Evidence Based Practice Pressure Ulcer Prevention Strategies: To Reposition or Turn

By: Jeanette Caddell, RN
No Conflict of Interest

I have received no support or funding for this presentation and bibliography will be provided at the end of the presentation.
Objectives

At the completion of the presentation participants will:

- Be able to identify EBP pressure ulcer prevention strategies.
- Be able to verbalize the importance of a pressure ulcer prevention program.
How does repositioning or turning the client with decreased mobility at frequent intervals as compared to not repositioning or turning reduce the development of pressure ulcers over a 90 day period?
Thesis Statement

Implementation of repositioning or turning will prevent development of pressure ulcers along with providing incontinent care, proper nutrition, and skin assessments.
BACKGROUND

- Pressure ulcers (PU) common findings in healthcare
- Occur when pressure is applied to an area for long periods of time
- Staged from 1-4 with stage 1 being the least worst and 4 being the worst
- Measured in centimeters (cm)
- Now called Pressure Injury
Stage 1

- Non-blanchable erythema of intact skin
- Skin is discolor or dark
- Color doesn’t return when pressure is applied
Stage 1
Stage 2

- Partial-thickness skin loss with exposed dermis
- Similar to an abrasion
- Top layer of skin isn’t present
- May have a intact blister present
Stage 2
Stage 3

- Full-thickness skin loss
- Top layer of skin is removed
- Fatty tissue is visible
Stage 3
Stage 4

- Full-thickness skin and tissue loss
- Worst of the worst
- All layers of the skin are removed
- Bone, ligament, or muscle may be visible
Stage 4
Pressure Ulcers/Injury
Significance

- In critically ill infants and children is 18% to 27%
- 3.55 million hospital admissions in Australia each year 10% or more will develop an ulcer
- Estimated cost to treat full thickness PU is about $70,000
- Yearly cost to treat PU in U.S. is about $11 billion
Proposed Interventions

- Implemented at a skilled nursing home w/ licensed nursing staff
- Repositioning or turning every 2 hours
- Side to side to back
- Even hours turn
- 90 day intervention
- Complete head to toe assessment each shift
- Incontinent care after each incontinent episode
- Pressure reduction mattress
Proposed Intervention: Turn Schedule
Methods

- Documentation of meal intake each meal
- Offer supplement if refused meal or oral intake less than 50%
- Documentation of fluid intake every shift
- Skin assessment
- Provide incontinence care
Ethical Considerations

- Obtain signed consent forms
- Privacy of clients
- No harm to clients
Pressure Ulcer Module
Pressure Ulcer Module

[Image: Home Health Wound Care Flow Sheet]

- Patient Name: 
- HCN: 
- Doctor Name: 
- Doctor Phone: 
- Wound Number: 
- Primary diagnosis: 
- Secondary diagnosis: 
- Tertiary diagnosis: 

Wound Shape/Size
- Irregular 
- Tunneling 
- Ulcerating 
- Circular 
  - depth cm 
  - area cm

Wound Definitions
- Undermining: Area of tissue destruction extending under intact skin along the periphery of a wound.
- Tunneling: Course or path of tissue destruction occurring in any direction from the surface or edge of the wound, results in dead space with potential for abscess formation.
- Eschar: Thick, black or brown leathery, necrotic tissue.
- Slough: Loose, may be white, yellow, tan or green, stringy, necrotic tissue.
- Signs and symptoms of infection: Erythema, induration, pain, fever, odor, purulent drainage, or increased bleeding.

Wound Type
- Trauma Wound (T) report cause: 
- Pressure Ulcer (P) report usage: 1, 2, 3, 4, 5, 6, 7, 8
- Surgical Wound (S) surgery date: 
- Diabetic Ulcer (D)
- Venous Stasis Ulcer (V)
- Arterial Ulcer (A)
- Other (O)

Wound Type Definitions
- Trauma Wound: A wound caused by external force or violence. Principal types of trauma involved include motor vehicle accidents, falls, burns, gunshot wounds, and drowning.
- Pressure Ulcer: Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers are usually over bony prominences and are staged to classify the degree of tissue damage observed.
- Venous Stasis Ulcer: An ulcer caused by inadequate venous circulation, usually found on inner legs or with irregular wound edges.
- Arterial Ulcer: An ulcer caused by inadequate arterial circulation, usually located distally in small, dry lesions with well-defined borders (punch-out lesions).
- Surgical Wound: A wound caused by a surgical intervention. Orthopedic pin with central lines (excluding PICC's), stapedial sutures, incisions, debrided graft sites, and wounds with drains are all examples of surgical wounds.

Wound Location
1. Mark the location of the wound on the figure.
2. Describe the location of the wound in words.
3. Attach a photograph of the wound if possible.
### Examples of Measurement

<table>
<thead>
<tr>
<th>Type of Wound/Location</th>
<th>Measurement of Wound Discovery/Date Wound Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer Left Heel; deep tissue</td>
<td>2.00 x 2.40 (Unstageable due to suspected deep tissue injury) 10/12/2016</td>
</tr>
<tr>
<td></td>
<td>2.00 x 2.40 (Unstageable due to suspected deep tissue injury)</td>
</tr>
<tr>
<td>Pressure Loss</td>
<td>5/5/16</td>
</tr>
<tr>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>7.10 x 0.50 x 1.00 (4)</td>
<td>6/01/2015</td>
</tr>
<tr>
<td>3.20 - 4.90 x 0.20 (4)</td>
<td>5.00 - 6.00 x 0.10 (4)</td>
</tr>
<tr>
<td>1/18/16</td>
<td>1/22/16</td>
</tr>
<tr>
<td>5.70 x 4.00 x 0.20 (4)</td>
<td>5.40 x 3.80 x 0.20 (4)</td>
</tr>
<tr>
<td>2/10/16</td>
<td>2/21/16</td>
</tr>
<tr>
<td>5.00 x 4.90 x 0.20 (4)</td>
<td>5.50 x 3.80 x 0.20 (4)</td>
</tr>
<tr>
<td>3/8/16</td>
<td>3/15/16</td>
</tr>
<tr>
<td>5.00 x 3.80 x 0.20 (4)</td>
<td>5.40 x 3.20 x 0.10 (4)</td>
</tr>
<tr>
<td>3/29/16</td>
<td>4/5/16</td>
</tr>
<tr>
<td>4.90 x 2.50 x 0.10 (4)</td>
<td>5.00 x 2.90 x 0.20 (4)</td>
</tr>
<tr>
<td>4/19/16</td>
<td>4/28/16</td>
</tr>
<tr>
<td>4.50 x 2.50 x 0.10 (4)</td>
<td>4.50 x 2.40 x 0.00 (4)</td>
</tr>
<tr>
<td>5/10/16</td>
<td>5/17/16</td>
</tr>
<tr>
<td>5.40 x 4.00 x 0.00 (4)</td>
<td>2.70 x 1.50 x 0.10 (4)</td>
</tr>
<tr>
<td>5/31/16</td>
<td>6/7/16</td>
</tr>
<tr>
<td>3.00 x 1.00 x 0.00 (4)</td>
<td>2.50 x 0.30 x 0.00 (4)</td>
</tr>
<tr>
<td>6/21/16</td>
<td>6/28/16</td>
</tr>
<tr>
<td>4.00 x 3.00 x 0.00 (4)</td>
<td>3.00 x 1.00 x 0.00 (4)</td>
</tr>
<tr>
<td>7/12/16</td>
<td>7/19/16</td>
</tr>
<tr>
<td>6.00 x 0.50 x 0.10 (4)</td>
<td>3.50 x 0.30 x 0.10 (4)</td>
</tr>
</tbody>
</table>
Importance of Preventing Pressure Ulcers

- It puts the client at risk for infection
- Increases client’s length of stay
- Decreases client’s life expectance
- Perceives the facility as an unfit place of business
- Increases costs at healthcare facility
- Possibility of survey by Joint Commission or State
KEEP CALM AND Prevent Pressure sores
Bibliography


Any Questions...
Just Ask!
That's all Folks!