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!!!!**

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Prevention of Pressure Injuries

Nursing Assistants are the key to a successful pressure injury/skin breakdown prevention and management program

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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!!!**

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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, co-morbidities and condition of the soft tissue.

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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.

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Regulatory and Litigation

The care setting must PROVE that the wound was …

Unavoidable

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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!!**

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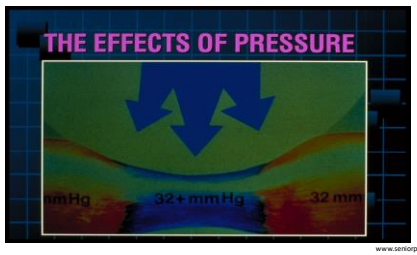
Pressure Injuries



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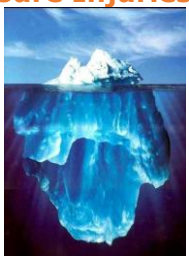
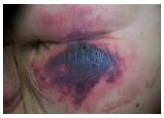
Pressure Injuries





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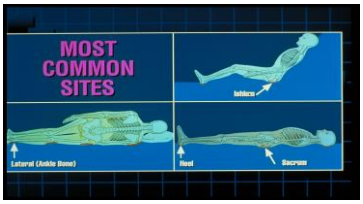
Pressure Injuries



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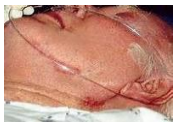
Sources of Pressure

- 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



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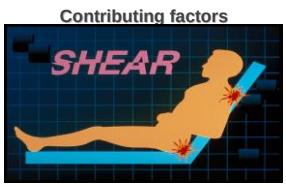
Prevention Interventions

- **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)

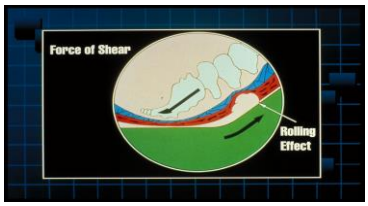
Prevention Interventions

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

Contributing Factors



Contributing Factors: Shear



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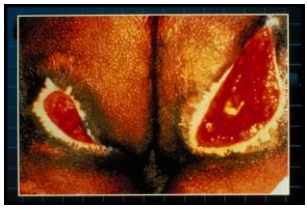
Contributing Factors: Shear



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Contributing factors: Friction Surface of the skin

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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

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Interventions for Friction and Shear

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

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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

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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

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Pressure Redistribution

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

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Pressure Redistribution

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

NO

NO

YES

YES

YES

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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

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Prevention Interventions

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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

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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

Turning and Repositioning

- 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

Turning and Repositioning

- **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

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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

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Pain Management

- Do not place Individuals directly on a wound when ever 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

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Prevention Interventions

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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

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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**

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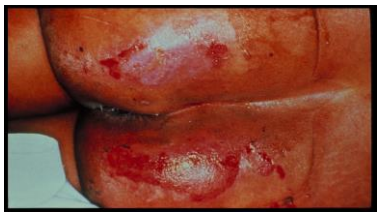
Moisture



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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)

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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

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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

Preventing Skin Breakdown – The Nursing Assistant's Role

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

Preventing Skin Breakdown – The Nursing Assistant's Role

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

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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

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Senior Providers RESOURCE, LLC

Thanks for your participation!!!

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