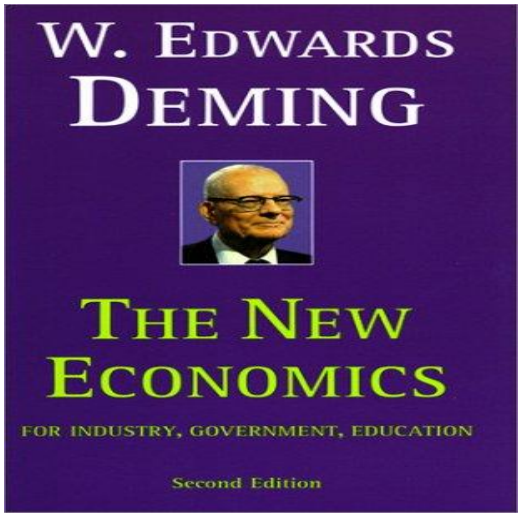
Staging/Categorising/of Pressure Ulcers Role & Necessity of Accurate Documentation

Pat Mc Cluskey

ANP Wound Care & Tissue Viability SSWHG

A Commitment to consider

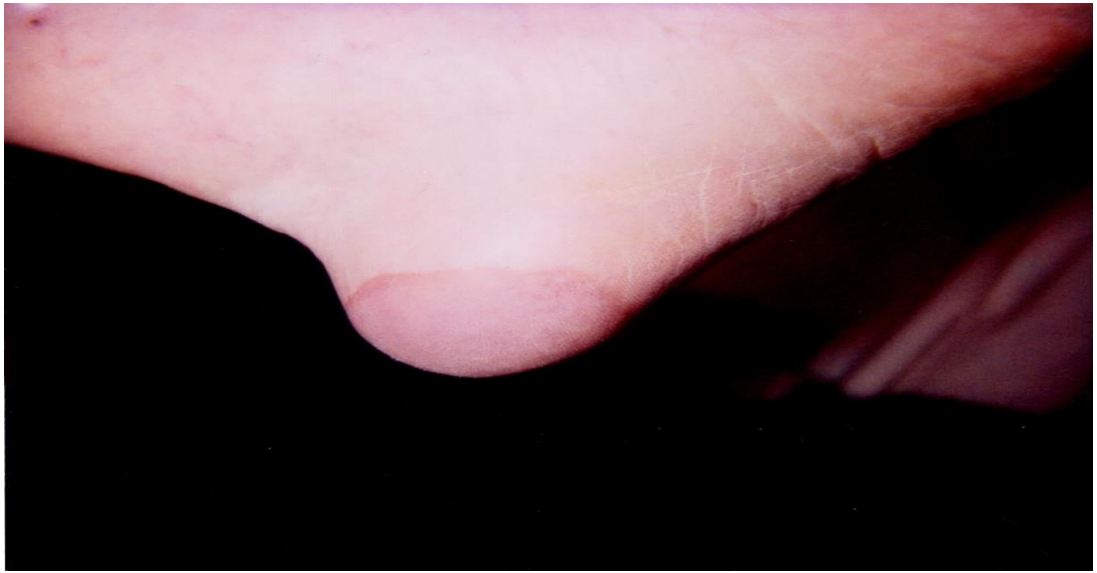


"It's not enough to do your best; you must know what to do, and then do your best"

W. Edwards Deming

Pressure Ulcer? Implications for practice?

Stage/Category



Pressure Ulcer? Implications for practice?

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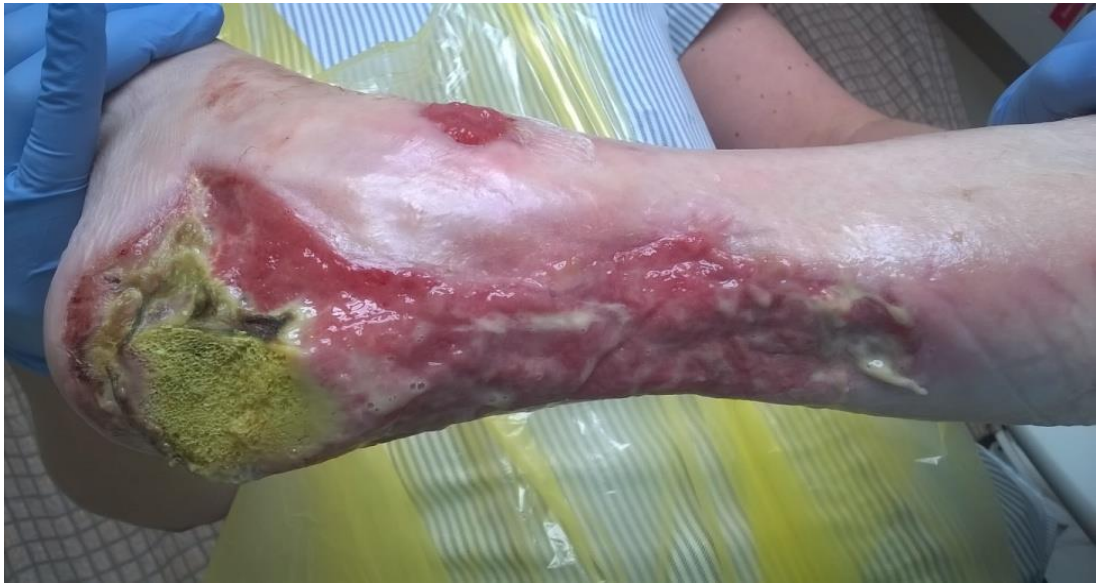

Pressure Ulcer? Implications for practice?

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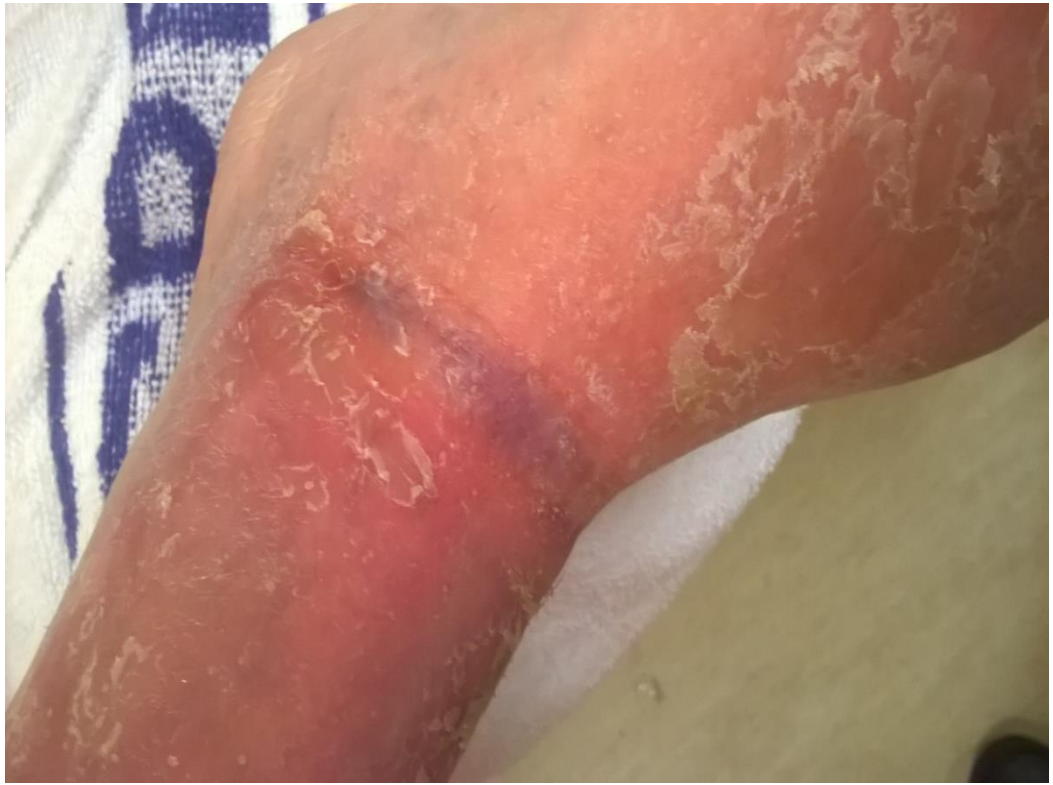

Pressure Ulcer? Implications for practice?

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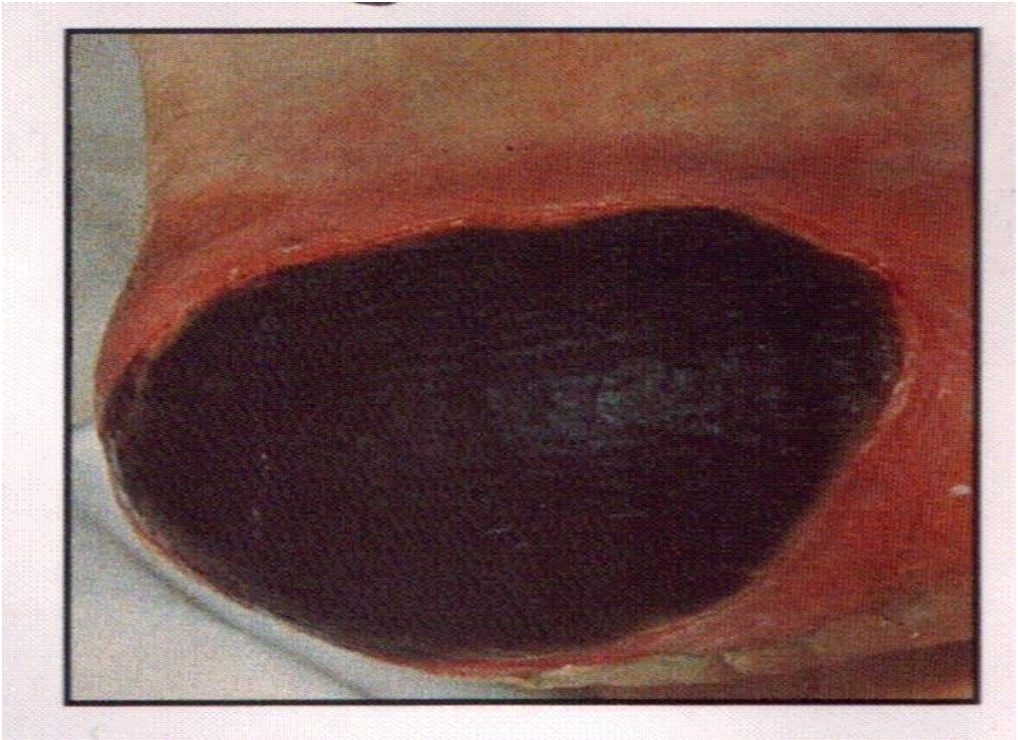

Pressure Ulcer? Implications for practice?

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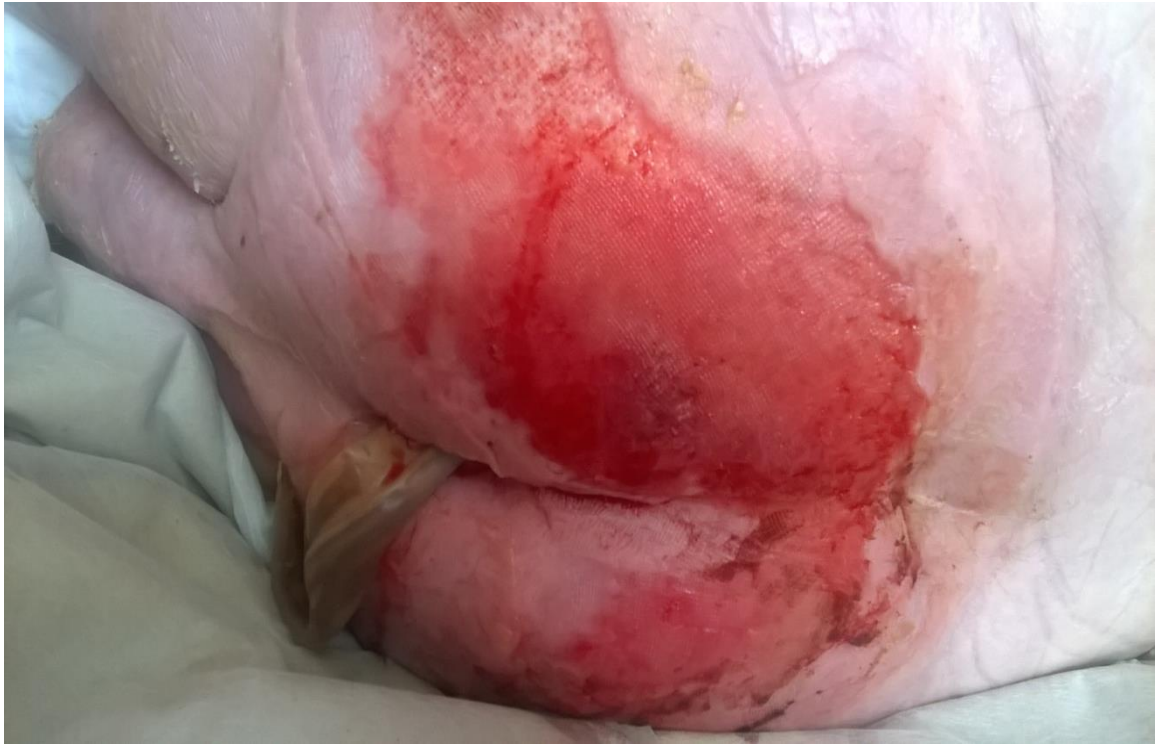
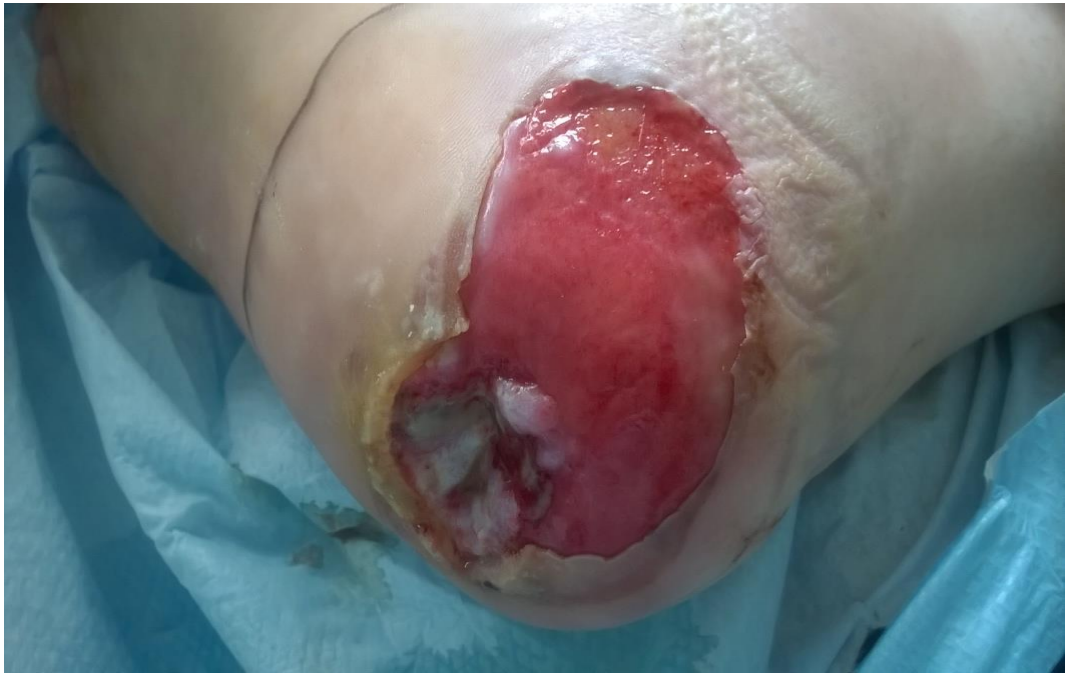


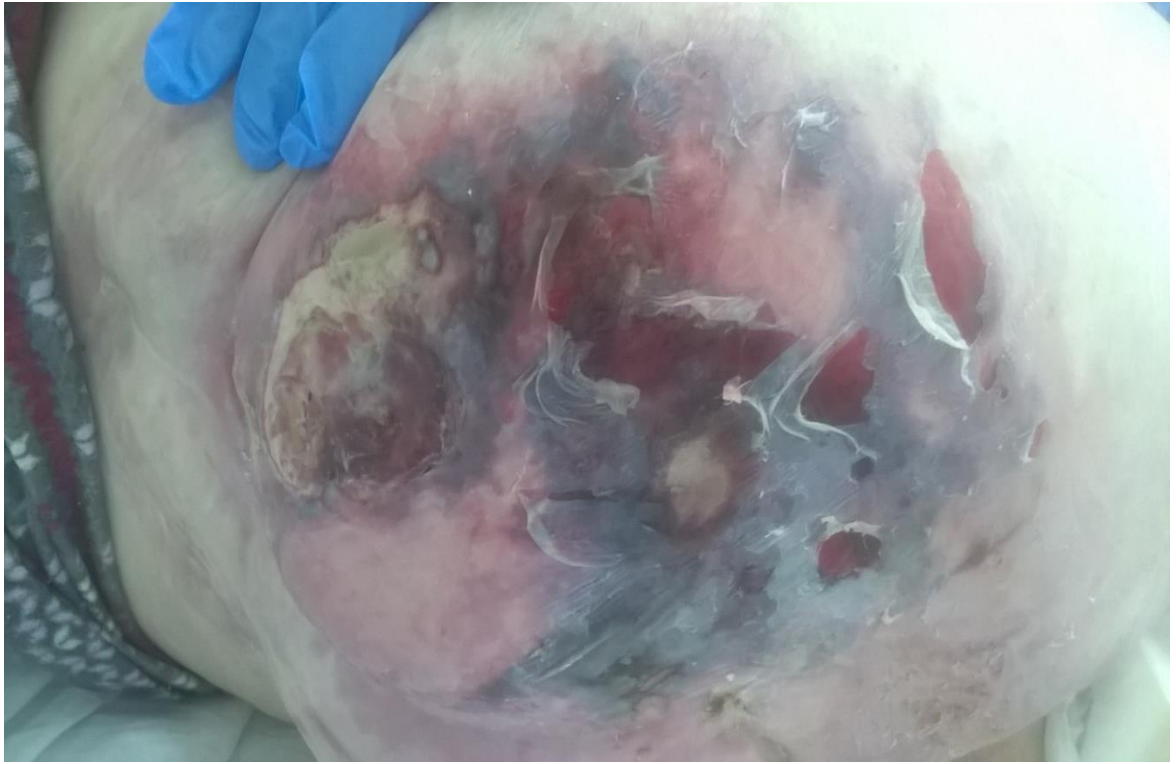
Pressure Ulcer? Implications for practice?



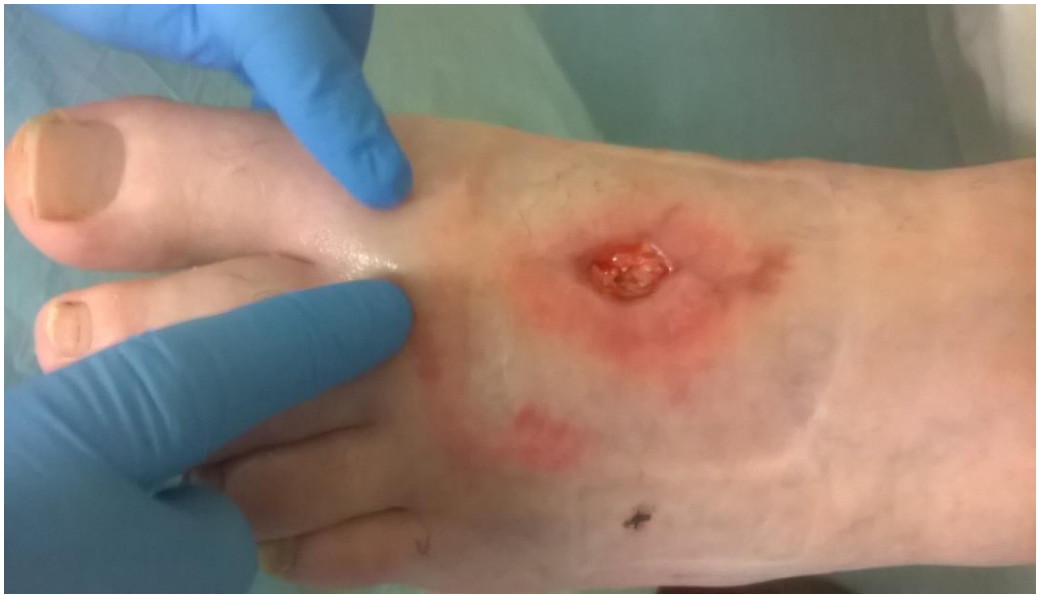
Stage/Category

Pressure Ulcer? Implications for practice?

Stage/Category



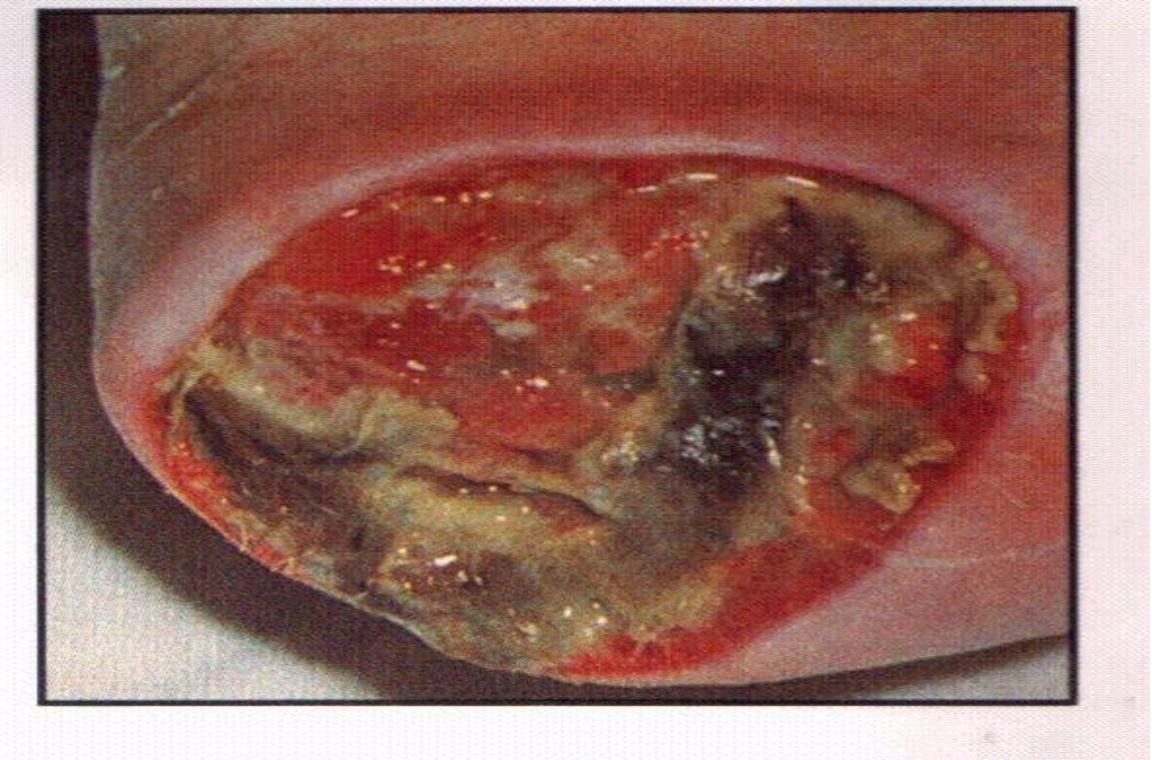
Pressure Ulcer? Implications for practice?



Stage/Category

Pressure Ulcer? Implications for practice?

Stage/Category



Pressure Ulcer? Implications for practice?

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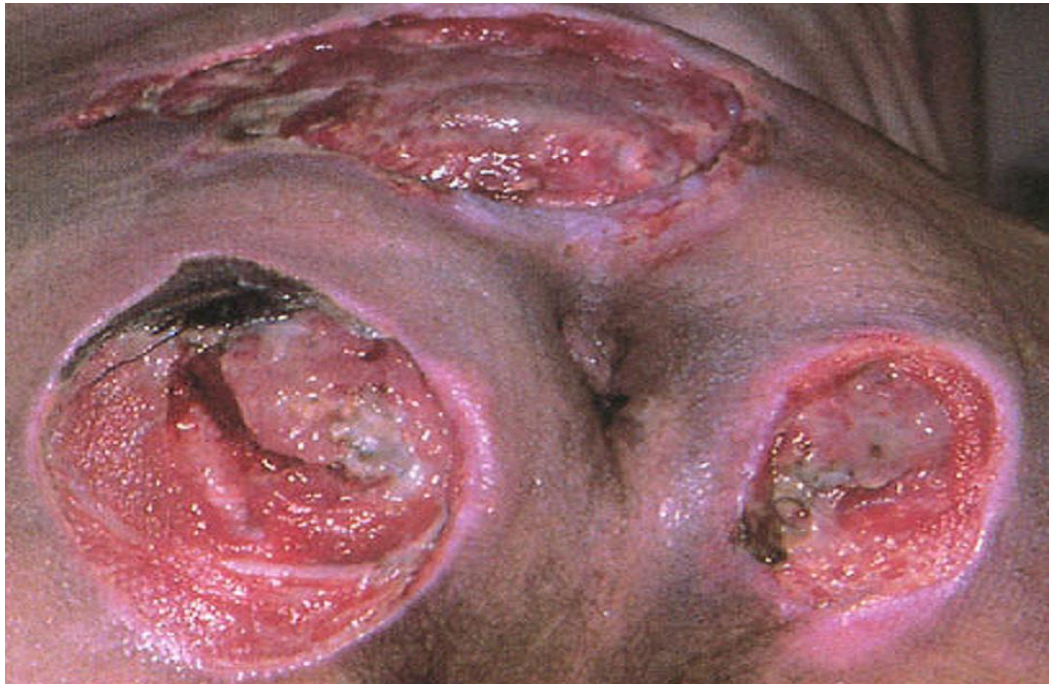

Pressure Ulcer? Implications for practice?

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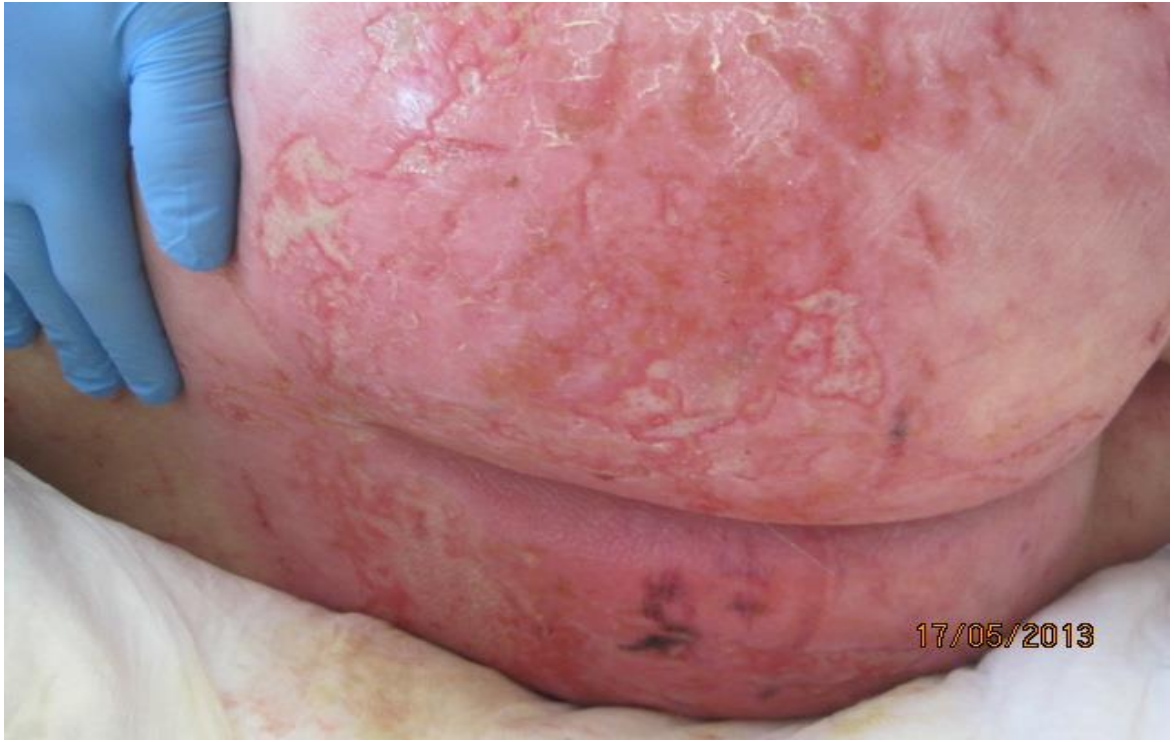
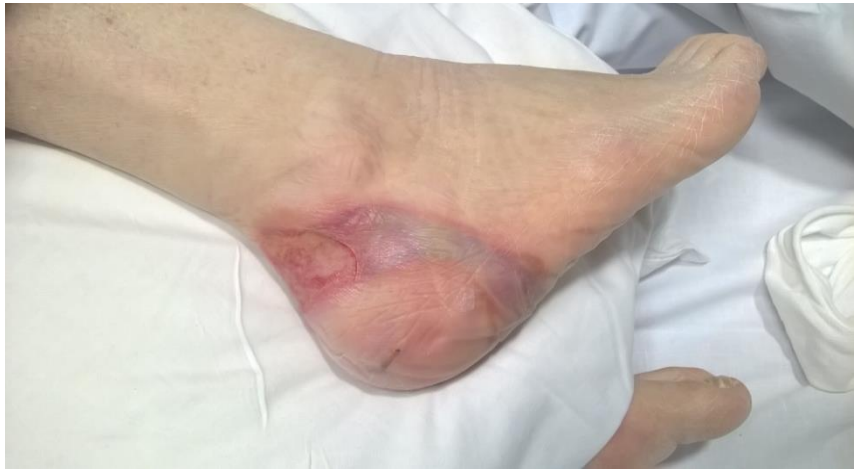
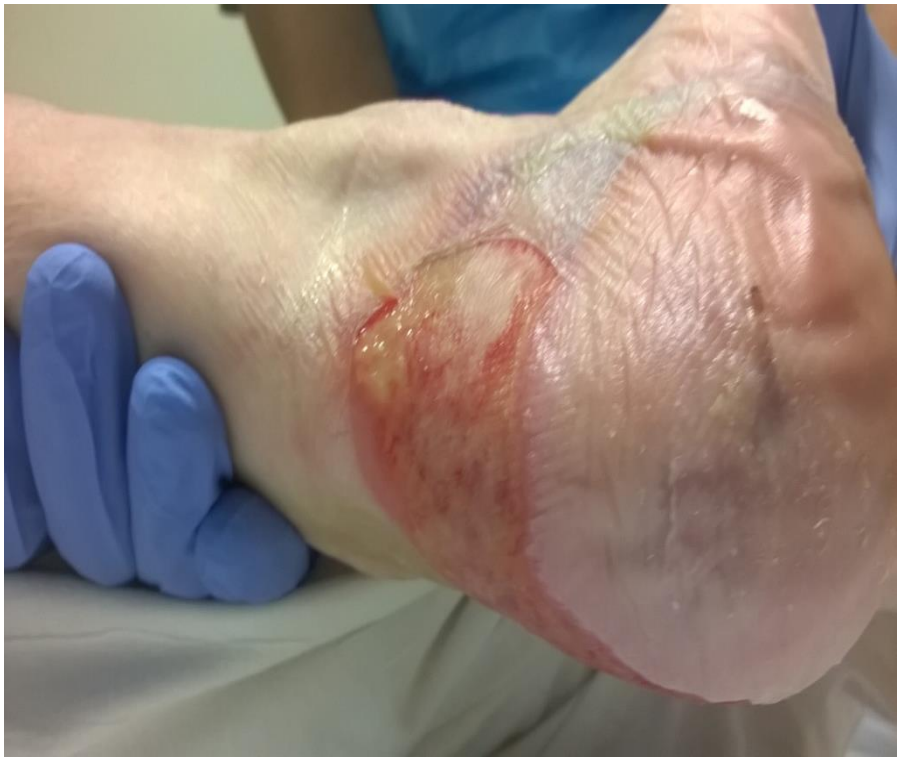
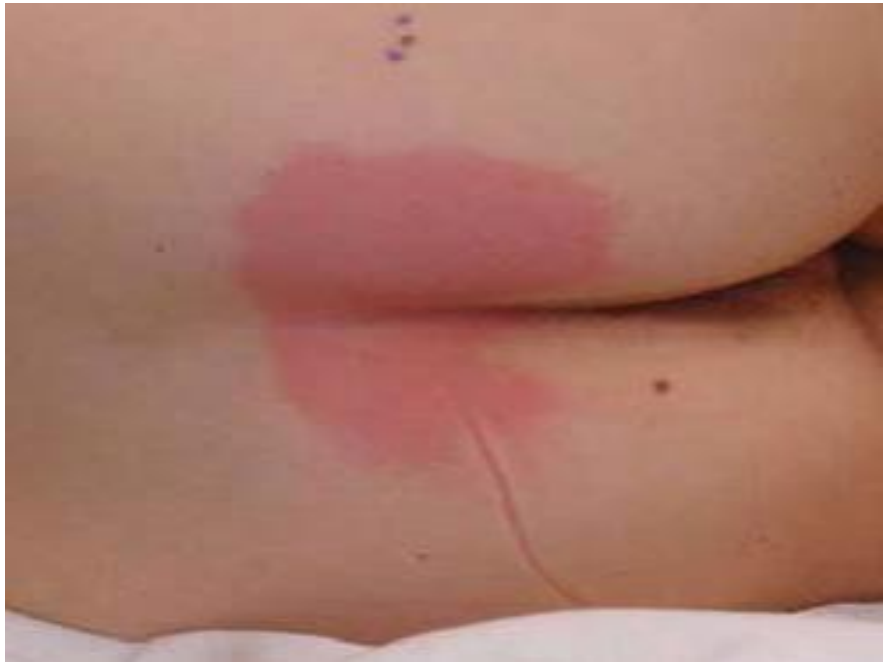


Pressure Ulcer? Stage/Category





Pressure Ulcer? Implications for practice?



Stage/Category

Documentation

- How to document
- What to report, locally & nationally
- Pitfalls
- Legal implications

Recap: Definitions

Pressure Ulcer: 'A PU is localised injury to the skin or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear' (NPUAP/EPUAP/PPPIA, 2014)

Avoidable PU: ' Avoidable means that the person receiving care developed a PU and the provider of care did not do one of the following; evaluate the person's clinical condition and PU risk factors, plan and implement interventions that are consistent with the persons' needs and goals and recognised standards of practice, monitor and evaluate the impact of the intervention, or revise the intervention as appropriate'

Definitions

- **Unavoidable PU:** ‘ Unavoidable means that the person receiving care developed a PU even though the provider of care had evaluated the persons’ clinical condition and PU risk factors, planned and implemented interventions that are consistent with the persons’ needs and goals and recognised standards of practice, monitored and evaluated the impact of the interventions and revised the approached as appropriate or the individual refused to adhere to prevention strategies in spite of education of the consequences of non-adherence’
- **Moisture- Associated Skin Damage (MASD):** ‘Inflammation and erosion of the skin caused prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucous or saliva and their contents. Characterised by inflammation of the skin occurring with or without erosion or secondary cutaneous infection’ (Gray et al, 2011).

Factors for consideration

Risk Factors

Risk may be defined as the probability of a patient developing a specific problem e.g. A pressure ulcer (Burt, 2001)

Risk Assessment Tools

- Select a tool that focuses on activity and mobility, including sensation and ability to move

- Recognise additional risk factors and use clinical judgement when using a risk assessment tool

Influencing Risk

External

- Surfaces
- Tubing /aids/devices
- Staff ratio
- Staff knowledge
- Patient knowledge
- Care settings – activity

Etc.....

Intrinsic

- **Perfusion & oxygenation**
- **Poor nutrition**
- **Increased skin moisture**
- **↑Body Temp**
- **Advanced age**
- **Sensory perception**
- **Haematological measures**
- **General health status**
- **Having had a previous PU**

Etc.....

(NPUAP/EPUAP/PPPIA 2014)

Prevention!

SSKIN Bundle

Skin:

Surface:

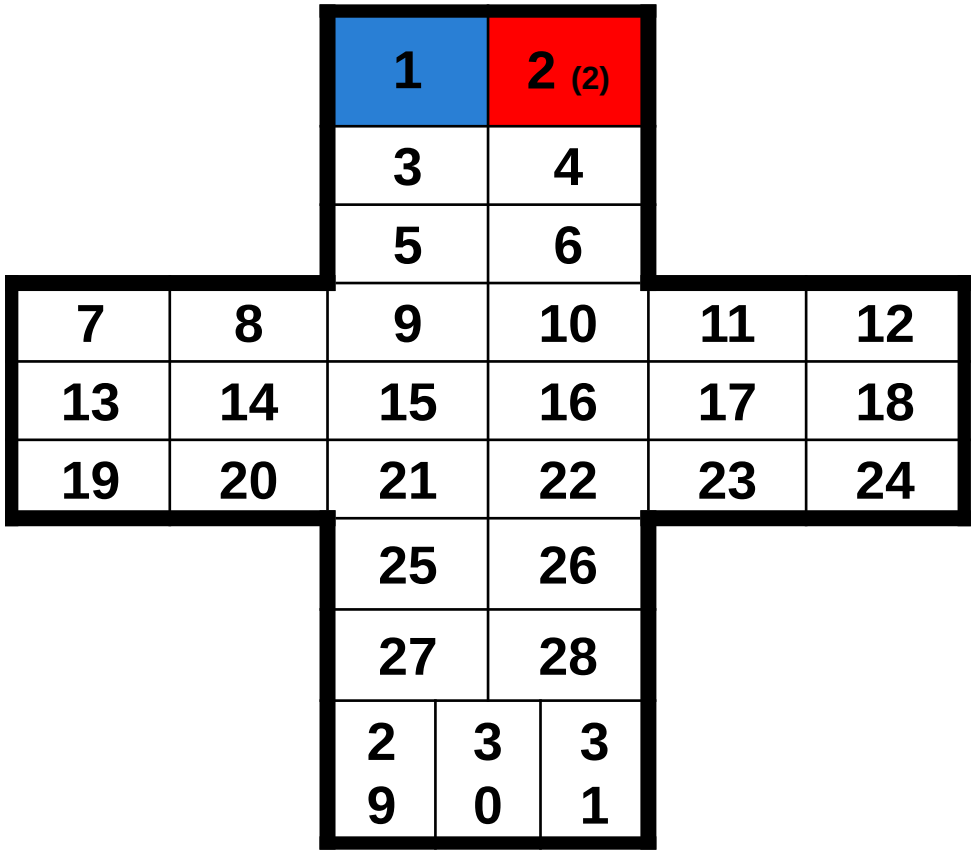
Keep Moving:

Incontinence:

Nutrition:

- Assessment of the patient's skin
- Provision of effective pressure redistributing surface (timely)
- Appropriate repositioning
- Managing moisture
- Adequate nutrition & hydration

Leads to significant reduction in PU incidence
(Tayyib et al, 2015)



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

SSKIN BUNDLE

Pressure Ulcer Prevention Care Plan
Commence when
Waterlow Score ≥ 10

Addressograph

Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly													
Date													
Time (24 Hour Clock)													
SURFACE	See advice re surfaces on LMHG Guideline on Pressure Ulcer Prevention (on T Drive). Indicate each day if Foam ☐ or Pressure Relieving Mattress ☐ (tick)												
Mattress appropriate & functioning correctly:													
Appropriate seating													
Heel protectors													
SKIN INSPECTION	Inspect skin at boney prominence every 2 – 4 hours. Existing Pressure Ulceration: Y/N (Circle). Stage* & site of existing ulceration recorded in wound assessment chart Y / N (Circle)												
Pressure areas checked													
New Redness State Site:													
KEEP MOVING	Frequency of repositioning is determined by skin inspection. If red at least 2 hourly.												
B R Side													
E L Side													
D Back													
CHAIR													
Standing / Mobilising													
INCONTINENCE	Incontinence Related Skin Care regimen Implemented (on T Drive, Tissue Viability Folder) Y / N												
Dry and clean													
Peri-anal skin healthy													
NUTRITION	Fluid Balance Chart / Food Chart in progress Y/N (circle and continue). Otherwise record below												
Meal / snack taken													
Drink taken													
Supplements taken													
Signature													
Grade: S/N = Staff Nurse,													
HCA = Health Care Attendant													
OT = Occupational Therapist													
D = Dietician													
P = Physiotherapist													
S =Student,													
SALT													

KEY: Care Delivered : √ = YES X = NO (if NO Document & Explain in Nursing notes)

RED SKIN – RELIEVE PRESSUE - REVERSE DAMAGE
Patient Pressure Ulcer Prevention Information booklet given ☐

Category/ Stage: *Please refer to the International NPUAP/ EPUAP Pressure Ulcer Classification system*

Pressure Ulcers to Zero

Assessment

Do we know the risk/cause and can it be eliminated?

Full medical, surgical and social history

- Physical examination to include: factors that may impede healing e.g., impaired perfusion, impaired sensation, systemic infection
- Vascular assessment for extremity ulcers
- Bloods to include Hb, Albumin, Total Proteins, C.R.P.
- Nutritional Assessment
- Risk of developing additional ulcers
- Psychological health, behaviour and cognition
- Social support systems
- Functional capacity in regard to positioning, posture
- Surfaces, Aids, Available care
- Individual/Family, Knowledge of existing PU, it's development, challenges and management to date

Surface:

Evidence on Support Surfaces for Pressure Ulcer Prevention

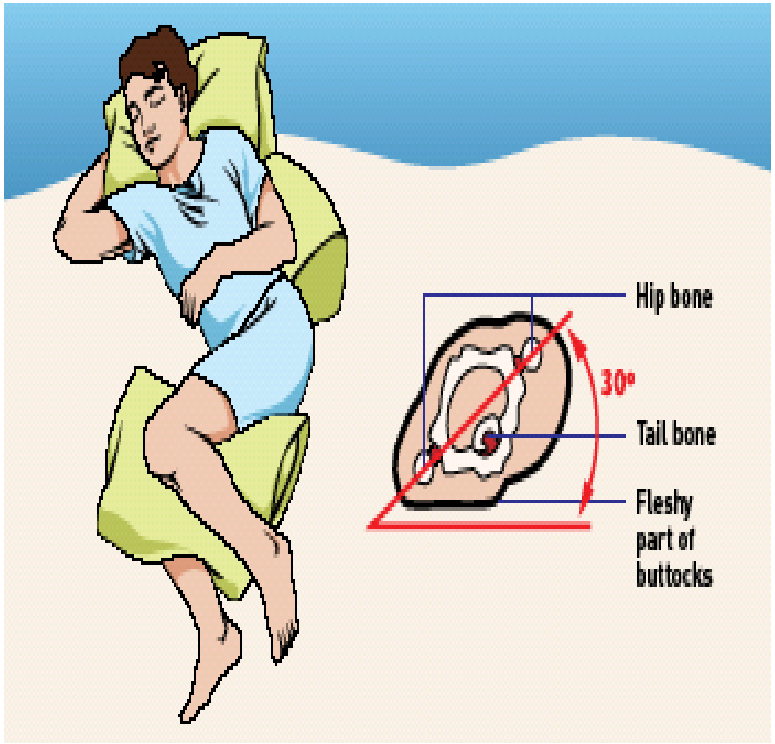
- The review found that people lying on ordinary foam mattresses are more likely to get pressure ulcers than those lying on a higher-specification foam mattress.

- In addition the review also found that people who used sheepskin overlays on their mattress developed fewer pressure ulcers.

- While alternating-pressure mattresses may be more cost effective than alternating-pressure overlays, the evidence base regarding the merits of higher-specification constant low-pressure and alternating-pressure support surfaces for preventing pressure ulcers is unclear (McInnes et al 2015).

- **Profiling Beds.....**
- **Hybrids..... High Specification.....Alternating surfaces**
- **Remember.....Envelopment.....Immersion**
- **Cushions.....**

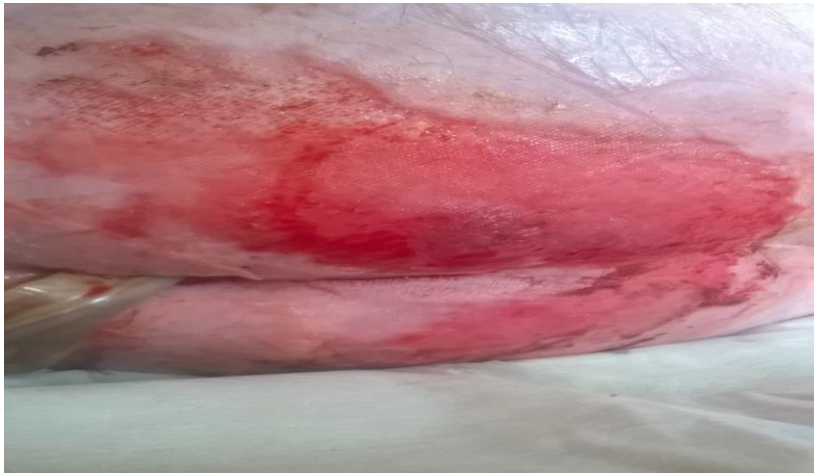
Repositioning



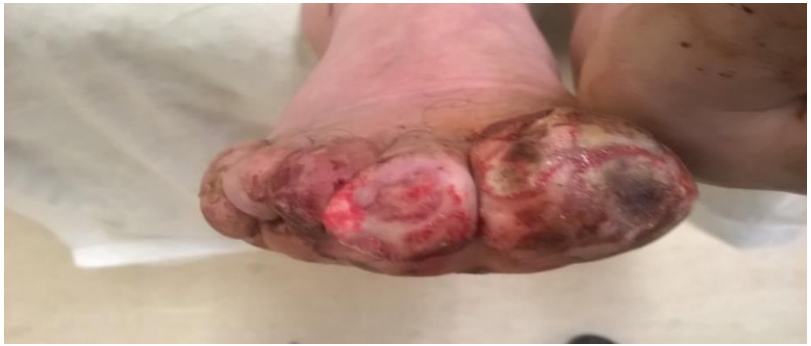
- Use the **30 degree** side-lying position (right side, left side, back side) if the patient can tolerate & their medical condition allows
- Avoid lying postures that increase pressure such as the **90 degree** side lying position or the semi-recumbent position
- Limit Head of bed elevation to **30 degrees**
- Prone position: Check all pressure areas, appropriate pressure relieving surfaces

Differential Diagnosis

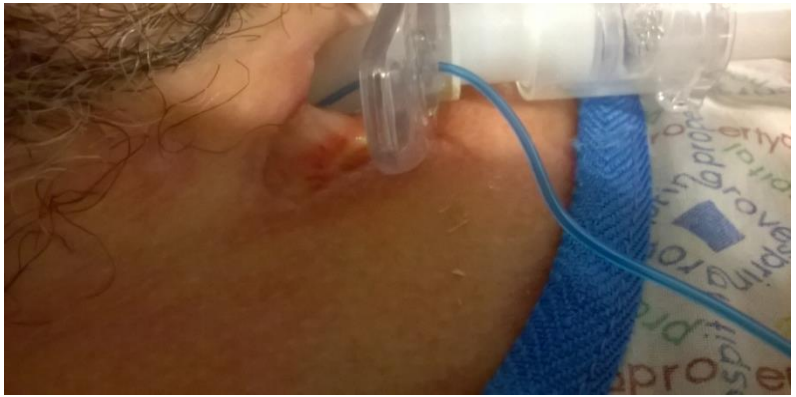
Moisture Associated Lesion



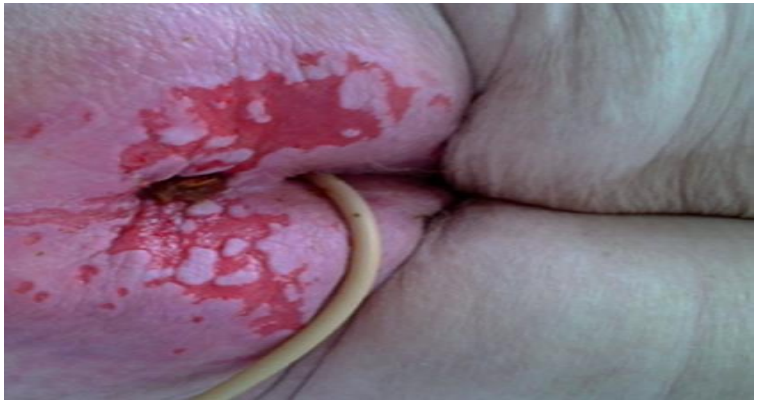
Moisture Associated Tissue Damage

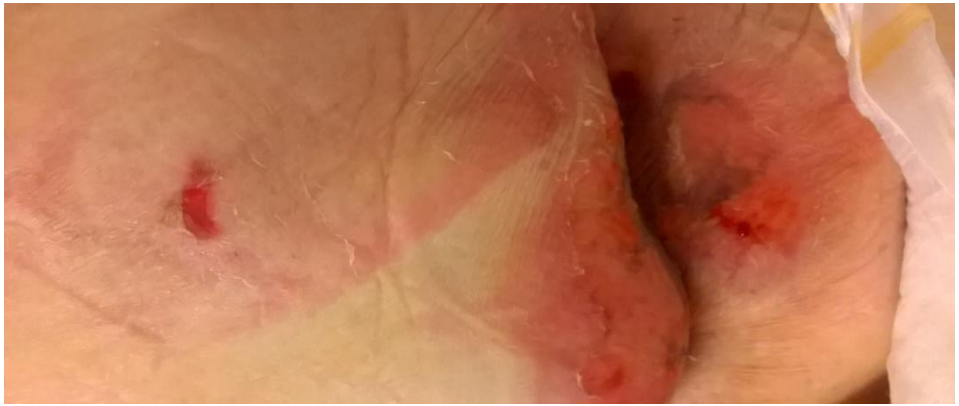


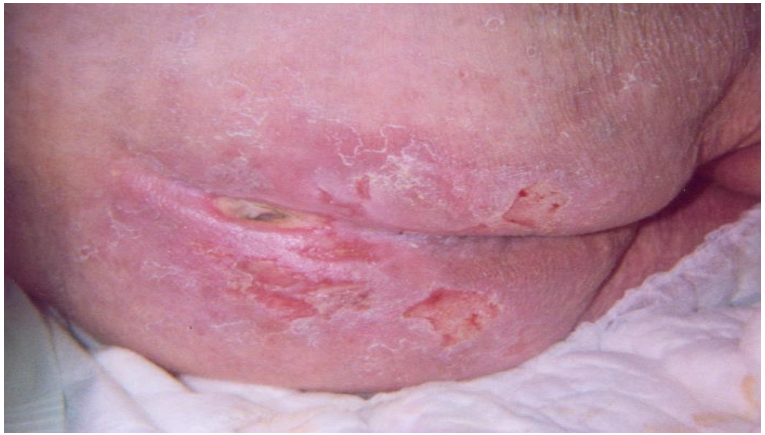
Device Related Tissue Damage

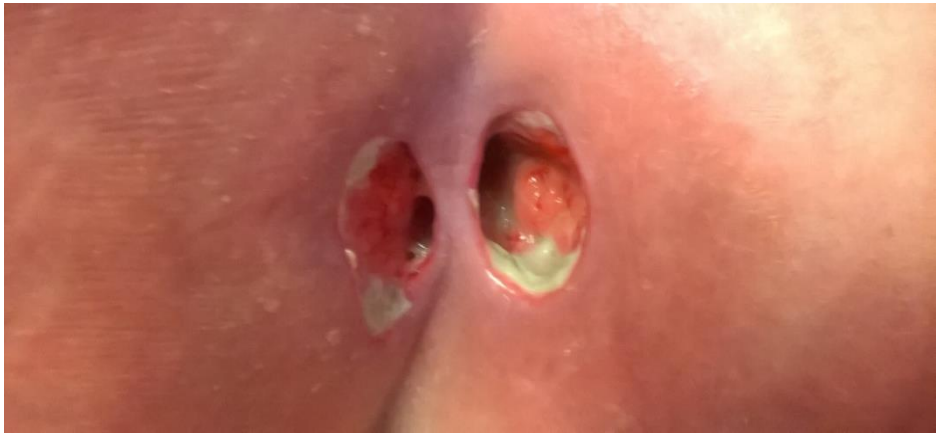


Moisture Lesions

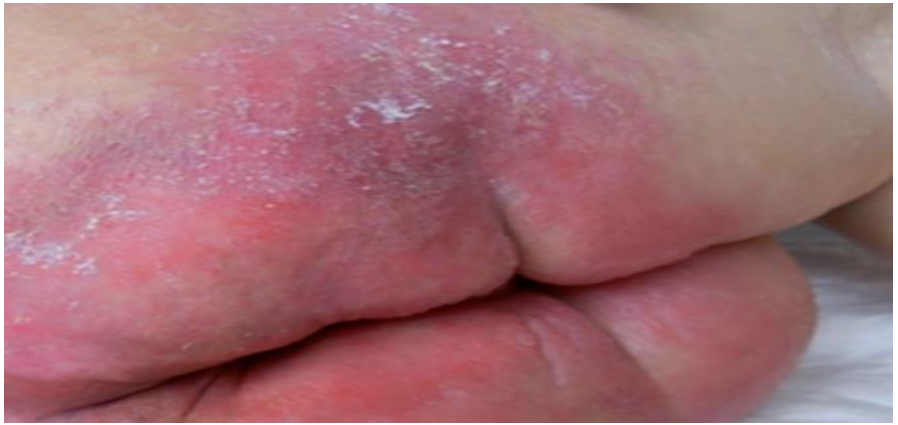


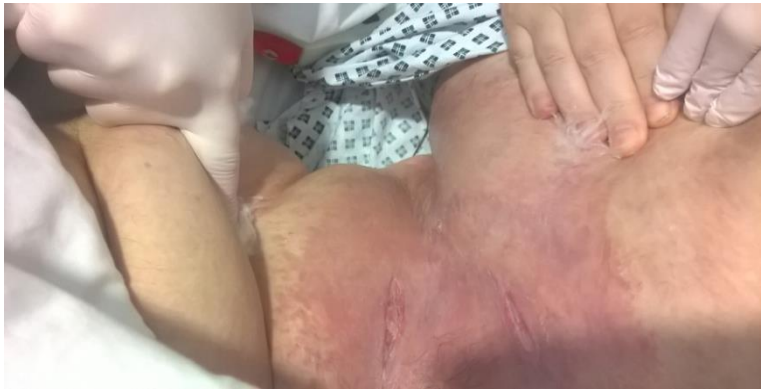


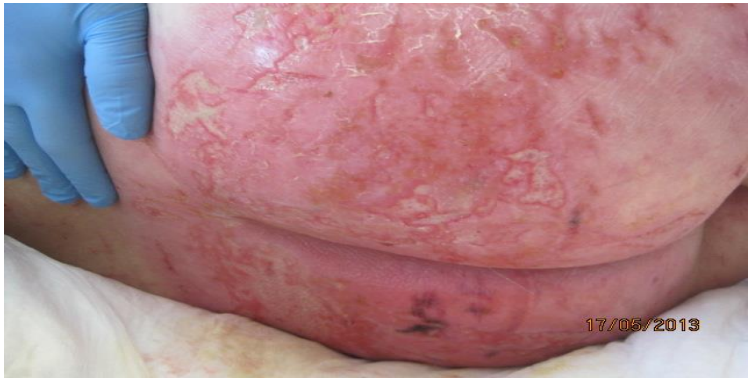




Incontinence Associated Dermatitis

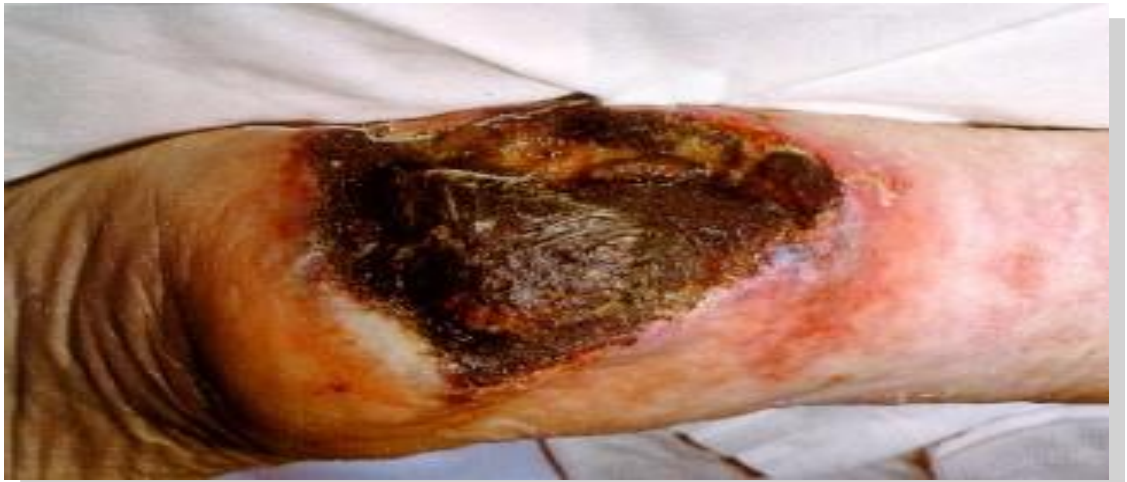






Alert

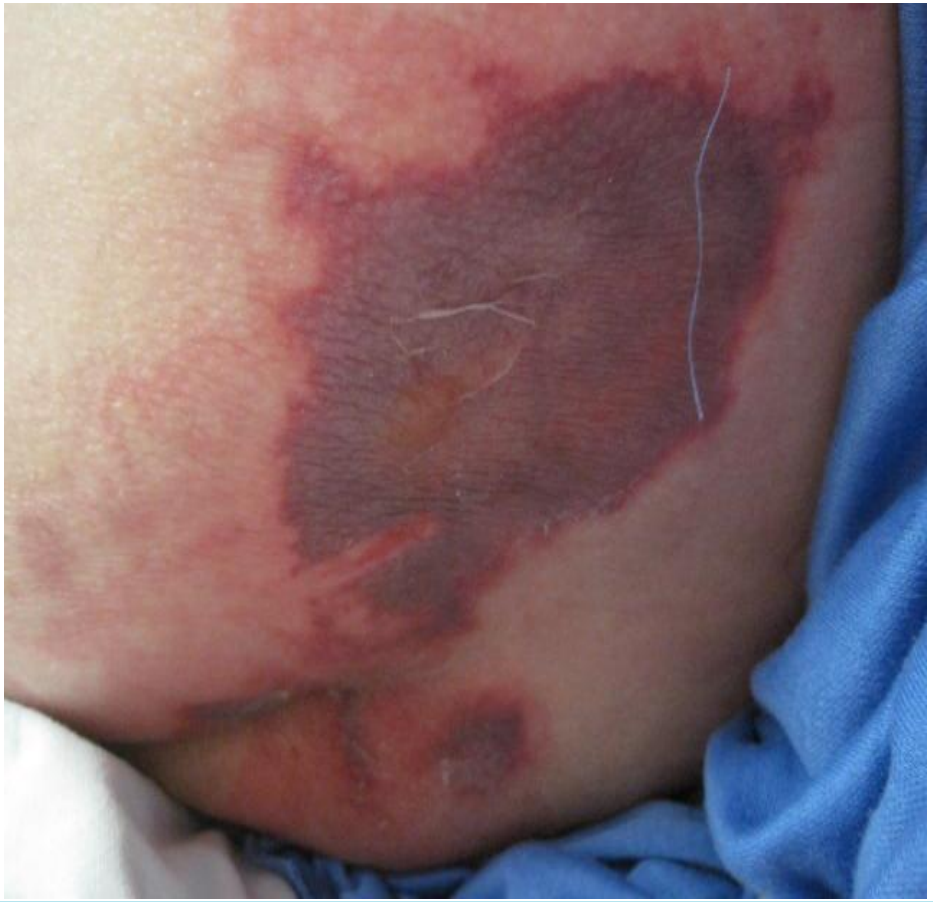
Where the wound bed of a PU is completely occluded by necrotic tissue or slough, record **at least a Stage 111, PU**



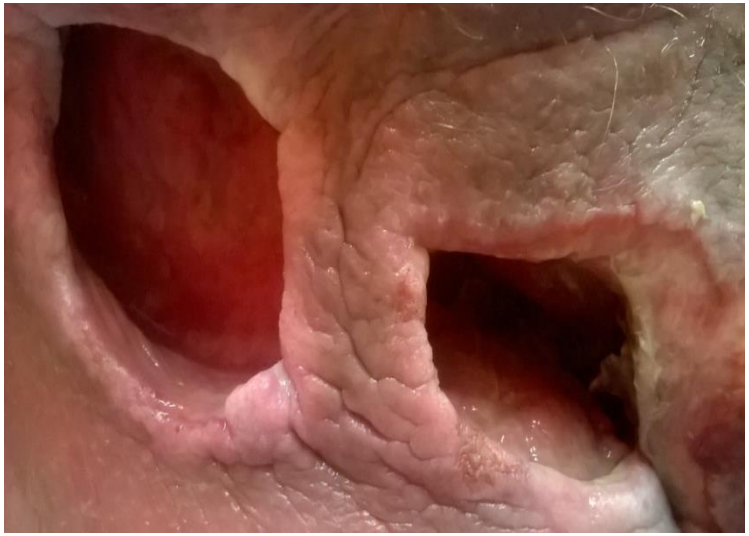
Alert

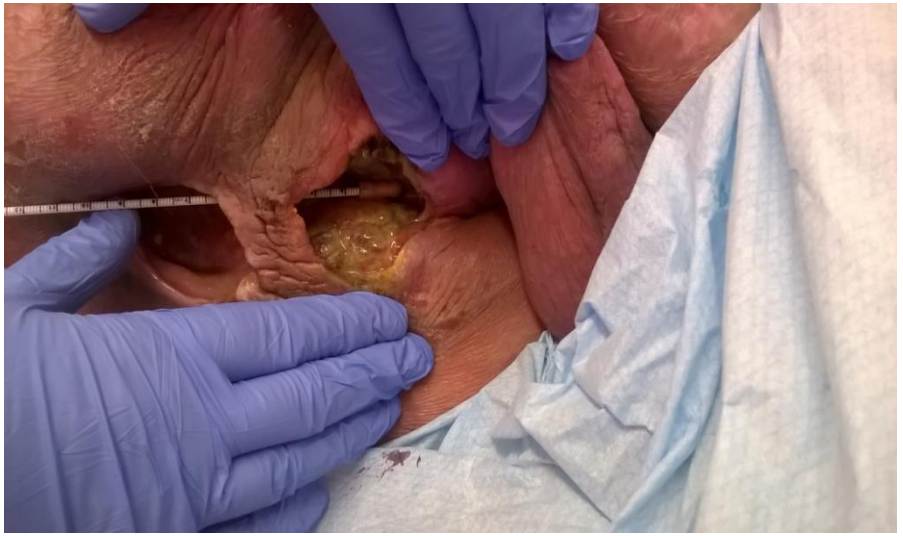
Where a **purple or maroon** discoloration of intact skin presents against a background of prolonged, unrelieved pressure/shear, this skin change, **may be** an indication of a an emerging Stage 111 or 1V PU. Clear **recording** of the exact nature of the visible skin changes should be recorded in the patient's medical notes. It could take between 3 – 10 days before the exact extent of damage can be recorded (Black et al, 2015)

It may resolve in a few days

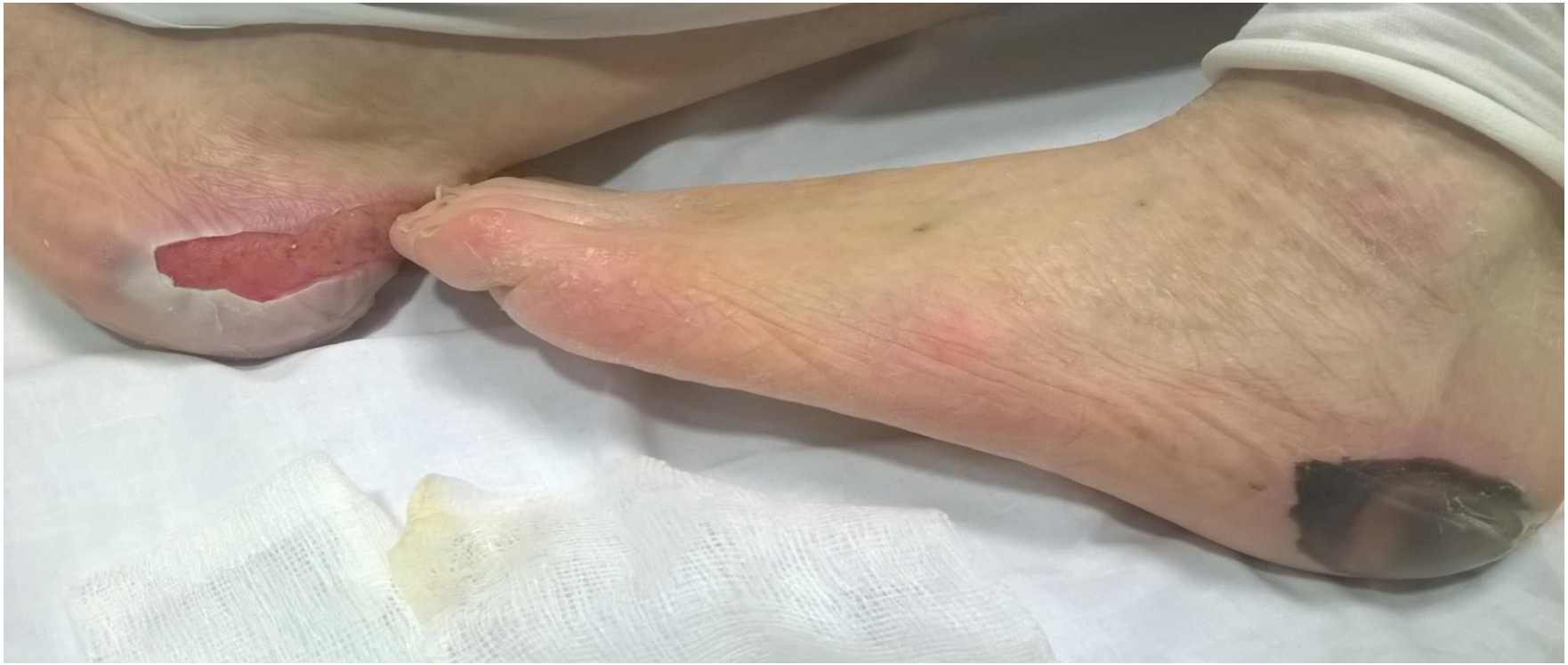


Just because it looks deep.....

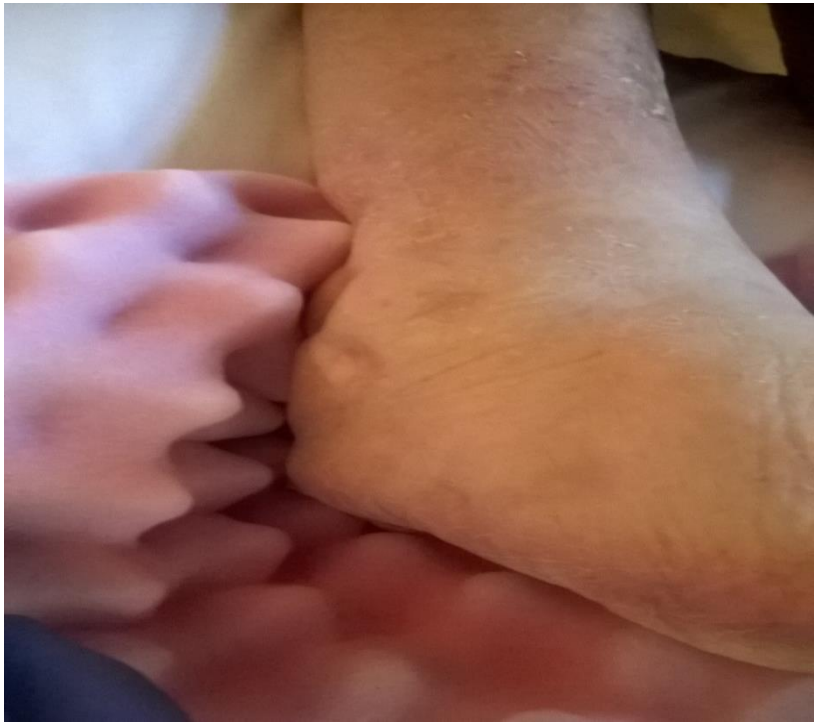


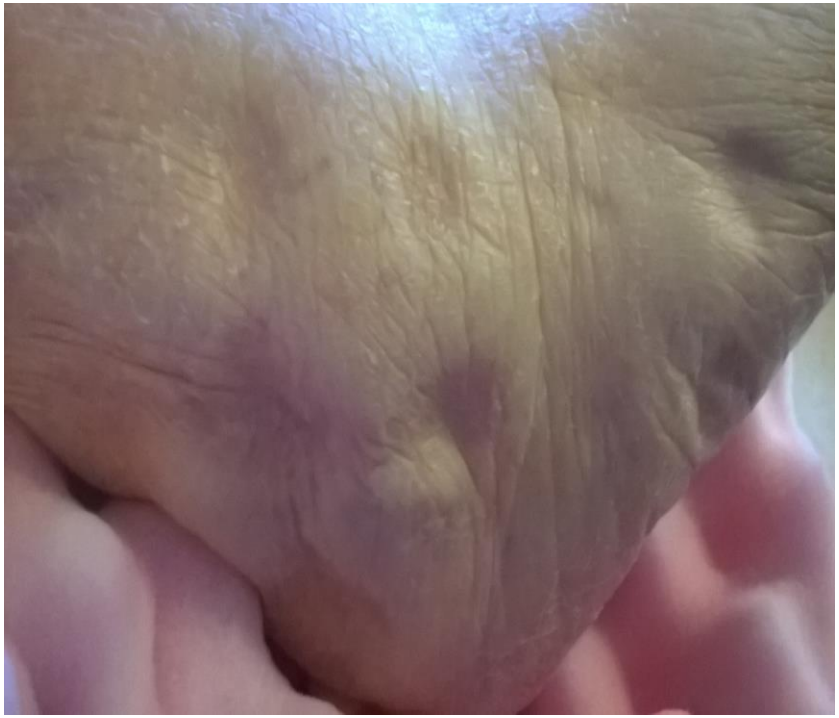


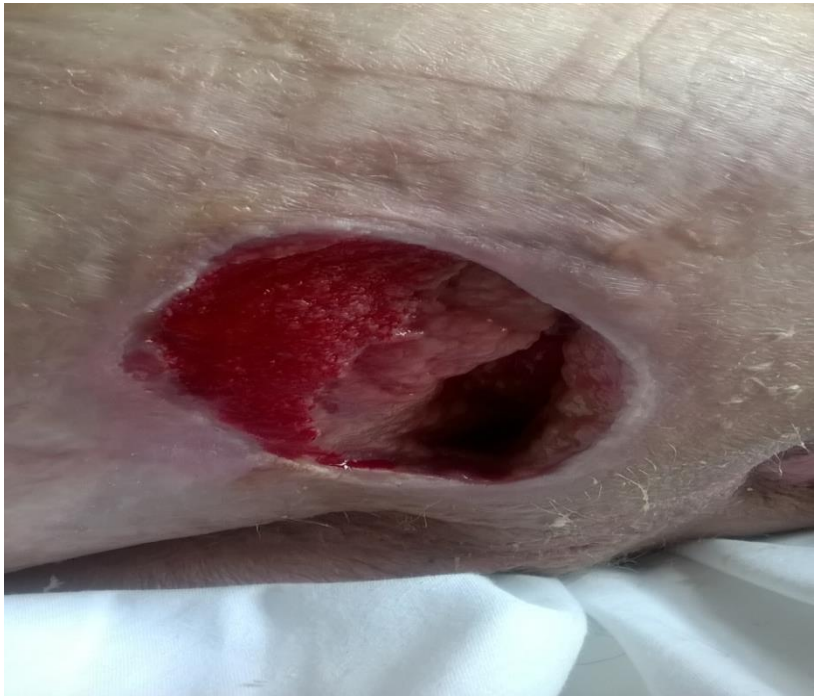
What questions should we be asking ourselves?

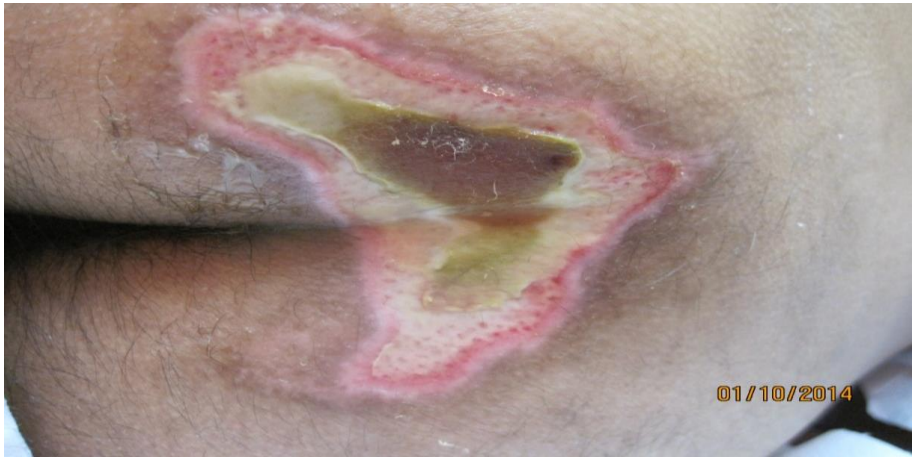


Do No Harm!





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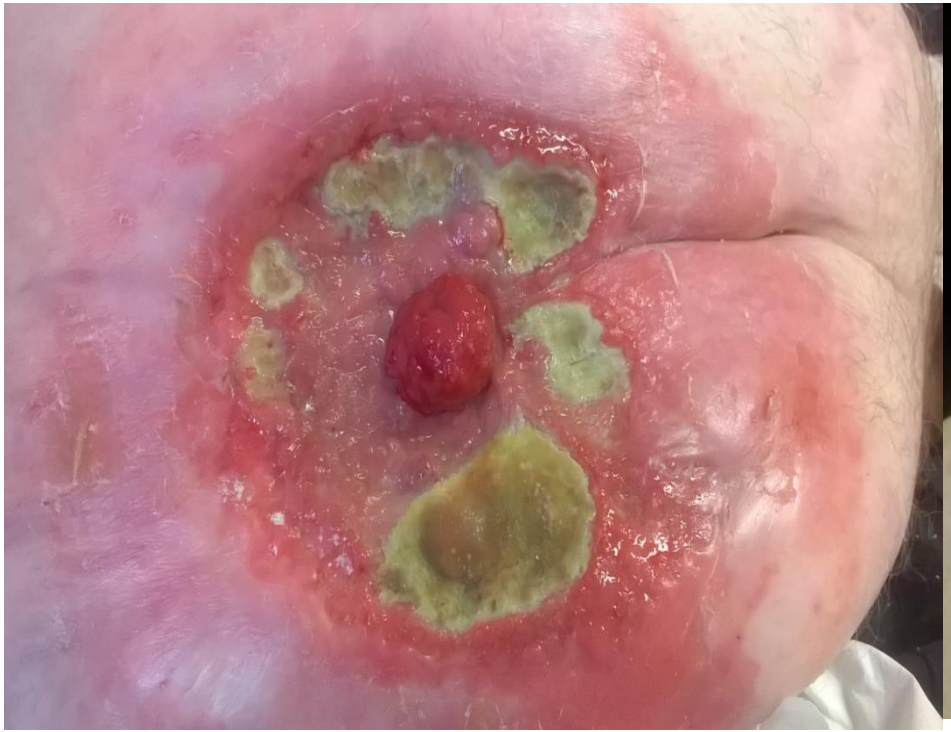
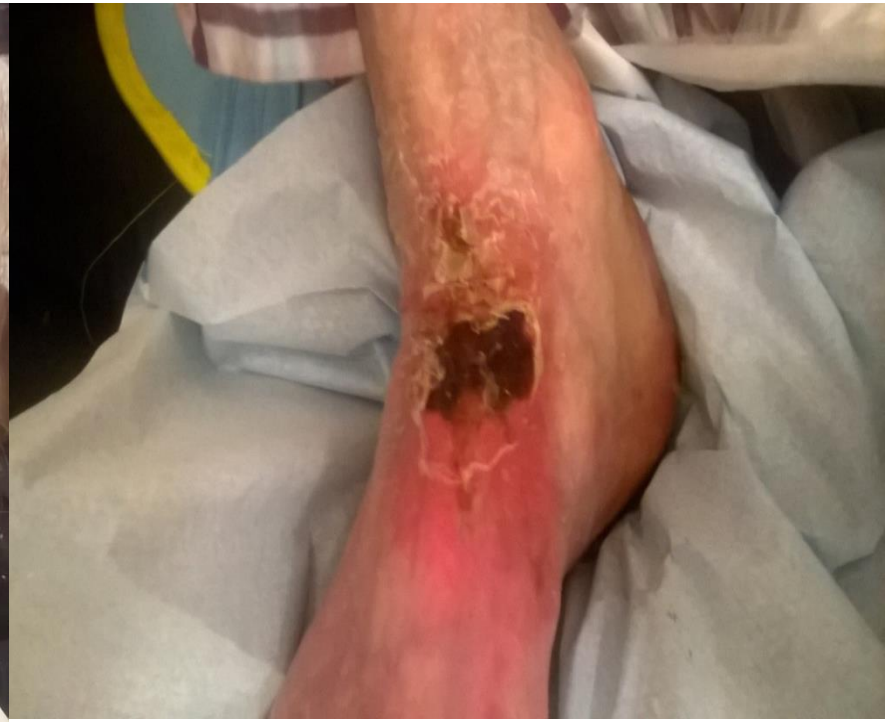
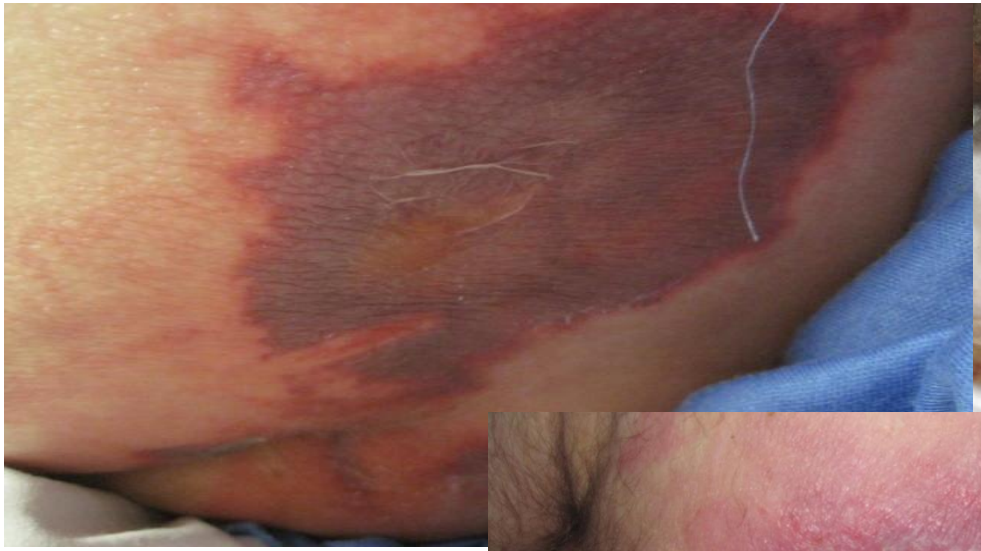
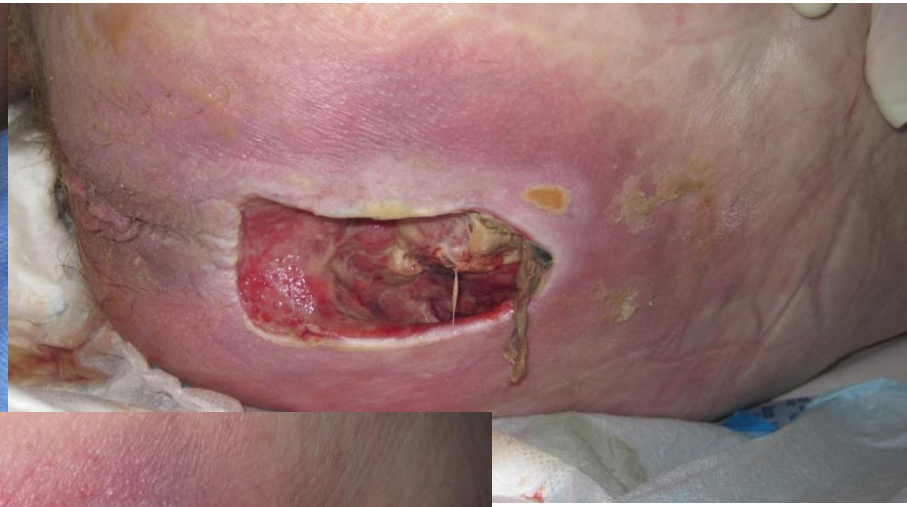
Device Related Pressure Ulcer

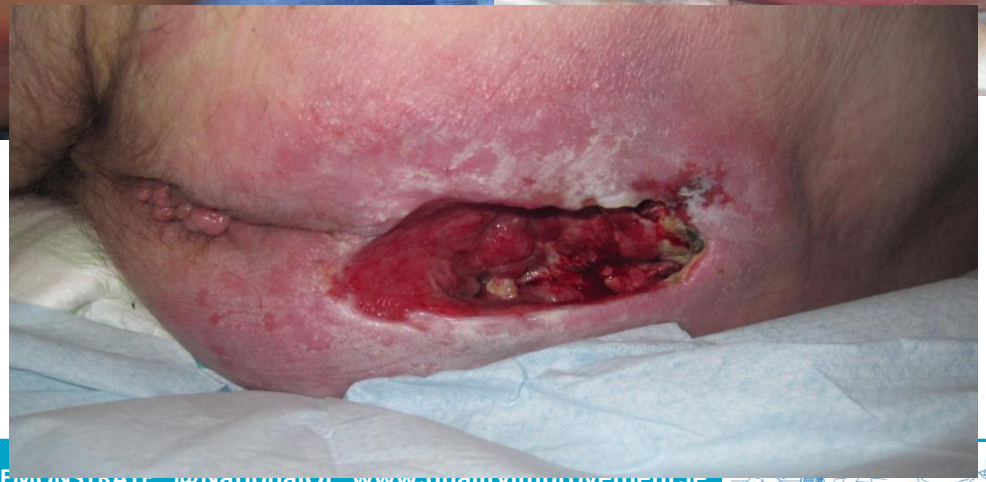




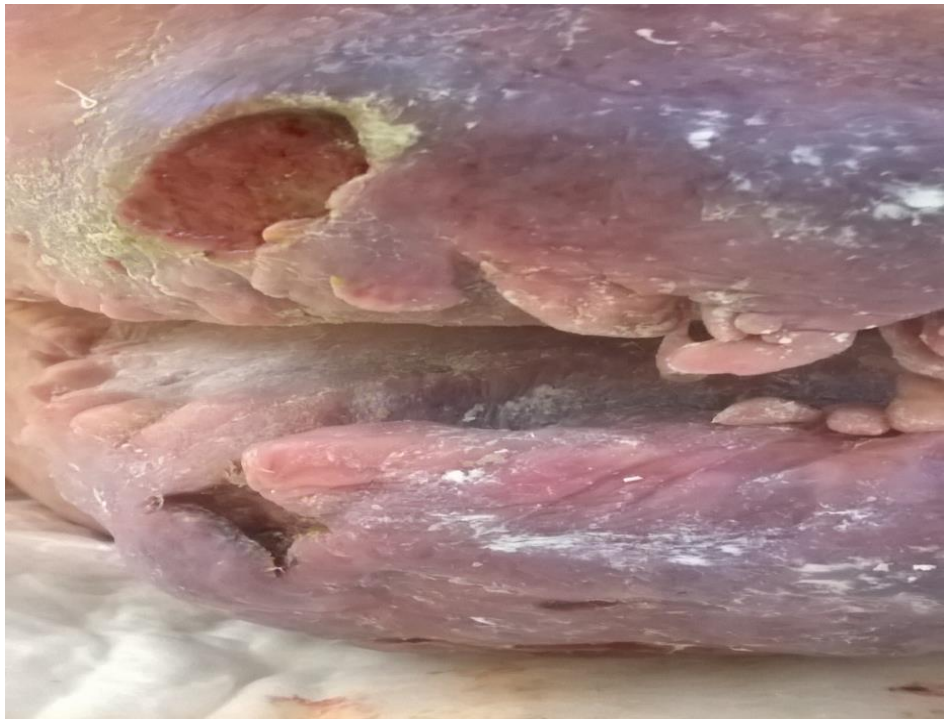
Sacral

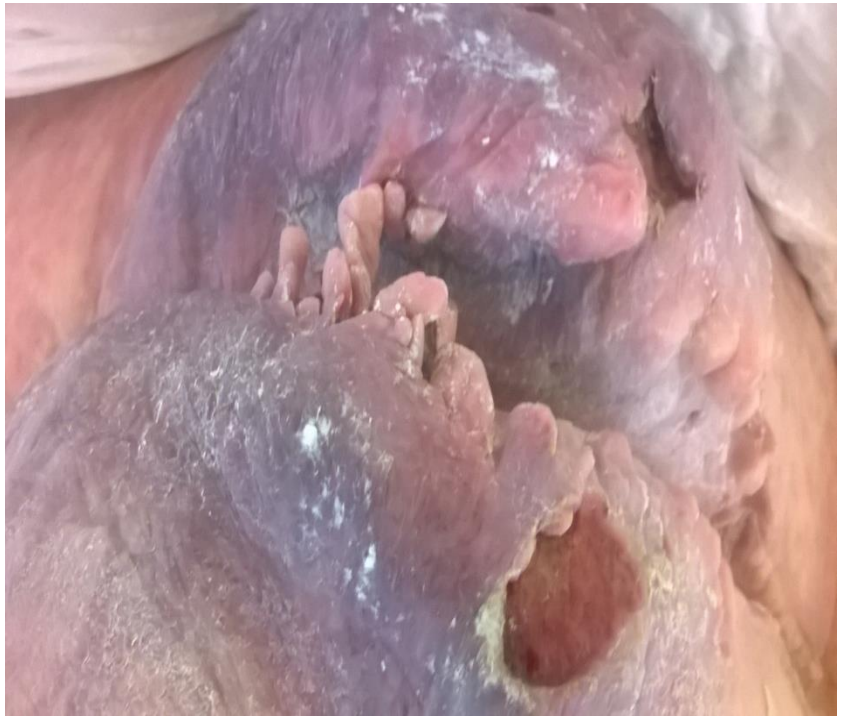




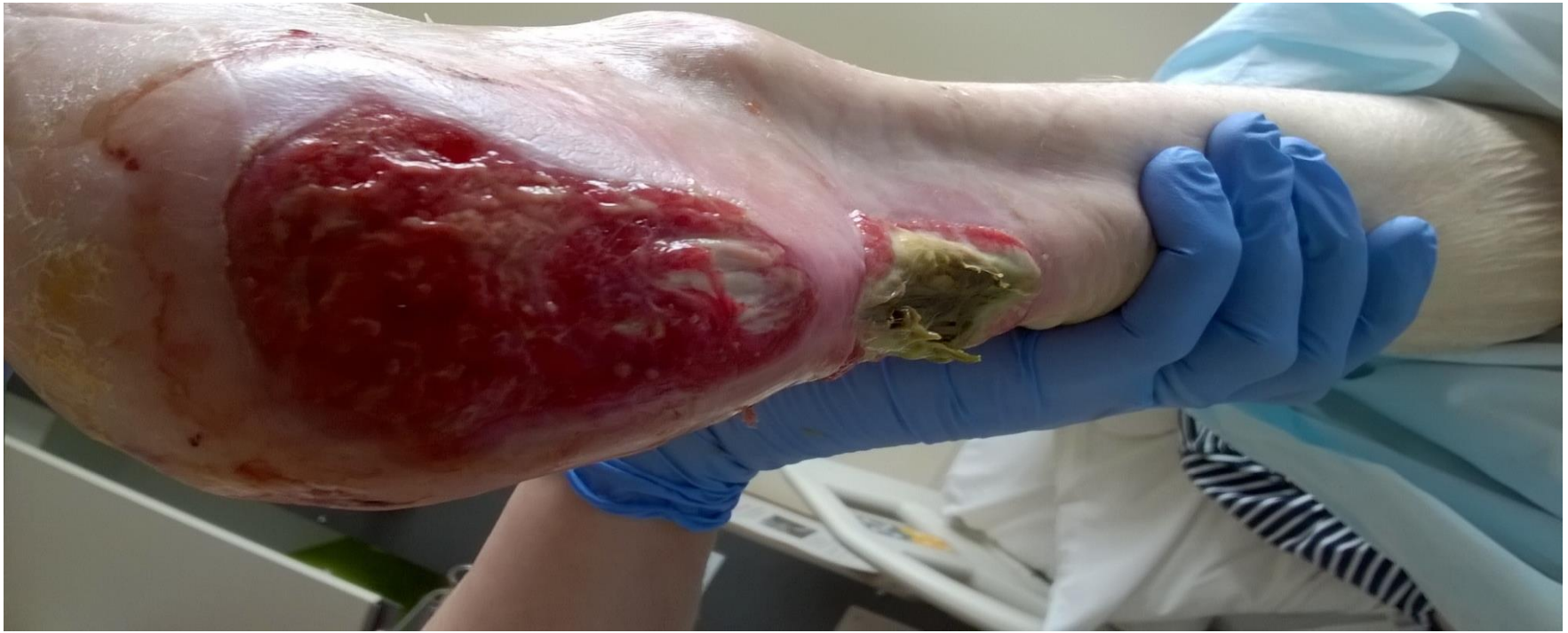


Sometimes pressure causes outward damage

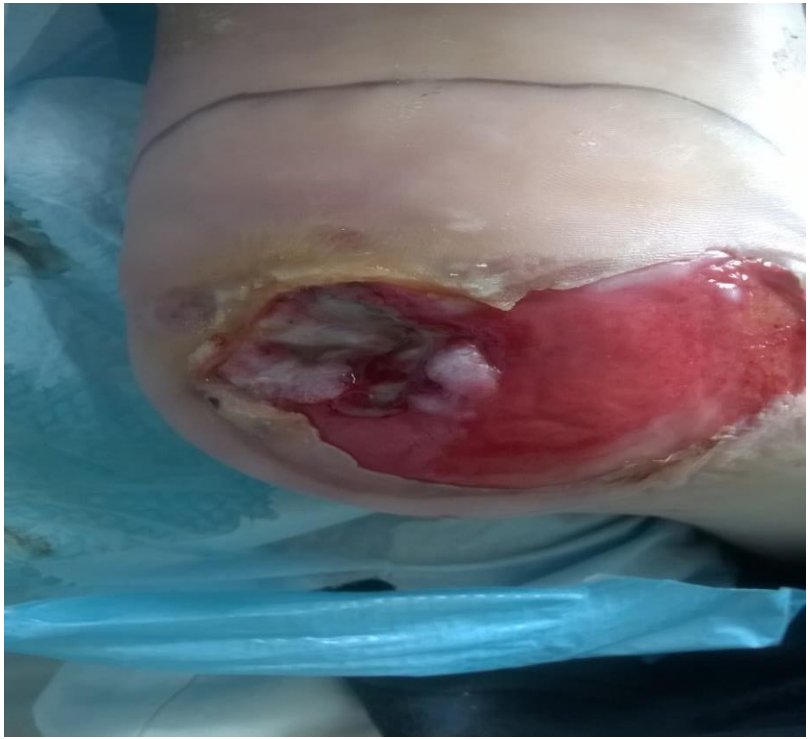


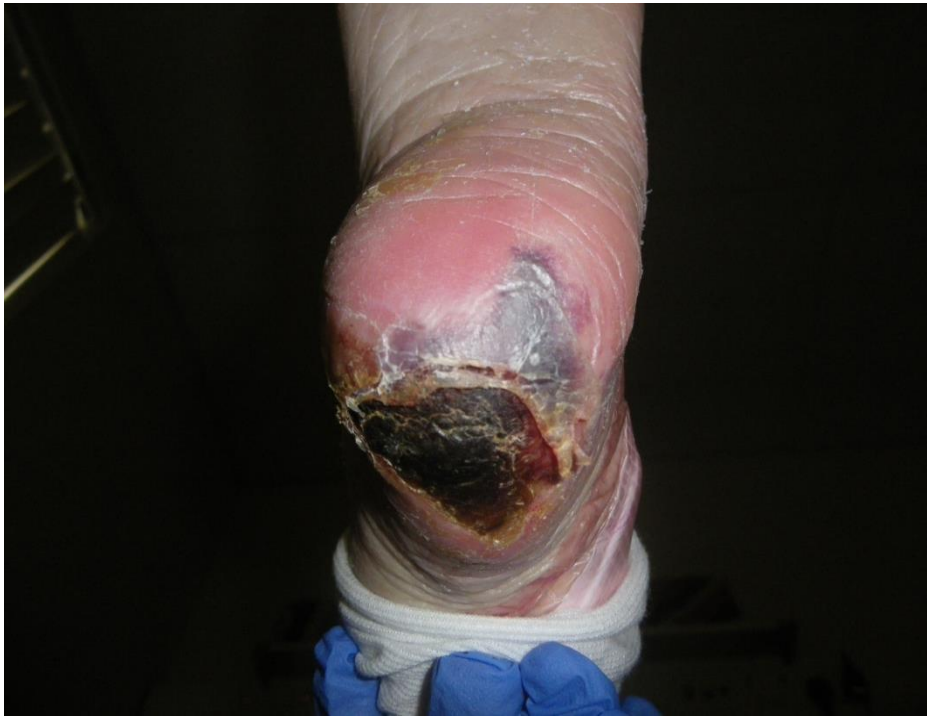


Even Stage 1V PU's can heal with the right interventions!!



Which heel is of greatest concern & why?





Remember……

‘We are, what we repeatedly do, Excellence therefore is not an act, it is a habit’

- Assess, Re-assess, Safety Cross, SSKIN Bundle, Build these components into each days practice, Think risk, Think Prevention, Think

……**Do no harm**

Pressure Ulcers to Zero

Thank you

Pat Mc Cluskey

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