Press Release

The Pressure is on to Relieve Pressure Ulcers!

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Disclosure Statement
None of the speakers of this presentation, “The Pressure is on to Release Pressure Ulcers” has declared a conflict of interest related to this presentation

OBJECTIVES
• Discuss the significance of pressure ulcers in today’s healthcare.
• Identify and stage pressure ulcers
• Identify wounds that may be confused with pressure ulcers
• Name wound care products for prevention and treatment of pressure ulcers
Slide 4

### Historical Perspective
- Pressure ulcers have been known to exist since ancient Egyptian times.
- Physicians of ancient Egypt were considered experts in the science of healing wounds such as pressure ulcers (PU) by packing them with the flesh and skin of lynx. This was revealed in the Smith Papyrus, one of the oldest medical texts in existence.
- Over the years, pressure ulcers have been given many names including: bed sores, bed ulcers, black sloughs and decubitus ulcers.
- Pressure ulcers continue to be a problem in modern times.

Headlines
www.dailynews.com - Since 1996

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Slide 5

### Why is it so important to prevent pressure ulcers?
- Patient safety
- Quality of life
- Financial implications (reimbursement)
- Medical liability

Headlines
www.dailynews.com - Since 1996

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Slide 6

### What happens when a patient acquires a pressure ulcer while under our care?
- REIMBURSEMENT
- CMS Guidelines - Hospital will not be paid for care provided for a stage III or stage IV hospital-acquired pressure ulcer
  - Medicare estimates that each pressure ulcer adds $43,180 in cost to a hospital stay
  - Cost of treatment ranges from $20,900-$151,700 per pressure ulcer.

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www.dailynews.com - Since 1996

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What happens when a patient acquires a pressure ulcer while under our care?

- PENNSYLVANIA LAW (Act 13 of 2002 – MCARE Act)
- Hospital must report all hospital-acquired pressure ulcers to the Patient Safety Authority
- Stage III and stage IV hospital-acquired pressure ulcers are “Serious Events” and have additional requirements:
  - Must also be reported to the Department of Health.
  - Must be disclosed to the patient/family
  - Patient/Family must be given a letter acknowledging the hospital-acquired pressure ulcer and confirming disclosure

Claims/Lawsuits

- Each year, more than 17,000 lawsuits are filed relating to pressure ulcers
- Claims for pressure ulcers represent the 2nd most common medical liability claim
- More claims are filed for pressure ulcers than for falls

What should I do when my patient refuses skin protective measures or when family members want to use alternative therapies?

- Ask thoughtful questions
- Acknowledge patient’s/family’s viewpoint and beliefs
- Educate and explain why it’s important
- If no change:
  - Don’t provide any treatment against the patient’s will – this could be a violation of the patient’s rights
  - Document the conversation and steps taken to educate the patient/family
  - Re-educate at every opportunity
What should I do when my patient refuses skin protective measures or when family members want to use alternative therapies?

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For every episode

- Document your discussion with the patient/family
- Use quotations to document exact words
- Document education/re-education provided
- Document how you made the situation as safe as possible

Important Documentation Advice

1. In good spirits – What does this mean?
2. Write as if your next promotion/paycheck depends on this note
3. Use sentences
4. Education and patient response
5. Documenting an event
Other tips …

• Chart completely, concisely, and accurately
• Don’t be afraid to use “I”
• It’s okay to document quotations from patients
• Document just the facts! No opinions, suspicions, guesses, or throwing anyone under the bus!

Classification of pressure ulcers
Risk Assessment

Prevention

- **Pressure** – perpendicular force resulting in compression of tissues between bony prominence and outside surface
- **Shear** – adjacent surfaces slide across one another
- **Friction** – repeated movements of skin over surfaces
- **Moisture** causes maceration, denuded or broken skin (Weir, 2007)

Stage I Pressure Ulcer

- Non-blanchable erythema
- Usually over bony prominence
**Slide 19**

**Stage I Pressure Ulcer Treatment**

- Off load
  - Float the heels
- Turn every 2 hours
- Do not massage reddened area!
- Pressure redistribution surface
- Skin barrier cream

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**Slide 20**

**Stage II Pressure Ulcer**

- Partial-thickness skin loss
  - Involves epidermis, dermis or both
  - Appear similar to partial-thickness burns
  - Appear as a shallow ulcer or a fluid-filled blister

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**Slide 21**

**Stage II Pressure Ulcer Treatment**

- Barrier ointment or cream
- Zinc oxide preparations
- Consider sacral borders for high risk patients such as the frail and palliative patient
Stage III Pressure Ulcer

- Full-thickness skin loss and involvement of underlying subcutaneous tissue
- Superficial to deep fascia

Stage III Pressure Ulcer Treatment

- Hydrofiber dressings
- Calcium alginate dressings
- Negative pressure wound therapy

Stage IV Pressure Ulcer

- Full thickness skin loss
  - Tissue necrosis or damage to muscle, bone, or tendon
  - Undermining and sinus tracts are often present
**Stage IV Pressure Ulcer Treatment**

- Irrigate with NSS, use 30cc syringe to clean wound effectively
- Hydrofiber dressings
- Calcium alginate dressings
- Loosely pack to wick wound
- Provide moisture w/ moist to dry prn
- Negative pressure wound therapy

**Deep Tissue Injury**

- A pressure related injury to subcutaneous tissue under intact skin
- Will develop into a Stage III or Stage IV pressure ulcer

**Unstageable Pressure Ulcer**

- Any ulcer that is covered by eschar or slough material
Slide 28

Treatment of an Unstageable Ulcer

- Alert physician
- Consult WOCN
- Needs debridement
  - Surgical
  - Enzymatic collagenase

Slide 29

Kennedy Terminal Ulcer

- Pressure ulcer that some people develop at end of life
- Sudden onset
- These patients have a high mortality rate within 48 hours

Slide 30

Treatment of a Terminal Ulcer

- Treatment follows the same regimen as care of the stage III and IV pressure ulcer
Wound types/skin injuries that are often misclassified as pressure ulcers include:

- Skin tears
- Venous ulcers
- Arterial ulcers
- Diabetic ulcers
- Incontinence associated dermatitis

**Skin Tear**

- Separation of both dermis and epidermis from underlying tissue
- Results from traumatic injury

**Treatment of a Skin Tear**

- Clean with NSS
- Non-adherent silicon mesh dressing
- Cover with dry sterile dressing and secure with elastic wrap if on extremity
- Do NOT Tape
Venous Ulcer
• Found on medial aspect of lower extremity
• Shallow and exudative
• Irregular edges, peri-wound maceration, crusting

Treatment of a Venous Ulcer
• Clean w/ NSS
• NSS wet to dry
• Hydrofiber dressing
• Enzymatic debriding agent prn
• Compression therapy per physician order

Arterial Ulcer
• May be found between toes, tips of toes, along sides of foot
• Small and deep, dry or minimal exudate
• Pale or necrotic with well defined borders
Slide 37

**Treatment of an Arterial Ulcer**

- Improve perfusion
  - Surgical/Vascular consult is necessary
  - Possible revascularization
- Pharmacologic agents
  - Hyperbaric oxygen therapy
- Lifestyle changes – stop smoking, therapeutic walking program 30 min, 3x/wk
- Amputation – treatment of last resort
- Dry eschar – DO NOT OPEN
- Hydrofiber dressing

Slide 38

**Diabetic/Neuropathic Ulcer**

- Sores or wounds on the plantar surface of foot

Slide 39

**Treatment of a Diabetic/Neuropathic Ulcer**

- Focus on disease control
- Proper shoe fit
- Daily foot inspection-reporting injury or breaks in skin early
- Always maintain dry, stable eschar
Assigning interventions from the care plan is one method to score success in the pressure ulcer prevention plan.

- Care plan is initiated by the RN for patients with a pressure ulcer and those at risk.
- Consults are accepted for the WOCN and dietitian for patients with a PU Stage III, IV, unstageable, or suspected deep tissue injury (SDTI).
- Interventions completed and documented.
A Team Approach in the Prevention of Pressure Ulcers

- Staff nurses
- WOCN
- Wound clinic registered nurse
- Nutritionist
- Occupational therapist
- Physician
- Educators

Evidence-based best practice for prevention of pressure ulcers are:

- Repositioning
- Proper surface selection
- Incontinence management
- Adequate nutrition

Innovative Strategies in Pressure Ulcer Prevention

- Daily reports are given to the charge nurse with a list of patients that have a documented pressure ulcer as of midnight in the Business Intelligence report. Live data and education are superior to retrospective data.

- Charge nurse collaborates with bedside nurse to assure patients with a pressure ulcer, or who are at risk for a pressure ulcer, have preventive measures in place.

S – Surface selection
K – Keep turning
I – Incontinence management
N – Good nutrition
Slide 49

Innovative Strategies in Pressure Ulcer Prevention

- Skin care teams have been formed on each clinical unit with the following requirements:
  - Interest
  - National Database of Nursing Quality Indicators (NDNQI) Pressure Ulcer Training
  - Principles of wound care 4 hour educational session provided by Wound Ostomy Continence Nurse (WOCN)
  - Negative pressure wound training

Slide 50

- Weekly skin care checks
- On the spot education for the Registered Nurse (RN) and Patient Care Assistant (PCA)
- Skin risk assessment (Braden Scale) scores placed in clinical summary for easy reference
- Education: Braden scale of 18 or less places the patient at risk for a PU; Braden Scale screen changed from basic to detailed to avoid subjective interpretation

Slide 51

- "Taking the Pressure Off" staff educational plan
  - i.e. Turn every 2 hours not 2.5 hours or more. Bed rotation is not turning!
- Patient and family education
Slide 52

**Brief Free!!**

- Briefs create skin injury from increased friction and shear.
- Briefs seal in moisture which promotes yeast and incontinence associated dermatitis.
- Briefs weaken the skin putting it at risk for maceration of tissues.
- Moist skin increases the risk of pressure ulcers.
- Wearing briefs may be considered a dignity issue.
- Briefs should never be worn in bed.
- When are briefs acceptable?
- Patient request, but check patient frequently for moisture.

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Slide 53

**Local News**

- Innovative Strategies in Pressure Ulcer Prevention
  - Documentation changes
  - Boney prominence versus device related
  - Links
    - Algorithm
    - Staging
    - Human Skeleton
  - Nutrition

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Slide 54

**Local News**

- Innovative Strategies in Pressure Ulcer Prevention
  - Wound care products
  - Nutrition
  - Daily reports to management team
  - Root-cause-analysis for all HAPU
  - Discharge instructions
  - Palliative wound care plan
Meet Pat…….

Case Study

• "Pat" is a 68 y.o. patient who fell at home on the morning of Christmas Eve landing on her bottom and back. She states she "lost [her] footing" and fell by tripping over the bottom of her recliner. The patient didn’t experience any pain from her "back and bottom" which is what brought her in today.

• "Pat" usually gets around with a walker for short distances and a wheelchair for longer distances because of her neuropathy. She also states that she is in her recliner for the majority of the day, including to sleep and has done that for the last three years.

• Her past medical history includes DMII, Heart Failure, COPD on O2 @ 6L/min chronically, HTN, depression, bipolar, and frequent falls. Before this fall, she was hospitalized 2/2013 and discharged to Lancashire Hall for Rehab for a month. "Pat" had VNA and home PT after discharge, but these services stopped in 4/2013 and her daughter states she has become less active since then.

Current Lab Work

• Albumin 3.1 (Normal 3.5 – 4.9 g/dl)

• Hemoglobin 8.7 (Normal 12- 16 g/dl)

• Dietician in her interview with patient asked if she had any weight loss without trying, patient has lost 23 lbs without trying and stated she has had a poor appetite. Observed only eating 25 % of lunch at time of visit.
Medications:
• Inhalers x 2
• Aspirin daily
• Two diabetic medications
• Two blood pressure medications
• Lasix daily
• Gabapentin (Neurontin) 40 mg TID
• Trazodone (Desyrel) 150 mg at bed time
• Mirtazapine (Remeron) 45 mg at bed time

What information you received from the assessment and history might indicate this patient is risk?
1. Sleeping in recliner & O2 dependent
2. Diabetes
3. Recent weight loss
4. Labs/Medications
5. All of above

Patient’s Story
Scroll Down to the Wound LDA's

• Also can check discharge tab for old LDA's

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Old LDA's

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Calculate a Braden Score

• Using the Cards/ Skin care policy on your table calculate a Braden Scale for Pat.
Slide 64

What Braden Score Did You Get?

A. 6 to 9
B. 10 to 13
C. 13 to 18
D. 18 to 23

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Slide 65

Admission Assessment

• Pat is now admitted to her unit and Nurse Jackie is completing the Admission Database
• After asking all the appropriate questions Nurse Jackie completes the Braden Score for Pat. Below is her score:

<table>
<thead>
<tr>
<th>Sensory Perception (Response to)</th>
<th>2 -&gt; very</th>
<th>1 -&gt; indifferent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moisture (Degree Skin Exposed to)</td>
<td>2 -&gt; very</td>
<td>1 -&gt; indifferent</td>
</tr>
<tr>
<td>Activity (Ability to Walk)</td>
<td>1 -&gt; bedridden</td>
<td></td>
</tr>
<tr>
<td>Mobility (Amount/Control of Body)</td>
<td>2 -&gt; vary</td>
<td>1 -&gt; bedridden</td>
</tr>
<tr>
<td>Nutrition (Quality of Food Intake)</td>
<td>2 -&gt; vary</td>
<td>1 -&gt; bedridden</td>
</tr>
<tr>
<td>Friction and Shear (Braden)</td>
<td>1 -&gt; prob.</td>
<td></td>
</tr>
<tr>
<td>Risk of Pressure Ulcer</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Additional Documentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Slide 66

Admission Assessment

• Nurse Jackie when doing her Head to Toe assessment and remembers upon doing so that she needs to check the largest organ of the body... the SKIN!
• She starts to examine the places where no nurse really cares to go, but she checks in all the nooks and crannies just like she was taught.
• In order to check all the creases, Nurse Jackie next examines the gluteal cleft and gets quite the surprise!
Based on the Braden Score and the assessment findings, what interventions could be initiated for Pat.?

1. Consult wound nurses and wait for further direction
2. Consult nutrition and wound nurses
3. Consult nutrition, wound nurses, OT/PT seating, heel protector boots
4. Consult nutrition, wound nurses, OT/PT seating, specially bed with air flow, calamine buttocks paste, heel protector boots, soft gel oxygen cannula with grey foam pads
Slide 70

What Stage is area # 1

1. Stage One
2. Stage Two
3. Stage Three
4. Stage Four
5. Suspected Deep Tissue Injury (sDTI)
6. Unstageable
7. Undeterminable

Slide 71

What is the location of area # 1

1. Left Ischial
2. Left Sacral
3. Left Buttocks
4. Left Coccyx

Slide 72

What is the location of area # 1

1. Left Ischial
2. Left Sacral
3. Left Buttocks
4. Left Coccyx
Slide 73

Slide 74

What Stage is area #2
1. Stage One
2. Stage Two
3. Stage Three
4. Stage Four
5. Suspected Deep Tissue Injury (sDTI)
6. Unstageable
7. Undeterminable

Slide 75
Slide 76

What is the location for area #2

1. Buttocks
2. Low Midline Sacral
3. Coccyx
4. Ischial

Slide 77

Area 3

Slide 78

What Stage is area #3

1. Stage One
2. Stage Two
3. Stage Three
4. Stage Four
5. Suspected Deep Tissue Injury (sDTI)
6. Unstageable
7. Undeterminable
Slide 79

What is the location for area # 3

1. Buttocks
2. Right Sacral
3. Coccyx
4. Ischial

Slide 80

Pat’s Plan of Care

- Pat was on a medical surgical unit
- IV antibiotics
- Respiratory therapy
- PT/OT
- Nutrition
- Medical management of DM II
- Support surface
- Case Management
- Wound for debridement
Slide 82

Patient chose to a palliative approach and was discharged to HOSPICE

Slide 83

Obituary

PRESSURE ULCERS SHOULD BE A NEVER EVENT!

Slide 84

References


References