In-Service Training Program

Pressure Ulcers: Reducing the Risk and Managing Care
OBJECTIVES

1. Define pressure ulcer and name three factors that contribute to pressure ulcers.
2. Describe the four stages of pressure ulcers using the National Pressure Ulcer Advisory Panel’s (NPUAP) classification system.
3. State three risk factors that contribute to pressure ulcers.
4. Name two interventions for prevention of pressure ulcers.
5. List monitoring and documentation guidelines required by federal regulations.
INTRODUCTION

- A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s).
- While friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers.
INTRODUCTION

These ulcerations have been referred to by a number of names, including:

- Decubitus ulcers
- Bedsores
- Pressure sores
- Dermal ulcers
- Pressure ulcers
INTRODUCTION

Although the regulatory language refers to pressure sores, the widely accepted term is pressure ulcers.
OVERVIEW OF PRESSURE ULCERS

In this section we will review:

- Causes
- Skin Ulcer Definitions
- Clinical Terms Related to Pressure Ulcers
- The Healing Pressure Ulcer
- Infections Related to Pressure Ulcers
- Classification System: NPUAP
OVERVIEW OF PRESSURE ULCERS

Causes:

- Unrelieved pressure on the skin squeezes the tiny blood vessels that supply the skin with nutrients and oxygen.
- When skin is starved of nutrients and oxygen for a prolonged period of time, the tissue dies and a pressure ulcer forms.
OVERVIEW OF PRESSURE ULCERS

Causes:

- Skin reddening caused by direct pressure that disappears after pressure is removed is normal and not a pressure ulcer.
- Immobility is the underlying cause of pressure ulcers. However, other factors contribute to the speed or intensity of damage caused by immobility.

(Refer to the Handout Section for the table titled Contributing Factors).
OVERVIEW OF PRESSURE ULCERS

Skin Ulcer Definitions

➢ At the time of assessment and diagnosis, the clinician is expected to document the clinical basis for determining the ulcer type (e.g., underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape and condition of surrounding tissues).

(Refer to the F315 and F309 “Definitions” handout).
OVERVIEW OF PRESSURE ULCERS

Clinical Terms Related to Pressure Ulcers

- There are a number of clinical terms related to pressure ulcers and their evaluation and treatment. Please refer to the “Definitions” handout.
OVERVIEW OF PRESSURE ULCERS

The Healing Pressure Ulcer

Research indicates that pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat and dermis) that were lost during the pressure ulcer development.
OVERVIEW OF PRESSURE ULCERS

Federal regulation 42 CFR 483.20(b)(1) F272 requires facilities to use the Resident Assessment Instrument (RAI), which includes directions to describe the healing of the pressure ulcer(s) for coding purposes for the MDS. Until the MDS is revised, the present coding system (reverse staging) must be used for completion of the RAI.
OVERVIEW OF PRESSURE ULCERS

Clinicians may use the National Pressure Ulcer Advisory Panel-Pressure Ulcer Scale for Healing (NPUAP-PUSH) tool. The NPUAP-PUSH tool documents pressure ulcer healing in terms of three ulcer characteristics and assigns a numeric value to the characteristics:

- Length (cm) times width (cm)
- Exudate amount
- Type of tissue (closed with epithelium, new pink, shiny epithelial tissue, clean, pink or beefy red, shiny, moist granulation tissue, slough tissue or necrotic eschar tissue)
OVERVIEW OF PRESSURE ULCERS

Clean pressure ulcers with adequate blood supply and innervation should show evidence of stabilization or some healing within two to four weeks.
OVERVIEW OF PRESSURE ULCERS
If a pressure ulcer fails to show some evidence of progress toward healing within two to four weeks, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be assessed.
OVERVIEW OF PRESSURE ULCERS

Re-evaluation of the treatment plan, including determining whether to continue or modify the current interventions is also indicated. If a determination is made to continue the current regimen, documentation in the medical record should include the rationale for continuing the present treatment.
OVERVIEW OF PRESSURE ULCERS

Infections Related to Pressure Ulcers

Infection occurs when bacteria invades the tissue surrounding or within the pressure ulcer. All Stage II, III and IV pressure ulcers are colonized with bacteria but may not be infected. Identification, diagnosis and treatment of infection, when present, are critical to healing a pressure ulcer.
OVERVIEW OF PRESSURE ULCERS

Classic signs and symptoms of infection may include:

- Purulent exudate
- Peri-wound warmth
- Swelling
- Induration or erythema
- Increasing pain or tenderness around the site or delayed wound healing
OVERVIEW OF PRESSURE ULCERS

The classic signs of infection may not be evident in someone with a granulating, chronic wound or an immuno-compromised or elderly resident. Some infections may present primarily with pain or delayed healing without other typical clinical signs of infection.
OVERVIEW OF PRESSURE ULCERS

Findings such as an elevated white blood cell count bacteremia, sepsis, or fever may signal an infection related to a pressure ulcer area or a co-existing infection from a different source.
OVERVIEW OF PRESSURE ULCERS

Wounds are classified as infected if the signs and symptoms of infection are present and/or a wound culture (obtained in accord with accepted standards) contains 100,000 or greater microorganisms per gram of tissue. A superficial swab may show the presence of bacteria, but is not a reliable method of identifying infection.
OVERVIEW OF PRESSURE ULCERS

Classification System: The National Pressure Ulcer Advisory Panel (NPUAP)

The National Pressure Ulcer Advisory Panel (NPUAP) has established a nationally used pressure ulcer classification system. This classification system, which has also been adopted by the Agency for Healthcare Research and Quality (AHRQ), helps to define only the visually observable characteristics of a wound. It cannot be used to identify the effects of pressure on deep tissue structures.
OVERVIEW OF PRESSURE ULCERS

The pressure ulcer classification system requires a qualified practitioner to measure, or “stage” pressure ulcers. Staging is an assessment system that classifies pressure ulcers based on anatomic depth of soft tissue damage.
OVERVIEW OF PRESSURE ULCERS

Measurements of the area are usually taken weekly to track progress and review the treatment regimen. Only pressure ulcers should be staged. Venous and arterial insufficiency ulcers should be described as partial thickness, full thickness, acute, chronic or by etiology. Burns should be classified as first, second and third degree burns.

(Refer to the NPUAP Description table in the handout section).
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

The care process should include efforts to:

- Stabilize, reduce or remove underlying risk factors.
- Monitor the impact of the interventions.
- Modify the interventions as appropriate.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

The first step in prevention is the identification of the resident at risk of developing pressure ulcers. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.
Assessment

It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission. The factors that influenced its development and the potential for development of additional ulcers must be recognized, assessed and addressed.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES
Measures to prevent the deterioration of existing pressure ulcers must be put in place. Any new pressure ulcer suggests a need to re-evaluate the adequacy of the plan for preventing pressure ulcers.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Because a resident at risk can develop a pressure ulcer within two to six hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial approaches.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

When assessing the ulcer itself, it is important to:

- Differentiate the type of ulcer (pressure-related versus nonpressure-related) because interventions may vary depending on the specific type of ulcer
- Determine the ulcer’s stage
- Describe and monitor the ulcer’s characteristics
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

- Monitor the progress toward healing and for potential complications
- Determine if infection is present
- Assess, treat and monitor pain, if present
- Monitor dressings and treatments
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

The admission evaluation may identify pre-existing signs (such as a purple or very dark area that is surrounded by profound redness, edema or induration) suggesting that deep tissue damage has already occurred and additional deep tissue loss may occur.
This deep tissue damage could lead to the appearance of an unavoidable Stage III or IV pressure ulcer or progression of a Stage I pressure ulcer to an ulcer with eschar or exudate within days after admission.
Because it is more difficult to identify erythema in a person with darkly pigmented skin, focus on other evidence of pressure ulcer development, such as bogginess, induration, coolness or increased warmth.
Other factors that affect the potential development and healing of pressure ulcers include:

- Pressure intensity
- Pressure duration
- Tissue tolerance
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Intrinsic factors due to aging include:

- Decreased subcutaneous tissue
- Decreased lean muscle mass
- Decreased skin elasticity
- Impaired circulation or innervation
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Pain

The assessment and treatment of a resident’s pain are integral components of pressure ulcer prevention and management. Recent research suggests that a resident with a Stage IV pressure ulcer can feel as much pain as those with a Stage I or II pressure ulcer.
The most common barriers to successful pain control are failure to assess for pain and failure to assess the effectiveness of pain relief measures. All residents should be screened for pain. Then, if pain is present, a full assessment should be performed and a pain management plan developed.
When assessing pain among residents with severe dementia, look to behavioral clues, such as facial expressions, behavior and changes in activities of daily living (ADLs.)

(Refer to the handout section for a more detailed list of non-verbal clues pertaining to pain).
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

During a thorough pain assessment, consider using “PQRST” method:

P – Palliative/provocative factors: What makes the pain better or worse?
Q – Quality: Describe the pain.
R – Radiation: Where is the pain and where does it spread?
S – Severity: Is this pain worse or less severe than prior pain?
T – Temporal factors: How is the pain related to the day's activities?
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Risk Factors

There are a number of risk factors that increase a resident’s susceptibility to develop and/or prevent healing of existing pressure ulcers. Examples of these risk factors include:

- Impaired/decreased mobility and decreased functional ability.
- Co-morbid condition, such as end stage renal disease, thyroid disease or diabetes mellitus.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

- Drugs such as steroids that may affect wound healing.
- Impaired diffuse or localized blood flow e.g., atherosclerosis or lower extremity arterial insufficiency.
- Resident refusal of some aspects of care and treatment.
- Cognitive impairment.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

- Exposure of skin to urinary and fecal incontinence.
- Under nutrition, malnutrition and hydration deficits.
- A healed ulcer. The history of a healed pressure ulcer and its stage is important, since areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown.
PREVENTION OF PRESSURE ULCERS:
NURSING STRATEGIES
Research has shown that a significant number of pressure ulcers develop within the first four weeks after admission to a nursing facility. Therefore, a standardized pressure ulcer risk assessment tool should be used to assess a resident’s pressure ulcer risk upon admission, weekly for the first four weeks after admission, then quarterly, or whenever there is a significant change in condition based on federal guidelines.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Each risk factor and potential cause should be reviewed to:

- Identify those factors that increase the potential for the resident to develop pressure ulcers
- Decide whether (to what extent) the factor(s) can be modified, stabilized or removed
- Determine whether targeted management protocols need to be implemented.
PREVENTION OF PRESSURE ULCERS:
NURSING STRATEGIES
Pressure Points and Tissue Tolerance

Assessment of a resident’s skin condition helps define prevention strategies. Sacrum pressure ulcers remain the most common location, however, pressure ulcers on the heel are common.
The skin assessment should include an evaluation of the skin integrity and the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects. Friction and shearing are also important factors in tissue ischemia, necrosis and pressure ulcer formation.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES
Pressure ulcers are usually located over a bony prominence, such as the sacrum, heel, the greater trochanter, ischial tuberosity, fibular head, scapula and ankle (malleolus).
Tissue closest to the bone may be the first tissue to undergo necrosis. Pressure ulcers may also develop at other sites where pressure has impaired the circulation to the tissue, such as pressure from positioning or use of medical devices.
PREVENTION OF PRESSURE ULCERS:
NURSING STRATEGIES

Some examples include:

- Pressure or friction on areas (e.g., nares, urinary meatus, extremities) caused by tubes, casts, orthoses, braces and cervical collars
- Pressure on the labia or scrotum related to positioning (e.g., against a pommel type cushion)
- Pressure on the foot related to ill-fitting shoes causing blistering
- Pressure on legs, arms and fingers due to contractures or deformity resulting from rheumatoid arthritis
Under Nutrition and Hydration Deficits
Adequate nutrition and hydration are essential for overall functioning. The skin is the body’s largest organ system. Skin condition reflects overall body function and may be the most visible evidence of a general catabolic state.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Unless contraindicated, nutritional goals for a resident with nutritional compromise who has a pressure ulcer or is at risk of developing pressure ulcers should include protein intake of approximately 1.2-1.5 gm/kg body weight daily (higher end of the range for those with larger, more extensive, or multiple wounds). A multivitamin supplementation is appropriate without additional vitamins or minerals.
There is no laboratory tests to warrant serial/repeating testing. Serum albumin, pre-albumin and cholesterol may be useful to help establish overall prognosis, however they may not correlate with clinical observation of nutritional status.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Water is essential to maintain adequate body functions. It is critical that each resident at risk for hydration deficit or imbalance, including the resident with a pressure ulcer or a risk of developing an ulcer, is identified and hydration needs addressed.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Unless contraindicated, hydration goals for a resident are 25-30ml/kg of body weight (higher end of the range for younger individuals).
Both urine and feces contain substances that may irritate the epidermis and may make the skin more susceptible to breakdown. Irritation or maceration resulting from prolonged exposure to urine and feces may hasten skin breakdown. Moisture may make skin more susceptible to damage from friction and shear during repositioning.
PREVENTION OF PRESSURE ULCERS: NURSING STRATEGIES

Differentiating dermatitis related to incontinence from partial thickness skin loss (pressure ulcer) is sometimes difficult. A Stage I pressure ulcer usually presents as a localized area of erythema or skin discoloration.
Perineal dermatitis usually appears as a more diffuse area of erythema or discoloration where the urine or stool has come into contact with the skin, and/or in the area where the incontinence brief or underpad has been used. The dermatitis/rash typically presents as intense erythema, scaling, itching, papules, weeping and eruptions.
INTERVENTIONS

The comprehensive assessment provides the basis for defining approaches to address residents at risk of developing or already having a pressure ulcer. Effective prevention and treatment are based upon consistently providing routine and individualized interventions.
INTERVENTIONS

The resident's plan of care should establish relevant goals and approaches to stabilize or improve co-morbidities, in the context of the resident's choices, clinical condition and physician input.

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INTERVENTIONS

Resident Choice
The resident (or the resident’s legal representative) has the right to exercise his or her right to make informed choices about care and treatment, or to refuse treatment.
INTERVENTIONS

The facility must discuss the resident’s condition, treatment options, expected outcomes, the consequences of refusing treatment, and offer relevant alternatives if the resident has refused specific treatments. The facility staff and practitioners are responsible for documenting valid reasons why such interventions were not appropriate or feasible.
INTerventions

Advance Directive

If a resident has a valid Advance Directive, the facility’s care must reflect a resident’s wishes as expressed in the Directive, in accordance with state law. The presence of an Advance Directive does not absolve the facility from giving supportive care. Basic care should continue if not prohibited by the Advance Directive.
INTERVENTIONS

Examples of basic care include:

➢ Redistribute pressure (such as repositioning, protecting heels)
➢ Minimize exposure to moisture and keep skin clean
➢ Provide appropriate pressure redistributing, support surfaces
➢ Provide non-irritating surfaces
➢ Maintain or improve nutrition and hydration status, where feasible
INTERVENTIONS

The resident’s drug regimen may worsen risk factors for development of pressure ulcers or for non-healing pressure ulcers (e.g., cause lethargy, anorexia or create/increase confusion) and should be identified and addressed. Interventions should then be incorporated into the plan of care and revised as the condition of the resident indicates.
INTERVENTIONS

Repositioning

Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. The care plan for a resident at risk of friction or shearing during repositioning may require the use of lifting devices for repositioning.
INTERVENTIONS

Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing.
INTERVENTIONS

Points to Remember

➢ A resident who can change positions independently may need supportive devices to facilitate position changes.

➢ A resident who is dependent on staff for repositioning should be repositioned at least every two hours or more frequently depending upon the resident’s condition and tolerance to pressure.
INTERVENTIONS

- Avoid, if possible, placing the resident directly on a pressure ulcer.
- Elevating the head of the bed or back of a reclining chair to or above a 30-degree angle creates pressure comparable to that exerted while sitting.
- Consider “off loading” (position change) hourly for dependent residents who are sitting or who are in a bed or reclining chair raised 30 degrees or more.
INTERVENTIONS

- A teachable resident should be taught to shift his/her weight approximately every 15 minutes while sitting in a chair.

- Repositioning should allow pressure relief for at least 10 minutes. For example, stand the resident up to walk or toilet to allow sufficient time for capillary refill and tissue perfusion.
Support Surfaces and Pressure Redistribution

Pressure redistribution refers to the function or ability to distribute a load over a surface or contact area. Pressure redistribution incorporates:

- **Pressure reduction** - reduction of interface pressure, not necessarily below capillary closure pressure
- **Pressure relief** - reduction of interface pressure below capillary closure pressure
INTerventions

The effectiveness of pressure redistribution devices (e.g., four-inch convoluted foam pads, gels, air fluidized mattresses and low loss air mattresses) is based on the potential to address the individual resident’s risk, the resident’s response to the product and the characteristics and condition of the product.
INTERVENTIONS

For example, a product that completely compresses (the caregiver can feel less than one inch between the resident and the support material) is unlikely to effectively reduce the pressure risk.
Points to Remember

- Static pressure redistribution devices (e.g., solid foam, convoluted foam, gel mattress) may be indicated when a resident is at risk for pressure ulcer development or delayed healing.
INTERVENTIONS

- Dynamic pressure reduction surfaces may be helpful when:
  - The resident cannot assume a variety of positions without bearing weight on a pressure ulcer
  - The resident completely compresses a static device
  - The pressure ulcer is not healing as expected and it is determined that pressure may be contributing to the delay in healing
INTERVENTIONS

- Never use donut-type cushions.
- A resident with a severe flexion contracture should be evaluated by an Occupational Therapist (OT) to determine what devices can be used to relieve pressure.
- Heels should be “floated” to relieve pressure. There are a number of commercial products available.
Some products (e.g., sheepskin, heel and elbow protectors) serve mainly to provide comfort and reduce friction and shearing forces. Although these products are not effective at redistributing pressure, they (in addition to pillows, foam wedges or other measures) may be employed to prevent bony prominences from rubbing together.
INTERVENTIONS

Other interventions to prevent pressure ulcers include establishing protocols for:

- Range-of-motion exercises
- Urinary and fecal incontinence
- Nutrition and hydration
- Surgical wound care and/or treatment
- Skin care protocols
- Foot care protocols
- Personal hygiene
INTERVENTIONS

Good foot care, especially for the diabetic resident, adheres to these guidelines:

- Inspect feet daily for blisters or reddened areas
- Dry feet carefully, especially between toes
- Never remove corns and calluses
- Trim toenails carefully
- Ensure that the person wears properly fitting socks and shoes
- Instruct the resident not to cross legs
- Support heels and ankles to avoid rubbing on bed linens
MONITORING AND DOCUMENTATION

Nursing facilities must have a system in place to assure that protocols for daily monitoring, periodic documentation of measurements, terminology, frequency of assessment and documentation are used consistently throughout the facility.
MONITORING AND DOCUMENTATION

When a pressure ulcer is present, daily monitoring and documentation should include:

- An evaluation of the ulcer, if no dressing is present.
- An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking).
MONITORING AND DOCUMENTATION

- The status of the area surrounding the ulcer (that can be observed without removing the dressing).
- The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (e.g., increased redness or swelling around the wound or increased drainage from the wound).
- Whether pain, if present, is being adequately controlled.
The amount of observation possible will depend upon the type of dressing that is used, since some dressings are meant to remain in place for several days, according to manufacturers’ guidelines.
MONITORING AND DOCUMENTATION

With each dressing change, or at least weekly, (and more often when indicated by wound complications or changes in wound characteristics) an evaluation of the pressure ulcer wound should be documented.
MONITORING AND DOCUMENTATION

At a minimum, documentation should include the date observed and:

- Location and staging.
- Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract.
MONITORING AND DOCUMENTATION

- Exudate, if present: type (such as purulent/serous), color, odor and approximate amount.
- Pain, if present: nature and frequency (e.g., whether episodic or continuous).
- Wound bed: color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar).
- Description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration and maceration) as appropriate.
MONITORING AND DOCUMENTATION

Signs and symptoms to report to the physician and document in the medical record include:

- The pressure ulcer is larger or deeper.
- Increased drainage or odor from the ulcer.
- The ulcer shows no signs of healing after two to four weeks.
- Signs of infection are noted.
- A significant weight loss is noted (as defined by federal regulations).
- General health becomes worse.
MONITORING AND DOCUMENTATION

At least daily, staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes.
MONITORING AND DOCUMENTATION

For example, a resident’s complaint about pain or burning at a site where there has been pressure or a nursing assistant’s observation during the resident’s bath that there is a change in skin condition should be reported so that the resident may be evaluated further.
MONITORING AND DOCUMENTATION

After completing a thorough evaluation, the interdisciplinary team should develop a relevant care plan and include prevention and management interventions with measurable goals.
Other monitoring and documentation includes:

- Skin assessment upon admission, weekly for the first four weeks from admission, then quarterly or if a significant change in condition occurs based on federal guidelines. Use the Braden or Norton Plus Scale tool.
MONITORING AND DOCUMENTATION

- Weekly observation of each resident’s body to determine skin condition (skin color, moisture, temperature, integrity and turgor.)
- Weekly assessment and review of all pressure ulcer sites, including measurements by a registered nurse.
- Resident’s response to treatment(s), including rationale for changes in the treatment plan.
DRESSINGS AND TREATMENTS

Chronic wounds such as pressure ulcers heal differently from acute wounds. Current clinical practice indicates that Stage III and Stage IV ulcers should be covered. Determination of the need for a dressing for a Stage I or Stage II ulcer is based on facility protocols and current standards of practice.
DRESSINGS AND TREATMENTS

Product selection should be based on:

- Relevance of the specific product to the pressure ulcer characteristics
- Treatment goals
- Manufacturer’s recommendations for use
DRESSINGS AND TREATMENTS

There is no significant advantage of one product over another, but not all products are appropriate for all pressure ulcers. Wound characteristics should be assessed throughout the healing process to assure that the treatment and dressings being used are appropriate to the nature of the wound.
Points to Remember

- Generally, clean technique can be used rather than sterile, however sterile technique may be needed for wounds recently surgically debrided or repaired.

- Debridement of nonviable tissue is frequently performed to reduce the amount of wound debris or nonviable tissue and reduce the risk of sepsis.
DRESSINGS AND TREATMENTS

- Generally, stable, dry, adherent and intact eschar of the foot/heal should not be debrided, unless signs and symptoms of local infection or instability are detected.
SUMMARY

Pressure ulcers represent a major health problem among the elderly. Prevention is the best solution and alleviates needless suffering and healthcare costs. All healthcare staff, residents and families share the responsibility for pressure ulcer prevention.
SUMMARY

Consistent care, careful observation and accurate documentation are essential from quality of care, legal and financial perspectives.