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THE CNA'S ROLE IN PRESSURE INJURY PREVENTION
Bundle of Care

"Preventing Pressure Ulcers in Hospitals," AHRQ

Certified Nursing Assistants (CNAs) can play an important role in pressure injury prevention planning and education.

This document is intended to provide CNAs with guidance in preventing pressure injuries in the hospital patients and the nursing home residents for whom they provide care.

About the Risk Factors

IMMOBILITY

Patients/residents who are immobile are likely to have external surfaces press on their skin for extended periods of time, causing pressure ulcers to develop. Immobility can be permanent or temporary based on the patient's/resident's circumstances. Regular repositioning prevents any one part of the patients/resident's body from being under pressure long enough to cause damage.

INCONTINENCE OR MOISTURE CONTROL

Incontinent patients/residents have up to five times higher risk of developing pressure injuries than patients/residents who are continent. Contact with moisture (wet and soiled clothing or linens) can cause skin breakdown, leading to pressure injuries. Anticipating toileting needs helps to prevent patients/residents from soiling themselves. Checking frequently on incontinent patients/residents will help to promptly detect and change wet and soiled clothing or linens.

NUTRITIONAL / HYDRATION STATUS

For skin to remain healthy, good nutrition and adequate fluid intake are essential.

SKIN PERFUSION

Signs of a stage 1 pressure injury could include redness over a pressure point that does not go away after five minutes or an area over a pressure point that was previously red but now is pale, white, or shiny. Early recognition and treatment of a pressure injury is important to prevent injuries from getting worse. The sooner a pressure injury is recognized, the better.

NEUROLOGIC DISEASE

(e.g., dementia, spinal cord injury, neuropathy, sensory loss)
Exercise and movement promote blood flow to the tissues and prevent patients/residents from staying in any one position for too long a time. Paralyzed or neurologically impaired patients/residents may not have the ability to remember or be able to move by themselves.

FRICTION/SHEARING

Friction (rubbing) and shearing (pulling) forces can injure the skin and lead to skin breakdown. This can damage the skin and underlying tissues and can put the patient/resident at risk for a pressure injury. Lift devices and lift sheets help reduce friction by allowing you to lift or roll, instead of dragging the patient/resident.

Implement Preventive Care Based on Risk Factors	
IMMOBILITY	• Turning and repositioning the patient/resident every two hours is recommended. • Float the patient's/resident's heels. Place pillows or foam wedges between the ankles and knees. • Intermittently assist or remind wheelchair or bed-bound patients/residents to shift weight while sitting. • Explain to patients/residents the tasks you are about to perform and why you are performing them.
INCONTINENCE OR MOISTURE CONTROL	• Round on patients/residents every two hours to offer and provide peri-care (cleaning of the private areas of a patient/resident) to minimize exposure to moisture, especially if they are incontinent of urine or feces. • Use thin layers of barrier creams; do not double up on incontinence padding. • Consider leaving patients/residents "open to air" (no briefs) while in the bed. Encourage patients/residents/families to report incontinent episodes immediately.
NUTRITIONAL/ HYDRATION STATUS	• Confirm patient's/resident's diet with the nurse and while you are providing care, encourage patients/residents to drink fluids. • Monitor and document intake of food and fluids. • Assist with feeding via verbal cueing, spoon feeding, and/or providing finger foods, etc.
SKIN PERFUSION	• Report to the nurse any changes that you see in the patient's/resident's skin during bath/shower, when providing AM/PM care, when assisting with toileting or incontinent care, when removing splints, or when patients/residents complain of pain or discomfort. • Inspect the skin daily; report all suspicious discolored areas.
NEUROLOGIC DISEASE (e.g., dementia, spinal cord injury, neuropathy, sensory loss)	• Remind or assist patients/residents who are paralyzed to change positions in the wheelchair or bed. • Patients/residents with neurological problems may not remember to move or cannot comprehend instructions. For these patients/residents, provide total care when necessary. • Do not assume that patients/residents can remember everything they should be doing for optimal care.
FRICTION/SHEARING	• Use equipment, if needed, to safely move patients/residents without dragging them up in the bed. • Use draw sheets or lift pads to assist in moving patients/residents up in bed. Prevent patients/residents from sliding down or slouching in a bed or chair. • Be cautious that body points such as elbows and heels are not pressing on a hard surface; e.g., elbows on a tabletop.

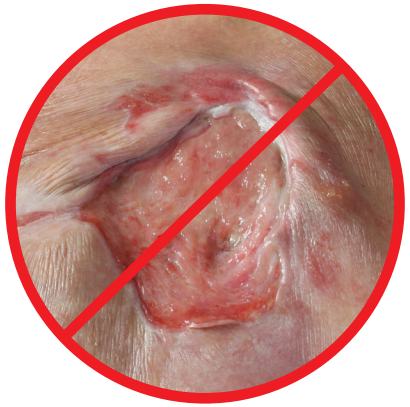
Source: Agency for Healthcare Research and Quality, Pressure Ulcer Treatment Strategies: Comparative Effectiveness; AHRQ Publication No. 13-EHC003-EF, May 2013
https://effectivehealthcare.ahrq.gov/products/pressure-ulcer-treatment/research?_gl=1*1o4ih62*_ga*OTM4OTc2ODg5LjE2ODQxNjM3OTc.*_%20ga_45NDTD15CJ*MTY5NDc4NDk4MS4xLjEuMTY5NDc4NTIyNi42MC4wLjA.#:~:text=https%3A//effectivehealthcare.ahrq.gov/products/%20pressure%2Dulcer%2Dtreatment/researchpressure%2Dulcer%2Dtreatment/research

Pressure Injury Preventative Care

ASSIST WITH MOBILITY

INCONTINENCE CONTROL

NUTRITION/HYDRATION



SKIN OBSERVATION/CARE

REPOSITIONING REMINDERS

AVOID FRICTION/SHEARING

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