Medicaid Redesign Team
Gold STAMP Project

Webinar

The Importance of a Comprehensive Skin Assessment and Proper Positioning in the Prevention of Pressure Ulcers

January 29, 2014  12-1:00 pm ET

This project is funded through a Memorandum of Understanding with the NYS Department of Health
There is no commercial interest funding this program
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- 1 hour presentation by Dr. Joyce Black including a discussion period at the end.
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Today’s Speaker

Dr. Joyce Black, PhD, RN, FAAN, CWCN, CPSN

- Associate Professor at the University of Nebraska Medical Center.
- Past president of National Pressure Ulcer Advisory Panel, member since 1998.
- Served as an expert witness in legal actions for over 20 years.

Objectives

After viewing this program, the participant will be able to:

- Identify 5 important factors to include in a comprehensive skin assessment in order to prevent pressure ulcers.
- Identify 3 methods to offload pressure on a person’s skin.

Skin Assessment and Positioning: Essential Aspects of Pressure Ulcer Prevention

Joyce Black, PhD, RN
University of Nebraska Medical Center
Omaha, NE
Skin Assessment Is Important

› Nursing “owns” the skin
› Skin wounds present on admission cannot be considered hospital acquired
  • Therefore, essential to develop a plan of care to promote healing or prevent worsening
  • And, crucial to limit liability by finding any and all wounds at the time of admission

Improving on Skin Assessment

› Documentation to collect data
  • Obvious entries
  • Not mixed in with bathing documentation
  • Methods to obtain needed detail
  • We collect more on pulmonary (respiratory rate, 5 lobes, sound types, type of breathing, etc) than on skin
› Expect that all skin be assessed
  • Admission with no exceptions
  • Every shift following
› CQI for complete assessments
  • TEDs, sequentials, devices removed?

Skin Assessment in Guidelines

› Use structured approach to risk assessment that includes a comprehensive skin assessment (SOE = C)
› Policy should include timing for skin assessments
  • Skin assessments must be done daily on all patients
  • Look closely at areas subjected to pressure of any kind
  • Deep tissue injury does not present for 48 hours, if patient has been immobile for any reason, check the skin closely for 3 days following that time
Skin Inspection for Stage I

- Skin inspection should include assessment for localized heat, edema or induration, especially in individuals with darkly pigmented skin. (SOE = C)
- Research on techniques to identify stage I ulcers in darkly pigmented skin needed.

Device related pressure ulcers

- Observe the skin for pressure damage caused by medical devices (SOE = C)
- Considered a pressure ulcer
- Mucous membrane ulcers are not staged

Issues with skin assessment

- Inability to see all the skin
  - For obese patients, get adequate help
  - For immobile patients, look whenever being moved for any reason
  - For patients with medical devices, remove the device and look beneath it
- Lack of knowledge of what common wounds look like
  - Leads to all open wounds being classified as pressure ulcers
  - See attachment on wound identification
Repositioning

- Repositioning should be undertaken to reduce the duration and magnitude of pressure over vulnerable area of the body (SOE = A)
  - Consider the condition of the individual
  - Short periods of intense pressure are equally damaging as long periods of lower pressure
  - Consider the support surface in use
  - Support surfaces do not replace repositioning!

Use pillows to keep bony prominences apart

- Keep legs apart by using a pillow between the lower legs

Turn to 30–40 degrees to avoid trochanter and lift sacrum from the bed

Repositioning Frequency

- Frequency depends on
  - Tissue tolerance
  - Level of activity and mobility
  - General medical condition
  - Overall treatment objectives
  - Condition of the skin (SOE = C)

- Developing policy
  - Consider a unit by unit policy based on usual or common levels of risk
  - Rehabilitation unit vs long term care vs skilled care
  - Simplify procedure
    - If you have q 2 hr turning now, and few ulcers, it is working
    - If you know you do not have q 2 hr turning, you may want to try individualizing the protocol by unit or wing. See Bergstrom paper for ideas of frequency
How Often Should the Patient Be Turned? Repositioned?

- RCT of residents in long term care on foam mattresses
  - Well designed with low bias, well powered
  - Residents turned randomly Q 2,3 and 4 hrs
  - Compliance with turning measured
- Outcomes
  - Pressure ulcer formation was the same at all frequencies of turning on viscoelastic foam
- Can we now get to a turning schedule we can live with? Need to be tested in other populations

General repositioning in bed

- Reposition to relieve pressure or redistribute it (SOE = C)
  - Use transfer aids to reduce friction and shear
  - Do not leave the device under the patient/resident
  - Check for placement of tubes and devices
  - Avoid placing patient/resident on stage I areas
  - Avoid positioning directly on side
  - Use 30–40 degree lateral position
  - Avoid head of bed elevation
    - If needed, pretreat sacrum with foam dressings

Repositioning in chair

- Frequency based on skin tolerance (SOE = C)
  - Hourly repositioning remains a viable goal
  - Limit time in chair if no pressure relief
  - Use chair cushion if patient does not move self in chair
- Position in chair (SOE = C)
  - As erect as possible
  - Place feet on footrest to prevent sliding
Support surfaces and repositioning

- Number 1 rule: no support surface replaces turning or repositioning
  - They may help with “turn assist” features
  - They may lengthen the time interval
  - But, all patients/residents must be moved
    - There are many hazards of immobility
  - Create a training point on this issue

Preventing Heel Ulcers

- Ensure that the heels are free of the surface of the bed (SOE = C)
  - Use heel elevation devices that completely offload the heel from the bed (SOE = C)
  - Use a pillow under the calf to so that the heels are elevated “floating” (SOE = B)
  - Avoid hyperextension of the knee
  - Create a risk management plan for high risk
    - If patient has DM or PVD elevated heels from bed
      - If PVD severe, consider placing leg dependent when in chair
      - Place high risk patients in boots
      - Check feet from injury from straps and boot on each shift

Bariatric Patients
Skin Assessment More Complex

- More than one person to move and lift
- Potential for injury with movement

Bariatric Pressure Ulcers

- Locations
  - Tissue on tissue pressure
  - Bed trash in skin folds
  - Under medical devices
  - Bilateral hip ulcers from sitting in undersized chairs, wheelchairs, and commodes

The Art of Positioning

- Offload turn q 2 hrs
  - Bariatric beds
  - 40 degree lateral
  - Small shifts
  - Support pannus
Pressure Ulcer Prevention for Critically Ill Patients

ICU Issues in Skin Management

› Often does not prioritize skin very high
  - ABC’s, where does the skin fit in?
› Patients kept in semi-Fowler’s position for prevention of VAP, observation, accessibility and for function of equipment
› Over-reliance on beds for ‘skin support’

Shear Injury from Kinetic Bed

› Obese ICU patient with a DTI placed on kinetic bed
› Massive pressure ulcer with loss of sciatic nerve, muscle
› Alive, but not able to rise from a chair, walk without aides or work
› Skin inspection must be done
Reducing Shear with Dressings

Treat high risk patients who will not be moved with multi-layer composite dressings to reduce pressure, shear, friction and microclimate

Brindle, 2009

Can pressure ulcer prevention take place in ICU?

- Yes...
- Nurses must prioritize skin high enough to care about it
  - True hemodynamic instability
  - Unstable spinal injury
- Elevate heels
- Move the body as much as possible

Pressure Ulcers in Spinal Cord Injured Patients

A unique group with unique risks
Prevention
- Turn every 2–4 hours if on an appropriate support surface
  - Kinetic beds cannot be considered adequate pressure redistribution
  - Do not wait for tissue changes to upgrade the bed
  - Use a turn team?
- Inspect the skin daily
  - All the skin, remove devices
  - Consider the effect of shear on skin when HOB up

Ischial pressure Ulcers
- Seen in patients who sit erect in chairs
- Sacral ulcers seen in those who slouch
- High risk persons
  - Neuropathic
  - Spend entire day in the chair for mobility
- Complex to treat
  - Extensive
  - Bowel and bladder
  - Recurrent

Wheelchair bound patients
- Obtain w/c cushion
  - Air filled columns (RoHo)
  - Good pressure relief
  - Gel filled (Jay)
  - Good for sliding transfers
- Teach patient/family/staff
  - How to confirm cushion still works
  - How to reposition patient in the chair
  - Lift feet so that patient reaches the floor or a stool to prevent sliding
  - Adherence to self repositioning
  - Checking skin nightly with long handled mirror
Pressure Ulcer Prevention at End of Life

Repositioning Guidelines

- Repositioning frequency will be influenced by the individual (SOE=C) and the support surface in use (SOE=A).
- Pre-medicate
- Protect bony prominences
- Strive to reposition at least q4hr on a foam mattress or q2hr on a regular mattress (SOE=B)

Pressure Ulcers In the Emergency Department

Joyce Black, PhD, RN
Associate Professor
University of Nebraska
Prevention of Pressure Ulcers in ED

- Usual surfaces of carts and chairs are not pressure redistributing
- If cart has over 4 inches of foam as the mattress, there is some pressure redistribution
- What happens when HOB is elevated?

Bed Selection and Procurement in ED

- If patient's admission is delayed
  - Place patient in hospital bed
  - Undress patient and place in hospital gown
  - Full examination to find ulcers
  - Documentation of ulcers “present on admission”
  - Consider a dedicated area for patients being admitted
- Consider size and girth of patient
  - If over 250 lbs may not fit standard hospital bed
  - Place in bariatric bed at onset

Diagnosis of Ulcers Present on Admission

- Examine all patients at risk for pressure ulcers upon ER admission
  - Institutionalized patients with changes in mental status
  - Institutionalized patients with chronic neurological diseases
  - Patients being seen for difficulty with swallowing or PEG tube problems
  - Patients with a working diagnosis of sepsis
  - Patients from home settings who appear to have been neglected
Pressure Ulcers in the Operating Room

Reducing risk in OR

- Foam or gel table pad
- Pressure point padding and heel elevation
- Composite dressings on sacrum
- Preventing prep solutions from pooling

Skin Assessment and Positioning: Essential Aspects of Pressure Ulcer Prevention

Joyce Black, PhD, RN
University of Nebraska Medical Center
Omaha, NE
Thank you!

Questions?

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CNE’s, CME’s

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