



Pressure Ulcers eCourse

Module 5.1: Treatment of Pressure Ulcers

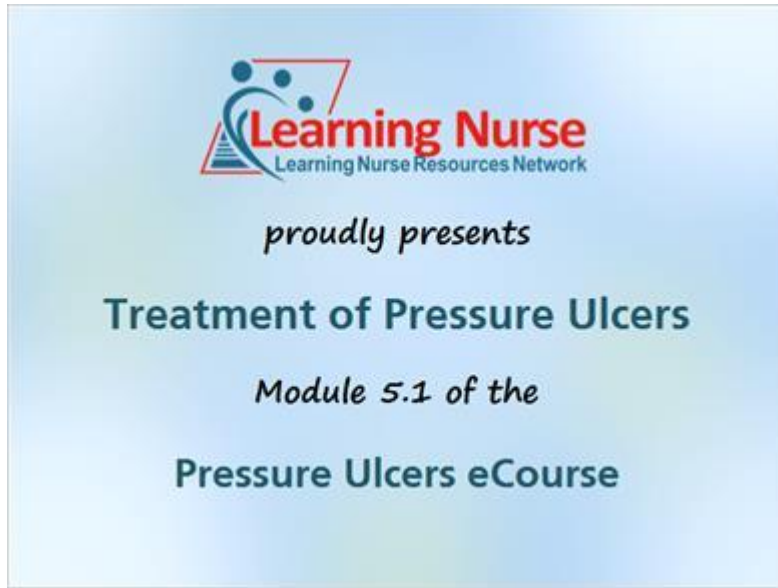
Handout

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Treatment of Pressure Ulcers

1. PU Treatment

1.1 Welcome



Narration

No narration, only music.

1.2 Topics



Narration

JILL: Hi ... I'm Jill and with me is Mark. Welcome to Module 5 of this Pressure Ulcer course.

MARK: Hi Jill. It looks like this is the final module in this course. What will we be covering?

JILL: Yes Mark, this is the last module. Module 5 is about treatment of pressure ulcers once they have developed. There are 8 sub-modules. In this sub-module, we will discuss treatment plans for pressure ulcers, and how to assess and monitor their healing. In the other 7 sub-modules, we will cover the treatments and interventions that involve: repositioning and support surfaces; cleansing and debridement; and dressings for pressure ulcers.

1.3 Topics 2



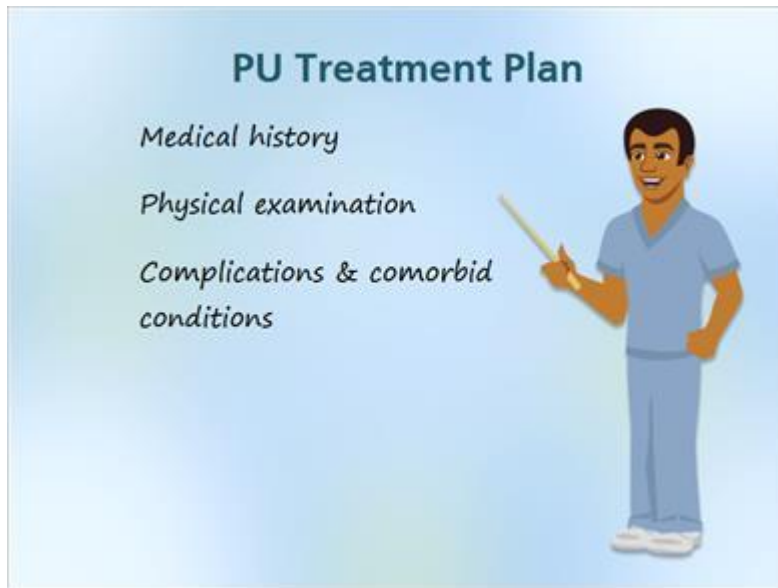
Narration

JILL: In the last 4 sub-modules we will cover: nutrition, infections, pain management and surgery for pressure ulcers.

MARK: Looks like we have a lot of information to cover. So let us begin!

JILL: Okay.

1.4 Treatment Plan



Narration

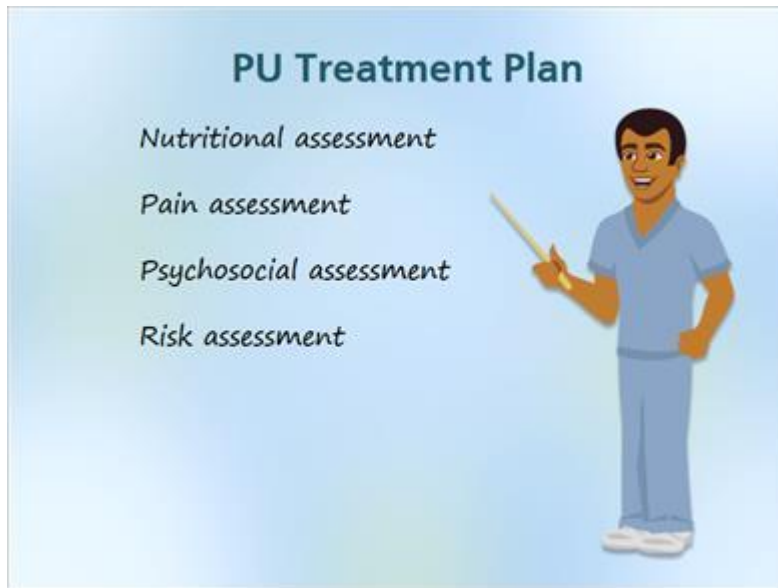
JILL: In the last module, we discussed the steps we take to prevent the development of pressure ulcers in patients or residents in our care. However, if our patients do develop pressure ulcers, or they come into our facility with pressure ulcers, then we need to prepare a treatment plan.

MARK: How do we do that?

JILL: We start with a complete and comprehensive assessment on the patient or resident. This will help us structure a patient-centered plan of care to maximize wound healing.

We should also perform a thorough physical examination. This will alert us to any complications and comorbid conditions that we may need to consider in developing our treatment plan.

1.5 Treatment Plan 2



Narration

JILL: We then should do a thorough nutritional assessment, including laboratory analysis.

MARK: We do this because the patient's general health and nutrition will have an impact on how quickly their pressure ulcer heals?

JILL: Yes, that's right. Pain should be assessed at every visit. It is not enough to ask if the patient has pain. It is also important to know what type of pain. This will give us clues on what type of therapy and medication may provide suitable pain relief.

A social assessment is important to determine support systems. Patients with strong family support have less risk for recurrence of pressure ulcers.

It is also critical to assess for the risk of developing future pressure ulcers. It is important to remember that it is often easier to prevent than to treat them.

MARK: Are these all the factors we have to consider for a treatment plan?

1.6 Assessment



Narration

JILL: Not quite, there are a few more.

The patient's functional capacity needs to be assessed. A patient who works and spends all day in their wheelchair is going to need a different care plan than one who is immobile and bedbound.

It is also important to assess the pressure relieving systems that are being used by the patient. We must assess the integrity of the seating and bed surfaces that the patient is using.

MARK: I'm not sure I know what you mean.

JILL: Beds and cushions wear out and need to be replaced if they are no longer effective at pressure redistribution.

MARK: Okay, got it.

JILL: Finally, we have to determine the views of the patient and their family. We need to get our patients to buy into the treatment plan, as they will feel empowered and this will improve their chances for clinical success.

1.7 Reassessment

Reassessment

Reassess if ulcer does not heal

- *expect healing within 2 weeks*
- *adjust expectations*



Narration

JILL: If all of the underlying factors have been assessed and clinical strategies maximized, and yet the wound is still not healing in two weeks, something is wrong.

MARK: So what should we do if this happens?

JILL: We need to reassess to determine if something has changed in the clinical picture. For example, is nutrition not where it should be? Or is pressure redistribution not being achieved? Many underlying clinical problems can impair the healing process.

MARK: How do we know the wound is healing?

JILL: General signs of healing include decreased length, width and depth of the ulcer; progressively less exudate; and changes in tissue type from less devitalized tissues to healthy tissues. We will be discussing more about monitoring healing shortly.

1.8 Communication



Narration

JILL: We have already mentioned the importance of communication with our patients. Mark, perhaps you can elaborate why this is important.

MARK: Sure thing, Jill. Communication with the patient or resident and the family is important. We need to know how much they understand, and to educate them about the healing process. By educating our patients, we empower them! We do this by making them aware of the things they need to do to help the healing process, such as eating well, stop smoking and staying mobile. By partnering with our patients, we can help them be part of the healing process.

JILL: That's right. We need to teach the individual and the family about the normal healing process and keep them informed about the progress, or lack of progress.

1.9 Monitoring Healing



Narration

JILL: Usually a two-week period is recommended for evaluating progress towards healing. However, weekly assessments are better because it gives us an opportunity to detect early complications and the need for changes in the treatment plan. Wounds can change rapidly. We need to work together and communicate any changes in the wound, and act quickly to promote faster healing and decrease complications.

MARK: We should also observe the pressure ulcer for developments that may indicate the need for a change in treatment every time we change the dressing.

JILL: Yes, good point.

1.10 Documenting



Documenting

After assessment, document:

- *wound location*
- *category / stage*
- *size (length, width & depth)*
- *tunneling & undermining*
- *dead tissue (slough, eschar)*

Narration

JILL: We have already discussed how to assess and document the physical characteristics of a pressure ulcer in the Assessment module. So this will be a review. Mark, why don't you do this one?


MARK: Okay. The information we need to record about a pressure ulcer include: the wound location; the category or stage of the ulcer; the size (length, width and depth); any tunneling and undermining; and the amount of dead tissue such as slough and eschar.

1.11 Documenting 2

Documenting

After assessment, document: (continued)

- exudate & drainage (amount, color, odor)
- granulation
- surrounding tissue
- support surfaces
- pain



Narration

MARK: Continuing with the information we need to document are: the amount, color and odor of any drainage; the amount of granulation; and the characteristics of the surrounding tissue.

JILL: We should also record the support surfaces used by the patient and the assessment of the degree and kind of pain.

MARK: That is some list. However, I guess we need all these details to monitor the progress of the healing ulcer.

JILL: Yes we do.

1.12 Documenting 3

Documenting

Note skin characteristics:

- color
- bruises
- temperature
- scars
- moles
- burns
- incisions
- intactness



A bruise

Narration

JILL: We should assess and record information about the patient's skin characteristics. Such things as skin color, temperature, moles, incisions, intactness, bruises, scars and burns should be noted.

MARK: I guess these help us identify any other potential skin problems.

JILL: Right.

1.13 Wound Measurement



Narration

JILL: Our next topic is wound measurement. We already talked about this in the Assessment module, so this will be a review. Mark let's see how much you remember about wound measurement.

MARK: Okay. The patient should be positioned in a consistent neutral position. This is because the wound may change appearance due to soft tissue distortion with different positions.

We should select a uniform, consistent method for measuring the wound length and width to compare wound measurements over time. We need to do the same when measuring the depth of the pressure ulcer. We also must measure the depth and direction of any tunneling or undermining.

JILL: With thorough wound assessments, treatment plans can be individualized to promote faster healing.

1.14 Wound Measurement 2



Narration

JILL: In this and the next couple of slides, we review the measurement method for pressure ulcers. This shows how to measure the length and width of a pressure ulcer.

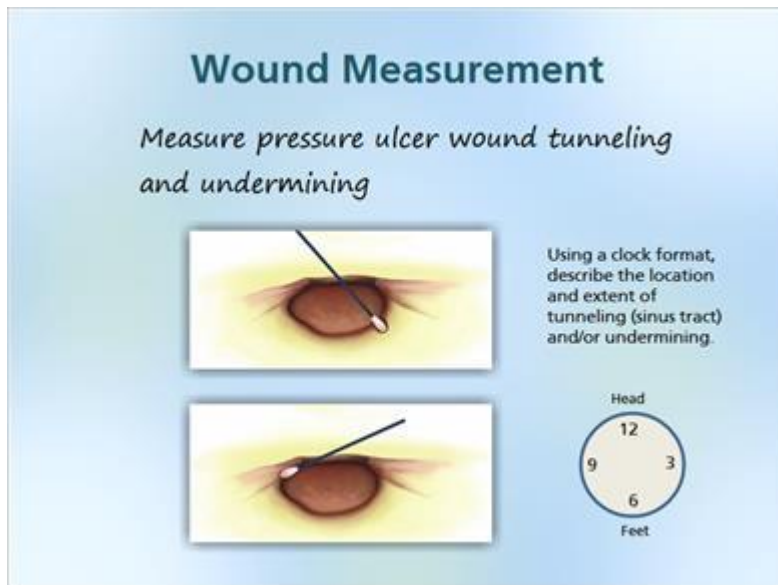
1.15 Wound Measurement 3



Narration

MARK: Depth and tunneling are performed through gentle insertion of a moistened cotton-tipped applicator to the gentle point of resistance. It is then marked at skin level and measured with a ruler in centimeters.

1.16 Wound Measurement 4



Narration

JILL: This illustrates how to measure and record tunneling and undermining in a pressure ulcer.

1.17 Assessment Tools

Assessment Tools

Pressure Ulcer Scale for Healing (PUSH)

- 3 factors (width, exudates, tissue type)
- monitors healing over time

Bates-Jensen Wound Assessment Tool (BWAT)

- 15 item scale
- 13 wound characteristics
- long and time consuming

Narration

JILL: Several validated tools have been developed to help us monitor healing of pressure ulcers. We will briefly describe two of these – PUSH and BWAT. Mark, why don't you describe the Pressure Ulcer Scale for Healing?

MARK: Sure. The PUSH tool was developed by the NPUAP as an alternative to “downstaging” as a method of monitoring healing ulcers. It looks at three factors: width, exudates amount and predominant tissues type. It helps monitor healing over time, but does not provide adequate information to serve as the basis for a comprehensive treatment plan.

JILL: The Bates-Jensen Wound Assessment Tool is a 15-item scale with 13 wound characteristics scored using a Likert scale. The shape of the wound and location are unscored items. Although the BWAT is considered a great tool, it is time consuming which may limit its use.

1.19 Clinical Judgment

Clinical Judgment

Use clinical judgment to assess healing:

- decreasing exudate
- decreasing wound size
- improvement in wound bed tissue



Narration

JILL: The final strategy for monitoring pressure ulcer healing is clinical judgment. The nurse can monitor the wound and use her clinical judgment to assess signs of healing that include: decreasing exudate, decreasing wound size, and improvement in wound bed tissue. It is important to document signs of healing so other members of the healthcare team are aware of what is going on.

1.20 Summary



Narration

JILL: That brings us to the end of this presentation. Mark, care to summarize?

MARK: I would be happy to. We began with a discussion of preparing an individualized treatment plan for patients or residents suffering from pressure ulcers. Next we looked at the assessment that needs to be done to provide information to develop the care plan. We briefly examined the importance of good communication with the patients and their family to get their help to facilitate healing. We then covered the different strategies that we can use to monitor the healing of a pressure ulcer. These include frequent reassessments, detailed documentation, wound measurements, monitoring tools, and last, but not least, our own clinical skills.

Did I miss anything?

JILL: You did a great job summarizing the key points. I'm Jill, along with Mark, saying goodbye for now. We see you again soon.

MARK: Goodbye.

1.21 The End



Narration

No narration, only music.