SSKIN BUNDLE OF CARE

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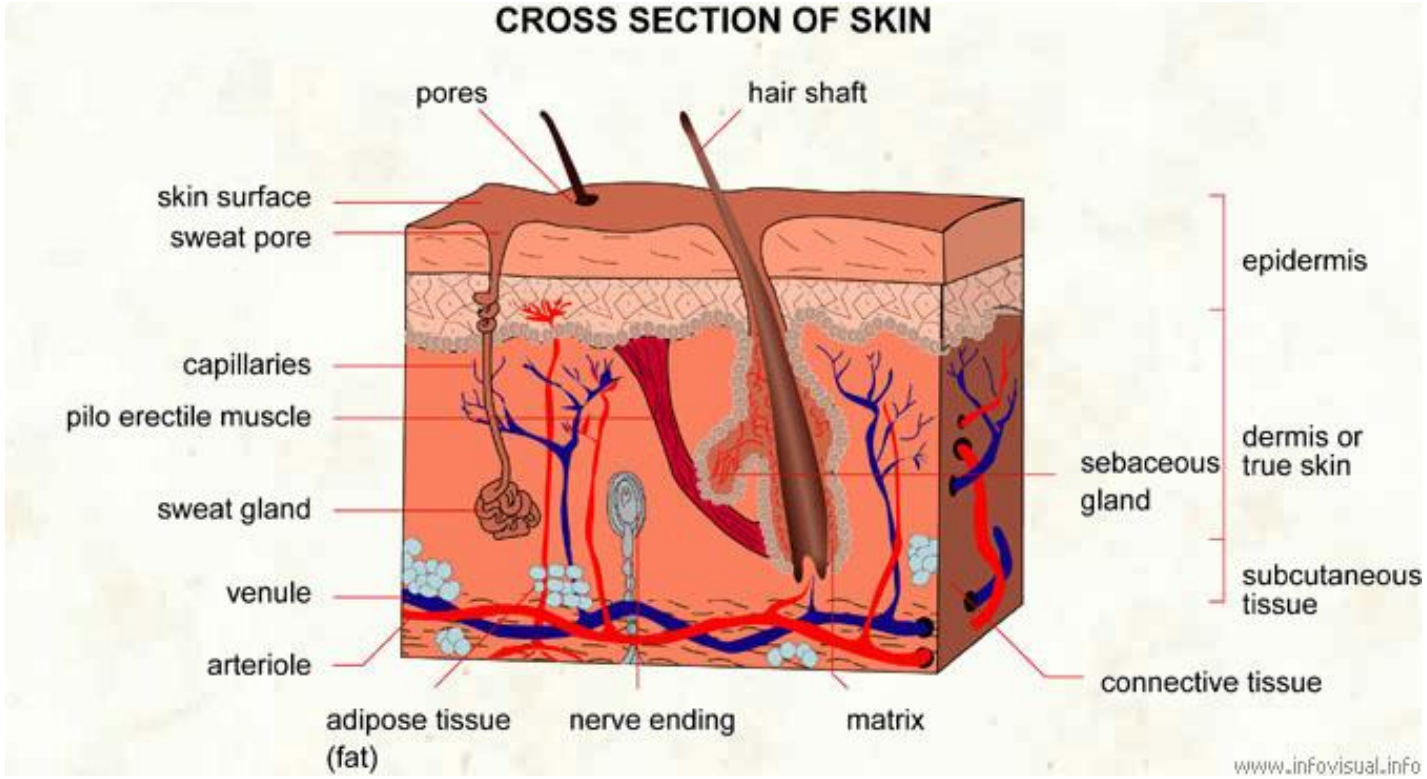
Session Focus Nov 2022
SSKIN Bundle

Skin largest organ in our body



What is Pressure Injury

A localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear

Pressure injuries usually occur over a bony prominence but may be also related to a medical device or other object

(The international Guideline 2019)

- A Health Quality and Safety commissioned investigation in 2014 found approximately 4-8% of those who receive health care in NZ experience PI, regardless of age or mobility and that the total cost of PI's to the healthcare system in New Zealand in 2015 estimated at $694 million per annum.
- This investigation also found approx 55,000 of people suffer a PI in New Zealand every year. It is noteworthy that over 3,000 of these people develop severe (Grade III or IV) PI each year, resulting in significant negative impact on their quality of life.

DELAYED REHABILITATION

‘My immunity was depleted because of the chemotherapy, so the pressure injury took seven months or so to heal. It was a long unpleasant time’

SOCIAL ISOLATION

‘It stopped me socialising. When I wore the large negative pressure wound machine, I hardly went out except to the doctor’s or for chemotherapy’

LOW MOOD/DEPRESSION

‘I withdrew into myself and I did not communicate a lot. I was very quiet’

THE

COST

PAIN

I told the doctors and nurses that I had a sore bottom but no one paid attention to it’

POOR QUALITY OF LIFE

‘Having a pressure injury seriously affected my life’

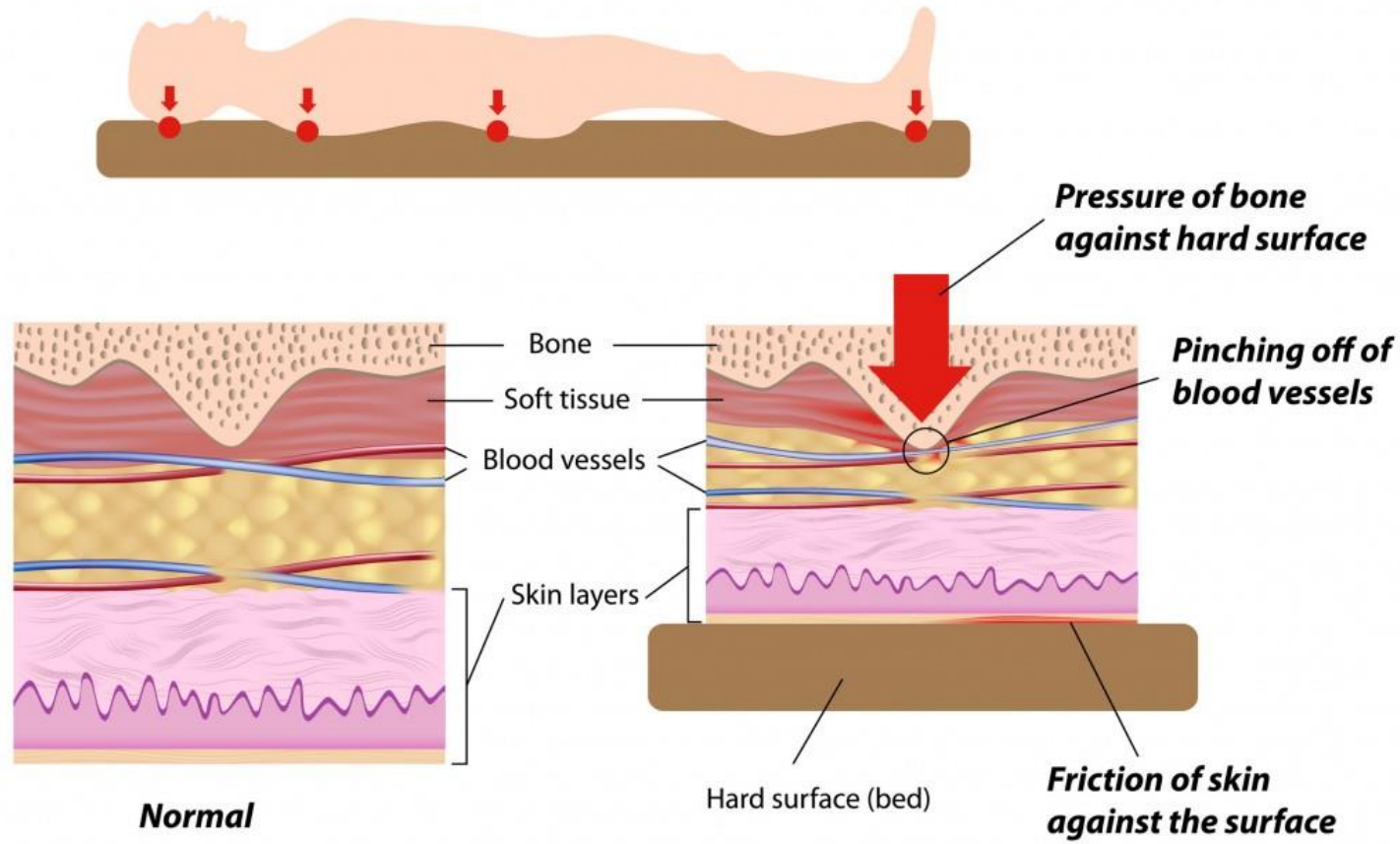
DEATH

‘The doctor noted sepsis as the cause of death’

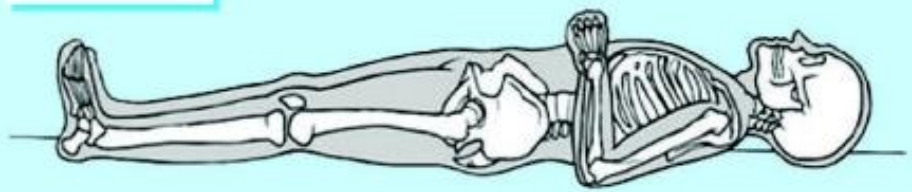
SOUTHERN WOUND HEALING GROUP

UNIVERSITY OF OTAGO
Te Whare Wānanga o Otāgo

Etiology of Pressure Sores



Supine position

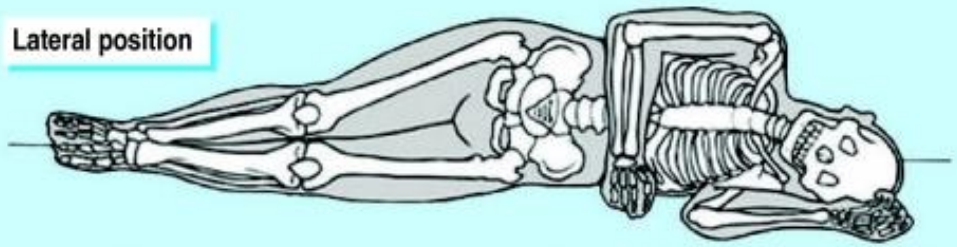


Heels | Sacrum | Elbows | Scapulae | Back of head

Prone position

Toes | Knees | Genitalia (men) | Breasts (women) | Acromion process | Cheek and ear

Lateral position



Malleous | Medial and lateral condoyle | Greater trochanter | Ribs | Acromion process | Ear

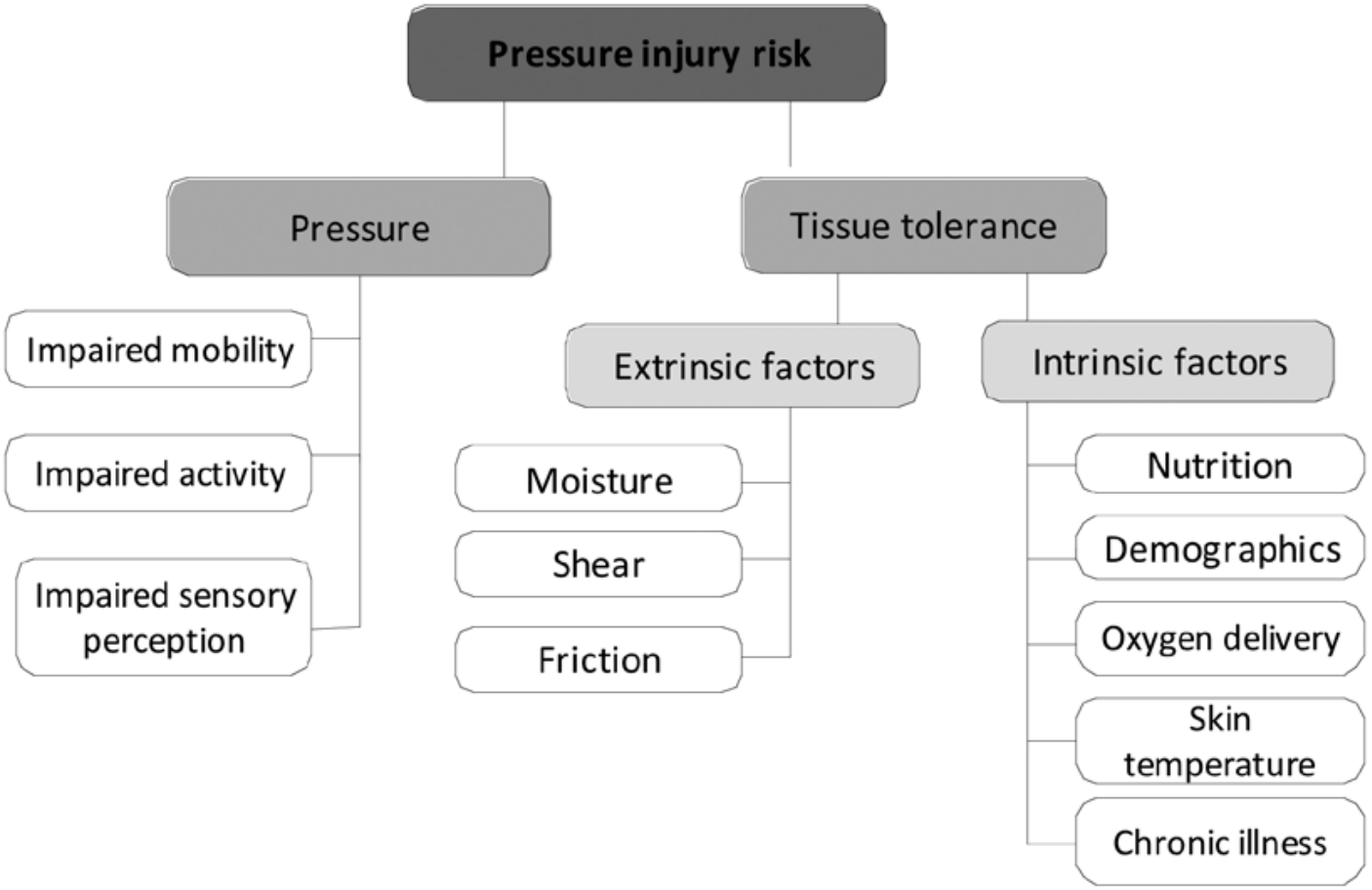
Medical devices causing pressure

Medical devices

To reduce the risk of medical device related pressure injuries, review and select medical devices with consideration to:

- The device's ability to minimize tissue damage
- Correct sizing/shape of the device for the individual
- Ability to correctly apply the device according to manufacturer's instruction
- Ability to correctly secure the device.
- Assess the skin under and around medical devices for signs of pressure related injury as part of routine skin assessment.

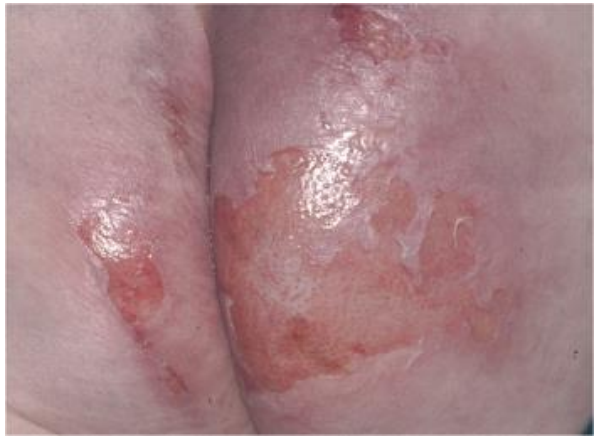
Contributing factors



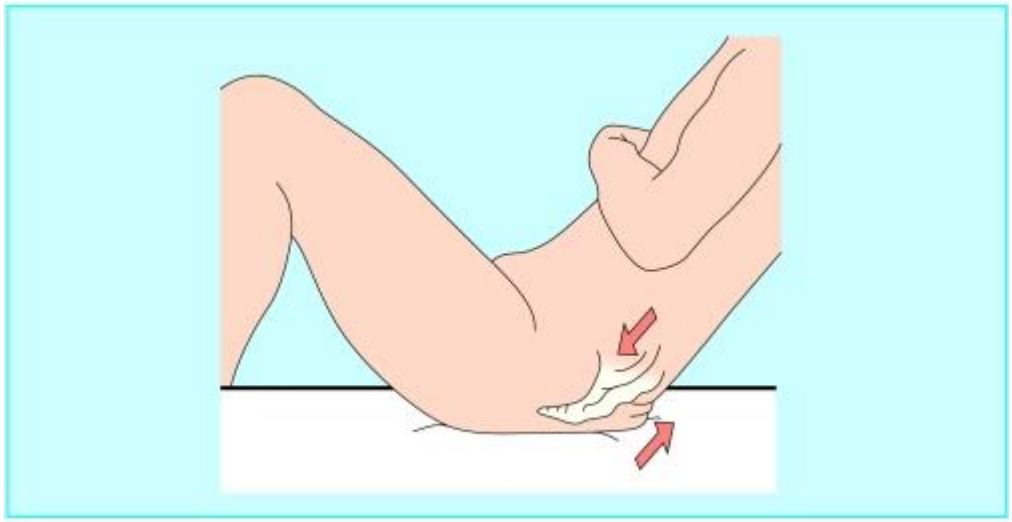
Pressure

- Mobility and Activity
- Impaired activity
- Impaired sensory perception

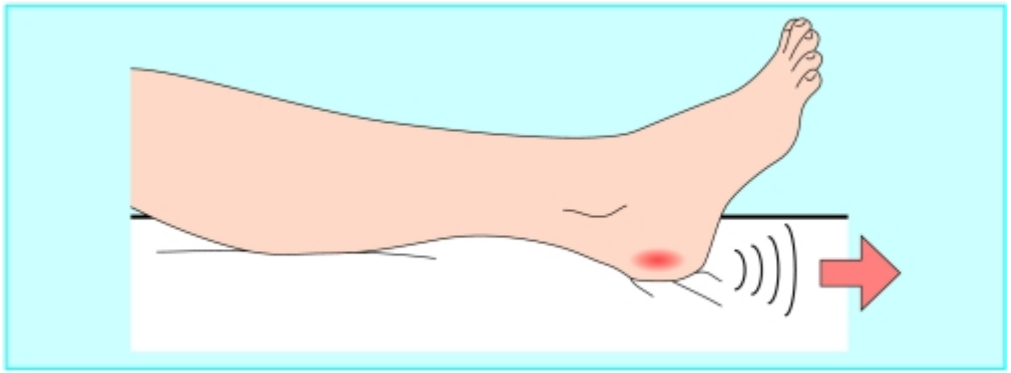
External factors



Moisture



Shearing



Friction

Factors affecting the skin (internal factors)

- Age
- Nutrition
- Chronic health condition
- Medications
- Infection
- lifestyle

m526233 [RM] © www.visualphotos.com

SSKIN

S	• **Skin inspection** • *Early inspection means early detection*
S	• **Support surface** • *Ensure the correct support surface is in place*
K	• **Keep moving** • *Keep patients moving*
I	• **Incontinence** • *Patients need to be clean and dry*
N	• **Nutrition** • *Provide healthy meals and plenty of fluids*

S Skin

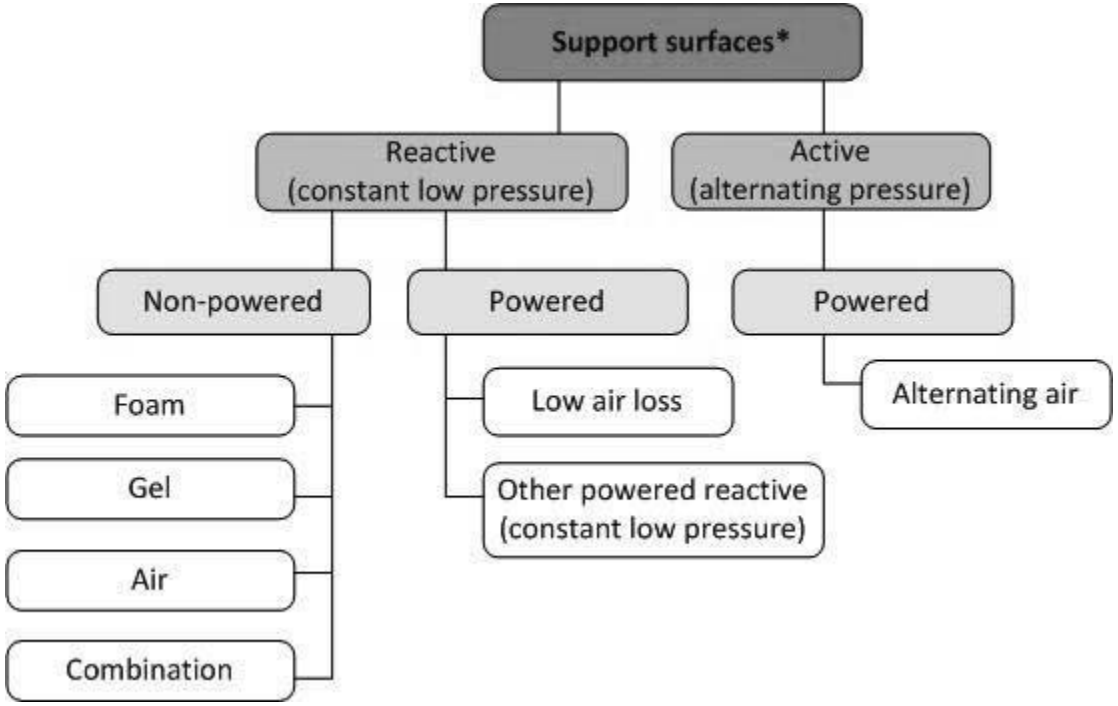
- Regular and frequent skin inspection is required for people at risk of damage
- Check skin at each position change and when you clean and change the person
- The key areas to look at are base of spine, back, buttocks, heels, hips and elbows
- Ask if anywhere is sore or painful and check these areas
- Document

Skin and tissue

- Erythema and its cause
- Skin and tissue temperature
- Tissue consistency/oedema
- Vascular/perfusion status
- Skin under devices and prophylactic dressings
- When assessing darkly pigmented skin, consider assessment of skin temperature and sub-epidermal moisture as important adjunct assessment strategies.

Blanching response
Existing Pressure Injuries

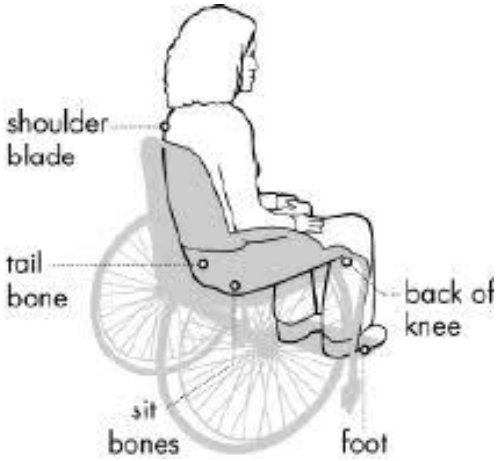
Support surfaces



Managing support surfaces

- Equipment
- Adults at lower risk-Use a high specification foam pressure redistributing support surface
- Adults at high risk of PI –Use a high specification foam pressure redistributing support surface or an alternating pressure support surface

- Sheepskins
- Support Cushions
- Lower limbs



Outdated interventions

OT involvement

Select a support surface that meets the individual's need for pressure redistribution based on the following factors:

- Level of immobility and inactivity
- Need to influence microclimate control and shear reduction
- Size and weight of the individual
- Number, severity and location of existing pressure injuries
- Risk for developing new pressure injuries

K Keep moving

- Implement individualised repositioning based on activity, mobility, independence , depending on skin condition
- Use good manual handling techniques to prevent shear and friction
- Encourage mobility where possible
- Involve physiotherapist ,steady as go class, Green prescription
- Provide written advice on preventing pressure injuries

Client handling

- Pressure redistributing support surface does not replace need for repositioning
- Reposition according to skin response, comfort, functional level, and medical history.

Incontinence

- Keep skin clean and dry
- Implement a skin hygiene plan
- Implement incontinence management strategies
- Use a pH balanced cleanser
- Protect skin with barrier product
- Treat inflammation/skin breakdown quickly
- Use specialist continence team

Pressure injury or Incontinence associated dermatitis (IAD)?

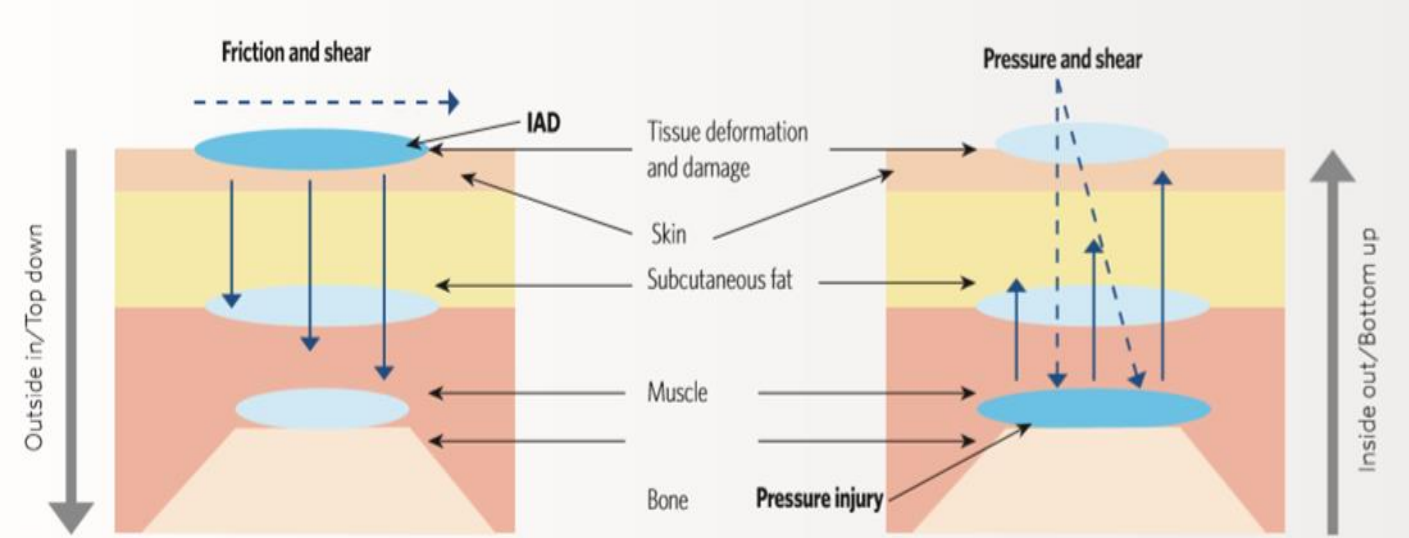


Figure 1. Possible mechanisms of action in IAD and pressure ulcer development (Wounds International, 2016)[17]

Use one incontinence product if needed

Avoid layers of incontinence products

N Nutrition

- Optimise nutritional intake of energy and protein
- Remember fluids
- Refer to dietician for a comprehensive nutrition assessment if patient has a nutritional risk
- Adults at high risk-provide nutritional intake of 30-35kcal/kg body weight and 1.2-1.5g protein/body weight daily

- Provide high-calorie, high-protein, arginine, zinc and antioxidant oral nutritional supplements or enteral formula for adults with a Category/Stage II or greater pressure injury who are malnourished or at risk of malnutrition.
- Develop and implement an individualized nutrition care plan for individuals with, or at risk of, a pressure injury who are malnourished or who are at risk of malnutrition.

Southern District Health Board

Malnutrition Screening Tool (MST) (District)

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

1. Have you recently lost weight without trying?	
No	0
Unsure	2
Yes: see next question	
If yes, how much weight have you lost?	
0.5 – 5 kg	1
5 – 10 kg	2
10 – 15 kg	3
> 15 kg	4
2. Have you been eating poorly because of a decreased appetite?	
No	0
Yes	1
MST score:	

Date	MST score	Action completed	Signature

Interventions		
Score	Malnutrition Risk	Actions
0 - 1	None/Low	• Continue usual diet • Rescreen weekly
2	Moderate	• HEHP diet* • Weekly weigh • Rescreen weekly • Red table mat
3 - 5	High	• HEHP diet* • Food charts • Dietitian referral • Red table mat

*HEHP (high protein high energy diet) – Change diet code on TrendCare

Malnutrition Screening Tool District

Southern District Health Board

Daily Food Chart

Dietetic & Nutrition Services (District)

Date: _____

Surname:		NHI:
Other names:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Please record all food and drinks (excluding tea, coffee, water) taken during the day
Please include nutritional supplements. Please write nil or refused if not eaten.

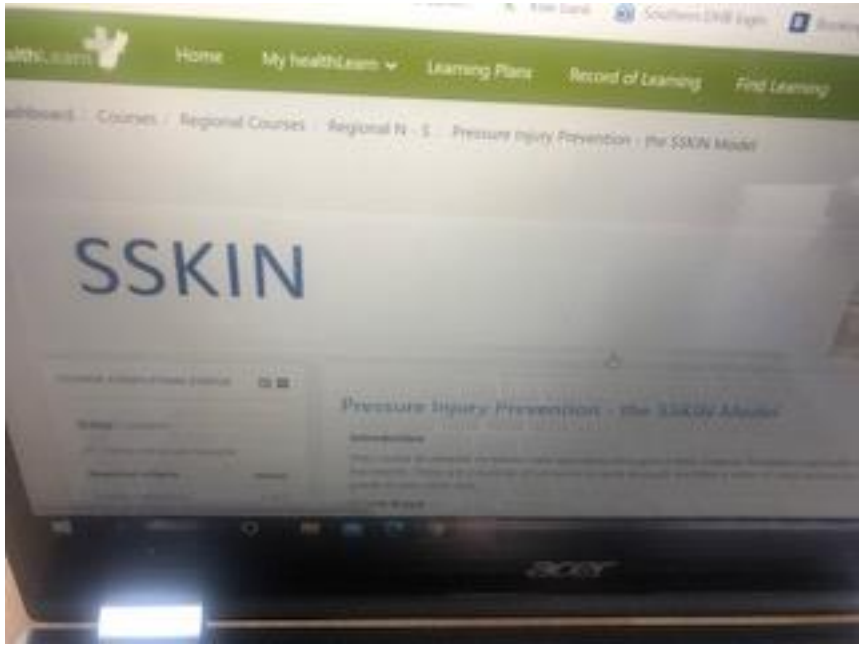
Specify type and amount of food and fluid offered (e.g. 2x toast, 200mL Ensure Plus, 185mL thickened juice) Meal size (please circle)	Amount eaten (tick ✓)					Dietitians Use Only	
						Energy (kcal)	Protein (g)
Breakfast petite / small / medium / large	Nil	¼	½	¾	All		
Morning Tea							
Lunch petite / small / medium							
Afternoon Tea							
Tea petite / small / medium							
Supper							
Other							
					Totals		
					Estimated daily requirements		
					% of daily requirements		

Daily Food Chart – Dietetic & Nutrition Services (District) MR1049 V3

Prevention of Pressure Injuries begins with the early identification of individuals who are susceptible to developing them

Other things to consider

- Pain- individualise care , use non-pharmacological pain management strategies Administer analgesia regularly
- Staging PI using classification system
- Psychosocial support
- Education
- Skills training

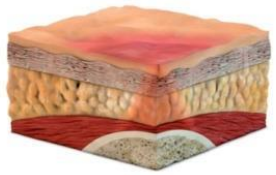
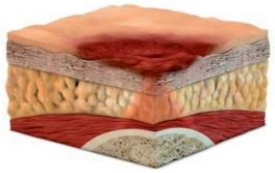
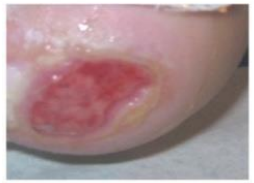
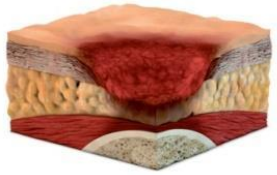
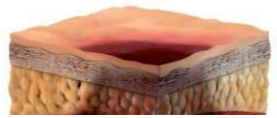
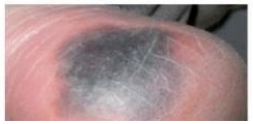


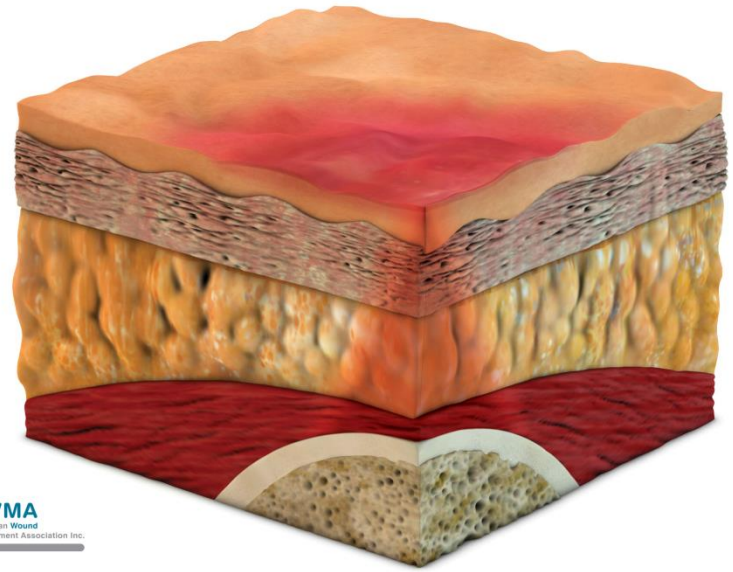
Documentation

- Client name
- Risk assessment scale-Braden,Waterlow Norton
- Date /time
- Area of pressure injury- example- Left or Right foot heel-medial/lateral dorsal/plantar
- Stage
- Is it painful
- Cause if known
- If skin broken or bleeding
- What has been done about it-covered up/off loading-referred
- Equipment in place, is the equipment working
- ACC
- Safety first –with photo (with consent)
- OT referral
- Notify/document

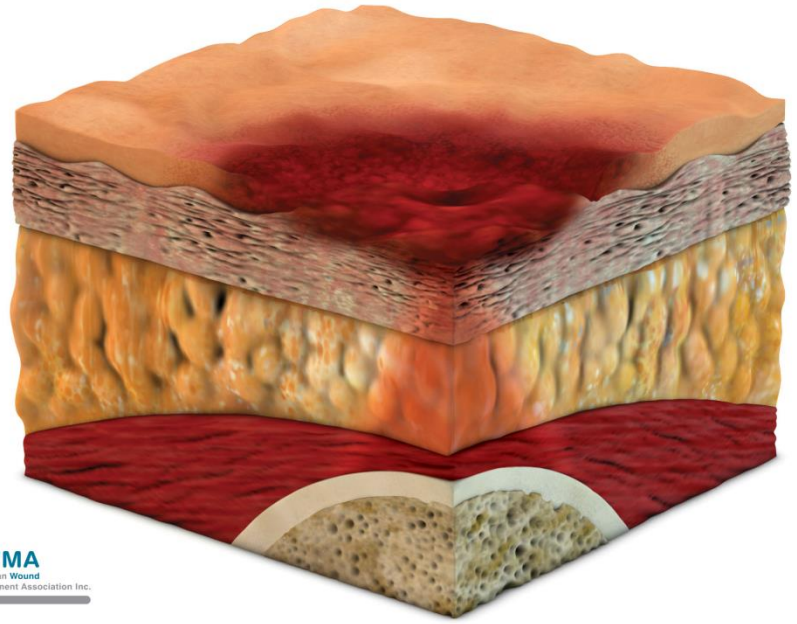
Classification tool

Table 7.1 NPUAP/EPUAP pressure injury classification system[4]

Stage I pressure injury: non-blanchable erythema	Stage II pressure injury: partial thickness skin loss	Stage III pressure injury: full thickness skin loss
• Intact skin with non-blanchable redness of a localised area usually over a bony prominence. • Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. • The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. • May be difficult to detect in individuals with dark skin tones. • May indicate "at risk" persons (a heralding sign of risk).	• Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough. • May also present as an intact or open/ruptured serum-filled blister. • Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). • Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	• Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. • The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.
 	 	 
Stage IV pressure injury: full thickness tissue loss	**Unstageable pressure injury: depth unknown**	**Suspected deep tissue injury: depth unknown**
• Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. • The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.	• Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. • Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.	• Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. • Deep tissue injury may be difficult to detect in individuals with dark skin tone. • Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
 	 	 



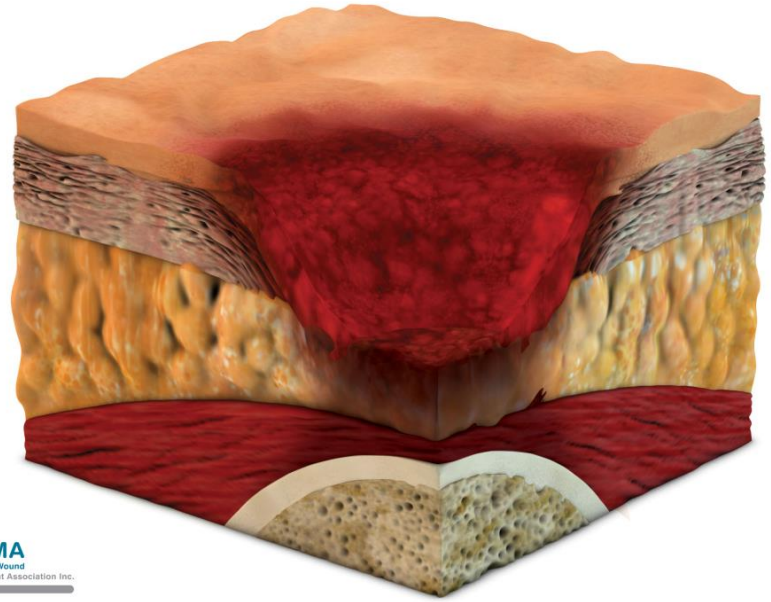
Stage I pressure injury: non-blanchable erythema



AWMA
Australian Wound Management Association Inc.
National
Healing Wounds Together

Stage II pressure injury: partial thickness skin loss

ABC of wound healing: Pressure ulcers Grey,Harding and Enoch 2006



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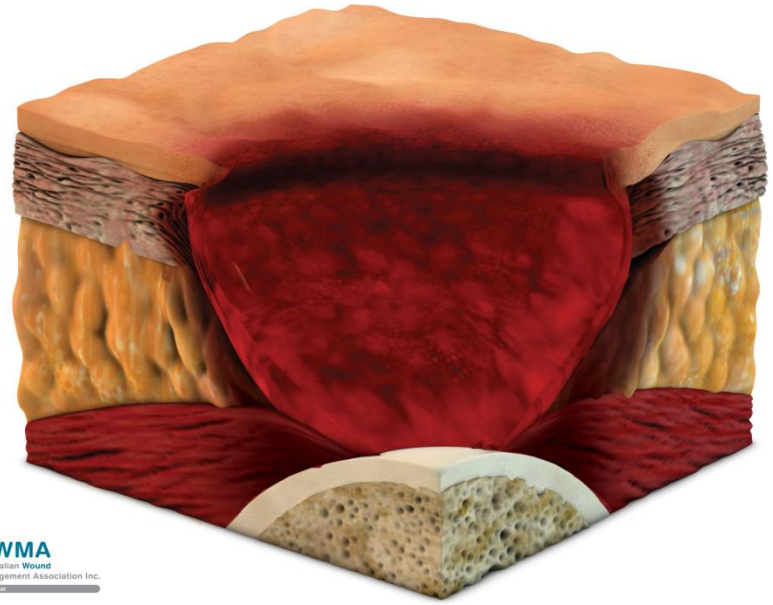
Australian Wound Management Association Inc.
National
Healing Wounds Together

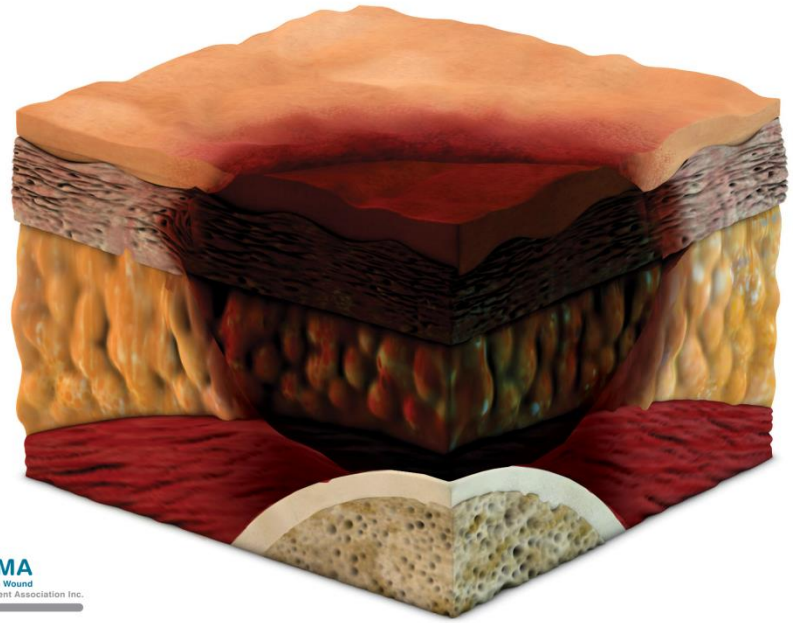
Stage III pressure injury: full thickness skin loss

ABC of wound healing: Pressure ulcers
Grey,Harding and Enoch 2006



Stage IV pressure injury: full thickness tissue loss

ABC of wound healing: Pressure ulcers Grey,Harding and Enoch



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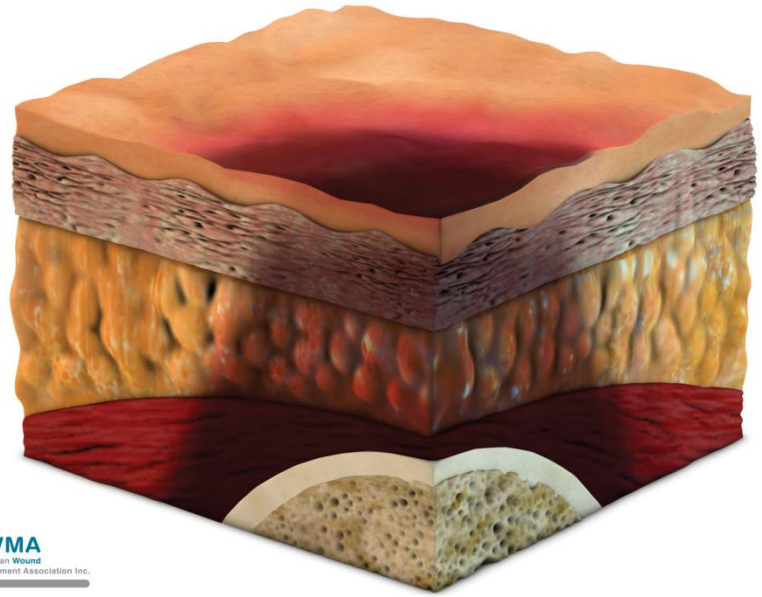
Unstageable pressure injury: depth unknown

ABC of wound healing: Pressure ulcers Grey,Harding and Enoch



AWMA
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National
Healing Wounds Together

Suspected deep tissue injury: depth unknown

NEW ZEALAND
WOUND CARE
SOCIETY

He ahu umanga ngaio hei whakamahu poka

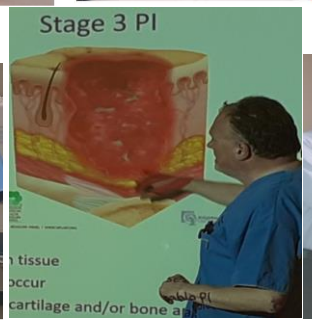
Advancing Practice and Knowledge in Wound Management

The New Zealand Wound Care Society Incorporated

- www.nzwcs.org.nz


WORLDWIDE
PRESSURE INJURY
PREVENTION DAY
NOVEMBER 17, 2022
STOP
PRESSURE
INJURIES
WWW.NPIAP.COM

STOP Pressure Injury Day 2020




WORLDWIDE
STOP
Pressure Injury Day
18th November 2021
PIC•COLLAGE

NHS Its SSKIN chant

Resources/websites

- White paper PRPPE Guideline/Covid 19 Prevention of skin lesions caused by Personal Protective Equipment (Face masks, respirators, visors and protection glasses) published by: Journal of Tissue Healing and Regeneration on NZWCS website
- Healthlearn
- www.nzwcs .org.nz New Zealand Wound Care Society
- www.epuap.org European Pressure Ulcer Advisory Panel
- www.awma.org.au Australian Wound Management Association
- www.ewma.org European Wound Management Association
- www.wound-uk.com Wound UK Online journals

References

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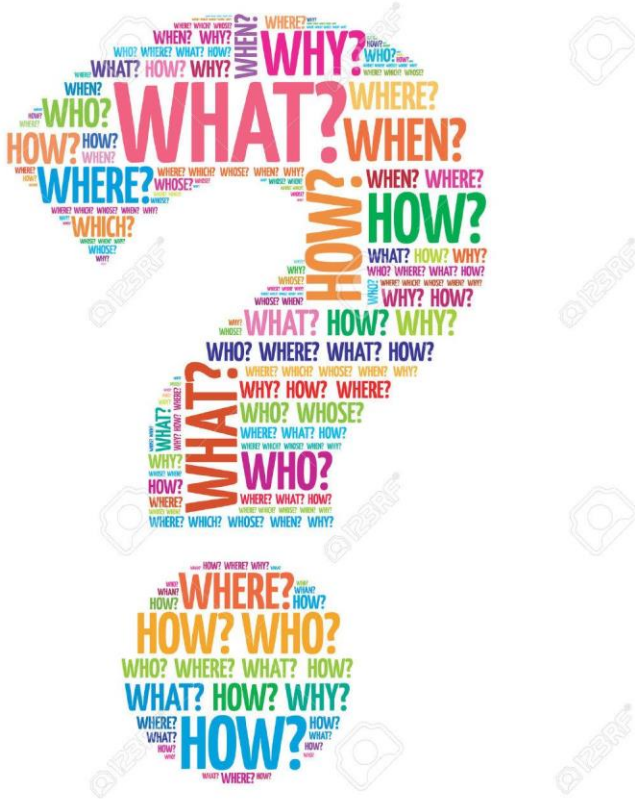
Questions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