Free essay about decubitus ulcer

Health & Medicine, Stress

Introduction

Decubitus ulcer also referred to as bedsore or pressure sore is an open wound on the skin (Thomas, 2006). Thomas (2006) indicates that the decubitus ulcer mostly occurs on the skin that covers the born areas. Notably, the most common areas for bedsore to appear are; hips, ankles, back and buttocks. Decubitus ulcer are common among the disabled, elderly and those people who spend long periods of time on wheelchairs or bed, and those who are not able to move certain parts of their body without assistance (Thomas, 2006). In keeping with Albert and Spencer (2007), decubitus ulcers/ bedsores are also prone to people with fragile skin. Remarkably, this condition is highly treatable, and recovery is fast with apposite diagnosis. This paper analysis the causes, stages of decubitus ulcer, use of hydrocolloid dressing in decubitus ulcer as well as advantages and disadvantages of this method of wound dressing.

Causes

According to Campbell and Charles (2010), one of the major causes of decubitus ulcer to appear on a person skin is excessive pressure. Campbell and Charles (2010) state that lying on a certain area for an extensive period may result to the skin breaking down. The other cause is the friction; Campbell and Charles (2010) note that a person creates friction when they rub their skin against rough or hard surface. Campbell and Charles (2010) further states that friction burns on the skin may damage he epidermis. Lastly, pressure sores can be caused by feces and urine. Campbell and Charles (2010) indicate that wearing clothes or undergarments that are

soiled for long durations may cause open sores on the skin which is irritant to the delicate outer skin layer (Campbell & Charles, 2010).

Stages of Decubitus Ulcers

According to Albert and Spencer (2007) decubitus ulcers come about in stages as per the National Pressure Ulcer Advisory Panel (NPUAP).

Stage 1: In this stage the skin is not broken; however, it shows discoloration. For a person with a light complexion that area appears red and for people with bark complexion the discoloration may vary from purplish to blue or it may even appear to be white.

Stage 2: At this point the skin is open and shows some signs of dead tissues around the wound. At this point the ulcer is shallow and not very deep.

Stage 3: The ulcer at this stage is deeper within the skin's tissue and has an appearance of a crater. Notably, a pus-like substance may be in the sore.

Stage 4: At this point, multiple layers of tissues are affected, this include bone and muscle. Albert and Spencer (2007) note that a dark substance (eschar) may be in the sore.

Unstageable: At this point the ulcer may be covered with a brown, yellow, or green scab. The damage to the tissue at this level is extensive and can only be removed.

Symptoms of Decubitus Ulcers

The symptoms of decubitus ulcers are based on the condition's stage. The healthcare provider may look at the following indications; skin discoloration, pain in the affected area, open skin, infection, skin that fails to lighten to the

touch, and skin that maybe firmer or softer to the surrounding skin (Fonder, Lazarus, Cowan, Aronson-Cook, Kohli & Mamelak, 2008).

Diagnosing Decubitus Ulcer

The healthcare provider may refer a decubitus ulcer patient a specialist and nurses who have experience in pressure sores (Fonder et al. 2008). The specialists may evaluate the ulcers on various critical aspects like:

- The size and depth of the pressure sore
- The type of tissue that is directly affected by the ulcer i. e. skin, bone or muscle.
- The coloration of the skin section affected by ulcers
- The amount of tissue death resulting from ulcer
- The condition of the pressure sore/ ulcer i. e. infection, bleeding and foul odor.

The specialist would specialist may take samples of the discharge and tissue found within the ulcer. Additionally, he may look for signs of possible growth and cancer.

Treatment

For a decubitus ulcer patient, the healthcare giver may request to offer treatment through following pre-emptive steps that can stop further damage to susceptible skin and boost the chance of recovery. Albert and Spencer (2007) indicate that hydrocolloid dressing on decubitus ulcers is used on individuals with stage two ulcers. This wound dressing is also used as primary dressing management for decubitus ulcers stages 3 and 4 that are healing well and have become shallow (Fonder et al. 2008).

Other treatments are usually done by health professionals and depend of the stage of the pressure sore. Primarily, areas of unbroken skin near the decubitus ulcer are covered with lubricant or protective film to protect the area from injury. Secondly, special dressings are applied to the wounded area to fasten healing and help take out miniature areas of dead tissue (Fonder et al. 2008). Vitally, huge areas of dead tissue can be trimmed off surgically or dissolved with an exceptional medication. If the patient’s skin gives any sign of potential infection, the specialist may prescribe antibiotics that may be applied as the ointment, given intravenously or taken as pills (Fonder et al. 2008).

Hydrocolloid dressing in decubitus ulcer

Hydrocolloid dressing, Albert and Spencer (2007) state is a method of wound dressing done by layer of gel-forming material attached to a form backing or a semi-permeable film. Albert and Spencer (2007) further elaborate that the gel layer involves an adhesive matrix that has a combination of absorbent substances like sodium carboxymethylcellulose, gelatin and pectin. In keeping with Lanel, Barthès-Biesel, Regnier and Chauvé (2007) the resulting dressing is self adhesive, absorbent, even in moist conditions.

According to Lanel et al. (2007) even though dissimilar hydrocolloid dressings may look alike, there have different fluid handling abilities. Various hydrocolloid dressings are obtainable in various shapes, thicknesses, and shapes. Elaborately, these may include those products that are designed for specific anatomical areas such as a heel or scrum (Campbell & Charles, 2010). Toshinori et al. (2011) note that some products are exceptionally thin or have pointed ends that make them less prone to ruck, wrinkle or roll at

the edges. Arguably, these thinner products maybe semi-transparent and allow visualization of he pressure sore without removing the dressing. Lanel et al. (2007) affirm that variations in the backing materials may verily alter sliding of the dressing. Those dressings with slippery outer surface reduce the coefficient of friction between the patient and the support surface and so lessen the amount of shear and friction spread to the patient’s skin. This is how they reduce the risk of further damage.

How hydrocolloid works

They are several major properties of hydrocolloid dressings that are necessary in the management of bed sores include; provision of barrier for bacteria and micro-organisms, production of moist wound environment, facilitation of autolytic debridement, management of exudates, and assisting in pain management. Hydrocolloid dressing also helps in creating the most favorable environment for pressure sore healing. This method of wound dressing is believed to promote angiogenesis, stimulate the production of granulation tissue, increase the amount of dermal fibroblasts, and increase the level of collagen synthesized.

Advantages of Hydrocolloid dressing

- The hydrocolloid is impermeable to infection, bacteria and other contaminants.
- The dressing may be used under venous compression products
- It has minimal disrupt healing
- Easy to apply
- It molds well and it is self-adherent

Disadvantages of Hydrocolloid Dressing

- Hydrocolloids dressings are not recommended when the infection is present neither are they recommended for wounds that have heavy exudates or sinus tracts.

- Albert and Spencer (2007) states that the dressings must be used with caution on the feet of diabetic patients. Hydrocolloid dressings can only be used safely on diabetic foot sores if (1) the would is superficial without any sign of infect (2) they are used on right wounds after thorough assessment of the patient (3) dressings are changed frequently (4) low to moderate exudates, and (5) there is no symptoms or signs of ischemia.

- May roll or curl at the edges

- May cause hyper-granulation

- May cause injury/trauma to fragile skin after being removed.

- May result to periwound maceration

- It is hard to assess if hydrocolloid dressing is obscure and opaque

- When removing, the dressing residue may adhere to the pressure sore and there may be a stench.

- May be dislodged if the sore produces heavy exudate

Applying hydrocolloid dressings

According to Lanel et al. (2007) hydrocolloid dressing selected must be of suitable size and shape for the wound. It should also overlap onto normal skin for approximately 1. 25 inches (3cms) around the pressure sore. Hydrocolloid dressing, according to Lanel et al. (2007), should be warmed between the hands before application. Notably, warming improves the adhesiveness and malleability of the dressing, thus allowing it to conform

excellently to the wound contours. Commonly, it is advisable that the patient refrains from putting the weight over the dressed part for around twenty five minutes after application. This gives the dressing time to stick properly. Lanel et al. (2007) states that if there is a problem of leakage from one side of the dressing i. e. due to gravity; it is advisable to consider applying the dressing such that there are greater overlaps on the skin of the leaking side. In keeping with Albert and Spencer (2007) dressing with tapered edges are less probable to wrinkle, roll up or ruck. Hydrocolloid dressings are usually waterproof are patients can freely bath or shower with the dressing in situ (Lanel et al. 2007).

Frequency of dressing

Hydrocolloid dressings are changes after every three to five days, even though there are those that can last for up to seven days (Lanel et al. 2007). Nonetheless, more frequent changes are necessary if exudates production is high i. e. at the beginning of the treatment, or if there is a suspicious infection. Lanel et al. (2007) stated that the early removal of hydrocolloid dressing is only advisable with clinical reasons. The hydrocolloid dressings must stay in place until the gel bubble which forms close to the edge of the dressing is realized. Arguably, the gel allows for easy and traumatic removal of hydrocolloid dressing. In case of removal before the gel bubble is formed, it should be done by lifting the edge and peeling off the hydrocolloid. Moistening the skin is recommended (Toshinori et al. 2011). Some dressings incorporate a system to indicate when dressing change is necessary.

Removing the hydrocolloid dressing

- Gently peel off the dressing from the skin to the direction of the hair growth.

In conclusion, hydrocolloids have established to be more cost effective than gauze while t comes to treatment of decubitus ulcers. Notably, this is due to less clinical contact time that is required while treating a hydrocolloid dressing. Understandably, the use of a hydrocolloid in the treatment plan can extend for as the dressing meets clinical purposes. At each dressing, it is critical that other critical parameters are assessed to determine the adjustments needed to the prevailing plan care. Arguably, use of a systematic approach to assessment is particularly necessary, perfectly with the use of a valid and reliable assessment tool. Always, careful documentation of the patient's would be critical in enhancing communication, providing a rationale for decision making as well as, demonstrating the delivery of high quality care. Hydrocolloid dressing is used on decubitus ulcers until the wound closes.

References

Albert E. & Spencer J. (2007). Clinical aspects of full-thickness wound healing Original Research Article. Clinics in Dermatology, Volume 25, Issue 1, Pages 39-48

Campbell C, & Charles P. (2010). The decubitus ulcer: Facts and controversies Original Research Article. Clinics in Dermatology, Volume 28, Issue 5, Pages 527-532

Fonder M, Lazarus G, Cowan D, Aronson-Cook B, Kohli A, & Mamelak A. (2008). Treating the chronic wound: A practical approach to the care of non-

healing wounds and wound care dressings Review Article. Journal of the American Academy of Dermatology, Volume 58, Issue 2, Pages 185-206

Lanel B, Barthès-Biesel D, Regnier C, & Chauvé T. (2007). Swelling of hydrocolloid dressings Original Research Article. Biorheology, Volume 34, Issue 2, Pages 139-153

Thomas D. (2006). Prevention and Treatment of Pressure Ulcers Original Research Article. Journal of the American Medical Directors Association, Volume 7, Issue 1, Pages 46-59

Toshinori I, Takahisa G, Jiro M, & Iwai T. (2011). Use of a hydrocolloid dressing to prevent nasal pressure sores after nasotracheal intubation. British Journal of Oral and Maxillofacial Surgery, Volume 49, Issue 7, Pages e65-e66