HCQU CARES

NURSING EDITION

Best Practices in **PRESSURE INJURY PREVENTION**

"Nurses Make the Difference," is the American Nurses Association theme for Nurses month 2024 and is also the theme of the HCQU CARES: Nursing Edition Newsletter. Nurses play a vital role in the embodiment of expert care, compassion, support, and safety for individuals with intellectual disability/autism (ID/A). The prevention of pressure injuries is a key area where nurses can provide resources, assistance, and education to the individual and their caregivers.

"Each year, more than 2.5 million people in the United States develop pressure injuries and about 60,000 individuals die as a direct result of pressure injuries" (The Hospital Healthsystem Association of Pennsylvania, 2023).

It is a nurse's responsibility to regularly assess the condition of the skin, promote movement, and encourage good hygiene and skin care routines. For nurses working in provider agencies, this responsibility includes educating families, caregivers, and people with ID/A on how to take care of the skin and what to do when problems are noted (Vohra Wound Care, 2022). The following story emphasizes the importance of education for caregivers and self-advocates in pressure injury prevention and care.

A STORY ABOUT PRESSURE INJURIES: EDUCATION, CARE PLANNING, AND EXCELLENT CARE

When I was working as a registered nurse in the home care setting, I had a person with a pressure injury on my caseload. She lived in a residential setting and was supported by paid caregivers who were not clinicians.

One of the first things I realized was that these caregivers really did not know what to look for, how to assess for changes or how to carry out the prescribed treatment.

So, I developed a plan to teach them what they needed to know. I taught the caregivers and the individual what changes to look for, what to report, proper cleaning technique, and how to perform prescribed pressure injury care. Soon after the education, the wound was healed because the individual was getting excellent care.

Clinicians are aware of the impact of a pressure injury on the person and caregivers. There can be body image concerns, loss of independence, and embarrassment, which can lead to refusal to be

around others and isolation. Caregivers, especially those bound by regulatory rules and policies, may feel unprepared to care for the wound and may not understand the vital importance of good wound and skin care.
The best approach is to take measures to prevent pressure injury. This newsletter reviews best practices in pressure injury prevention and provides materials to help educate caregivers and self–advocates. Please continue reading to learn more.

REFERENCES

IMedline. (2024, February). Skin Integrity: What it is and how to protect every layer. Retrieved on April 12, 2024, from https://www.medline.com/strategies/skin-health/skin-integrity/

The Hospital Healthsystem Association of Pennsylvania (HAP). (2023). The Problem of Pressure Injuries. Retrieved on April 12, 2024, from https://www.haponline.org/Clinical-Quality/Quality-Safety/Pressure-Injury

Vohra Wound Care. (2022, March 14). Impaired Skin Integrity Nursing Diagnosis and 05 Best Care Plan. Retrieved on April 12, 2024, from https://cert.vohrawoundcare.com/impaired-skin-integrity-nursing-diagnosis/

Wiley Online Library. (2022, June 29). Patient and carer experience of living with a pressure injury: A meta- synthesis of qualitative studies. Retrieved on April 12, 2024, from https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.16431

WAYS TO HELP

Pressure injuries can result in some serious and debilitating conditions. Therefore, identifying areas of concern on an individual's skin and knowing the risk factors that increase their risk for developing pressure injuries is key to pressure injury prevention. One of the most important steps to prevent pressure injuries is completion of daily skin assessments. Skin assessments consist of an inspection of the individual's skin; noting changes in skin color, such as paleness, blueness, jaundice, or redness; and looking for bruising, lesions, opened areas, or skin breakdown. Palpation of the individual's skin can reveal other important details, such as temperature, moisture, texture, skin turgor, capillary refill, and edema. Regular skin assessments help identify potential problems earlier, allowing interventions to prevent further damage.

It is important to consider more frequent skin assessments for individuals with diabetes, a history of skin impairment, incontinence, immobility, altered nutrition status, vascular disease, recent hospitalizations, and/or changes in baseline behaviors, as individuals with these conditions have an increased risk of pressure injuries. Individuals with ID/A who communicate without using words have a higher risk, too. They might communicate skin concerns by rubbing a body part, refusing to put shoes on, or refusing to sit in a chair. Such behaviors could indicate that impaired skin integrity is causing pain.

PRESSURE INJURY TOOLS

Many tools consider factors that affect skin condition, such as physical and mental status, sensory perception, nutritional status, moisture, and mobility. Tools that can be utilized to predict risk of impaired skin integrity are:

- Braden Scale (used in the United States) – considers sensory perception, moisture, activity, mobility, nutrition, and friction and shearing
  - https://www.in.gov/health/files/Braden_Scale.pdf
- Norton Scale (used in the United Kingdom) - considers physical condition, mental condition, activity, mobility, and incontinence
  - https://www.merckmanuals.com/professional/multimedia/table/the-norton-scale-for-predicting-pressure-ulcer-risk
- Waterflow Scale - considers build/weight for height, visual assessment of the skin in the area at risk, sex and age, continence, mobility, Malnutrition Screening Tool score, and special risk factors including tissue malnutrition, neurological deficit, and major surgery or trauma.
  - https://www.hauoratairawhiti.org.nz/assets/Documents/Pressure-injuries/Pressure-injury-bundles-community-pdf.pdf

REFERENCES

Agency for Health Research and Quality. (2019). Pressure Ulcer Assessment and Prevention: A Comparative Effectiveness Review. Retrieved on April 12, 2024, from https://effectivehealthcare.ahrq.gov/products/pressure-ulcer-prevention/research-protocol#:~:text=A%20number%20of%20tools%20have,Scale%2C%20and%20the%20Waterlow%20Scale.

Select Medical (2016,0ctober 28). Pressure Ulcers and Skin Inspection. Retrieved on April 12, 2024, from https://selectmedical.co.uk/skin-inspection/#:~:text=Daily%20Skin%20Inspection,as%20shown%20in%20the%20diagram.

HRST: A SKIN INTEGRITY TOOL AT YOUR FINGERTIPS

Preserving skin integrity is an essential part of a caregiver's responsibility and data from the Health Risk Screening Tool (HRST) can provide a quick means of identifying those at risk. HRST scoring areas encompass a range of factors that impact skin such as mobility, nutrition, and overall health status. The custom report feature of the HRST can make it easier for the nurse to identify those at risk. Upon identification the nurse can talk with caregivers on how to monitor the skin and develop proactive measures to maintain skin integrity. The data may even support the need for developing skin policies for the agency.

Keeping the HRST up to date and regularly looking at its data is a tool at your fingertips to easily gather relevant information that can be shared with the caregivers. IntellectAbility, the company that designed the HRST, also has information on their website that nurses may find useful when talking about skin with caregivers. The Pennsylvania HRST application can be found at https://paodp.hrstapp.com/. Please contact the HCQU for more information on developing HRST custom reports and other resources for promoting healthy skin integrity.

REFERENCE

Health Risk Screening Tool for Pennsylvania Department of Human Services Office of Developmental Programs. (2024). Intellect Ability. Retrieved on April 12, 2024, from https://paodp.hrstapp.com/

DEVELOPING A PLAN OF CARE: AN INTERDISCIPLINARY APPROACH

An interdisciplinary approach to skin care has been shown to increase healing and decrease wound recurrence. However, development of an optimal plan of care requires shared decision-making among all members of an individual's care team.

It is important to gather information from many sources, especially from health professionals and wound care specialists. Their input can be critical to the identification of underlying factors that impact the healing process. If a person's physician prescribes special dressings and therapies to encourage skin healing, the treatments must be reflected accurately in the plan of care. This information helps to promote positive outcomes.

Comprehensive information about a wound can include other health factors that might affect wound healing and management. A plan of care should include all factors that affect the person, such as new or existing behaviors, mobility, nutrition, and mental health concerns.

INFORMATION TO INCLUDE IN A PLAN OF CARE:

- Wound attributes (type, date of occurrence, dimensions, and appearance)
- Pain assessment
- Current treatment plan (dressings, pressure relief, needed equipment)
- Conditions that could affect wound healing
- Frequency for wound assessment/re-evaluation

INFORMATION USEFUL FOR DEVELOPMENT OF A PLAN OF CARE (AS APPLICABLE):

- Medical and surgical history
- Allergies and history of adverse reactions (including skin reactions to adhesive)
- Medications
- Blood glucose and hemoglobin A1c values
- Functional ability and mobility levels
- Nutritional status
- Psychological and/or socioeconomic barriers

- Wound assessment process
  - Who will be responsible for the assessment?
  - What should the caregiver look for when assessing the wound and surrounding area?
    - Physical measurement of the pressure injury
    - Odor, color, drainage, swelling, and pain level
  - How often should the assessment be completed?
    - Consider how often the dressing is to be changed when scheduling the frequency of the assessment.

Factors may be added or omitted as necessary, so the plan of care is individualized. Discuss the plan with the person's healthcare professionals to assure that it is person-centered and reflects prescribed treatments. A review of the provider facility's protocols can help to align a plan with the provider's mission and values. If no skin care policy exists, consider writing one. Share the plan of care with all members of the person's interdisciplinary care team and invite suggestions for improvement.
When observing the healing progress and changes to a wound after treatment, identify factors that may indicate the need to reassess the strategy and plan of care. Wound stalling or healing, a change in the individual's health status, or the presence of infection will require modification of the plan.
Once the interdisciplinary plan of care has been developed, caregivers and the self-advocate must be educated on maintaining skin integrity, identification of risk factors for pressure injuries, and proper care if a pressure injury develops.

REFERENCE

IMedlinePlus. (2022, April 17). How to Care for Pressure Sores. Retrieved on April 12, 2024, from https://medlineplus.gov/ency/patientinstructions/000740.htm#:~:text=Here%27s%20how%20to%20care%20for%20a,help%20support%20and%20cushion%20the%20area.&text=Here%27s%20how%20to%20care,and%20cushion%20the%20area.&text=to%20care%20for%20a,help%20support%20and%20cushion

EDUCATING CAREGIVERS ABOUT SKIN

A strategy for maintaining healthy skin integrity includes the education and training of caregivers about normal and abnormal skin conditions related to skin integrity. The HCQU has trainings and resources available to help educate caregivers about assessing skin for changes and risk factors for acquiring pressure injuries. The trainings and resources are available on the HCQU website (www.hcqu.acentra.com)

- Caregiver trainings:
  - Pressure Injuries
  - Skin Care: Common Problems
- Informational Resources:
  - Skin Care: Preventing Pressure Injuries Booklet
- HealthSheetsTM
  - Multiple resources on pressure injury topics

Consideration may be made as to the timing and frequency of caregiver training on skin integrity topics. Caregivers supporting individuals with increased risk factors might require additional education, resources, or insight from the nurse.

Documentation of caregiver training related to skin integrity can ensure completion of training(s) by each caregiver within the proper time frame. Development of a skin care monitoring policy and process might be necessary. The policy should include the frequency with which the nurse is to perform skin assessments and caregivers are to perform reviews (annually, monthly, weekly, upon hospital return, etc.) and provide contingencies for individuals requiring daily, weekly, or monthly evaluations based on their needs and risk factors. To make the process more feasible for caregivers, consider skin inspections that coincide with another activity, such as bathing, and provide a simple form for documenting their findings. An example of a simple form is available in the Preventing Pressure Injuries Booklet (page 26) at https://5627605.fs1.hubspotusercontent-na1.net/hubfs/5627605/Client%20Sites/PA%20HCQU/Informational%20Materials/Skin_Care-Prevent_Pressure_Injuries_booklet(All%20HCQUs)%208-22.pdf.

A portion of the policy should address to whom skin concerns should be reported. When a skin injury is reported, changes in daily care, positioning, assistive devices, adaptations, referrals, and/or medical interventions may be necessary to prevent further deterioration of skin and promote healing

Caregivers need to know who may be at risk for skin breakdown. Offering a list of conditions and medical concerns that increase the risk of skin injury and posting this list with the form used to evaluate the skin might assist the care team to be vigilant of risk factors affecting the skin. This may be especially helpful for individuals who have a significant change in status. Factors to consider for the list include but are not limited to:

- Broken bone or sprain
- Change in mobility status
- Chronic kidney disease
- Communication limitations
- Contractures
- Decrease in appetite
- Dehydration
- Depression
- Diabetes
- Illness that requires bedrest
- Incontinence
- Lack of mobility
- Medical devices, such as prosthetics, crutches, and wheelchairs
- Peripheral artery disease
- Obesity
- Oxygen use
- Stroke

Keep in mind that a change in any aspect of the person's health status may change the evaluation timeline and require additional education for caregivers.

REFERENCES

Medline. (2023, September). Comprehensive skin assessment: Are you doing it correctly. Retrieved on April 12, 2024, from https://www.medline.com/strategies/skin-health/comprehensive-skin-assessments-correctly-get-whole-picture/#:~:text=7%20steps%20to%20a%20proper%20skin%20assessment%3A%20Nursing,areas.%20...%207%207.%20Document%2C%20document%2C%20document.%20

Mondragon, N., Zito, P. (2022, August 25). Pressure Injury. Retrieved on April 12, 2024, from StatPearls; National Library of Medicine, https://www.ncbi.nlm.nih.gov/books/NBK557868/

EDUCATING SELF ADVOCATES ABOUT THE SKIN

Self-advocates (SAs) should be educated about the vital role skin plays in protecting their body and the need to keep it as healthy as possible. Nurses can encourage caregivers to encourage SAs to participate in caring for and looking at their skin. The agency nurse can develop trainings or find basic information for caregivers to share with SAs.

Best Practice Tips When Instructing SAs:

- Keep instructions simple.
- Provide teaching in a quiet setting away from distractions, allowing them to hear and focus on instruction.
- Use repetition.
- Use communication devices, pictures, and stories as appropriate to their abilities.
- Keep the session short.
- Use simple words.

Instructions for SAs to Examine Their Skin During a Bath or When Drying:

- Look at your skin to watch for changes.
- Check your skin to look for areas that look red, areas that feel warm when you touch them, or areas that have liquid coming out of them.
- Check your skin for areas that are a different color than the rest of your skin.
- Check your skin for areas that hurt if you touch them, areas that feel “prickly”, and areas that you do not feel if you touch them.
- If you find any area like the ones in this list, tell your caregivers or family.

Other things to teach SAs:

- Tell someone if your skin hurts when you put on your shoes, walk, or sit in a chair.
- Tell someone if you get a cut or injury on your skin.
- If your clothes get wet for any reason change into dry clothes.

REFERENCE

American Cancer Society. (2024). How to do a skin self-assessment. Retrieved on April 12, 2024, from https://www.cancer.org/cancer/risk-prevention/sun-and-uv/skin-exams.html

CONCLUSION

A nurse's expertise and guidance can assist caregivers and people with ID/A to prevent pressure injuries. Nurses in the ID/A healthcare system really do "make the difference" in helping individuals in their care maintain good skin integrity. Prevention is key, and using the tools and information from this newsletter can assist you to assure everyone knows the importance of good skin integrity, how to maintain it, and what to do if there is a problem.

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