HQIN
Health Quality Innovation Network

Pressure Free Zone

8-week Educational Program to Reduce Facility Acquired Pressure Injury

Pressure Free Zone

The Pressure Free Zone program is a turnkey educational toolkit to assist nursing homes with ongoing prevention and elimination of facility-acquired pressure injuries. The Health Quality Innovation Network (HQIN) developed this program for use during the winter season when increased trends are noted in the high-risk pressure injury quality measure across the nation but it can be used at any time to reinforce preventive practices.

The program package includes consistent messaging about the importance of daily pressure injury preventive practices with the following "ready-to-use" tools: memo board to post the number of "Pressure Free" days for each unit or for facility-wide totals; step-by-step plans for brief, instructions to conduct hands-on demonstrations; intervention tools suggested for direct staff and "Pressure Point" posters to reinforce the educational content.

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All documents are available online at www.HQIN.org

Pressure Free Zone
Five Simple Steps to Get Started

1. Commit, as a Leadership team, to participate in the Pressure Free Zone program.
   - Involve your entire team to set goals and plan implementation steps.
   - Identify a CNA champion to work with your leadership team and each unit to achieve the goal.
   - Sponsor a kick-off for direct care staff during the program.
   - Create a competition between units for the most number of days without facility acquired pressure injuries. If you only have one unit, challenge each hallway, assignment or nurse med. cart to reach the goal.
   - Set some simple rewards for staff with best performance. Examples of performance that could be rewarded: Unit with longest number of days without an acquired pressure injury; Unit with the most number of total days without acquired pressure injury; most improved unit. Reward Ideas: a star posted to celebrate the unit with the longest number of days free of acquired pressure injuries; an ice cream sundae party; doughnut day; pizza.
2. Provide education to direct care staff using programs prepared by the Health Quality Innovation Network (HQIN).
   - Use brief, educational sessions and demonstrations designed for quick "on the unit" in-services. Added bonus: presentations do not require time away from the unit.
   - Assign accountability. Designate one staff member per unit to conduct the in services and post the "Pressure Points" posters (included in booklet).
3. Post weekly "Pressure Points" posters in common staff areas. These are visible reminders to your staff to keep prevention as the focus and achieve the goal of ZERO. One 8.5 x 11 poster per unit is provided.
4. Post the Pressure Free Zone wipe-off board on each unit to track your successes. Assign one team member to update each tracking board daily to indicate the number of days since an acquired pressure injury was recorded.
   - Request this information to be reported each day at morning meetings.

Preventive Skin Care
Week 1

Objective To educate your staff on the typical seasonal increase of pressure injury during winter with a focus on pressure injury prevention.

First Discuss your facility's commitment to keep acquired pressure injuries at zero. Next, discuss why they think this happens each year? (Some answers can include flu, symptoms of depression, pneumonia, cardiac issues, and weight loss.) Ask why they think their answers put residents at risk for skin breakdown.

Review

a. The facility's Pressure Free Goal of No Acquired Pressure injuries on their residents
b. The plan for weekly prevention in-services
c. The Pressure Points Poster
d. The Pressure Free Zone wipe-off board for the number of days without an acquired pressure injury
e. Update tracking chart for each unit.

Ask How can we do this?

a. Turning and repositioning frequently
b. Using pillows to float heels
c. Toileting per individualized schedule
d. Keeping skin moisturized
e. Enhancing incontinence care with barrier creams
f. Providing appropriate use of equipment to reduce friction and shearing (lifts, transfer boards, gait belts, etc.)
g. Reporting resident changes immediately (eating, drinking, confusion, diarrhea, fever, coughing, wheezing, behaviors)
h. Conducting daily skin assessment; focus on pressure points; report redness or discoloration immediately

Ask each participant what he/she can do differently in his/her daily routine to affect pressure injuries in his/her residents?

Emphasize Do what you do best — take great care of your residents…they depend on you.

Lesson Winter months show an increase in pressure injury. Preventive care is the key to ZERO acquired pressure injuries. Let us get in the Pressure Free Zone!

Preventive Skin Care
Week 1: Pressure Points

1. **Reposition** frequently; use positioning devices to relieve pressure
2. Clean quickly after **incontinence**
3. Apply skin **barrier creams** and lotions
4. **Toilet** per resident's need
5. Keep linens **clean and wrinkle-free**
6. **Check fit** of wheelchairs, braces and splints
7. **Check skin** around and under oxygen tubing, GT sites, catheters, support stockings and casts
8. **Inspect** skin daily… **report** all suspicious areas
9. Provide appropriate assistance with transfer to **prevent friction and shearing**
10. Begin **immediate** preventive care when illness occurs (ex: diarrhea, fever, colds, flu)

Repositioning
Week 2

Objective To focus your staff on repositioning as a pressure injury prevention intervention.

First Ask staff how many days their unit has been since they acquired a pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injury.
b. Congratulate each successful day!
c. Update your Pressure Free Zone tracking wipe board.

Review

a. The importance of repositioning residents both lying and sitting to keep acquired pressure injury at zero.
b. The Pressure Points poster and each tip for pressure relief.
c. The "Tip the Waiter" teaching guide to promote a new technique for shifting weight while residents are sitting. Have staff practice this technique during session.
d. Those residents at higher risk for developing pressure injuries in the winter month.

Ask

a. Do you have enough positioning devices to properly position your residents?
b. What can you do differently in your daily routine to provide frequent weight shifts in your residents? (possible answers include: "Tip the Waiter", toilet more frequently, use pillows and positioning devices, tilt chairs back, keep head of bed at 30 degrees or below, naps, etc.)

Emphasize Repositioning is critical in prevention of pressure injuries. Pressure on a bony prominence decreases blood supply leading to tissue damage.

Lesson Frequent repositioning and weight shifting are essential to preventing zero acquired pressure injuries with our residents.

Repositioning
Week 2: Pressure Relief Technique

"Tip the Waiter"

Like a three-legged stool, when we sit, our weight rests on 3 bones: **the left ischial tuberosity, the right ischial tuberosity, and the coccyx**. People who sit for long periods of time, and who are unable to effectively shift their weight, such as those with severe cognitive or neurological impairment, are at risk for developing pressure injuries in these areas.

TIP THE WAITER is a simple repositioning technique that not only provides temporary pressure relief in these areas, but can also increase capillary blood flow to the tissue. **TIP THE WAITER** is very easy for health care staff and family to do without fear of injury, if done correctly.

The term "**TIP THE WAITER**" can help you remember the technique. Any time a person cannot effectively reposition themselves, they are waiting to be repositioned by someone else, and thus they are the waiter. By tipping the person forward and holding them in a tipped or forward leaning position for a period of time (one to two minutes), a caregiver can provide pressure relief to the coccyx and ischial tuberosities. Caregivers should hold the person as necessary to prevent them from falling.

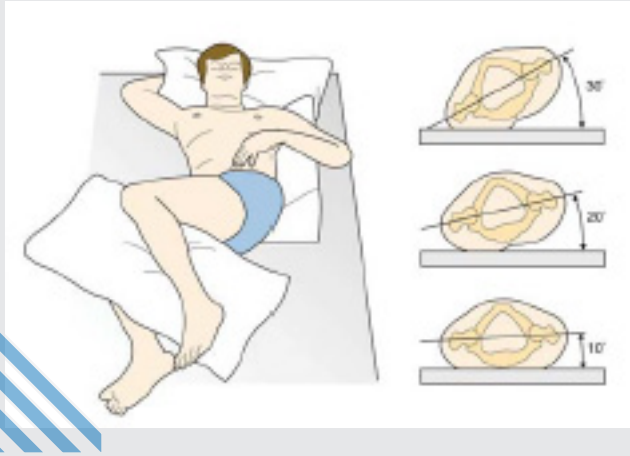
The caregiver may employ therapeutic touch and therapeutic communication with the patient or resident, while holding them in a tipped position. Remember this practice with **Three Ts (tip, touch, talk)**.

TIP THE WAITER is a simple technique that can be employed by health care staff, family and other caregivers to help relieve pressure from an area highly susceptible to pressure injuries. This technique does not replace the need for total repositioning at least every two hours.

Note: Tip the Waiter is a recommendation to help relieve pressure, which is a method for pressure injuries prevention. Currently, there is no scientific evidence of the effectiveness of this technique in the prevention of pressure injuries.

Repositioning
Week 2: Pressure Points

1. **Turn** bed-bound residents frequently; use pillows, wedges, etc.
2. **Reposition** chair-bound residents frequently
   a. Encourage **weight shifts** – "Tip the Waiter"
   b. Change degree of tilt in reclining chairs
   c. Avoid "doughnuts" in chairs
3. **Specialty** beds/overlays
   a. Check bed and/or overlay for function and desired settings
   b. Reposition frequently while on specialty mattresses
4. **Refer** to Occupational Therapy (OT) for proper chair fit and positioning
5. **Lift**, **do not drag**, resident during repositioning and transferring
6. Encourage **rest periods**
7. **Float heels** in beds and in recliner chairs
8. Turn resident to **30 degrees** to remove pressure from sacrum



Incontinence Management
Week 3

Objective To focus your staff on repositioning as a pressure injury prevention intervention.

First Ask staff how many days their unit has been since they acquired a pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injury.
b. Congratulate each successful day!
c. Update your Pressure Free Zone tracking wipe board.

Review

a. "The Barrier Reef" education lesson plan
    i. Need: two clear bowls, red food coloring, barrier cream, paper towels or wipes
b. The Pressure Points poster and each tip for incontinence management

Ask

a. Can you think of specific residents that need special attention to skin and incontinence care?
b. What can you do differently in your daily routine to maintain unbroken skin your residents? (possible answers: use barrier creams after each incontinence episode, keep barrier within easy reach for staff, assess need for toileting plan, etc.)

Emphasize Toileting and incontinence care are important components of preventing pressure injuries.

Lesson Frequent toileting and use of barrier creams after each incontinent episode promotes skin health and leads to zero acquired pressure injuries with our residents.

Incontinence Management
Week 3: Educational Demonstration

The Barrier Reef

Objective After submerging both hands into colored water, the participant should notice a difference in skin color between the unprotected hand and the hand with barrier ointment. In addition, water will bead (be repelled) only on the protected hand.

- Apply moisture barrier to top of one hand (Hint: For this demonstration, it is best to use a clear barrier ointment (i.e., A&D) rather than white zincoxide).
- Pan of water with generous amount of food coloring (Hint: red works great!)
- Have participant place both hands in the water for a few minutes. Ensure water covers the tops of the hands. While the hands are soaking, ask the audience what they expect the hands will look like when removed.
- Remove the hands and compare them. The knuckles of the unprotected hand will appear "colored" while the protected hand repels the food coloring and water beads on it.
- Hint: an effective analogy to draw is reminding them how a car with a good wax application repels (beads) the water when it rains. A sign that the car is being protected. In the same respect, they will see water beading on the hand with barrier ointment.
- Have towels available for drying

Lesson Moisture is a risk factor for developing pressure injuries. The importance of using barrier creams is they will help protect the skin during an incontinent episode.

Incontinence Management
Week 3: Pressure Points

1. Increase incontinence management during new illnesses, such as diarrhea, urinary infection, flu and colds
2. Consider leaving resident "open to air" (no briefs) while in bed
3. Monitor perineal and buttock areas with each care opportunity for redness, rash or odor

Do

- Know your residents' incontinence patterns and check frequently
- Toilet frequently to avoid incontinence
- Use gentle soap or skin cleanser
- Apply topical barrier to protect skin with EVERY perineal care

Don't

- Scrub the skin
- Skip application of barrier creams
- Use more than one incontinence pad on a bed
- Use plastic incontinence pads on low air loss beds

Friction and Shear
Week 4

Objective To focus your staff on proper prevention techniques that reduces friction and shear.

First Ask staff how many days their unit has been since they acquired a pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injury.
b. Congratulate each successful day!
c. Update your Pressure Free Zone tracking wipe board.

Review

a. "You're Tearing Me Apart" education lesson plan
   i. Need: wax paper
b. The Pressure Points poster and review each tip

Ask

a. Staff for tasks that place the residents at high-risk for friction and shearing?
   i. Have staff identify some residents at high risk and tell why.
b. What can you do differently in your daily routine to reduce friction and shear for your residents? (possible answers: use lifts, use draw sheets and lift pads, lay bed flat, use two staff, use cushioning devices in positioning, etc.)

Emphasize Shear and friction cause damage to tissue under the skin and cannot always been seen immediately. Avoidance of friction and shear plays an important part in eliminating acquired pressure injuries.

Lesson Using proper lifting, transferring and positioning techniques reduce friction and shear. Damage to tissue under the skin places the resident at a high risk for pressure injuries.

Friction and Shear
Week 4: Educational Demonstration

You are Tearing me Apart

Objective As the participant slides against the wall with the wax paper, he/she is replicating friction and shearing. The wax paper should crinkle and may even tear.

- To make this fun, ask for a participant, who is the "wild one" in the group. Usually the group points out this individual.
- Give participant a piece of wax paper
- Advise the audience to think of the wax paper as fragile skin and the wall as the bed linen.
- Have the participant lean against the wall on the paper
- Advise the participant that you are going to see how "wild" he/she really is. Have him/her slide up and down the wall, and side to side. At the same time, ask the participants what they expect to happen to the wax paper.
- Allow the audience to view the participant's wax paper.
- Ask the participants to discuss ideas on how to reposition residents to reduce friction.

Lesson To prevent friction and shearing, use draw sheets and lifting devices to "lift" rather than "drag" residents. Keep the HOB at, or below, 30 degrees or at the lowest degree of elevation, consistent with the resident's medical condition, to prevent sliding and shear injuries. Use cushioning devices, such as pillows, to prevent the touching of bony prominences.

Friction and Shear
Week 4: Pressure Points

FRICTION injuries involve the superficial skin layers and occur when moving across a coarse surface (for example: elbows on tabletops)

SHEARING injuries involve damage to tissue under the top layer of skin and occur when skin slides over muscle and bone causing friction, abrasion and a decrease in circulation (for example: pulling up in bed)

- Prevent residents from **sliding** down or **slouching** in a bed and/or in a chair
- **Avoid massage** of red areas as this can damage the tissue under the skin

High-Risk Residents

- May have frequent **agitation**
- May have uncontrollable **spasticity or movement**
- May have a **recent decline** in physical and mental health
- May require assistance with **transfer aids** such as lifts, gait belt, slide boards, etc.
- May require assistance with a **bed mobility**
- May have **poor nutrition**
- Need to be **lifted**...not dragged
- Use **draw sheets** or lift pads to pull residents up in bed
- ALWAYS lay the **bed flat** and use 2 people
- Use mechanical **lifts**, as needed

No matter how you say it,
STOP injuries from Friction and Shear

Daily Skin Check
Week 5

Objective To focus your staff on completing skin as assessments on all residents during care in assessment of skin. Special attention needs to be focused on residents with darker skin tones.

First Ask staff how many days their unit has gone without an acquired pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injuries.
b. Congratulate each successful day!
c. Check that the Pressure Free Zone board is up-to-date.

Review

a. "You Bruise, You Lose" education lesson plan
    i. Need two fruits of contrasting colors, one dark skin and one light skin. (ex. plum/nectarine; green or yellow apple/dark red apple, and banana)
b. The Pressure Points poster and review each tip

Ask

a. What is the biggest barrier to getting skin assessments done on your shift?
b. What can you do differently in your daily routine to identify suspicious skin problems? (possible answers: carry a flashlight if providing care at night, touch areas to assess for redness, heat or coolness, ask resident about skin pain, itching, etc., follow protocol for reporting skin concerns)

Emphasize Direct care staff is our first "eyes" for identifying skin concerns. Look carefully at discolorations on dark skin-toned residents.

Lesson Direct care staff is the first line of defense for early skin damage. Constant inspection of pressure points during routine care is essential. Special attention needed for residents with darker skin tones as damage is not easily seen.

Daily Skin Check
Week 5: Educational Demonstration

You Bruise, You Lose

Objective To educate staff on the challenges of assessing residents with dark skin (African American, Asian, Hispanic, Mexican, American Indian, etc.)

- Ask for two volunteers; hand one of them the plum/red apple and one the yellow/green apple to locate the bruise. The staff member with the yellow apple will immediately identify the bruise. The one with the red apple will have to look carefully, cast a shadow on the apple, or feel to help identify a bruise. If they ask for help, look very hard and make the point of the difficulty you are having finding the bruise.
- When the bruise is found on both apples, ask "what is the difference here?" They should answer skin color/tone.
- Discuss how this compares to your residents. Reinforce special attention is needed with darker skin tones, especially over bony prominences or after times of prolonged sitting or lying. Explain how critical it is to look for discolorations in good light and touch the skin, especially over pressure points to determine thickness or temperature. It is difficult to "see" redness, purple discoloration, or assess blanching in dark skin tones.
- Now pick up the banana and discuss again the ease of identifying the obvious bruises that would need to be reported in a skin assessment. To make the point that you cannot always tell what is under the skin, peel the banana back and "see what's underneath". Remind them that even slight skin tone changes or a "mushy"feeling may indicate tissue damage and needs to be treated. To achieve the best outcome, it is best to identify early before the skin breaks.
- Remember to report what you see! When you see a suspicious area make sure you report it to the nurse. If you have information about how the area may have occurred, make sure you report that, also.

Lesson Daily assessment of skin is essential to maintain skin health. Staff must be extremely observant when assessing residents with darker skin tones for slight discolorations and change in feel and/or appearance of the skin. Remember to report ALL suspicious areas.

Note: Purchase fruit a couple of days before the in-service. You'll need: 1 red apple or plum: buy without any obvious bruises; create one with your finger, a yellow/green apple: can be purchased with bruises, bananas: purchase without serious bruises; create one with your finger. Some bruising on the rim is good to show what is on the outside is not indicative of what is on the inside.

Daily Skin Check
Week 5: Pressure Points

During care, look at your residents' skin every time, with special focus on pressure points

Color

- Difficult to assess in darker skin tones
  - Red, Purple, Black, Pink
  - **Monitor** for slight color changes in residents with darker skin tones

Temperature

- **Different** from the normal for this resident
  - **Hot or cold**

Skin Condition

- **Dry**, **scaly**, **peeling** skin similar to the texture of an orange peel
- **Moist**, **soft**, **wrinkled** skin
- **Edema** (swelling)
- **Blisters**
- Any **openings**: cracks, scabs, tears, rashes, boils
- **"Mushy"** feeling to an area

Skin Condition

- Any complaints of **pain** from lying or sitting during repositioning or touching of the area
- Complaints of **itchy** areas, especially over bony prominences

Report any suspicious areas!

Floating Heels
Week 6

Objective To focus your staff on prevention techniques that reduce the risk of heel pressure injuries and to reinforce the importance of assessment of heels during care.

First Ask staff how many days their unit has gone without an acquired pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injuries.
b. Congratulate each successful day
c. Update your Pressure Free Zone tracking wipe board.

Review

a. "You're Pushin' Too Hard on Me" and "Mom, She's Squeezin' Me" ˜ Need: manual blood pressure cuff and a balloon.
b. The Pressure Points poster and each tip for pressure relief

Ask

a. What situations do you encounter daily that place your residents at high-risk for heel pressure injuries?
    i. Have staff identify a few residents at high-risk and explain why.
b. What can you do differently in your daily routine to reduce the risk of heel pressure injuries for your residents?
c. What makes it difficult to float your residents' heels? Discuss solutions to issues identified.

Emphasize Heels must always be floated to prevent tissue damage that leads to pressure injuries. Assessing heels by sight (use your new mirrors) and touch is critical to the prevention of heel pressure injuries. Avoidance of pressure is the best prevention tool.

Lesson Floating heels is the best way to prevent heel pressure injuries.

Floating Heels
Week 6: Educational Demonstration

Between a Rock and a Hard Place

Objective A blood pressure cuff, partially inflated on the participant's arm, will enable the individual to experience low-intensity pressure.

- Apply a blood pressure cuff to participant's arm
- Inflate to 60 mm — this number was chosen arbitrarily to demonstrate low-intensity pressure.
- Ask the audience "How much pressure does it take to develop a pressure injury? A lot of pressure or a little bit of pressure?"
- Ask the participant "Do you feel pressure?" If yes, ask "How much…a lot or a little?" If no, ask "If the blood pressure cuff was left on for 5 more minutes, would you be uncomfortable then?"

Lesson Reminder that even low pressure over a long period can cause tissue damage. One way to relieve pressure is through consistent turning schedules. The turning schedule for bed bound residents is every 2 hours. Reposition chair-bound individuals every hour. Encourage these individuals to shift weight every 15 minutes, if possible.

Objective Pushing the stick on the balloon will create an area of high-intensity pressure and the balloon will pop (develop a wound).

- Gather a small balloon and a sharpened pencil
- Have participant apply pressure on the balloon with pencil, until it pops

Lesson Tissue damage can occur within a short period with high-intensity pressure. Actions that minimize pressure, such as using pillows and wedges between bony prominences, will help prevent pressure injuries.

Daily Skin Check
Week 6: Pressure Points

a. ELEVATE the heels! This is the KEY to preventing pressure injuries on the heels!

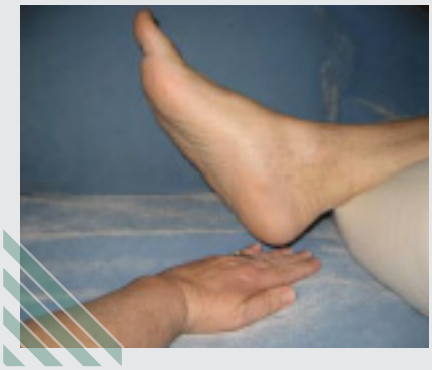
- Ensure **space** between the bed and heels ("floating"); your hand should fit between the heel and the bed/chair
- Use pillows or positioning devices to **elevate heels** off bed surfaces and in reclining chairs
- Keep residents' **knees slightly bent** by placing a pillow or soft support under the knees

b. INSPECT by looking and touching to assess heels

- Use mirrors to **check heels** and other areas hard to visualize
- **Check for injury** from positioning devices and splints when used for heel elevation (for example: multipodus boots, heel lifts, etc.)
- Use a **flashlight** if lighting is not adequate

c. TURN frequently and use pillows or positioning devices between ankles and knees for pressure reduction

d. MOISTURIZE feet and legs to soften and prevent skin tears and abrasions



Nutrition and Hydration
Week 7

Objective To focus your staff on the importance of adequate nutritional and fluid intake. To reinforce the importance of immediately reporting sudden changes in intake for investigation.

First Ask staff how many days it has been since their unit acquired a pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injury.
b. Congratulate each successful day!
c. Update your Pressure Free Zone tracking wipe-off board.

Review

a. Undernourished and dehydrated skin is fragile and dry, causing increased risk for breakdown. Healthy skin is dependent on the intake of a well-balanced diet that includes meat, vegetables, fruits, dairy products and a minimum of 1500 ml of fluids per day (Follow fluid intake orders for each resident. Some may have fluid restrictions.).
    i. Oral supplements are effective in maximizing nutrition and adding fluids.
    ii. "Treasure Hunt" ˜ Need: old glasses, petroleum jelly, garden/cotton gloves, colorful plate, colored Goldfish® or M&M's®.
b. The Pressure Points poster and review each tip.
c. Explain how the activity of "offering a toast" is especially effective with fluid intake in cognitively impaired residents. Proper etiquette dictates that it would be bad manners to refuse and residents will usually take at least one sip.

Ask

a. What kind of changes should you report and investigate?
    i. Have staff identify a few residents at high-risk and have them explain why.
b. What can you do differently in your daily routine to increase fluids and nutrition in your residents?

Emphasize The importance of encouraging food and fluid intake and monitoring for sudden changes in appetite. Consumption of oral supplements by residents reduces the risk of pressure injury development.

Lesson Decreased intake of food and fluids leads to malnutrition and dehydration, placing the resident at a high risk for pressure injury development.

Nutrition and Hydration
Week 7: Educational Demonstration

Treasure Hunt

Objective The participant will experience the difficulties a resident encounters while eating. The safety glasses and gloves replicate vision impairment and arthritis. A time limit placed on "meal time" emphasizes these difficulties.

- The participant applies safety glasses coated with petroleum jelly.
- The participant applies cotton gloves or garden gloves.
- Use a plate with colors similar to colored Goldfish® crackers. Put about 25 colored Goldfish® within the respective colors on the plate.
- Advise the participant that he/she has 30 seconds for meal time. To complete his/her meal, the participant must use this time to pick up each Goldfish® individually and place it on another plate. Time the start and finish of the activity.
- Note if the participant was able to complete their meal and what difficulties they had.

Lesson Physical limitations can be a factor in poor nutritional intake. Assist residents to eat as necessary. Understand how residents may feel about their limitations.

Nutrition and Hydration
Week 7: Pressure Zone

Residents at risk for malnutrition and dehydration may have:

- **Sudden illness:** flu, colds, pneumonia, fever, diarrhea, constipation, etc.
- **Long-term illness:** stroke, diabetes, heart failure, etc.
- **Dementia:** cognitive loss, confusion
- **Change in behavior:** combativeness, refusal of care or food, agitated
- **Sadness:** loss of self-worth
- **Open areas:** pressure, skin tears, abrasions
- **Pain**
- **Restraints:** physical and chemical
- **Medication changes**

What you can do:

- **Monitor** intake of food and fluids
- **Encourage** residents to drink every time you provide care; offer a "toast" to encourage fluid intake
- **Assist** with feeding through verbal cueing; spoon feeding, providing fit finger foods, etc.
- **Report behavior changes** immediately
- **Offer snacks and supplements** if inadequate meal intake noted... **YOU** know what your residents like!

Skin Protection
Week 8

Objective To focus your staff on the importance of the skin as the first line of defense in protecting the body from harm and to reinforce the staff's role in providing care that promotes skin integrity.

First Ask staff how many days it has been since their unit acquired a pressure injury?

a. If zero, ask how many days in the past week have they been without an acquired pressure injury.
b. Congratulate each successful day!
c. Update your Pressure Free Zone tracking wipe-off board.

Review

a. "The Barren Desert" ˜ Need: dry peeling onions, white tube socks, lotion.
b. The Pressure Points poster and each tip for pressure relief.

Ask

a. Staff to identify a few residents at high-risk for skin breakdown and explain why.
b. What can you do differently in your daily routine to protect your residents' skin?

Emphasize Skin is the body's first line of defense and ANY opening in the skin places the resident at risk for infection, further skin breakdown, pain and other complications.

Lesson Excellent skin care is critical for protecting residents' skin and reducing the risk of pressure injuries, skin tears and abrasions.

Skin Protection
Week 8: Educational Demonstration

The Barren Desert

Objective To visually see the effects of friction on the skin. Dry onion skin should tear and shed when inserted in and out of a long tube sock. Applying lotion should moisturize the onion skin, reduce friction and help prevent skin tears.

a. Advise the participants to think of the onion as an elder's fragile skin, and the sock as his or her bed linen.
b. Have dry onions available (Hint: Onions should be dry, and kept at room temperature for best skin shedding).
c. Have a volunteer try to put a dry onion in and out of a long tube sock. Note what happens to the onion's skin. Turn the sock inside out so the group can see all of the onion's skin that has shed.
d. Now apply lotion generously all over another dry onion. With a clean sock,repeat the process. Turn the sock inside out to show that little to no shedding occurred.
e. Ask how applying lotion changes the results seen on the onion's skin (Hint: To reduce friction, have a volunteer roll the sock all the way down to the toes in order to reduce "sliding" the entire sock over the onion).
f. Have paper towels available for participant to clean lotion from his/her hands.

Lesson The importance of moisturizer in the prevention of pressure injuries. When applying lotion, avoid vigorous massage over bony prominences or reddened areas.

Skin Protection
Week 8: Pressure Points

- Skin is the armor that protects the body from invasion!
  - Skin is the first line of defense that protects us from infections, fluid loss and temperature control
- Maintain healthy skin every day by using:
  - Moisturizers: lotions and creams with a.m. and p.m. care
  - Barrier creams: after each incontinent episode
  - Protective devices: skin sleeves, splints, dressings, etc.
- Ensure proper fit fitting clothing, shoes, socks, briefs, etc.
- Use specialty devices that reduce pressure in wheelchairs, recliners and bed
- What you can do:
  - Daily skin checks and report suspicious findings
  - Repositioning using pressure reducing devices...lift, do not drag
  - Monitor intake of food and fluids
  - Moisturize and use barrier creams
  - Report changes in resident condition

Pressure Free Days
Celebrating

Facility Acquired

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

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