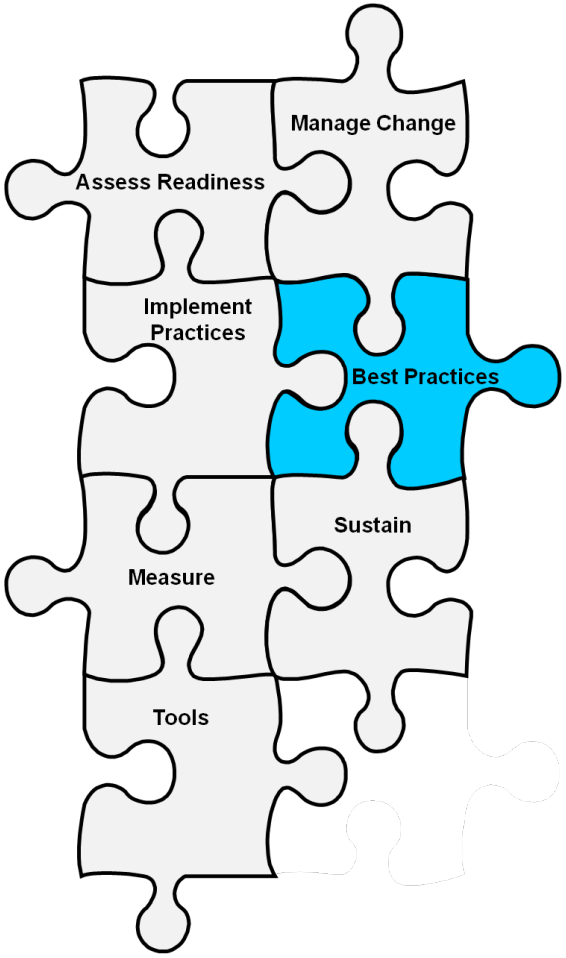
Best Practices in Pressure Injury Prevention

ADD Hospital Name

Module 3

Best Practices

- Best practices are those care processes—based on literature and expert opinion—that represent the best ways we currently know of preventing pressure injuries in the hospital.
- AHRQ Patient Safety Network (PSNET) https://psnet.ahrq.gov/



Module 3 Goals

- Identify opportunities for improvement:
  - Which pressure injury prevention practices to use
  - How to perform a comprehensive skin assessment
  - How to conduct a standardized assessment of pressure injury risk factors
  - How to incorporate risk factors into care planning

Note: At various points during the module, we'll discuss which best practices you want to include in **your** prevention program.

Bundle of Best Practices

- Pressure injury prevention practices checklist:
  - ❑ Comprehensive skin assessment
  - ❑ Standardized pressure injury risk assessment
  - ❑ Care planning and implementation to address areas of risk

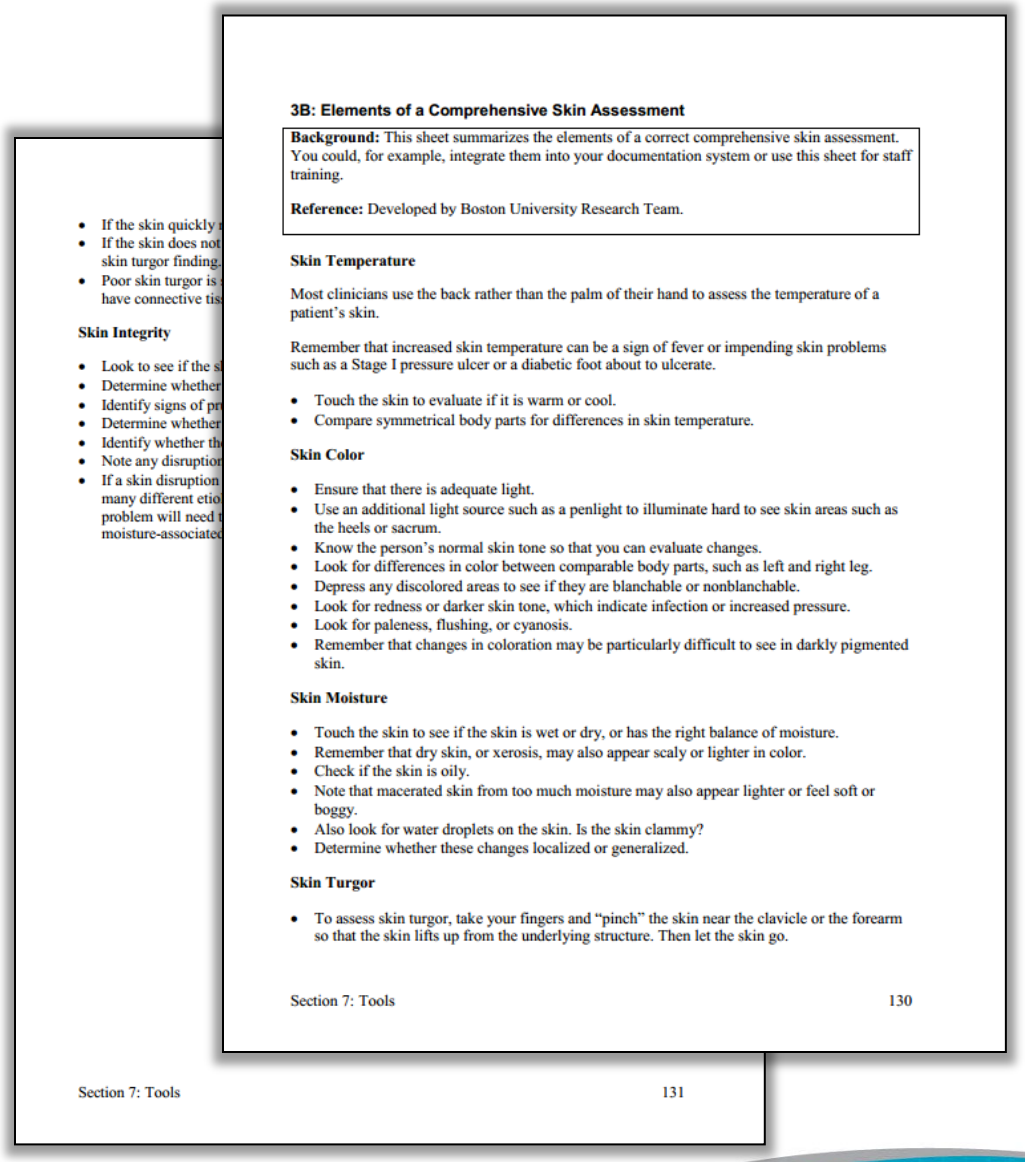
BEST PRACTICE

COMPREHENSIVE SKIN ASSESSMENT

Comprehensive Skin Assessment

- Examine the entire skin (from head to toe) for abnormalities.

Tool 3B



3B: Elements of a Comprehensive Skin Assessment

Background: This sheet summarizes the elements of a correct comprehensive skin assessment. You could, for example, integrate them into your documentation system or use this sheet for staff training.

Reference: Developed by Boston University Research Team.

Skin Temperature

Most clinicians use the back rather than the palm of their hand to assess the temperature of a patient's skin.

Remember that increased skin temperature can be a sign of fever or impending skin problems such as a Stage I pressure ulcer or a diabetic foot about to ulcerate.

- Touch the skin to evaluate if it is warm or cool.
- Compare symmetrical body parts for differences in skin temperature.

Skin Color

- Ensure that there is adequate light.
- Use an additional light source such as a penlight to illuminate hard to see skin areas such as the heels or sacrum.
- Know the person's normal skin tone so that you can evaluate changes.
- Look for differences in color between comparable body parts, such as left and right leg.
- Depress any discolored areas to see if they are blanchable or nonblanchable.
- Look for redness or darker skin tone, which indicate infection or increased pressure.
- Look for paleness, flushing, or cyanosis.
- Remember that changes in coloration may be particularly difficult to see in darkly pigmented skin.

Skin Moisture

- Touch the skin to see if the skin is wet or dry, or has the right balance of moisture.
- Remember that dry skin, or xerosis, may also appear scaly or lighter in color.
- Check if the skin is oily.
- Note that macerated skin from too much moisture may also appear lighter or feel soft or boggy.
- Also look for water droplets on the skin. Is the skin clammy?
- Determine whether these changes localized or generalized.

Skin Turgor

- To assess skin turgor, take your fingers and "pinch" the skin near the clavicle or the forearm so that the skin lifts up from the underlying structure. Then let the skin go.

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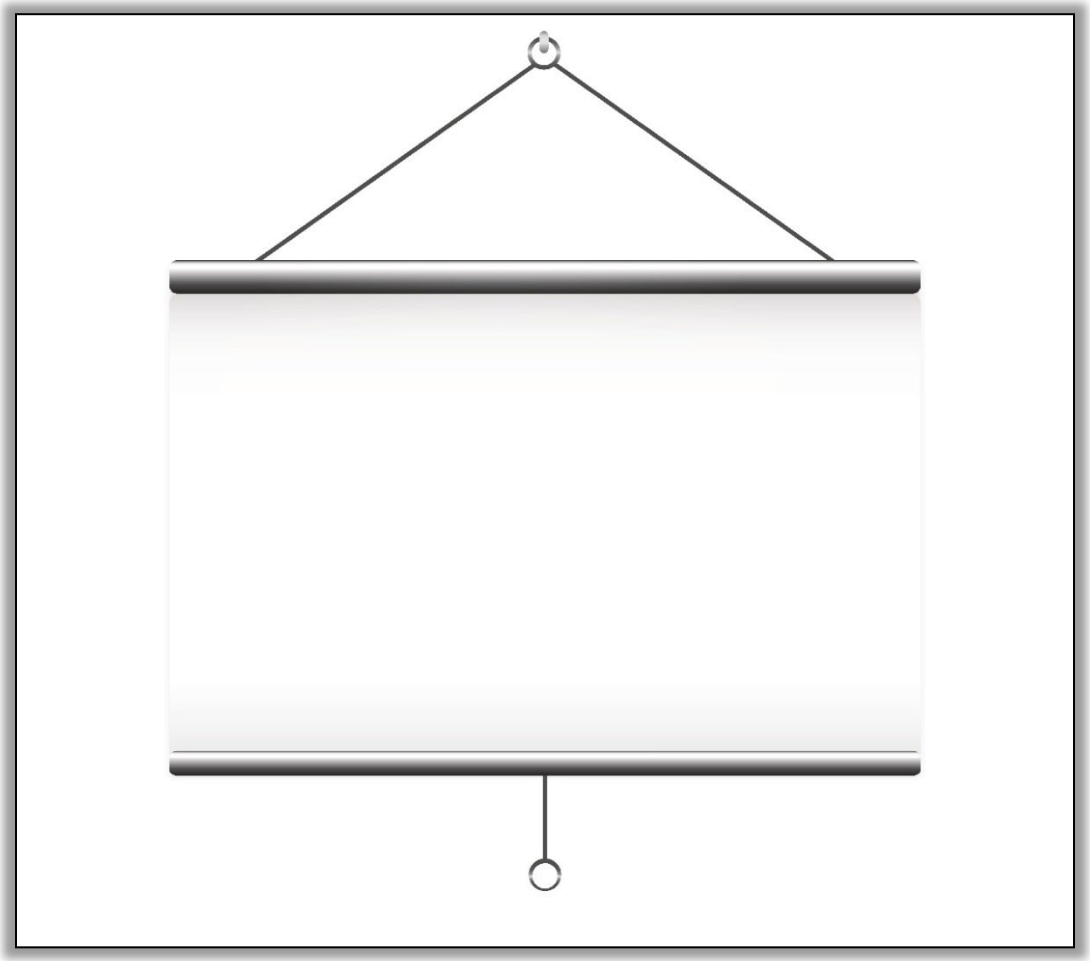
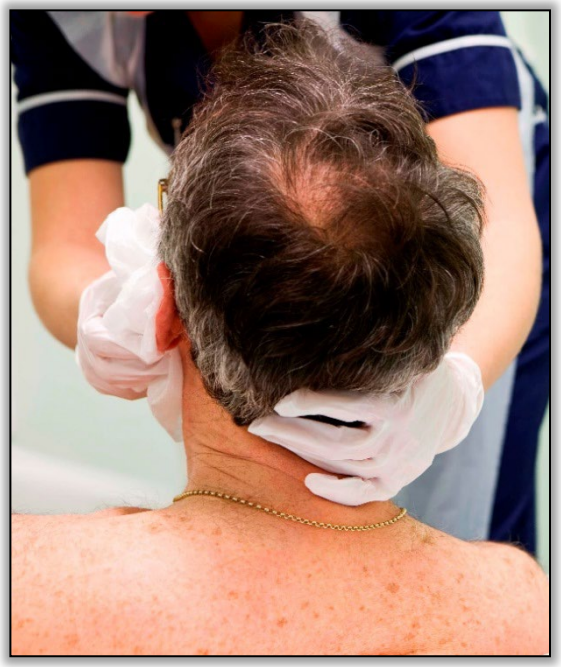
How To Do a Skin Assessment

Video Clip of Skin Assessment



Skin Assessment Frequency

- Not a one-time event
- Repeated on a regular basis
- Optimally done daily in a systematic manner by a single individual at a dedicated time
- May be integrated into routine care—any time the patient is cleaned or turned

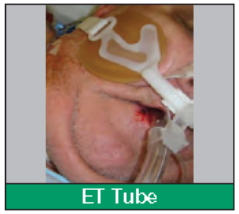


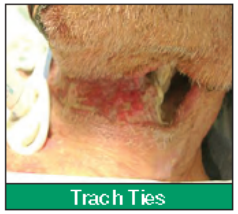
Medical Device Skin Assessment

NATIONAL PRESSURE ULCER ADVISORY PANEL

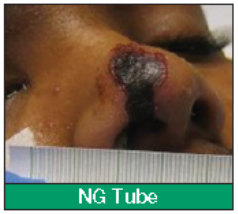
Best Practices for *Prevention* of *Medical Device-Related* Pressure Ulcers

- ✔ **Choose** the correct size of medical device(s) to fit the individual
- ✔ **Cushion** and protect the skin with dressings in high risk areas (e.g., nasal bridge)
- ✔ **Remove** or move the device daily to assess skin
- ✔ **Avoid** placement of device(s) over sites of prior, or existing pressure ulceration
- ✔ **Educate** staff on correct use of devices and prevention of skin breakdown
- ✔ **Be aware** of edema under device(s) and potential for skin breakdown
- ✔ **Confirm** that devices are not placed directly under an individual who is bedridden or immobile


ET Tube


Trach Ties


Retention Sutures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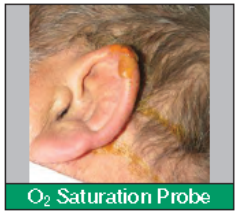
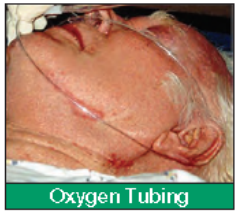
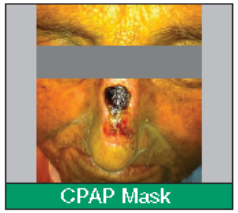
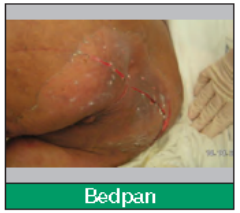
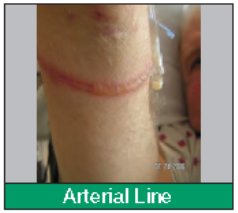

O_2 Saturation Probe


Oxygen Tubing


CPAP Mask

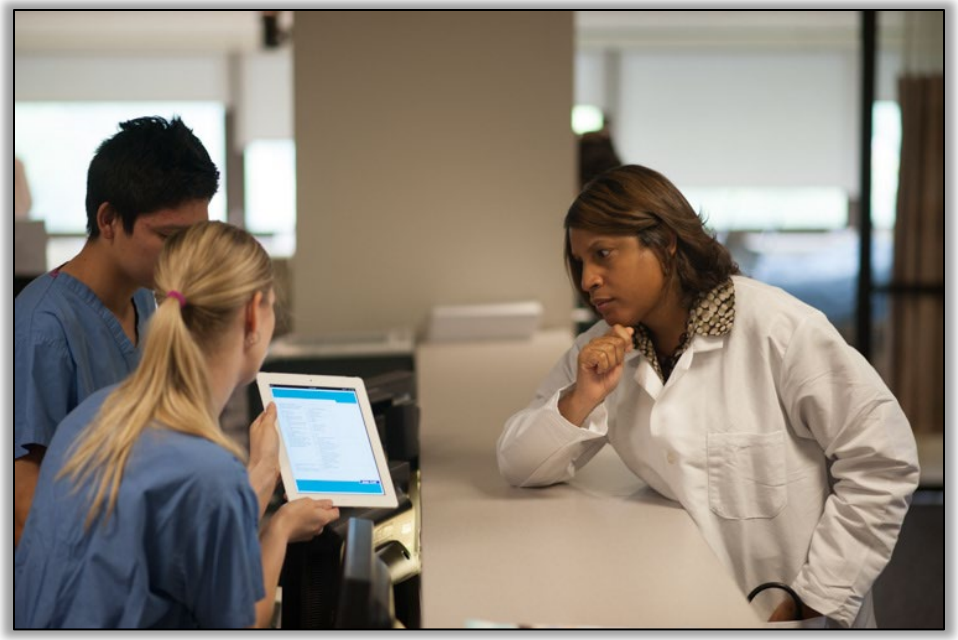

Bedpan


Arterial Line


Wrist Splint

Reporting and Documenting

- Skin assessment results must be documented in the medical record. Then staff must be made aware of the assessment.



Barriers to Practice

- Finding time for skin assessments
- Determining correct etiology of wounds
- Using inadequate documentation forms
- Lacking ways to empower staff to report abnormal skin findings:
  - Consider using Tool 3C: Pressure Ulcer Identification Pocket Pad.

ID Pocket Pad

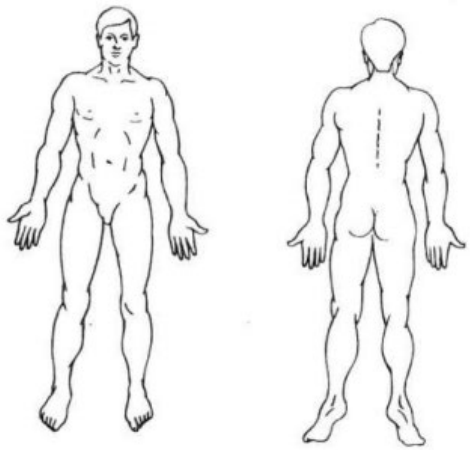
PRESSURE ULCER IDENTIFICATION POCKET PAD

Place the patient's/resident's name on the top of the pad, date it and place an "X" on the area on the body where you see the skin concern. Give this to the nurse and ask him or her to check the patient/resident. They will follow up as needed.

Date: _____ Time: _____

Patient's/Resident's Name: _____

Reporter: _____



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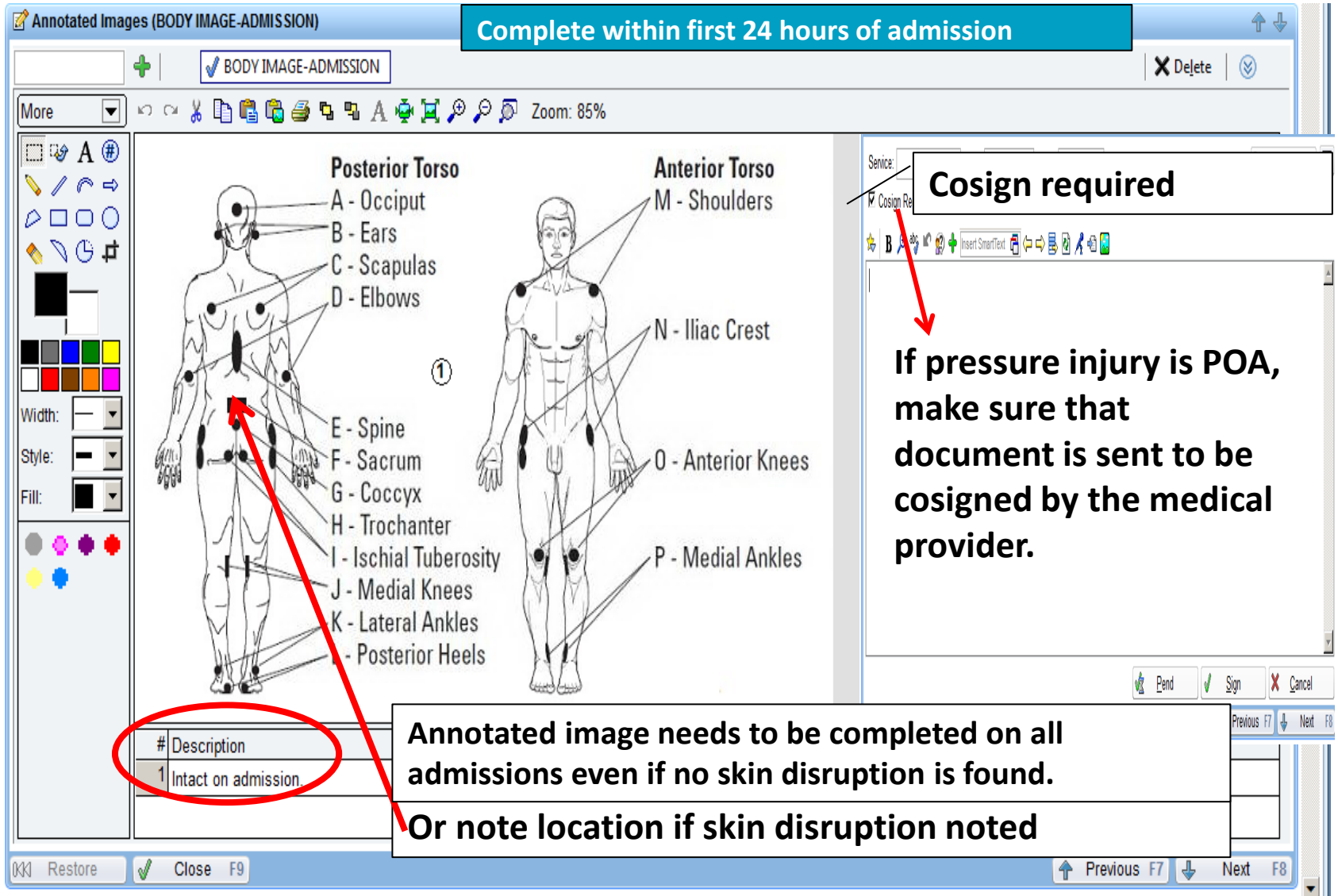
Tool 3C

Practice Insight



Improving Assessment Practice

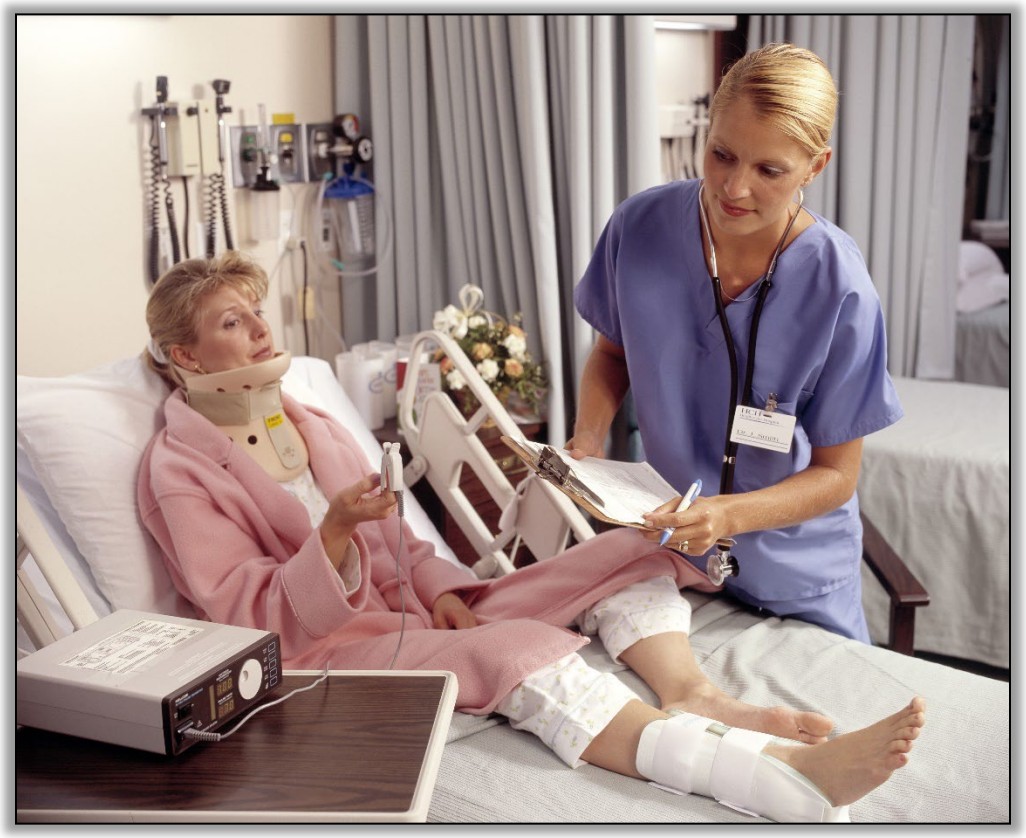
- Ask a colleague to confirm skin assessment.
- Perform skin assessment with an expert.
- Ask for clarification.
- Use available resources.
- See tips for making assessments part of the routine.  Page 42

BEST PRACTICE

PRESSURE INJURY RISK ASSESSMENT

Pressure Injury Risk Assessment

- Next step in prevention
- Goal: to identify patients at risk



Risk Assessment Scales

- Only one part of risk assessment
- Meant to be used in conjunction with a review of other risk factors and clinical judgment
  - More factors to consider  Page 44
- Especially helpful in identifying patients at mild to moderate risk
- Two widely used scales:
  - Braden Scale (Tool 3D)
  - Norton Scale (Tool 3E)

Braden Scale

- Six subscales, scored from 1-4 or 1-3:
  - Sensory perception
  - Moisture
  - Activity
  - Mobility
  - Nutrition
  - Friction/shear

Risk Assessment Case Study – Mr. K

Braden Scale – Mr. K

Braden Pressure Ulcer Risk Assessment

Patient's Name _____ **Evaluator's Name** _____ **Date of Assessment**

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2. Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment:** Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist:** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or non-existent. Cannot bear weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY ability to change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations:** Makes major and frequent changes in position without assistance.				
NUTRITION *usual* food intake pattern	**1. Very Poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEAR	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					

How Often?

- Recommendations vary.
- In general acute care settings, do risk assessment upon admission, then daily or with a significant change in condition.
- In critical care settings, frequent assessments should be done, such as at every shift.
- For risk assessment in pediatrics.

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Documentation

- Have computerized (or paper) form in medical record.
- Incorporate results in daily patient flowsheet.
- Include results in patient report or handover.

Next Steps

- Knowing which patients are at risk is not enough; you must also do something about it.
- Care planning guides what will be done to prevent pressure injuries.

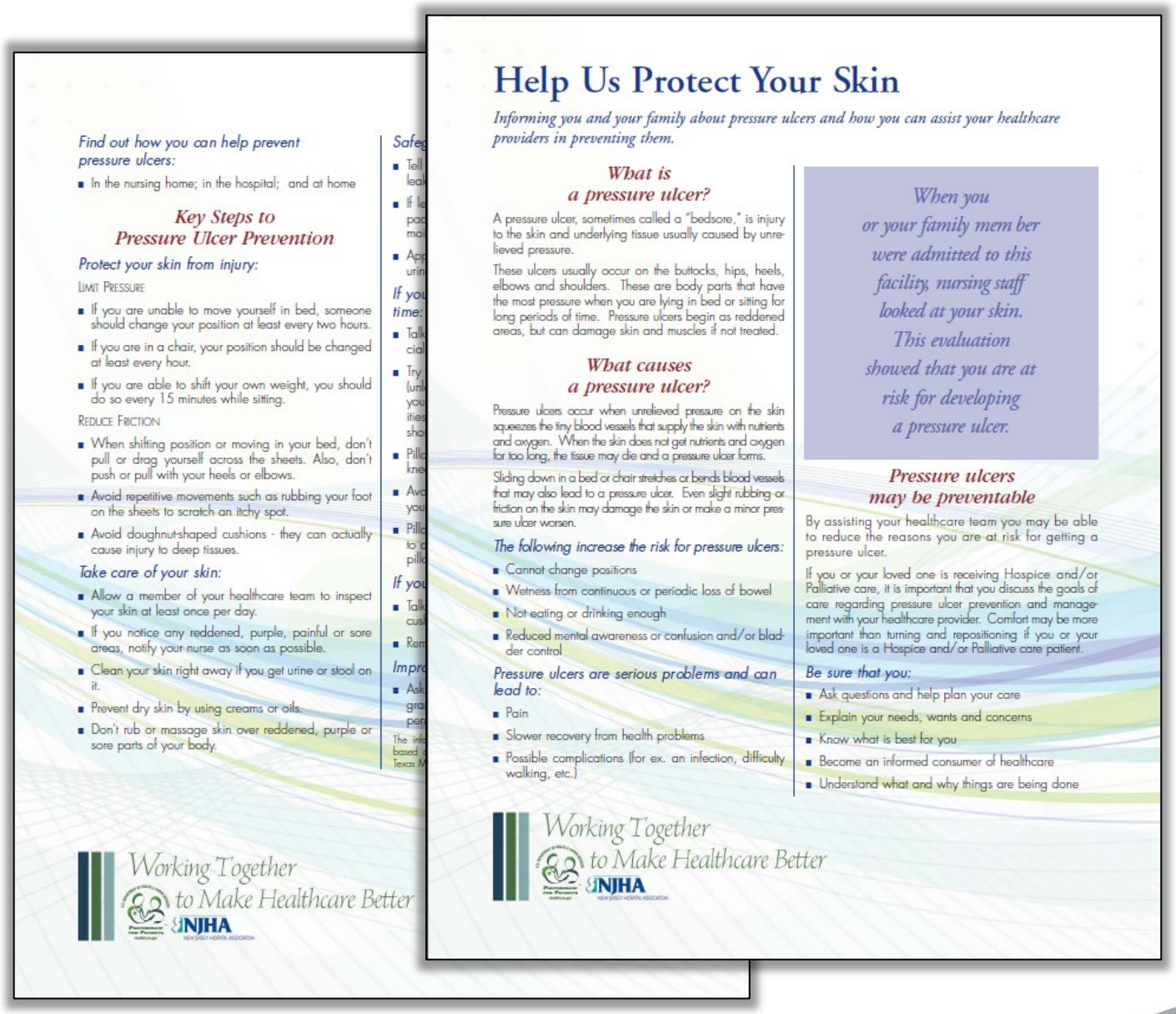
BEST PRACTICE

PRESSURE INJURY CARE PLANNING

Care Planning

- A process to transfer the patient's risk assessment information into an action plan to address his or her needs:
  - Implement care practices so that your patient does not develop a pressure injury.
  - Develop a care plan for any area of risk.
  - Tailor the plan to fit the patient's needs.
  - Modify as needed to capture your patient's response to interventions and any changes in condition.

Patient and Family Education



Find out how you can help prevent pressure ulcers:

- In the nursing home; in the hospital; and at home

Key Steps to Pressure Ulcer Prevention

Protect your skin from injury:

LIMIT PRESSURE

- If you are unable to move yourself in bed, someone should change your position at least every two hours.
- If you are in a chair, your position should be changed at least every hour.
- If you are able to shift your own weight, you should do so every 15 minutes while sitting.

REDUCE FRICTION

- When shifting position or moving in your bed, don't pull or drag yourself across the sheets. Also, don't push or pull with your heels or elbows.
- Avoid repetitive movements such as rubbing your foot on the sheets to scratch an itchy spot.
- Avoid doughnut-shaped cushions - they can actually cause injury to deep tissues.

Take care of your skin:

- Allow a member of your healthcare team to inspect your skin at least once per day.
- If you notice any reddened, purple, painful or sore areas, notify your nurse as soon as possible.
- Clean your skin right away if you get urine or stool on it.
- Prevent dry skin by using creams or oils.
- Don't rub or massage skin over reddened, purple or sore parts of your body.

Working Together to Make Healthcare Better

NJHA

Help Us Protect Your Skin

Informing you and your family about pressure ulcers and how you can assist your healthcare providers in preventing them.

What is a pressure ulcer?

A pressure ulcer, sometimes called a "bedsore," is injury to the skin and underlying tissue usually caused by unrelieved pressure.

These ulcers usually occur on the buttocks, hips, heels, elbows and shoulders. These are body parts that have the most pressure when you are lying in bed or sitting for long periods of time. Pressure ulcers begin as reddened areas, but can damage skin and muscles if not treated.

What causes a pressure ulcer?

Pressure ulcers occur when unrelieved pressure on the skin squeezes the tiny blood vessels that supply the skin with nutrients and oxygen. When the skin does not get nutrients and oxygen for too long, the tissue may die and a pressure ulcer forms.

Sliding down in a bed or chair stretches or bends blood vessels that may also lead to a pressure ulcer. Even slight rubbing or friction on the skin may damage the skin or make a minor pressure ulcer worsen.

The following increase the risk for pressure ulcers:

- Cannot change positions
- Wetness from continuous or periodic loss of bowel
- Not eating or drinking enough
- Reduced mental awareness or confusion and/or bladder control

Pressure ulcers are serious problems and can lead to:

- Pain
- Slower recovery from health problems
- Possible complications (for ex. an infection, difficulty walking, etc.)

When you or your family member were admitted to this facility, nursing staff looked at your skin. This evaluation showed that you are at risk for developing a pressure ulcer.

Pressure ulcers may be preventable

By assisting your healthcare team you may be able to reduce the reasons you are at risk for getting a pressure ulcer.

If you or your loved one is receiving Hospice and/or Palliative care, it is important that you discuss the goals of care regarding pressure ulcer prevention and management with your healthcare provider. Comfort may be more important than turning and repositioning if you or your loved one is a Hospice and/or Palliative care patient.

Be sure that you:

- Ask questions and help plan your care
- Explain your needs, wants and concerns
- Know what is best for you
- Become an informed consumer of healthcare
- Understand what and why things are being done

Working Together to Make Healthcare Better

NJHA

Tool 3G

Updated brochure available at: http://www.njha.com/media/43477/puconsumereng.pdf

Sample Care Plan

Tool 3F

Sample Care Plan

Braden Category	Braden Score: 1	Braden Score: 2	Braden Score: 3	Braden Score: 4
Sensory Perception	**Completely limited** • Skin assessment and inspection q shift. Pay attention to heels. • Elevate heels and use protectors. • Consider specialty mattress or bed. • Use pillows between knees and bony prominences to avoid direct contact.	**Very limited** • Skin assessment and inspection q shift. Pay attention to heels. • Elevate heels and use protectors. • Consider specialty mattress or bed.	**Slightly limited** • Skin assessment and inspection q shift. Pay attention to heels. • Elevate heels and use protectors .	**No limitation** • Encourage patient to report pain over bony prominences. • Check heels daily.
Moisture	**Constantly Moist** • Skin assessment and inspection q shift. • Use moisture barrier ointments (protective skin barriers). • Moisturize dry unbroken skin. • Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes. • Check incontinence pads frequently (q 2-3h) and change as needed. • Apply condom catheter if appropriate. • If stool incontinence, consider bowel training and toileting after meals or rectal tubes if appropriate. • Consider low air loss bed	**Moist** • Use moisture barrier ointments (protective barriers). • Moisturize dry unbroken skin. • Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes. • Check incontinence pads frequently (q 2-3h). • Avoid use of diapers but if necessary, check frequently (q 2-3h)and change as needed. • If stool incontinence, consider bowel training and toileting after meals. • Consider low air loss bed	**Occasionally Moist** • Use moisture barrier ointments (protective skin barriers). • Moisturize dry unbroken skin. • Avoid hot water. Use mild soap and soft cloths or packaged cleanser wipes. • Check incontinence pads frequently. • Avoid use of diapers but if necessary, check frequently (q 2-3h) and change as needed. • Encourage patient to report any other moisture problem (such as under breasts). • If stool incontinence, consider bowel training and toileting after meals.	**Rarely Moist** • Encourage patient to use lotion to prevent skin cracks. • Encourage patient to report any moisture problem (such as under breasts).
Activity	**Bedfast** • Skin assessment and inspection q shift. • Position prone if appropriate or elevate head of bed no more than 30 degrees. • Position with pillows to elevate pressure points off of the bed. • Consider specialty bed. • Elevate heels off bed and/or use heel protectors. • Consider physical therapy consult for conditioning and W/C assessment. • Turn/reposition q 1-2h. • Post turning schedule.	**Chairfast** • Consider specialty chair pad. • Consider postural alignment, weight distribution, balance, stability, and pressure relief when positioning individuals in chair or wheelchair. • Instruct patient to reposition q 15 minutes when in chair. • Stand every hour. • Pad bony prominences with foam wedges, rolled blankets, or towels. • Consider physical therapy consult for conditioning and W/C assessment.	**Walks Occasionally** • Provide structured mobility plan. • Consider chair cushion. • Consider physical therapy consult..	**Walks Frequently** • Encourage ambulating outside the room at least bid. • Check skin daily. • Monitor balance and endurance.

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Braden Category	Braden Score: 1
	• Teach or do frequent small shi body weight.
Mobility	**Completely Immobile** • Skin assessment and inspectio • Turn/reposition q 1-2 hours. • Post turning schedule. • Teach or do frequent small shi body weight. • Elevate heels. • Consider specialty bed.
Nutrition	**Very Poor** • Nutrition consult. • Skin assessment and inspectio • Offer nutrition supplements ar • Encourage family to bring fav foods. • Monitor nutritional intake. • If NPO for > 24 hours, discuss MD. • Record dietary intake and I & appropriate.
Friction and Shear	**Problem** • Skin assessment and inspectio • Minimum of 2 people + draw pull patient up in bed. • Keep bed linens clean, dry, an free. • Apply elbow/heel protectors t skin over elbows and heels. • Elevate head of bed 30 degree

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Practice Insight

EHR Care Plans Triggered Based on Risk Assessment

Braden Scale for Predicting Pressure Sore Risk

SENSORY PERCEPTION	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment
MOISTURE	1. Constantly Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist
ACTIVITY	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently
MOBILITY	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitation
NUTRITION	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent
FRICTION & SHEAR	1. Problem	2. Potential Problem	3. No Apparent Problem	
				Total Score

Sensory Perception	**Less than 3**	**Sensory Perception Care Plan Triggered**
Moisture	**Less than 4**	**Moisture Care Plan Triggered**
Activity	**Less than 3**	**Activity Care Plan Triggered**
Mobility	**Less than 3**	**Mobility Care Plan Triggered**
Nutrition	**Less than 3**	**Nutrition Care Plan Triggered**
Friction & Shear	**Less than 3**	**Friction & Shear Care Plan Triggered**

Improve Care Planning

- Ensure that staff appreciate the value of care planning.
  - Let staff know their roles and responsibilities in reducing pressure injury incidence.
  - Empower staff to carry out their roles.

Improve Care Planning

- Make care planning more streamlined—link to the assessment task.
  - Document using the computer to tie the assessment directly to the care plan (saves time).
  - Use prompts to update the plan as your patient's condition changes (helps ensure his or her needs will continue to be met).

Improve Care Planning

- Examples of prompts linked to routine practice:
  - Generate a reminder to conduct pressure injury risk assessment when a patient is in the OR for more than 4 hours.
  - Order support surfaces and skin care products for patients you identify as at risk.
  - Include the care plan in shift reports and patient handoffs.

Remember: Let all levels of staff know what is required daily so they automatically carry out the task.

IDENTIFY YOUR BUNDLE OF BEST PRACTICES

Identify Best Practices

- Comprehensive skin assessment
- Standardized risk assessment:
  - Norton? Braden? Waterlow?
  - Another validated scale?
- Care planning

Identify Best Practices

- Comprehensive skin assessment:
  - Would you recommend that each admitted patient receive a skin assessment?
  - When would you recommend it get done again, if needed?
  - How do you want the assessment to be conducted?

Identify Best Practices

- Risk assessment:
  - Which standardized risk assessment scale do you plan to use?
  - When do you plan to complete risk assessments?

Identify Best Practices

- Care plan:
  - Does your current pressure injury planning process suffice for your prevention program?
  - Or should it be revised? If so, who will revise it?

Best Practices

- Need to be customized:
  - Each patient has a different set of pressure injury risk factors, so care must address each patient's unique needs.

Practice Insight

Pressure Ulcer Prevention Program
ACTION PLAN: JUNE 2015 - JANUARY 2016

KEY INTERVENTIONS/TASKS	STEPS TO COMPLETE TASK AND TOOLS TO USE	TEAM MEMEBERS RESPONSIBLE	TARGET DATE FOR COMPLETION	✓
Analyze Current State of Pressure Ulcer Prevention Practices	Create Policy-When to Call ET Services	Team Lead and LF, CT, and JL	August 10, 2015	✓
	Send Survey - Nursing Views on Pressure Ulcer Prevention	Team Lead	June 12, 2015	✓
	Send Survey - Pieper Knowledge Test	Team Lead	August 6, 2015	✓
	Data Review - Determine Target Goals	DC	June 17, 2015	✓
	Core Team to Review Webinars 3-8	CORE TEAM	August 10, 2015	✓
Identify the Bundle of Prevention Practices to be Used in Redesigned System	Develop Pocket Pad with Body Outline	JL, CS, MW, LS staff review	July 3, 2015	✓
	Skin Assessment on Hand-Off Nurse Worksheet	JL, CS, MW	July 31, 2015	✓
	Project Screen Savers for Pilot Computers	JL & RNs	Sep 30, 2015	✓
	Reorganize Pyxis for Pressure Ulcer Products	Unit RNs & Central Supply	Nov 30, 2015	IP
	Skin assessment documentation each shift	Pilot 6W, 7E - Real time documentation	July 31, 2015	✓
	Process for Pressure Ulcer education pamphlet distribution to our Roswell patients	JL to discuss with 6W staff for ideas	July 24, 2015	✓
	Unit Champion Selection for Pilot Units	JL, CT, MV	July 13, 2015	✓
	Develop Intervention Guidelines from Braden Score - paper to trial before building in EMR	JL, CT, MV to Review with staff	July 31, 2015	✓
	Create PU Note in EMR where MD and WOC documentation will be aligned w/ ICD-10	Team Lead	January, 2016	IP
	Decide on Information for Quality Board & Post	CORE TEAM	June 26, 2015	✓
	Develop SharePoint site for Team Members	JL	June 22, 2015	✓
	Decide on a Logo to use for Project	CORE TEAM	June 17, 2015	✓
Patient and Staff Education	Staff pocket booklet on PU Prevention	CORE TEAM	Nov 30, 2015	IP
	Patient Education on Pressure Ulcers	CORE TEAM	August 8, 2015	✓
	Staff Education on AHRQ PUP Program	Team Lead, LF, CT	Nov 30, 2015	IP
	Pressure Ulcer Prevention Bed Algorithm	Team Lead, LF, CT, BS	Nov 30, 2015	IP
	Reliability for Braden Score between nurses	Team Lead, LF, WD	October, 2015	IP
	Learning from Pressure Ulcer Case Reviews	Post in Breakroom	August 8, 2015	✓
	Financial Analysis on HAPUs - 2015 Data	Accounting	August 8, 2015	IP
	Understanding Prevalence & Incidence Rates	CORE TEAM	October, 2015	✓

Action Plan

- Discuss action steps for Key Intervention 2.
- Determine who is responsible for this task and when it will be completed.

Pressure Ulcer Prevention Action Plan **Date:** _____

Improvement Objective:

Key Interventions/Tasks	Steps To Complete Task and Tools To Use	Team Members Responsible for Task Completion	Target Date for Task Completion
1. Analyze current state of pressure ulcer prevention practices in this organization.			
2. Identify the bundle of prevention practices to be used in redesigned system.			
3. Assign roles and responsibilities for implementing the redesigned pressure ulcer prevention practices.			
4. Put the redesigned bundle into practice.			
5. Monitor pressure ulcer rates and practices.			
6. Sustain the redesigned prevention practices.			

Refer to your Action Plan Template.

Summary

- We reviewed:
  - Comprehensive skin assessment.
  - Braden and Norton risk assessment tools.
  - Care planning.
- You identified best practices for your hospital.
- You completed Key Intervention 2 of the Action Plan.