

LEARN: Pressure Injuries Slide Presentation

20 minutes

Purpose:

Participants will learn about contributing factors, location and assessment of pressure injuries.

Materials:

- *Introduction to Pressure Injuries* slide presentation

Facilitation Steps:

1. Tell students to keep their handouts from the Focus part of the lesson as reference for use during the slide presentation.
2. Share the following information with students as you complete the slide presentation:

Slide 2: See *Introduction to Pressure Injuries* worksheet. Discuss locations of bony prominences.

Slide 3: According to the Agency for Healthcare Research & Quality (AHRQ) as part of the US Department of Health and Human Services, pressure injuries are one of the most common health conditions in the United States. It is costly for patients, families and health care systems.

Slide 4:

Pressure - Have students press down vertically on the tip of their finger (or palm if skin color is dark). Have them note that it turns white with pressure thus occluding the blood supply to the area. When pressure is relieved, the skin color returns. This is called blanching. Example of pressure is sitting in the same position.

Shear - Have the students rub the area slowly parallel to the skin surface (slide finger against finger or palm). The same

happens. Example of shear is a patient sliding down in bed.

Friction - Have the students rub their thumb and pointer finger together back and forth. The same happens. Example of friction is the rubbing of a brace on the body.

Slide 5: In addition to pressure and shear, the risk for a pressure injury increases if the patient also has:

Age - older patients tend to have more risk factors

Impaired tissue perfusion/oxygenation - some diseases such as diabetes affect the blood vessels thus causing perfusion and oxygenation issues

Poor nutrition - patients lacking proteins, vitamins and minerals are at risk

Incontinence - moisture compromises the protective barrier of the skin and overhydrates it making it susceptible to breakdown

Loss of sensation - decreases the patient's ability to respond to increased pressure

Immobility - restricts a patient's ability to change and control positions. It can increase pressure over bony prominences.

Lack of activity - a person who is restricted to bed is at a greater risk than a person who is partially or fully mobile.

Slide 6: The Braden Scale for Predicting Pressure Sore Risk is among the most widely used tools for predicting the development of pressure injuries
<http://www.bradenscale.com/images/braden-scale.pdf>

Slide 7: It is important to observe every area of the skin. Working head to toe is an efficient manner.

If there is a reddened area, check for a blanch response. If the skin color returns, continue to monitor the area but it is not a pressure injury yet.

Warmth and swelling can indicate an infected area. Patients with darkly pigmented skin cannot be assessed for pressure injuries by solely examining the skin color.

Pressure injuries can be very painful. It is important to treat and document the patient's pain related to an injury.

Mechanical devices such as nasal cannulas (tubing that delivers oxygen through the nose), bedpans and braces can cause skin breakdown. Critically ill and pediatric patients have the highest rates of mechanical device pressure injuries.

Slide 8: If the patient has a pressure injury, it is important to document the following:

Anatomic location

Size (length, width and depth in centimeters) Length is head to toe direction, width is side to side direction, there can be multiple depths depending on the wound. When measuring a wound, always wear gloves and do not place measurement device directly onto the wound as this can increase chance of infection. May demo this.

Tracts or tunneling – these are channels going from the wound bed into surrounding tissue. It is important to measure the depth of these using a sterile cotton tip applicator (similar to a Q-tip) May demo this.

Necrotic tissue – This tissue is black in color and is dead tissue. Necrotic tissue is

removed prior to placing a dressing on the wound.

Wound bed (granulation tissue present?) – The bed of the wound should be a beefy red color. This is called granulation tissue and is required for the healing process.

Odor – Noticeable odor can indicate infection.

Pressure injury edges and surrounding skin (redness, warmth, induration (hardness), swelling and signs of infection)

Slide 9: Serous - this is usually found during the healing process

Sanguineous - this indicates fresh bleeding and the amount should be monitored

Serosanguinous - this indicates that the fresh bleeding is stopping and the serous drainage is beginning

Purulent - this indicates infection and should be reported to the health care provider

Slide 10: Accuracy in pressure injury staging is important for prompt and appropriate care.

Slide 11: Stage I pressure injuries may be difficult to detect in patients with dark skin tones. May show model as example from the Pressure Injury Simulation Kit.

Slide 12: Stage II: May show model as example

Slide 13: Stage III: May show model as example

Slide 14: Stage IV: May show model as example

Slide 15: Here is a documentation sample.