Pressure Ulcers

Secondary to Mechanical forces of

Shearing, friction & pressure

Ischemia & necrosis

Surface- mattress, bedrail, wheelchair pad, floor, etc.

Microvascular occlusion

Ischemia

Inflammation & anoxia

↑ tissue vulnerability to trauma & delayed healing

Patients at risk:
Prolonged bedrest
Pharmacological/disease related paralysis

Contributing factors:
DM, vascular disorders, contractures, skin quality, incontinence, bacterial infection, malnutrition, hypoproteinemia, anemia

Assessments/Nursing Actions:
Look at PMH for nutrition status, disease status & risk
Perform focused skin assessment
Assess labs
Assign skin score
Consult wound care
Follow up through documentation, assessments and collaborators
Assess for condition changes putting your patient at risk

Damage in order by tissue type:
Muscle- within 2 hrs.
Skin- within 12 hours
Bone

Labs to assess:
CBC- WBC- infection
Hgb/Hct- anemias
Sed rate- inflammation/infection
Albumin
Pre-albumin
Transferrin
Serum protein
Cultures- blood, urine, stool
Biopsy sites- tissue, bone, wound

Assess nutrition
**New Staging Guidelines: The National Pressure Ulcer Advisory Panel**

**Suspected deep tissue injury**: discolored, intact skin secondary to underlying soft tissue damage (NEW CLASSIFICATION)

**Stage I**: intact skin with impending ulceration signs- blanching, warmth, induration, edema, white appearance

**Stage II**: shallow, open ulcer with pink wound bed (partial thickness)

**Stage III**: full thickness with tunneling not involving the fascia

**Stage IV**: full thickness with extension into muscle, bone, tendon or joint

**Unstageable**: full thickness where full depth is unable to be determined due to wound coverage with slough & eschar

<table>
<thead>
<tr>
<th>Wound Dressing</th>
<th>Example</th>
<th>Stages Of use</th>
<th>How it Works</th>
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</thead>
<tbody>
<tr>
<td>Hydrocolloid</td>
<td>Duoderm</td>
<td>I,II,III,IV</td>
<td>Forms occlusive barrier, prevents infection, Allows healing, prevents friction</td>
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<tr>
<td>Transparent</td>
<td>Tegaderm</td>
<td>I,II,III</td>
<td>Prevents bacterial contamination &amp; promotes Epithelialization, minimizes friction</td>
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<tr>
<td>Alginate</td>
<td>Sorbsan</td>
<td>II,III,IV</td>
<td>Forms a gel when it contacts wound drainage To form a barrier- can be used with infectious and non-infectious wounds</td>
</tr>
</tbody>
</table>

Debridement - removes exudates, infection & eschar to promote healing:

**Mechanical**: wet to dry NSS dressings

**Surgical**: removes tissue serving as a reservoir for ongoing contamination