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The CNA's Role & Responsibility in Preventing, Identifying and Reporting Pressure Injuries

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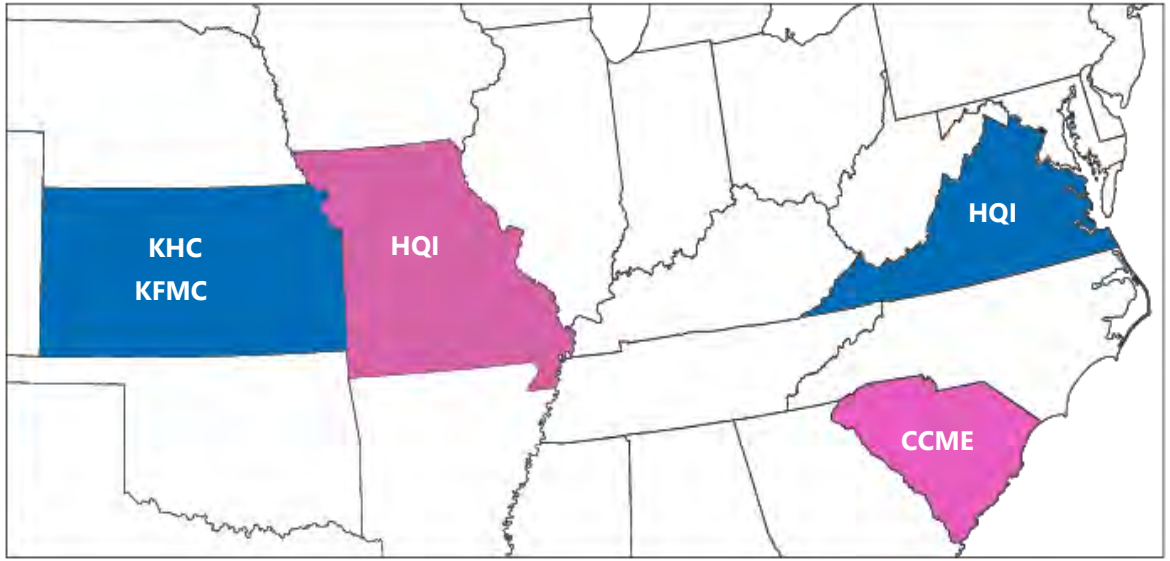

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Logistics – Zoom Webinar

To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

You have been automatically muted with video turned off.

Today's Speaker

Participants will:

Explore

- **Explore role and responsibility for preventing and identifying pressure injuries while: providing daily care**

Explore

- **Explore signs of potential skin breakdown**

Explore

- **Explore interventions for care of residents who have pressure ulcer / injury**

What is a Pressure ulcer / injury?

- **"Pressure Ulcer/Injury (PU/PI)"** refers to localized injury to the skin and/or underlying soft tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. It may also be related to a medical or other device.
  - A pressure injury can present as intact skin and may be painful.
  - A pressure ulcer may present as an open ulcer, the appearance of which will vary depending on the stage and may be painful.

What causes a Pressure Ulcer / Injury?

- The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.
- The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, other medical conditions such as circulation issues, diabetes, etc. and condition of the soft tissue

Examples of Risk factors

Impaired/decreased mobility and decreased functional ability;

Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus;

Drugs such as steroids that may affect healing;

Impaired blood flow, for example, vascular or arterial insufficiency;

Resident refusal of some aspects of care and treatment;

Cognitive impairment;

Exposure of skin to urinary and fecal incontinence;

Under nutrition, malnutrition, and hydration deficits; and

The presence of a previously healed PU/PI

Which residents are at High-Risk for Pressure Ulcers/Injuries?

High risk residents:

- May have frequent agitation
- May have uncontrollable spasticity or movements
- May have a recent decline in physical and mental health
- May require assistance with transfer aids such as lifts, gait belts, slide boards, etc.
- May require assistance with a bed mobility
- May have poor nutrition

The Skin- the first line of defense

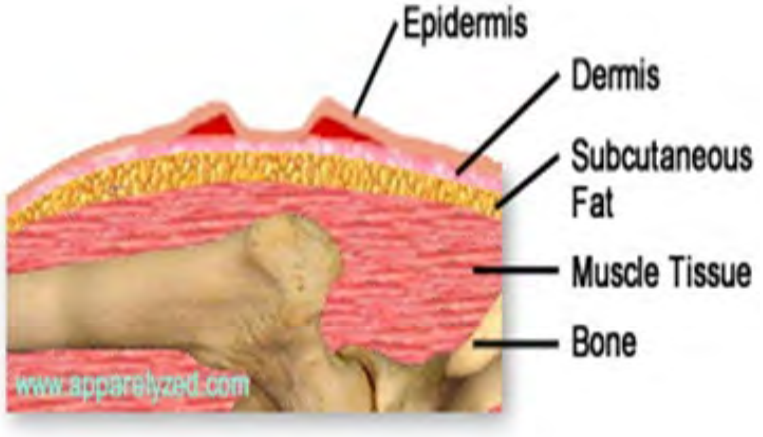
- Largest organ of the body
- Weighs 6-8 pounds
- Varied thickness
- Elastic
- Has many functions:
  - Protection
  - Transmits sensations
  - Regulates body temperature
  - Excretes waste
  - Prevents excessive loss of body fluids

The Skin

Three major levels:

1. Epidermis-exterior
2. Dermis- middle
3. Subcutaneous tissue- interior

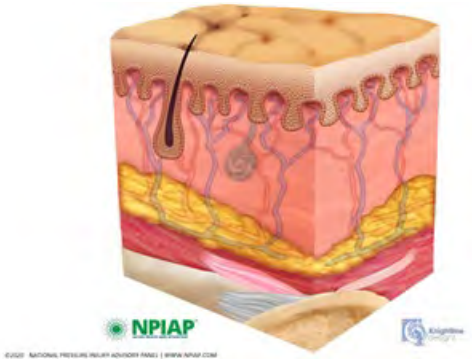
The Skin by Layer



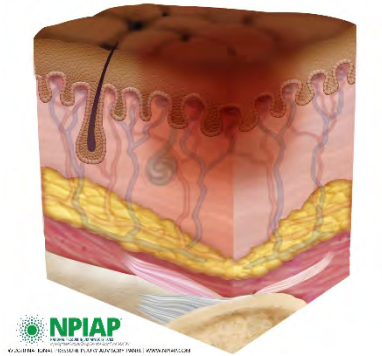
It is often difficult to see early skin changes in residents with darker pigmented skin

- May have slightly darker shade
- May appear to look blue, purple or maroon in color
- May have no difference in color,
  - Look for change in skin condition [dry, flakey, moist].
  - Look for area that feels differently
  - Look for area that has different temperature
  - Look for an area with tenderness

Healthy Sl



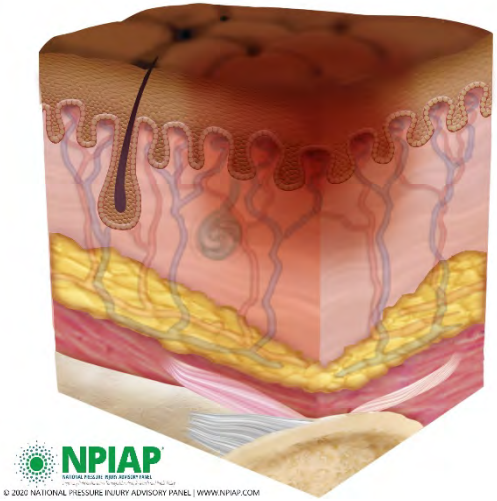
Stage 1 Pl



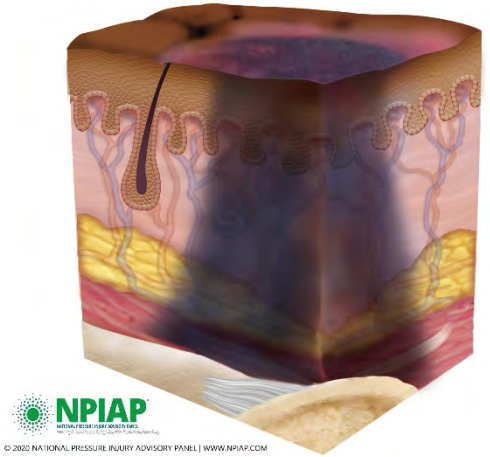
What do pressure ulcer/injury look like?

Stage I or Deep Tissue Injury ulcer is always intact and not open.

A Deep Tissue Injury may appear as a “blister"



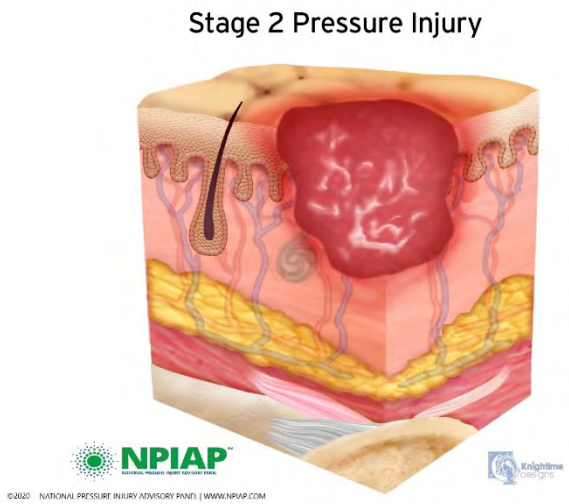
Stage 1 PI



Deep Tissue Injury

What do pressure ulcer/injury look like?

- Open PIs have different levels of staging depending or what the ulcer looks like.
- It is important to immediately report any observed open areas to a licensed nurse.

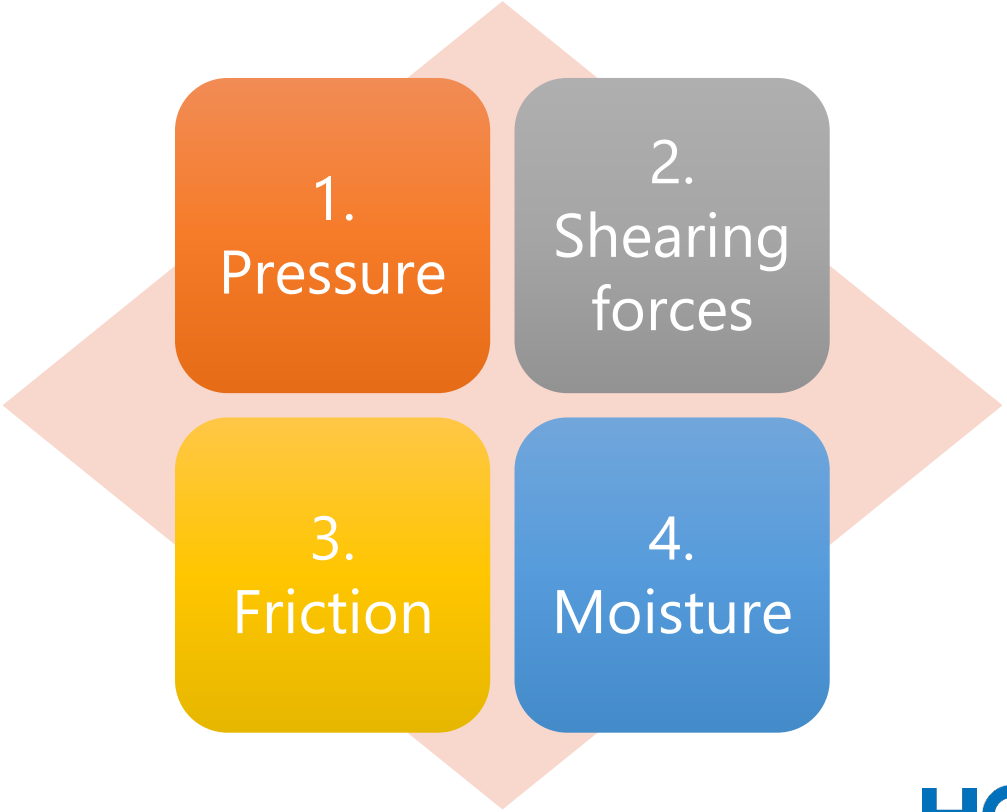


Aging and Skin Changes

- Thinning of all layers
- Fewer sweat glands
- Decrease of sebaceous glands
- Collagen/elastin fibers degenerate
- Atherosclerosis of the vessels
- Decrease in immune response
- Less elasticity
- Changes to temperature regulation
- Higher incidence of benign and malignant skin growths

Factors Influence

4 Main External Factors that lead to Pressure Ulcers

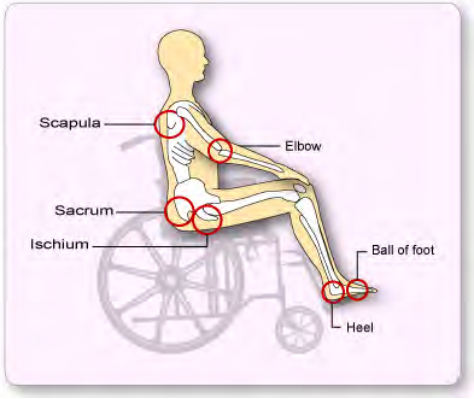


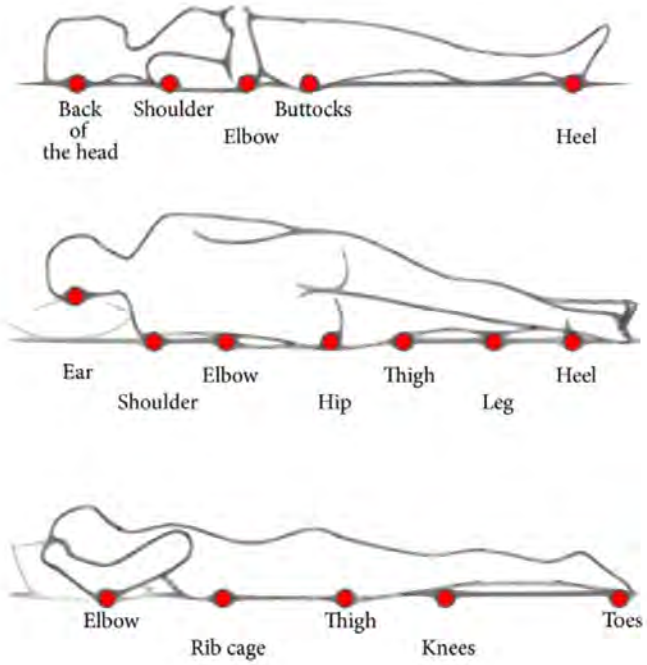
Pressure

- Pressure applied to the skin in excess of the arteriolar pressure prevents the delivery of oxygen and nutrients to tissues.
- Pressure is the greatest over bony prominence where weight bearing points come into contact with external surfaces.
- Pressure in the same area for over 2 hours can cause irreversible tissue damage. In some individuals the time may be much less with some individuals breaking down within 30 minutes of lying in the same position.

What part of the body gets the most pressure ulcers?

- Sacrum / buttock
- Heels
- Boney points such as elbows, shoulders, back, ankle, etc.





Shearing Forces

- Shearing forces occur when a resident is placed on an incline.
- Deeper tissues, including muscle and subcutaneous fat, are pulled downwards by gravity, while the superficial epidermis and dermis remain fixed through contact with the external surface.
- Shearing forces in the presence of pressure can cause severe tissue damage.

Friction

- Occurs when residents are dragged across an external surface.
- This causes an abrasion with damage to the most superficial layer of skin.
- Friction is likely to cause a pressure injury.

Moisture

Exposure to moisture in the form of:

- Perspiration
- Urine
- Feces

Can lead the skin to maceration and predispose to superficial ulceration

6 Main Internal Factors that lead to Pressure Ulcers

- Immobility
- Incontinence
- Nutritional Status
- Skin Perfusion
- Neurologic Disease
- Other Factors

Immobility

- Immobility is one of the most important host factors that contributes to pressure ulcer development.
- Immobility can be permanent or temporary due to residents' circumstances.

Incontinence

- Urinary incontinence is frequently cited as a predisposing factor for pressure injuries.
- Incontinent residents have up to five times higher risk of developing pressure injuries.

Nutritional Status

- Nutritional status does impact pressure injury potential.
- Malnourishment has been found to lead to more severe pressure-induced skin destruction.
- Residents with protein deficiencies-hypoalbuminemia (a blood protein that makes up a significant portion of the blood plasma).

Skin Perfusion

Several factors can cause tissue ischemia:

- Hypotension
- Dehydration
- Vasomotor failure
- Shock
- Heart failure
- Medications
- The body will shift blood to vital organs before sending to the skin

Neurologic Disease

Could include:

- Dementia
- Delirium
- Spinal cord injury
- Neuropathy
- Sensory loss

Other Factors

Other factors might include:

- Older age
- White race
- Male gender
- Presence of dry skin
- Recent Lower extremity fracture
- Diabetes
- Cardiovascular disease

Preventative Care

1. Incontinence and/or moisture control
2. Positioning needs – turning/re-positioning;
3. Support surfaces / pressure re-distributions [mattress/cushions, etc.]
4. Nutrition / hydration needs
5. Pain / Comfort
6. Report Changes

Incontinence or Moisture Control

- Frequently round on residents to offer and provide peri-care to minimize exposure to moisture.
- Use barrier creams.
- Make sure briefs fit appropriately.
- Keep linens clean and wrinkle-free.
- Do not double up on incontinence padding or products.
- Consider leaving resident “open to air” (no briefs) while in the bed.

Positioning Needs

- Regular turning schedule of 2 hours is recommended.
- Residents should be placed at a 30-degree angle to avoid direct pressure over the greater trochanter
- Elevation of the head of the bed should be limited to minimize exposure to shear forces.

Preventing Shearing and Friction

- Prevent residents from sliding down or slouching in a bed or chair.
- Be cautious that body points are not pushing on a hard surface- elbows on a tabletop.
- Use equipment if needed to safely move the resident without dragging them up in the bed.
- Use draw sheets or lift pads to pull residents up in bed ALWAYS lay the bed flat.
- Avoid massaging red area as this can damage the tissue under the skin.

Consider floating the HEELS

- Elevating the heels is key to preventing pressure ulcers on the heels.
- Inspect by looking and touching the heels.
- Turn frequently and use pillows or positioning devices between ankles and knees to reduce pressure.
- Moisturize feet and legs to soften and prevent skin tears and abrasions.

Pressure Redistribution Devices

- Pillows or foam wedges may need to be placed between the ankles and knees.
- Pressure redistributing mattresses may be necessary.
- Check fit of wheelchairs cushions, and braces.
- Protective booties and pads.
- Check skin around and under oxygen tubing, GT sites, catheters, support stockings and casts.

Nutrition-hydration Needs

Be on the lookout for malnutrition and dehydration:

- 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

Nutrition-hydration Needs

- 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 finger foods, etc.
- Report behavior changes immediately.
- Offer snacks and supplements if inadequate meal intake noted…YOU know what your residents like!

Pain/ Comfort

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

Report Changes

Look and report to the nurse any changes that you see in the resident's skin

- During bath / shower
- When providing AM/PM care
- When assisting with toileting or incontinent care
- When removing splints
- When residents complain of pain or discomfort
- Inspect skin daily- report all suspicious areas

What do I look for?

Any change in the resident's skin

- Change in color
- Change in temperature
- Change in skin condition – i.e., dryness, scaly, callous,
- Any open area
- Presence of any drainage
- Change in pain or comfort

How can I be a Pressure Relief Champion?

- Assist the resident with frequent turning / re-positioning
- Provide prompt and timely incontinent care
- Make sure pressure reduction / relieving devices are in place and functional
- Assist the resident with meals and hydration
- Carryout other interventions in the care plan
- Report resident refusal of care to licensed nurse
- Report to the licensed nurse whenever care is not provided or accepted by the resident
- Report to the licensed nurse when resident behavior impacts care – i.e. resident is restless in bed and kicks “boots” off

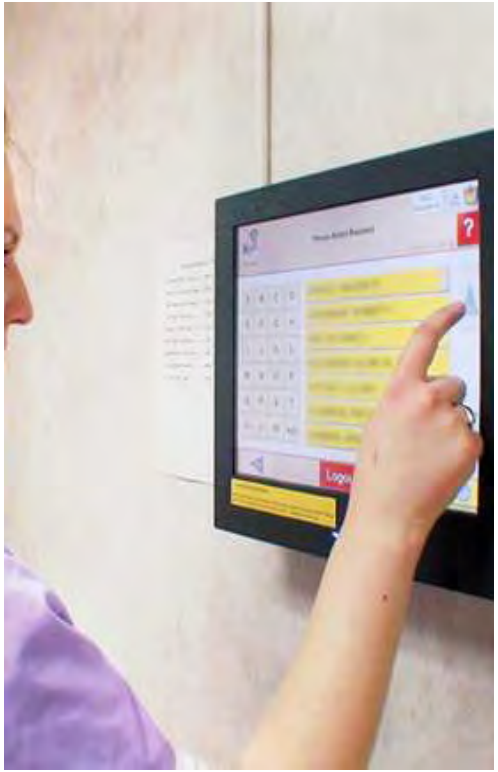
What do I have to document?

- Document the care that you provide, for example:
  - Bath/shower; ADL assistance; incontinence care including application of barrier cream, etc.
- Document the care that is not provided, accepted or is refused by the resident
- Document the resident's response to care, for example
  - Frequency of incontinency; presence / frequency of diarrhea
  - Percentage of meal consumed; fluid intake if appropriate

Why do I have to document?

Documentation tells a story about the care that you provide, what you see and hear is important to that story

- The story is important because it helps us:
  - Identify the care that is needed, and why,
  - Communicates to the team who is to do what and when and why
  - Identify and respond to change in the resident's condition or behavior
  - Evaluate if the care that is planned is being provided
  - Evaluate if the care we are providing is consistent with resident preferences and if it achieving the expectations of care



Next Session Date and Topics

- **Session 6 (August 17):** Care Planning: Resident/Family Engagement/Education
- **Session 7 (August 31):** Ongoing Practices and Monitoring: Best Practices from High Performing Nursing Homes

FOR MORE INFORMATION

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