

# ***PADONA Journal***

***An Affiliate of ASLTCN -  
The American Society for Long Term Care Nurses***

***September - December 2013***

***MEDICARE RECOVERY AUDITORS LOOKING AT SNF PSY-  
CHIATRIC CONDITIONS***

***RECENT DEVELOPMENTS OFFER TIPS FOR REDUCING  
RISKS OF HIPAA VIOLATIONS AND MEDICAID REPAY-  
MENTS***

***SELF-AWARENESS (THE COMMON DENOMINATOR OF  
GREAT LEADERS)***

***WEAVING CREATIVITY INTO THE LIVES OF RESIDENTS***

***SERVANT LEADERSHIP: WHAT DOES IT MEAN FOR THE  
DIRECTOR OF NURSING (OR ANY NURSING LEADERSHIP  
POSITION)***

***MANAGEMENT OF PERSISTENT PAIN IN OLDER ADULTS***

***HERBAL USE IN OLDER ADULTS***

***FROM MANIPULATION TO TEMPER TANTRUMS: MANAG-  
ING EMOTIONS AT WORK***

***AVOIDING RISK OF PRESSURE ULCERS***



# Wound Care

## AVOIDING RISK OF PRESSURE ULCERS

Anne Scheurich

*How can your facility pursue best practices in the prevention of pressure ulcers? Learn about avoidable versus unavoidable pressure ulcers, pressure ulcer prevention points, and critical steps in wound documentation.*

Pressure ulcers (PrUs) are a significant, common, and costly medical problem in long-term care residents. Residents with PrUs have decreased quality of life and increased morbidity and mortality rates.<sup>1</sup> Facilities that have implemented comprehensive PrU-prevention protocols have demonstrated a decrease in incidence of PrUs.<sup>2-7</sup> With implementation of PrU-prevention protocols, long-term care facilities may also reduce costs associated with treating PrUs, improve resident quality of life, and decrease risk of litigation.<sup>4,8,9</sup>

An avoidable pressure ulcer is defined as one that can develop when the provider of care has failed to follow certain steps. These steps can be attributed to several factors. The most common factor is failure to evaluate a patient's clinical condition and pressure ulcer risk factors. In addition, it is also important to define and implement interventions consistent with individual needs, individual goals and recognized standards of practice. A lack of monitoring and evaluation of the impact of the interventions, or the revision of interventions as appropriate, can produce unnecessary pressure ulcers in patients.<sup>10</sup>

The National Pressure Ulcer Advisory Panel recommends five basic elements for preventing pressure ulcers.<sup>10</sup>

### 1. Risk Assessment

Consider conducting a risk assessment for all bed-bound and chair-bound persons, or those whose ability to reposition is impaired, to be at risk for pressure ulcers. It is recommended to use a

valid, reliable and age appropriated method of risk assessment that ensures systematic evaluation of individual risk factors, for example the Braden Scale.<sup>11</sup> Upon admission to a health care facility all patients and/or residents should undergo an at-risk assessment. This should be done at regular intervals thereafter and with a change in condition.

A schedule is helpful and this should be based on individual acuity and the patient care setting.

- Acute care: assess on admission, reassess at least every 24 hours or sooner if the patient's condition changes
- Long-term care: assess on admission, weekly for four weeks, then quarterly and whenever the resident's condition changes.
- Home care: assess on admission and at every nurse visit.

Once all individual risk factors have been identified (decreased mental status, exposure to moisture, incontinence, device related pressure, friction, shear, immobility, inactivity, nutritional deficits) specific preventive treatments should be in place, remembering to modify care according to the individual factors.

Document risk assessment subscale scores and total scores, and then implement a risk-based prevention plan.

### 2. Skin Care

A daily head to toe skin assessment, especially checking pressure points such as the sacrum, ischium, trochanters, heels, elbows, and the back of the head should be performed as part of the prevention plan for pressure ulcers.

Bathing should be individualized and frequent, using a mild cleansing agent, avoiding hot water and excessive rubbing. Use lotion after bathing and moisturizers for dry skin. Strive to minimize environmental factors leading to dry skin such as low humidity and cold air. Avoid massaging over bony prominences.

For neonates and infants follow evidence-based institutional protocols.

Patients suffering from incontinence should have a personalized bowel and bladder program, especially when incontinence cannot be controlled. In such cases cleanse skin at time of soiling and use a topical barrier to protect the skin. Upon selecting under pads or briefs look for those that are absorbent and provide a quick drying surface to the skin. If necessary, consider a pouching system or collection device to contain stool and to protect the skin.

### 3. Nutrition

Identifying and correcting factors compromising the patient's protein and caloric intake are another important element in the prevention of pressure ulcers. These parameters need be consistent with overall goals of care. In the event of deficiencies in the patient's diet, additional nutritional supplementation should be considered. These can include offering the patient a glass of water when turning the patient over, as a way to keep the resident hydrated. Multivitamins with minerals - per physician's order - are a common supplement used in these cases.

### 4. Mechanical Loading and Support Surfaces

Bed-bound persons should be changed position at least every two hours and chair-bound persons every hour consistent with overall goals of care. Postural alignment, distribution of weight, balance and stability as well as pressure redistribution are part of the protocol to be used when repositioning persons in chairs and wheelchairs.

Keeping a written reposition schedule for all residents at risk, is a recommended method to avoid unnecessary complications. Follow these basic steps:

- Teach chair-bound persons - those who are able - to shift weight every 15 minutes.
- Use pressure-redistribution mat-



- tresses and chair cushion surfaces.
- Avoid donut-type devices and sheepskin for pressure redistribution.
- In the operating room use pressure-redistribution devices.
- Use lifting devices - trapeze or bed linens - to move persons rather than dragging them during transfers and position changes.
- Use pillows or foam wedges to keep bony prominences - knees and ankles - from direct contact with each other. Pad skin subjected to device related pressure and inspect regularly.
- Use devices that eliminate pressure on the heels. For short-term use with cooperative patients, place pillows under the calf to raise the heels off the bed. Place heel suspension boots for long-term use.
- Avoid position directly on the trochanter when using the side-lying position; use the 30° lateral inclined position.
- Maintain the head of the bed at or below 30° at the lowest degree of elevation consistent with the patient's/resident's medical condition.

Additionally, institute a rehabilitation program to maintain or improve mobility/activity status.

## 5. Education

Education is key to prevention of painful pressure ulcers. It is imperative that facilities implement comprehensive PrU educational programs that are structured, organized, comprehensive and directed at all levels of health care providers, patients, family and caregivers. These programs should incorporate mechanisms that evaluate program effectiveness in preventing pressure ulcers.

Information should include the following:

- Etiology of and risk factors for pressure ulcers.
- Risk assessment tools and their application.

- Skin assessment.
- Selection and use of support surfaces.
- Nutritional support.
- Program for bowel and bladder management.
- Development and implementation of individualized programs of skin care.
- Demonstration of positioning to decrease risk of tissue breakdown.
- Accurate documentation of pertinent data.

## Critical Steps in PrU Documenting

Documenting pressure ulcers is an integral part of staff and or care givers' responsibilities. Facility wound management should consider the following eight components of effective documentation practices.

### 1. Evaluate the individual's clinical condition and pressure ulcer risk factor.

Consider use of a standardized tool recommended by NPUAP and WOCN. The most widely used are the Braden<sup>11</sup> Scale and the Norton Scale<sup>12</sup>. Standards of practice dictate an assessment be done upon admission to the facility and with any change in condition. For Long Term Care environments - upon admission - once weekly for the first month and then monthly is the recommended standard.

### 2. Define and implement interventions consistent with individual needs.

This is achieved by paying close attention to the individual's sub-score within the Braden risk tool.<sup>11</sup> Individualizing interventions based on the sub-scores (moisture, nutrition, mobility, etc.) will provide evidence of care targeted to the individual's needs.

### 3. Set individual goals.

Keep in mind that not every wound will heal. Whether is due to the patient's clinical status, personal compliance or

location of the wound, healing may not always be an appropriate goal. Make sure to clearly discuss the goal of care with the individual and document the discussion.

### 4. Reference standards of practice.

As part of recognized Standards of Practice, always be sure to look at the whole patient not just the hole in the patient... Standards of practice dictate that the issues of Nutrition, Repositioning, Support Surface and Hemodynamic Instability be addressed in conjunction with specific wound site management.

### 5. Consider nutrition.

Engage the facility dietician for a nutrition plan that addresses the at-risk individual. The role of the CNA is in reporting dietary consumption. Consistently reviewing and documenting the sub-scores on your Risk Assessment tool will help you monitor progress.

### 6. Consider repositioning & support surfaces.

*Repositioning* should be done every two hours as a guideline, not a standard. The individual's specific wound history, clinical history and compliance need to be considered and documented to support a turning schedule that is effective.

Preventive *support surfaces* for individuals at risk should be provided on a continuous basis during the time that they are at risk. These should be assessed and applied carefully. Be sure to consider special needs of seated patients.

### 7. Consider hemodynamics.

Any pharmacologic or mechanical support required to provide adequate cardiac output or normal blood pressure, constitutes hemodynamic instability. More broadly as global or regional perfusion that is not adequate to support normal organ function, including the skin. (NPUAP, Feb 2011)

(Continued on page 28)



# Wound Care

(Continued from page 27)

Be sure to check labs such as Albumin and Pre-Albumin in the case of chronic or slow to heal wounds.

## 8. Monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

Treatment protocols will only work when one frequently and consistently reassesses the situation. As a general rule if no progress is noted in a 14 day time span, change the treatment plan. This may include any of the previously outlined interventions (nutrition, repositioning, etc.)

Consider use of an objective tool such as PUSH<sup>13</sup> to track and monitor progress towards healing.

Documentation of wound care is an important part of pressure ulcer prevention and healing. Increasingly facilities are including wound photography as part of the documentation record to show wound progression and document admissions status.

In summary, long term care facilities help win the war against pressure ulcers by consider the prevention points and following best practices in documentation.

Anne Scheurich, BS,RN, CWOCN, is the Vice President of Clinical Services for WoundRounds®, *the wound management and prevention solution that empowers nurses to deliver better wound care in less time*. Ms. Scheurich is a certified wound, ostomy and continence nurse (CWOCN), past president of the Northern Illinois Affiliate of the Wound Ostomy Continence Nursing Association and the former editor of WOCNews. She can be reached at [anne.scheurich@woundrounds.com](mailto:anne.scheurich@woundrounds.com)

## References

1. Berlowitz DR, Brandeis GH, Anderson J *et al*. Effect of pressure ulcers on the survival of long-term care residents. *J Gerontol A Biol Sci Med Sci* 1997;52A: 106-110.
2. Cuddigan J, Ayello EA, Sussman

C, eds. *Pressure Ulcers in America. Prevalence, Incidence, and Implications for the Future*. Reston, VA: National Pressure Ulcer Advisory Panel, 2001.

3. Bodnar B, Myron P. Portrait of practice: Reducing the prevalence of pressure ulcers. *Decubitus* 1992;5: 49-52.
4. Regan M, Byers PH, Mayrovitz HN. Efficacy of a comprehensive pressure ulcer prevention program in an extended care facility. *Adv Wound Care* 1995;8: 49-55.
5. Kartes SK. A team approach for risk assessment, prevention, and treatment of pressure ulcers in nursing home patients. *J Nurs Care Qual* 1996;10: 34-45.
6. Boettger JE. Effects of a pressure-reduction mattress and staff education on the incidence of nosocomial pressure ulcers. *J Wound Ostomy Continence Nurs* 1997;24: 19-25.
7. Xakellis GC, Frantz RA, Lewis A *et al*. Cost-effectiveness of an intensive pressure ulcer prevention protocol in long-term care. *Adv Wound Care* 1998;11: 22-29.
8. Hu T, Stotts NA, Fogarty TE *et al*. Cost analysis for guideline implementation in prevention and early treatment of pressure ulcers. *Decubitus* 1993;6: 42-46.
9. Xakellis GC, Frantz RA. The cost-effectiveness of interventions for preventing pressure ulcers. *J Am Board Fam Pract* 1996;9: 79-85.
10. The National Pressure Ulcer Advisory Panel, [www.npuap.org](http://www.npuap.org)
11. Braden BJ, Makelbust J. Preventing pressure ulcers with the Braden scale: an update on this easy-to-use tool that assesses a patient's risk. *Am J Nurs* 105(6): 70-2., [Bradenscale.com](http://Bradenscale.com)
12. Norton D, McLaren R, Exton-Smith AN. An investigation of geriatric nursing problems in the hospital. London, UK: National Corporation for the Care of Old People; 1962
13. Pressure Ulcer Scale for Healing PUSH Tool 3.0, <http://npuap.org/pushins.htm>

## Additional Resources

- Ayello EA. Preventing pressure ulcers and skin tears. In Mezey M, Fulmer T, Abraham I, Zwicker DA (editors). *Geriatric nursing protocols for best practice*. 2<sup>nd</sup> ed. New York: Springer Publishing Company, Inc. 2003. p. 165-84.
- Ayello EA, Braden B. How and why to do pressure ulcer risk assessment. *Adv Skin Wound Care*. 2002 15(3): 125-131.
- Baharestani MM, Ratliff C and the National Pressure Ulcer Advisory Panel. Neonatal and pediatric pressure ulcers: an NPUAP white paper. *Adv Skin Wound Care*. 2007.
- Black JM. Preventing heel pressure ulcers. *Nursing* 2004 Nov 34 (11):17
- Brienza DM, Geyer MJ. Using support surfaces to manage tissue integrity. *Adv Skin Wound Care*. 2005 18(3): 151-7.
- Using support surfaces to manage tissue integrity, *Adv Skin Wound Care*. 2005 18(3): 151-7.
- Cullum N, Deeks J, Sheldon TA, Song F, Fletcher AW. Cochrane Review. Beds, Mattresses and Cushions for Pressure Sore Prevention and Treatment. In: *The Cochrane Library*, 2000. Issue 3.
- Posthauer, ME. Hydration: an essential nutrient. *Adv Skin Wound Care*. 2005 18(1): 32-3.
- Posthauer, ME, Jordan, RS, Sylvia, C. & National Pressure Ulcer Advisory Panel. Support Surface Initiative: Terms and Definitions and Patient Care. *Adv Skin Wound Care*, Nov 2006 19 (9): 487-9
- The National Pressure Ulcer Advisory Panel's Summary of the AHCPR Clinical Practice Guideline, *Pressure Ulcers in Adults: Prediction and Prevention* (AHCPR Publication No. 92-0047. Rockville, MD: May 1992). © 1993 NPUAP
- Wound Ostomy and Continence Nurses Society. (2003) *Guideline for Prevention and Management of Pressure Ulcers*. Glenview: IL. WOCN.