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Workshop : Decreasing Complications of Mobility Impairment through Collaborative Practice

PART C. Best Practices in Safe Skin

Basic Principles of Wound Care

Ghada Bakhos-Kesserwani, BSN, RN

SKIN ASSESSMENT

- Patient Assessment (Demographic data, medical &surgical patient history, smoking, allergy---.)

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- Skin Assessment

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- Wound Assessment

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- Adequate Care Plan

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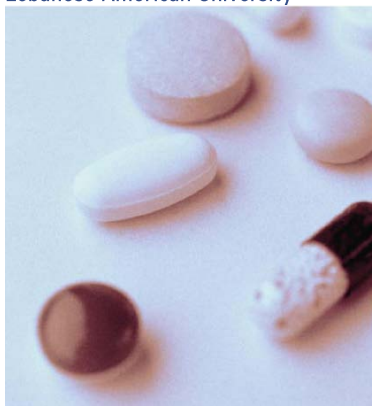
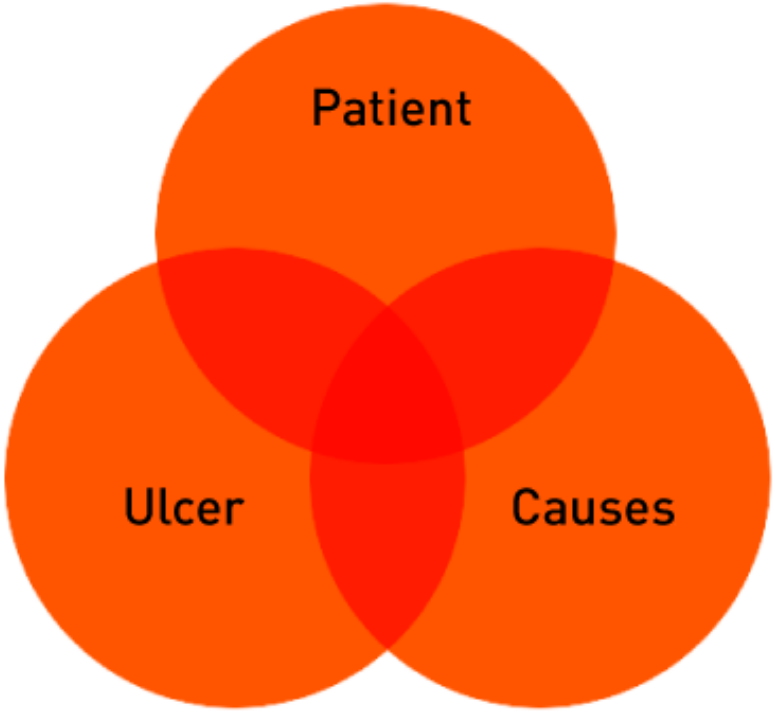
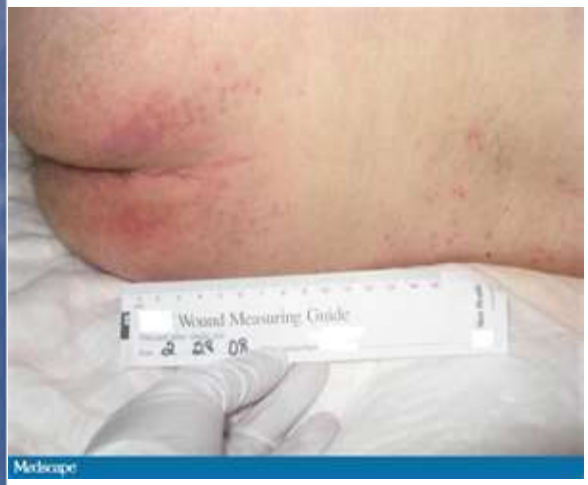
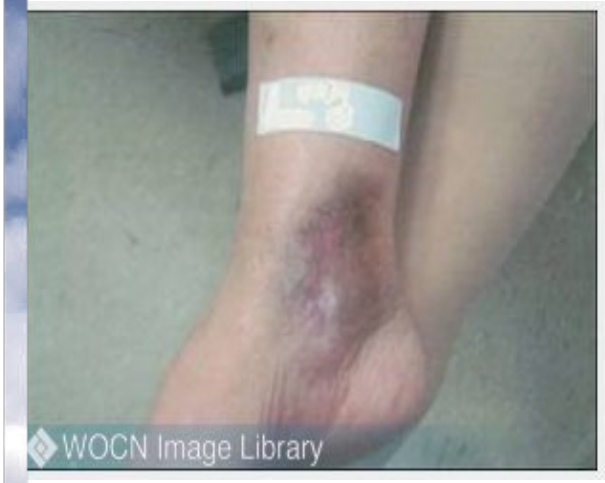




When to assess Patient ?

- On admission
- Every shift
- Before transfer patient to another facility
- Change in patient health status



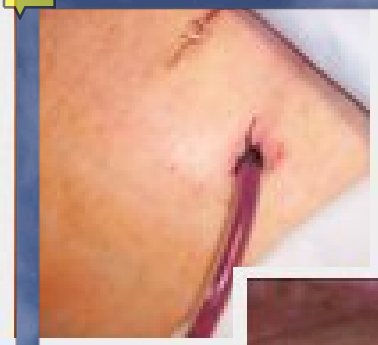


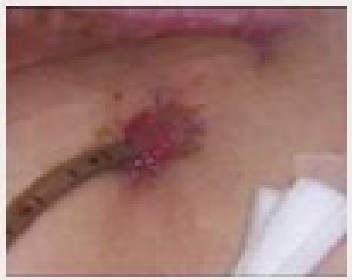
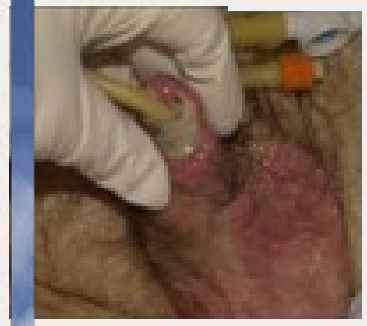
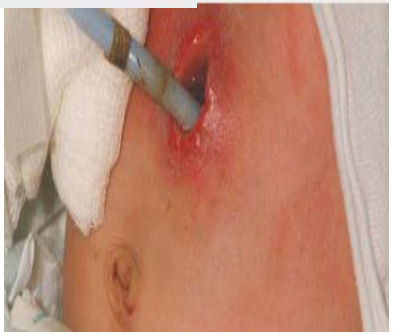
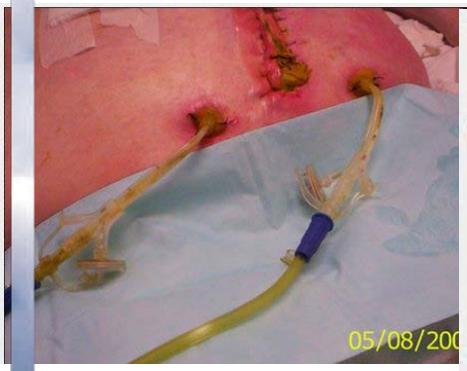
SKIN ASSESSMENT: from head to toe

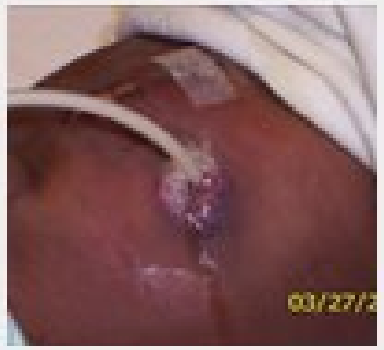
Palpate for :

- Warmth,
- Tenderness
- Edema
- Ulcer
- Skin diseases

Document every detail



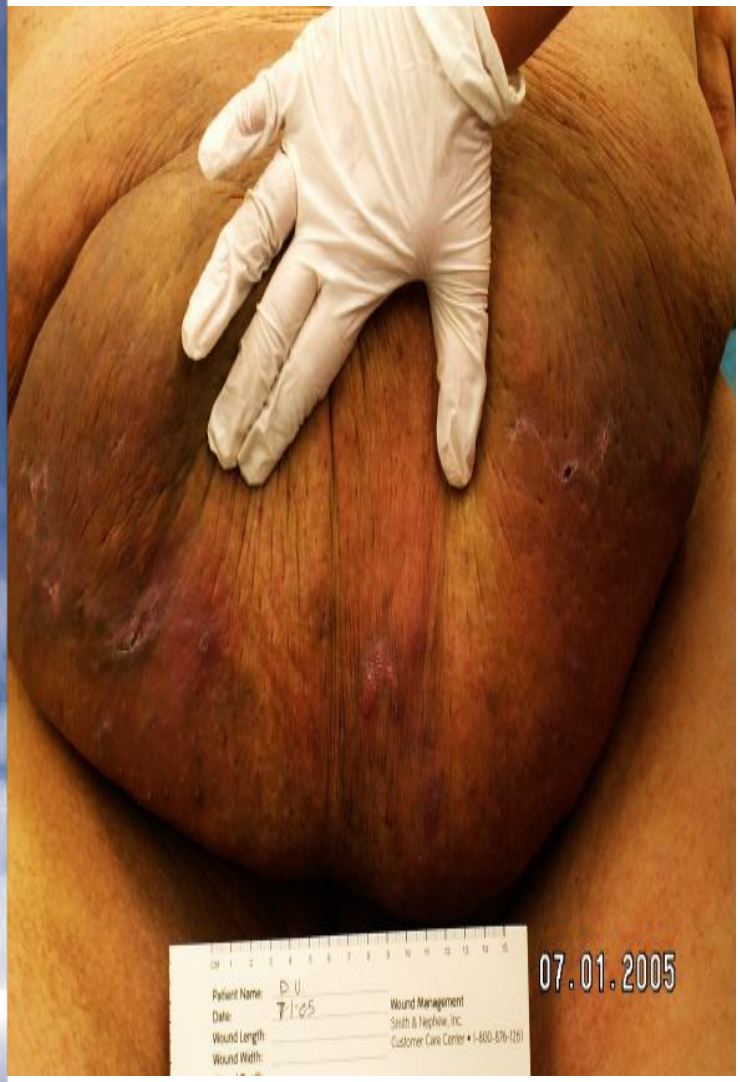







ASSESS MEDICAL DEVICES

Document:

- Type of devices
- Site
- Date of insertion or replacement
- Tube site
- Peri tube , or peri stoma
- Presence of :
  - 1- erosion,
  - 2- hypergranulation
  - 3- infection



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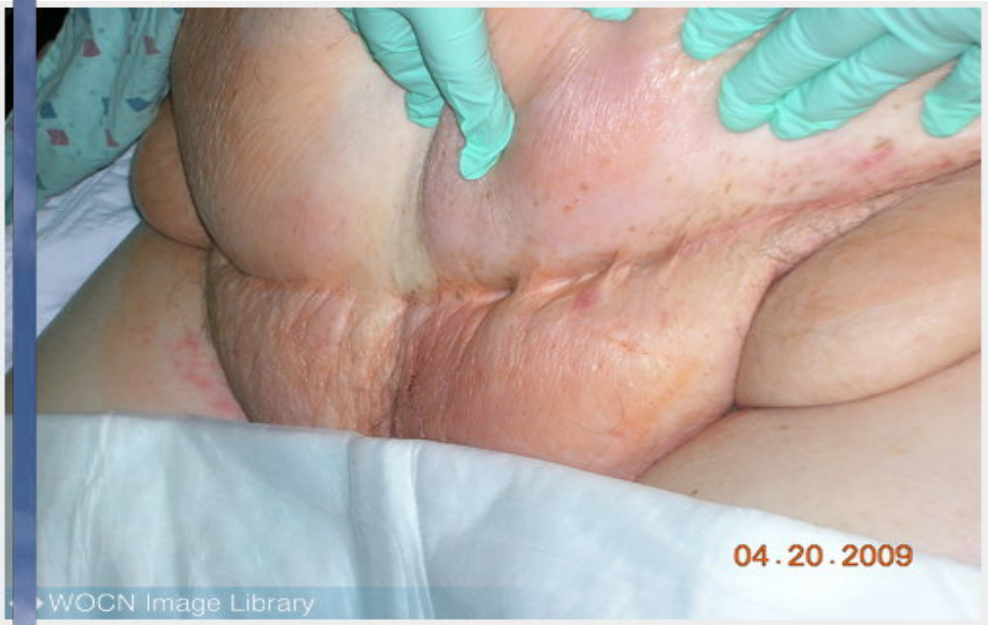
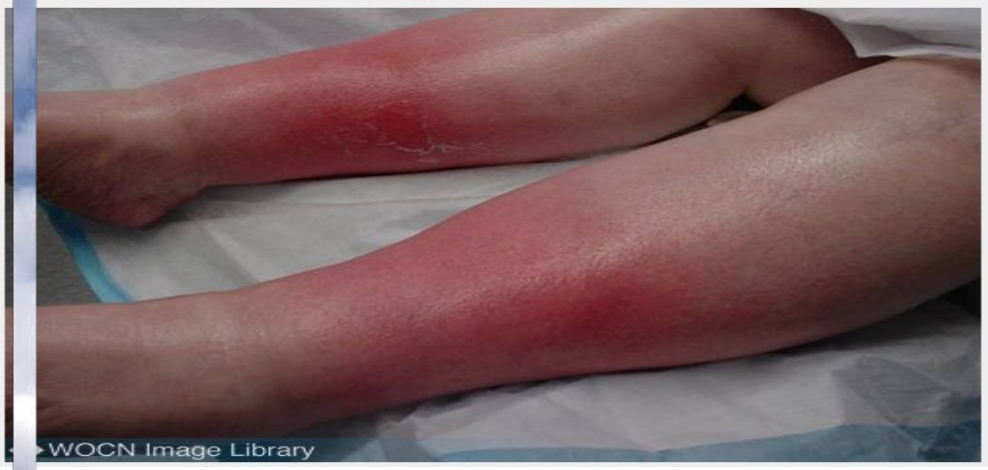
SKIN ASSESSMENT:

Skin folds:

Document presence of:

- Moisture
- Rash
- Candida
- Lesions

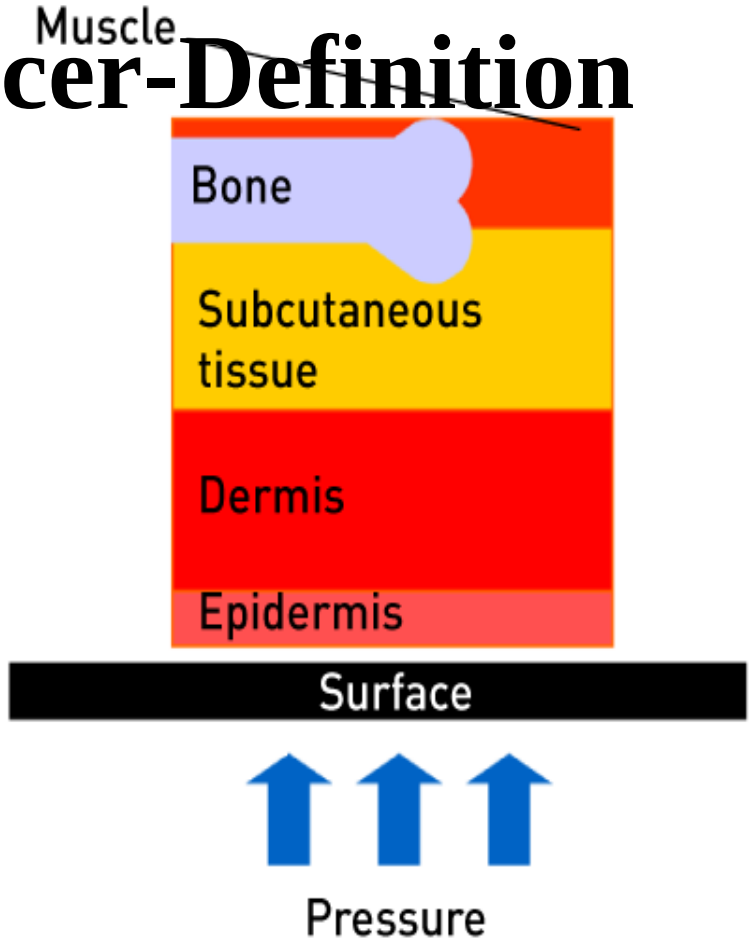




BARIATRIC SKIN ASSESSMENT

Incontinence-related dermatitis secondary to inability to perform personal hygiene, pressure ulcers (including sites other than bony prominences), venous Insufficiency/ulceration, and/or lymphedema.

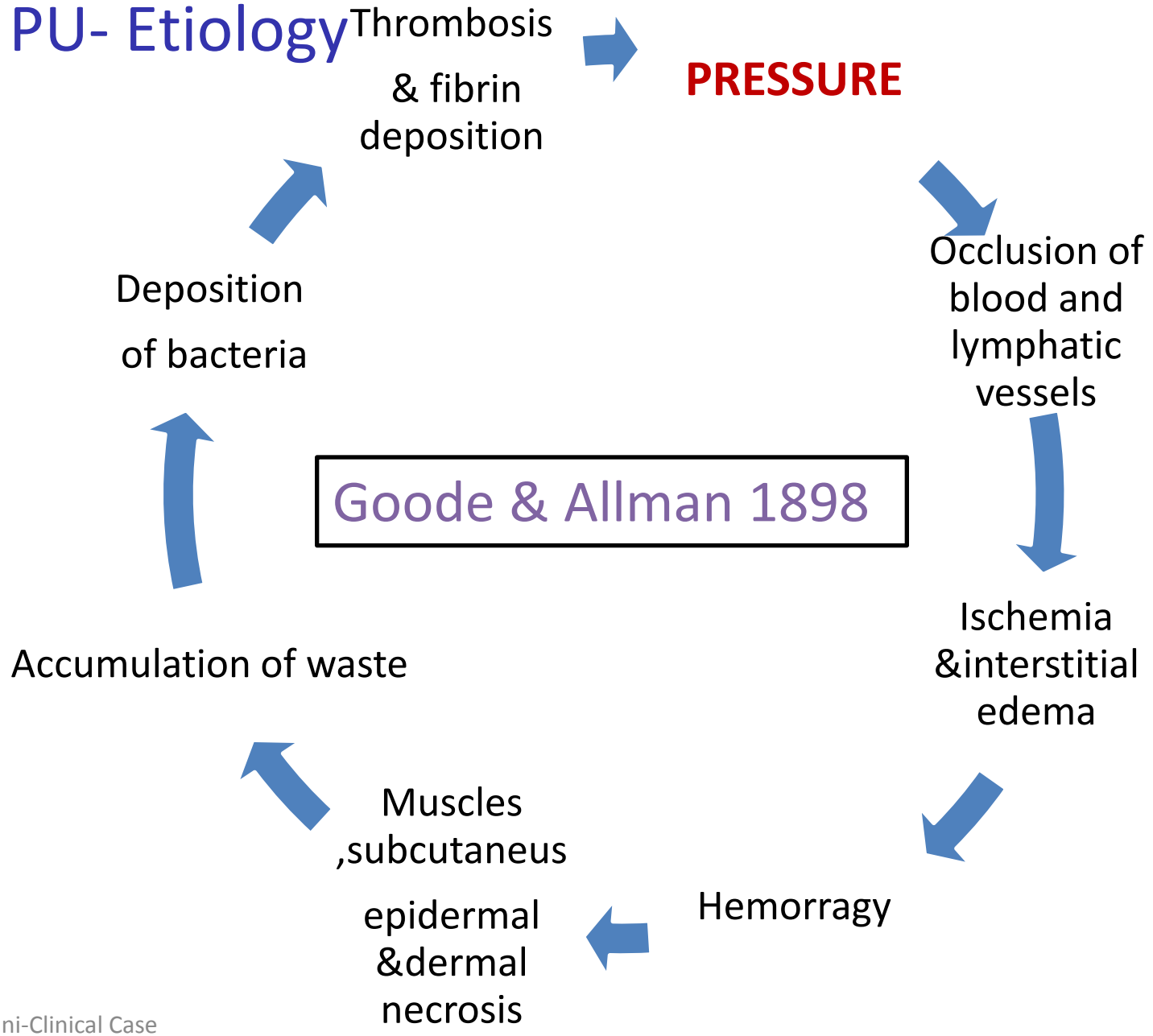
Pressure Ulcer-Definition



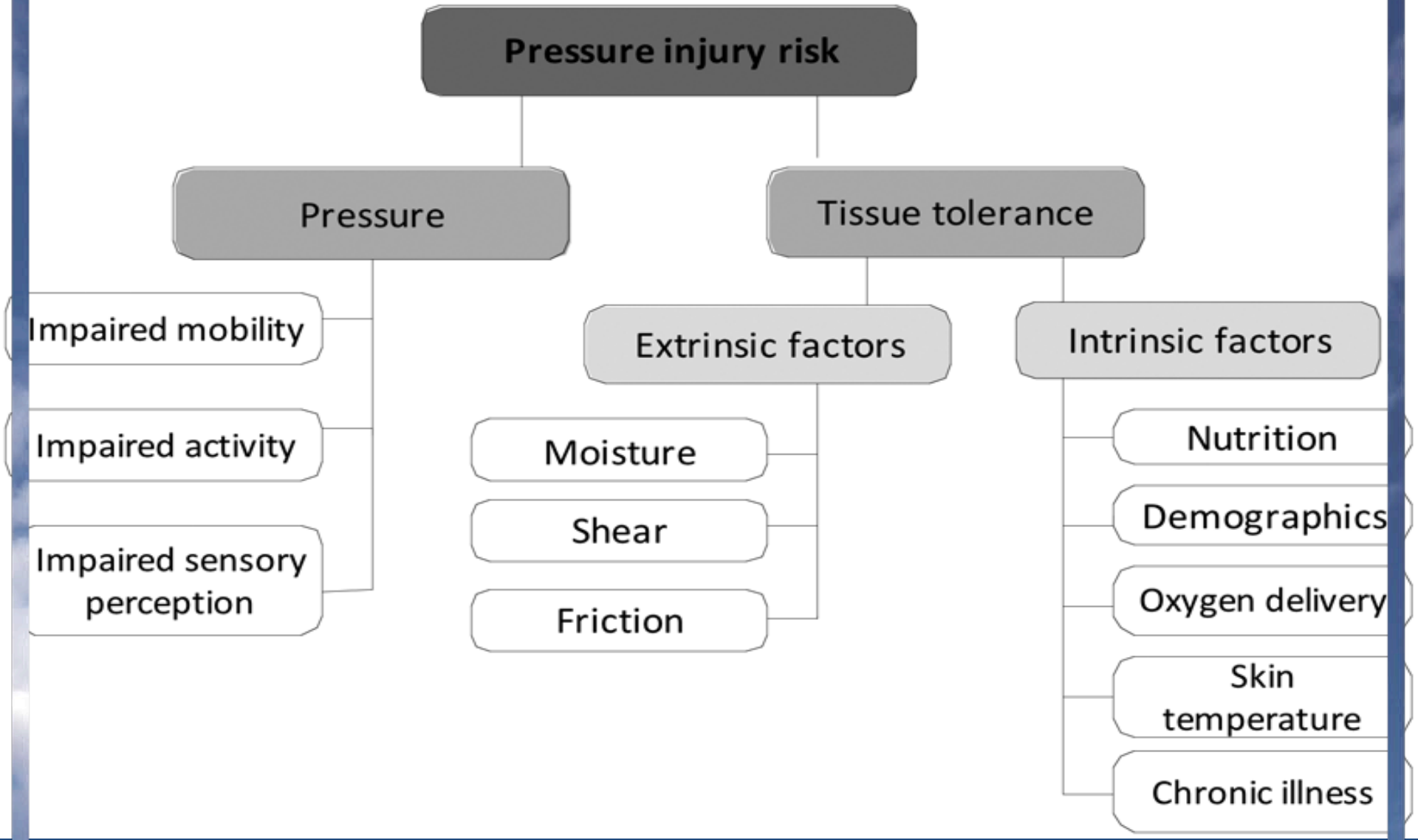
A pressure ulcer is "localized Injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction" (NPUAP, 1989).

Bed sores most often develop on skin that covers bony areas of the body, such as the heel, ankles, hips or buttocks.

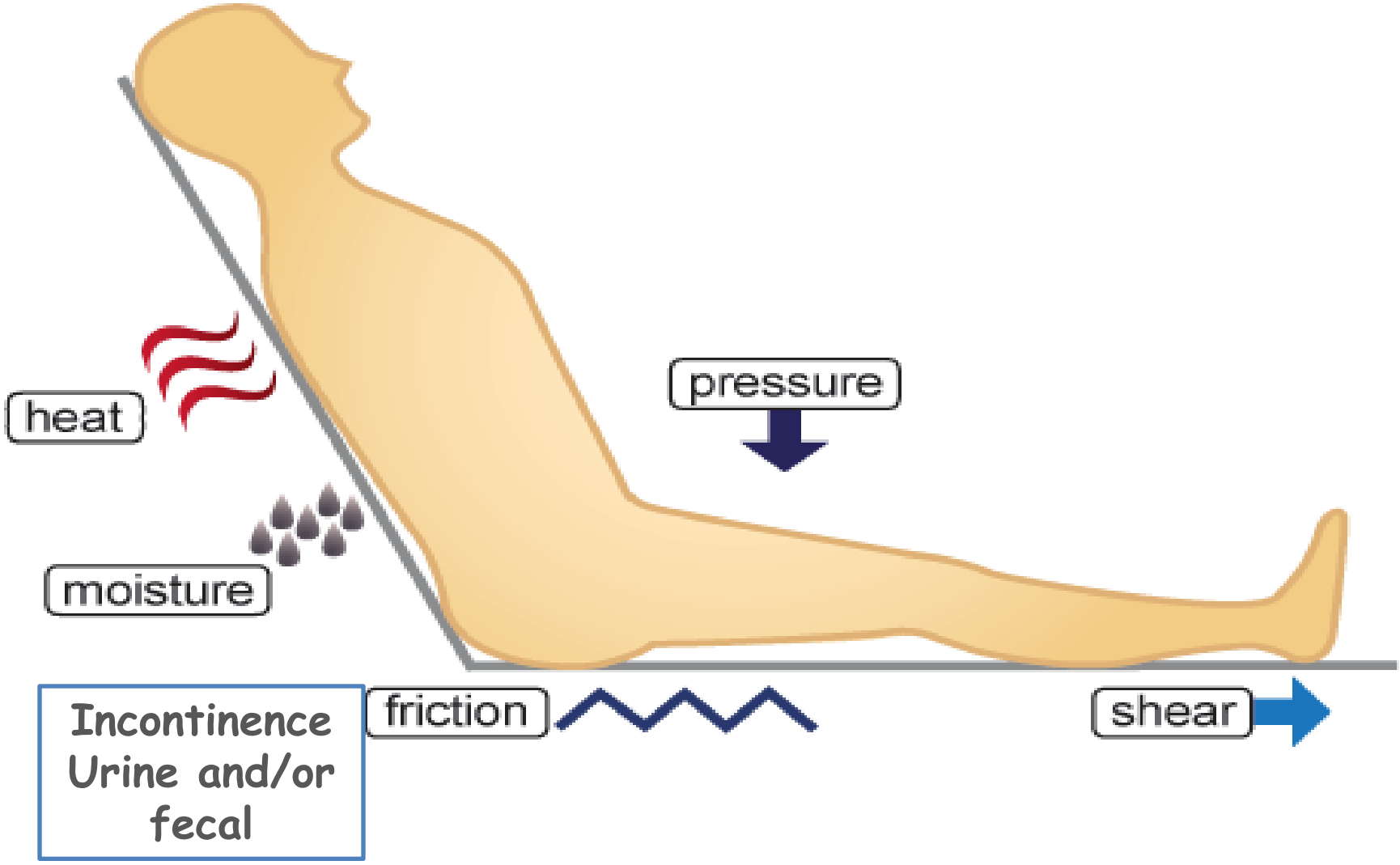
PU- Etiology


Thrombosis & fibrin deposition
PRESSURE
Occlusion of blood and lymphatic vessels
Ischemia &interstitial edema
Hemorragy
Muscles ,subcutaneus epidermal &dermal necrosis
Accumulation of waste
Deposition of bacteria
Goode & Allman 1898

PU- Risk Factors

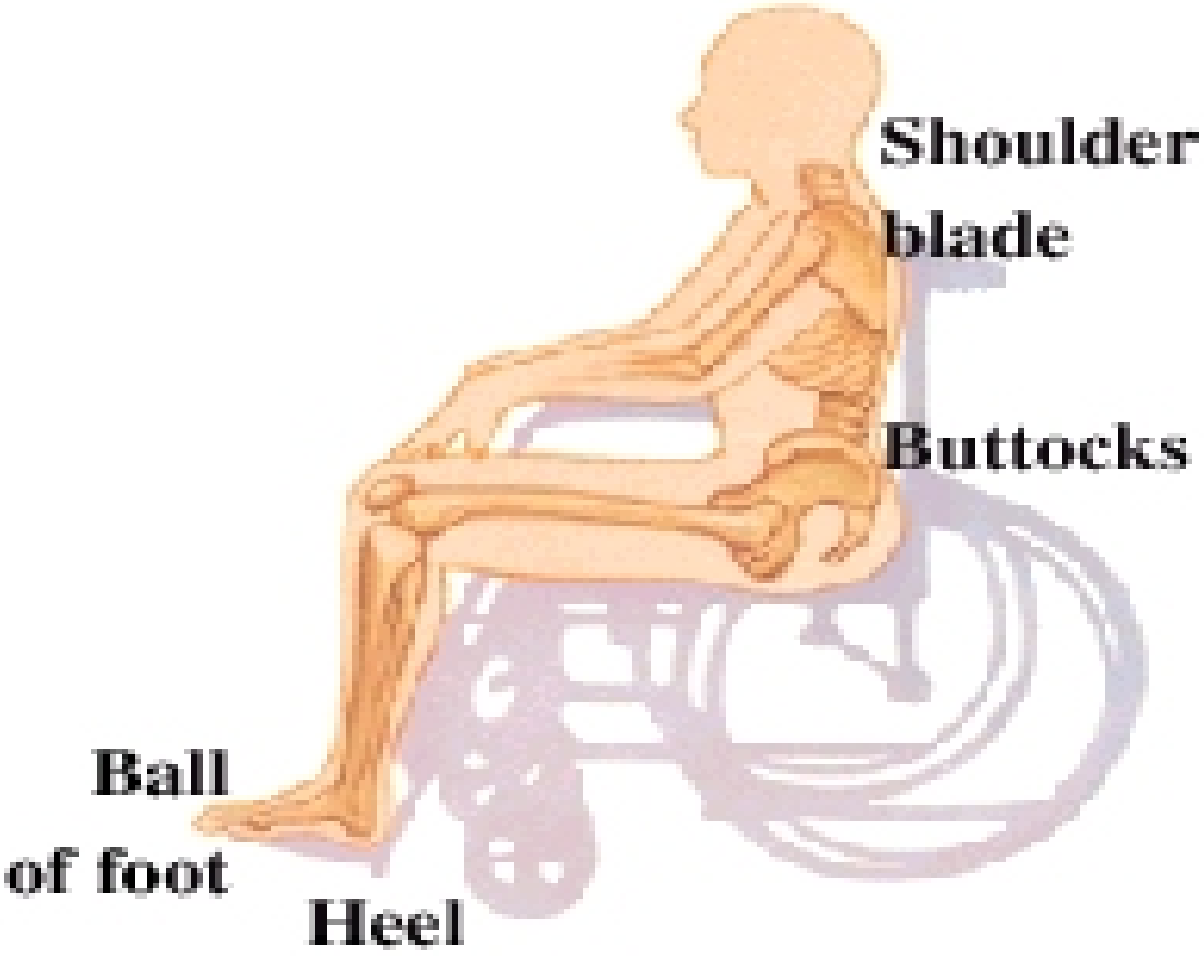


PU- Risk Factors



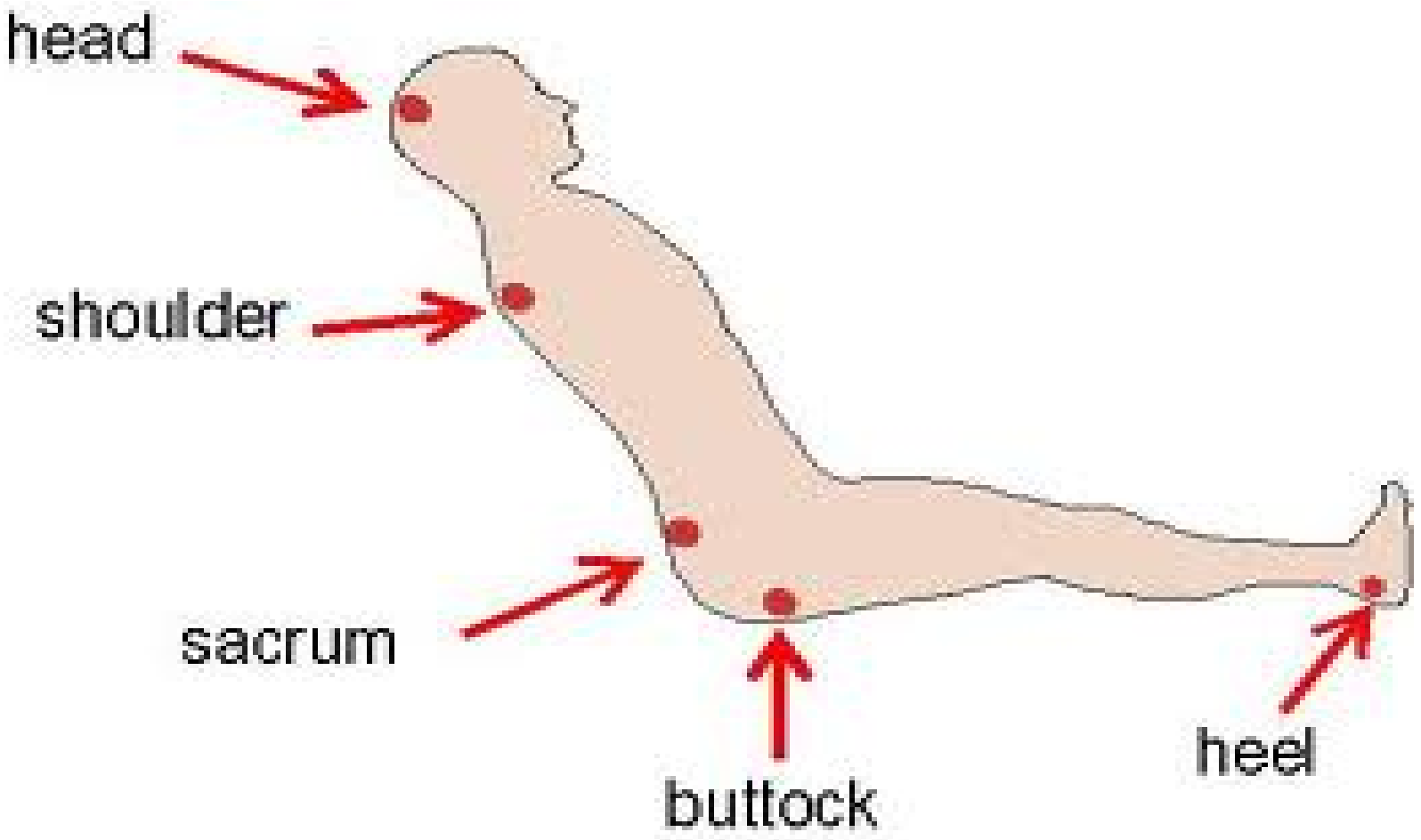
Common Sites of Pressure Points

Wheelchair position

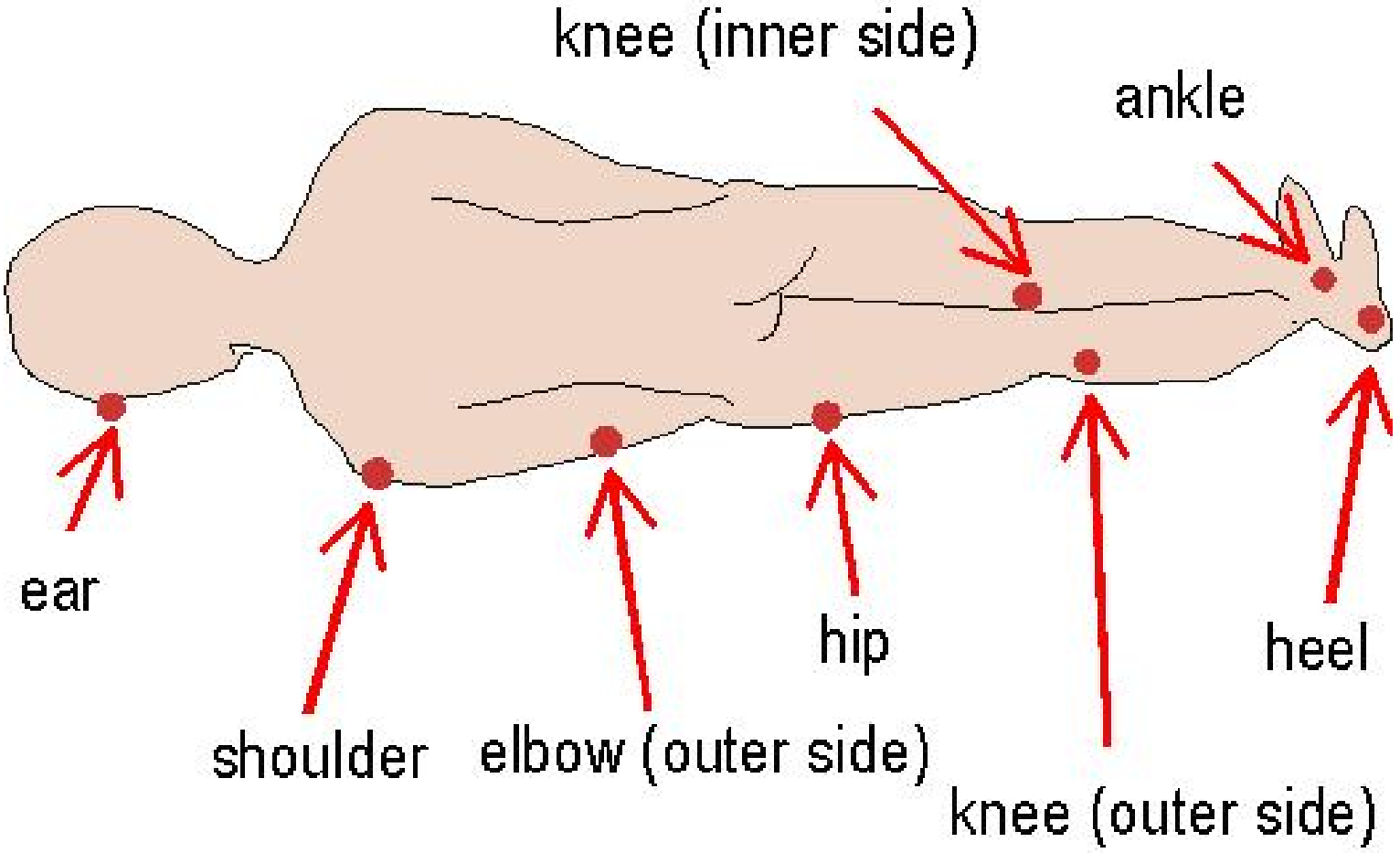


Common Sites of Pressure Points

Sitting Position

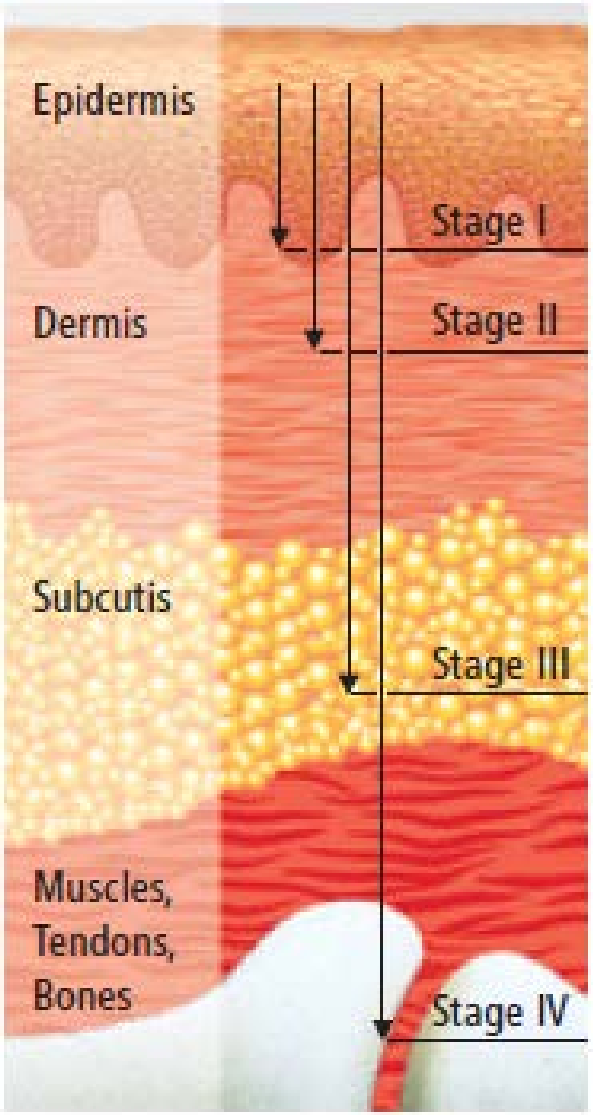


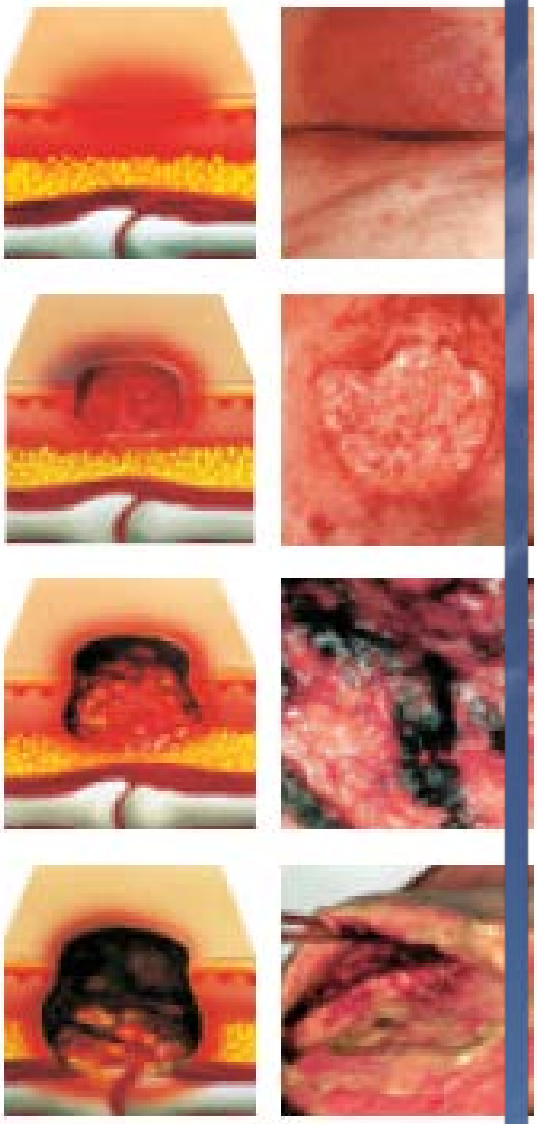
Common Sites of Pressure Points
Lateral Position



Pressure Ulcers Classification

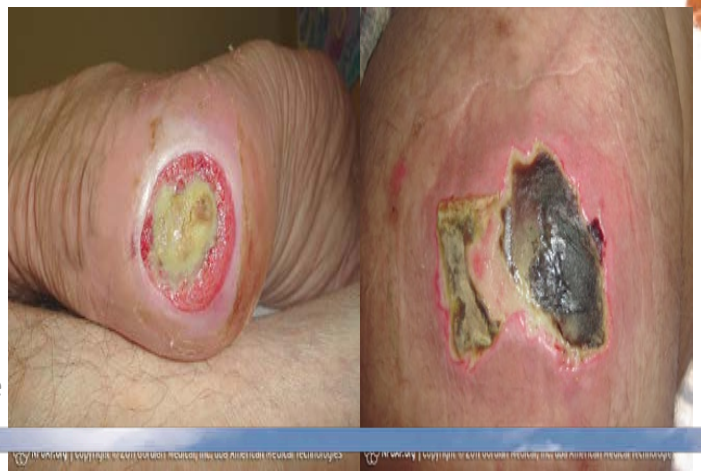
- Stage I
- Stage II
- Stage III
- Stage IV



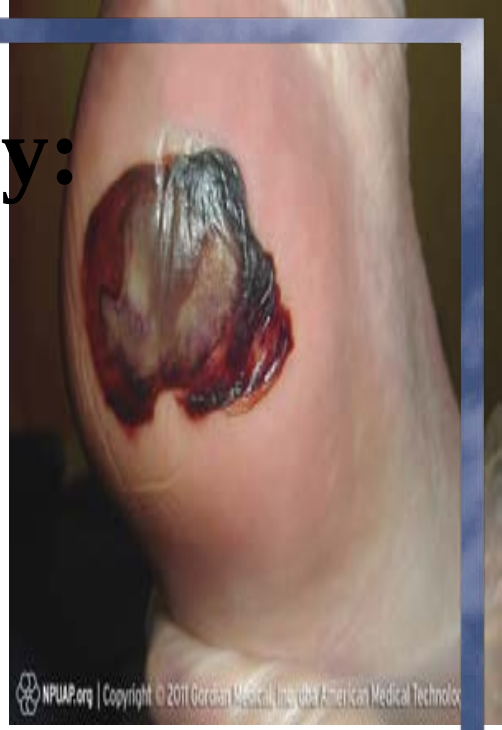


PU- Unstageable:

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

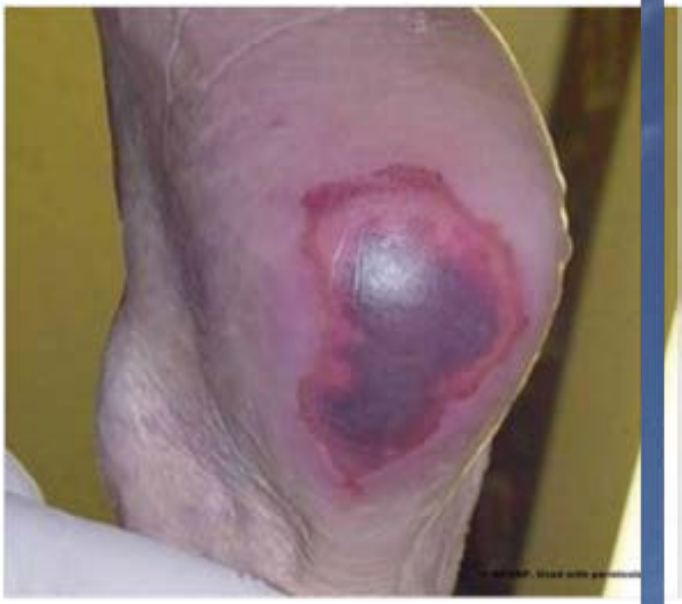


Suspected Deep Tissue Injury:



Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar.

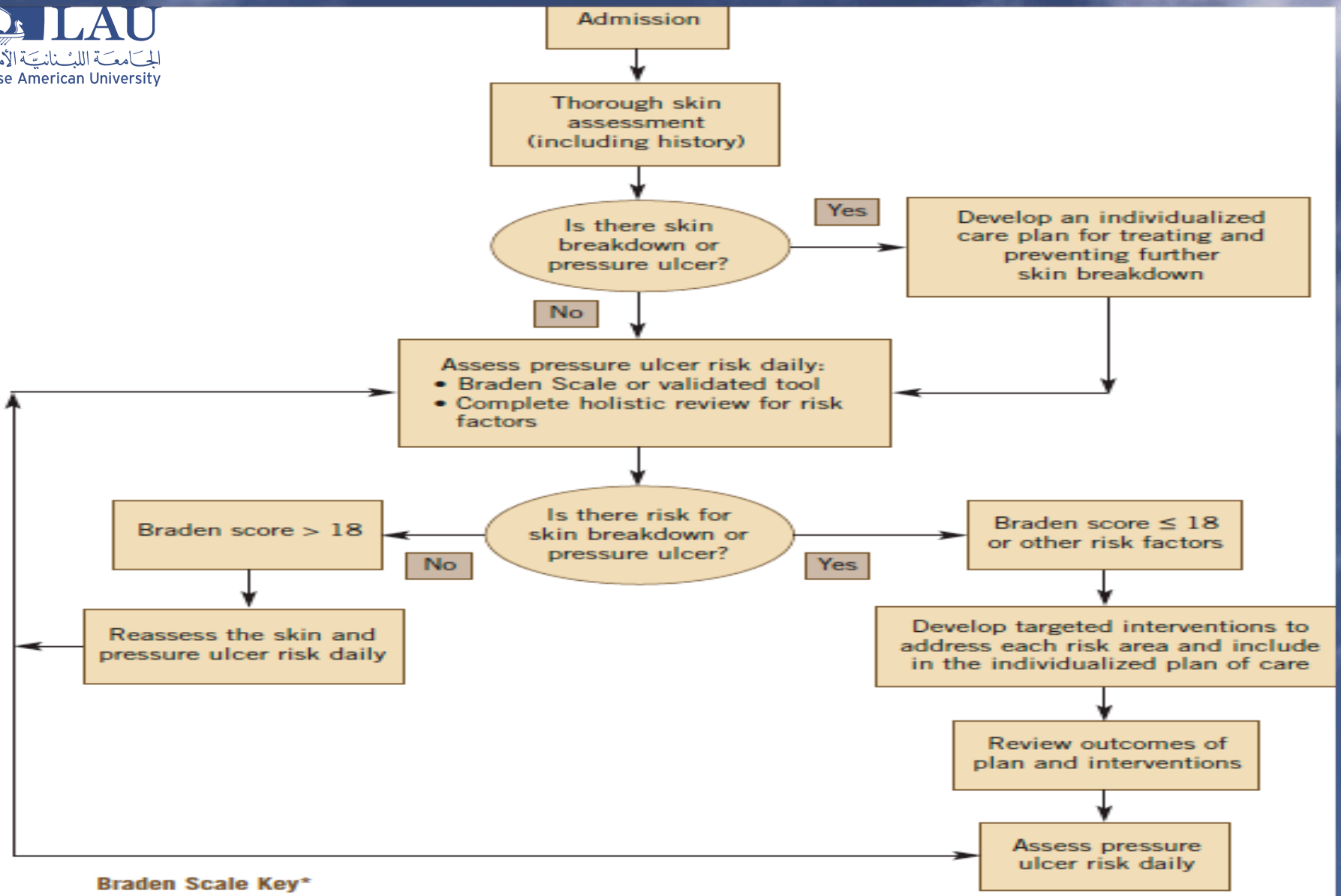
Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name_____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
								Total Score



Braden Scale Key*

Braden Scores:	
At Risk:	15–18
Moderate Risk:	13–14
High Risk:	10–12
Very High Risk:	≤ 9

*Braden Scale for predicting Pressure Score Risk. Available at http://www.bradenscale.com/newlevels.htm. Accessed May 13, 2008.

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PREVENTION PROTOCOL

Prevention is better than treatment

Instructions to prevent Pressure Ulcer:

A- **Offloading:**

- Use water /foam /air mattress
- Cushions: foam dressing, Hydrocolloids, Foam and gel devices----.

B- **Changing position**

- Change position Q 3hrs, keeping patient in the new lateral position held with a pillow.

B- CHANGING POSITION

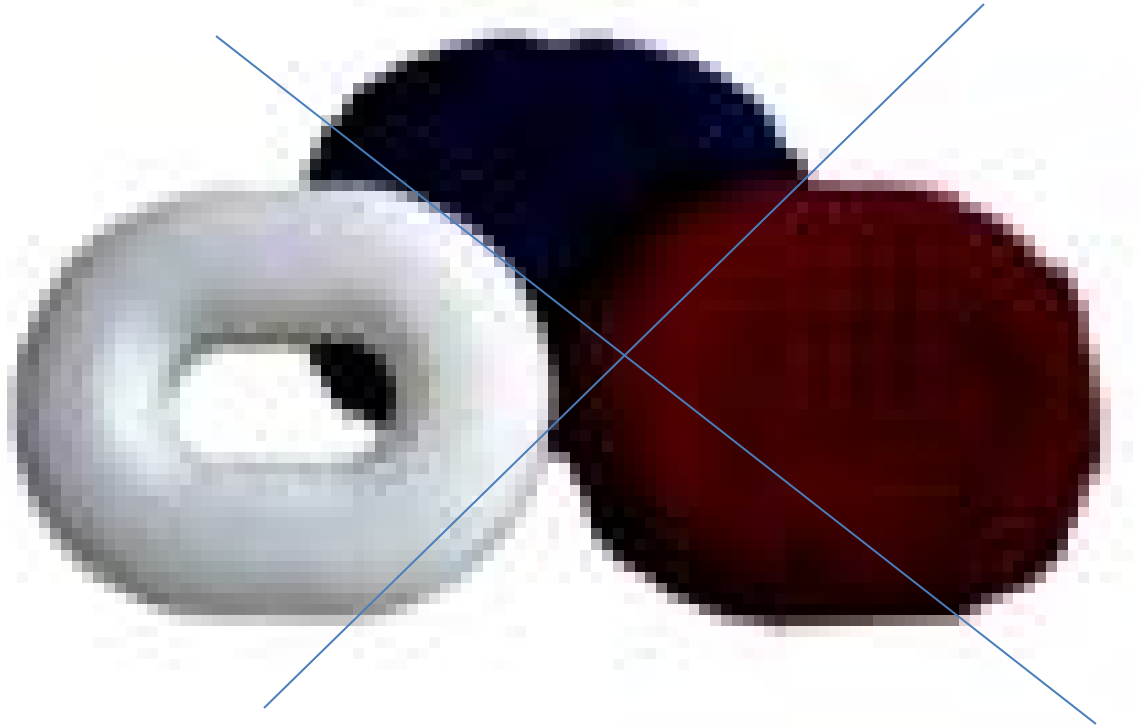
- Out of Bed as soon as possible with assistant.
- Avoid positioning patient directly on the trochanter
- Do not massage over bony prominences.
- Keep head elevated 30 degree .
- Use lifting device - Trapeze.
- Involve physiotherapist

C- Moisture management:

- Avoid moisture by changing patient dressing and bedding (if sweating).
- Prevent incontinence by using a foley or a condom as prescribed by physician.
- Change diapers frequently
- Apply a protect barriers over bony prominences to avoid friction
- Apply a skin protectant to minimize contact urine/feces

D- Other Instructions to prevent Pressure Ulcer:

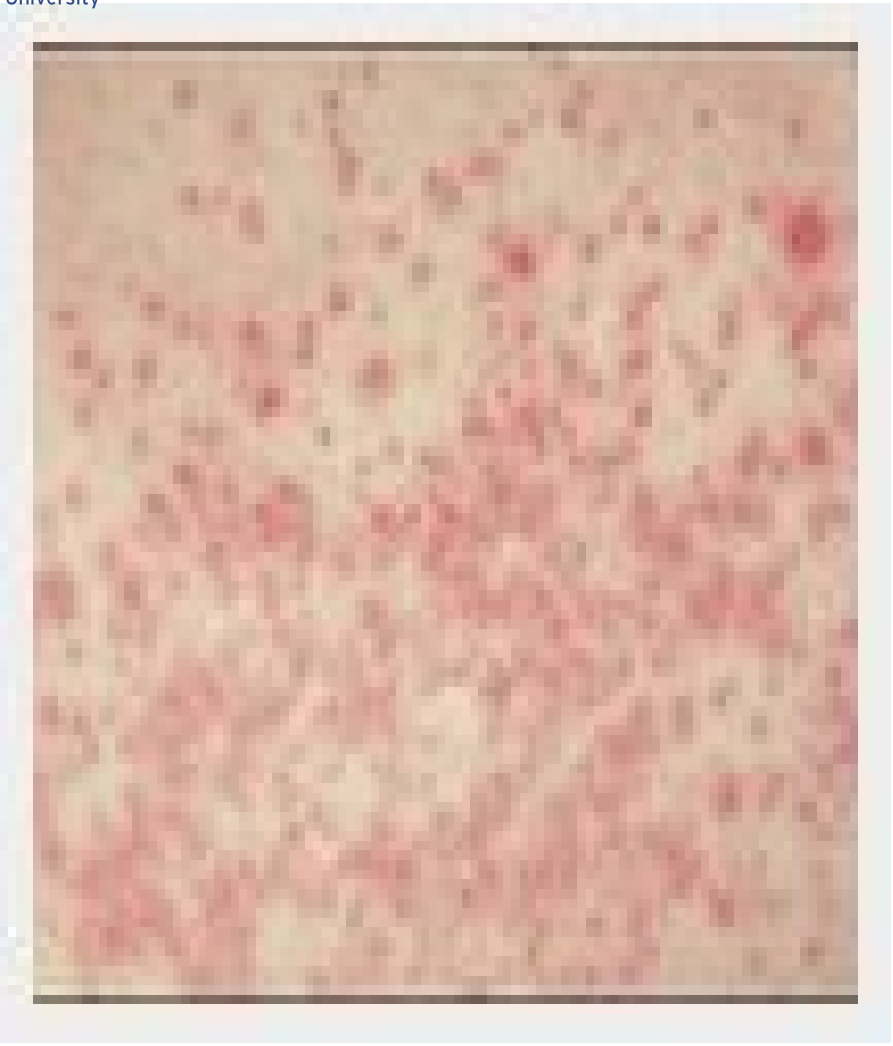
- Have the patient take a bath everyday and as needed.
- Check temperature.
- Check if sign of infection: induration, fever, erythema, edema.
- Do not use Betadine, Eosine and Alcohol.
- Use a mild lotion or skin moisturizer during daily skin care.
- Use cotton underwear and cotton socks
- Quit smoking
- Consult your doctor as needed. .
- Respect the physician prescription .
- Diet rich in protein



Donuts are for eating

Not sitting on

NO DONUT SHAPED CUSHIONS



INCONTINENCE ASSOCIATED DERMATITIS (IAD)

Incontinence-associated dermatitis is a common problem affecting as many as half of the patients with urinary or fecal incontinence who are managed with absorptive products.

TABLE 3

Recommendations for Prevention and Treatment of Incontinence-associated Dermatitis (IAD)

Condition of Skin	Treatment Goals	Interventions
Intact skin in person with urinary or fecal incontinence	Prevent IAD Minimize contact with irritants (urine, stool, and excessive moisture) Maintain skin protection Reduce barriers to appropriate care	Begin a structured skin care regimen (1) Cleanse perineal skin daily and after each major incontinence episode using a no-rinse cleanser (2) Avoid scrubbing the skin; use a soft or disposable washcloth (3) Apply an appropriate moisturizer (often a cream product containing humectant and emollient) (4) Apply a skin protectant to minimize contact between urine and/or stool [ointment containing petrolatum, zinc oxide, dimethicone, or combination of these products, or apply a copolymer film product (skin sealant) in patients judged to be at high risk for developing IAD (high-volume/high-frequency urinary or fecal incontinence, double fecal and urinary incontinence, and fecal incontinence with liquid stool)] (5) Combine steps using a product containing a cleanser plus a moisturizer with or without a skin protectant (6) Educate caregivers to apply structured skin regimen and routinely assess for IAD (7) Begin aggressive treatment program for underlying incontinence
Mild-to-moderate IAD (skin remains intact but erythema present, with or without candidiasis)	Minimize contact with irritants (urine, stool, and excessive moisture) Maintain skin protection Eradicate cutaneous candidiasis	(1) Combine a structured skin care program with active treatment of IAD (2) Routinely cleanse and moisturize the skin using the steps noted above (3) Routinely apply a skin protectant, options include: (a) an ointment containing petrolatum, zinc oxide, dimethicone, or combination of these products (b) a copolymer film product (skin sealant) (c) skin protectant ointment with active ingredients designed to promote wound healing [Balsam-Peru, castor oil, and trypsin (BCT) ointment or BCT gel] (4) Treat cutaneous candidiasis when present (5) Apply moisturizer or moisture-barrier combination product with antifungal agent (azole or allylamine) (6) Educate caregivers to apply structured skin regimen and routinely assess for resolution or progression of IAD (7) Evaluate or begin management program for underlying incontinence