Pressure sores

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Patients undergoing surgery for a prolonged period of time are vulnerable to the development of a pressure sore or to worsening of a pre-existing sore as a result of prolonged immobility during, and sometimes after, the operation. Careful positioning and padding of the patient are standard practice result of friction or persisting pressure on soft tissues. They particularly a ff ect the pressure points of a recumbent pa tient, including the sacrum, greater trochanter and heels. Risk factors are poor nutritional status, dehydration, lack of mobility and nerve block anaesthesia technique. Early mobilisation of the patient and regular inspection of pressure points by the nursing team can act to prevent pressure sores. High-risk patients may be nursed on an air mattress, which automatically relieves the pressure areas. Pressure ulcers can be graded according to an interna - tionally recognised grading system based on the extent of skin loss. Category 1 ulcers involve non-blanching erythema with intact skin. Category 2 ulcers have partial thickness skin loss and appear as a shallow open ulcer with a r ed-pink wound bed or an intact or ruptured serum-filled blister. Category 3 ulcers have full thickness skin loss, with subcutaneous fat visible in the wound, but not bone, tendon or muscle. Category 4 ulcers have full thickness loss with exposed bone, tendon or muscle; osteomyelitis may develop at these sites. Summary box 24.8 he Preventing pressure sores /uni25CF /uni25CF /uni25CF

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