It Begins with Prevention

Impact of Wounds

- Older adults are at greater risk for wound development and delayed wound healing.
- Wounds decrease the quality of life for our residents, placing them at greater risk for chronic pain, infection, and alterations in mobility.
- Chronic wounds are associated with increased morbidity and mortality in an already vulnerable population.

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So, What Can We Do?

- Many wounds are avoidable - Prevention is key!
- Skin risk assessments – Identify high-risk residents
- Thorough skin assessments at admission and weekly
- Closely monitor pressure points (heels, coccyx, elbows, mid-back in kyphotic patients)

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So, What Can We Do? (cont.)

- Closely monitor placement of medical devices (oxygen tubing, nasogastric tubing, splints, and braces)
- Staff education to report skin alterations
- Nurse education to properly assess, identify, and document skin alterations
- Ensure preventive measures are in place at admission and reviewed/modified with significant changes

Risk Assessment

Review resident's record and identify disease conditions that place the resident at greater risk for developing wounds or delayed healing in an existing wound.

- Assess patient risk factors utilizing facility-designated tool (ex. Braden Scale)
  - Risk for exposure to moisture – incontinence or moisture in skin folds?
  - Risk for exposure to friction or shear – does resident scoot in bed, or use slide board for transfers?

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Risk Assessment (cont.)

- Assess patient risk factors utilizing facility-designated tool (ex. Braden Scale) (cont.)
  - Resident's nutrition and hydration status – protein intake, under/overweight, on a restrictive/modified diet?
  - Resident's mobility – is resident able to turn themself in bed to avoid prolonged pressure to an area?
  - Resident's activity level – bedfast or wheelchair bound?
  - Resident's sensory perception – can a resident feel an injury or discomfort from prolonged pressure?

Risk Assessment (cont.)

- Visual inspection of all skin by the nurse, observing for open areas or areas of discoloration
  - Turn or stand resident to visualize posterior, lift legs, utilize mirrors, if necessary, to clearly see heels. Visualize areas beneath braces, splints, oxygen tubing, etc.
- Skin redness is known as erythema. The redness is classified as either blanchable or non-blanchable.
  - Blanchable erythema is visible skin redness that becomes white when light pressure is applied and reddens when pressure is relieved.

Risk Assessment (cont.)

- Skin redness is known as erythema. The redness is classified as either blanchable or non-blanchable. (cont.)
  - Non-blanchable erythema is visible skin redness that persists with the application of pressure. It indicates structural damage to the capillary bed/microcirculation
- Light palpation of bony prominences, especially in residents with altered mobility, assessing for erythema or changes in skin consistency (boggy heels or crepitus)
  - Pressure ulcers are often missed in the early stages of residents with darker skin tones – light palpation allows the nurse to assess for changes in temperature, skin consistency, and pain

Prevention Strategies

- Utilize pressure reduction support surfaces
  - Inspect mattresses and wheelchair cushions routinely to ensure resident does not injure self due to tears in the support surface
  - If a resident has a wound, investigate upgrading support surfaces and initiate ASAP to prevent worsening of wound
    - Air loss mattresses
    - Air cushions

Prevention Strategies (cont.)

- Monitor weight and hydration status
  - Significant weight loss/gain or change in intake should trigger a new skin risk assessment
  - Monitor albumin/prealbumin if a wound is present – protein is vital to wound healing
- Repositioning schedules
- Reduce exposure to moisture
  - Barrier cream/properly fitting incontinence products/absorbent fabrics in skin folds
- Float heels when in bed
- Assist to bed or different surface during the day or after meals

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Prevention Strategies (cont.)

- Refer to therapy to assist with positioning to alleviate prolonged pressure
- Ensure dietitian is reviewing high-risk residents
- Skin checks before and after placement of brace/splint/contracture prevention devices
- Collaborate with physician and resident to control blood glucose levels
- Utilize preventive dressing per facility protocols
- Review significant changes in residents with interdisciplinary team (IDT)

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Let’s Keep it Going...

- Document any skin alterations noted during routine assessments
- Identify, measure, and describe wound appropriately in assessment
- Document preventive measures already in place and any new initiated

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Let's Keep it Going... (cont.)

- Identify a skin champion who:
  - Spot checks support surfaces
  - Observes positioning devices in place
  - Observes that residents receive nutritional supplements at meals
  - Conducts a random skin assessment following brace/splint/contracture prevention device removal
  - Checks skin risk assessments at admission/readmission/significant change

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In Summary

This presentation was intended to provide a summary of pressure injury prevention strategies in long-term care. This provides only a snapshot and there are many good strategies to choose from!

Utilize CMS Care Pathways in the development of your facility's wound management policy and program. Always refer to your facility's policy and procedures.

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Additional Resources

The National Pressure Injury Advisory Panel has a host of resources that can be found on their site National Pressure Injury Advisory Panel (npiap.com)

The American Healthcare Research and Quality has also developed a toolkit for training and prevention that can be found here: AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention | Agency for Healthcare Research and Quality

The Wound, Ostomy and Continence Nurses Society developed an evidence- and consensus-based support surface algorithm.

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References

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019 International Guideline

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Thank You

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