



Nightingale University

Wound Prevention and Care What you need to know



Identification of Patients at Risk for Skin Breakdown

1. All elderly are at risk due to the decrease in elasticity of their skin.
2. All diabetics are at risk due to their disease process; their circulation and ability to heal are decreased.
3. Those who are bed or chair bound are at risk due to increased pressure on bony prominences and lack of repositioning.
4. Those who are extremely thin.
5. Those who are extremely obese with large skin folds.
6. Those with debility due to acute or chronic illness, recovering from surgery or are malnourished.

Prevention of Pressure Wounds

1. Hydrate - keep patients hydrated, our bodies are 97% water and we need frequent fluids ALL YEAR ROUND.
2. Moisturize – in the morning, after bathing, before bedtime and after EVERY episode of incontinence.
3. Inspect – each time you toilet, bathe, dress or reposition a patient you have the perfect opportunity to look for red or open areas. Look at all bony prominences and between any skin folds.
4. Massage – if you discover a reddened area over a bony prominence or on the buttocks use some lotion and gently massage the area to increase the circulation then position the patient so there is no pressure on that spot.
5. Pressure Relief – use bunny boots to decrease pressure on heels from bed or recliner leg rest. Place pillows between knees when in bed and at all times if legs are contracted. Place a hand roll or soft cloth in palms to prevent contracture and breakdown.
6. Positioning – remember to turn and reposition every two hours.
7. Communicate – inform your scheduler immediately if you see new skin breakdown or suspect potential breakdown.

Identifying Wound Deterioration & Infection

1. Wounds can develop or become worse in as little as two hours. Our goal is to prevent new wounds and provide appropriate treatment to existing wounds. If we meet this goal our patients will be able to stay @ home. ALL wounds put our patients at risk for infection, they may be due to pressure, burns, skin tears, incisions or other irritations.
2. If you are present when the nurse or family member is changing a dressing be observant. Does the wound look clean and pink or beefy red? This is what we want.
3. Redness around wound edges, increased drainage, change in color or appearance of drainage, foul smell, dark or black spots in or around the wound, loose stitches or staples or any other change in appearance should be reported immediately.
4. Soiled dressings –re-enforce with a dry dressing and notify the nurse immediately.
5. REMEMBER – you are our eyes and ears and in this case our nose. You're with the patient more than anyone. We depend on your observations to help us take care of our patients.
6. And as always...remember to wash your hands before and after patient contact and wear gloves as needed.