



What you should know about...**PRESSURE AREAS**

Overview:

Pressure areas are also known as pressure sores, or bed sores and develop through a number of stages:

- Stage 1:** A change in skin colour (e.g., a reddened area) appears that does not turn white when touched. This generally occurs in the area of a bony prominence (e.g., the tailbone, the heels).
- Stage 2:** A sore or blister develops.
- Stage 3:** An ulcer forms that affects the surface tissue.
- Stage 4:** A deepening cavity forms that can penetrate the deep soft tissue right down to the bone. Such wounds generally take many weeks or months to heal.

It is important for health care workers to identify who may be at risk of developing pressure areas, so that steps can be taken to reduce that risk. Furthermore, if pressure areas do develop it is essential that health care workers have some understanding of management strategies. The purpose of this Fact Sheet is to provide some general information to support health care workers in their work with clients.

Key Points:

Understand that prevention is better than cure! To reduce the risk of developing pressure areas you should:

- Educate individuals to move those body parts they can regularly (at least every hour, if not more frequently). Assist individuals who are immobile with passive movements of limbs, such as range of motion exercises and stretching.
- Ensure individuals are appropriately positioned and regularly repositioned (at least every 2 hours, if not more frequently) and gently massage pressure sensitive areas after a position change to assist circulation.
- Appropriately use equipment to support clients as required (e.g., pressure reducing cushions/pillows and mattresses) and take care when lifting or positioning a client to avoid skin damage.
- Check the skin daily for a change in skin colour (i.e., a reddened area=Stage 1).
- Ensure the individual does not wear tight clothing and footwear. Also, remove creases in sheets or clothing and food crumbs that may create skin friction.
- Keep the skin clean and moisturised, but avoid excessive periods where the skin may become damp or wet such as in hot/humid conditions (e.g., sweating), or if the bed linen and clothing is soiled (e.g., an incontinent client).
- Ensure appropriate nutrition and fluid intake.

Key tips to help you identify individuals who may be more likely to develop pressure areas:

- ☞ Understand the individual's general medical condition as some conditions make it harder for pressure areas to heal.
- ☞ Know how much mobility the individual normally has, since if he/she is bed or chair bound, or unable to reposition him/herself, then he/she will be at higher risk of developing pressure areas.
- ☞ Find out if the individual has impaired sensation as he/she will be less likely to detect a pressure area and require visual checks of their body.
- ☞ Appropriately manage incontinence as the development of pressure areas is more likely in the presence of moisture, increased temperatures and wet clothing.
- ☞ Recognise if an individual is underweight or has muscle wasting, bony areas will be more prominent and make skin breakdown more likely. While, if an individual is overweight, pressure areas may occur due to shearing or friction forces arising when the client moves or is moved.
- ☞ Find out if the individual has had a pressure area before since such individuals are at a higher risk of developing future problems.

Frequently Asked Questions (FAQs):

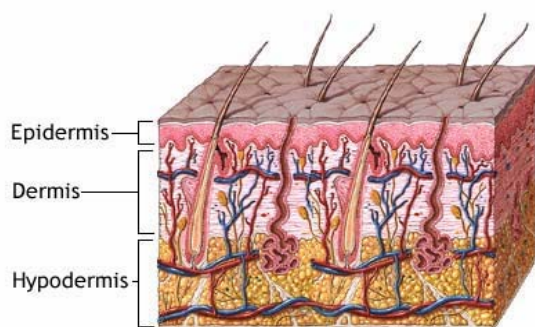
1. What causes pressure areas?
2. What should I do if risk management has been ineffective and one or more open wounds develop?

Responding to FAQs:

1. The main causes of pressure areas are:
 - (a) Compression and gravity - caused by prolonged positioning (e.g., sitting or lying in one position for too long). The pressure from the weight of the body parts affects the blood supply to the skin and the tissue under the skin. When body position is not changed, the blood supply decreases and a sore may form. The areas most likely to be affected are the heels, elbows, the tailbone and the buttocks.
 - (b) Friction and shearing forces on the skin – causing damage to the soft tissues over bony prominences (e.g., repositioning a client by pulling him/her over the bed linen).

Individuals who have a combination of the following factors, such as poor nutrition, circulation, sensation, limited mobility and incontinence issues are certainly more vulnerable to developing pressure areas. While, we may associate these problems more with elderly clients, young individuals requiring hospitalisation or long-term care due to ill-health or injury are similarly susceptible.

2. Once an open wound has developed appropriate management by specialised nursing staff is required to reduce the risk of infection and worsening of the problem. This will include a thorough assessment of the affected area(s), wound care using appropriate dressings and provision of advice to the individual, their carers and family. In extreme cases, surgery may be necessary resulting in a period of hospitalisation.



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Useful Resources:

1. Your organisation's **Nursing staff** should be able to provide appropriate advice and assistance on client management.
2. **The Independent Living Centre**, located at The Niche, Suite A, 11 Aberdare Road, Nedlands, WA 6009 can provide information and advice on appropriate equipment to reduce the risk of pressure areas. To contact: Ph: 1300 885 886 (local call cost from anywhere in WA) or email: general@ilc.com.au. Also refer to the website: www.ilc.com.au.
3. **Silver Chain**, 6 Sundercombe Street, Osborne Park, WA 6017 offer a range of services including home support and personal care and may accept self-referral or require referral via a GP or hospital. To make general enquires, individuals in the metropolitan area should contact: Ph: (08) 9242 0242, or for country callers Ph: 1300 650 803. Alternatively, email: info@silverchain.org.au. Also you can refer to the website: www.silverchain.org.au.



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