TURNING AND REPOSITIONING

Introduction

Prolonged pressure on one area of the body may cause tissue damage. Some patients do not or can not reposition themselves. It is important that the care providers in skilled nursing facilities are vigilant about turning and repositioning patients. Charting turning and repositioning care is very important.

Learning Objectives

1. Describe why it is important for the skilled nursing home patient to reposition.
2. Identify conditions causing patients not to reposition themselves.
3. Describe what to look for when turning and repositioning.
4. Demonstrate how to chart turning and repositioning.

Lesson

Prolonged periods in a one position can result in tissue breakdown and discomfort for patients. Patients may not be able to reposition themselves for many reasons and rely on caregivers to assist them. Caregivers must be alert to the risk of tissue damage, the conditions that prevent independence in turning and repositioning, the proper technique for turning and repositioning and the proper documentation for repositioning care.

Why reposition?

You may recall a time when you woke up after sleeping hard and had wrinkles in your skin or your arm felt tingly. This occurs from lying in one position for a prolonged period of time.

In healthier individuals, the body can withstand longer periods in one position without tissue breakdown however, many long term care patients suffer tissue breakdown if maintained in one position for too long.

Our aging patients often have skin that is thinner and less resistant to trauma. The padding over the bony areas thins and the patient is more susceptible to tissue damage from prolonged positions. Our patients often have illnesses that make them more susceptible to injury or infection.

Proper turning and repositioning is a method to reduce the chance of tissue breakdown and wound development.

Tissue breakdown may mean that a wound develops on the outside of the body. This wound may provide an opportunity for infection to set in. It is important that whenever possible, wounds be avoided.

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Is my patient at RISK?

Not all wounds can be avoided. It is important to identify patients who are at greater risk for developing tissue breakdown, including wounds, so that preventative treatment can be attempted.

In order to identify patients at risk, you must be familiar with your patient, their diagnoses and their needs. If you are uncertain whether your patient is at risk it is important that you speak with the charge nurse, DSD, supervisor or Director of Nursing.

Patients who are at higher risk include:

Patient who are immobile for any reason.

- Stroke victims.
- Patients with neuropathy from diabetes.
- Comatose patients.
- Patients with casts or braces.
- Spinal cord injuries.
- Some Alzheimer's patients.
- Post-surgical patients.

Patients with chronic diseases that put them at greater risk for tissue breakdown include those with:

- Diabetes.
- Blood flow problems.
- Swelling (Edema).
- Incontinence.
- Obesity.
- Dehydration/malnutrition.
- Patients with prominent (stick out) bones.
- Fever.
- Anemia.
- Patients with confusion, forgetfulness and other mental conditions.
- History of smoking.
- Existing wounds.

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Steps To Prevent Tissue Breakdown

Educate the patient and family on the need to reposition.

Encourage patients who can reposition independently to do so, but monitor their compliance.

Encourage food and fluids within the patient's diet.

Follow the turning and repositioning schedule established at your Center.

Monitor routinely for incontinence and promptly change the patient.

Know you patient's treatment plan. If there are reddened areas or areas of skin breakdown, discuss repositioning options with the DSD or treatment nurse.

Provide routing hygiene and skin care.

Provide range of motion exercises with repositioning as outlined in the treatment plan.

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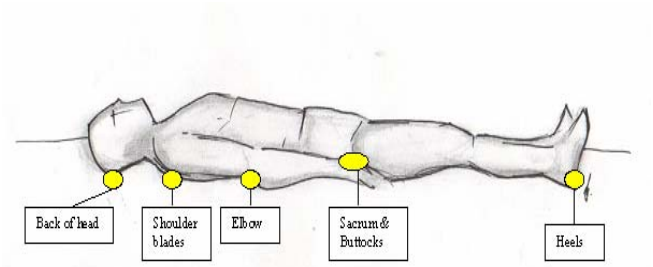
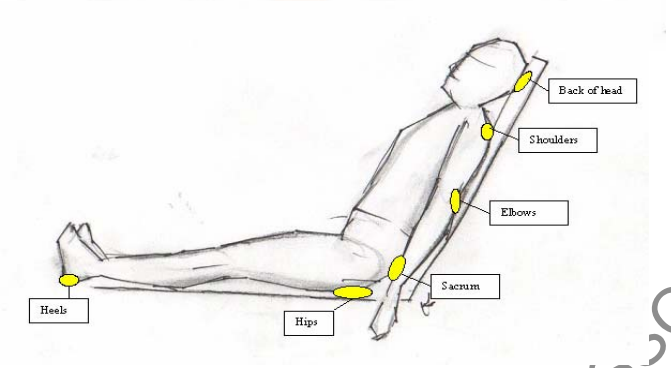
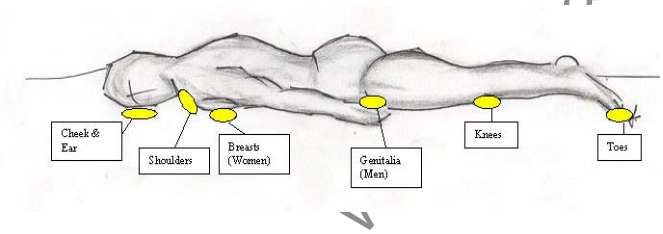
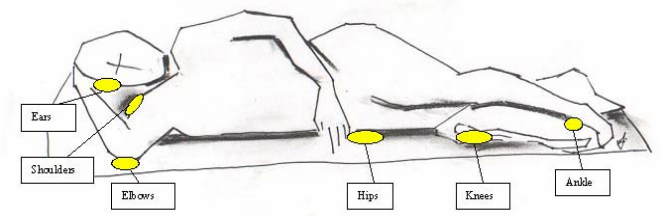
Pressure Points Most Vulnerable to Breakdown

Some areas of the body are more susceptible to pressure due to the bones in the area.









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TURNING AND REPOSITIONING PROCEDURES

1. Identify your patients who require turning and repositioning.

2. Follow the turning and repositioning schedule. Repositioning is not just for patients in bed. The repositioning schedule also applies to patients in the chair or wheelchair.

3. Wash your hands before any patient contact.

4. Assemble all supplies.

5. Tell the patient/family what you are going to do.

6. Provide hygiene care as needed to keep the patient's skin clean and dry.

7. Avoid **friction** when moving the patient. Friction is caused by the skin rubbing across the sheets or clothes. Lift and turn, do not drag the patient.

8. Avoid **shearing** of the skin whenever possible. Shearing is caused by downward pressure of gravity pulling the patient to the foot of the bed. This often occurs when the head of the bed is elevated. Shearing may be unavoidable when the head of the bed must be elevated due to other health conditions.

9. Manage **moisture** caused by incontinence or perspiration because it can cause the skin to be more susceptible to breakdown.

10. Maintain your body alignment and that of the patient when you are turning and repositioning the patient. Request assistance from a co-worker whenever necessary to avoid injury to yourself and your patient. Use pillows and/or repositioning devices as outlined in the patient's treatment plan.

11. Keep the linens and clothing free from wrinkles that may cause impressions in the skin.

12. Observe the bed and chair surfaces and compare them to what the care plan calls for. If they are not the same, tell the charge nurse, DSD, or treatment

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nurse about your concern.

13. Observe the patient's feet/heels. If the care plan calls for heel protectors, see that the heel protectors are in place. If the care plan calls for floating of the heels, float the heels with pillows under the calves to avoid pressure on the heels. If the care plan calls for a foot cradle, see that the foot cradle is in place and is not putting pressure on the patient's feet.

14. Observe the area of skin that was previously in contact with the bed or chair for redness or breakdown. If there is redness or breakdown, promptly chart your observation and tell the charge nurse, DSD, or treatment nurse.

15. Bathe your patient and massage the skin with lotion as part of the routine hygiene program. Avoid massage directly on a reddened area.]

16. Clear the bed of any food crumbs, bandages, discarded clothing or other items that may prevent a smooth surface.

17. Encourage independent turning and repositioning whenever possible and fluid and food intake as prescribed. Also encourage the patient to communicate any discomfort.

18. Replace the bedside rails, alarms or other restraint devices if they are part of the patient's care plan.

19. Replace the call light within the patient's reach.

20. Offer fluids during the repositioning process if there are no fluid restrictions.

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DOCUMENTATION

1. There are two important opportunities for documentation regarding your patient's turning and repositioning.

2. When you inspect your patient's skin after with turning and repositioning, any redness, blistering, bruising, abrasion or breakdown is documented in the area designated for CNA documentation (often on the back of the activities of daily living form). This information is also promptly shared with the charge nurse, DSD or treatment nurse.

3. Activities of Daily Living flow sheets. Most Centers have a flow sheet for CNAs to document turning and repositioning. Each shift accurately document the turning and repositioning that you have done, using the back of the form for any notes of significance for that shift.

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Our Center's goal is to maintain the turning and repositioning schedule of our patients 100% of the time.

Your goal is to maintain the turning and repositioning schedule of your patients 100% of the time.

If you need help, ask a teammate for assistance. If you skin changes, chart it and tell the appropriate person.

Post-Test

Question 1
Which of the following conditions does not place a patient at higher risk for skin breakdown?

A. Paralysis

B. Diabetes

C. History of smoking

D. All of the above

Question 2
Lotion should not be used on bedridden patients because it creates an increase in moisture build-up.

A. True

B. False

Question 3
It is not important to tell anyone about redness observed on the skin because it is likely to disappear.

A. True

B. False

Question 4
Tissue damage and skin breakdown are avoidable in all cases in nursing home patients.

A. True

B. False

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Question 5
It is acceptable to chart my turning and repositioning in the patient's record sometime later in the week if I am too busy to chart it the day it is done.

A. True

B. False

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Post-Test

Question 1

Which of the following conditions does not place a patient at higher risk for skin breakdown?

A. Paralysis. (Partially correct-Patients who might be at higher risk for skin breakdown include stroke victims, diabetic neuropathy, comatose or paralyzed patients, patients with casts or braces, Alzheimers or dementia, confused or depressed patients, post-surgical patients, patients with blood flow problems, swelling, obesity, undernourished/skinny, incontinent, fever, anemia or those with pre-existing wounds.)

B. Diabetes. (Partially correct-Patients who might be at higher risk for skin breakdown include stroke victims, diabetic neuropathy, comatose or paralyzed patients, patients with casts or braces, Alzheimers or dementia, confused or depressed patients, post-surgical patients, patients with blood flow problems, swelling, obesity, undernourished/skinny, incontinent, fever, anemia or those with pre-existing wounds.)

C. History of smoking. (Partially correct-Patients who might be at higher risk for skin breakdown include stroke victims, diabetic neuropathy, comatose or paralyzed patients, patients with casts or braces, Alzheimers or dementia, confused or depressed patients, post-surgical patients, patients with blood flow problems, swelling, obesity, undernourished/skinny, incontinent, fever, anemia or those with pre-existing wounds.

D. All of the above. (Correct-Patients who might be at higher risk for skin breakdown include stroke victims, diabetic neuropathy, comatose or paralyzed patients, patients with casts or braces, Alzheimers or dementia, confused or depressed patients, post-surgical patients, patients with blood flow problems, swelling, obesity, undernourished/skinny, incontinent, fever, anemia or those with pre-existing wounds.

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Question 2

Lotion should not be used on bedridden patients because it creates an increase in moisture build-up.

A. True. (Incorrect-Moisture is beneficial to patients because it moisturizes dry skin, may create a protective barrier to the skin, may provide healing benefits from human touch and may stimulate circulation to the skin.)

B. False. (Correct-Moisture is beneficial to patients because it moisturizes dry skin, may create a protective barrier to the skin, may provide healing benefits from human touch and may stimulate circulation to the skin.)

Question 3

It is not important to tell anyone about redness observed on the skin because it is likely to disappear.

True (Incorrect—While skin redness may be temporary in some cases, it may also be a sign that tissue beneath the surface of the skin is damaged. It is important to communicate this observation in two ways: 1) document the findings in the patient's medical record and 2) tell the charge nurse, DSD or treatment nurse promptly.)

False (Correct—While skin redness may be temporary in some cases, it may also be a sign that tissue beneath the surface of the skin is damaged. It is important to communicate this observation in two ways: 1) document the findings in the patient's medical record and 2) tell the charge nurse, DSD or treatment nurse promptly.)

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Question 4

Tissue damage and skin breakdown are avoidable in all cases in nursing home patients.

A. True. (Incorrect.-Despite the best of care some patients have tissue damage or skin breakdown. In any event it is important to following the turning and repositioning procedure outlined by your Center to support the healing process of existing tissue damage and skin breakdown and, if possible, prevent further damage.)

B. False. (Correct.-Despite the best of care some patients have tissue damage or skin breakdown. In any event it is important to following the turning and repositioning procedure outlined by your Center to support the healing process of existing tissue damage and skin breakdown and, if possible, prevent further damage.)

Question 5
It is acceptable to chart my turning and repositioning in the patient's record sometime later in the week if I am too busy to chart it the day it is done.

A. True. (Incorrect-Charting needs to be done as close in time as possible as the care is given. It is unlikely and impractical to try to recall the care you provided days prior. Also, charting for care to be provided in the future is not allowed under any circumstances.

B. False. (Correct. Charting at a time as close as possible to when the care was provided or the observation was made provides a more thorough record for the team providing care and is likely to provide the most accurate information. Charting for care to be provided in the future is not allowed.

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