The role of the nurse in the treatment and prevention of pressure ulcers

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ABSTRACT

Pressure Injury (PI) is an involvement of the skin or underlying tissue, usually over a bony prominence and/or may be related to medical devices. PI can be classified according to the degree of tissue involvement, which are: 1st degree, intact skin with redness, usually over a bony prominence; 2nd degree, partial loss of skin thickness, is superficial and presents with a pink blister; 3rd degree, loss of total tissue thickness, where subcutaneous fat is visible, without bone exposure; 4th degree, loss of total tissue thickness with bone exposure; and non-classified lesions, where there is full-thickness skin loss, presence of necrotic tissues (Correia, 2019).

In the hospital environment, the main peop´le involved in the prevention and treatment of PI are the nursing professionals. As measures, skin hydration, change of decubitus every two hours or according to the need defined by the nurse, adequate nutritional support, daily skin check, use of comfort pads, change of clothes, diapers or wet pads, among others. (Campos, et al., 2021).

In nursing, it is essential that professionals deepen their research and techniques in order to offer broad conditions for PIanning interventions that can ensure the patient's well-being. The nurse, through the NCS (Systematization of Nursing Care), develops strategic ways to detect possible problems and control the patient's clinical alterations, to develop quality care, aiming at the patient's recovery in a comprehensive and free way, warning the patient's health (Citolino, et al., 2023).

Certifying and ensuring that the patient is safe is also a role of the nursing team, which assesses the patient's condition, and communicates to the team clearly, which priority care procedures will be established for the patient's treatment. The Ministry of Health (MoH) through the National Patient Safety Program (PNSP), established by Ordinance No. 529, of April 1, 2013 with the objective of contributing to the qualification of health care in all health institutions in the national territory; Patient safety is attributed to the quality of care and has acquired great importance from professionals to patients and has the purpose of offering safe care (MINISTÉRIO DA SAÚDE, 2021).

Keywords: Nursing, Care, Hospital, Assistance.

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INTRODUCTION

Pressure Injury (PI) is an involvement of the skin or underlying tissue, usually over a bony prominence and/or may be related to medical devices. PI can be classified according to the degree of tissue involvement, which are: 1st degree, intact skin with redness, usually over a bony prominence; 2nd degree, partial loss of skin thickness, is superficial and presents with a pink blister; 3rd degree, loss of total tissue thickness, where subcutaneous fat is visible, without bone exposure; 4th degree, loss of total tissue thickness with bone exposure; and non-classified lesions, where there is full-thickness skin loss, presence of necrotic tissues (Correia, 2019).

The appearance of PI can vary according to the duration, intensity and inflexibility of the skin. When Blood pressure also decreases (dehydration, cardiovascular disease or sepsis) there may be an exaggerated capillary compression that impedes the supPIy of blood flow, which may cause ischemia, edema and cell necrosis, etc. Other factors that contribute to the onset of PI is when the cutaneous blood supPIy is reduced by increased external pressure. (Costa, *et al.,* 2022).

In the hospital environment, the main peoPIe involved in the prevention and treatment of PI are the nursing professionals. As measures, skin hydration, change of decubitus every two hours or according to the need defined by the nurse, adequate nutritional support, daily skin check, use of comfort pads, change of clothes, diapers or wet pads, among others. (Campos, *et al.*, 2021).

The nurse is responsible for evaluating the lesions and verifying that the treatment is effective and adequate; this evaluation follows the following criteria: location of the lesion, degree, type of tissue, odor, size, exudate, coverings and the time the dressing was performed. When it comes to the nurse's self-determination in the care of patients with PI, the professional's commitment and effort to perceive the other care needs is highlighted, from the initial assessment to the final healing process. (Bussaleno, *et al.*, 2022)

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