Skin & Wound Care Prevention & Treatment

By Candy Houk, RN
Skin & Wound Program Manager

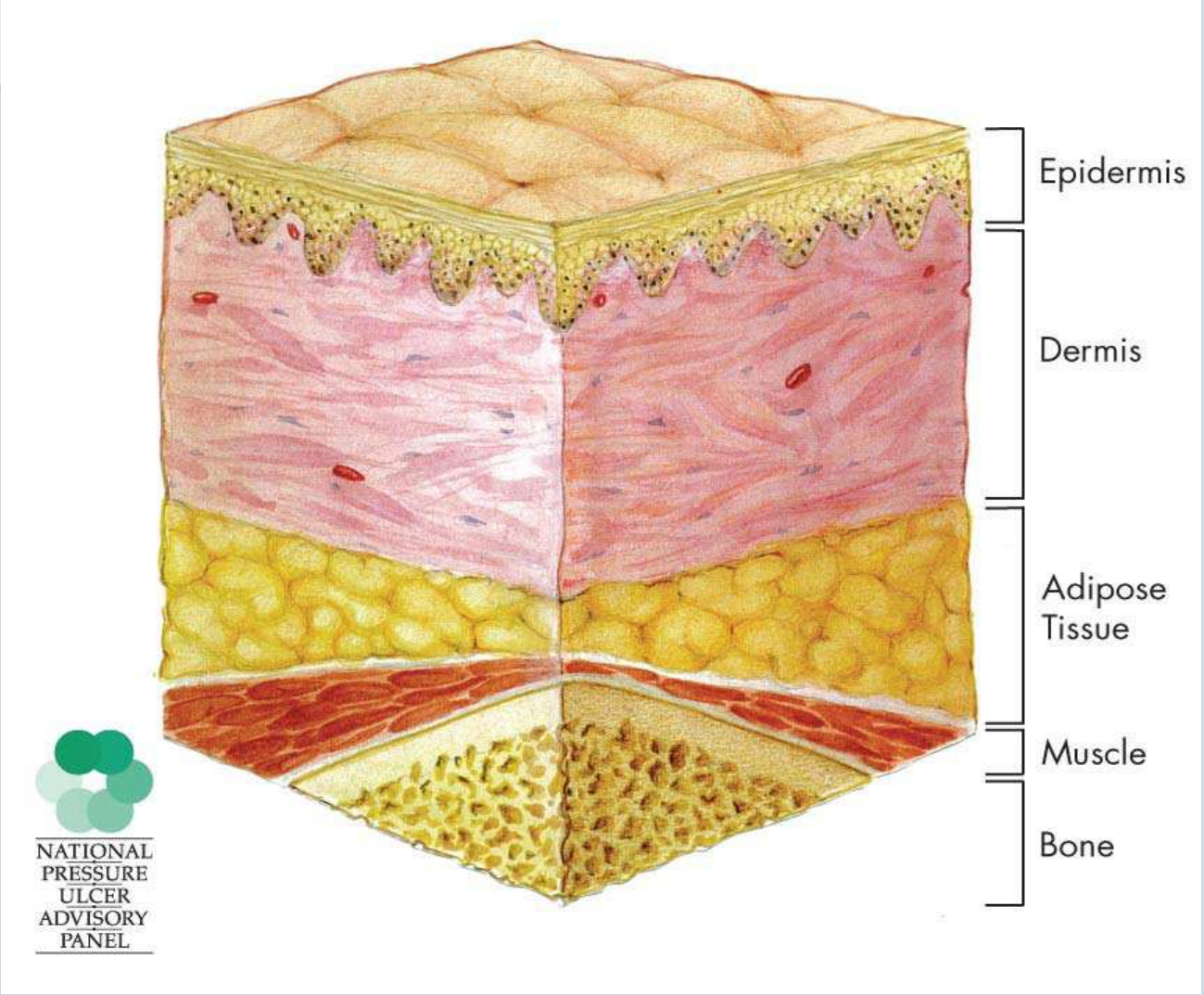
OBJECTIVES

- Classify Stage 1 and 2 pressure ulcers
- Recognize suspected Stage 3, 4, DTI, and unstageable pressure ulcers and need to obtain confirmation of staging before documentation of these ulcers.
- Recognize and implement the Wound Assessment/Dressing Documentation and Braden Score/Skin Protection Measure forms.
- Verbalize when to perform skin assessments and where to document findings.

Skin Facts

- -Skin is the largest organ in the body.
- -From birth to maturity skin undergoes about a 7-fold expansion.
- -Average adult has about 2 square meters of skin.
- -Skin weighs about 6 pounds.
- -The skin receives about 1/3 of the body's circulating blood volume.
- -Skin is capable of self generation.
- -Can withstand limited mechanical & chemical assaults.

Normal Skin


Epidermis
Dermis
Adipose Tissue
Muscle
Bone
NATIONAL PRESSURE ULCER ADVISORY PANEL

Factors altering skin characteristics

-Age

-Sun

-Hydration

-Soaps

-Nutrition

-Medications

Types of Wounds

Vascular – arterial ischemic, venous ischemic, lymphatic wounds

Neuropathic – diabetic wounds

Pressure/Friction – pressure ulcers

Surgery/Trauma –clean or contaminated

Other – anorectal fistulas, stoma-related, neoplasmic, vasculitic, inflammatory

Normal Healing

Wounding

Vascular response with platelets, fibrin meshwork, capillary dilation

Inflammation

neutrophils, macrophages

Proliferation

lymphocytes, fibroblasts, collagen deposit, granulation tissue, epithelium

Maturation

Endothelium, collagen remodeling, scar maturation

About Pressure Ulcers….

- IHI's 5 Million Lives Campaign
  "Goal is Zero"
- Most litigated ulcer
- Costly to treat
- Carry a higher mortality & morbidity
  Patients can die from pressure ulcers.
- Infection is the most common complication
- They hurt!
- Patient & family education

Prevention Prevention Prevention

The Finances of Pressure Ulcers

- **Effective Wed. Oct 1st, the cost of treating hospital acquired pressure ulcers will not be reimbursed by MediCare.**
- Cost for a full thickness pressure ulcer can be as much as $70,000. Less serious PUs can cost $2,000 – $30,000.
- The average hospital incurs direct costs of $400,000 - $700,000 annually to treat pressure ulcers.
- **Reduction in the occurence of pressure ulcers is a QVMC Strategic Goal for 2009**

What is a Pressure Ulcer?

- 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.
- The extent of injury or damage is determined by the intensity of the pressure, the duration of the pressure, and the tissue tolerence (ability to withstand the pressure).

Definitions

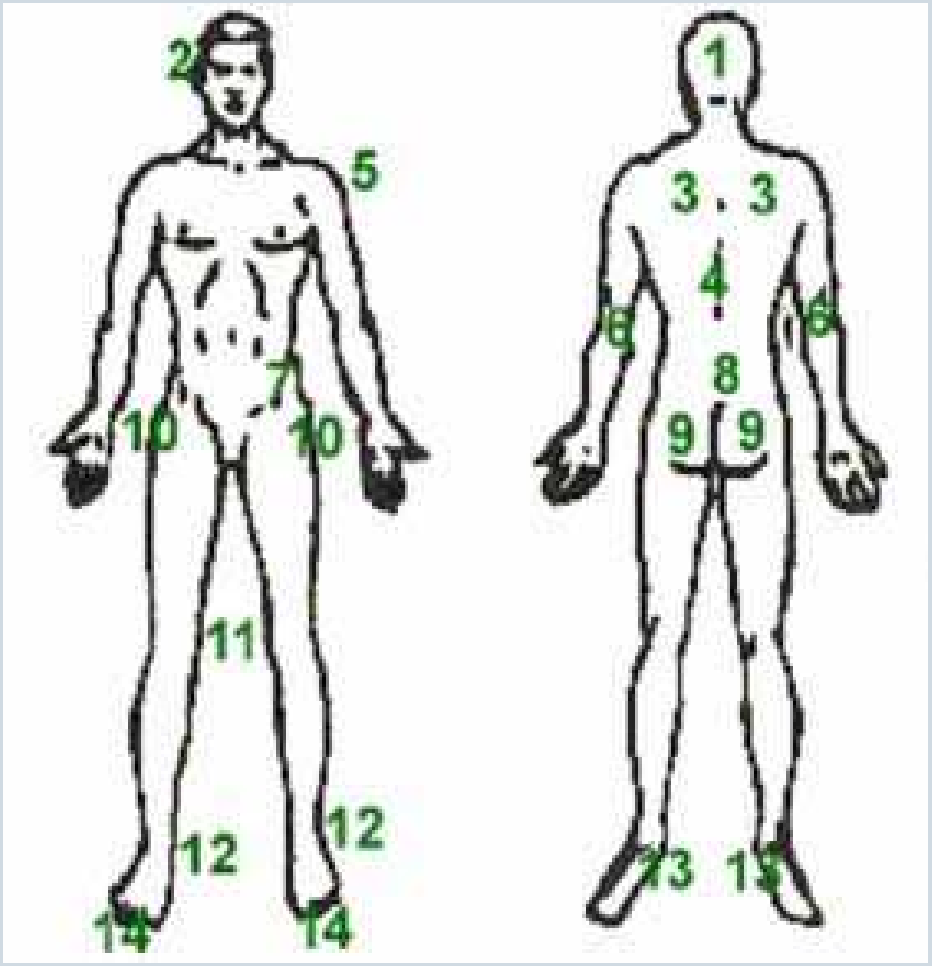
- **Pressure** - Pressure compresses underlying tissue and small blood vessels against the surface beneath. Pressure is exerted vertically. Tissues become ischemic and die.

- **Friction/ Shear** - Friction is the resistance created when one surface moves horizontally across another surface to create the tissue injury.
  - (e.g. dragging a patient across bed linen).
  - Shear occurs when one layer of tissue slides horizontally over another, deforming and disrupting blood flow (e.g. when the head of the bed is raised > 30 degrees & patient slides down in bed).

- Both require pressure exerted by the body against an external surface.

Usual Pressure Ulcer Locations

- Over Bony Prominences
- Occiput
- Ears
- Scapula
- Spinous Processes
- Shoulder
- Elbow
- Iliac Crest
- Sacrum/Coccyx
- Ischial Tuberosity
- Trochanter
- Knee
- Malleolus
- Heel
- Toes

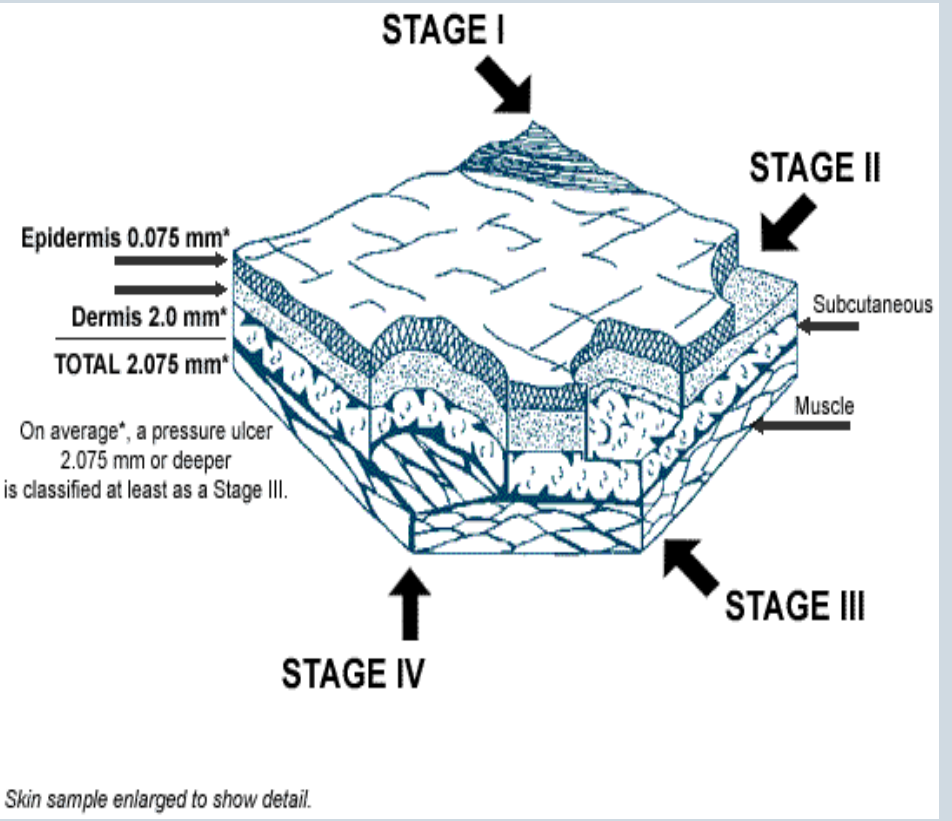


Other Pressure Ulcer Locations

- Any skin surface subjected to excess pressure examples include skin surfaces under:
  - Oxygen tubing
  - Drainage tubing
  - Casts
  - Cervical collars
  - Other medical devices
  - Teds stockings

Pressure Ulcer Staging

- Stage I
- Stage II
- Stage III
- Stage IV
- Unstageable
- Deep Tissue Injury (*considered suspected injury)*



Staging of Pressure Ulcers

- **Only** pressure ulcers are staged. Other ulcer types are not staged: diabetic, venous, etc.
- **RNs may stage pressure ulcers that are Stage 1 or 2. Any pressure ulcer suspected to be more serious than Stage 2 requires a Wound Nurse consult.**
- Accurate staging requires visualization & identification of the tissues in the wound bed.
- As the ulcer heals, it cannot be "reverse" staged because the original tissue does not regenerate, ie., a Stage 4 ulcer does not become a Stage 2. One would document "healing Stage 4 ulcer".

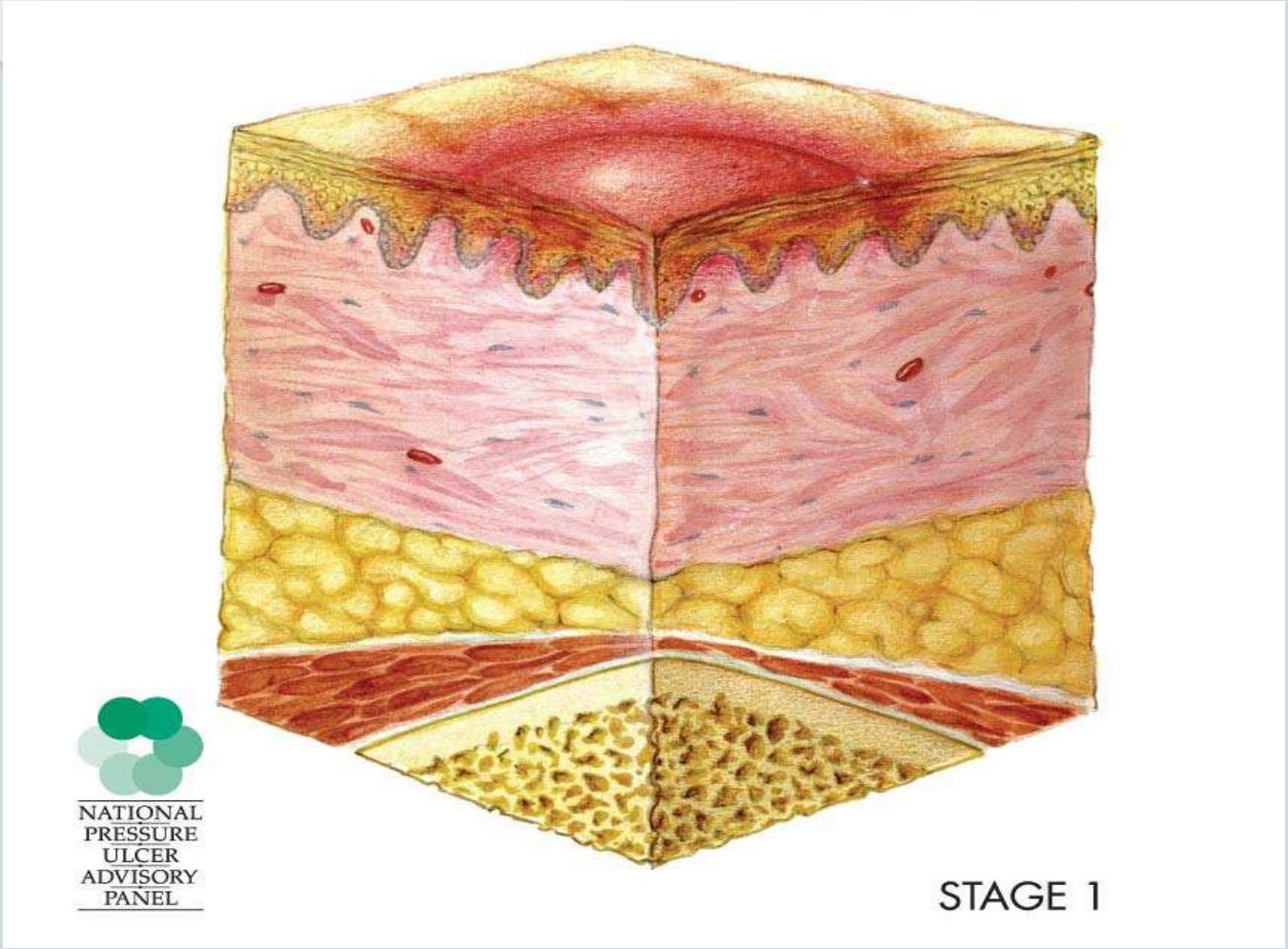
Stage I Pressure Ulcer

- **Intact skin**
  - Non-blanchable redness of a localized area
  - Usually over a bony prominence.

Darkly pigmented skin:

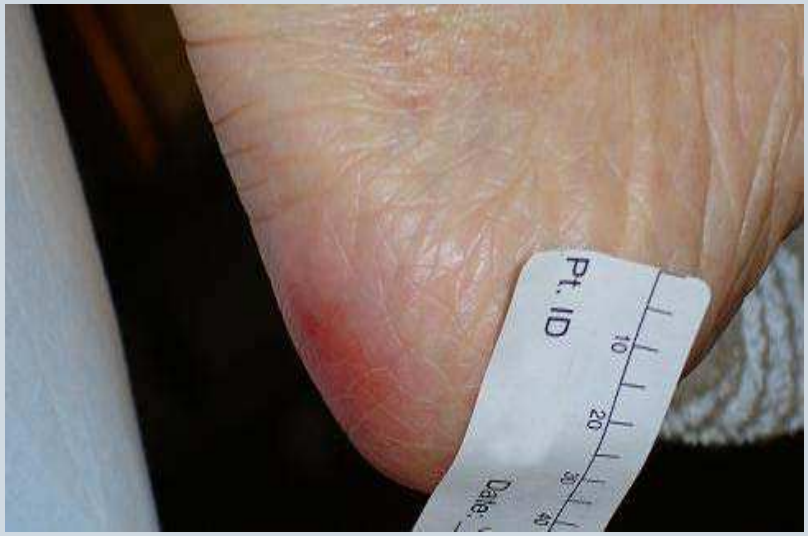
- *May not have visible blanching*
  - *Its color may differ from the surrounding area.*

Stage 1 Pressure Ulcer



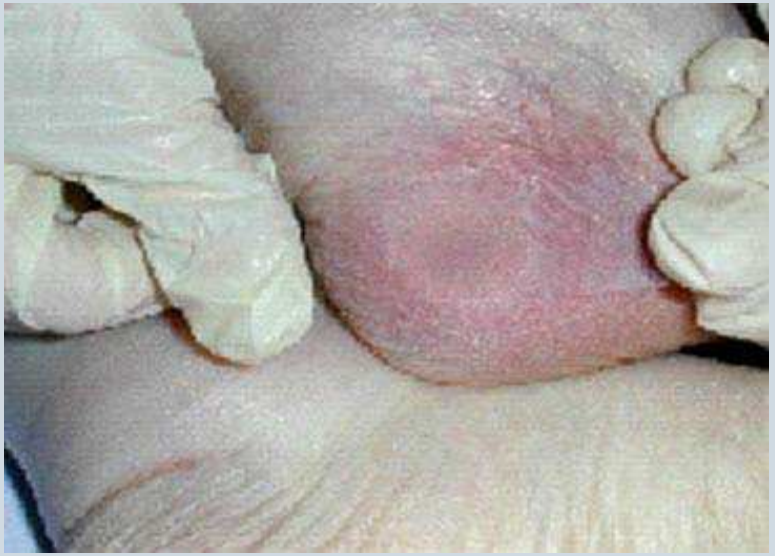
Stage I Ulcer

- A reddened area is seen on the left heel.
- The skin surface is unbroken.
- No blistering of the skin is observed.
- Skin color remains unchanged after pressure is removed



Non-Blanchable Erythema

- The ulcer appears as:
  - *defined area of redness*
  - *does not blanch*
  - *Becomes pale under applied light pressure*.

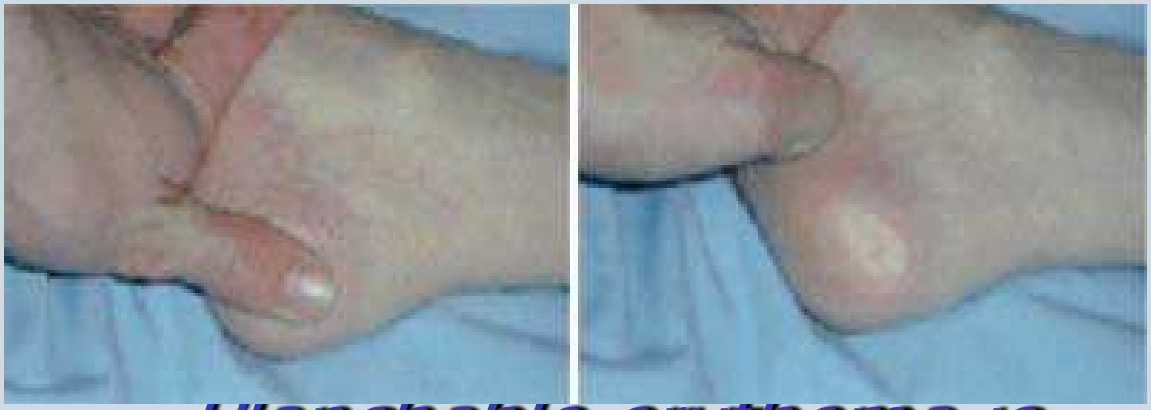


NOTE:

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

Blanchable Erythema

- Reddened area that *turns pale* under applied light pressure.

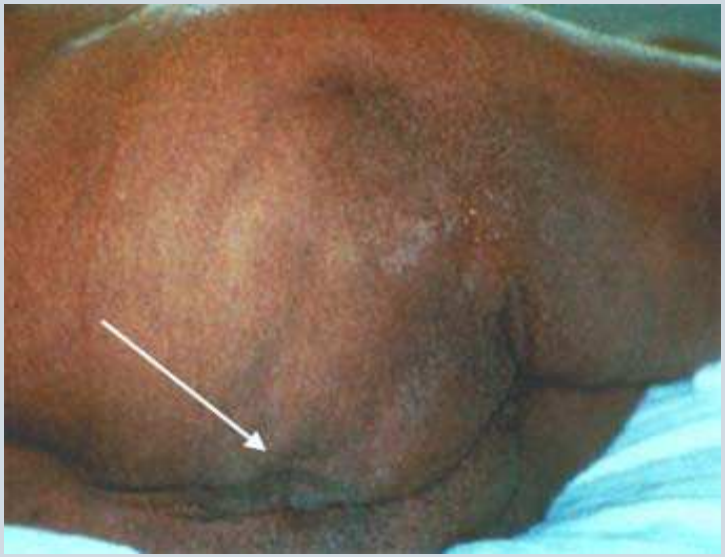


Blanchable erythema is

<u>NOT</u> a Stage I pressure ulcer.

Stage I Ulcer

- Skin color over the affected site is deeper in color than the surrounding skin.
- The skin surface is unbroken.
- The alteration in skin color persists after pressure is removed.



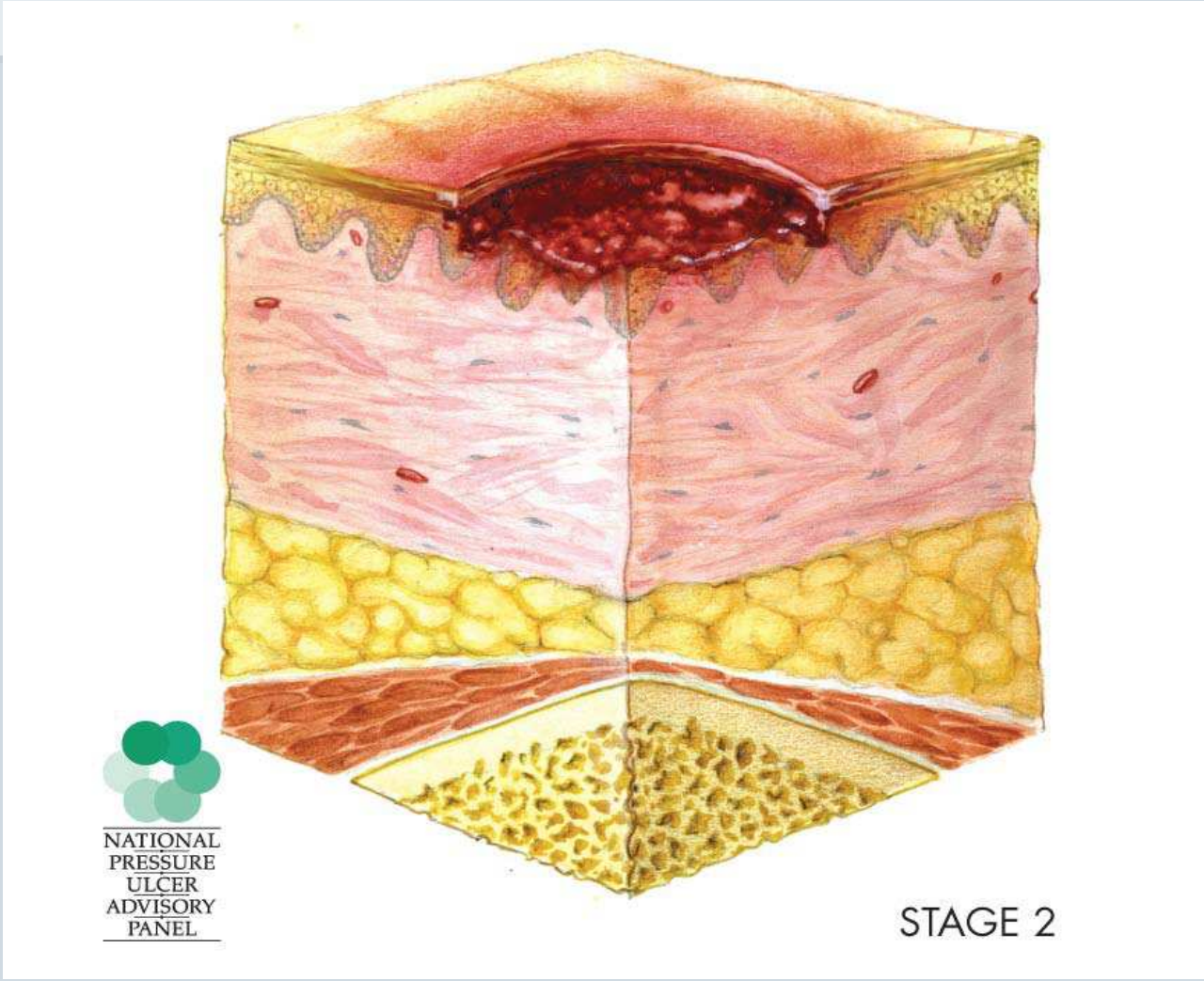
Stage II Pressure Ulcer

- Partial thickness loss of dermis

  Presents as:

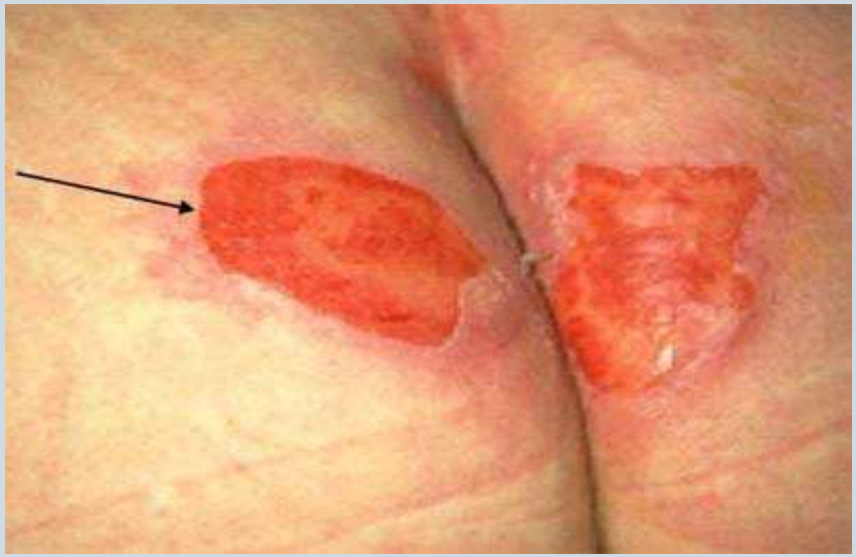
  - Shallow open ulcer
  - Red-pink wound bed
  - **Without slough**
  - Intact or ruptured/open serum-filled blister.

Stage 2 Pressure Ulcer



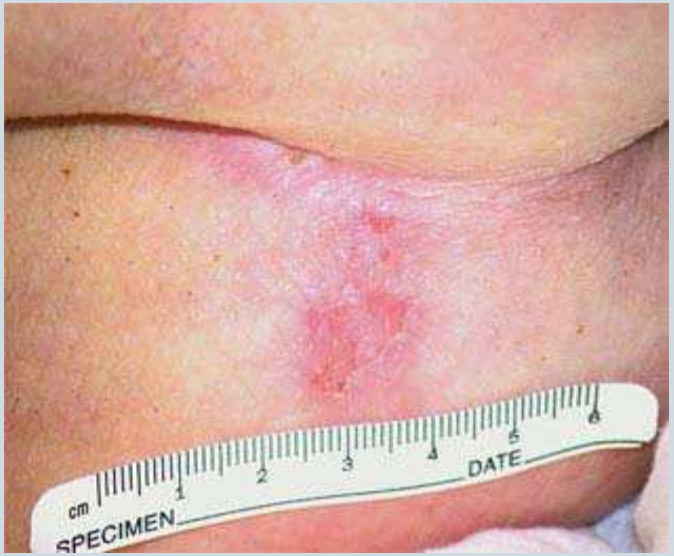
Stage II Ulcer

- This pressure ulcer is shallow with loss of dermis.



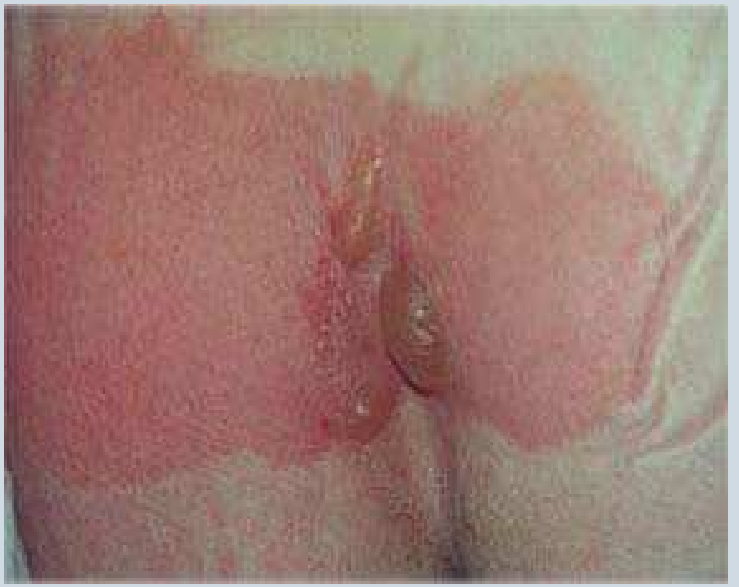
Stage II Ulcer

- This pressure ulcer is approximately 2 cm in length and 3 cm in width.
- The epidermis has been lost in several areas.
- Tissue surrounding the areas of epidermal loss are erythemic.



Stage II Ulcer

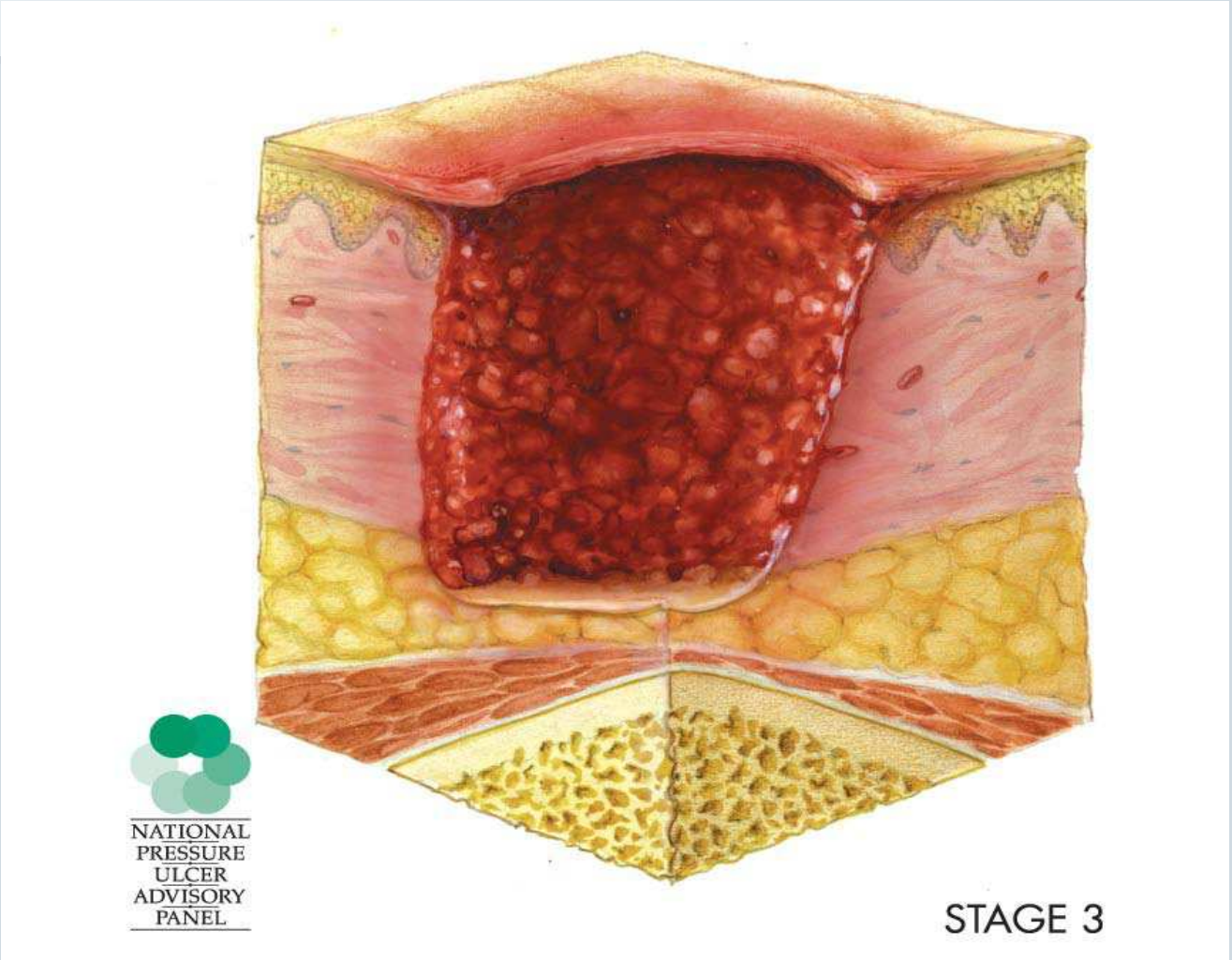
- Skin over the coccyx is reddened.
- Several intact serum blisters are located within the reddened area of skin.



Stage III Pressure Ulcer

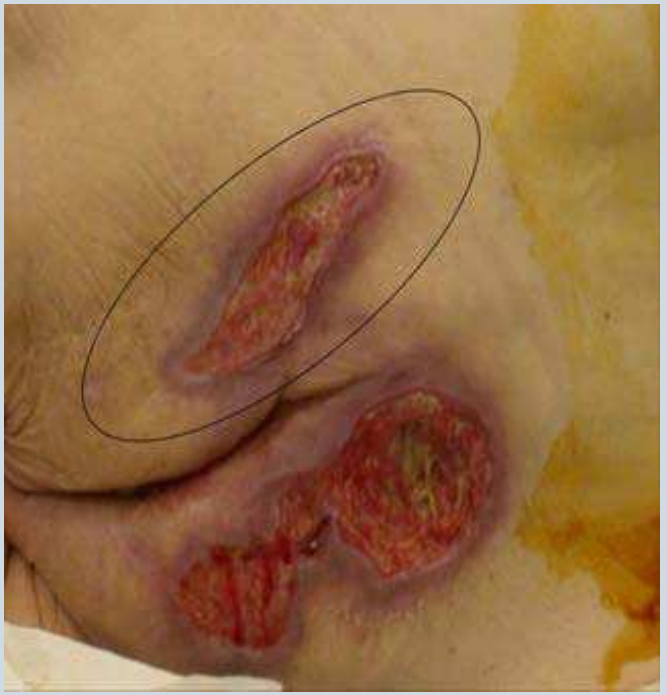
- Full thickness tissue loss.
- Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed
- Slough may be present but does not obscure the depth of tissue loss.
- May include undermining and tunneling.

Stage 3 Pressure Ulcer



Stage III Ulcer

- The circled pressure ulcer is approximately 11 cm in length and 3 cm in width.
- Subcutaneous fat is visible in the wound bed. No tendon, bone or muscle is visualized.
- Slough is present at the left proximal wound edge. The slough does not obscure the depth of tissue loss.

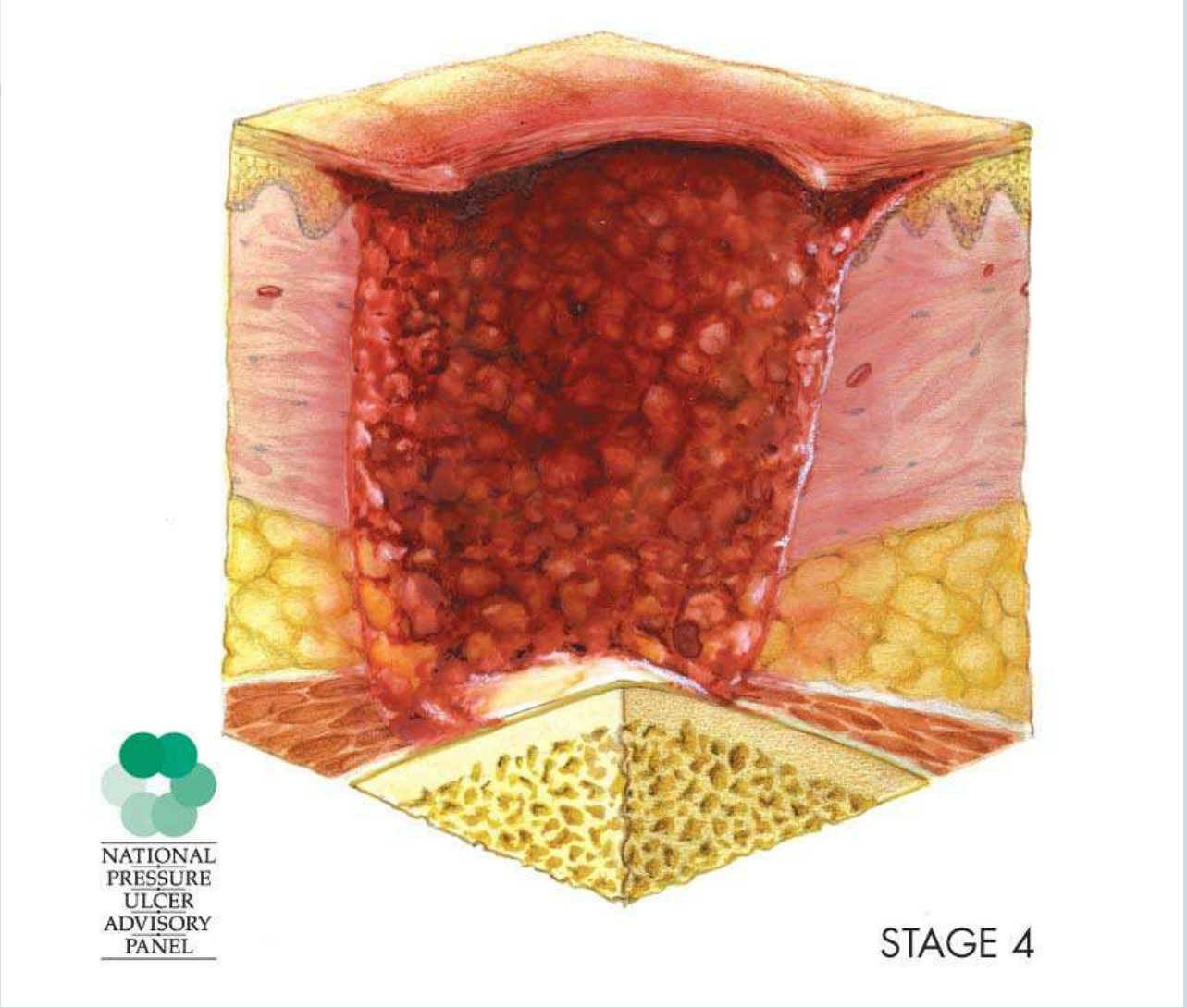


Stage IV Pressure Ulcer

- Full thickness tissue loss with exposed bone, tendon or muscle.
- Slough or eschar may be present on some parts of the wound bed.

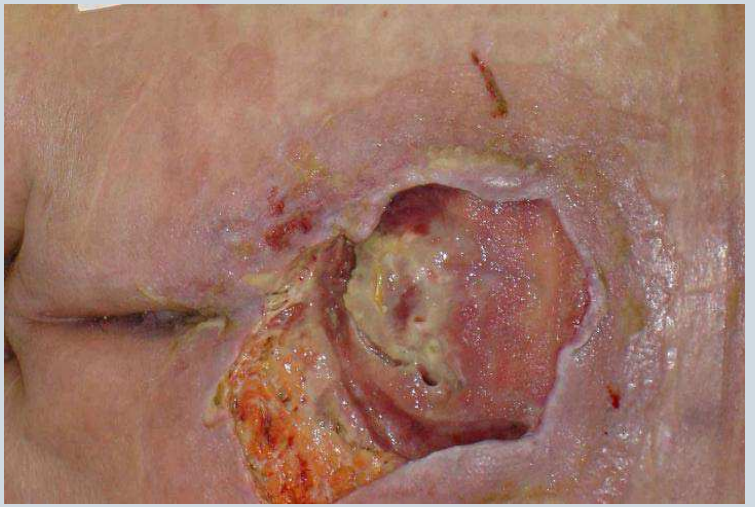
Often includes undermining and tunneling.

Stage 4 Pressure Ulcer



Stage IV Ulcer

- Pressure ulcer over the sacrum has exposed muscle tissue.
- Slough is present on parts of the wound bed.
- Undermining of the wound edge also is noted.

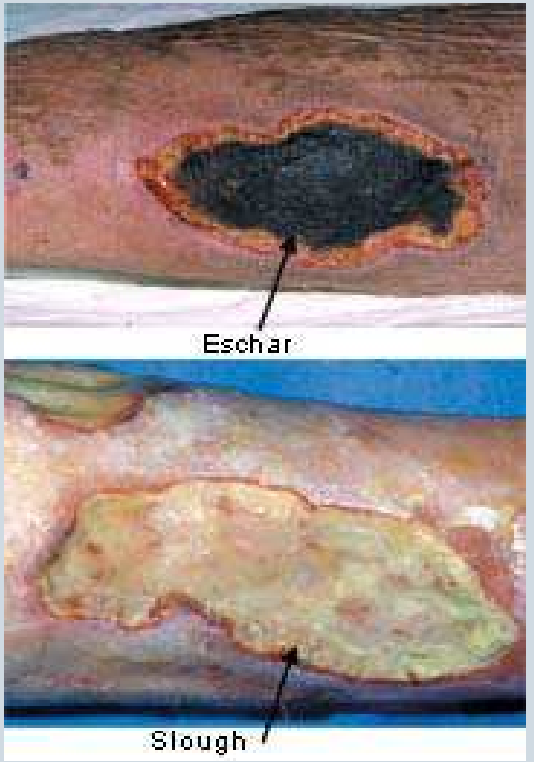


Stage IV Ulcer

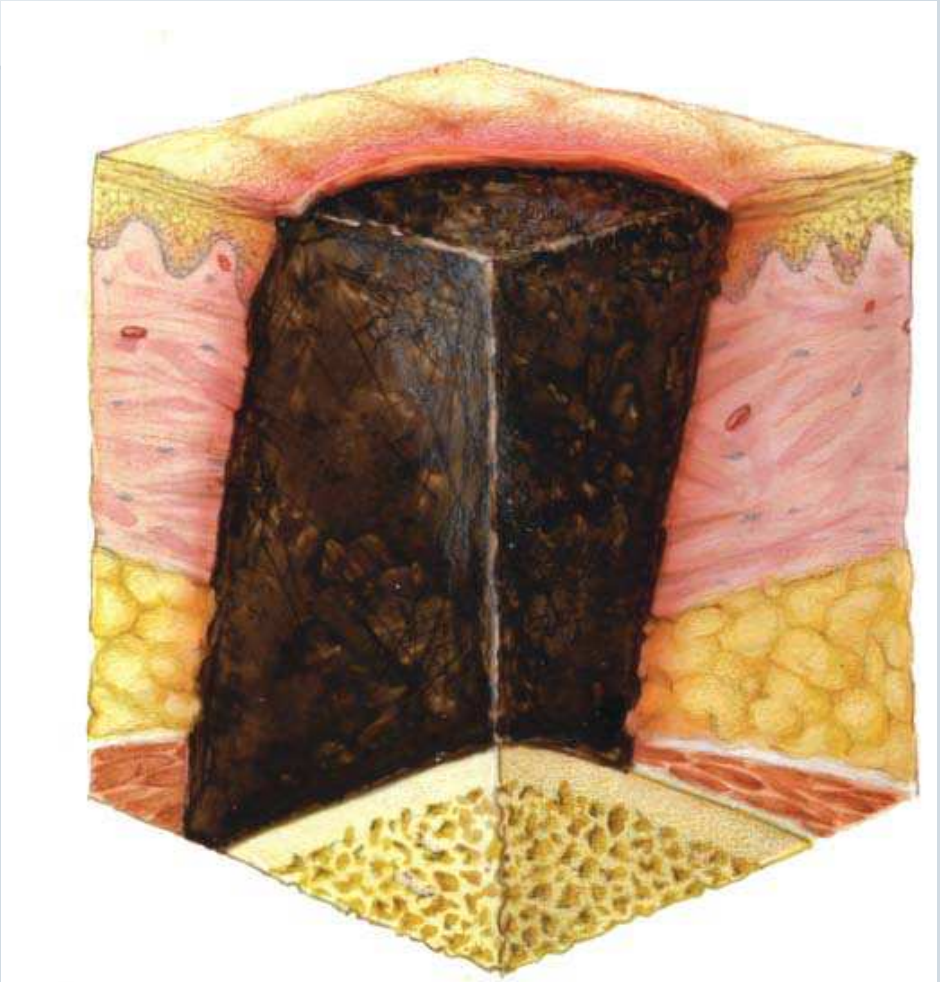
- Extensive loss of muscle tissue is noted in this very large pressure ulcer.
- The base of the wound is visible.

Unstageable Pressure Ulcer

- Full thickness tissue loss
- The base of the ulcer is covered by slough in the wound bed:
  - yellow, tan, gray, green or brown
  - and/or eschar; tan, brown or black

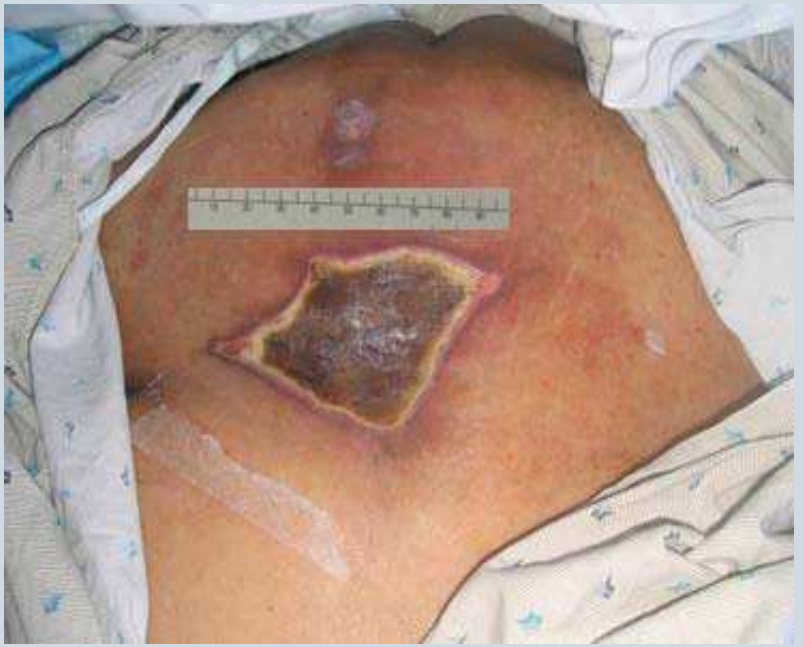


Unstageable Pressure Ulcer



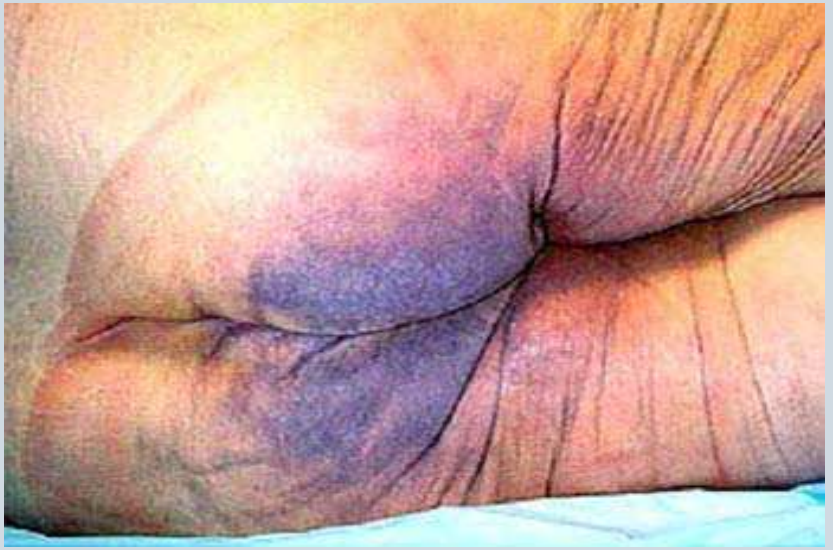
Unstageable Ulcer

- The sacralcoccyxgeal ulcer measures 6.5 cm in width and 8 cm in length.
- Eschar completely covers the wound base.



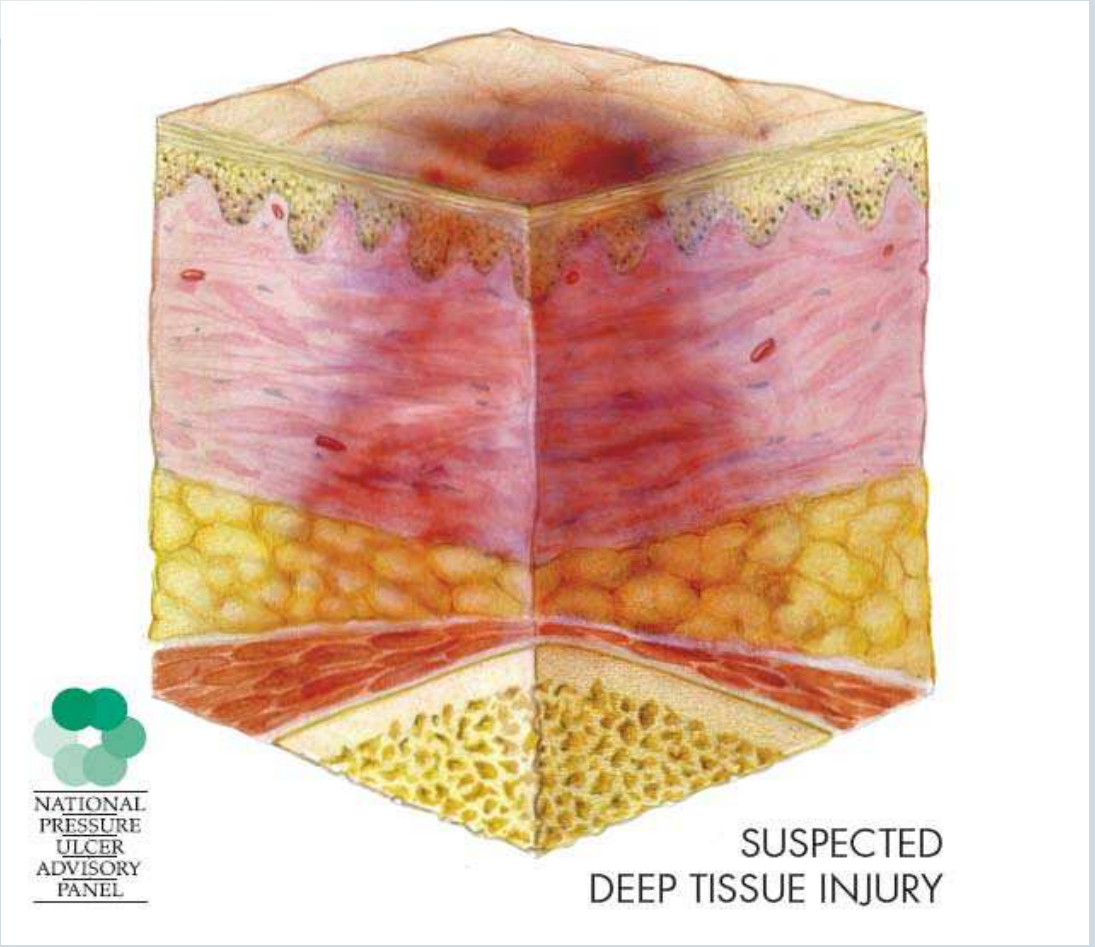
Deep Tissue Injury

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.
- The area around the DTI may be painful, firm, mushy, boggy, warmer or cooler.



The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Suspected Deep Tissue Injury

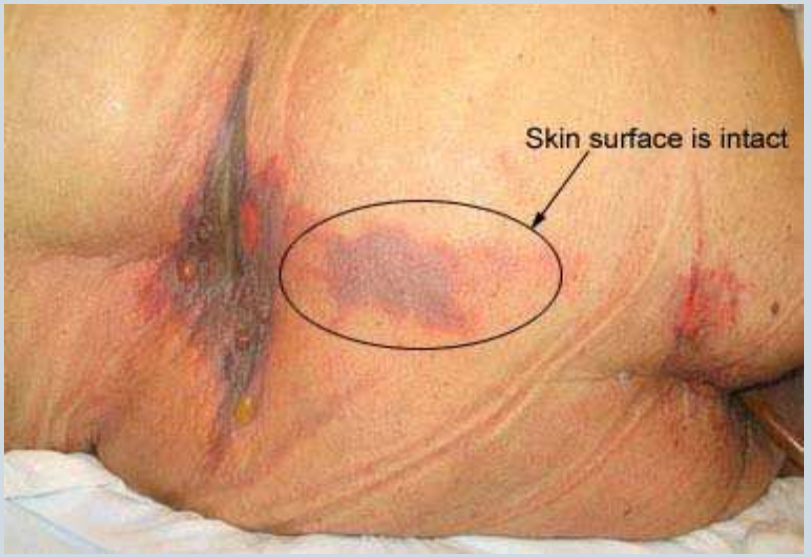


Proposed Etiology of DTI

- Pressure to the skin and soft tissue and ischemia
- Muscle injury associated with a decrease in nutrient supply
- Vasopresser use
- Injury or damage to the fascia from shearing injury or torsion of the perforating vessels

Deep Tissue Injury (DTI)
Further Description

- Difficult to detect in individuals with **dark skin tones.**
- Evolution may include a thin blister over a dark wound bed.
- The wound may further evolve and become covered by thin eschar.

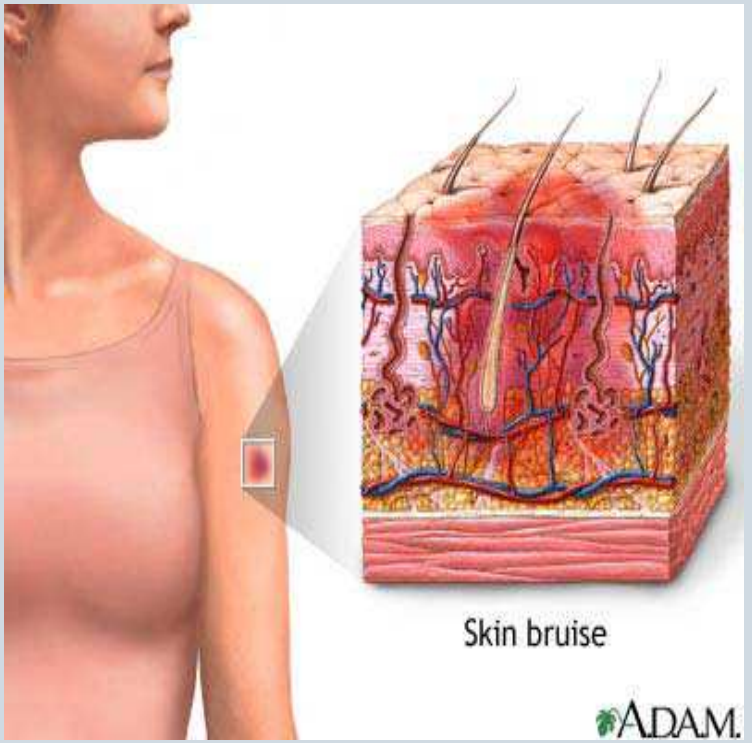


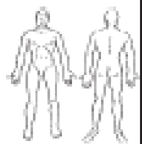
Documentation

- All patients have their skin assessed daily.
- All wounds, including pressure ulcers, are measured on admission and at least weekly on “Wound Wednesday” and documented on the “Wound Assessment/Dressing Documentation” form, including any dressing changes, **one wound per form**.
- Preventive measures: turning every 2 hours, cleansing skin, incontinence care, floating heels, moisture barrier applications are documented on the “Braden Score & Skin Protection Measures” form.
- **Any pressure ulcers present on admission must be documented on the Interdisciplinary Assessment form.**
- The POC should be updated to reflect any wound during the course of hospitalization.

Patient Assessment

- Perform initial skin assessment upon admission and complete documentation within 24 hours.
- If wound is present complete Wound Assessment Form
- Identify Pressure Ulcer
  - If suspected to be more serious than Stage 2, obtain Wound Nurse consult.
  - If it isn't noted on admission it is considered **hospital** acquired.



Wound # ______________ Location: ______________ (One wound per page) Type: ______ __________ __________ 	Date: __________ **A** Physician order for dressing: Nugauze packing Wound VAC NS Wet to Dry Wound Gel Enzymatic: Other: ________________ Other: ________________ Frequency: Supplies/Miscellaneous	Date: __________ **B** Physician order for dressing: Nugauze packing Wound VAC NS Wet to Dry Wound Gel Enzymatic: Other: ________________ Other: ________________ Frequency: Supplies/Miscellaneous	Date: __________ **C** Physician order for dressing: Nugauze packing Wound VAC NS Wet to Dry Wound Gel Enzymatic: Other: ________________ Other: ________________ Frequency: Supplies/Miscellaneous

Notify the primary physician of ALL wounds
Identify Wound Dressing by circling appropriate treatment as ordered (above) with each dressing change
Every dressing change should be documented below with identification of treatment provided –. (Fill in boxes top to bottom)

Wound Care/Dressing Change A B C Date: ______ Time: ______ Initials: ______ Notes:	Wound Care/Dressing Change A B C Date: ______ Time: ______ Initials: ______ Notes:	Wound Care/Dressing Change A B C Date: ______ Time: ______ Initials: ______ Notes:	Wound Care/Dressing Change A B C Date: ______ Time: ______ Initials: ______ Notes:
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INITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

Plan of Care: See interdisciplinary care plan in admission book , action items to include:
Wound care: ■ Dressing changes as ordered. ■ **Complete wound assessment weekly and prn wound changes(on back)**
Skin care: Initiate measures for incontinence management such as skin cleansers, skin barriers, collection devices for urine and stool as appropriate.
Pressure Ulcer Prevention: Daily action items for pressure ulcer prevention include measures to minimize friction and shear such as keeping skin dry, using lift sheets, overhead trapeze bar if appropriate. Patients with a Braden Scale 18 or less, initiate: ■ Turning schedule every 2 hours ■ Float Heel

If there are no changes in wound dimensions or wound characteristics in 2 weeks:

- **review treatment**
- **consider nutritional status, infection, bed surface, etc.**
- **Notify wound/skin care nurse at ext. 2810**

Queen of the Valley Medical Center

ST JOSEPH HEALTH SYSTEM

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WOUND ASSESSMENT / DRESSING DOCUMENTATION

Wound measurements should be completed on admission, every 7 days and prn with changes (i.e.surgical debridement, incision and drainage)

Date: __________ Length (cm): _______ Width(cm): ________ Depth (cm): ________ Tunnel(s) (cm @ _____o clock) ______ @ ________ ______ @ ________ Undermining (cm at _____o clock) ______ @ ________ ______ @ ________ ______ @ ________ ______ @ ________ Appearance: Drainage: (circle one) None Scant Moderate Copious Type/Color: (circle one) Serous Purulent Serosanguinous Odor: Yes No If applicable, Pressure Ulcer Stage ______	Date: __________ Length (cm): _______ Width(cm): ________ Depth (cm): ________ Tunnel(s) (cm @ _____o clock) ______ @ ________ ______ @ ________ Undermining (cm at _____o clock) ______ @ ________ ______ @ ________ ______ @ ________ ______ @ ________ Appearance: Drainage: (circle one) None Scant Moderate Copious Type/Color: (circle one) Serous Purulent Serosanguinous Odor: Yes No If applicable, Pressure Ulcer Stage ______	Date: __________ Length (cm): _______ Width(cm): ________ Depth (cm): ________ Tunnel(s) (cm @ _____o clock) ______ @ ________ ______ @ ________ Undermining (cm at _____o clock) ______ @ ________ ______ @ ________ ______ @ ________ ______ @ ________ Appearance: Drainage: (circle one) None Scant Moderate Copious Type/Color: (circle one) Serous Purulent Serosanguinous Odor: Yes No If applicable, Pressure Ulcer Stage ______	Date: __________ Length (cm): _______ Width(cm): ________ Depth (cm): ________ Tunnel(s) (cm @ _____o clock) ______ @ ________ ______ @ ________ Undermining (cm at _____o clock) ______ @ ________ ______ @ ________ ______ @ ________ ______ @ ________ Appearance: Drainage: (circle one) None Scant Moderate Copious Type/Color: (circle one) Serous Purulent Serosanguinous Odor: Yes No If applicable, Pressure Ulcer Stage ______
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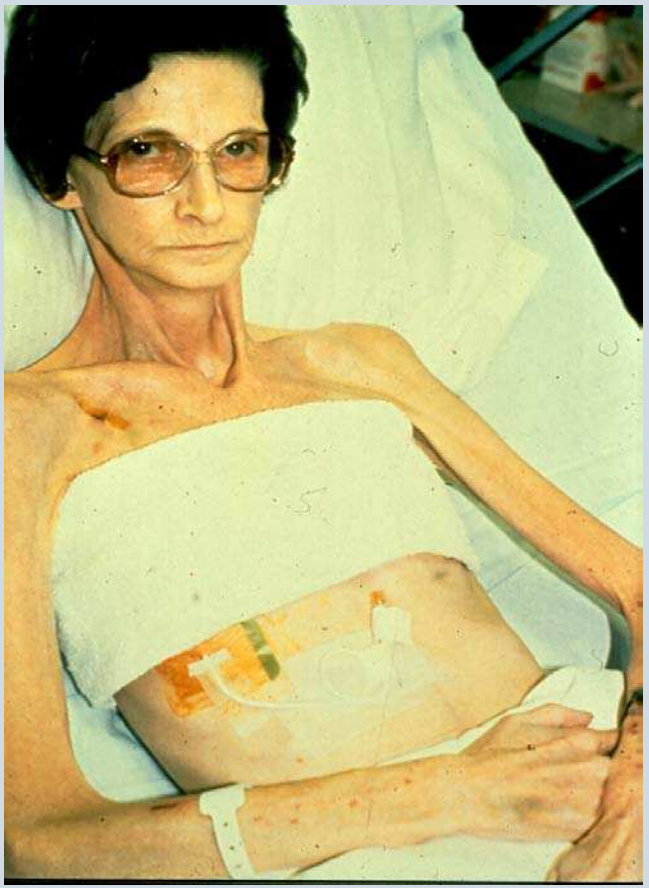
Identify Patients at High Risk (Braden Scale)

- Sensory perception-ability to respond meaningfully to pressure related discomfort.
- Frequently wet or soiled
- Mobility, ability to change & control body position
- Friction & Shear, ability to transfer self
- Poor nutritional status
  - Poorly controlled diabetes



Circle one score for each category; * Bolded Braden Scores should initiate pressure ulcer prevention measures

KEY	DATE:	DATE:	DATE:	DATE:
KEEP OFF OF ______ SIDE Position:	Moisture **Constantly moist (1)** **Very Moist (2)** **Occasionally Moist (3)** Rarely Moist (4)	Moisture **Constantly moist (1)** **Very Moist (2)** **Occasionally Moist (3)** Rarely Moist (4)	Moisture **Constantly moist (1)** **Very Moist (2)** **Occasionally Moist (3)** Rarely Moist (4)	Moisture **Constantly moist (1)** **Very Moist (2)** **Occasionally Moist (3)** Rarely Moist (4)
L=left B=back R=right O=out of bed CH=position shift in chair	Sensory Perception **Completely limited (1)** **Very Limited (2)** **Slightly limited (3)** No impairment (4)	Sensory Perception **Completely limited (1)** **Very Limited (2)** **Slightly limited (3)** No impairment (4)	Sensory Perception **Completely limited (1)** **Very Limited (2)** **Slightly limited (3)** No impairment (4)	Sensory Perception **Completely limited (1)** **Very Limited (2)** **Slightly limited (3)** No impairment (4)
Prevention Measures: H=heels floating M=moisture barrier applied R=reposition	Activity **Bedfast (1)** **Chair fast (2)** **Walks occasionally (3)** Walks frequently (4)	Activity **Bedfast (1)** **Chair fast (2)** **Walks occasionally (3)** Walks frequently (4)	Activity **Bedfast (1)** **Chair fast (2)** **Walks occasionally (3)** Walks frequently (4)	Activity **Bedfast (1)** **Chair fast (2)** **Walks occasionally (3)** Walks frequently (4)
S=skin cleansed T= scheduled toileting (every 1-2 hours) D=diet supplementation	Mobility **Completely immobile (1)** **Very limited (2)** **Slightly limited (3)** No limitations (4)	Mobility **Completely immobile (1)** **Very limited (2)** **Slightly limited (3)** No limitations (4)	Mobility **Completely immobile (1)** **Very limited (2)** **Slightly limited (3)** No limitations (4)	Mobility **Completely immobile (1)** **Very limited (2)** **Slightly limited (3)** No limitations (4)
Patient Adherence: C=Cooperative R=Refuse	Nutrition **Very Poor (1)** **Probably inadequate (2)** **Adequate (3)** Excellent (4)	Nutrition **Very Poor (1)** **Probably inadequate (2)** **Adequate (3)** Excellent (4)	Nutrition **Very Poor (1)** **Probably inadequate (2)** **Adequate (3)** Excellent (4)	Nutrition **Very Poor (1)** **Probably inadequate (2)** **Adequate (3)** Excellent (4)
Specialty Bed See Bed decision grid (low air loss , bariatric, fluidized sand)	Friction or Shear **Problem (1)** **Potential problem (2)** No apparent problem (3) TOTAL SCORE: ______	Friction or Shear **Problem (1)** **Potential problem (2)** No apparent problem (3) TOTAL SCORE: ______	Friction or Shear **Problem (1)** **Potential problem (2)** No apparent problem (3) TOTAL SCORE: ______	Friction or Shear **Problem (1)** **Potential problem (2)** No apparent problem (3) TOTAL SCORE: ______

Initiate and document pressure ulcer prevention measures on patients with Braden Score 16 or less

	07	08	09	10	11	12	07	08	09	10	11	12	07	08	09	10	11	12	07	08	09	10	11	12
Position																								
Prevention Measures																								
Adherence																								
	13	14	15	16	17	18	13	14	15	16	17	18	13	14	15	16	17	18	13	14	15	16	17	18
Position																								
Prevention Measures																								
Adherence																								
	19	20	21	22	23	24	19	20	21	22	23	24	19	20	21	22	23	24	19	20	21	22	23	24
Position																								
Prevention Measures																								
Adherence																								
	01	02	03	04	05	06	01	02	03	04	05	06	01	02	03	04	05	06	01	02	03	04	05	06
Position																								
Prevention Measures																								
Adherence																								
SPECIALTY BED																								

* Bolded Braden Scores should initiate pressure ulcer prevention measures: refer to skin care policy
* For education pertaining to pressure ulcer prevention, see Patient Education Record in Plan of Care

INITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

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BRADEN SCORE AND SKIN PROTECTION MEASURES

8700-123 (9/00)

Pressure Ulcer Treatment

- **Daily Skin Assessments:**
  - Keep skin clean and dry – manage incontinence & moisture issues
  - Address nutritional and fluid intake needs
  - NEVER position patient on the pressure ulcer or wound – use pillows or wedges for support and cushioning
  - Use the Specialty Bed Decision Grid to determine if a special mattress is indicated
  - No creases in the linen, no blue pads - use drawsheet

Pressure Ulcer Prevention

- Take action to reduce risk
  - Frequent and regular turning and repositioning
  - 2 hours in a single position while in bed
  - 1 hour if in chair
  - Maintain head at 30 degrees when side lying
  - Float heels
  - Use pillows between legs and ankles
  - Educate patient and family

Specialty Bed Decision Grid

- Turning surfaces: back, left side, right side
- Based on Braden Scale and available turning surfaces: if the patient has 2 turning surfaces without wounds, a specialty bed is not needed unless Braden Scale is < 12. (Exception: flap repairs)
- A specialty bed or mattress does not preclude the need to turn patient & address skin issues! These beds are an adjunct - not the solution.

Appendix C

SPECIALTY BED DECISION TREE

Specialty Beds are a therapy; a physician's order must be obtained prior to implementation.

Braden Score	Regular Mattress	Low airloss mattress	Bariatric Bed	Air Fluidized Therapy
Above 16	No wound is present OR Wound present and patient can be positioned off the wound	Pt of any weight has breakdown in 2 or more major turning surfaces*	Consider if The patient weighs more than 250 lbs. (114 kg)	Status post flap repair
12-16	No wound is present on major turning surface	Pt of any weight has a stage III or IV pressure ulcer	Consider if patient is larger than 250 lbs. (114 kg)	Status post flap repair
Less than 12		The patient of any weight is at risk and may or may not have a wound	Consider if the patient is larger than 250 lbs. (114 kg)	Status post flap repair

*Major Turning Surfaces are defined as:
Back (sacrum, coccyx, ischeal tuberosities) Right Side (right trochanter) Left Side (left trochanter)

Rev 4-07

Prevention! Prevention! Prevention!

- The most impactful step we can take toward achieving a higher quality of care and reducing skin management costs.

- Proactive skin care:
  - -improves staff time efficiency
  - -supply reductions
  - -improved infection control

Use of InterDry Ag

- For treatment of intertrigo-caused by moisture & friction between skin folds.
- Store in Med Room-do NOT take roll into the patient's room.
- Change every 5 days & PRN soiling
- Cleanse & inspect skin daily – reposition Interdry
- At least 5 cm of the textile must be exposed to air on at least one side.