

Nurse I See Red: Pressure Sore Prevention Can Be Done!

Introduction

Pressure ulcers present a significant health threat to patients in acute care hospitals. In order to educate non-licensed personnel (Technical Partners) to recognize patients at risk for developing pressure ulcers or early stage pressure ulcers, the institution developed a continuing education program for Technical Partners (TPs). The *Nurse I See Red Program* was instituted in response to an increase in the number of nosocomial pressure ulcers in acute care.

Nurse I See Red

The one hour program was developed by the ET Nurse to teach technical partners factors that contribute to pressure ulcer development, recognition of early stages and prevention methods. The program content was geared for the non-licensed personnel and included multiple opportunities for participant interaction. Content category includes:

- What is a Pressure Ulcer
- What does a Pressure Ulcer look like
- What are the Risk Factors
- What can I do to Prevent Pressure Ulcers



Risk Factor

Prevention

Risk Factor	Prevention
Moist Skin <ul style="list-style-type: none"> ■ Perspiration ■ Incontinence ■ Wound drainage 	<ul style="list-style-type: none"> ■ Bathe patient carefully paying particular attention to skin folds and perineal tissues ■ Use skin cleansers and skin protectant on all incontinent patients and patients who use a bedpan ■ Place absorbent material between the skin folds of obese patients ■ Limit use of diapers to patients who are out of bed or who have large amounts of urine or diarrhea at one time ■ Check incontinent patients frequently ■ Discuss a toileting schedule with the RN ■ Avoid plastic barriers and sheepskin ■ Report any signs of redness to RN
Loss of Sensory Perception <ul style="list-style-type: none"> ■ Paralysis (loss of voluntary motion and/or sensation) ■ Neuropathy ("pins and needles" sensation in affected limb, decrease in sensation) ■ Decrease in mental awareness 	<ul style="list-style-type: none"> ■ Inspect patient's skin for areas of redness with every position change ■ Avoid massaging bony prominences ■ Turn and reposition every 2 hours (minimum) ■ Elevate heels off of bed surface with pillows ■ If on Comfortex DeCube mattress, remove appropriate cubes ■ Check position of foot in Heel Lift boot and reposition as necessary ■ Remove Teds for ½ hour every day and check heels. If patient is at risk for heel breakdown, consider checking more frequently ■ Perform active and passive range of motion (ROM) of all involved extremities
Limited Activity and Mobility <ul style="list-style-type: none"> ■ Paralysis (loss of voluntary motion and/or sensation) ■ Neuropathy ("pins and needles" sensation in affected limb, decrease in sensation) ■ Decrease in mental awareness 	<ul style="list-style-type: none"> ■ Encourage patient to change position frequently or turn patient every 2 hours ■ Utilize turning clock (currently being piloted at LVH-M) ■ If patient is not moving because of poor pain control, discuss with the RN ■ Promote ambulation at regular intervals (consider PT consult if patient has difficulty with mobility) ■ OOB to chair no longer than 2 hours at one sitting. Reposition after one hour. IF patient is able to do, remind to shift position every 15 minutes <ul style="list-style-type: none"> ● Hint: suggest that position be shifted each time there is a commercial on TV ■ Use chair cushion if patient is at risk
Altered Blood Flow <ul style="list-style-type: none"> ■ Decreased flow of blood to extremities <ul style="list-style-type: none"> ● Vascular patients ● Diabetic patients ■ Edema ■ Hypotensive episode-BP 	<ul style="list-style-type: none"> ■ Report the following unexpected changes to the RN ■ Change in vital signs and color and temperature of skin surfaces <ul style="list-style-type: none"> ● Decrease in urine output ● Swelling in any body tissues ■ Keep in mind that patient's with altered circulation are susceptible to skin damage and heat and cold from items such as heating pads, hot packs and cold packs
Friction and Shearing <ul style="list-style-type: none"> ■ Friction – abrasion of the top layer of skin ■ Shearing – the skin separating from underlying tissues 	<ul style="list-style-type: none"> ■ Assess need for assistive devices (heel protectors, extra pillows) ■ Use turning and transfer aids, i.e., pull sheets, trapeze ■ Use lubricants on dry skin surfaces where applicable ■ Prevent shearing by maintaining bed at 30 degrees or less and gatch knees when possible ■ Secure tubes appropriately ■ Maintain proper positioning in chair ■ Have patient wear socks to avoid shearing/friction when pulling patient up in bed ■ Pad patient's buttocks (disposable diaper) when using a transfer board to get in and out of bed if at risk for skin breakdown ■ Powder bedpan edges before placing patient on bedpan

What is a Pressure Sore?

- Any injury caused by unrelieved pressure that damages the skin and underlying tissue (tissue under skin)
- Also called decubitus ulcers, pressure ulcers or bedsores
- Severity ranges from reddening of skin to deep craters extending to muscle and bone

Why are Pressure Ulcers a Problem:

- Pressure sores can produce poor outcomes for patients including loss of a limb or even death
- Pressure sores are costly
 - Increased length of stay
 - Added hospital costs
 - Additional recovery time

Results

Early program evaluations included positive comments from the participants. Overall rates for nosocomial pressure ulcers have declined housewide.

Conclusions

A decline in the number of nosocomial pressure ulcers since the inception of the Nurse I See Red Program can be attributed to a number of initiatives. The positive evaluations prompted inclusion of the program in the orientation program for new TPs.

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