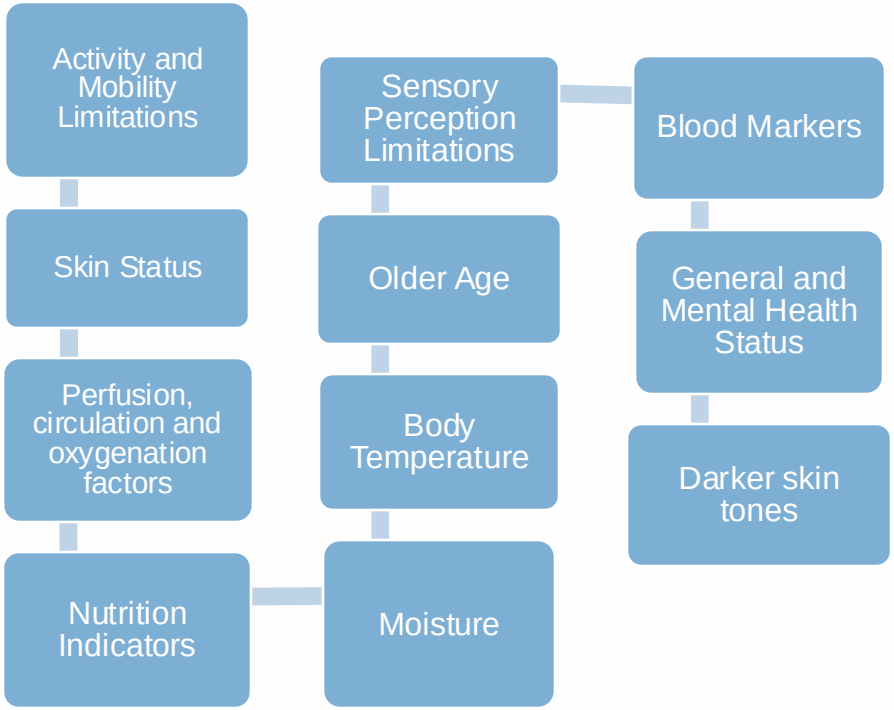
Is Preventing Pressure Ulcers/Injuries Possible?

Ann Marie Nie, PhD, MSN, FNP-BC, WOCNF

2019 International Guidelines: Step 1
Assess Patient's risk for PU/PI

- Start with risk factors
  - Does your patient have modifiable factors that the bedside clinician can influence?
    - eg: Activity/mobility, nutrition, moisture
  - Does the patient have non-modifiable risk factors?
    - Older age, sensory perception limitations, skin tone
  - Does the patient have risk factors that might be modifiable r/t current medical condition?
    - Perfusion, circulation, oxygenation factors, body temperature, blood markers



dayton children's

Other Potential Risk Factors

- Critical Care
  - Duration of critical care unit stay
  - Mechanical ventilation
  - Use of vasopressors
  - Acute Physiology and Chronic Health Evaluation (APACHE II) score.
- Operating Room
  - Time to surgery
  - Duration of surgery/anesthetic
  - Positioning/number of surgeries
- Pediatric Patients
  - Skin texture/maturity
  - Perfusion and oxygenation measures
  - Presence of medical device
  - Severity of illness
  - Length of ICU stay

Risk Assessment Tool

- Can be used in conjunction with assessing for risk factors
- The findings should inform the development and implementation of a prevention plan

- Braden Scale Score
- Norton Scale Score
- Waterlow Score
- Cubbin-Jackson Scale Score
- Braden Q and Braden QD
- Glamorgan

Understand the validity and reliability of the score before instituting it at the bedside.

The individual subscores are more important than the total score of the tool

Step 2: Conduct a Comprehensive Skin Assessment for all Hospitalized individuals

- Inspect the skin from head to toe as soon as possible following admission or transfer to the healthcare facility
- A skin assessment is part of the risk assessment
- Complete as part of the bedside nurse shift care
- Complete prior to discharge
- Pay particular attention to the skin overlying bony prominences: this includes the sacrum, heels, hip, pubis, thighs, torso and occipital.
- Assess the skin for s/s of maceration, erythema, open skin, darker skin for individuals with dark skin tones.
- Assess the skin under all medical devices as part of the routine skin assessment
- Assess the skin underneath prophylactic dressings

Steps to Assessment

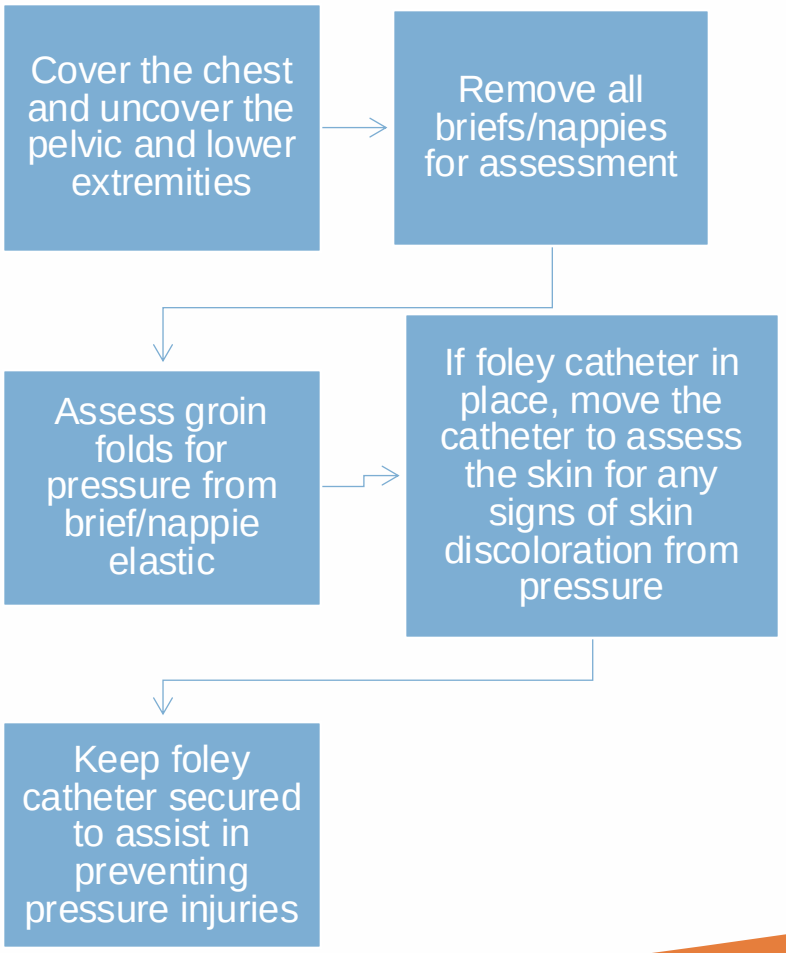
1. Overhead light is imperative; dim light creates shadows that can appear as skin discoloration
2. Obtain assistance in repositioning
3. Assess the available visible body prior to turning
4. If in a supine position, start at the head and assess bil ears, cheeks, forehead
5. Move to neck and assess trach site if one is present

- Before moving to anther body section, apply prevention measure if necessary
  - If nasogastric tube resting on the ear, move the tube and protect the ear with a Mepilex border 1.6 x 2 cm
  - If there is moisture at a trach site; older child: apply a Mepilex Lite or Mepilex foam under the trach; neonate in humidified air, apply Mepilex transfer

Assessment of chest and waist

- Remove clothing to expose only the arms, and torso
- For women, assess under bil breast for moisture and pressure
- If IV's present to the arms, assess the skin that is visible; make sure that the PIV hub is protected by foam padding
- Move any IV lines away from the medial aspect of the arms as they can cause pressure against the skin; pad the area with a Mepilex border as needed
- Assess skin under EKG leads; move as necessary
- When putting the patient in a prone positioned, move EKG leads to the back once turned
- Assess the waist for tightness from a brief/nappy
- Keep loose to prevent pressure from the elastic

Assessment of the Pelvic Region



- Assess the LE
- If a child and PIV present, assess the PIV site and pad under the IV hub with a foam dressing as needed
- Assess the bil heels by lifting them off the surface; if unable to assess due to mobility concerns, use a mirror under the heel to assess

Reposition Patient

- With assistance, move the patient to their side
- Put the top leg over the bottom let with a pillow between
- Start at the head and feel the back of the head, concentrating on the occipital ridge
- Move the hair during palpation if notice any hardness or bogginess
- If a trach is present, look under the trach at the back of the neck; with any moisture related discoloration, apply Mepilex Lite under the trach ties

Assess the patient's back and pelvic region

- Look for any linear areas of discoloration that may indicate that the patient was lying on a line/tubing or bed linen crease
- If patient was on a cooling blanket, assess the skin for a pattern that resembles the cooling blanket
- In the pelvic region, if skin discoloration is present, it is imperative to note the location and coloring
- Pressure injuries can mimic moisture associated skin damage
- If the patient has normal dark skin tones, a deep tissue may be difficult to visualize; moisturize the skin and use a good flashlight to see skin tones

Pelvic Region

- If a rectal tube is in use, lift the tube and assess the rectum for any points of pressure
- Once assessment is complete, re-apply the brief/nappy
- If the region's skin is WNL, clean and dry and apply a Mepilex border sacrum for padding that will assist in pressure injury prevention.
- If using a moisture barrier for incontinent patients, apply the Mepilex border sacrum first, then apply the moisture barrier

Lower extremity

- Assess the back of the legs and feet
- Note any skin discoloration

- If heels have noted erythema, may apply a Mepilex heel protector, elevate the heels with z-flo or apply z-flex boot as appropriate
- If the patient is to remain side-lying, elevate the heels off the bed with a z-flo fluidized positioner

Completing the Skin Assessment

- Put the patient in a different position than they were in when you first entered the room
- Use a fluidized position to elevate the coccyx off the surface
- If the head of the bed is to be at 30°, it is imperative that when the feet are raised, the coccyx is off the surface using a fluidized positioner
- Check that all medical devices have been padded for prevention as needed

Key Tips for a Skin Assessment

1. Appropriate lighting
2. Have foam dressings available to use for padding under medical devices and over bony prominences
3. Look, feel, touch any skin discoloration
4. If a pressure injury is located, document the body location, description of the wound (include measurements) and stage
5. Communicate your findings with the bedside staff and the medical team
6. Develop a treatment plan if needed

Questions