Prevention of Pressure Injuries for the Caregiver and Front-Line Staff
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Prevention of Pressure Injuries

• ALL Staff need to help with pressure injury & skin breakdown prevention!!!!

Prevention of Pressure Injuries

Nursing Assistants are the key to a successful pressure injury/skin breakdown prevention and management program
Common Causes of Skin Breakdown

• Pressure Injuries: unrelieved or prolonged pressure
• Skin tears: Due to thin skin that has lost its elasticity
• Maceration: Irritation of the skin with superficial open areas secondary to urine and/or fecal contamination
• Rashes or irritation from allergies, medications, etc.
• Lower leg ulcers: Secondary to circulation concerns (arterial and/or venous insufficiency), loss of protective sensation (neuropathy) and complications of diabetes which leads to circulatory and loss of sensation issues.
• Bruising: Ecchymosis due to trauma
• Even if it looks old still report it!!!

The Definition of Pressure Injuries

• National Pressure Injury Advisory Panel (NPIAP) Definition April 2016:
  • A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

Regulatory: F686

• Based on the comprehensive assessment of a resident, the facility must ensure that
  • A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and
  • A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
The care setting must PROVE that the wound was ...

**Unavoidable**

**Avoidable/Unavoidable**

- **Unavoidable**
  - Means that the resident developed a pressure ulcer/injury even though the facility had:
    - Evaluated the resident’s clinical condition and risk factors;
    - Defined and implemented interventions that are consistent with the resident needs, goals and professional standards of practice;
    - Monitored and evaluated the impact of the interventions; and
    - Revised the approaches as appropriate
  - NOT AS SIMPLE AS HAVING THE PHYSICIAN WRITE IT WAS UNAVOIDABLE!!

**Pressure Injuries**
Pressure Injuries

Sources of Pressure

- Improper support surface on the bed or wheelchair
- Staying in one position too long
- Head of bed elevation the majority of the day
- Medical Devices (tubes, casts, braces, shoes, positioning devices)
- Hard surfaces
Prevention Interventions

• Inspect skin daily with cares
  ▪ Inspect bony prominences by looking and FEELING
  ▪ Look for any discoloration, bruises, open areas, skin tears, rashes, etc.
  ▪ Feel for skin temperature changes, cold in the area or hot compared to surrounding skin
  ▪ Feel for consistency changes such as mushy, boggy, firm or hard areas compared to surrounding skin
  ▪ Look under medical devices (cast, tubes, orthoses, braces, etc).
  ▪ If dressings are soiled, loose or missing report to the nurse
  ▪ Notify the nurse of any concerns immediately (in writing if possible)

Prevention Interventions

• Weekly skin inspection by the Licensed Nurse, typically on the bath day

Contributing Factors

Contributing factors
Contributing Factors: Shear

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Contributing factors: Friction
Surface of the skin
Interventions for Friction and Shear

- Lift – do not drag – individuals
- Utilize lifting devices and slings
  - Ceiling lifts
  - Transfer lifts
  - Sit to stand lifts
  - Walking lifts
  - Lateral transfer devices
  - Specialty slings (do not leave under the resident)
    - Repositioning slings
    - Limb lifter slings

Interventions for Friction and Shear

- Raise the foot of the bed before elevating
- Wedge wheelchair cushions (therapy referral)
- Pillows

Other Preventive Interventions

- Dry or Fragile Skin
  - Apply nonirritating lotion at least daily
  - Lower legs petroleum for dry skin
  - Protective clothing
  - Protective dressings or skin sealants
  - Handle with care
Risk Factor: Immobility or Inactivity

- Decreased activity level leading to staying in one position for a long period of time
- Chairfast
- Bedbound
- Choosing not to get out of the bed or chair
- Chooses not to change positions

Restorative & Mobility Programs

- Referral to Therapy and Restorative Nursing
  - ROM and PROM
  - Walking
  - Transfers
  - Bed mobility
  - Amputation/Prosthesis Care
  - Communication
  - Eating
  - Self care training/ADLs
  - Toileting
  - Splint/brace

Restorative & Mobility Programs

- Assistive devices to promote mobility:
  - Grab Bars for repositioning & egress
  - Bed at correct egress height
  - Utilize electric bed to assist to a standing position
  - Lifts (ceiling, sit to stand, transfer, walking)
  - Transfer devices
  - Repositioning slings
  - Walking devices (cane, walker, etc)
  - Assistive devices
Pressure Redistribution

- Definition: Ability of a support surface to evenly distribute the load over the contact area of the human body
- Term Pressure Redistribution replaces prior terminology of Pressure Reduction and Pressure Relief support surfaces
- Goal of Support Surface:
  - Evenly distribute pressure over the surface
  - Envelop and immerse into the support surface
  - Control microclimate

Pressure Redistribution

- Appropriate support surface for the bed
- Never a substitute for turning and repositioning schedules
- Heels especially vulnerable even on specialty support surface

Pressure Redistribution

- Heel Elevation: Elevate heels completely off the surface
  - Pillow prop
  - Wedges
  - Heel lift boots
- Always provide heel elevation bilaterally
- Feel to ensure the heel has no pressure
Pressure Redistribution

- All wheelchairs should have a cushion!!!
- Report any wheelchair that doesn’t have a cushion
- Air and gel is more aggressive than foam products
- A sitting position = head elevation of 30 degrees or higher
- Referral to therapy for wheelchair cushion selection

Prevention Interventions

- Inspect bed surface and wheelchair cushions for:
  - On properly
  - Proper inflation and working properly
  - Cover is intact
  - Equipment is clean
  - Only a thin sheet to cover the mattress (do not layer linen/incontinence products)
  - No linens/slings in wheelchair
Turning and Repositioning

• Establish an Individualized repositioning schedule based on:
  • Individual tolerance
  • Preferences (i.e., wanting uninterrupted sleep, comfort)
  • Characteristics of the pressure redistribution support surface
  • Utilize repositioning and positioning devices as appropriate

• Momentary pressure relief followed by a return to the same position is usually NOT beneficial (micro-shifts of 5 to 10 degrees or a 10-15 second lift)
  • “Off-loading” is considered 1 full minute of pressure RELIEF
    - Good compromise if unable to fully reposition

• Watch for persistent redness in an area
  • Hyperemia response is when the skin turns temporarily red in an area immediately after pressure has been removed
  • If this happens keep the resident off the area and re-inspect it after 30 minutes, if it is still red, notify the nurse
Restraints

• Release restraints at designated intervals
• More importantly try to eliminate restraints

Pain Management

• Report to the nurse if turning and repositioning or any cares/interventions cause pain for the resident.
• Work with the nurse so they can pre-medicate the individual 20-30 minutes prior to repositioning, treatment or cares as appropriate or so they can provide scheduled pain medication

Pain Management

• Do not place individuals directly on a wound whenever possible or limit the time on the area
• Pad and protect bony prominences (note: sheepskin, heel and elbow protectors provide comfort, and reduce shear and friction, but do NOT provide pressure reduction)
• Do not massage over bony prominences
Prevention Interventions

Nutritional Risk – Delay Healing

• Nutritionally at Risk
  • Low calorie intake and low protein levels lead to poor healing and increase risk of pressure ulcers
  • Dehydration can lead to dry and fragile skin, as well as circulation issues

Nutritional Interventions

• Accurate intake, output and weight
• Report poor intake of a meal or fluids
• Provide food per individual preferences
• Provide supplements timely and report if resident is refusing or doesn’t like them
• Ensure assistance to those who can not feed themselves
• Give fluids in small dosages throughout the day – each time you interact with the resident
• Notify Nurse if there is a change in the resident’s ability to eat or swallow
**Moisture**

![Image]

**Interventions for Protection from Moisture**

- Individualized Bowel and Bladder Program
- Peri-care after each episode of incontinence
- Appropriate, dignified absorptive incontinent products
- Apply a protective skin barrier to peri-area or wound edges (ensure skin is clean before application and appropriate with the absorptive product)

**Interventions for Protection from Moisture**

- 4x4’s, pillow cases or dry cloths in between skin folds
- Inter Dry Ag sheets if prone to fungal infections
- Antifungal powder or ointment for active fungal infections
- Bathe with MILD soap, rinse and gently dry
- Keep linen dry and wrinkle free
Lower Extremity Ulcers

• Report any swelling in the lower legs or feet
• Inspect the legs, feet, and heels by looking and feeling, don’t forget to look between the toes – report any findings
• No foot soaks
• Keep toes and feet clean and dry
• Toenails should be trimmed by trained person – report long toenails
• Ensure proper fitting footwear at all times
• Report if leg wraps are falling off or loose

Other Considerations

• Notify Nurse of:
  • If a resident refuses to allow you to do any of the interventions, notify your nurse immediately
  • Explain to resident and/or family members reason for why you are doing certain cares or providing special equipment
  • Re-approach as appropriate

Prevention from Day One

• Admission Checklist
  ✓ Oriented to room & bathroom
  ✓ Oriented and demonstrated back how to use the call light
  ✓ Bed placed for proper egress side of bed and height
  ✓ Proper mattress on bed & functioning
  ✓ Ensure proper placement and access to mobility devices – parking spot
  ✓ Cushion in wheelchair
  ✓ Proper footwear
  ✓ Heels off the bed if non-mobile
  ✓ Turning schedule set up for sitting and lying
  ✓ Clear path to bathroom/Toileting plan
  ✓ Proper toilet seat height
  ✓ Needed items in reach
  ✓ Frequent checks for the first 24-72 hours
Preventing Skin Breakdown – The Nursing Assistant’s Role

Wellness Rounds:
• Every 2 hours
  ✓ Pain is managed
  ✓ Offer toileting/incontinence care
  ✓ Offer fluids/snack
  ✓ Turn/reposition or off loading
  ✓ Proper footwear and/or heel elevation

Wellness Rounds:
• Before leaving the room
  ✓ Support surface is functioning properly
  ✓ Call light in reach
  ✓ Fluids/snacks/belongings in reach
  ✓ Mobility devices in proper place for access
  ✓ Bed height & equipment appropriate
  ✓ Commode and urinal in place
  ✓ Clear path to bathroom

Documentation
• ADL tracking/point of care
• Ensure you are filling out any required documentation and that it is accurate
Review of Risk Factors to Watch for and Report

✓ Change in mobility level
✓ Change in continence status
✓ Change in cognition
✓ Change in appetite and intake
✓ Dry skin
✓ Preferring to stay in one position for long periods of time
✓ Acute illness
✓ Becoming more dependent with cares
✓ Refusing cares

Review Interventions

✓ Correct bed surface & functioning
✓ Correct wheelchair cushion
✓ Heel elevation
✓ Peri care with each incontinence episode
✓ Turn per turning and repositioning schedule
✓ Proper nutrition and hydration
✓ Keep skin hydrated – lotion and petroleum to lower legs
✓ Ensure proper footwear and/or heel elevation
✓ Handle with care

Thanks for your participation!!!

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