

Bedsore

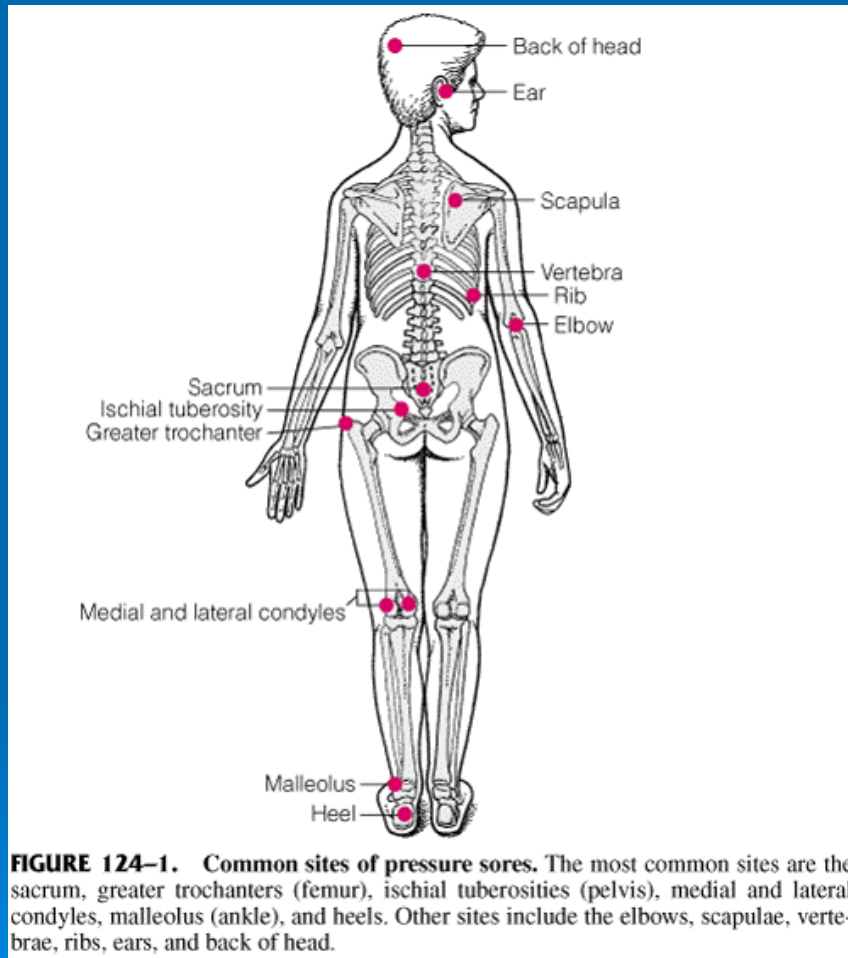


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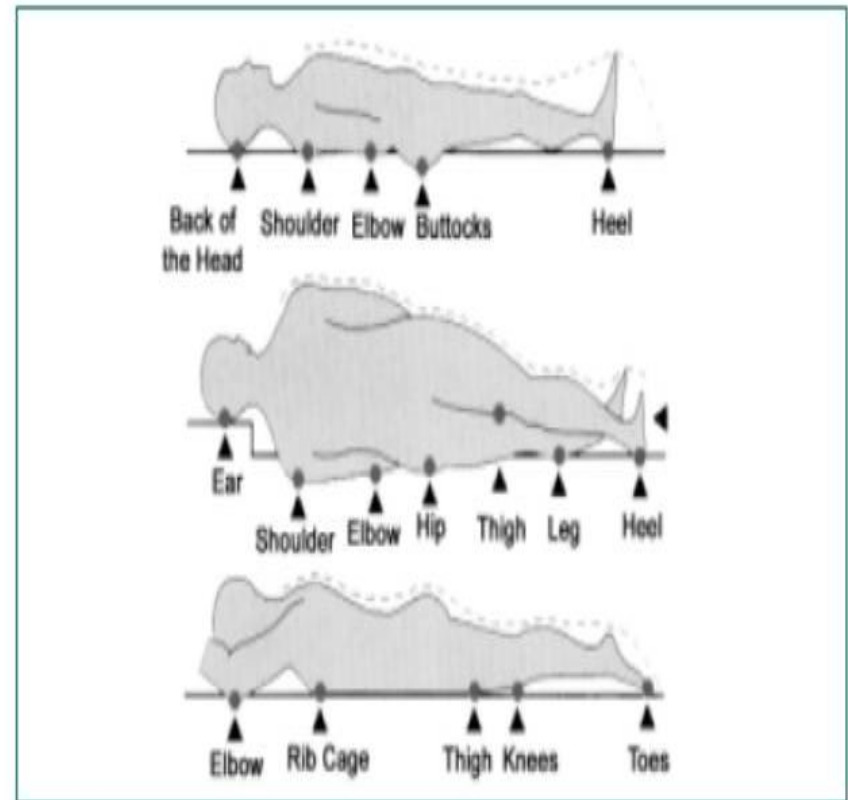
- are also called *decubitus ulcers*, *pressure ulcers*, or *pressure sores*. These tender or inflamed patches develop when skin covering a weight-bearing part of the body is squeezed between bone and another body part, or a bed, chair, splint, or other hard object.

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Common sites in pressure ulcers



Common sites for pressure ulcers



(Diagram courtesy of the Tissue Viability Society)

The Norton Scale

Note: Scores of 14 or less rate the patient as “at risk”

	Physical Condition	Mental Condition	Activity	Mobility	Incontinence	Total Score
	Good 4	Alert 4	Ambulant 4	Full 4	Not 4	
	Fair 3	Apathetic 3	Walk/help 3	Slightlz Limited 3	Occasional 3	
	Poor 2	Confused 2	Chairbound 2	Very Limited 2	Usually-urine 2	
	Bad 1	Stupor 1	Bedridden 1	Immobile 1	Doubly 1	
Name: Date:						
Name: Date:						
Name: Date:						

Modified Norton/Scale

Risk for pressure ulcers

acc. to modified Norton-Scale: low (25 - 24 points) high (18 - 14 points)
medium (23 - 19 points) very high (13 - 9 points)

Points	4 Points	3 Points	2 Points	1 Point
Readiness for cooperation / motivation	full	less	partly	none
Age	< 10	< 30	< 60	> 60
Condition of skin	o.k.	scaly, dry	moist	wounds, allergic lacerations
Additional Diseases	none	undermine of resistance, fever, diabetes	multiple scleroses, adiposis	artery occlusion
Physical Condition	good	fair	poor	very bad
Mental Condition	alert	apathetic	confused	stupor
Activity	ambulant	walk-help	chair-bound	stupor
Mobility	full	slightly limited	very limited	immobile
Incontinent	not	occasional	usually urine	doubly

RISK FACTORS FOR DEVELOPMENT OF PRESSURE SORES

Extrinsic risk factors

Pressure

Friction

Shearing

Maceration

Intrinsic risk factors

Immobility

Inactivity

Fecal and urinary incontinence

Malnutrition

Decreased level of consciousness

Corticosteroid use

Smoking

Medical conditions associated with intrinsic risk factors

Anemia

Infection

Peripheral vascular disease

Edema

Diabetes mellitus

Stroke

Dementia

Alcoholism

Fractures

Malignancies

Stage 1

- **The skin is intact but shows a persistent pink or red area that does not turn white when you press it with your finger. The wound may look like a mild sunburn. The affected skin may be tender, painful or itchy. It may feel warm, spongy or firm to the touch.**



Stage 2

- The skin outer layer is broken, red and painful. Surrounding tissues may show areas of pale, red or purple discoloration. Some swelling and/or oozing may be present.

The wound is no longer superficial and the ulcer is an open sore that does not extend through the full thickness of the skin.



Stage 3

- The skin has broken down and the wound now extends through all layers of the skin. **The ulcer has become a crater involving damage or necrosis of subcutaneous tissues.** The pressure ulcer has become deeper and very difficult to heal. At this stage, a large percentage of patients may require treatment of up to one year. **The wound is now a primary site for a serious infection to occur.**

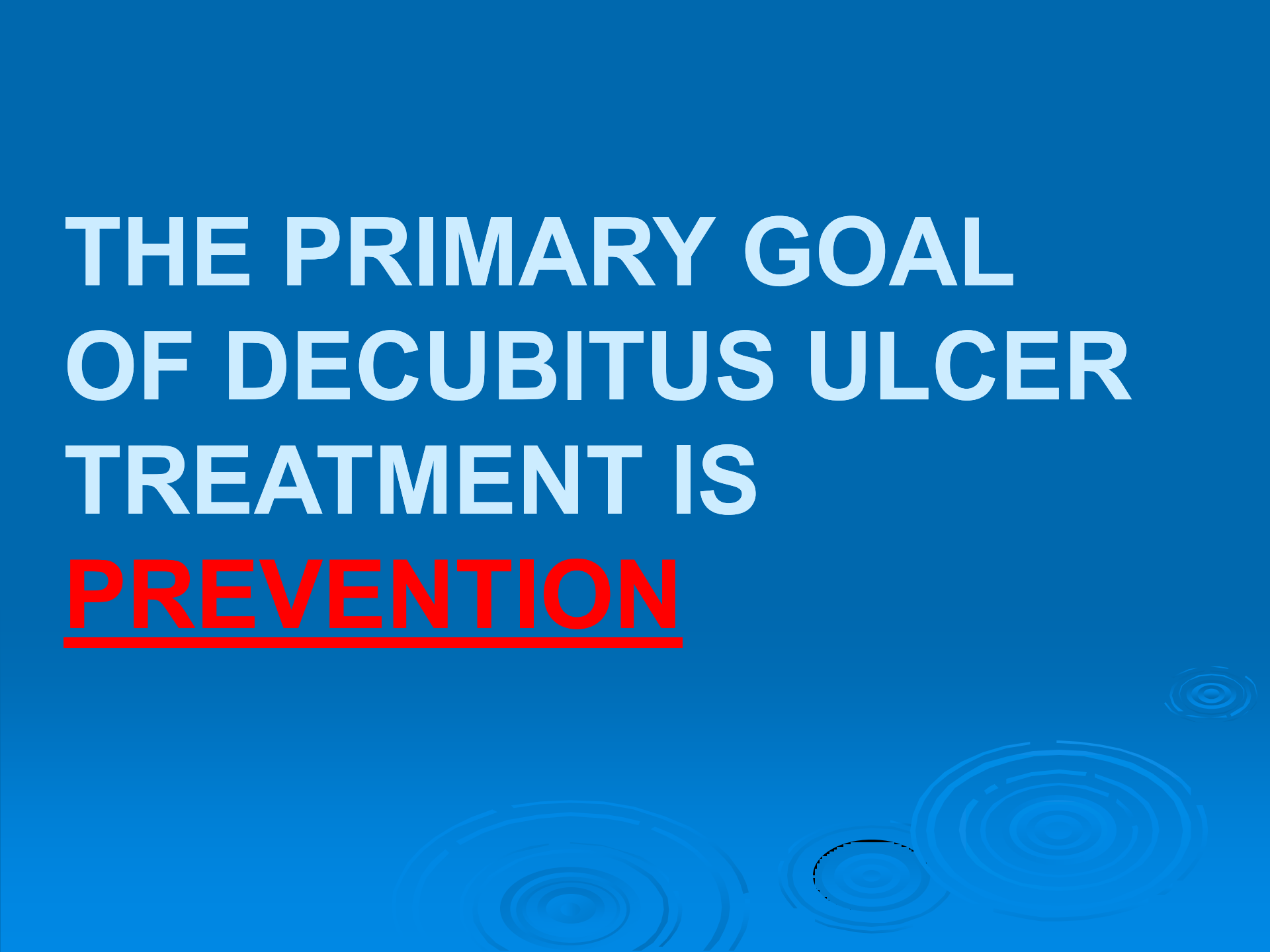


Stage 4

- **There is full-thickness skin loss with extension beyond the deep fascia and involvement of muscle, underlying organs, bone, and tendon or joint space. This deep open wound may show blackened tissue called eschar. The decubitus ulcer is now extremely deep, having gone through the muscle layers and now involving underlying organs and bone. Surgical removal of the necrotic or decayed tissue is often used on wounds of larger diameter. Surgery is the normal course of treatment. The wound is very serious and can produce a life threatening infection, especially if not treated aggressively.**



THE PRIMARY GOAL
OF DECUBITUS ULCER
TREATMENT IS
PREVENTION

The background is a solid blue color. In the lower right quadrant, there are several faint, concentric circular patterns that resemble ripples in water, centered around a point. These circles are light blue and fade out towards the bottom right corner.

