CLINICAL EDUCATION

Prevention and Early Intervention of Pressure Ulcers

CLINICAL EDUCATION

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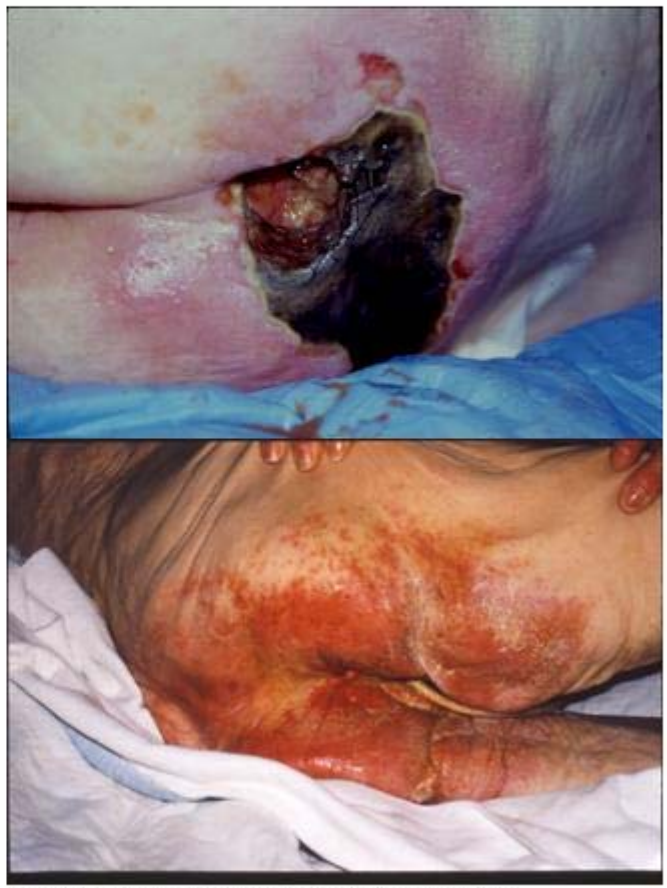
Statistics Speak…

- More than 1 million patients develop pressure ulcers each year
- Approximately 1.5 to 3 million patients are living with pressure ulcers in the U.S.[1]



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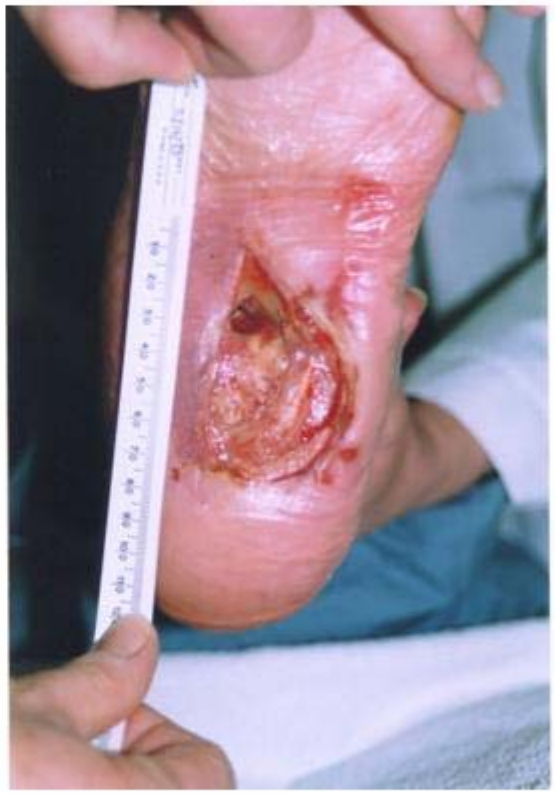
Statistics Speak…

- Estimates of the prevalence of pressure ulcers in nursing home patients range from 3 to 28 percent,[2-4] with an annual incidence of 2 to 13 percent[5]



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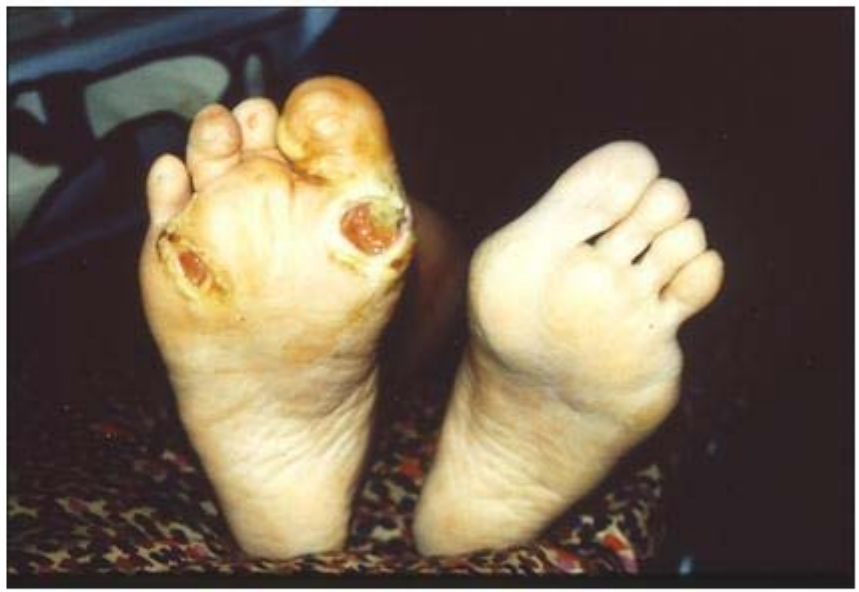
Statistics Speak…

- Pressure ulcer cost in acute care represents $2.2 to $3.6 billion to the United States Healthcare System [6]



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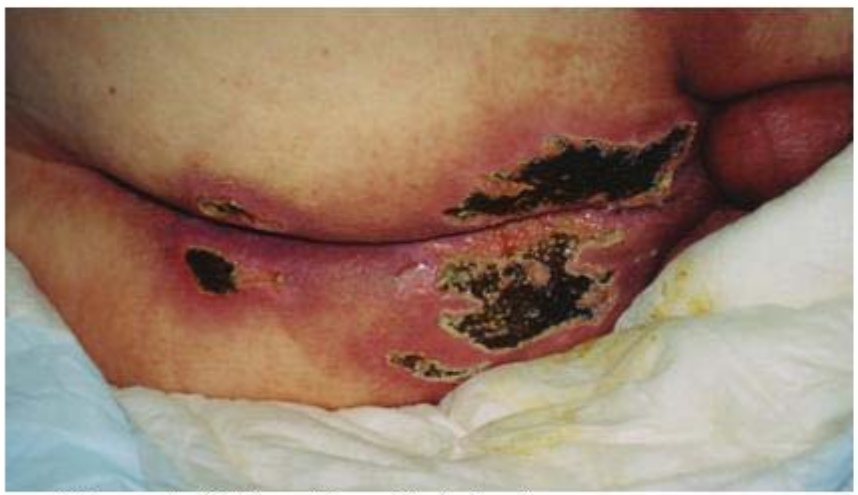
Today Statistics …



- Increased incidence rates of all wound types
- Increased litigation in all care settings
- Evidenced by published data on CMS website
- Continued staffing shortage/turnover

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Specific to Long Term Care: Focus on Quality Care

- CMS Regulations: Revised in November 2004
- Understanding the regulations surrounding wound care is paramount
- Number of regulations/F-tags that must be considered and reviewed

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Focus on Quality Care Federal Regulations, Guidance to Surveyors, and Survey Protocols

- F-tags relevant to wound care include:
  - F272: Comprehensive Assessments:
    - (xii): Skin Condition
  - F309: Quality of Care
  - F325, 326, 327: Nutrition
  - F431: Labeling of drugs and biologics
  - F441: Infection Control
  - F514: Clinical Records
  - **F314: Pressure Sores**

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Focus on Quality Care

F314: Pressure Sores

Based on the comprehensive assessment of a resident, the facility must ensure that:

- A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrated that they were unavoidable; and
- A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing

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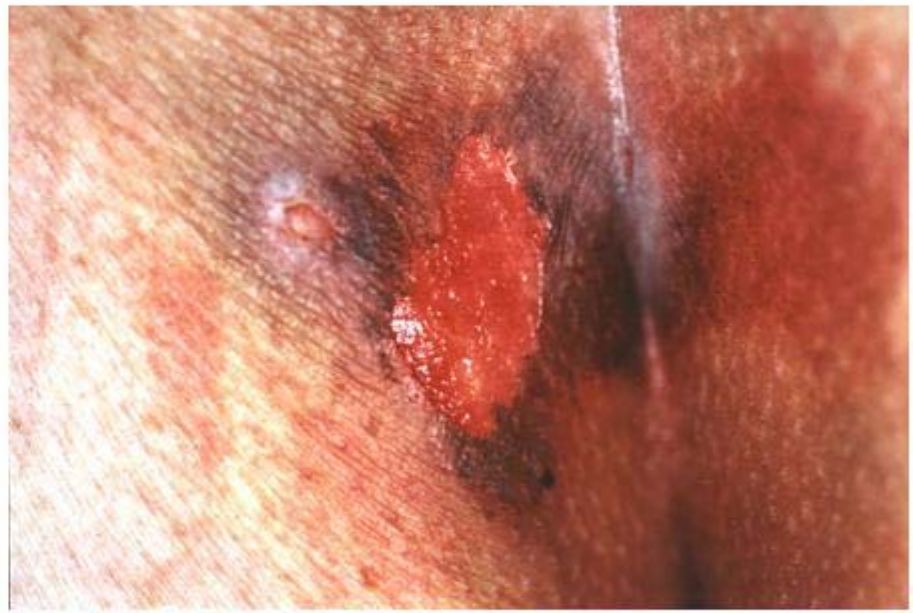
Pressure Ulcer: Staging

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstagable



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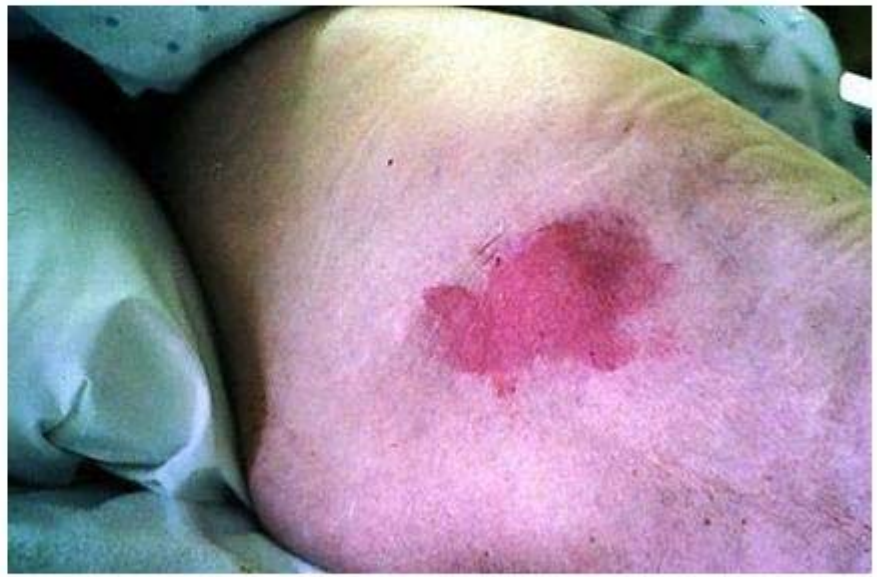
Pressure Ulcer: Stage 1

- Nonblanchable erythema of intact skin



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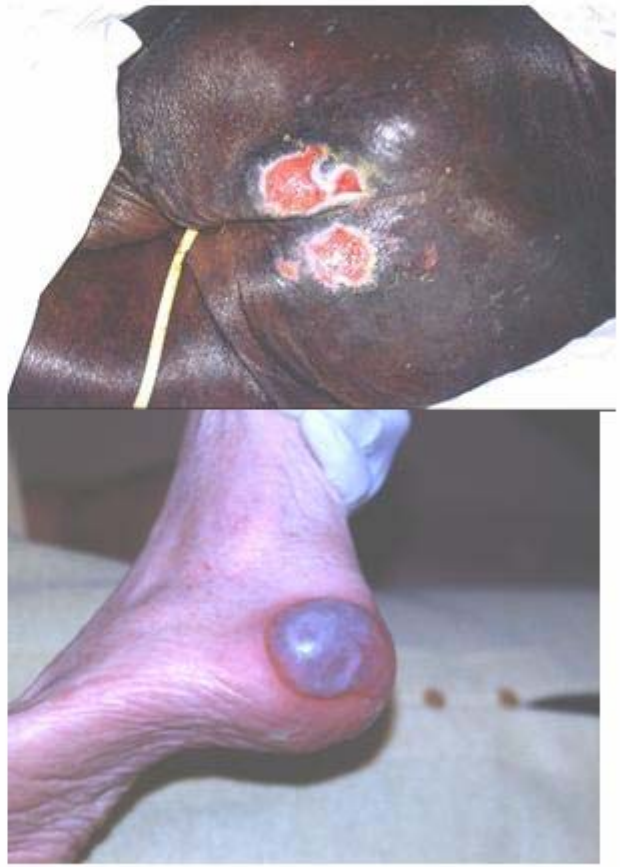
Pressure Ulcer: Stage 2

- Partial thickness skin loss
- Ulcer is superficial and presents as an abrasion, blister, or shallow crater



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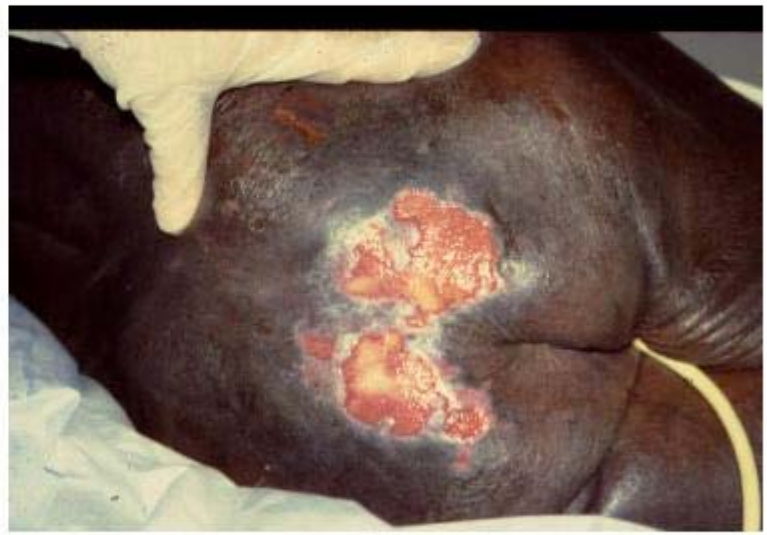
Pressure Ulcer: Stage 3

- Full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia



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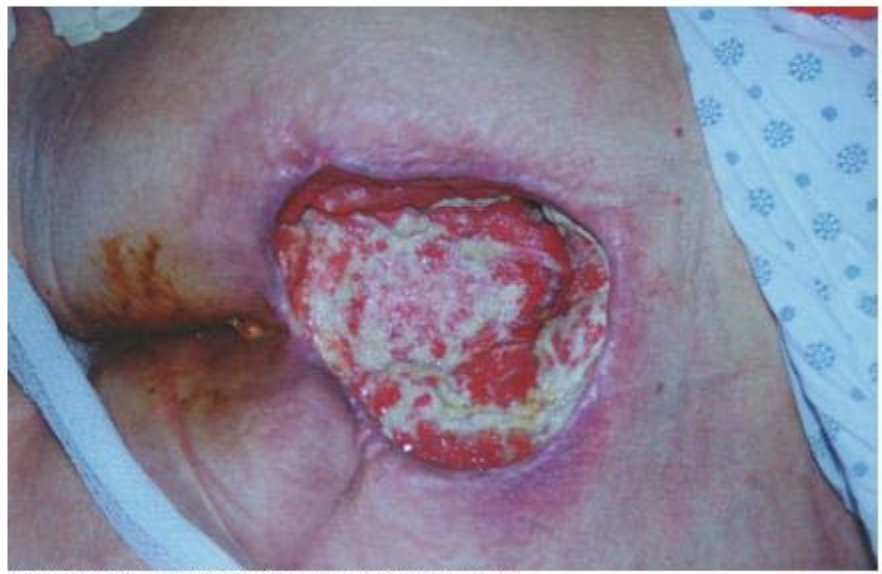
Pressure Ulcer: Stage 4

- Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or support structures (such as a tendon or joint capsule)



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Develop an Action Plan…

- Risk Assessment Tools and Risk Factors
- Skin Care and Early Treatment
- Mechanical Loading and Support Surfaces
- Education

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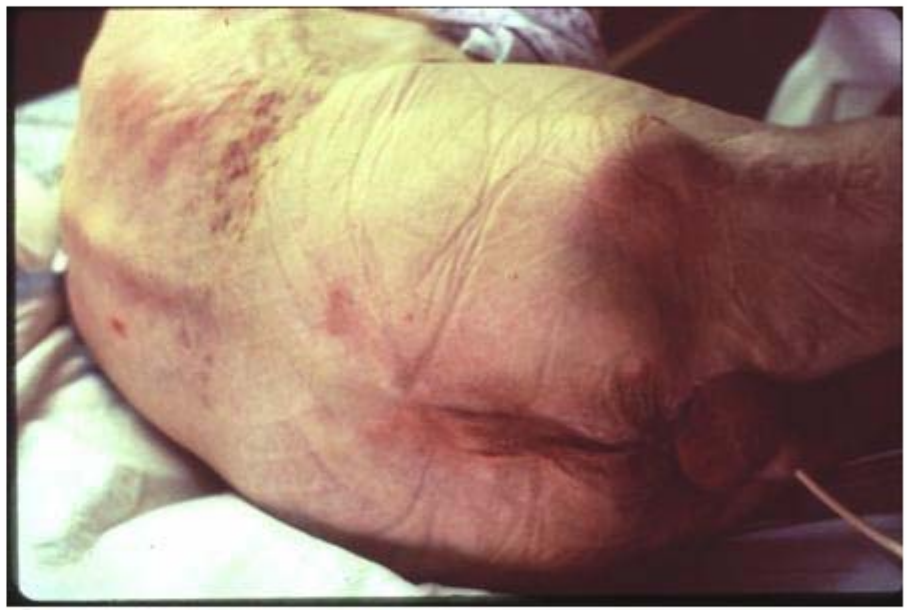
Risk Assessment

- Choose a validated risk assessment tool
- Risk assessment on admission
- Reevaluate the patient regularly and with each significant change in the patient's condition



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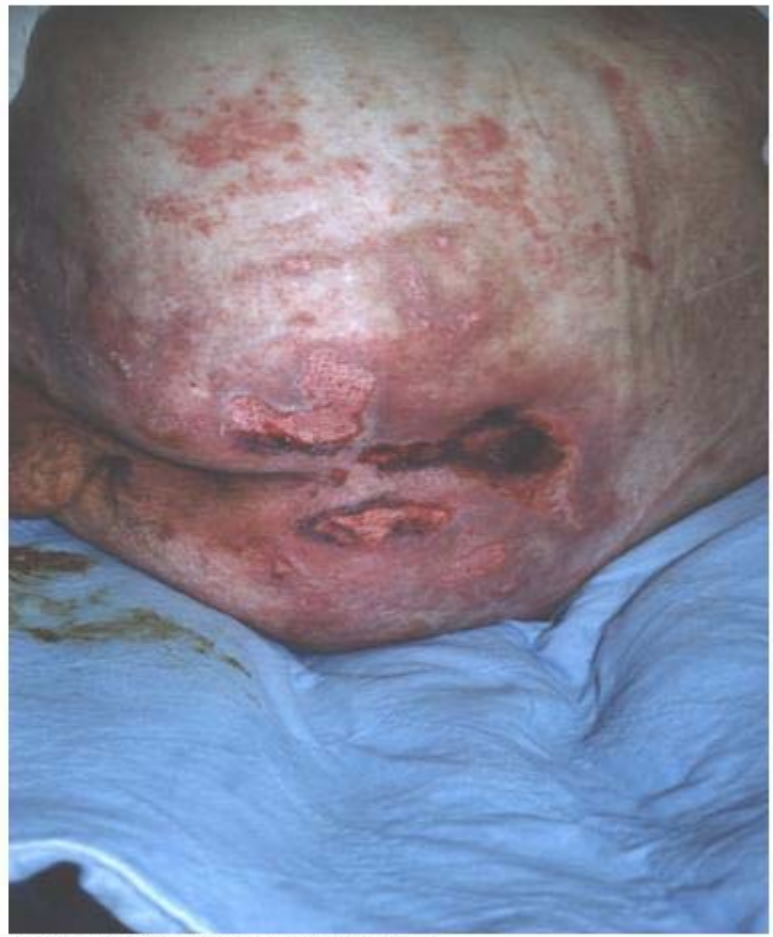
Patient's at-risk…

- Bed and chair-bound patients
- Patient's with:
  - Immobility
  - Incontinence
  - Impaired nutritional status
  - Altered level of consciousness



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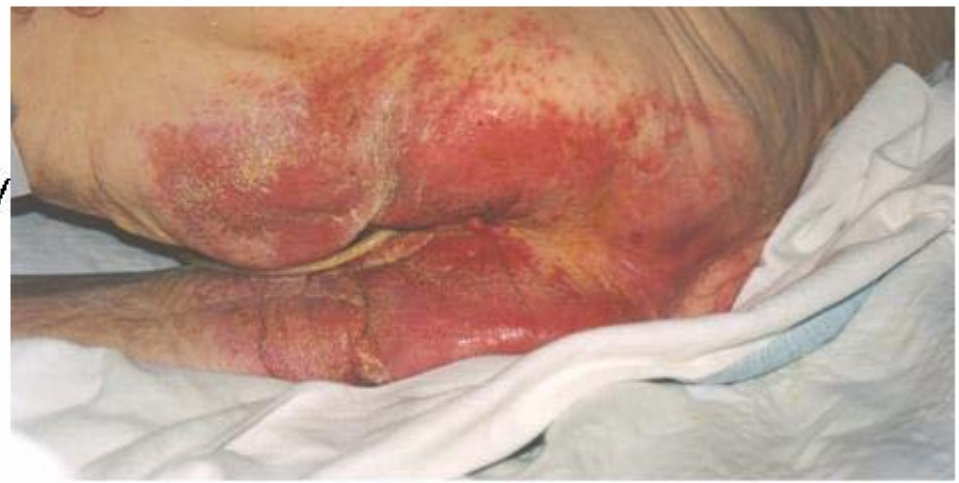
Risk Assessment Schedule

Acute care:

- Assessment on admission
- Re-assess at least every 48 hours and/or if the patient's condition changes or deteriorates



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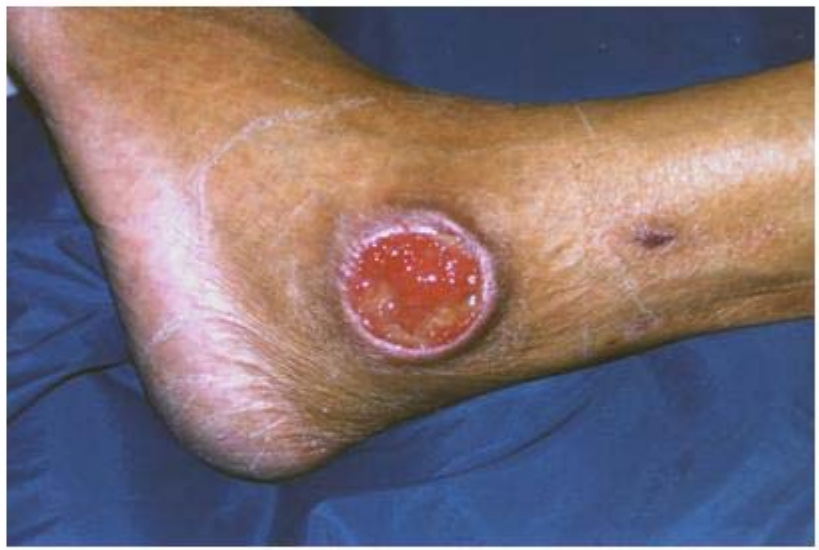
Risk Assessment Schedule

Home care:

- Assessment on first visit
- Re-assess every visit



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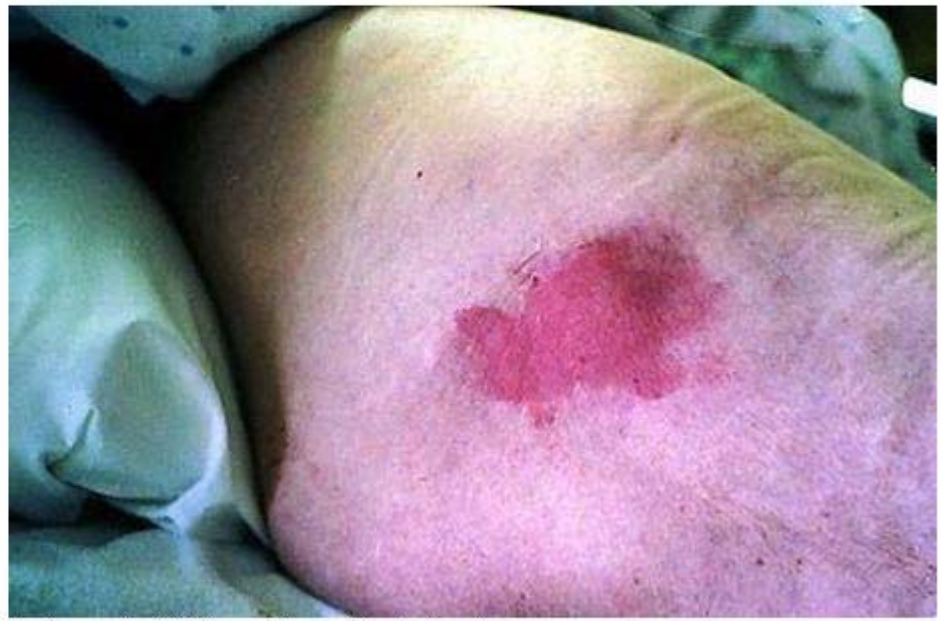
Risk Assessment Schedule

Long-term care:

- Assessment on admission
- Re-assess weekly, or sooner - first four weeks then quarterly and/or if the patient's condition changes or deteriorates



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Develop an Action Plan…

- Risk Assessment Tools and Risk Factors
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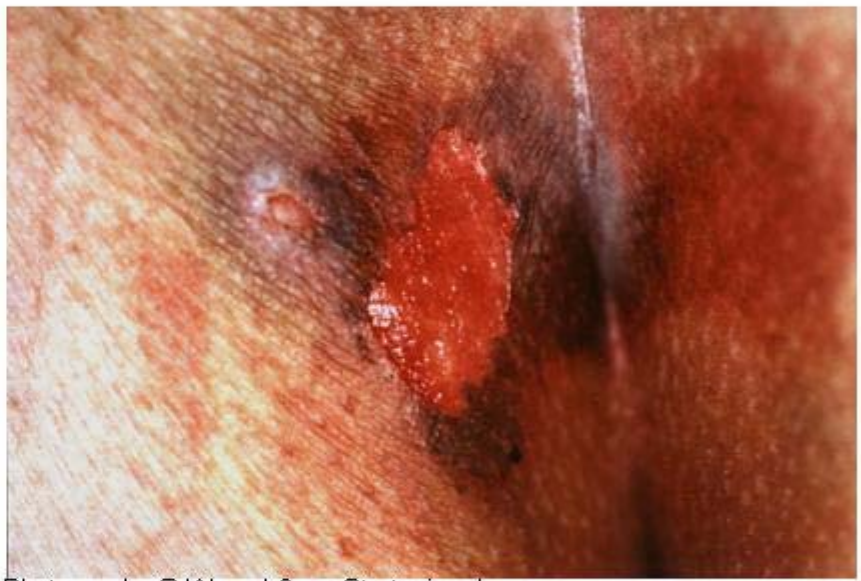
Develop Strategies to…

- Maintain intact skin
- Prevent complications
- Identify and manage complications
- Involve patient/caregiver in self-management



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Consistency counts…

In all settings:

- Identify high risk patients
- Assess for history of pressure ulcers
- Inspect bony prominences daily
- Perform nutritional assessment initially, routinely and with each change in condition
- Assess and monitor pressure ulcers with each dressing change
- Assess for impediments to the healing status (i.e. osteomyelitis, fistula formation, etc.)
- Assess and evaluate healing

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Consistency counts…

- Avoid dry skin; moisturize skin
- Minimize exposure to moisture
- Minimize friction and shear forces through proper turning/positioning and transferring of patient
- Document and monitor interventions and outcomes

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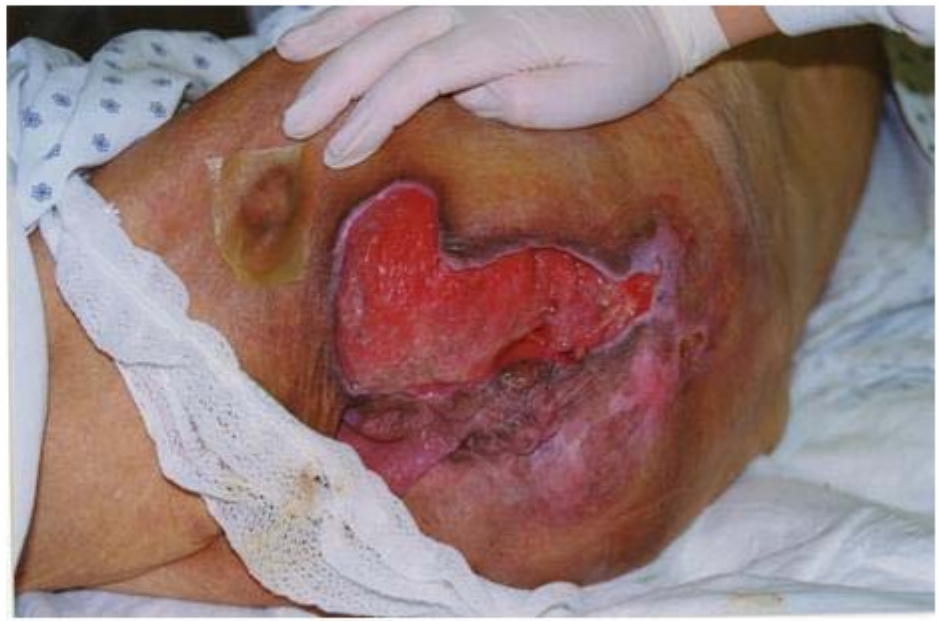
Consistency counts…

- Reposition and turn patients with normal circulatory capacity at least every 2 hours. A written schedule should be used
- Use positioning devices to avoid placing patient on an ulcer or area at risk



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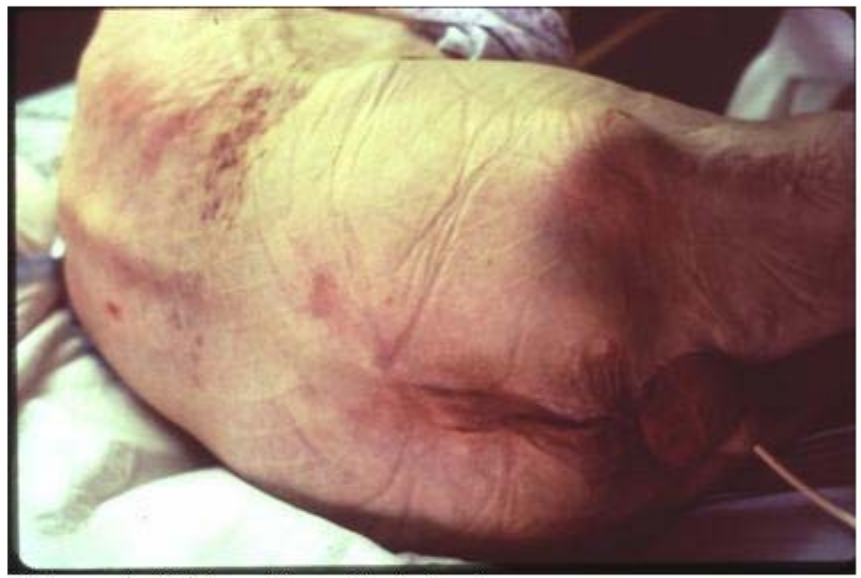
Consistency counts…

- For immobile individuals, use devices that totally relieve pressure on the heels
- Do not use donut-type devices
- For bed-bound patients, protect bony prominences



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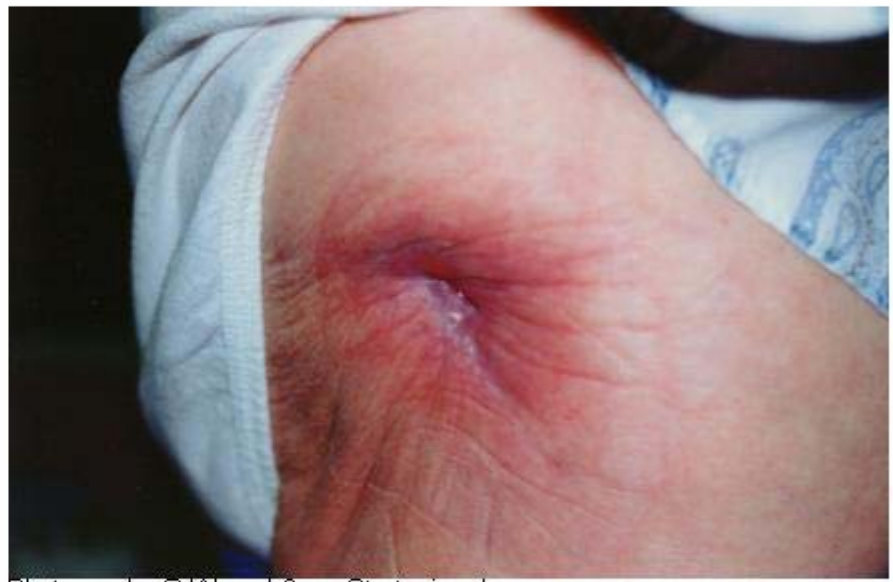
Consistency counts…

- Avoid positioning directly on the trochanter
- Keep the head of the bed at the lowest degree of elevation
- Use lifting devices such as a trapeze or bed linen to move individuals in bed



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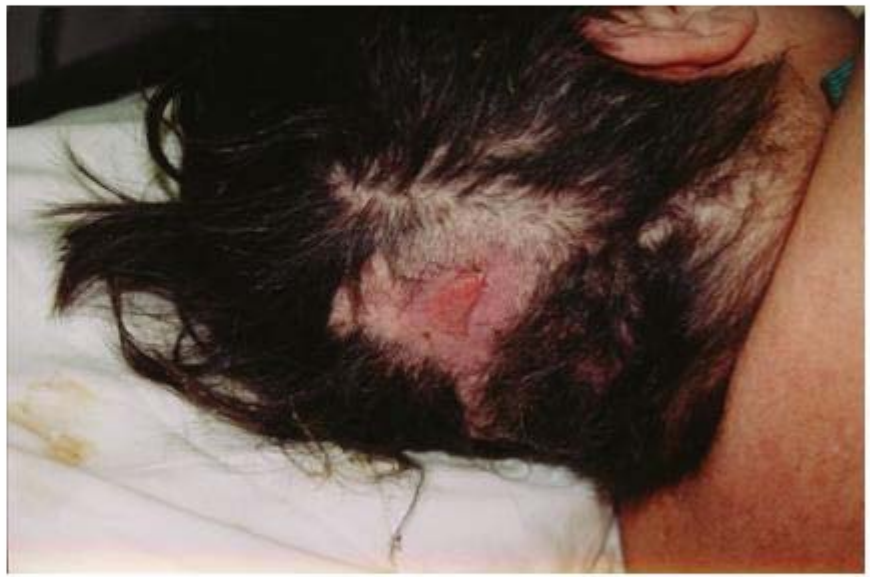
Consistency counts…

- At risk patients should be placed on a pressure-reducing device
- At risk patients sitting in a chair or wheelchair should be taught to reposition every hour and shift body weight every 15 minutes



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Develop an Action Plan…

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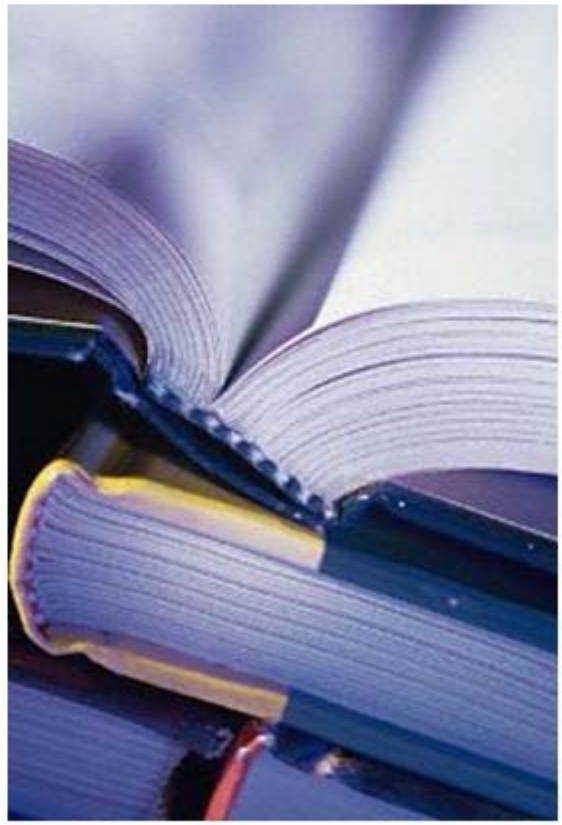
Consistency counts…

- Educate the patient and/or caregiver on the causes and risk factors for pressure ulcer development and how to minimize risks



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Consistency counts…

- Education for the patient and/or caregiver should include:
  - Etiology and risk factors
  - Risk assessment tools and their application
  - Skin assessment
  - Selection and use of support surfaces
  - Development and implementation of proper skin care programs
  - Demonstration of positioning to decrease tissue breakdown
  - Instruction on accurate documentation
- Reassess knowledge periodically

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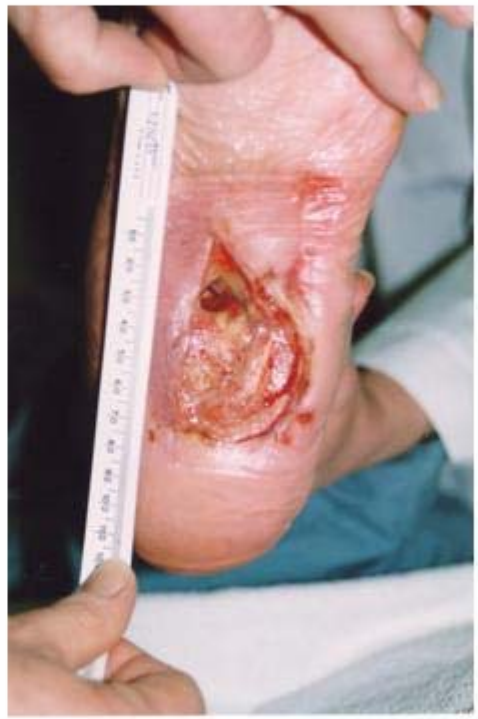
Simple Steps to Start…

- Assess and determine patients skin care needs
- Implement a risk assessment tool
- Determine support surface to be utilized



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Simple Steps to Start…

- Develop a skin care formulary to maintain or improve the patient's skin integrity
- Incorporate a multi-disciplinary skin care team to evaluate the patient on admission and periodically thereafter
- Assess and reassess the degree of malnutrition associated with the patient's age, weight, intake and lab values

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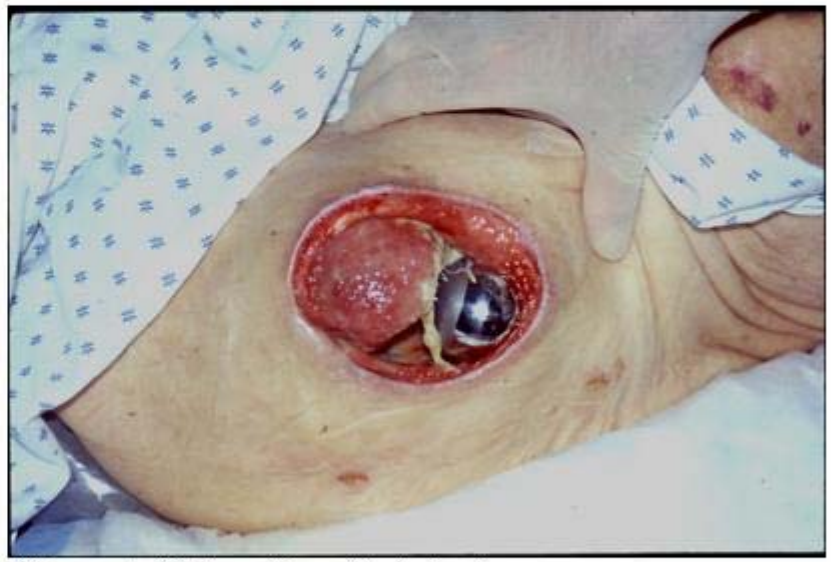
Implement Interventions…

- Maintain head of bed at, or below, 30 degrees or at the lowest degree of elevation consistent with the patient's medical condition
- Turn and position patients at least every 2-4 hours on a pressure-reducing mattress or at least every 2 hours on a non-pressure reducing mattress
- Reposition chair-bound individuals every hour if they cannot perform pressure-relief exercises every 15 minutes



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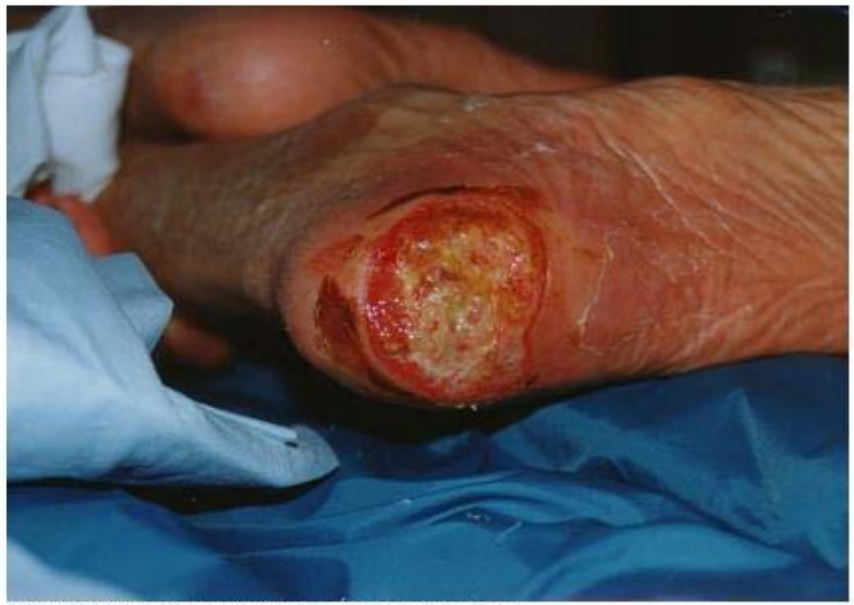
Implement Interventions…

- Avoid foam rings, donuts and sheepskins as pressure reducing devices
- Incorporate use of pressure-relief devices in the operating room for patients at risk for pressure ulcer development
- Relieve pressure under heels by using pillows or other devices
- Establish a bowel and bladder program for patients with incontinence



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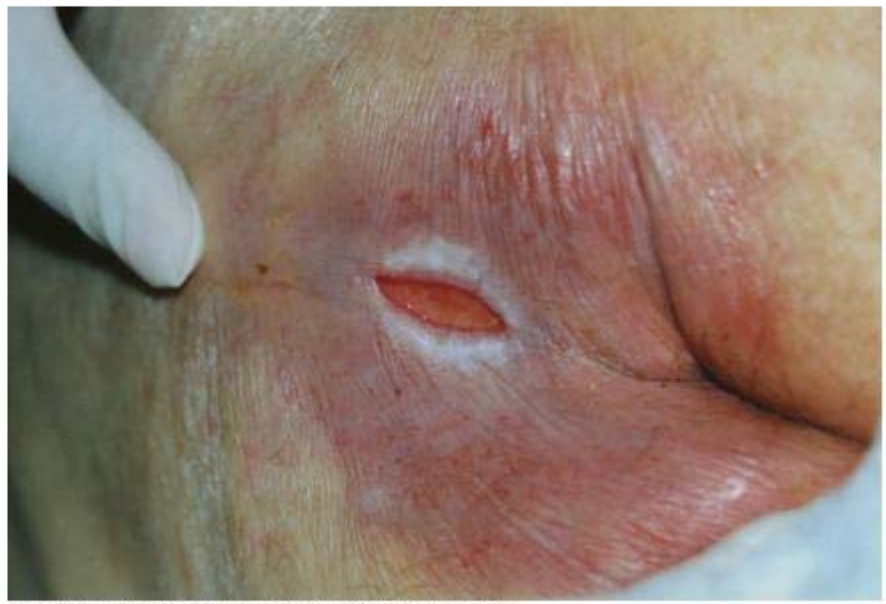
Implement Interventions…

- Use incontinent barriers to protect skin integrity
- Consider use of a collection device to contain urine or stool
- Maintain adequate nutrition



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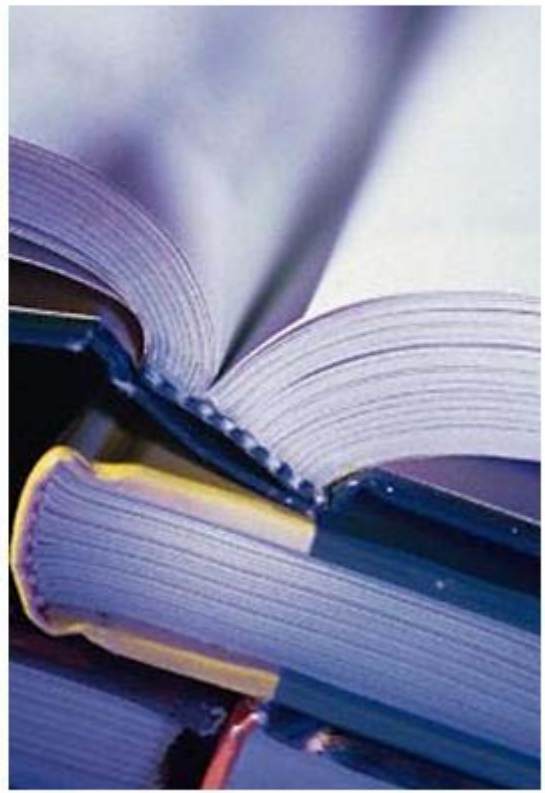
Implement Interventions…

- Provide education to patients and/or caregivers regarding the causes and risk factors for pressure ulcer development and approaches that minimize risk
- Develop a plan consistent with the patient's overall goals



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Your role in prevention…

- Education is the basis for the development of clinical strategies for skin care

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References

1. Eckman, K. The prevalence of dermal ulcers among persons in the US who died of Pressure Ulcers, Decubitus, 2(2), 36-40; 1989.
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