

DECUBETIC ULCER (Bed Sores)

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Objectives

After this presentation the student will be able to:

- Define Decubetic ulcer
- Identify the factors that can cause ulcer
- Explain the pathophysiology of bed sore
- Know the sites of bed sore
- Describe the stages of Bed sore
- Know the medical management of ulcer
- Apply the nursing intervention to prevent ulcer

DEFINITION

- ❖ A Pressure Ulcer or Pressure Sore or Decubitus Ulcer or Bedsore is localized injury to the skin and other underlying tissue, usually over a body prominence, as a result of prolonged unrelieved pressure.

RISK FACTORS THAT CAN CAUSE **ULCER**

1. Friction
2. Shear
3. Impaired Sensory Perception
4. Impaired Physical Mobility
5. Altered Level Of Consciousness
6. Fecal And Urinary Incontinence

7. Malnutrition

8. Dehydration

9. Excessive Body Heat

10. Advanced Age

11. Chronic Medical Conditions- Diabetes,
Cardiovascular Diseases.

Pathophysiology

Various risk factors act on areas of soft tissue overlying bony prominence



When this pressure exceeds normal capillary pressure



Occlusion & tearing of small blood vessels



Reduced tissue perfusion

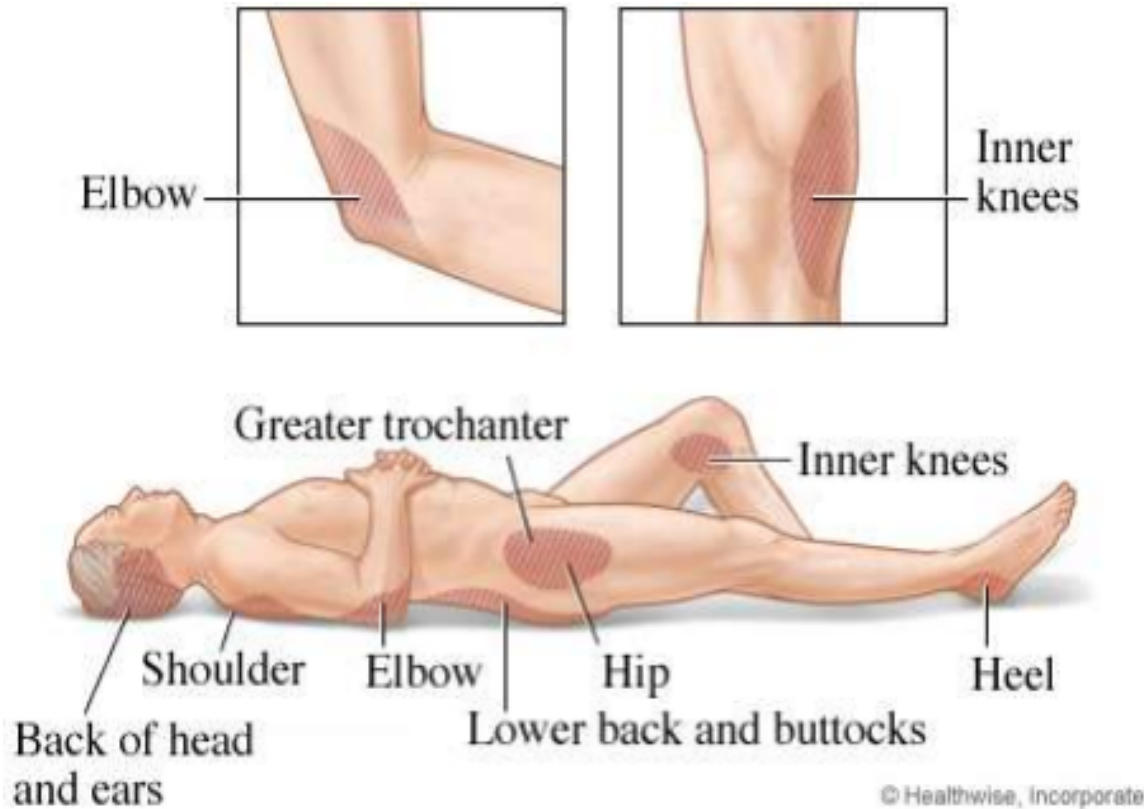


Ischemic necrosis



Pressure sore

COMMON SITES OF ULCER

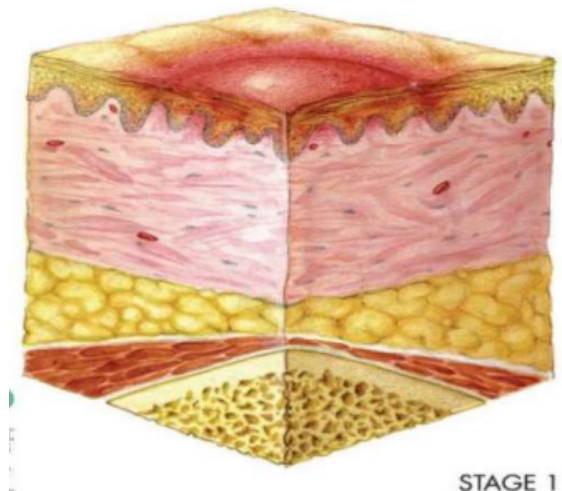


STAGES / CLASSIFICATION OF ULCERS

- Staging systems for pressure ulcers are based on the depth of tissue destroyed.
- Based on the depth there are four stages of bedsores
 1. Stage I
 2. Stage II
 3. Stage III
 4. Stage IV

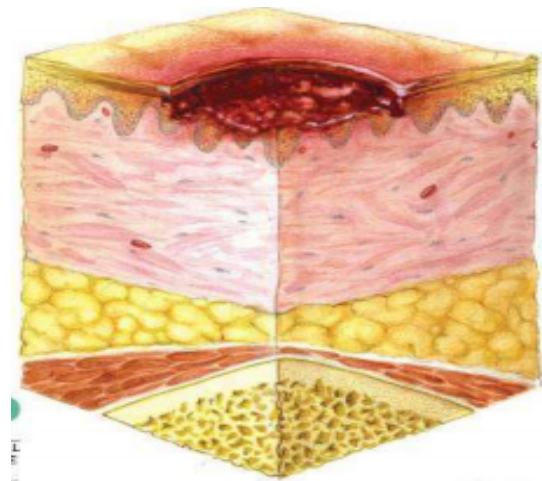
STAGE I: NONBLANCHABLE REDNESS OF INTACT SKIN

- Intact skin presents with non-blanchable erythema of a localized area usually over a bony prominence.
- Discoloration of the skin, warmth, edema or pain may also be present.
- Stage I indicates “at-risk” persons.
- Involves only the epidermal layer of skin.



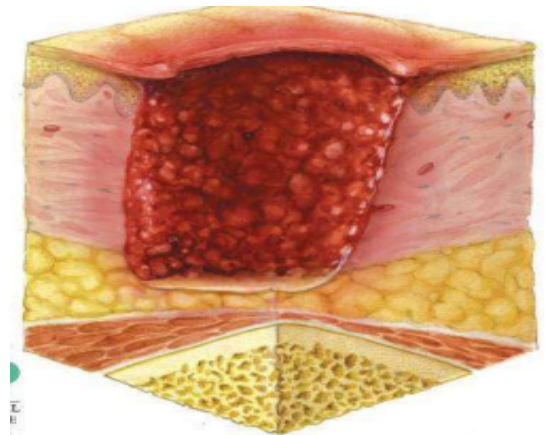
STAGE II: PARTIAL-THICKNESS SKIN LOSS OR BLISTER

- A partial thickness loss of dermis presents as a shallow open ulcer with a red-pink wound bed without slough.
- Stage II is damage to the epidermis and the dermis. In this stage, the ulcer may be referred to as a blister or abrasion.



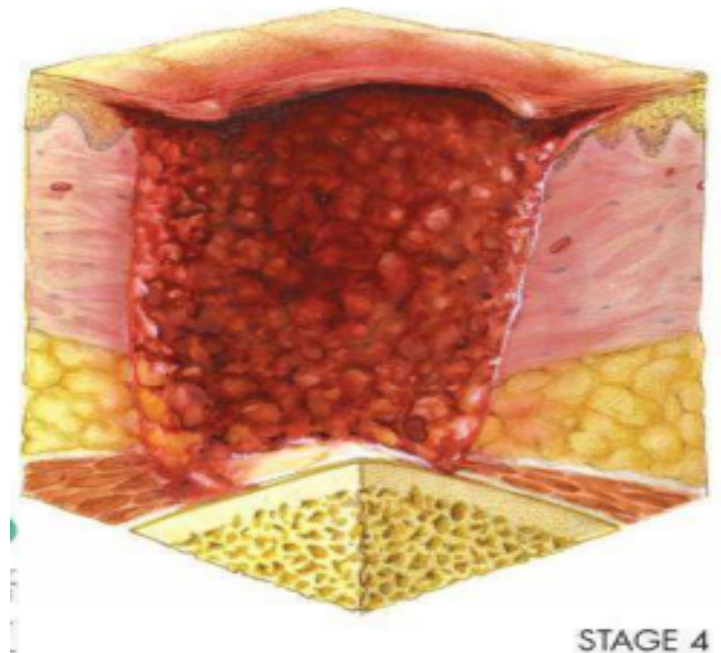
STAGE III: FULL-THICKNESS SKIN LOSS (FAT VISIBLE)

- A stage III ulcer is a full-thickness tissue loss. Subcutaneous fat may be visible; but bone, tendon, or muscle is not exposed.
- Epidermis, dermis and subcutaneous tissues involved.
- subcutaneous layer has a relatively poor blood supply.
- So its difficult to heal.



STAGE IV: FULL-THICKNESS TISSUE LOSS

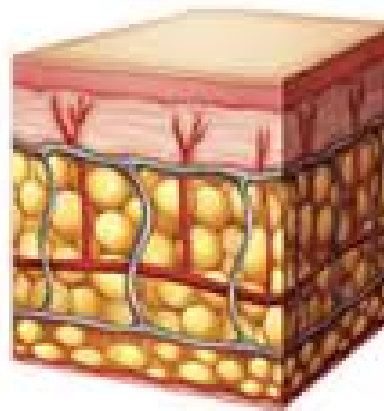
- A stage IV ulcer is the deepest, extending into the muscle, tendon or even bone.
- Full thickness tissue loss with exposed bone, tendon or muscle.



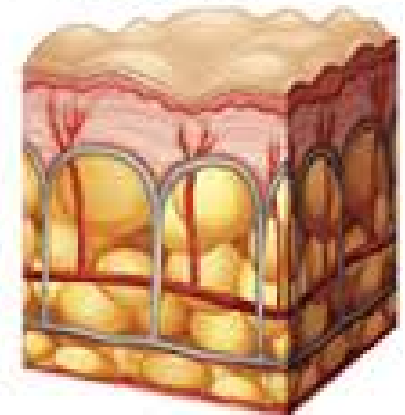
COMPLICATIONS

- Cellulitis
- Bone and joint infections
- Sepsis
- Cancer

Cellulite (Human Skin)



healthy skin



skin with cellulite

Treatment

1. Changing positions often: Carefully follow the schedule for turning and repositioning, approximately every 15 minutes if in a wheelchair and at least once every two hours when in bed. If unable to change position on own, a family member or other caregiver must be able to help.
2. Using support surfaces: These are special cushions, pads, mattresses and beds that relieve pressure on an existing sore and help protect vulnerable areas from further breakdown.

3. Cleaning. It's essential to keep wounds clean to prevent infection. A stage I wound can be gently washed with water and mild soap, but open sores should be cleaned with a saltwater (saline) solution each time the dressing is changed.
4. Controlling incontinence
5. Removal of damaged tissue (debridement). To heal properly, wounds need to be free of damaged, dead or infected tissue.
6. Dressings.
7. Oral antibiotics.
8. Healthy diet.
9. Educating the caregiver

MEDICAL TREATMENT

1. Surgical repair.
2. Tissue flap.
3. Plastic surgery may be required to replace the tissue.
4. Other treatment options Researchers are searching for more effective bedsore treatments. Under investigation are hyperbaric oxygen and the topical use of human growth factors.

PREVENTION

- Bedsores are easier to prevent than to treat. Although wounds can develop in spite of the most scrupulous care, it's possible to prevent them in many cases.

Role Of Nurse In Prevention & Management Of Bed Sores

The nurse should be continually assessing the client who are at risk for pressure ulcer development Assess the client for:

- The predisposing factors for bed sore Development.
- Skin condition at least twice a day.
- Inspect each pressure sites. Evaluate circulatory status (eg. Peripheral pulses, edema).
- Palpate the skin for increased warmth.

ROLE OF NURSE

1. Interventions for a patient with Decreased sensory perception:

- Assess pressure points for signs of bed sore development.
- Provide pressure-redistribution surface. Interventions for a patient with incontinence.

2. Assess need for incontinence management:

- Following each incontinent episode, clean area and dry thoroughly.

3. Interventions to avoid Friction and shear:

- Reposition patient using draw sheet and lifting off surface.
- Use proper positioning technique.
- Avoid dragging the patient in bed.
- Use comfort devices appropriately.

4. Interventions for a patient with Decreased activity/ mobility:

- Establish individualized turning schedule.
- Change position at least once in two hours and more frequently for the high risk individuals.

5. Interventions for a patient with Poor nutrition:

- Provide adequate nutritional and fluid intake.
- Assist with intake as necessary.
- Consult dietician for nutritional evaluation R

Thank you