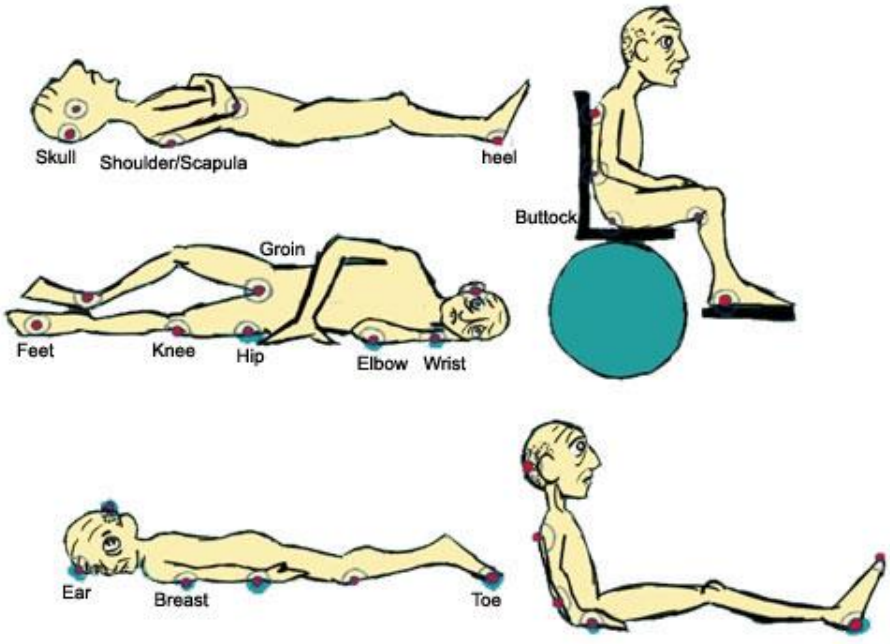
Stage IV – In this stage, damage extends into the muscle and may extend as far down as the bone, during this stage. Slough or eschar (thick black or dark brown leather- like dying tissue) may be present. Deep tunnels and foul smelling drainage are common. At this point, infection to the bone or blood may resul**t.** Stage IV ulcers are very difficult to heal.

Unstageable - The stage of ulcer is either a Stage III or IV, but the true depth and stage of the ulcer cannot be determined due to slough (yellow, tan, gray, green or brown tissue) or eschar (brown or black tissue).

High Risk Areas

Remember, pressure ulcers result when tissue is squeezed between a person's bones and a surface, which cuts of blood supply to the area. It is not surprising then that pressure ulcers most often develop over bony prominences like:

- Elbow
- Heels
- Hips
- Ankles
- Sides of the knee
- Shoulder blades
- Back
- Back of head
- Buttocks/Coccyx



What this mean for you, as a caregiver

The nurse may not see a resident's skin very often and thus will not always be able to identify skin problems early. You are the eyes and ears for the nurse and need to report any skin issues you see. Pay attention to the skin when assisting with bathing, dressing or other tasks. Watch for rashes, bruises, scrapes, blisters or changes in the skin. Feel the skin with a gentle touch, especially over bony areas. Observe changes in texture, temperature or firmness. Most importantly, is the area different from the last time it was observed? Do not forget to listen to the resident. Maybe he/she is telling you that something is not comfortable. Pay attention to these complaints no matter how minor they might seem. Even itchiness might lead you to discover the beginnings of a pressure ulcer (Cateora, 2008; Oregon Department of Human Services, 2008; Pressure Ulcer Awareness and Prevention).

Now that you can identify the common areas where residents develop pressure ulcers, it is important to recognize the risk factors that make your residents vulnerable. If a resident is identified as being at high risk for developing pressure ulcers, then interventions can be put in place to prevent them and special attention can be made to recognize skin changes early (Oregon Department of Human Services, 2008).

Risk Factors

Not everyone at your facility will be at risk for developing a pressure ulcer. Many residents may be able to shift their weight enough to take pressure off whenever discomfort is felt. By doing so, tissue damage does not occur. Yet, some of your residents are either unable to feel discomfort, express discomfort or move themselves to relieve pressure.

Who are those at risk?

- **Age** - While aging itself does not cause pressure ulcers, it does cause changes in tissues that make pressure ulcers more likely to develop. When people age, the outer layers of skin become thin. Additionally, many older people have decreased muscle and fat, which helps absorb pressure and provides a cushion to bony areas. Also with age, the number of blood vessels decrease and the vessels become more fragile. Therefore, all wounds heal more slowly.

- **Decreased Mobility** - Anyone who is unable to move all or some parts of their body are at risk. These residents can develop pressure ulcers in as little as 1 to 2 hours. They are unable to shift their position to relieve pressure. Anyone who spends a lot of time in a chair or in bed is also at high risk. If residents can move, encourage them to avoid sitting or lying for prolonged periods of times.

- **Impaired Cognition** - Residents with impaired cognitive or sensory capabilities such as, residents with dementia or those who are under the influence of medications are at risk. Their ability to sense pain or discomfort may be reduced. Also residents with neuropathy such as, diabetics, paraplegics or quadriplegics fit into this category.

- **Impaired Communication Abilities** - Stroke victims may be able to sense discomfort, but may not be able to express it.

- **Poor Nutrition Intake** - Poor nutrition and hydration contributes to unhealthy skin and inhibits healing. Poor nutrition decreases a person's immune system putting them at a greater risk for infection. Additionally, dehydration contributes to pressure ulcers because proper fluid intake helps provide padding over bony prominences and helps ensure proper circulation.

- **Incontinence** - Anyone whose skin is subject to frequent moisture caused by urinary or fecal incontinence or perspiration have a greater likelihood of developing pressure ulcers.

- **Smoking** - Smoking decreases blood flow to the skin. Nicotine weakens circulation and decreases the amount of oxygen in the blood.

- **Health Conditions** - When multiple health conditions are present at the same time, a resident is at a greater risk. For example, residents who have diabetes,

have a history of stroke, have cancer or congestive heart failure are at a greater risk to develop skin breakdown. Any disease affecting blood circulation, such as diseases of the heart also contribute to pressure ulcers. When parts of the body do not receive the blood it needs, these cells are more likely to die. Likewise, a fever may put extra strain on areas of the skin that are already prone to pressure ulcers.

- **Prior History** – If a resident had a prior pressure ulcer that is now healed, that area is prone to re-open again. That area has developed scar tissue, which is not as strong as the rest of the resident's skin.

What does this mean for you?

Your administrator or facility nurse may alert you to residents at high risk. He/She may provide information on what interventions should be implemented in order to prevent pressure ulcers. However, this may not always be the case. Therefore, it is important to recognize residents who are at high risk, so that you can be alert to monitor for skin changes and report any concerns immediately to your nurse, administrator and/or the resident's doctor.

Finally, residents may enter the facility in relatively good health with a low risk of developing a pressure ulcer. Yet, an illness such as pneumonia or a minor surgery may quickly change their risk. Therefore, it is important for you as a caregiver, to recognize residents whose risk may have increased, so that you can be proactive and consult with the whole team on ways to keep your resident's skin healthy. At the completion of this module, you will understand interventions that will help prevent pressure ulcers from developing in your vulnerable residents (Cateora, 2008; Oregon Department of Human Services, 2008; Pressure Ulcer Awareness and Prevention, n.d.; The Merck Manual of Health and Aging, 2009).

Interventions

A) Inspect skin daily

For residents who are bed-bound or chair-bound, look at bony areas. Also check where the residents' sensation may be reduced such as, the residents' feet or legs.

Multiple skin issues can occur in these residents and you may not even know, until it is too late. For example, if a resident's buttock is scraped against a surface while transferring, an injury may have occurred resulting in an undetectable injury.

If a resident's blood flow is compromised, then you have the ingredients for a pressure ulcer. Likewise, residents with spasticity or spasms may develop skin lesions if their arms/legs bang uncontrollably against an object.

Therefore, it is vital that these residents' skin be inspected daily. Make it a part of your routine.

B) Relieve Pressure

- Reposition residents at least every two hours to relieve pressure and ensure the resident's blood is flowing to all areas of his/her body.

- If a resident is bed-bound, but can move his or her body, encourage the resident to change positions every three to four hours.

- Ask your administrator or nurse about a therapeutic mattress or special positioning devices such as, foam wedges, pillows or cushions.

- Pad the bony parts of the resident's body. This can be done by placing pillows between the legs, behind the back or underneath each arm.

- Consider developing a "turning schedule" with the position changes written next to the times the resident should be positioned and document what position the resident was in.

- Pay special attention to the heels. Support the length of the legs with a pillow and allow the resident's heels to drop over the end of the pillow. Do not allow the pillow to put pressure on the heels.

- For residents who are wheelchair or bed bound:
    a) Reposition the resident every 15 to 30 minutes if the resident cannot move him or herself.
    b) If the resident has a pressure ulcer, ensure he/she is not sitting directly on the pressure ulcer.
    c) If the resident has a wheelchair cushion, make sure it is positioned correctly.

d) Consider consulting with an occupational therapist or physical therapist to do a sitting assessment and assess proper alignment.

e) Encourage the resident to align their elbows, forearms and wrists so they rest comfortably on the arm supports. Encourage the resident to keep their thighs horizontal to the ground with his or her ankles resting on the floor or foot rest.

For residents who prefer sitting in recliners for long periods of time:

a) Encourage the resident to make small adjustments in their position every 15 to 30 minutes.

b) Consider adjusting the reclining degree to help re-distribute his or her weight, to reduce pressure points.

C) Prevent Friction/Shearing/Moisture

- Keep the residents' sheets neat and tight. Keep the bottom sheet free of wrinkles and ensure the top sheet is not tucked in tight at the bottom of the bed or around the resident.
- Sprinkle the residents' sheets with cornstarch to reduce friction.
- Use a turning sheet to reposition residents or a lifting device, so the resident is not dragged. Make sure you have received instructed on how to reposition residents, prior to doing so.
- Limit moisture by providing frequent peri-care to incontinent residents and ensuring their skin is clean and dry.
- To avoid shearing, keep the head of the bed lower than a 30-degree elevation, if possible.
- If the head of a resident's bed is raised, lift the resident's body away from the surface of the bed to reduce tension and shearing forces. Carefully monitor the resident's tailbone.
- Consider placing pillows or foam wedges at the resident's hips and shoulders to reposition the resident.
- Protect the resident's heels from friction burns by using heel booties, socks or pillows.

D) Proper Skin Treatment

- Dry skin should be treated with moisturizers.
- Bony areas should not be massaged because it can cause tissue damage.
- Consider moisture barriers to protect skin, when appropriate.
- Only mild cleansing products and warm water should be used when cleaning residents.
- Do not scrub the resident's skin at the time of soiling.
- Keep an eye on residents' skin folds by looking for redness or open wounds that can develop inside the fold.
- Keep the folds clean and dry. If ordered, use anti-fungal powders.
- Use mattress pads and briefs that wick moisture away from the skin and are highly absorbent.

E) Watch for objects

Sitting or lying on hard objects can contribute to pressure ulcers. Watch for the following objects:

a) Safety Pins
b) Curlers or bobby pins
c) Buttons on mattresses or jeans/slacks
d) Bulky seams
e) Objects in pant pockets
f) Catheter clamps/connectors
g) Crumbs in bed
h) Wrinkled bed sheets

F) Ensure Proper Nutrition

- Offer a good variety of foods from all the different food groups.
- Provide protein through leans meats, dairy foods and beans.
- Offer carbohydrates through breads, rice and pastas.
- Ensure a colorful diet to provide Vitamin A and C with foods like oranges, grapefruits, broccoli, carrots, sweet peppers and potatoes.
- Iron and Zinc are important nutrients found through red meats, whole grains, fortified cereals, beans and nuts.
- If a resident does not eat well:
    a) Offer small, frequent meals on a schedule.

b) Take advantage of the time of day the resident is the most energetic and serve the largest meal then.

c) Limit liquids during meals, so the resident does not get too full. Offer frequent liquids between meals.

d) Consider milkshakes, soups and supplemental nutritional drinks for residents who have problems swallowing.

e) For residents who don't like meat, offer cottage cheese, peanut butter, yogurt, nuts and beans.

f) Don't rush residents during meals.

g) Make meal time pleasing to encourage eating.

h) Provide assistance with eating for those residents who need it.

i) Consult with a dietitian or speech therapist if available.

j) Keep residents' preferences in mind when preparing meals.

k) Make sure the resident's dental needs are met. If a resident's teeth are decayed or his/her dentures fit poorly, he/she may not want to eat.

G) Ensure Clothes Fit Properly

Monitor that your residents are wearing clothing that fits appropriately. For example, if clothing is too big, it can forms wrinkles that can contribute to pressure ulcers when the resident is sitting or lying down. On the other hand, if the clothing is too tight, it can decrease a resident's circulation. Remember that blood circulation is important to keep cells healthy. Also be aware that residents who are wheelchair bound should not sit on thick seams of denim or other heavy materials. When a resident wears a new article of clothing, be sure to monitor their skin afterwards, to ensure the material did not cause any skin damage.

Interventions for High Risk Residents

Edema - Swelling in the hands, feet or legs, is called edema and puts your residents at risk for skin breakdown. In these areas where edema is present, the skin is thin and the person's circulation is poor. Assist the resident to do range of motion exercises (with a doctors approval) and elevate their legs and hands during the day. Wearing compression stockings such as, TED hose also helps treat edema and assist with circulation.

Anemia - You may care for residents who are anemic, meaning they have a decline in red blood cells. This puts them at risk for skin breakdown, as red blood cells carry oxygen to the tissues. A resident who is anemic may be prescribed iron or other nutritional supplements. Ensure the resident is eating a healthy diet and taking the proper prescribed supplements (Cateora, 2008; Oregon Department of Human Services, 2008; Pressure Ulcer Awareness and Prevention, n.d.; The Merck Manual of Health and Aging, 2009).

Communication

It isn't just up to you to prevent pressure ulcers. You must be able to communicate with the whole team regarding a resident's care. This team includes other caregivers, the facility nurse, your administrator, a resident's physician and if applicable outside services, such as physical therapists or home health nurses. Also, communicating with the resident's family may be important. Does the resident need assistance in obtaining proper fitting clothing or shoes? Are there certain foods the resident enjoys that the family may be aware of? Reduced rates of pressure ulcers can only work if everyone is after the same goal and everyone is consistently implementing the necessary interventions. Education on pressure ulcer prevention and skin health must be ongoing.

What to report?

If you notice skin changes report them immediately to your facility nurse, administrator and the resident's doctor. Report the following:

- Location of the skin lesion or pressure ulcer.
- Is it red?
- Is it swollen?
- Is there drainage? What does the drainage look like?
- What does the surrounding skin look like?
- What does then center of the ulcer look like?
- Is the skin broken open?
- How big is the ulcer in inches (width, length and depth)?
- Is the ulcer warm to touch?
- Is there an odor?
- Does the resident have a fever?
- Does the resident experience pain?
- Does the resident have any other symptoms?

After you report the information to the facility nurse, he/she should assess the wound and provide further instructions to you. He/She may have the resident seek further medical attention from the resident's physician or a home health agency may get involved. Additionally, the resident may need physical therapy to increase mobility. Whatever the case, be sure to follow the facility nurse's or physician's instructions.

Also remember to do the following:

- Remove pressure on the area of the ulcer.
- Wash your hands thoroughly before providing any cares.
- Do not care for the ulcer yourself, unless delegated by the nurse and you understand instructions from the nurse.
- Do not use any cleansers or agents on the ulcer unless ordered. For example, hydrogen peroxide or iodine can kill new skin and slow the healing process.
- Keep the resident's bed and clothing wrinkle free, dry and clean.
- Carefully monitor the resident's nutritional intake and notify the facility nurse, administrator and physician with concerns (your company policy should guide you).
- Carefully monitor the resident's healthy skin and keep it clean, dry and free from pressure.

Report Complications

Infection can occur quickly when the skin is damaged and can spread throughout the body. Report any of the signs below immediately:

- ❖ The resident has a fever or expresses he/she is chilled.
- ❖ The resident develops an increase in pain in the area or swelling.
- ❖ The area begins to smell or you notice yellow or green drainage.
- ❖ You notice an increase in redness, warmth or you see black areas within the sore.
- ❖ The sore does not show signs of healing after two weeks of treatment (residents with wounds in assisted living must show signs the wound is healing every two weeks).
- ❖ The resident is feeling or acting unusual.
- ❖ The resident has a rapid heart beat or an increase in weakness.
- ❖ The resident is experiencing an increase in confusion.

Pressure ulcers can be life threatening, if bone infections or blood poisoning develops. These infections may even resist antibiotics and can be difficult to treat (Oregon Department of Human Services, 2008). Therefore, it is important for you to report any of the above signs early. When in doubt, report!

Documentation

The facility nurse should be documenting his/her assessments and treatments of the wound, but you must also document your observations as well. Document the date you first saw it, what it looked like, who you notified (RN, MD, administrator) and what you were instructed to do. Document any changes you notice and be sure to notify the appropriate people of these changes according to your company policy. Document any cares you provide to the resident to improve the healing. Nutrition, incontinence care, and repositioning are examples of things that should be documented. Your company policy should help guide you on your documentation requirements.

Admission of new residents

Your administrator and nurse should be carefully evaluating residents before they are admitted. They should determine if a resident is at a high risk for developing pressure ulcers. They may be asking the family members and the resident questions evaluating a resident's mobility status, their ability to eat nutritious meals, their history of pressure ulcers, and their toileting needs. All of these factors contribute to their risk of developing pressure ulcers. It is also important that you as a caregiver are aware of these risk factors. You must understand the level of assistance the newly admitted resident needs, and carefully monitor the resident's skin. The nurse and administrator may miss an existing skin condition when the resident is admitted, so you should report any concerns you have right away.

Process of Prevention

Your facility should develop a process to prevent pressure ulcers from forming.

Consider the following:

- **Determine Risk -** Identify high risk residents (see attachments for ideas).
- **Observe** - Monitor changes in skin daily.
- **Assess -** Notify the nurse to assess any changes to the skin.
- **Develop a plan** - Create an individualized plan to prevent pressure ulcers and/or treat existing ones.
- **Implement the plan** - Ensure everyone is carrying out the plan consistently. Not implementing interventions over the weekend could result in pressure ulcers.
- **Re-evaluate -** What is working? What isn't working?

While there isn't a lot of research conducted regarding assisted living practices and pressure ulcers, a lot of research has been conducted within nursing homes. This is due to the high incidence of pressure ulcers, the costs associated with pressure ulcers and the mortality rates. New research is suggesting that a team approach is most effective, which requires enlisting everyone from laundry workers to in-house beauticians. The following are some examples:

Lutheran Home in Fort Wayne, Indiana: laundry workers helped the registered nurses recognize that some clothes weren't fitting the residents properly and were restricting their skin. Additionally, the kitchen staff began putting protein powder in cookies to increase nutrition for everyone. They also added buffet dining to encourage more ambulation, so residents would not remain in one position for so long, compressing their fragile skin. Furthermore, the beauty shop decided wait times needed to be decreased and residents should be repositioned while getting their hair done.

David Place (nursing home) in David City, Nebraska: implemented a team approach. They focused on assessing each resident's risk for pressure ulcers, which was translated to assignment sheets used by nursing assistants. Those residents identified at a high risk, were the last up for meals and the first down after meals, which reduced the time spent in their wheelchairs; this reduced the pressure put on their bottoms. Yellow plates were assigned to residents at risk for weight loss, so that all staff could encourage and assist residents as necessary to eat. The nursing home also bought new mattresses made of high-density foam to reduce pressure in vulnerable areas. New moisture barrier creams were implemented with residents who were incontinent and extra efforts were made to keep feet elevated for those residents at risk of developing ulcers on their heels (Schaffer, 2008).

Important Items to Consider

- Susan D. Horn, a senior scientist at the Institute for Clinical Outcomes stated, "They are not just little sores. If you've ever seen a very bad one, frankly, it would make you sick. You see a very reddened outer area, then you see, depending on how deep it is, just this hole in the skin, and it goes right down to the bone."

- "Preventing pressure ulcers is a 24/7/365 kind of job. It's not as in one person can get it all done. And if it fails just a little bit, just during the weekends, for instance, you are not going to get the results. It takes tremendous consistency", says Jeff West, a clinical reviewer at Qualis Health in Seattle.

- "Bedsores are a major quality-of-life issue, and a self-esteem issue. No one wants to have sores on their bottom. I don't care how old you are. You still want your skin intact," says Joanie Jones, a nurse of David Place in Nebraska.

- Christopher Reeve, who fought a heroic battle against paralysis, died of a bedsore infection in 2004 (Schaffer, 2008).

Conclusion

Pressure ulcers are costly to treat and can lead to serious complications, decreasing the overall quality of residents' lives. Most pressure ulcers can be prevented with carefully planned interventions. Quick discovery of any reddened areas can reduce the likelihood that serious complications will occur. However, it takes a team effort and the effort starts with you.

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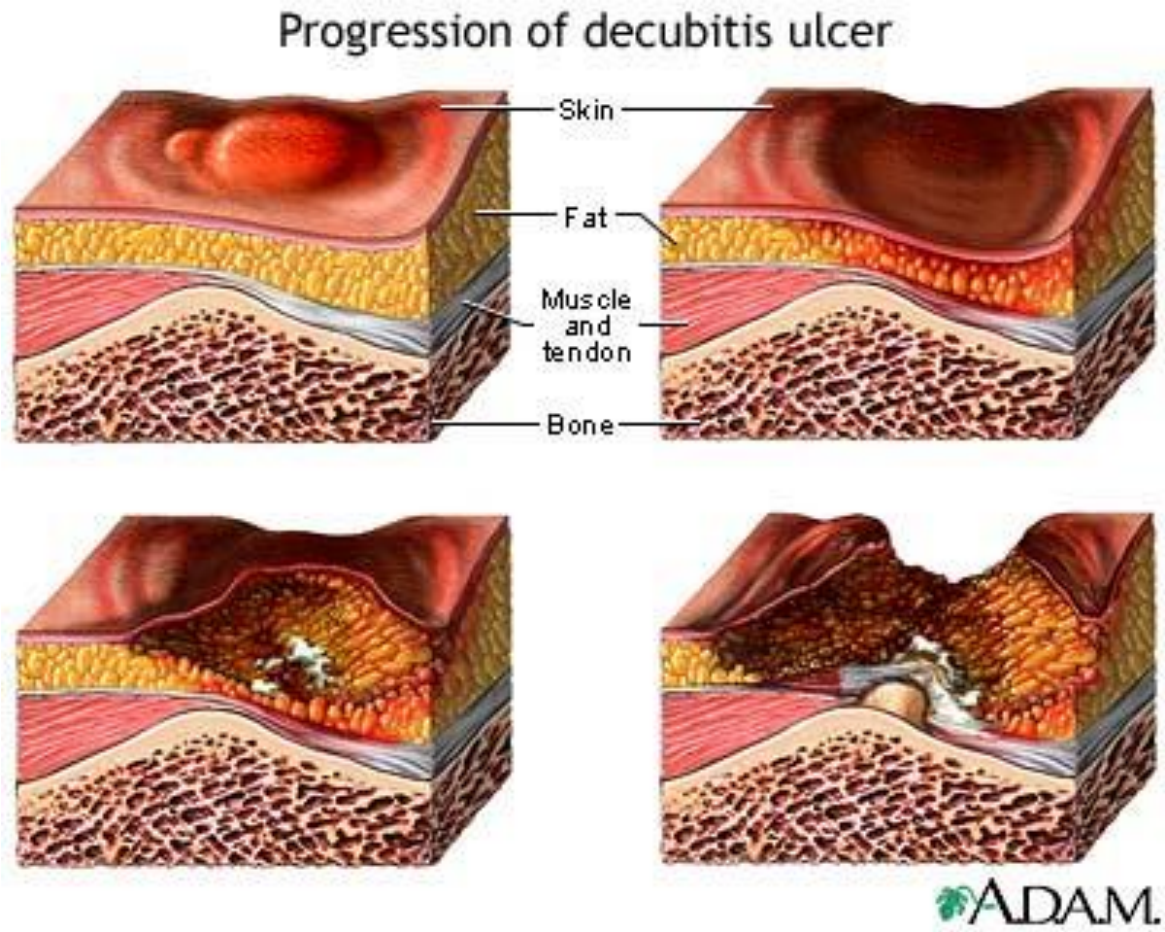
Resources


Progression of decubitis ulcer
Skin
Fat
Muscle and tendon
Bone
A.D.A.M.

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name _____ Date of Assessment

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	**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 the 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. Very 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 non-existent. 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 room at least twice a day and inside room at least once every two 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 Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ 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 and/or maintained on clear liquids or IV's 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 per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN 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 & 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.					
				Total Score				

Figure 1: Obtained permission from Prevention Plus; www.bradenscale.com