Pressure Injury & Documentation

By: Dr. Payam Tehrani, MD
SNF Wound Care

Goals of this lecture…

This presentation focuses on pressure injuries = bed sores = decubitus ulcers.

By the end of this lecture, you should understand

- What is a pressure injury
- Pathology of a pressure injury
- The different Stages of pressure injuries
- How to prevent pressure injuries
- How to treat pressure injuries
- How to DOCUMENT pressure injuries

Our Goals…

Zero in-house pressure injury or areas of skin breakdown on all patients.

Quick recognition and interventions when breakdown occurs, leading to early resolution of pressure injury.

CNA understanding of why pressure injury occurs and incentivize CNA for their good work and hold others accountable.

Activity

Sit in an uncomfortable position without moving for 20 minutes.

What is a Pressure Sore?

Also known as *"pressure injury", "decubitus ulcers"* & *"bed sores".*

It is an injury to the skin and underlying tissue resulting from prolonged pressure and/or friction on the skin.

Pressure against the skin reduces blood flow to the skin and nearby tissue, reducing the flow of oxygen leading to distal tissue ischemia.

This reduced blood flow causes the skin to redden then open causing a wound which can be deep and difficult to heal.

What Causes Pressure Injury?

Prolonged Pressure:

An individual lying or sitting in a position for a prolonged period of time.

The flow of blood is decreased and/or stops flowing to the area.

The skin and tissue distally becomes damaged and reddens then opens.

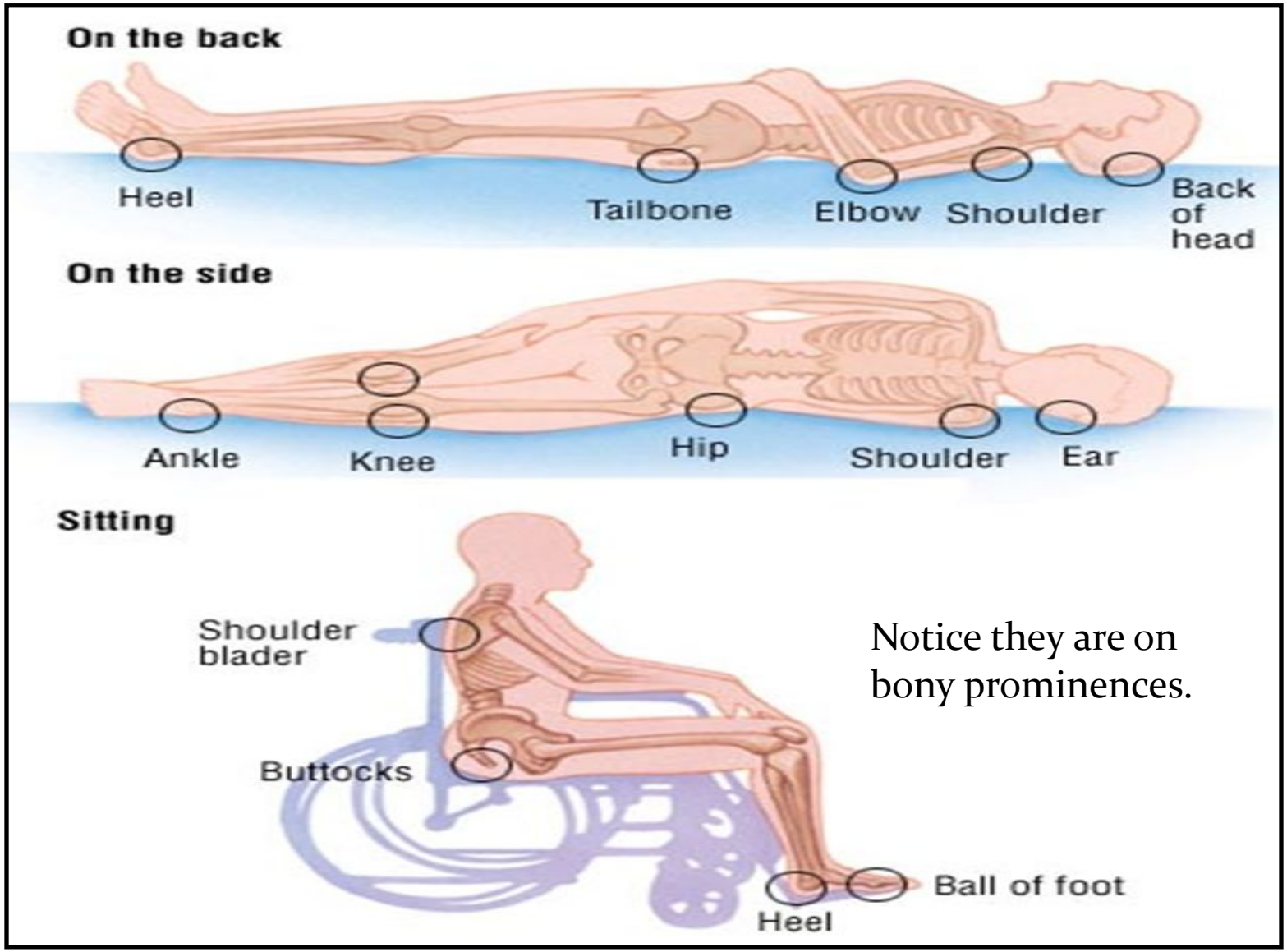
Bony Prominences are high Risk

Be aware that there are areas on the body that are at higher risk of breaking down due to pressure and friction.

HINT: They are on bony prominences!

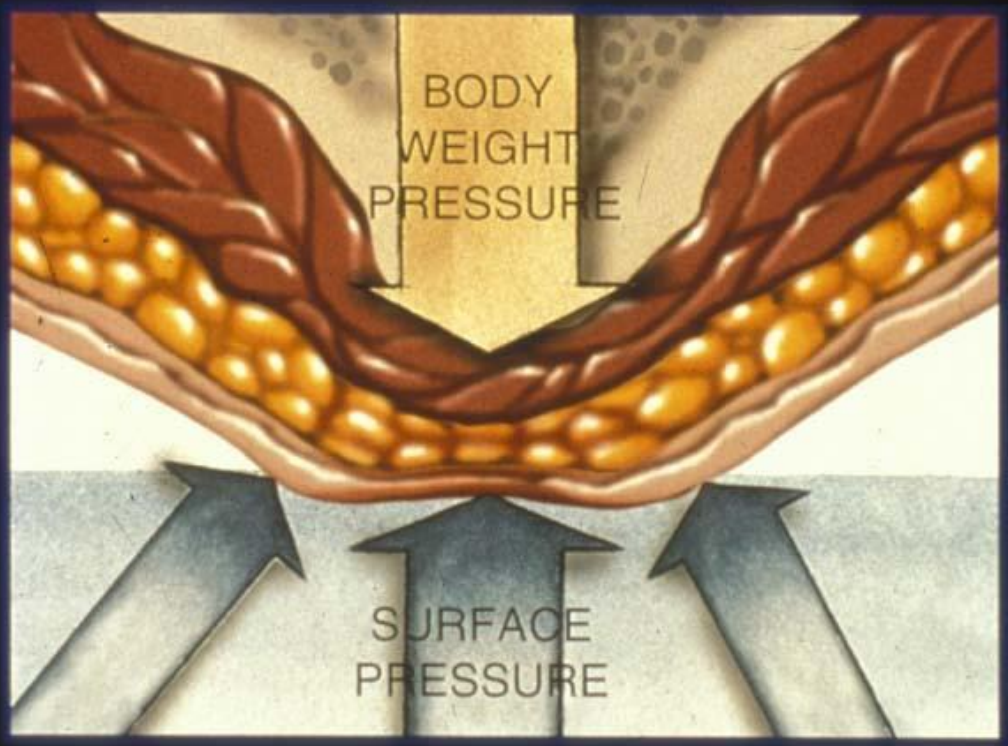
Name some of these bony prominences!

Common Pressure Points



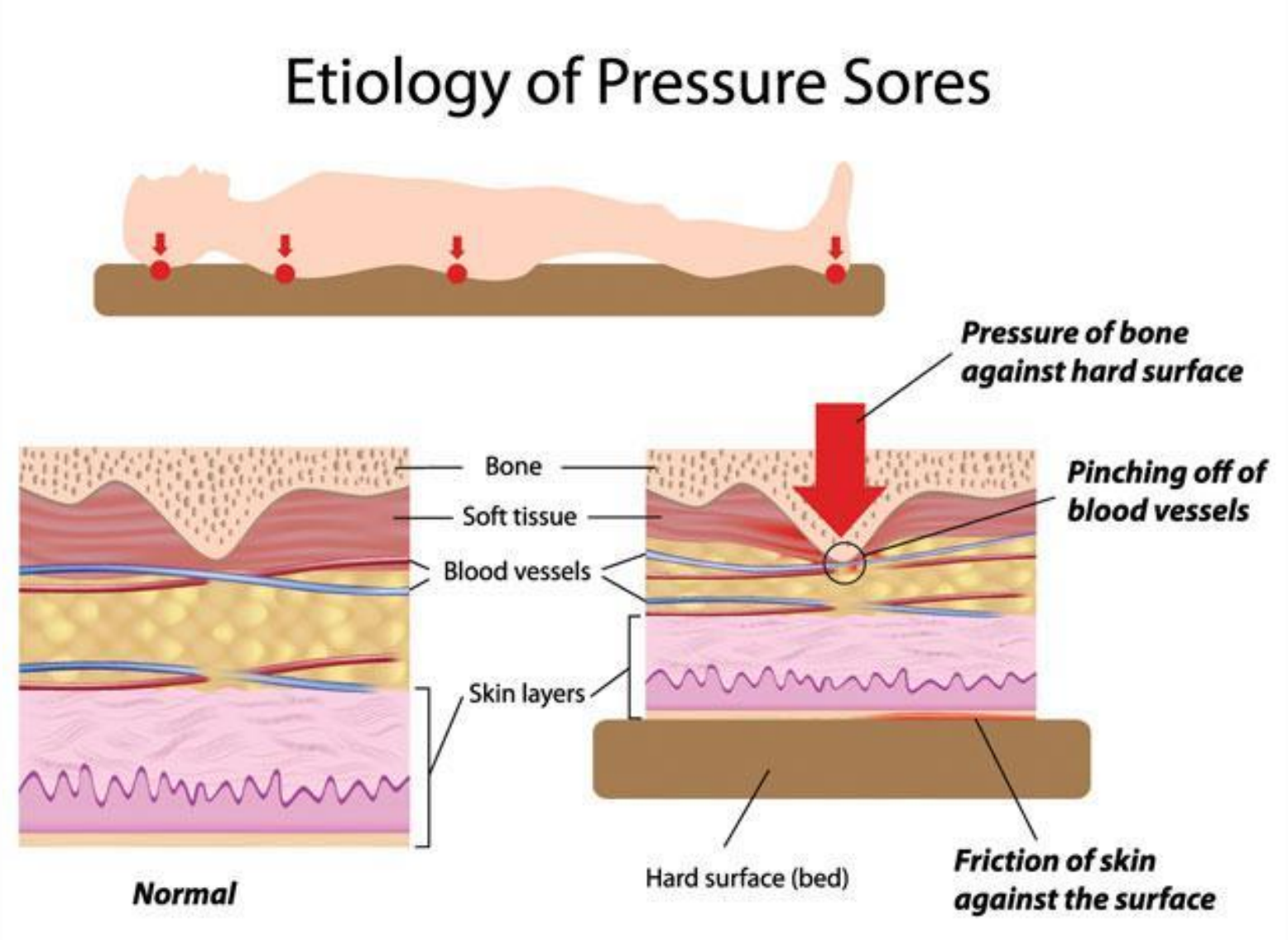
Notice they are on bony prominences.

Pressure



Compression or squeezing together of soft tissue caused by weight or tension, resulting in ischemic response and, potentially, tissue necrosis.

Collapse of the Blood Vessel



Pathogenesis of Pressure Injury

1. Intensity of pressure on capillary closing
2. Duration and sustenance of pressure
3. Tissue Tolerance

Pathogenesis of Pressure Injury

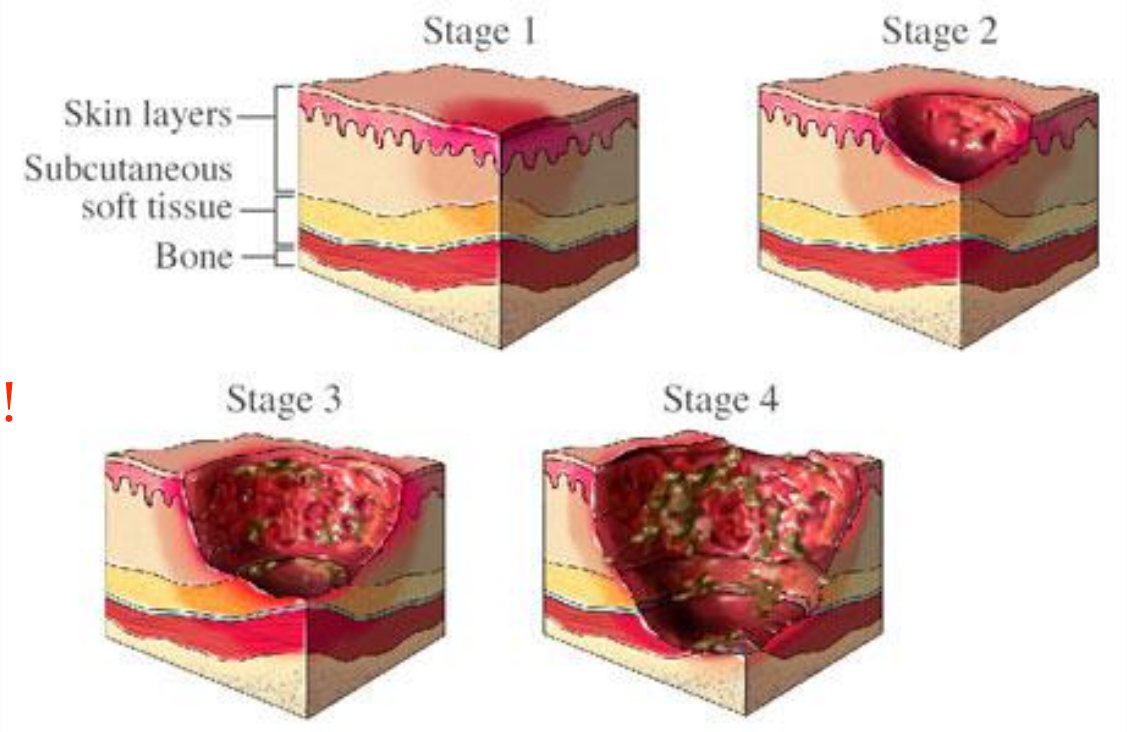
Bony prominences are at highest risk (sacrum, heels, elbows, lateral malleoli, greater trochanter, ischial tuberosities).

Pressure injury form as a result of time/pressure relationship.

The greater the pressure and duration of pressure, the greater the incidence of ulcer formation.

Stages of Pressure Injury

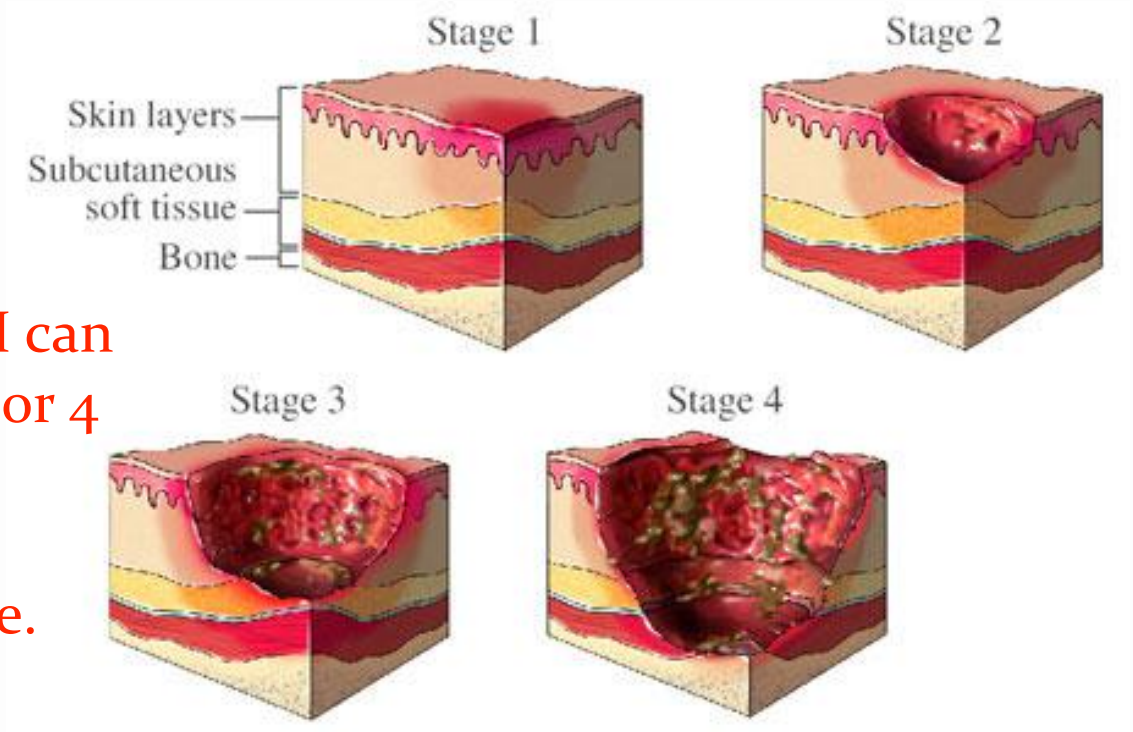
There are different stages of pressure injury, Stage 1 being the least serious and Stage 4 being the most serious condition.



Name the other 2 pressure injury types!

Unstageable & DTI

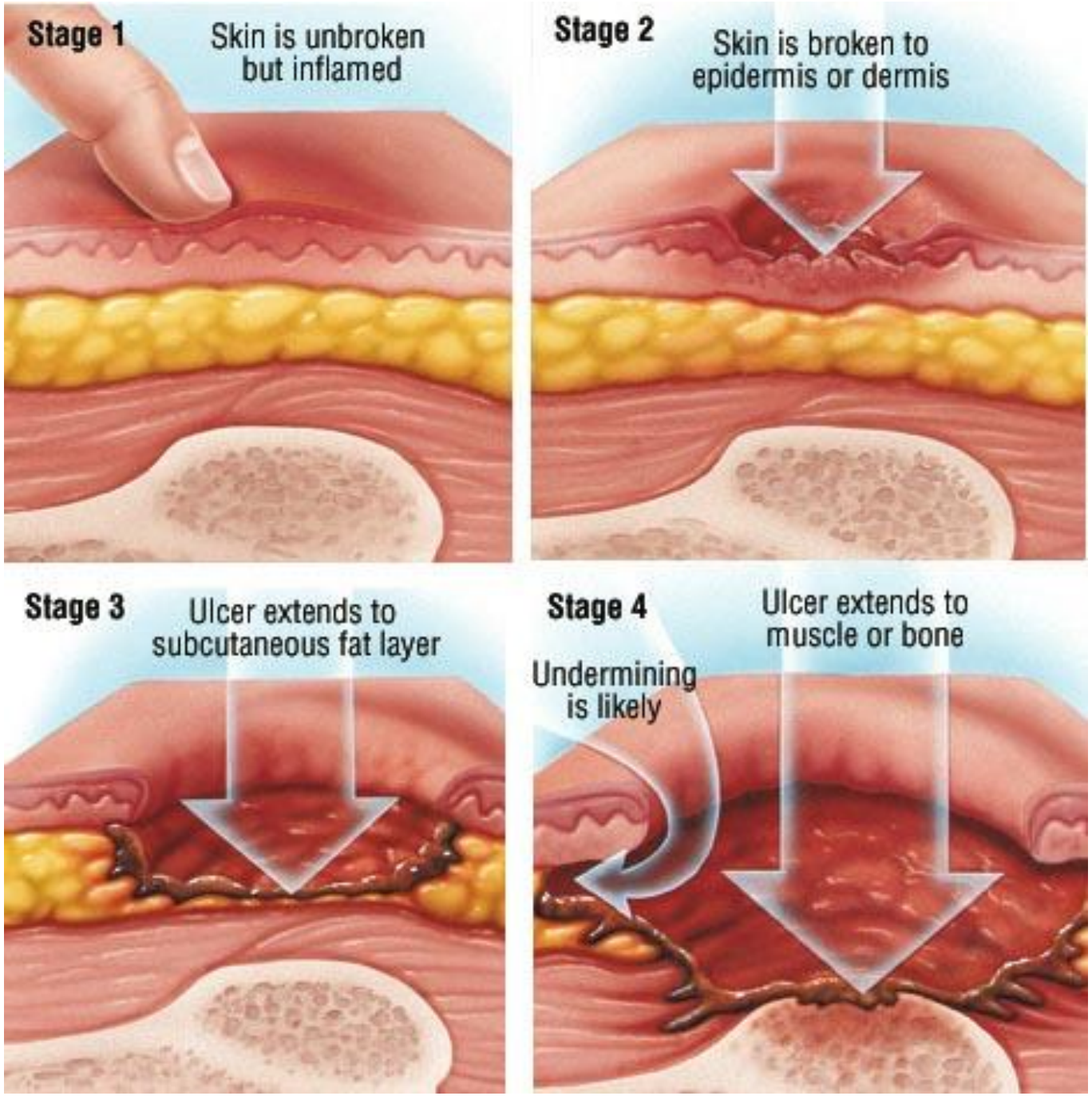
Unstageable and DTI fall between Stage 3 and Stage 4



Unstageable and DTI can only become Stage 3 or 4 Not Stage 2.

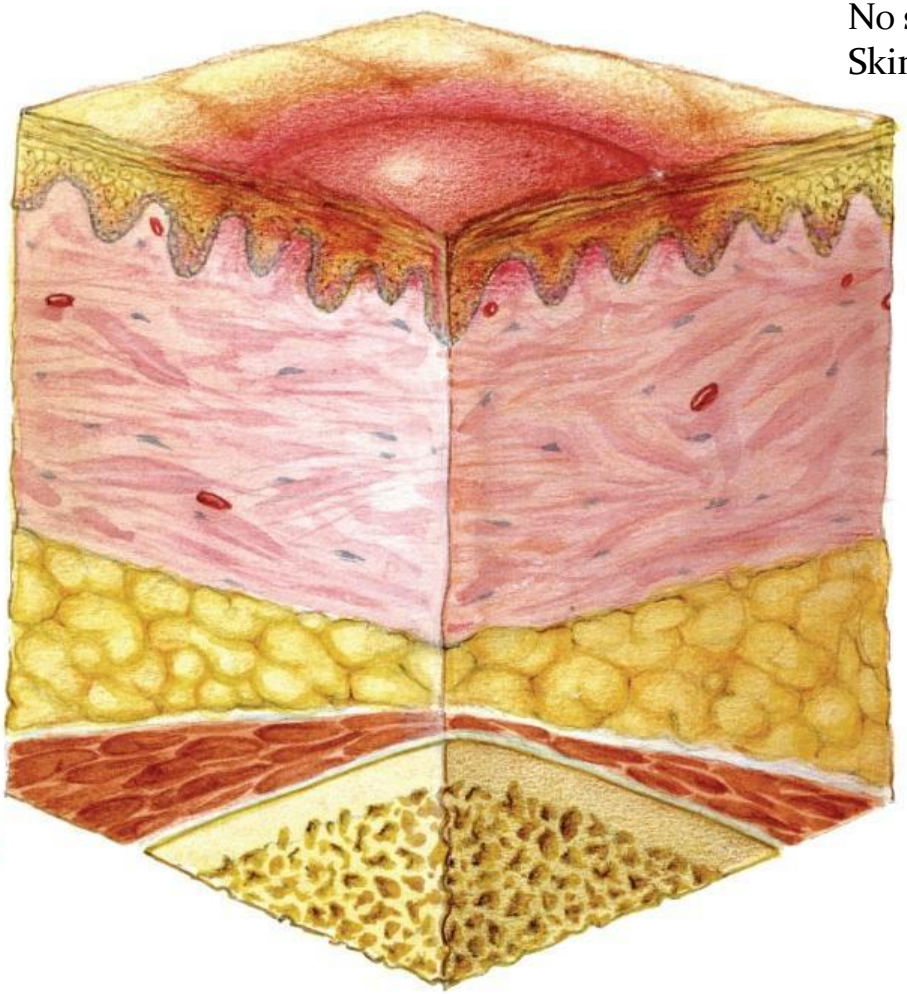
Stage 4 is most severe.

SNF
WOUND CARE



Stage I

No skin breakdown.
Skin is still intact, just pinkish.



NATIONAL PRESSURE ULCER ADVISORY PANEL

STAGE 1

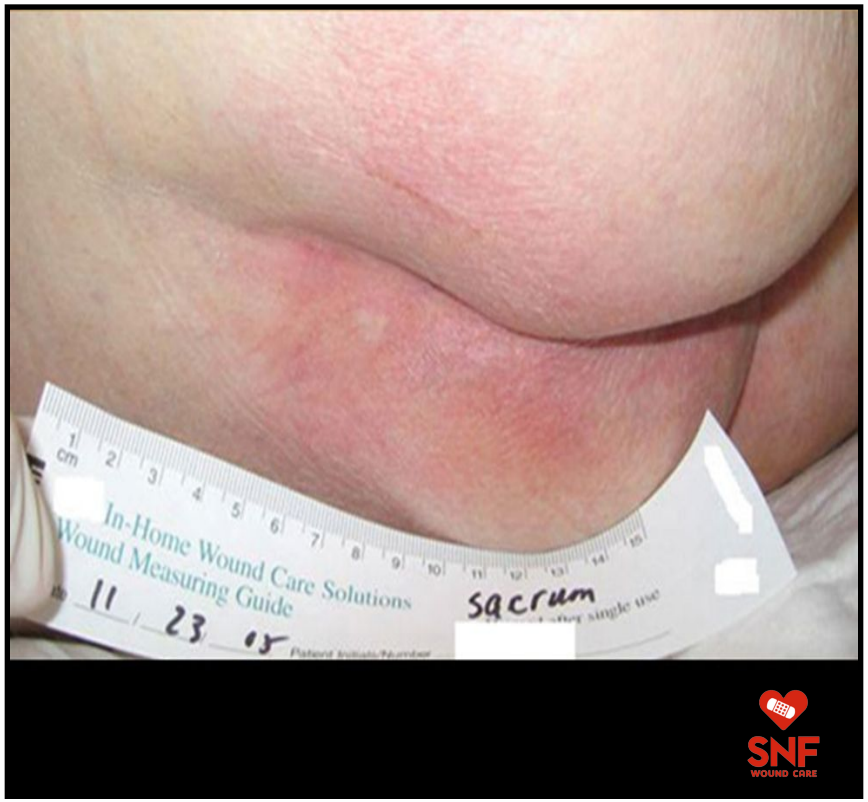
Staging and Evaluating a Pressure Injury

STAGE I:

A persistent area of skin redness that does not disappear when pressure is removed (non-blanchable).

The skin is not broken. Skin appears red. Skin may not lighten "blanche" when lightly pressed/touched.

The site may be tender, painful, firm, soft and warm or cool compared to the surrounding skin.



Stage 1

Stage 1

Wounds are NOT OPEN!

Non-Blanchable Redness

Stage 1 can feel either firmer or softer than the area around it.

Stage I Pressure Injury

Intact skin with non-blanchable redness of a localized area commonly over a bony prominence.

Darkly pigmented skin may not have blanching: its color may differ from the surrounding area.

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

Stage I may be difficult to detect in individuals with darker skin tones.

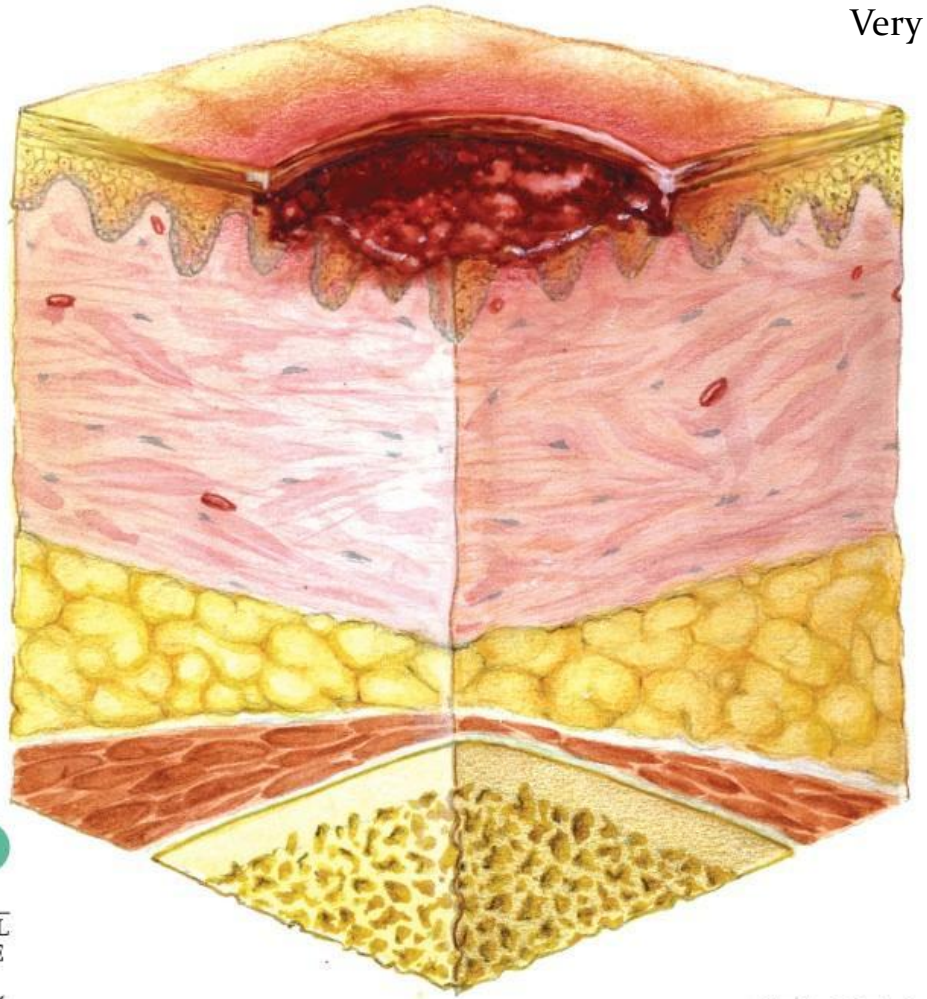
Stage I Treatment

Off-load pressure
Off-load pressure
Off-load pressure

Moisture barrier creams
(Zinc or Calmoseptine or Vitamin A&D)

Stage II

Very superficial break in skin.



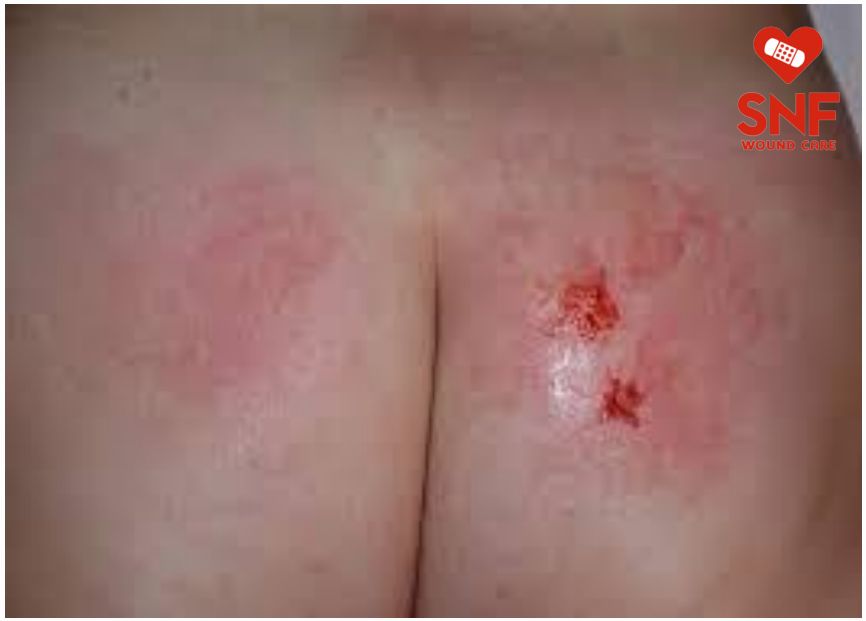
Staging and Evaluating a Pressure Injury

STAGE II:

The outer layer of skin (epidermis) and the inner layer (dermis) is damaged or lost.

The wound bed (open area) may be shallow and pinkish or red.

The wound may look like an abrasion, fluid-filled blister or shallow crater.



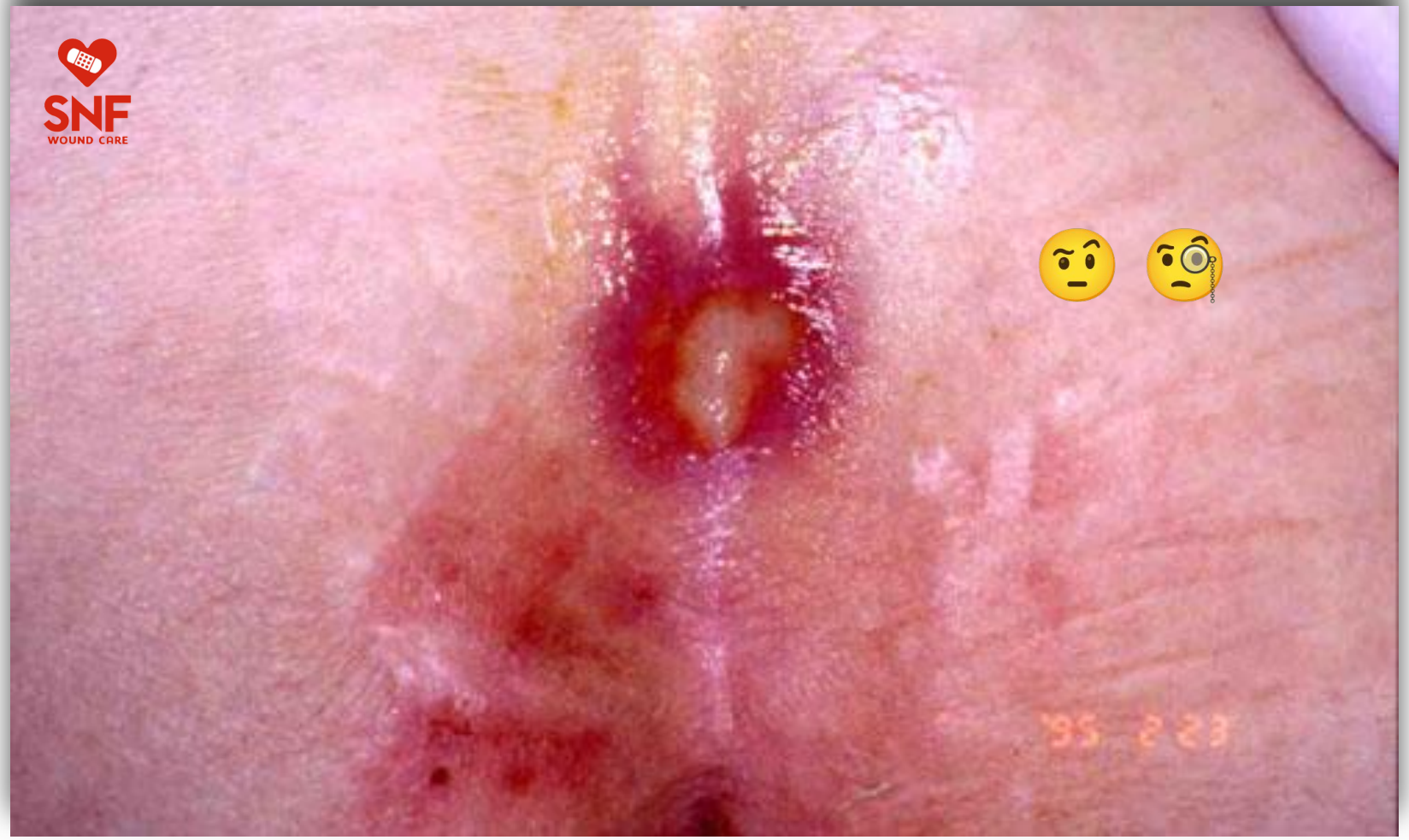
Stage II Pressure Injury

Partial thickness skin loss involving the epidermis and/or dermis. It appears superficial.

The ulcer is superficial and presents clinically as an abrasion, blister, or shallow open ulcer.

Presents as shiny or shallow ulcer (red/pink wound bed) without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage II



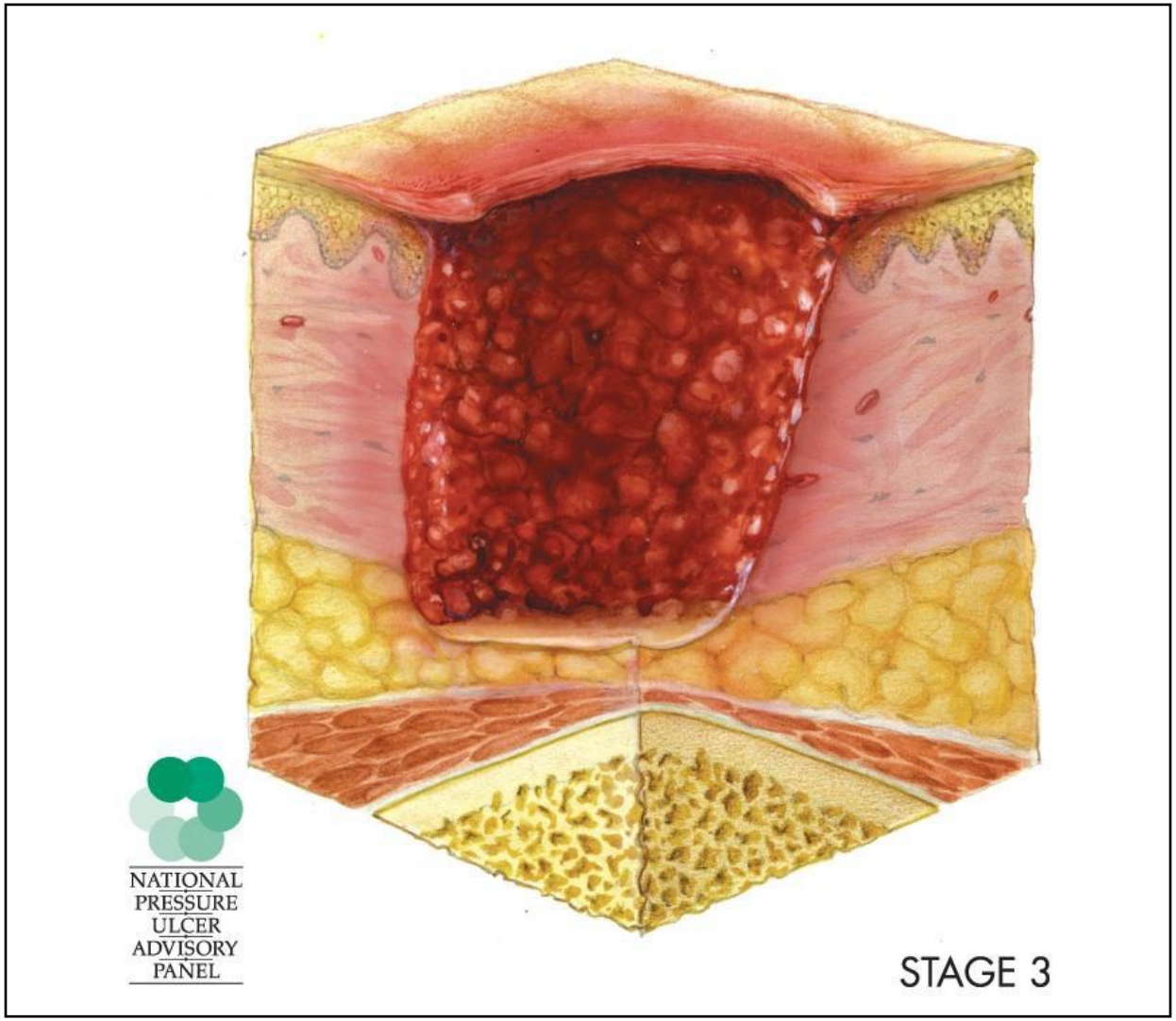
Stage II Treatment

Off-load pressure, Off-load…..

Barrier cream

Patients who are at a high risk for breakdown should be put on a low air loss mattress.

Stage III



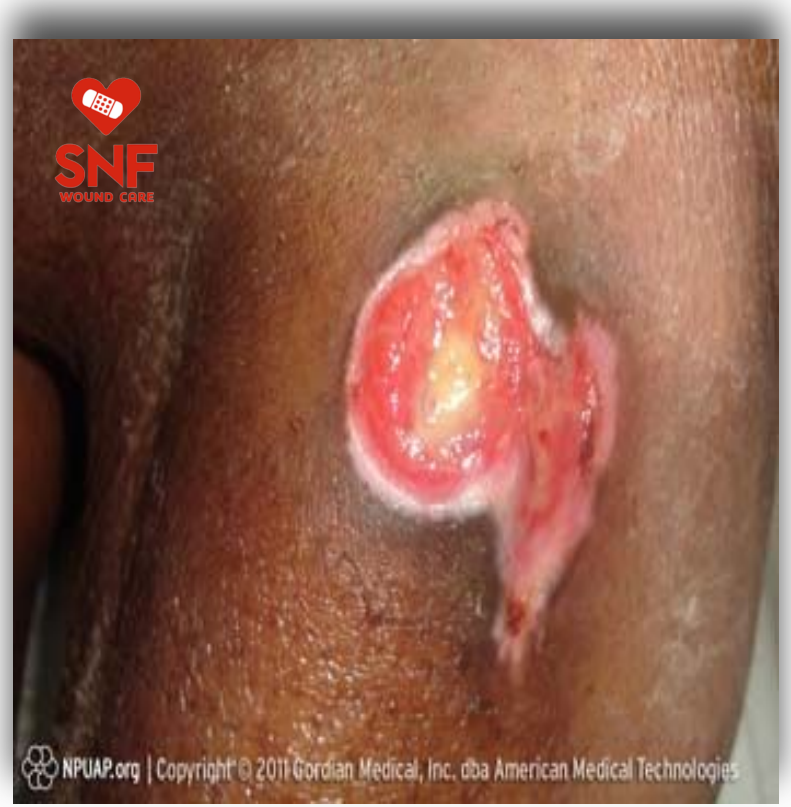
Staging and Evaluating a Pressure Injury

STAGE III:

A full thickness of skin is lost.The loss of skin usually exposes the fat layer.The ulcer/sore looks like a "crater."

The bottom of the wound bed may have yellowish tissue (slough).

The damage may extend beyond what you see to below layers of healthy skin.



Stage III

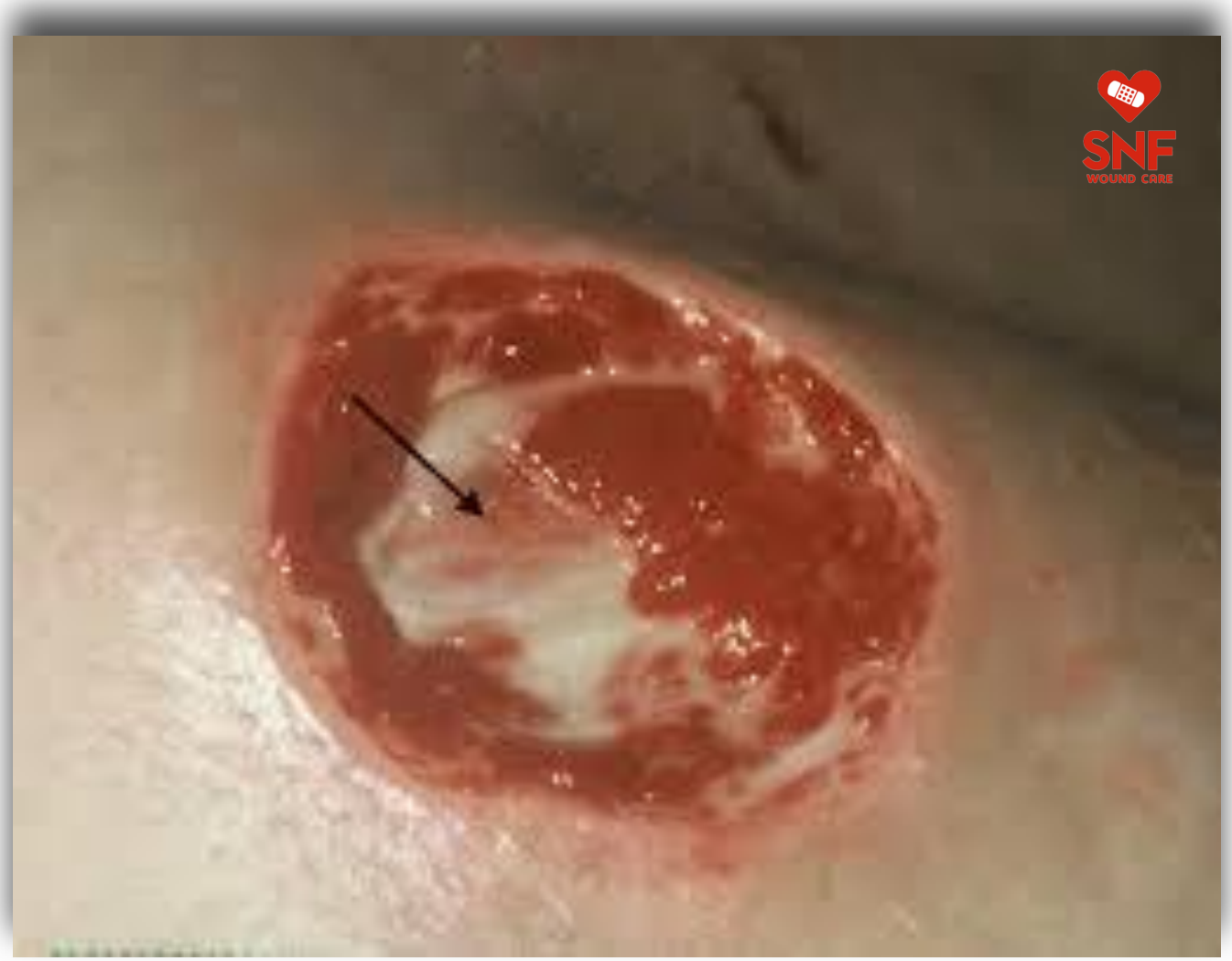
Full thickness skin loss involving damage or necrosis to subcutaneous tissue that may extend down to, but not through underlying fascia.

Ulcer presents as a deep crater with or without undermining or tunneling of adjacent tissue.

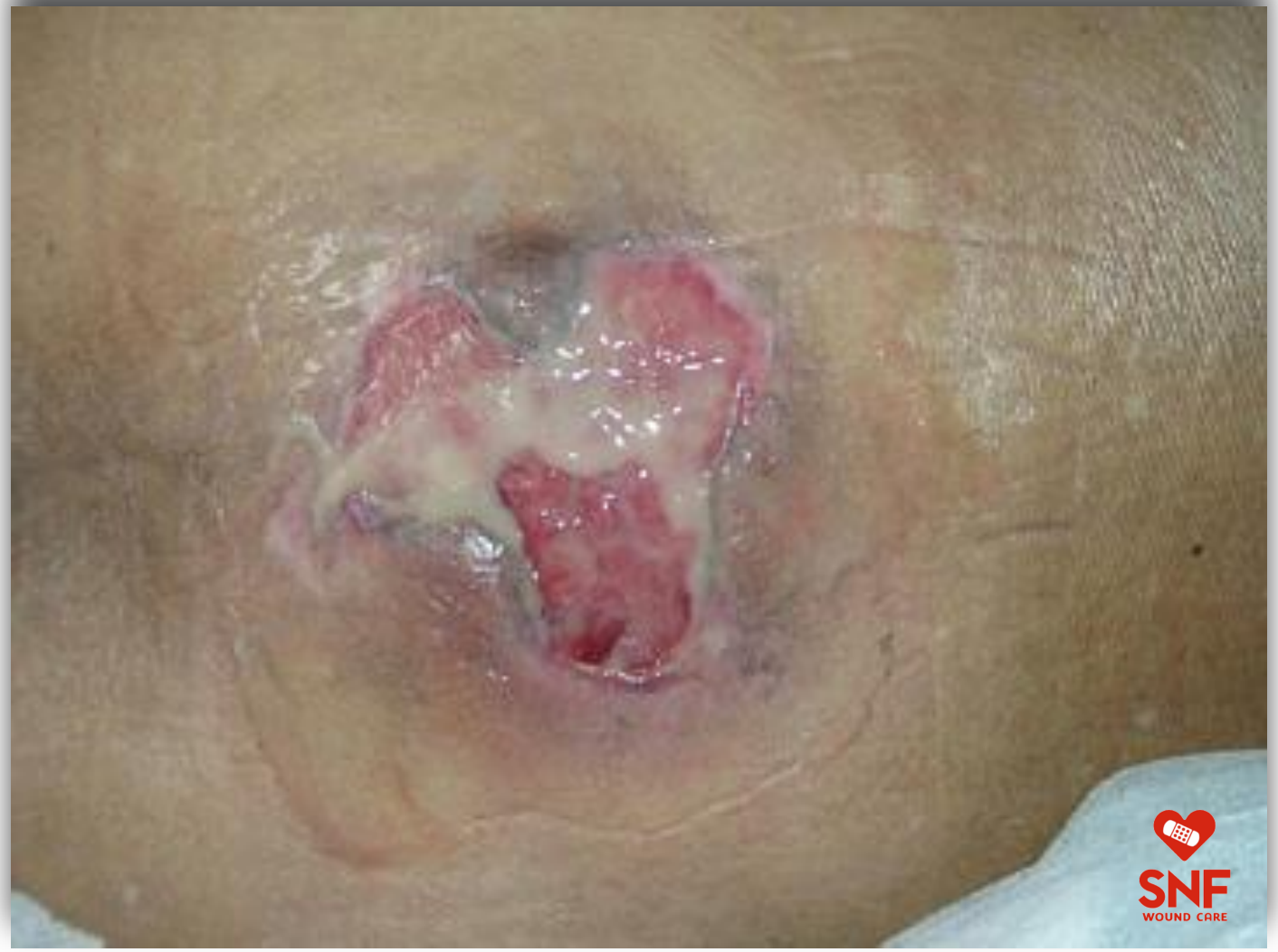
Slough may be present but does not obscure the depth of tissue loss.

Depth varies by anatomical location.

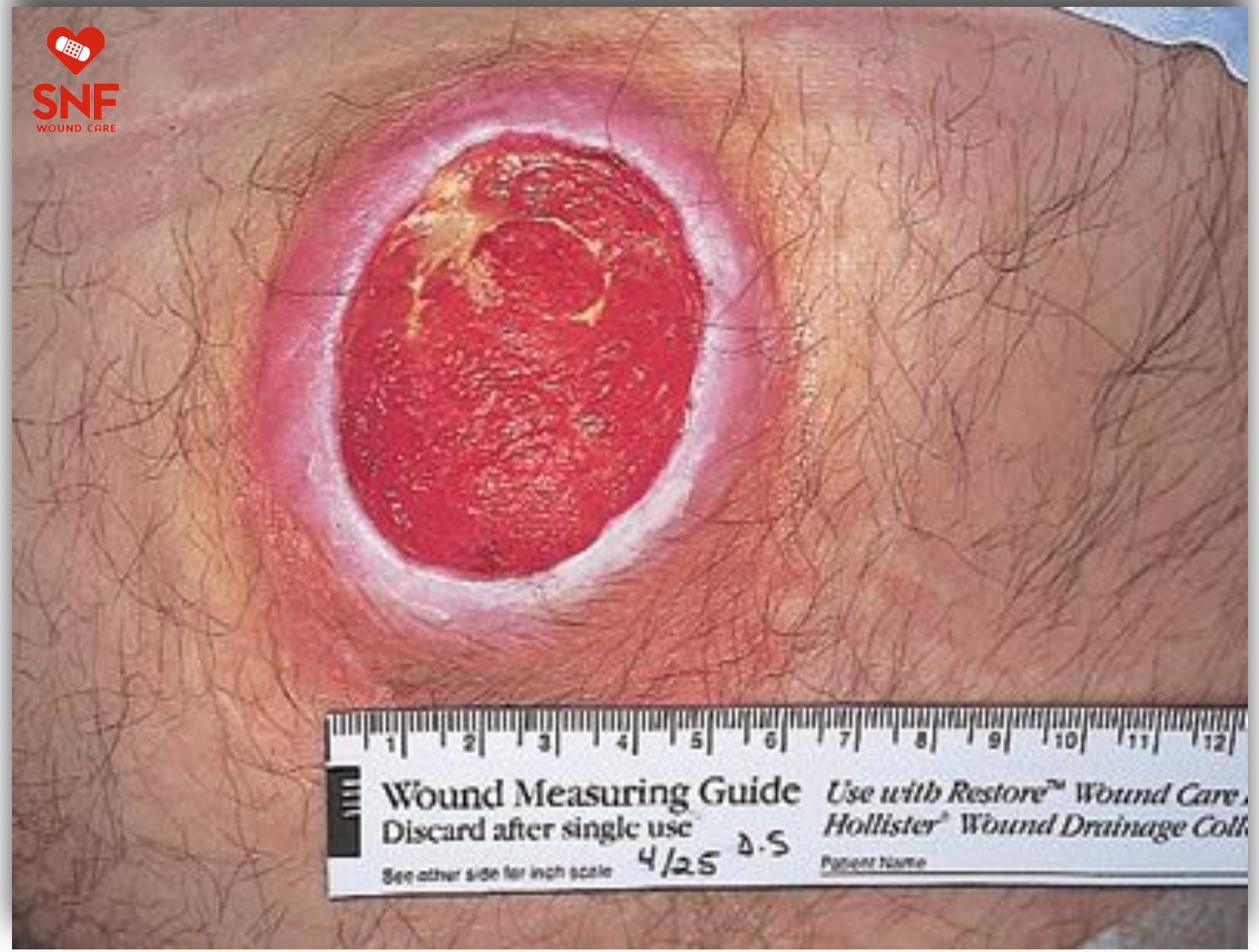
Stage III



Stage III



Stage III


Wound Measuring Guide
Discard after single use
See other side for inch scale
4/25
Use with Restore™ Wound Care
Hollister® Wound Drainage Coll
Patient Name

Stage III

Stage 3 is often seen by a Physician and slough is debrided if present.

No Muscle, Bone, Tendon or Cartilage (otherwise it's a stage 4)

Granulation and slough are almost always present.

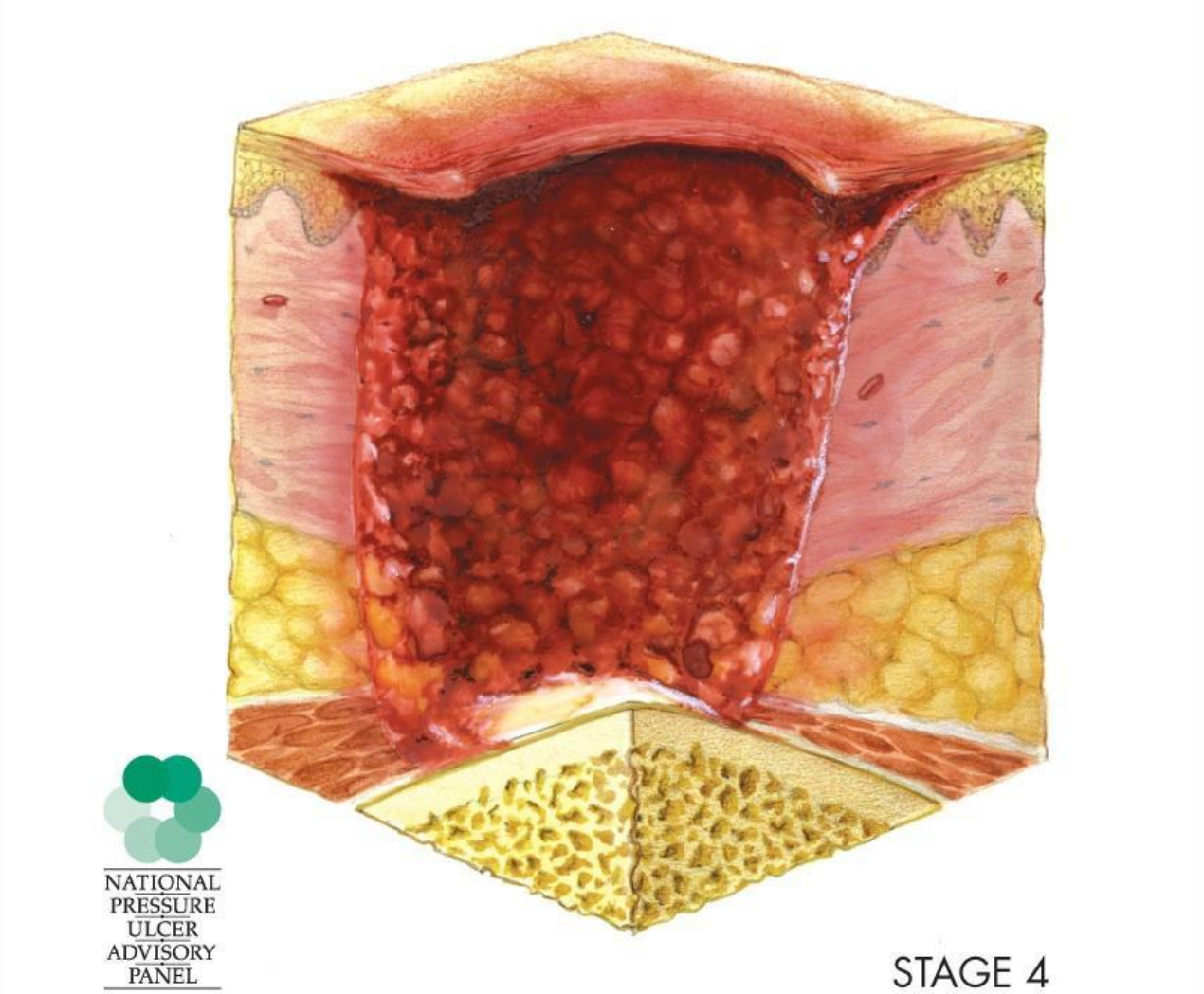
Undermine can be present.

Most of these patients are immobile and have poor sensation.

Treatment includes honey, santyl, silvadene, wet to dry…

Low Air Loss Mattress, aggressive offloading.

Stage IV



Staging and Evaluating a Pressure Injury

STAGE IV:

The pressure injury is very deep, reaching into muscle, bone, cartlidge and or tendon causing extensive damage.

Damage to deeper tissues, joints may occur.

Stage 4 is diagnosed when Muscle, Tendon, Cartilage or Bone is exposed.

Stage IV

Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, tendons and/or cartridge (ear).

Undermining and tunneling are commonly associated with Stage 4 ulcers but can also be seen in stage 3.

Slough or eschar is commonly present on the wound bed.

Depth of wound varies by anatomical location.

Very important:

Just because you don't see bone doesnt mean its not a stage 4.

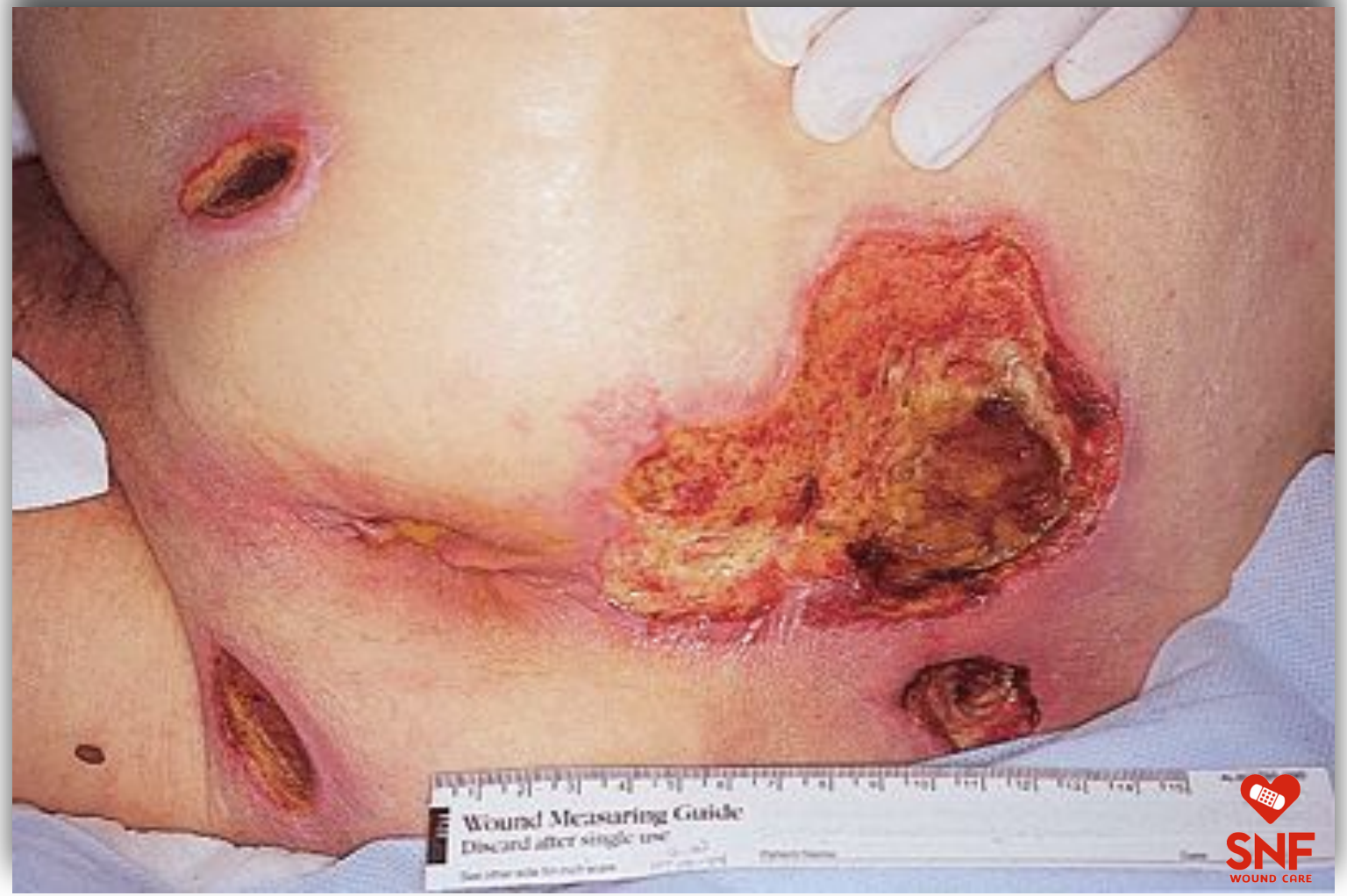
If bone is palpable, its stage 4!

Exposed bone is commonly visible or directly palpable.

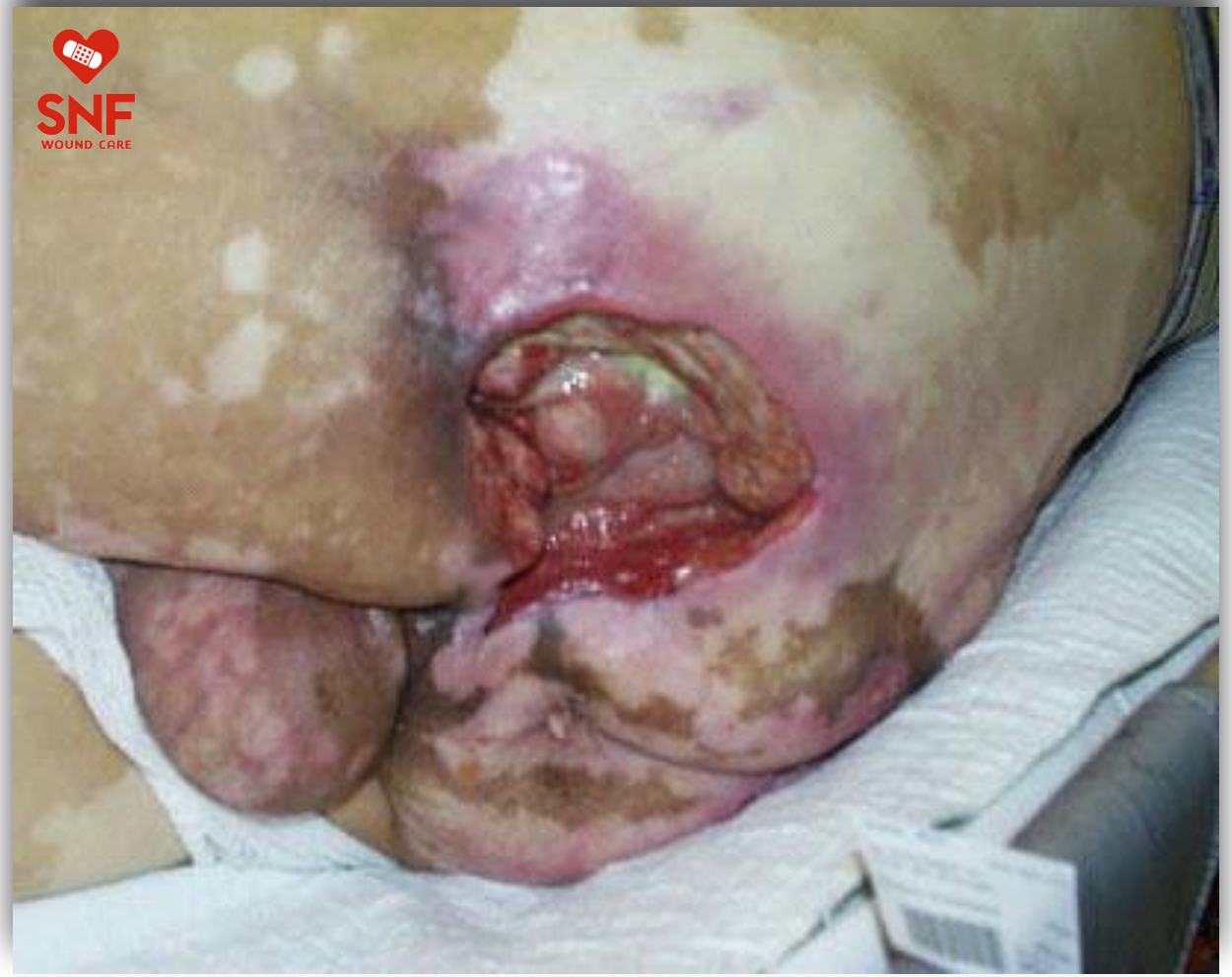
Stage IV

Stage IV

Stage 4 can also have undetermined depth.



Stage IV



Unstageable Wounds

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, black) in the wound bed.

The true depth of the wound cannot be determined until slough or eschar is removed, therefore stage cannot be determined.

Stable eschars serve as the body's natural biological cover and should not be removed unless suspect purulence underneath.

Unstageable is also known as UTD (Undetermined)

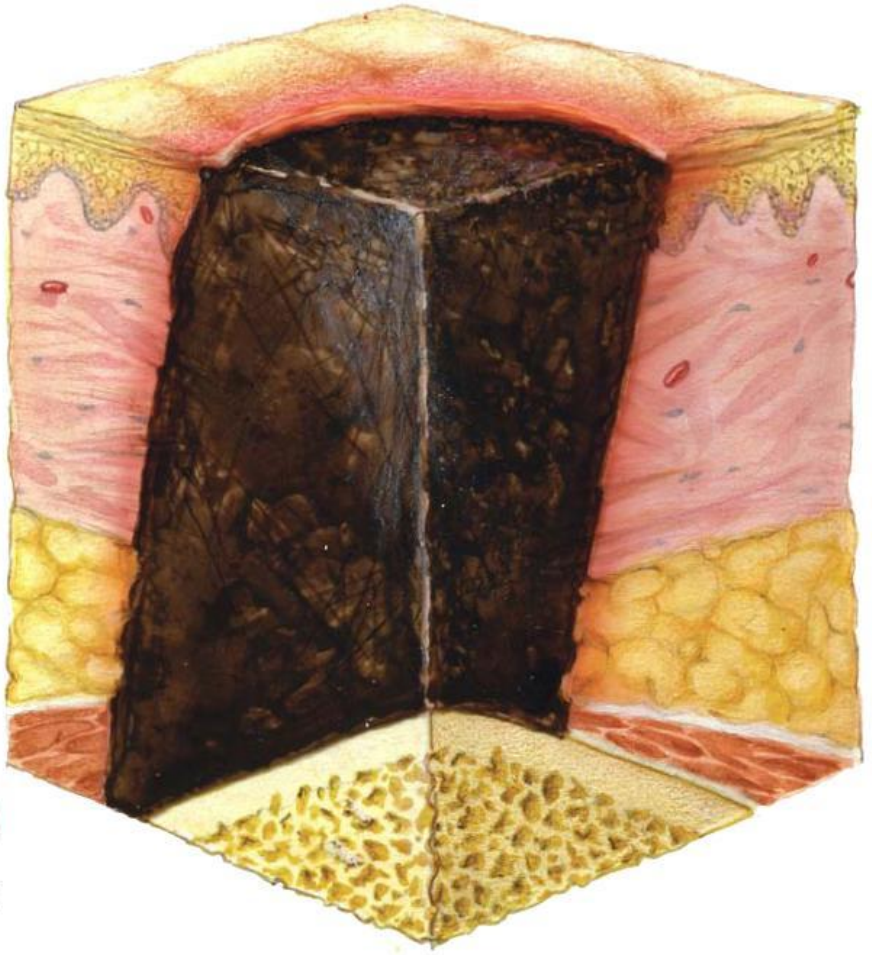
Unstageable

True depth can NOT be determined.

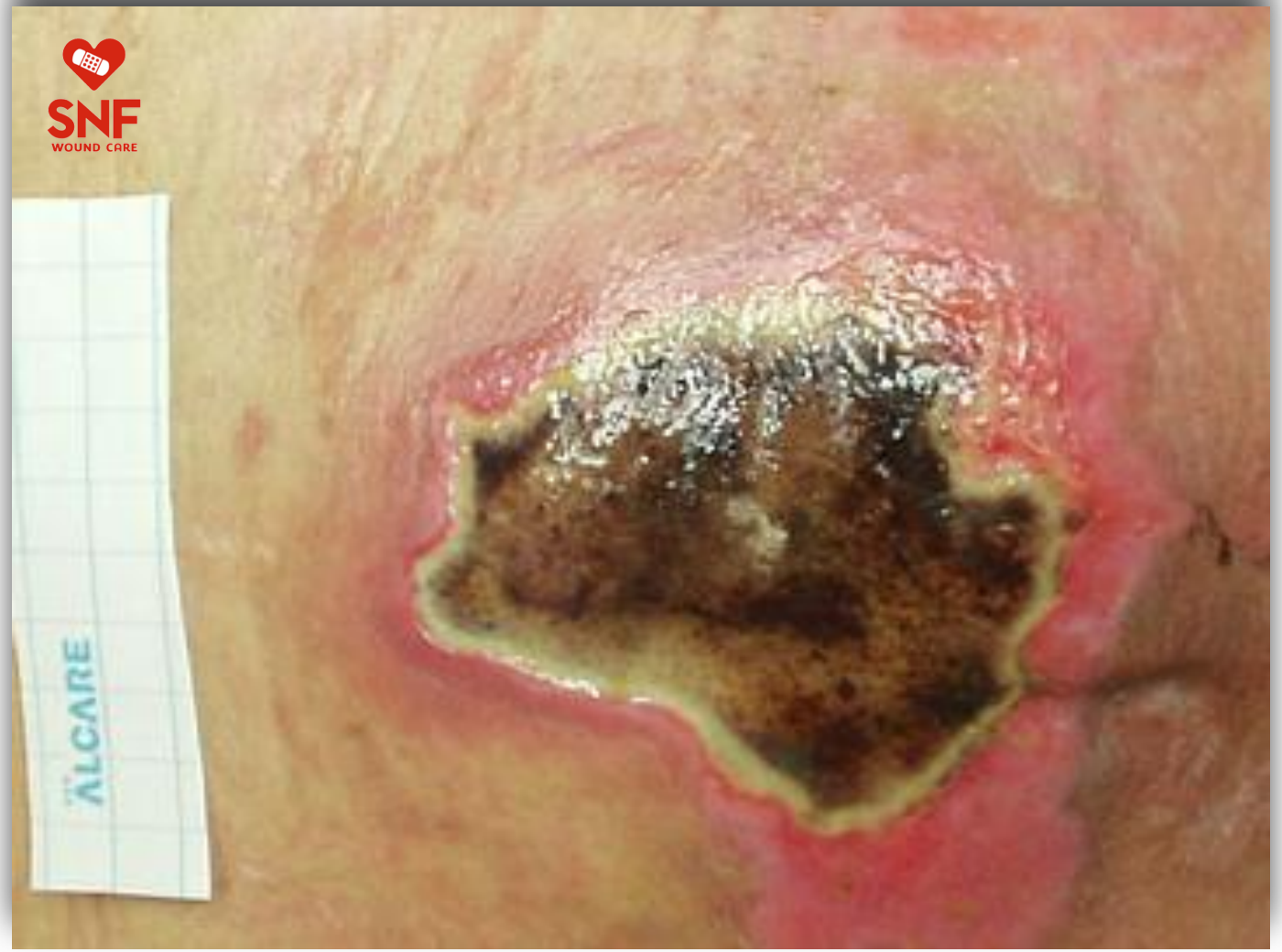
Do not Stage as 2 or 3 upon admission, then in a week the wound bed opens up and you see muscle/bone.

It'll appear as if this happened in-house!

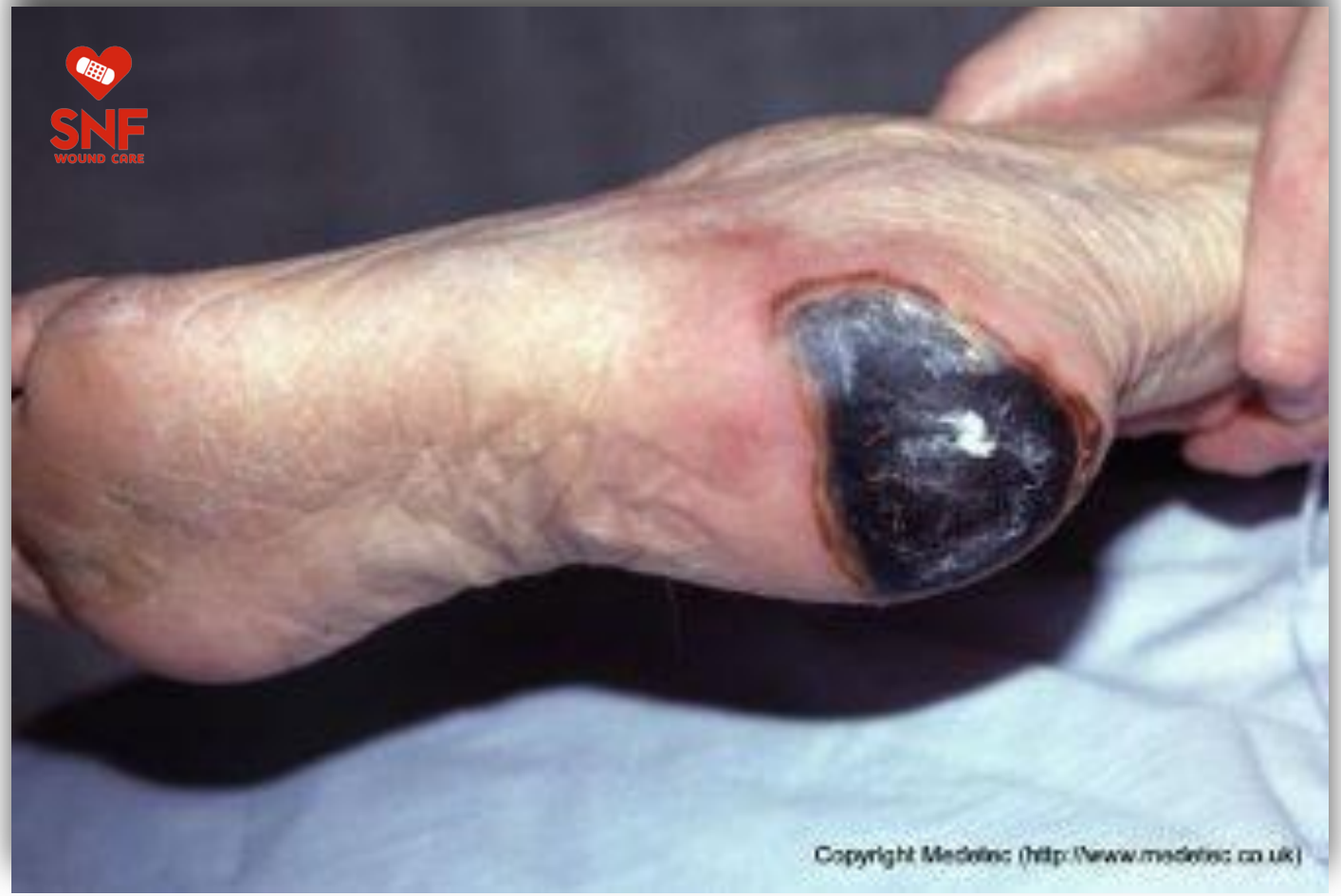
Your DON won't be very happy!



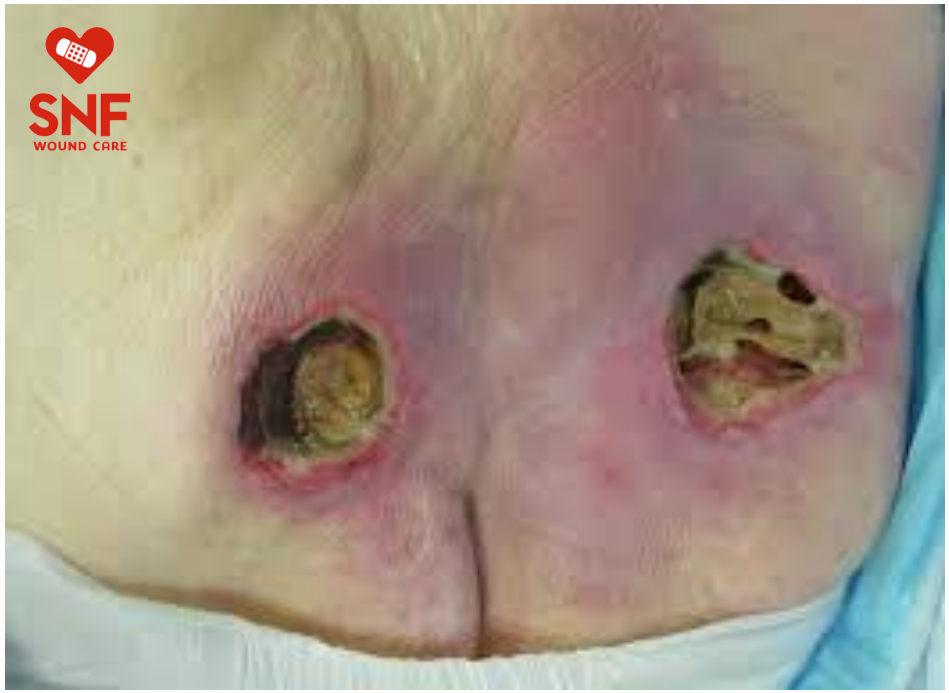
Unstageable Wounds



Unstageable Wounds



Unstageable Wounds



Deep Tissue Injury (Deep Bruise)

Purple or maroon localized area of discolored, yet INTACT skin due to the damage of underlying soft tissue from pressure or shear.

The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

May be difficult to detect with darker skin tones.

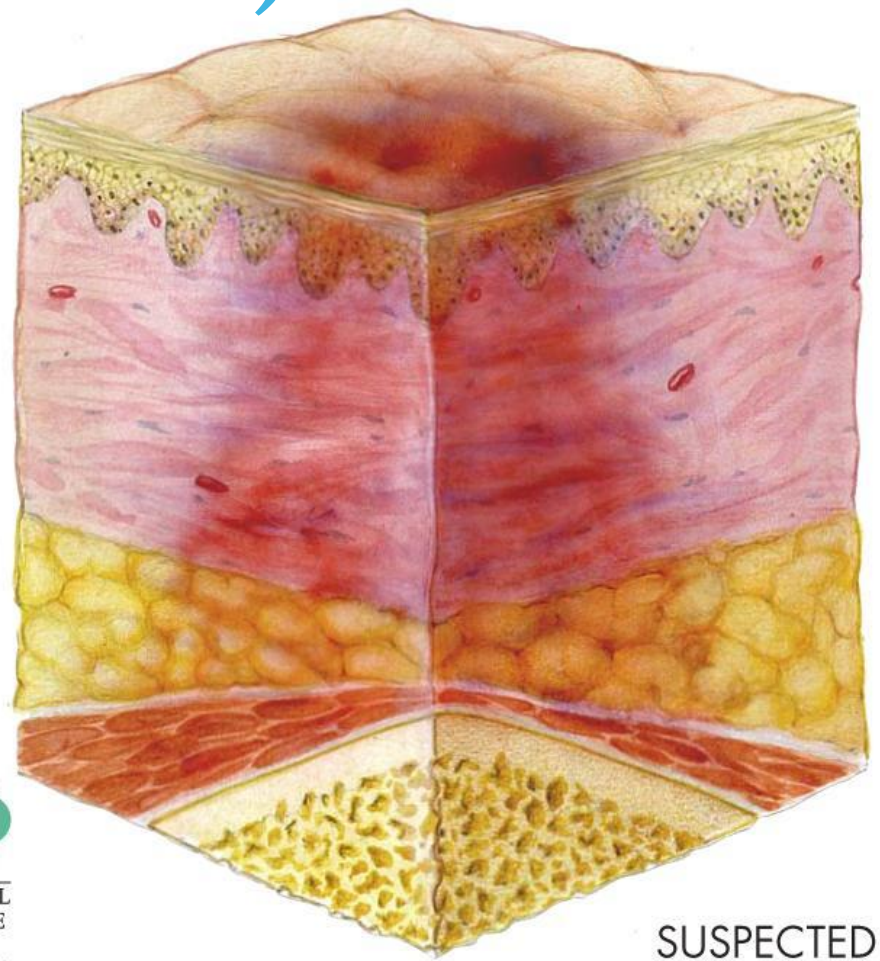
Evolution may include a thin blister over a dark wound bed.

Deep Tissue Injury (Deep Bruise)

Notice bruising of underlying tissue including muscle and bone.

Often on the sacrococcyx this may present similar to a Stage 1 but will open up to a Stage 4.

Need to Stage correctly!



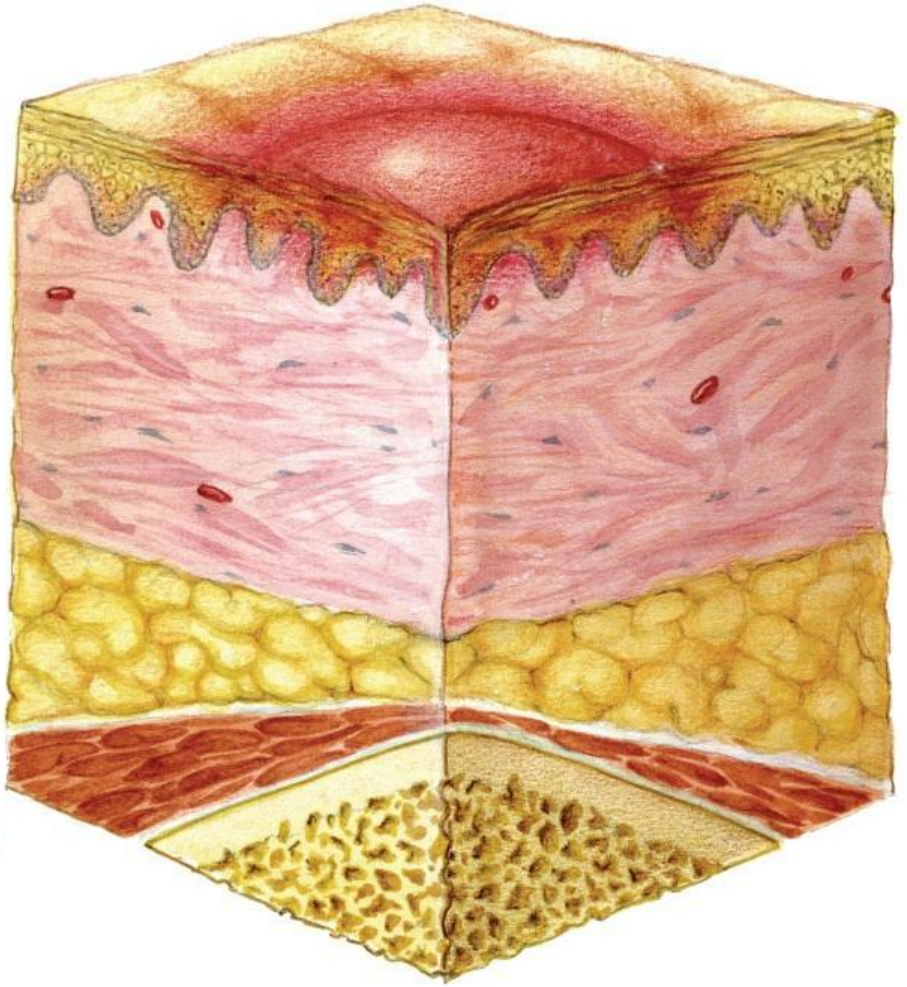
Stage I

Notice there is NO bruising of the underlying deep structures in Stage 1.

Both DTI and Stage I are closed intact skin!

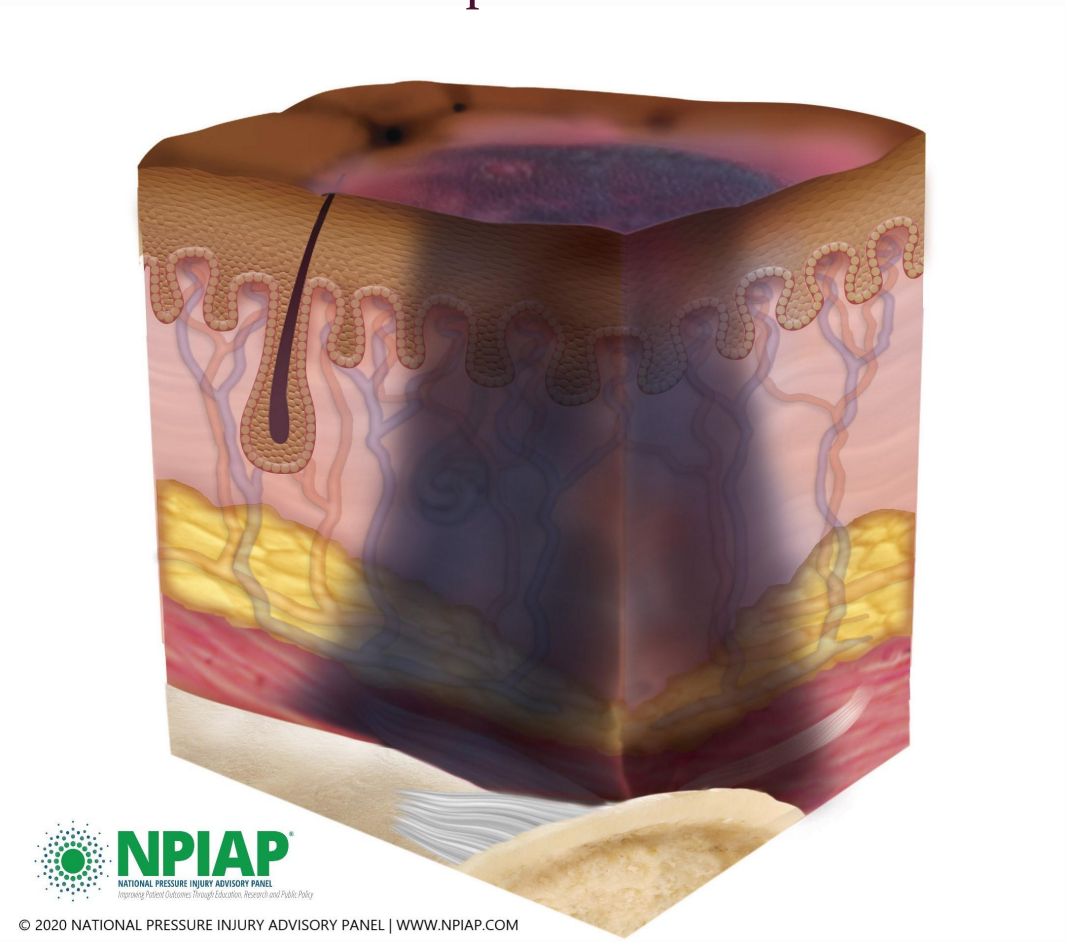
They can look very similar!

Be very careful differentiating Stage 1 and DTI.

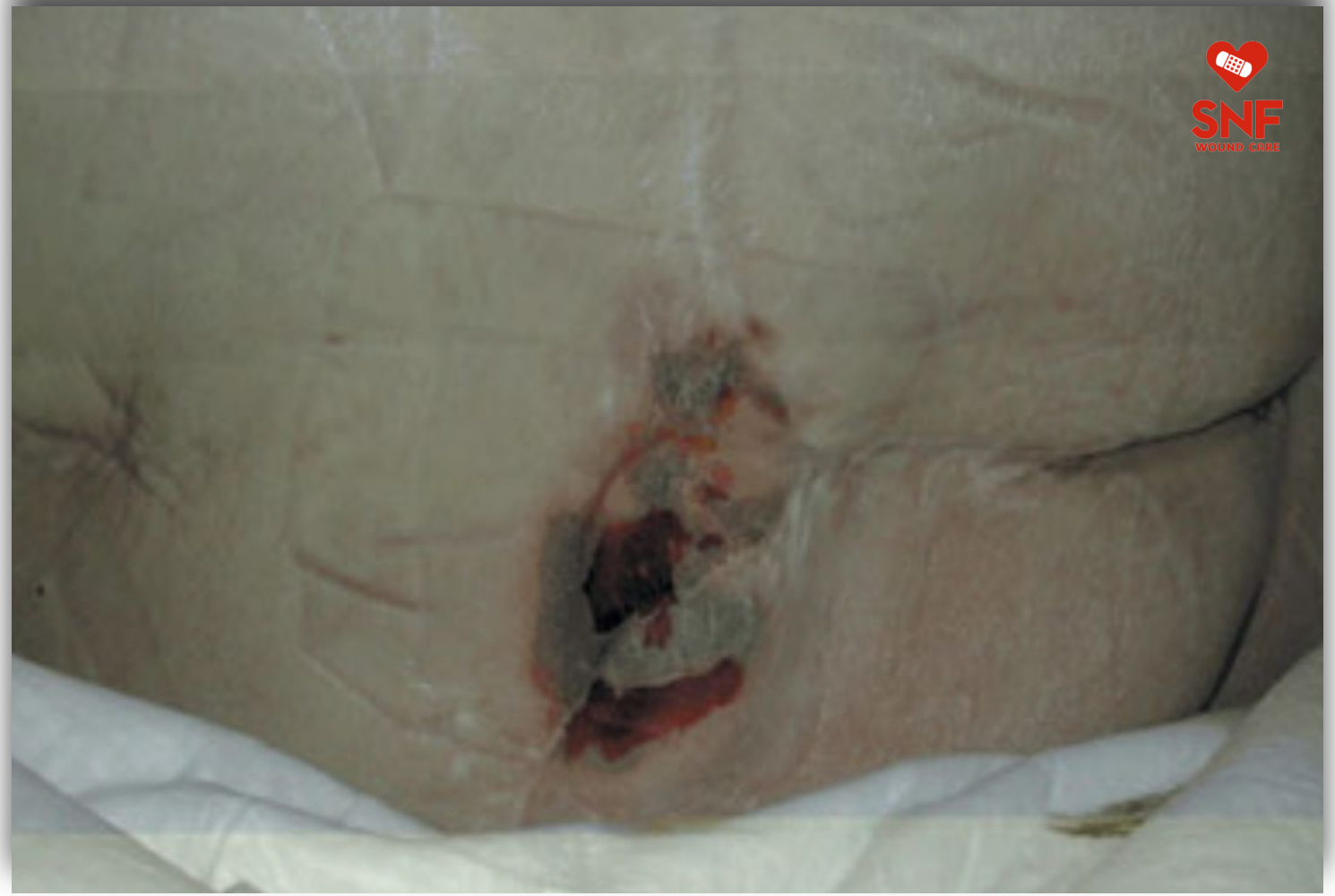


Deep Tissue Injury

Deep Bruise



What would you call this?



Causes continued….

What devices and objects that a patient may use can cause pressure and friction?

Answers: splints/casts, abdominal binders, medical-tubing such as foleys and G-tubes, oxygen tubing, CPAP, restraints, ID bands, clothing…

Who is at Risk for Pressure Injury?

Individuals with chronic health conditions.

Individuals who take 8 or more medications.

Patients on heavy sedation or patients who are in a coma.

Paraplegics, Multiple Sclerosis, Gunshot victims, Hip replacement, Altered Mental Status.

Individuals who are post surgery/or have recently had a medical procedure where they are now less mobile.

Anyone who is immobile is at risk!

Non-Compliance

Non-compliance if very often overlooked but can save facilities from hefty fines from the health department.

- Refuses turning and repositioning?
Does patient allow reposting at 11PM? How about 1AM? 3AM? 5AM? **DOCUMENT IT!**

- Sits in wheelchair from 9AM - 6PM? **DOCUMENT IT!**
Document sits in wheelchair for multiple hours at a time and doesn't offload. Goes out on pass without offloading. **DOCUMENT IT!**

- Refuses care/treatment? Aggressive to staff? **DOCUMENT IT!**

- Double Diaper? Multiple chucks? **DOCUMENT IT!**

- Refuses low-air loss mattress? Poor diet? Smokes? **DOCUMENT IT!**

At high risk facilities we have a log sheet where staff documents q2h positioning if patients refuses turning. Sometimes a soft bell q2h to remind staff to reposition high risk patients.

Non-Compliance

Of important note:

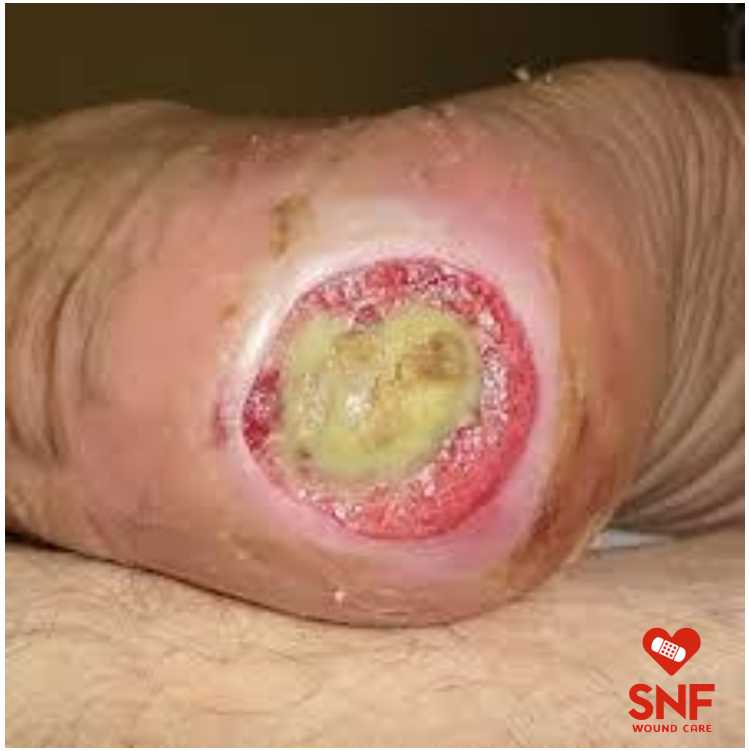
Just because on hospital discharge the hospital paperwork states "Stage 2 pressure injury", do not believe the paperwork, evaluate for yourself!

The hospital may be wrong or hiding something! Don't be fooled!

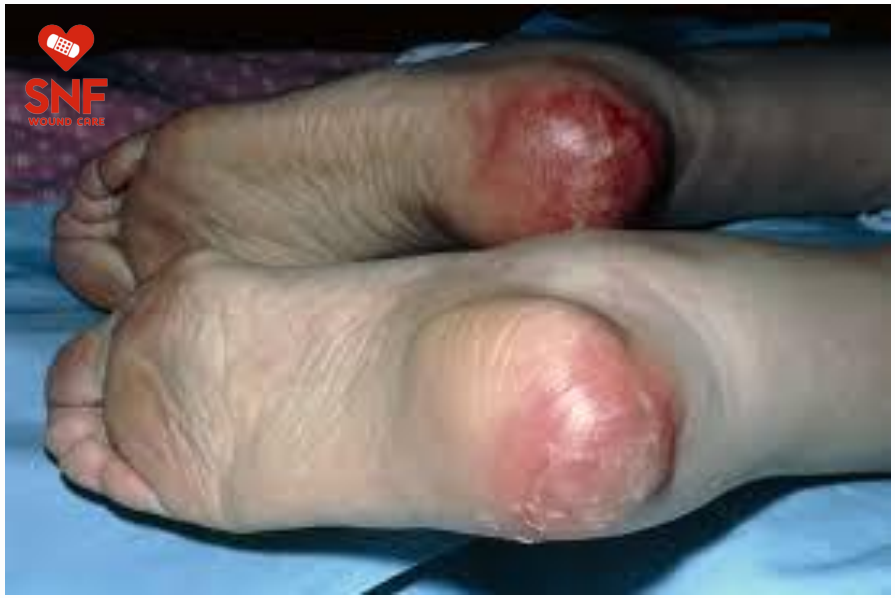
Evaluate for yourself! Trust your judgement!

Not paperwork!

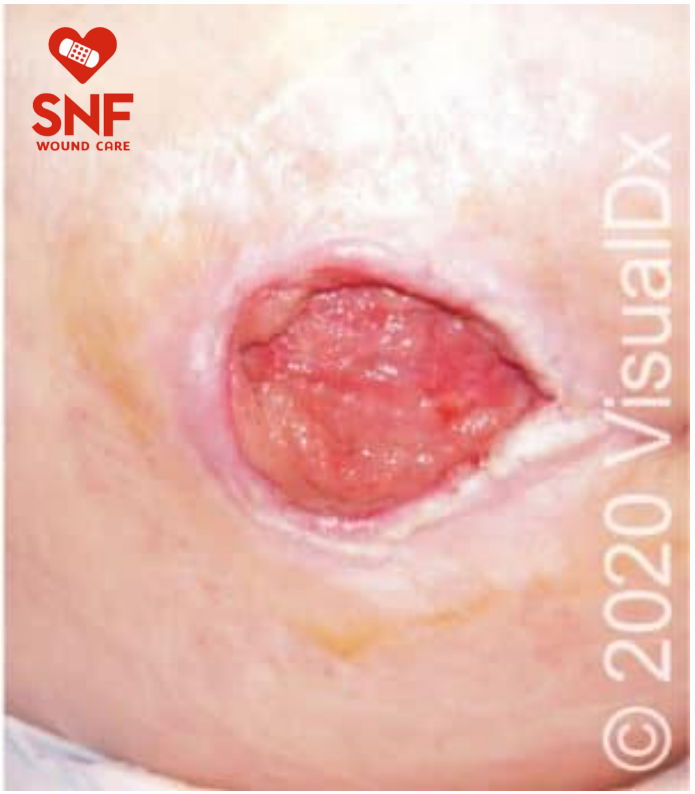
Stage it!



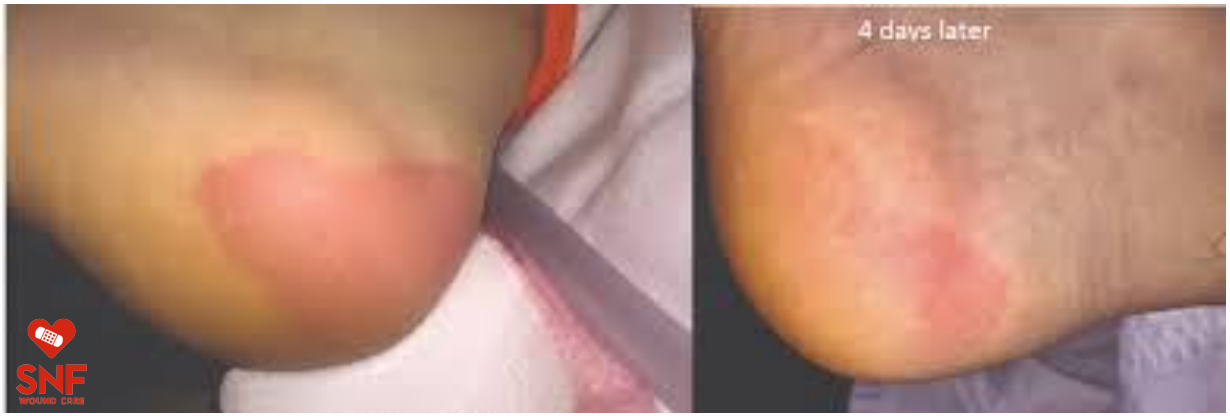
Stage it!



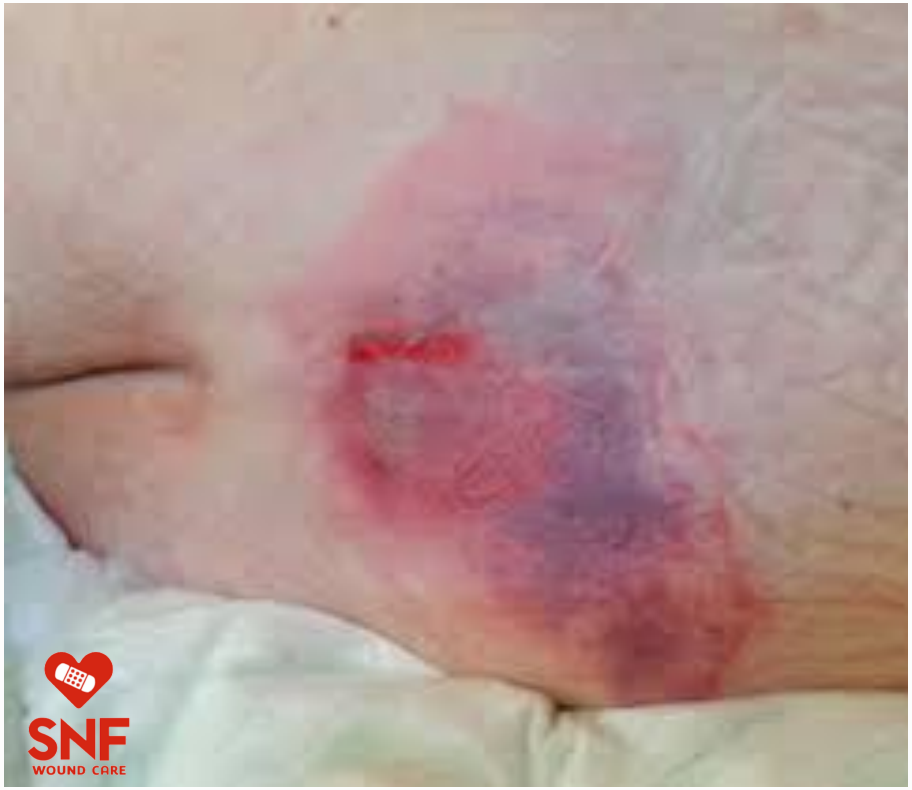
Stage it!



Stage it!



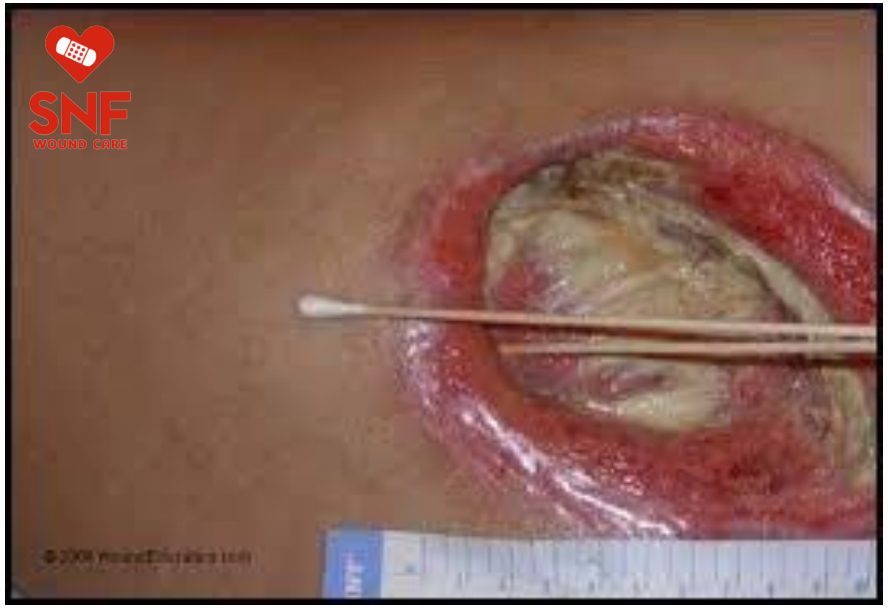
Stage it!



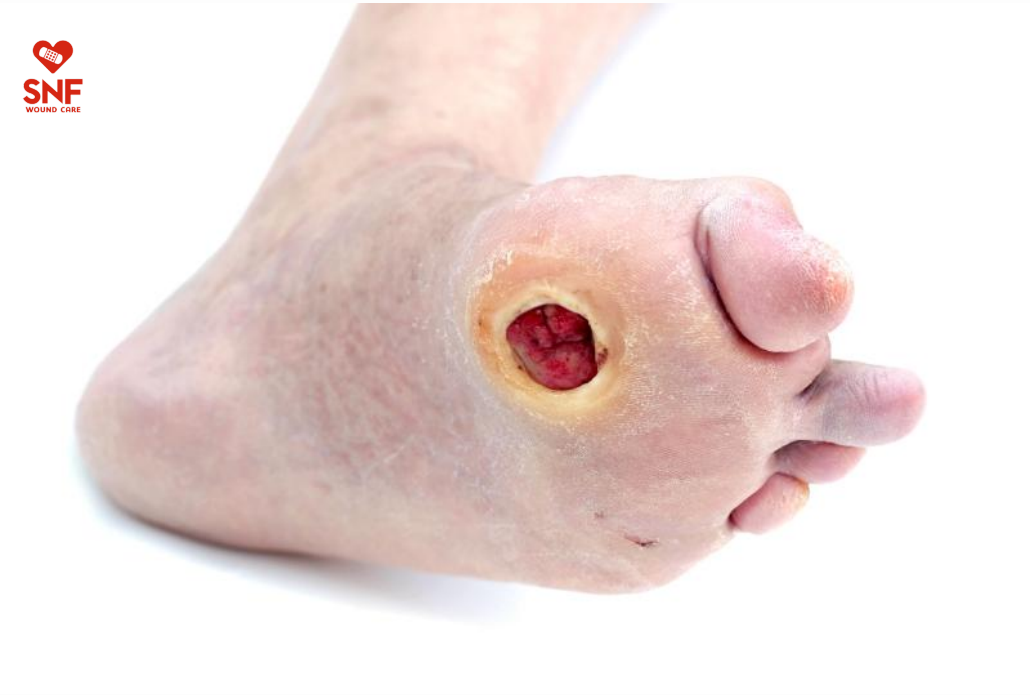
Stage it!


SNF
WOUND CARE
NPUAP.org | Copyright © 2011 Gordian Medical, Inc. dba American Medical Technologies

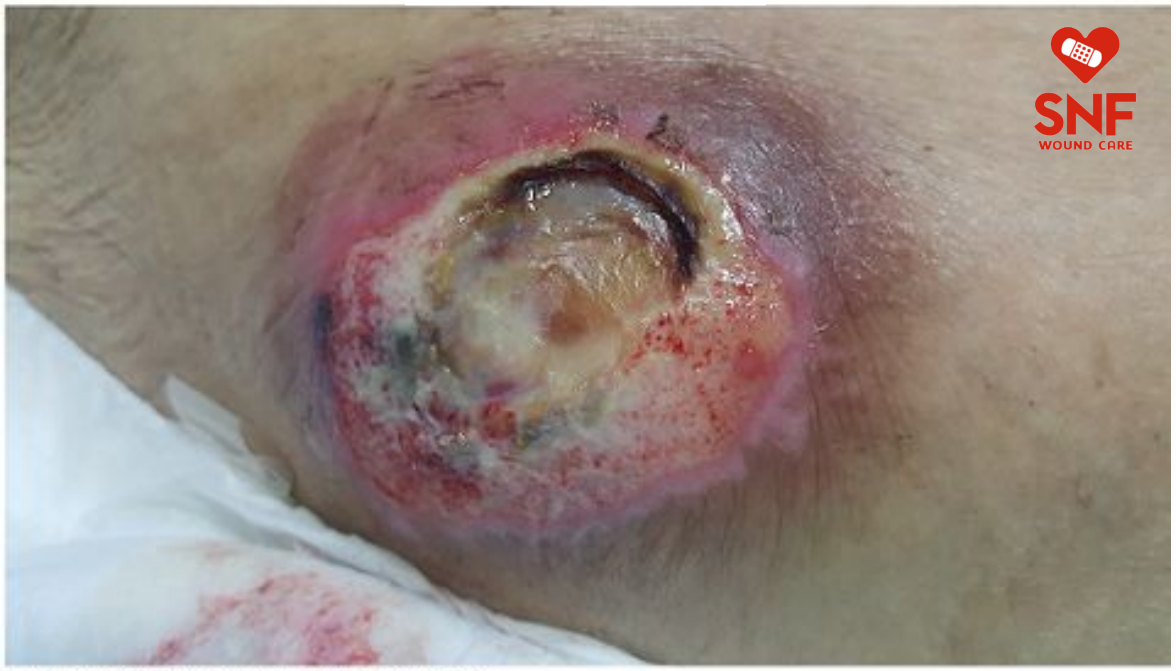
Stage it!



Stage it!



Stage it!

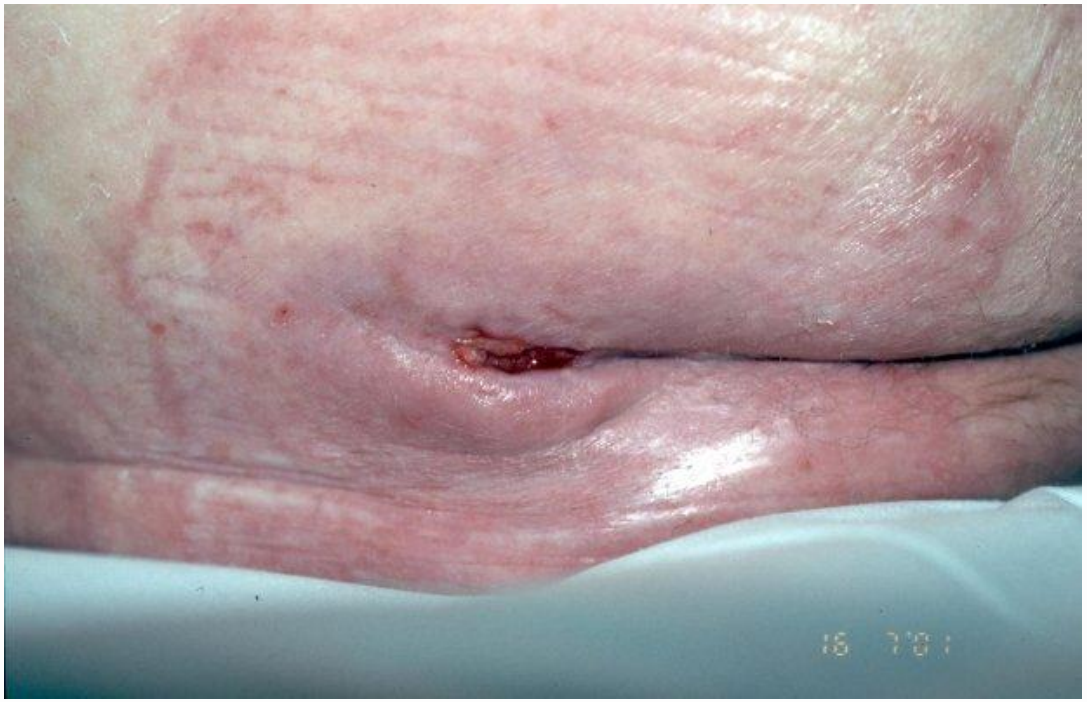


MASD

Moisture Associated Skin Disease

Moisture-associated skin damage, MASD for short is caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus, saliva, and their contents.

MASD is characterized by inflammation of the skin, occurring with or without erosion or secondary cutaneous infection.

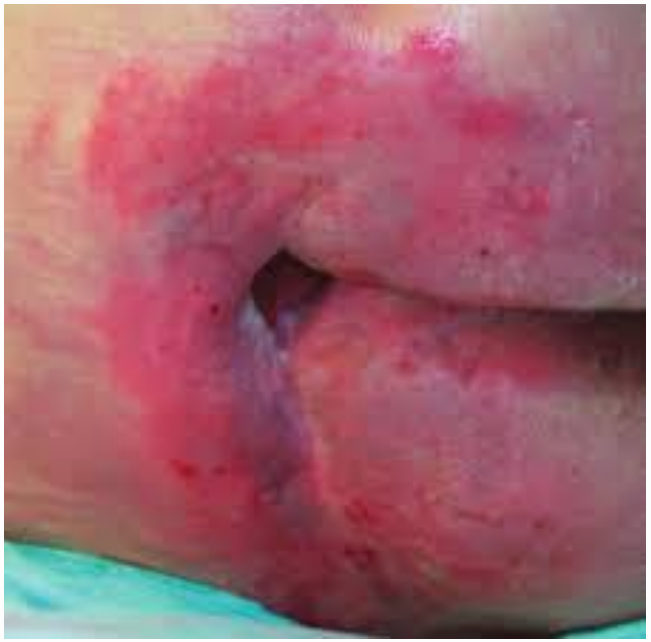


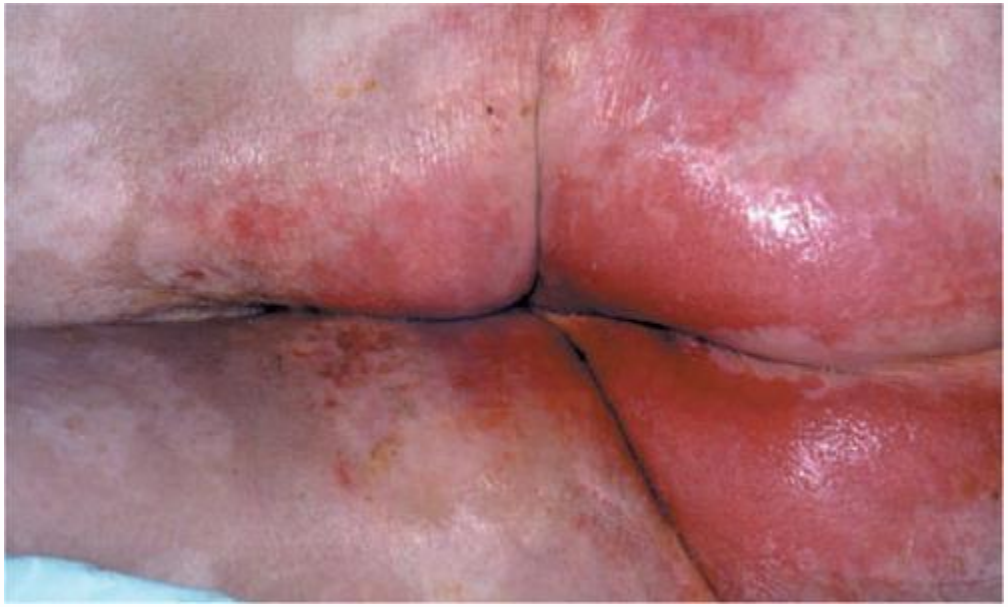
MASD

Moisture Associated Skin Disease

Due to moisture, fungal infections are common in MASD.

Treatment: Barrier cream +/- Fungal cream and control moisture.





PREVENTION! PREVENTION!

What can YOU do?

<u>Repositioning:</u>

If in bed, reposition at least every two hours. Side to side, using pillows under one side of the back and then reposition again and place a pillow on the opposite side of back.

Use pillows and cushions/wedges between and under knees. Place cushion support under feet and ankles.If in a wheelchair, encourage individual to reposition every 15 minutes, use tilt feature on chair to reposition every hour.

Document, Document!

Clearly document when staff notices a problem.

Make sure to differentiate pressure injury from non-pressure injury, specially upon admission! MOST IMPORTANT!

IF ITS A PRESSURE INJURY, STAGE IT! DO NOT BELIEVE HOSPITAL DISCHARGE PAPERWORK! USE YOUR JUDGEMENT AND STAGE IT!

If you are unsure of the stage, ASK!!! Never ever blindly stage!
Can lead to big fines if staged wrong!

Send a picture to your provider to help with staging if needed!

Thank You…

For always following the protocols.

For always providing these interventions with care.

For always being observant and reporting all changes.

For always documenting.

For working as a team to prevent skin breakdown, falls and other injuries to the individuals we support.

For being our eyes and ears.

Thank you for coming!


SNF
WOUND CARE
ORIGINAL PRICE: $29.99
WOUND LEARNING ACADEMY
FREE!
30 CEU
CREDITS
IN
WOUND CARE
MANAGEMENT
30 CEU credits for
RN, LPN/LVN & PT
USE CODE: SNFwoundcare
www.SNFwoundcare.com
Approved by California Board of Registered Nursing, California Board of Vocational Nursing, & California Physical Therapy Association

SNF
WOUND CARE

SERVICES WE OFFER

- Weekly bedside surgical wound care

- Prioritize the use of generic wound care supplies

- Optimal documentation aimed at protecting the SNF

- Nursing Wound Care Compliance

- Dermatological/ rash evaluation to prevent clinic transfer

- Free 30 CEU staff education with license renewal for RN, LPN/LVN & PT

- G-Tube replacements
- Supra-pubic replacements
- Central Line removal
- NG Tube Placement
- PICC Line
- Midline Insertion

Website:
https://www.SNFwoundcare.com
Email: info@SNFwoundcare.com
Call us: 1.833.Dr.Wound

Find us on Social Media: @SNFwoundcare

WOUND CARE CERTIFICATION

by
WOUND LEARNING ACADEMY

30 CEU CREDITS IN
WOUND CARE MANAGEMENT
PLUS WOUND CARE CERTIFICATION

Approved by
California Board of Registered Nursing
California Board of Vocational Nursing
California Physical Therapy Association

Name that Wound

Well, I'm not sure; I think it's a Stage II, but it could be . . .