Mythbusters
The Truth About Pressure Ulcer Prevention
Faculty Disclosure Statement

The speaker(s) do not have any financial interest or affiliation with any corporate organizations associated with the manufacture, license, sale, distribution or promotion of a drug or device.
Objectives

Upon completing this session, participants will be able to:

1. Identify three factors that increase a resident’s/patient’s risk of developing a pressure ulcer.
2. Describe multiple strategies to prevent pressure ulcers.
3. Discuss the importance of early detection.
1. There is little a nurse or a STNA can do to prevent pressure ulcers; they just happen.
FACT: Most pressure ulcers are preventable.

Suggested strategies\textsuperscript{1,2}:

- Know who is at risk.
- Know what to look for (inspection).
- Know what needs to be done to prevent pressure ulcer development.
- Know what you can do to promote pressure ulcer healing.
2. Residents/patients who are in a chair or wheelchair don’t need to be repositioned; they only need to be repositioned when they are in bed.
FACT: Residents/patients in chairs and wheelchairs, as well as those in bed, need to be repositioned.

Suggested strategies\(^3,4\):

- Reposition sitting residents/patients to shift pressure points at least every hour.
- If this schedule cannot be kept or is inconsistent with overall treatment goals, return the resident/patient to bed.
- Individuals who are able should be taught to shift their weight every 15 minutes.
True or False?

3. Residents/patients should be repositioned no more than every 2 hours while in bed.
FACT: Residents/patients need individualized turning and repositioning plans for bed and chair.

Suggested strategies:
- Create individualized plans that include:
  - Turning every 2 hours for in bed
  - Repositioning every hour for in chair
  - OR more frequently as needed to prevent pressure ulcer development
4. **Poor nutrition and/or dehydration may increase the risk of developing a pressure ulcer.**
FACT: Nutrition and hydration are key factors in pressure ulcer development.

Suggested strategies:\n- Assist in meals, snacks, and hydration.
- Allow residents/patients adequate time to eat.
- If appropriate, offer a glass of water when turning to keep patient hydrated.
- Consider nutritional supplements.
- Monitor nutritional intake.
- Offer snacks and fluids between meals.
- Weigh residents and report any weight loss immediately.
True or False?

5. Residents/patients who are incontinent have a greater risk of developing a pressure ulcer.
FACT: Incontinence puts residents/patients at higher risk for pressure ulcer development.

Suggested strategies\(^{6,7,8}\):

- Cleanse skin at time of soiling and at routine intervals.
- Use absorbent underpads.
- Use moisture barriers for incontinent residents.
- Treat dry skin with moisturizers.
- Follow individualized toileting plan. Toilet in advance of need.
True or False?

6. Once a pressure ulcer is healed, prevention measures can be discontinued.
FACT: History of a pressure ulcer can increase the risk of developing a new pressure ulcer.

Suggested strategies:\n- Continue implementing prevention measures to prevent skin breakdown.
- Continue to develop and modify plans as appropriate for each individual.
True or False?

7. The resident's/patient's skin should be checked at least daily if they are at risk for developing a pressure ulcer, even if they don't have one now.
FACT: Skin should be checked at least daily for residents/patients at risk for developing a pressure ulcer, even if they don’t have one now.

Suggested strategies$^{2,9,10}$:

- **Acute care**: Inspect skin daily.
- **Long-term care**: Inspect high-risk patients daily; inspect all residents weekly.
- **Special attention should be given to high-risk areas**:
  - Sacrum
  - Back
  - Buttocks
  - Heels
  - Device-related Pressure
  - Elbows
  - Back of head
  - Arms, legs, fingers – due to contractures or deformities
Pressure Points
True or False?

8. A reddened area on the skin can be a pressure ulcer.
FACT: Reddened area on the skin may be an indication of a Stage I pressure ulcer.

Suggested strategies:\n
- Look for:
  - Intact skin
  - Non-blanchable redness (doesn’t go away when pressure has been relieved)
- Stage I pressure ulcers:
  - Are usually on bony prominences
  - May be painful, firm, soft, warmer or cooler compared to adjacent tissue
  - May appear with consistent red/blue/purple hues in darker skin tones
Stage 1 Pressure Ulcer
9. It is only the wound care nurse’s responsibility to detect and treat pressure ulcers.
FACT: Pressure ulcer prevention and detection is every caregiver’s responsibility.

Suggested strategies:\textsuperscript{9,10}:

- Incorporate skin inspections into daily routine care – whenever a staff member has visual access to a resident’s skin.
- Opportunities include:
  - Bath/shower time
  - Dressing time
  - Incontinence care
  - Therapy time
  - Activities
10. Once a resident/patient says they don’t want to be turned anymore, there is nothing more you can do to prevent pressure ulcers.
FACT: Effective pressure ulcer prevention plans are customized for individual needs.

Suggested strategies:\n
- Consider the needs, concerns, and abilities of specific residents/patients when developing individualized plans.
- Integrate resident/patient/family education into all plans.
11. Medical devices and personal items on or around a resident can cause a pressure ulcer.
FACT: Many factors, including medical devices and personal items, can increase the risk for pressure ulcer development.

Suggested strategies:

- Monitor residents with devices such as casts, orthoses, cervical collars, tubes, splints, and pommel cushions.
- Assess routinely to ensure that shoes fit properly.
- Maintain wrinkle-free bed linens.
- Keep personal alarm pads as wrinkle-free as possible.
- Keep personal items within reach - not under residents/patients.
12. A blister or reddened area on a resident’s patient’s heel is nothing to worry about.
FACT: A blister or reddened area on a resident’s patient’s heel may be an indication of a developing pressure ulcer.

Suggested strategies\(^{3,4}\):

- When indicated, provide pressure relief by eliminating contact between the heel and underlying surface.
- Inspect heels daily.
- Report blisters/reddened areas immediately.
13. Massaging a bony prominence promotes circulation and prevents pressure ulcers.
FACT: Current evidence suggests that massaging over bony prominences may be harmful.

Suggested strategies\(^3\):
- Adopt prevention and treatment options such as:
  - Resident/patient education
  - Regular repositioning schedules
  - Frequent monitoring
True or False?

14. Bony prominences should not have direct contact with one another.
FACT: Direct contact of bony prominences can increase the risk for pressure ulcer development.

Suggested strategies:\n- Use pillows or foam wedges to keep bony prominences such as knees and ankles apart.
True or False?

15. The head of the bed should be placed in the highest position possible.
FACT: Improper bed positioning can lead to friction and shear, and contribute to pressure ulcer development.

Suggested strategies:

- Maintain the head of the bed at the lowest degree of elevation consistent with medical conditions and other restrictions.
- Limit the amount of time the head of the bed is elevated. The shear forces generated when an individual slides down the bed contribute to ischemia and necrosis of sacral tissue and undermining of existing sacral ulcers.
- Educate residents/patients and families about bed positioning.
Friction And Shear
True or False?

16. Simple, hands-on rolling is the best way to turn a resident/patient in bed.
FACT: Hands-on rolling is not advised as a method for turning residents/patients.

Suggested strategies:\n\- Use lifting devices to move rather than drag individuals during transfers and position changes.
\- Protect skin from mechanical injury via slide board, turn sheet, trapeze, and/or lubricant use.
17. Residents/patients who can shift their own weight and reposition themselves don’t need to know about pressure ulcer prevention.
FACT: Pressure ulcer education should be provided to all residents/patients, including those who can shift their own weight and reposition themselves.

Suggested strategies:\(^2\):
- Provide supportive devices (trapeze, bad canes, etc.) to facilitate position changes.
- Educate residents/patients/families about the importance of repositioning and how to do it properly.
- Encourage residents/patients to change positions regularly (as often as necessary to prevent skin breakdown).
- Monitor frequency of repositioning.
18. Moisture on the skin will increase the risk of developing a pressure ulcer.
FACT: Moisture is a key factor in pressure ulcer development.

Suggested strategies:\n
- Minimize exposure of skin to moisture (incontinence, perspiration, wound drainage).
- Individualize bathing frequency.
- Use mild cleansing agents; avoid hot water and excessive rubbing.
- Use lotion after bathing, and avoid massaging over bony prominences.
- Follow bowel/bladder/toileting plan.
- Cleanse skin at the time of soiling.
- Use topical barrier to protect skin.

True.
19. Residents with the following conditions are more likely to develop a pressure ulcer:

- Recent weight loss
- Recent incontinence
- Limited mobility
- Taking more than 8 medications

True or False?
FACT: These conditions may increase the likelihood for pressure ulcer development.

Suggested strategies:\(^2\):
- Monitor all residents/patients, especially those at high risk for pressure ulcer development.
- Adopt appropriate preventive measures, such as bowel/bladder/toilet plans and proper transfer methods.
Figure 3. Percentage of nursing home residents with pressure ulcers, by selected resident clinical characteristics: United States, 2004

- No recent incontinence: 7%
- Recent incontinence: 12%
- Eight or fewer medications: 9%
- More than eight medications: 13%
- No high immobility: 5%
- High immobility: 16%
- No recent weight loss: 10%
- Recent weight loss: 20%
- All nursing home residents: 11%

1 Significantly different from residents who had no recent incontinence.
2 Significantly different from residents who took eight or fewer medications.
3 Significantly different from residents who had no high immobility.
4 Significantly different from residents who had no recent weight loss.

SOURCE: CDC/NCHS, National Nursing Home Survey.
20. The care I give to my residents/patients every day can help prevent them from developing a pressure ulcer.
FACT: The care you provide every day can help residents/patients live happier, healthier lives.


Questions