Prevention of Skin Breakdown “Bundle”

• Skin breakdown is almost always preventable, if the right steps are taken. The wound care team is implementing a “prevention bundle” to outline the steps that can make a difference.

• Adherence to the bundle will be audited by wound care team daily.
Assess for Risk of Breakdown

- Assess the patient for breakdown risk on admission and every shift
  - How well do they move?
  - Are they incontinent?
  - How good is their nutrition?
  - Do they have edema/swelling?
  - Do they have fragile, elderly skin?
  - Do they have a loss of sensation? (Paralysis, diabetic neuropathy)
  - Do they have medical devices that could cause pressure? (Braces, tubing, equipment, etc)
Skin Assessment

• Assess skin on admission and reassess every shift, with particular attention to high risk areas.
  – Bony prominences, such as sacrum, hips, heels, ears.
  – Inspect skin folds for cracks, irritation, rashes, yeast.
• If reddened areas noted, avoid repositioning back to that reddened area until resolved. Do NOT massage the area!
• If rash noted, use Criticaid Antifungal Barrier Cream.
• Use the Wound Care – Nursing Communication sheet to see if any of your findings are new developments. Notify wound care immediately if new areas found.
Risk Factor: Immobility

- If your patient requires any assistance to move:
  - Implement a turning schedule
  - Float the heels
  - Pad between knees/ankles while on side
  - Consider low air loss mattress
Risk Factor: Immobility

Turn Schedule

- Turn patients following the Turn Clock schedule
- Color coded
  - Red = Right
  - Blue = Back
  - Yellow = Left
- Turn clocks will be specific for that patient, example, might be only Left/Right or Back/Left
- On the clock pictured, patient would be on Back from 12-2, Right from 2-4, Left from 4-6
Risk Factor: Immobility
Float the Heels

Heels are the 2\textsuperscript{nd} most common area for pressure ulcers, and this is easily prevented!

- Float the heels so that they are not touching the mattress, pillow, siderail or footboard. You can:
  - Float off the end of pillows
  - Use Heel Protector Boots
  - Put a rolled blanket or towel beneath ankles if patient can’t tolerate the height of a pillow
  - Notify Wound Care Team at the first hint of red/purple heels! Heel ulcers can lead to amputation!

Monitor that heels are not resting on the footboard or siderails!
Risk Factor: Immobility in Chair

- Patients should be shifted/repositioned every hour while up in the chair.
- All patients at risk of breakdown should have a pressure relief cushion in their chair. A pillow is not a pressure relief cushion!
- Help patients maintain their posture in the chair. Poor posture increases pressure areas.
Risk Factor: Incontinence/moisture

- Moist skin is 5 times more likely to break down than normal skin
- Stool and urine contain acids that are very harmful to skin
- Perform incontinence care as often as needed
- Use barrier creams to protect the skin
  - Criticaid clear antifungal barrier cream for most patients
  - Calmoseptine for frequent stools, raw broken skin
- Use perineal wash and damp cloth, avoid harsh soaps
- Do not try to “scrub off” all of the barrier cream, just remove soiled areas
Risk Factor: Use of Medical Devices

- Take care when repositioning patient to avoid laying on IV tubing, telemetry boxes, Lopez valves (PEG tube stopcock), SCD hose tubing or other attached devices.
- Pad behind ears to protect from nasal cannula irritation, on nose to protect from BiPAP mask.
- Pad beneath cervical/orthopedic braces.
- Smooth out wrinkles on TED hose, make sure they aren’t too tight at the top or across toes.
- NOTE: patients with edema (swelling) are at much higher risk of breakdown related to medical devices. Be extra careful!
Risk Factor: Nutrition

• Nutritional status is a major factor in preventing skin breakdown.
• Monitor intake. If patient’s intake declines, or patient is not eating protein foods (meat, eggs, dairy, supplements), notify registered dietician.
• Identify foods that patient is willing to eat that are still within dietary restrictions.
• Assist patients with feeding if necessary. There are many reasons a patient might not be eating or feeding self – request speech therapy or dietician consults as needed.
• Request appropriate nutritional supplements.
Prevention Bundle Recap

- Hospital acquired pressure ulcers are almost always preventable.

- Assess skin every shift. Identify your patient’s risk factors, such as immobility, edema, moisture and nutrition.

- Do what you can to reduce those risk factors and keep them from leading to skin breakdown. This includes turning, floating heels, keeping clean and dry, proper chair cushions, good nutrition, and protection from medical devices.

- The wound care team will be auditing daily for compliance.

- Please take the prevention bundle quiz now!