

# PRESSURE ULCER ASSESSMENT

Pressure ulcers (also called pressure sores, decubitus ulcers, and bedsores) occur when prolonged pressure damages the skin and underlying tissues, impairing blood supply. They typically develop in people with reduced mobility, such as those confined to bed, elderly, or with diabetes and circulation problems.

## VULNERABLE PRESSURE ULCER AREAS

Areas prone to pressure ulcers are typically over bony prominences, vulnerable due to heightened pressure and friction from prolonged contact with surfaces like beds or chairs. Commonly affected areas include:

- Back of the head
- Elbow
- Knee
- Shoulder
- Hip
- Low back
- Buttocks
- Heel
- Lower back and buttocks



## ASSESSMENT

- Explain the assessment to the patient and obtain informed consent.
- Wash your hands and don personal protective equipment as per hospital guidelines.
- Conduct a comprehensive assessment, considering overall health, medical history, and individual needs.
- Inspect the skin for temperature, color, moisture, integrity, and elasticity.
- Check for warning signs of pressure ulcers, such as color changes, warmth, and tenderness.
- If evidence is present, gently press down the skin (use a thumb or a blunt object) to test for color change (use fingers to test for color change in darker-skinned patients).

## SKIN INSPECTION

Inspect the skin for temperature, color, moisture, integrity and elasticity.

If there is an area of reduced pressure, gently press down on it for 15 seconds. It should turn pink. If the redness should return after you remove your finger, this is a warning sign that the skin is not healthy. If the skin remains red when you remove your finger, this indicates a pressure ulcer in the underlying tissue. If left untreated, this can develop into a pressure ulcer.



## PRESSURE ULCER STAGES



1. Skin is intact but inflamed, red or purple, and hot, with increased pain, and stiffness.



2. Skin is broken, with a shallow open ulcer or partial-thinning.



3. Full-thickness tissue loss with a crater-like ulcer extending to subcutaneous fat, with a high risk of infection.



4. Full-thickness tissue loss extending to muscle or bone, with a significant risk of infection and sepsis.

## PREVENTION

Use pressure-relieving cushions and support aids to reduce pressure and prevent ulcers. Implement regular repositioning, a thorough skin care routine upon discharge, and adopting a healthy lifestyle, including a balanced diet, exercise, hydration, and quitting smoking.

## TREATMENT

Relief of pressure on the damaged skin, wound care, pain control, infection prevention, and appropriate nutrition are all part of treating pressure ulcers.

Keep the area dry and apply a barrier cream to any surrounding skin where incontinence is an issue. Avoid friction with rubbing or pressure. Apply a barrier cream to any surrounding skin where incontinence was an issue. Avoid friction with rubbing or pressure.

## WOUND CARE

When an ulcer is present, record the anatomical location and measure the size of the wound, assess the wound's dimensions, appearance, evaluate underlying tissue, its circumferential area and if any red sign of infection, edema, or pain is present.

Follow the general care policy and the healthcare provider's directions for the dressing. Record on the patient's notes the assessment and findings, measurements and date and initial the dressing.

# Pannus Treatment Manual Guide

**N Colangelo**

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