Hospital Acquired Pressure Injuries (HAPIs)

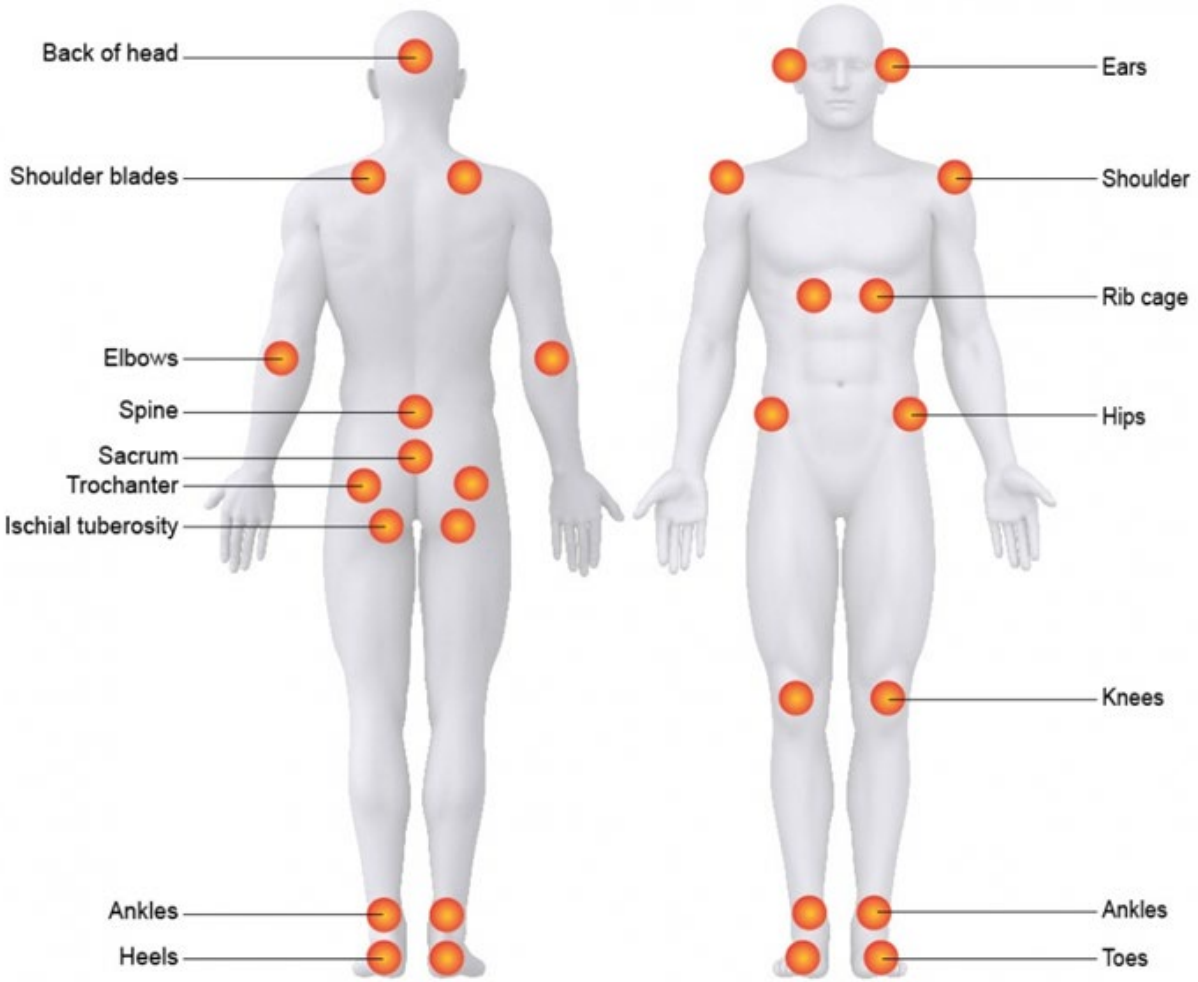
For Traveler RNs

What is a Pressure Injury?

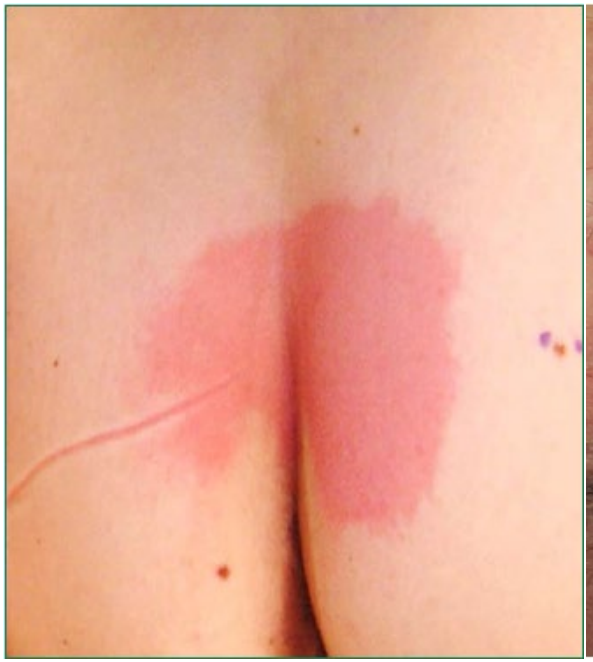
- Localized damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear.

- Usually occur over bony prominence but may also be related to a medical device or other object.

Bony prominences

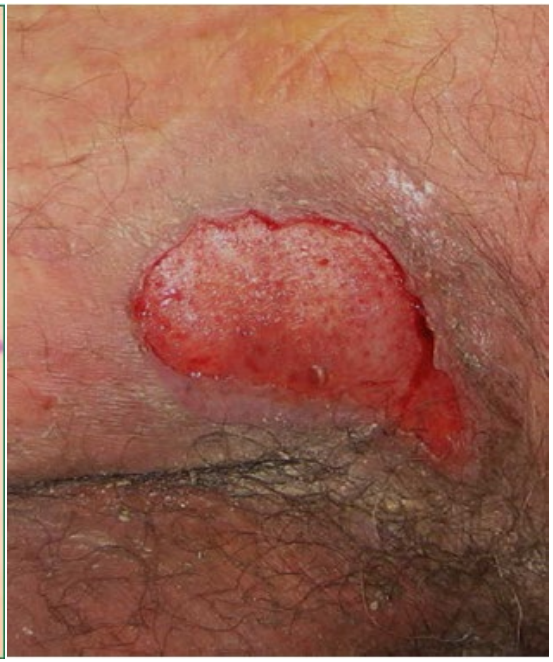


What do pressure injuries look like?



Stage 1

Intact skin, red, does not blanch

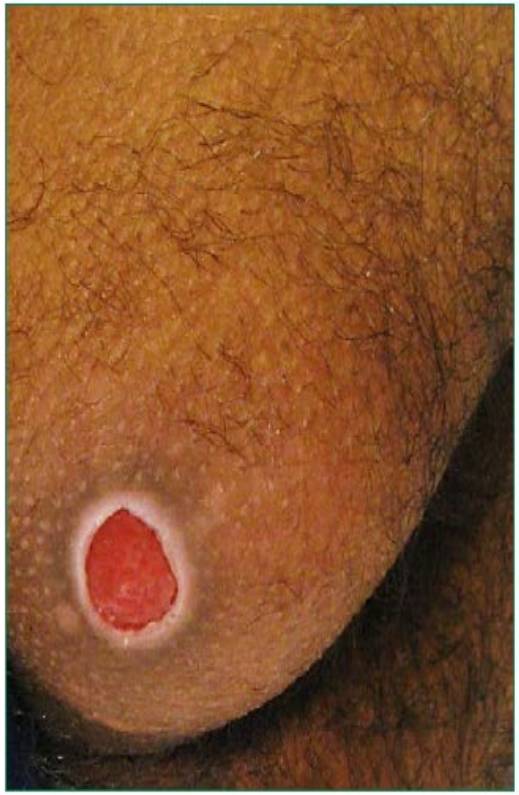


Stage 2

Partial loss of dermis, shallow, red or pink wound bed

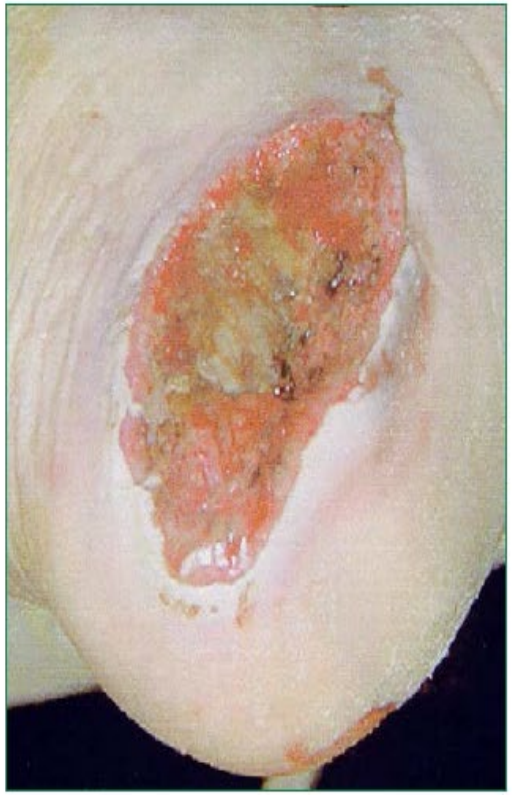
- Skin can be intact or open
- Injury can vary in depth and size
- May be painful or in an area with decreased sensation

Stage 3 Pressure Injuries



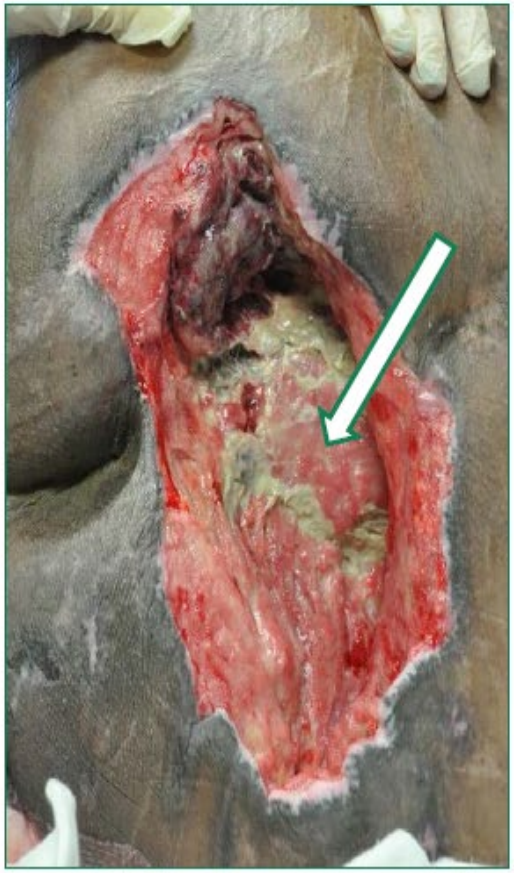
Ischium

Sacrum

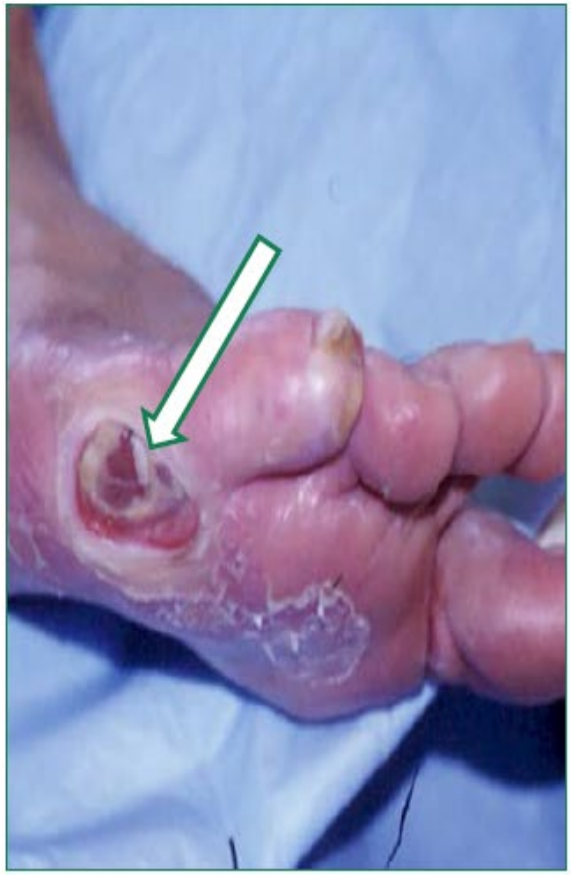


Heel

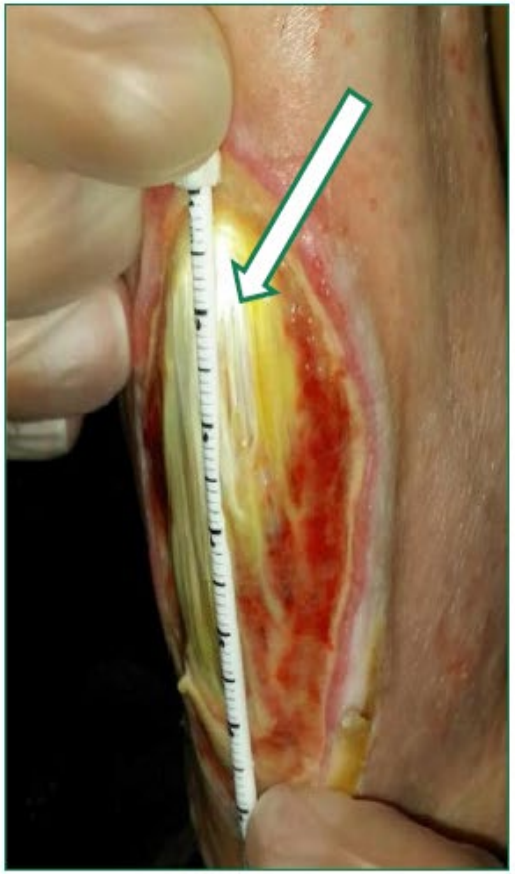
Stage 4 Pressure Injuries



Muscle

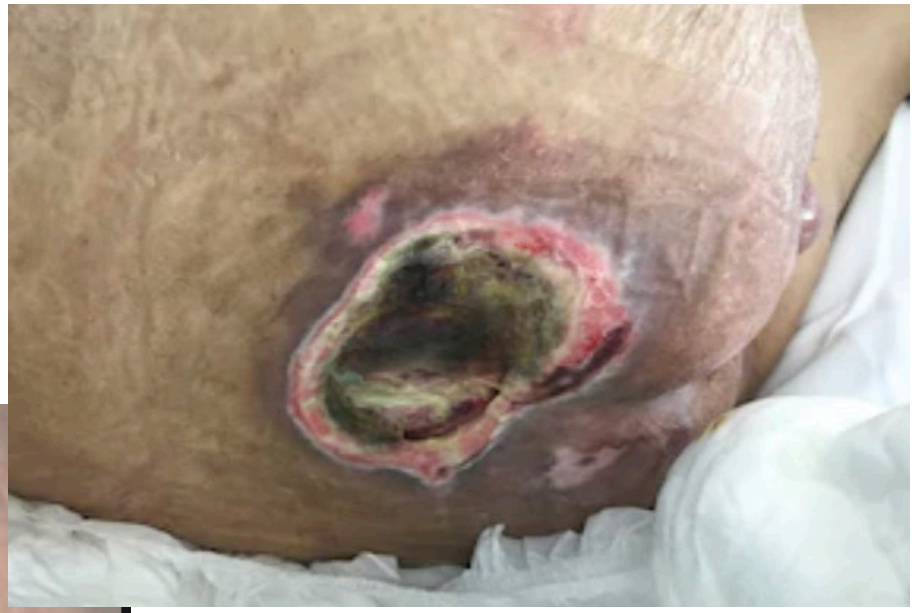


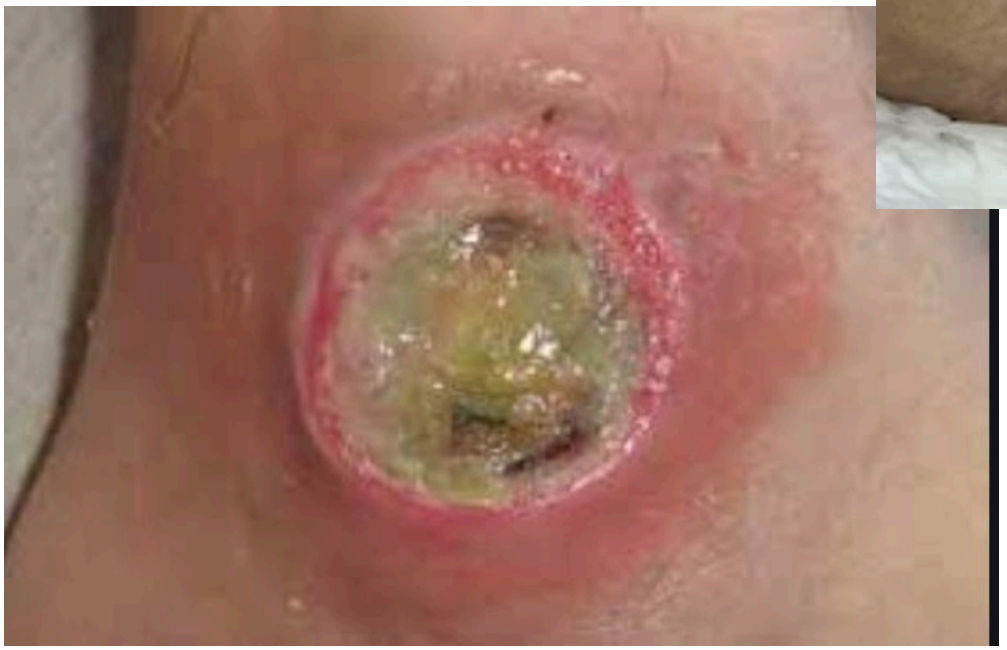
Bone



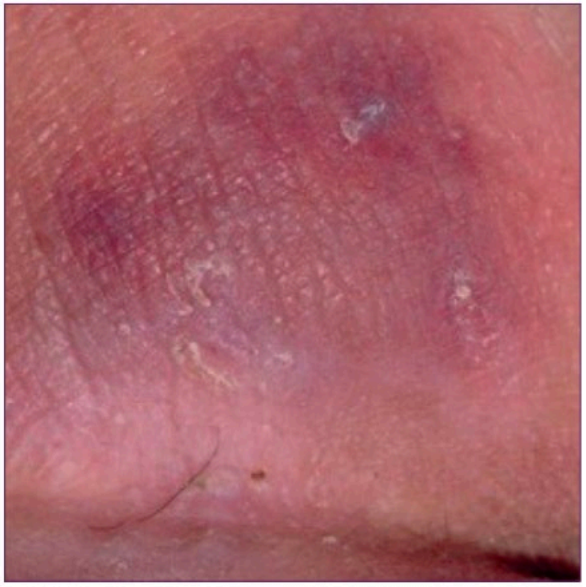
Tendon

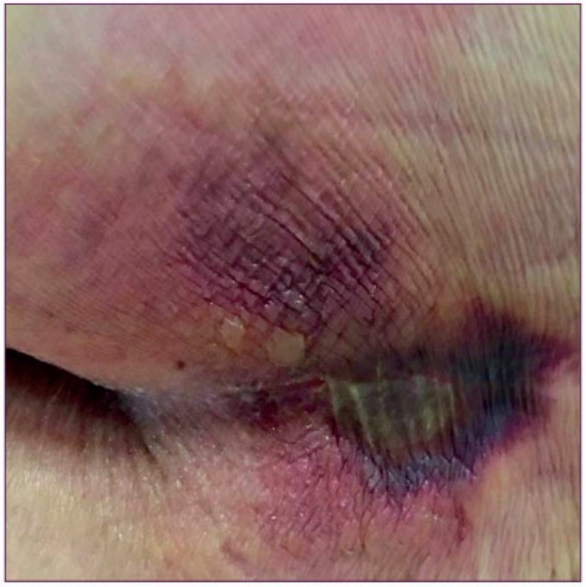
Unstageable Injuries

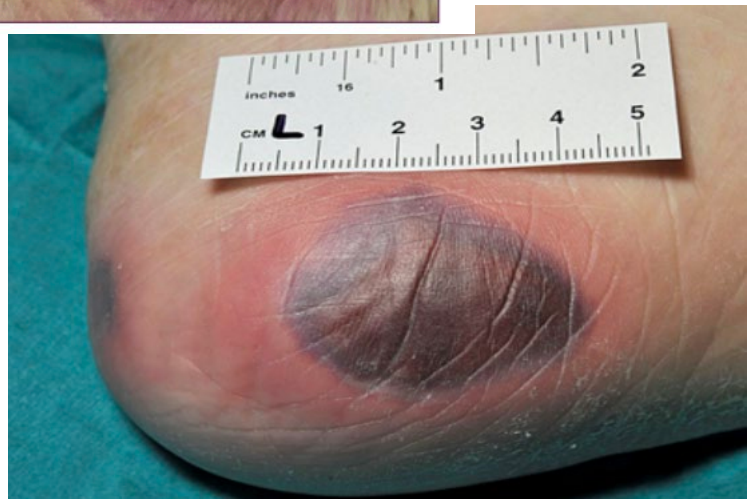




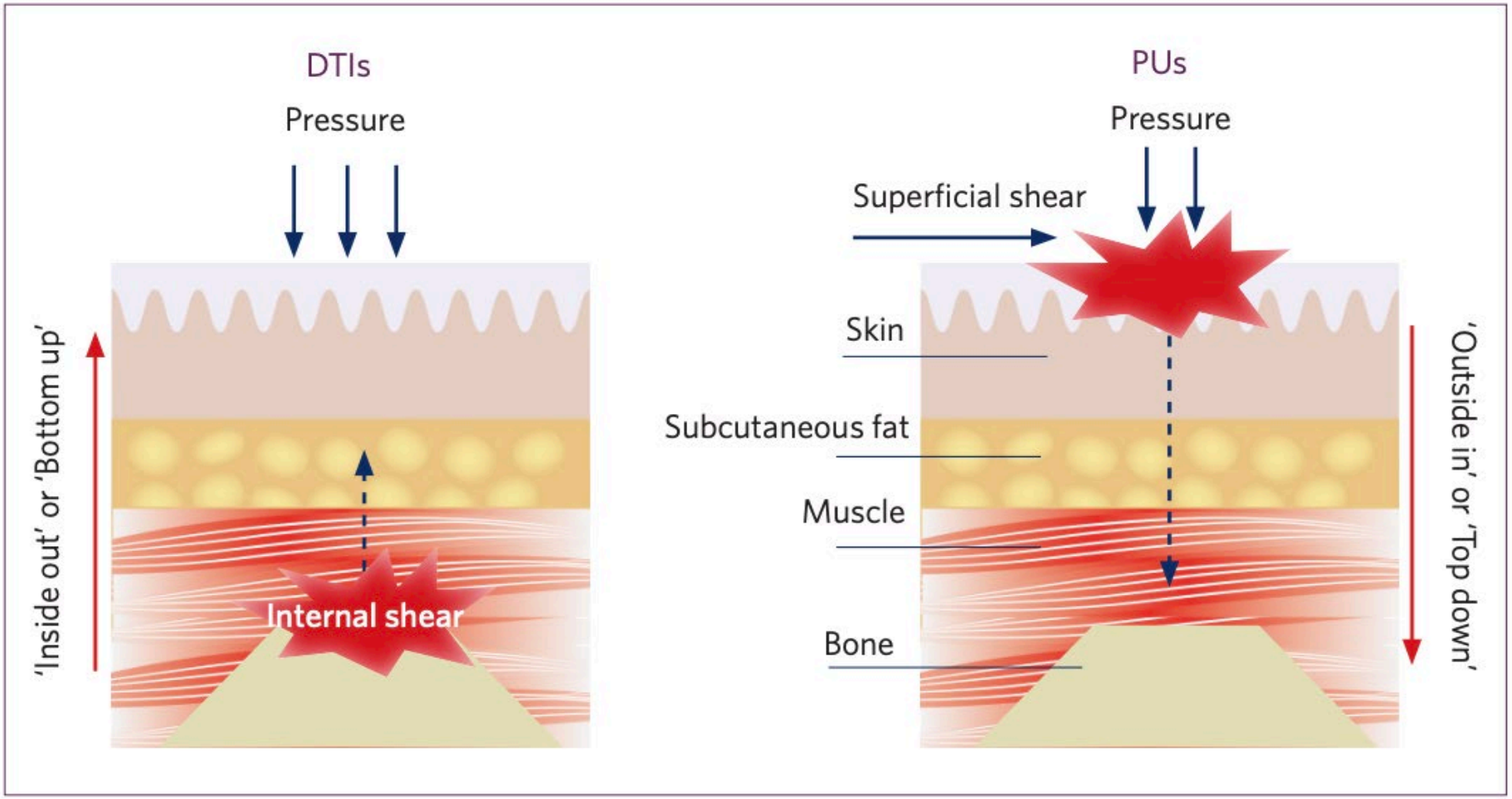
Deep Tissue Injuries



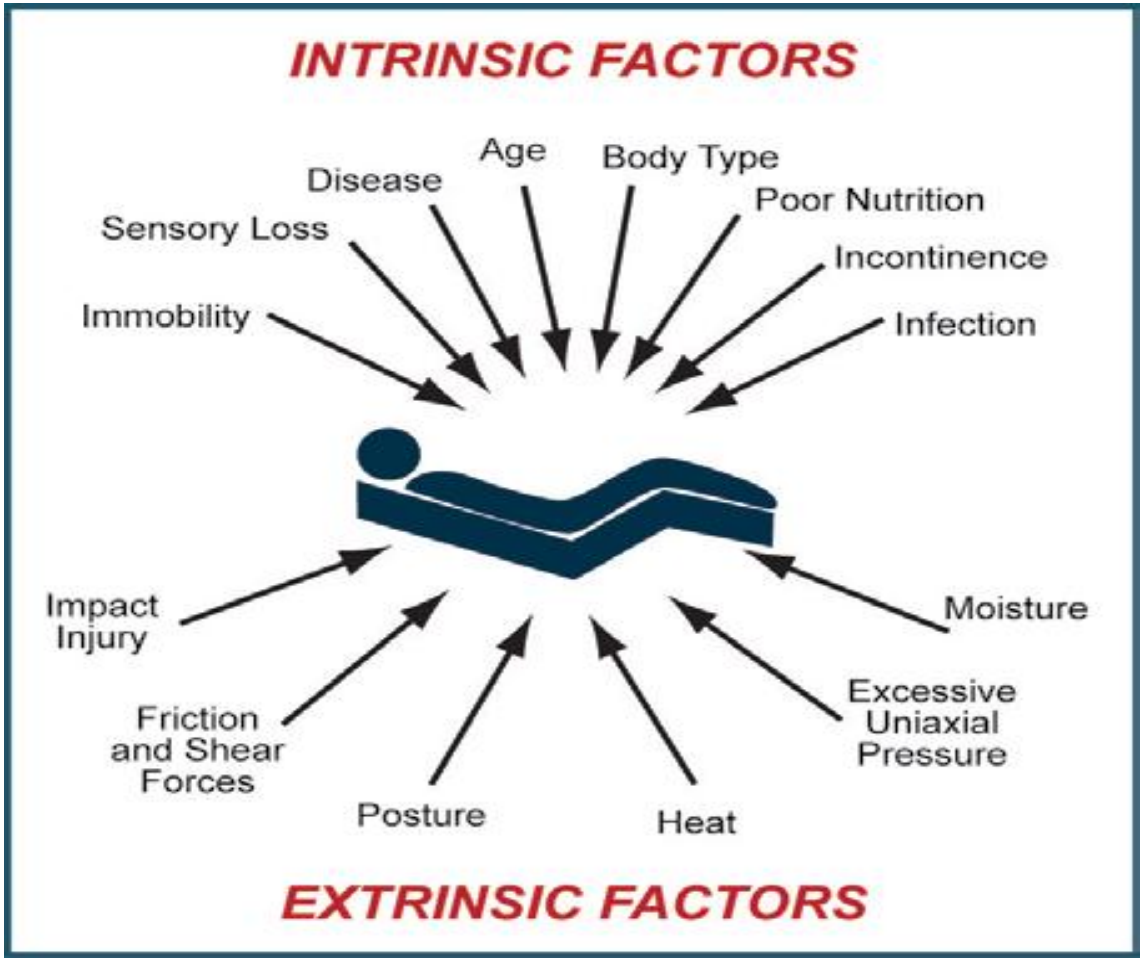




Deep Tissue Injuries



What puts people at risk for pressure injuries?



PAMC Pressure Injury Guideline - RNs

4 eyes in 4 hours

- RN and 2nd caregiver do a head-to-toe skin check together, within 4 hours of arrival to the unit.
- RN documents **skin assessment** **and** Braden or Braden Q **risk assessment** within 4 hours of arrival to the unit.
- Start Braden based interventions.

Decreased Sensory Perception (Braden ≤ 2)

Limited ability or complete inability to feel or communicate pain/discomfort

Eliminate sources of pressure

- Eliminate sheet wrinkles & clear devices/objects from under patient
- Use bed extender to prevent feet pushing against end of bed
- Adjust critical care beds so heels sit in low pressure zone
- Limit time on bedpan

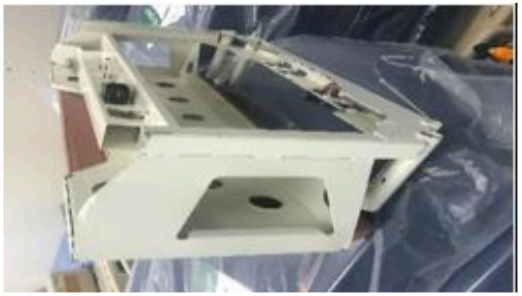
Relieve/redistribute pressure

- Pad locations with skin-to-equipment contact
  - Under/around tubes, hard chair arm rests
- Apply foam dressings to bony prominences
  - Elbows, spine, hips, sacrum
- Float heels off the bed
- Use chair cushion when up in chair

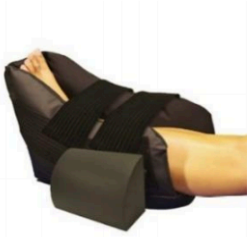
Protect skin under/around medical devices

- Inspect skin at least twice daily
- Reposition medical devices when patient condition allows
  - Reposition nasogastric tube q shift
- Refit/resize problematic devices & remove as soon as patient condition allows

Bed extender:



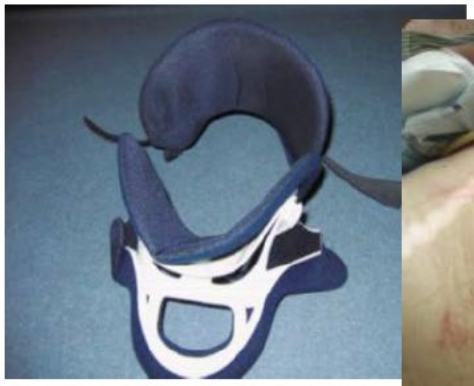
Heel protection Boots:

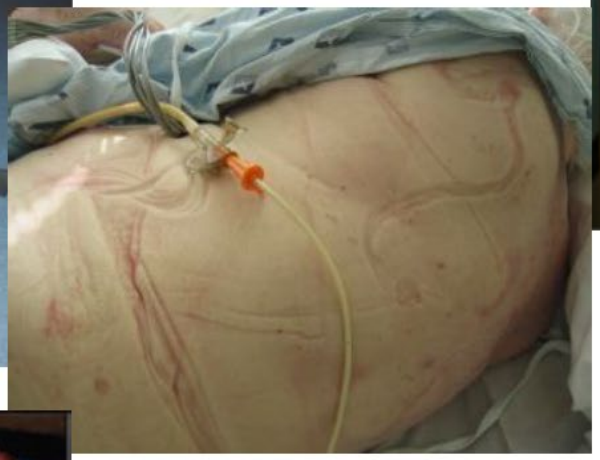


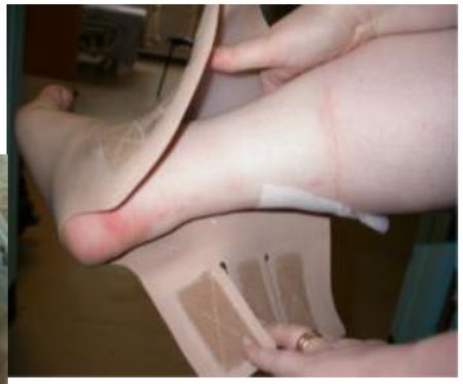
Foam dressings:

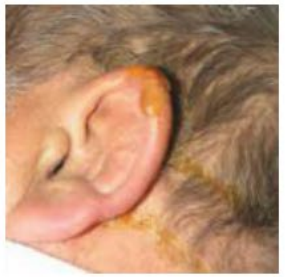
Pressure injuries from **mechanical devices**

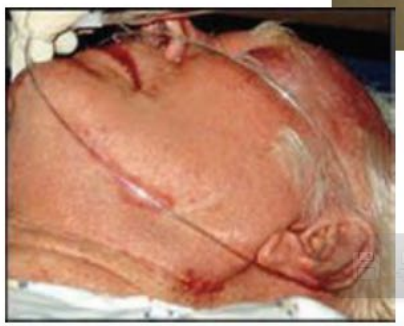
Assess skin under device











Moisture (Braden ≤ 2)

Skin occasionally moist, very moist, or constantly moist

Keep skin clean, dry, and moisturized. Minimize exposure to excessive moisture.

Manage incontinence

- Attempt toileting q 2 hour
- Remove depends/diaper to increase air flow
- Replace cloth pad with paper wicking chux
- Clean skin & apply barrier promptly after episodes of incontinence.
  Barriers range in protection, see Attachment C
- Use male/female external catheter
- Use fecal management system for liquid stools

Keep skin folds clean and dry. Use a moisture-wicking antimicrobial fabric in skin folds to wick moisture away.

- Beneath pannus, under breasts, in groin

For patients with pressure injuries who also have moisture problems, a specialty bed that circulates air might be beneficial. Ask Wound Therapy.

Medline Remedy Skin Care Products (Attachment C)

Paper wicking chux:

CLEANSE HIGH RISK SKIN	CLEANSE WOUND SPECIFIC	MOISTURIZE LOW RISK	MOISTURIZE HIGH RISK	PROTECT/TREAT	PROTECT/TREAT	PROTECT/TREAT
Phytoplex Hydrating Foaming Body Cleanser	**SKINTEGRITY Wound Cleanser**	**Moisturizing Lotion**	**Phytoplex Nourishing Skin Cream**	**Phytoplex Hydraguard**	**Zinc Protectant Paste**	**Phytoplex Z-Guard**
						
Mfr# MSC092104UNSC Lawson# 591797	Mfr# MSC6008 Lawson# 250686	Mfr# MSC092MBL04 Lawson# 575409	Mfr# MSC0924004UNS Lawson# 591803	Mfr# MSC092532UNSC Lawson# 458201	Mfr# MSC092ZP04H Lawson# 575410	Mfr# MSC092542 Lawson# 432033
No-rinse Use on intact, irritated or denuded skin Clings where applied, wipe clean with a washcloth Removes barrier pastes and creams, blood and fecal material OK for all ages	Gentle cleansing of wounds in all stages. Mist or stream spray Non-ionic surfactant Non-cytotoxic	Everyday use	Sensitive, fragile, very dry Restores moisture balance and barrier properties of skin No mineral oil or other petrochemicals; skin breathes	Creates a breathable, water-resistant film over skin Use on very fragile skin Reduces the appearance of red, cracked and scaly skin while soothing dry, itchy skin	Relieves chapped or cracked skin Helps seal out wetness	Prevents/treats rash and macerated skin caused by wetness, urine and/or stool Use on intact, irritated or denuded skin Temporarily protects and relieves chapped or cracked skin Temporarily protects minor cuts, scrapes a burns

Green is for clean

Purple is for pretty/preventative

Blue is for barrier protection

Orange is for open wound

Decreased Activity & Mobility (Braden ≤ 2)

Activity: Walks occasionally, chair or bed fast.
Mobility: Makes frequent slight changes in body position to totally immobile

In bed repositioning: to offload pressure, start with q 2 hour turns, inspect skin with turns and increase turn frequency if needed.

In chair repositioning: Use chair cushion. Instruct patient to shift weight every 15min, if able. If unable, assist patient to offload pressure every hour with short moments of standing or leaning forward from sitting position.

Apply repositioning sensor if utilized in unit (i.e., LEAF)

AVOID positioning patient on pressure injuries

- If pt has a L buttock pressure injury, reposition on R side & supine

Float heels with pillows or offload with heel protecting boots

Encourage patient mobility & discuss starting PT/OT with LIP

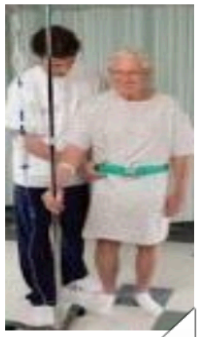
- Up in chairs for meals, use lift equipment to walk halls

When patient is "Independent" with positioning, ensure patient can (and is!) effectively repositioning self. If not, start a repositioning schedule and modify your Braden score.

Wedges:

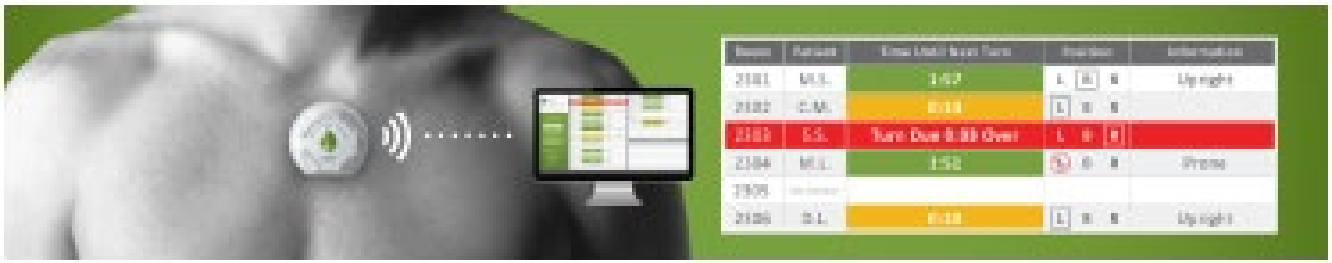
Chair Cushion:

Early Ambulation:



Repositioning with LEAF ICUs, PCU, 3W, 5N

Leaf Patient Monitoring System wirelessly monitors a patient's position, movement and activity.



The Leaf Patient Monitoring System consists of a wearable sensor that continuously monitors patient position/movement and provides staff with notifications when patient repositioning is required to prevent pressure injuries.

If your patient is on LEAF you document “patient being monitored by LEAF” once per shift.

Poor Nutrition (Braden ≤2)

Rarely eats complete meal, occasionally takes dietary supplement, inadequate tube feed intake, NPO or clears liquids > 5 days

Assess barriers to achieving optimal nutrition

- chewing difficulties, impaired swallowing, social isolation

Order Nutrition Consult

- If Nutrition Braden Subscale ≤ 2
- With any stage pressure injury

Encourage eating and drinking

- Ensure water is available & encourage intake if appropriate
- Assist to set up tray and feed patient
- Order snacks/meals that pt likes
- Obtain order for nutritional supplements. Consider administering oral meds with liquid nutritional supplements instead of water.
- Avoid empty calories: cake, cookies, sodas, energy drinks

Record accurate fluid/food intake to help Dietitians assess adequate intake

Risk for Friction & Shear (Braden ≤ 2)

Moves feebly/potential drag and shear with movement. Min to max assist. Pt slides down in bed or chair. Almost constant friction from spasticity, contractures, or agitation.

Use lift equipment for repositioning & transfers, never drag pt

- Hovermatt, tube slide sheets, ceiling lifts, slide boards

Apply foam dressings to protect areas at risk for shear damage

- The sacrum for patients who slide down in bed
- Elbows and heels for patients who shift themselves up in bed

Keep skin moisturized to provide some protection

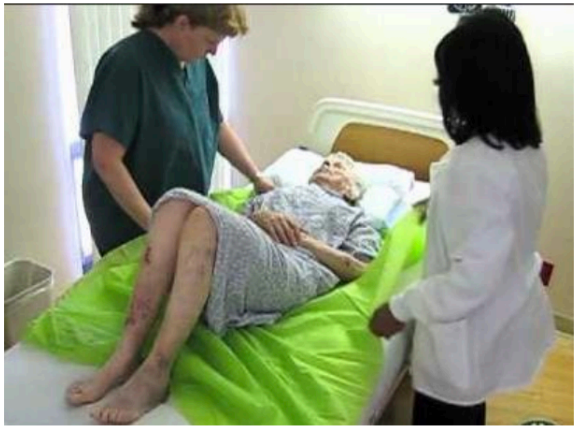
Protect contracted/spastic extremities

- skin sleeves, padded rails, foam dressings, creative & frequent repositioning

Place Head of Bed @ 30 degrees or less (unless contraindicated).

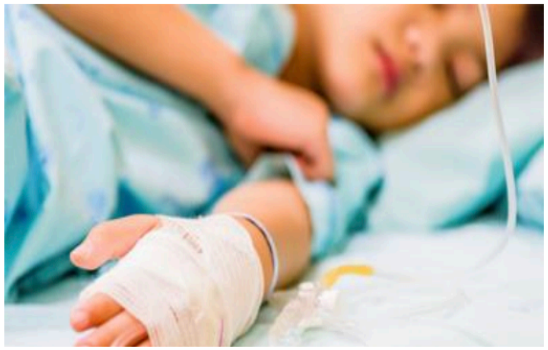
Avoid massage over reddened areas/bony prominences

Avoid foam rings/cut-outs, synthetic sheepskin, & donut devices.



Decreased Tissue Perfusion & Oxygenation (Braden Q for pediatrics)

- **Continuous pulse oximetry & cardiorespiratory monitoring**
- **Increased frequency of monitoring** (e.g. VS, areas of potential or impaired circulation such as extremities with casts, etc.)
- **Normalize temperature** (e.g. warm fluids, antipyretics as needed; discontinue cooling blankets as soon as possible)
- **Collaborate with LIP to optimize systemic perfusion:**
  - ***Preload***: fluid bolus
  - ***Contractility***: inotropes, correct hypoxia, electrolyte & acid-base imbalances, and hypoglycemia/hypocalcemia, treat poisoning
  - ***Afterload*** [SVR]: vasopressors or vasodilators
  - ***Heart rate***: chronotropes for bradycardia, antiarrhythmics, correct hypoxia, pacing
- **Collaborate with LIP to optimize oxygen delivery:**
  - ***Right device*** (e.g. size, disease process)
  - ***Adequate HGB***
  - ***Secretion clearance*** (e.g. suction, incentive spirometry)
  - ***Promote ambulation & repositioning*** (e.g. prone)

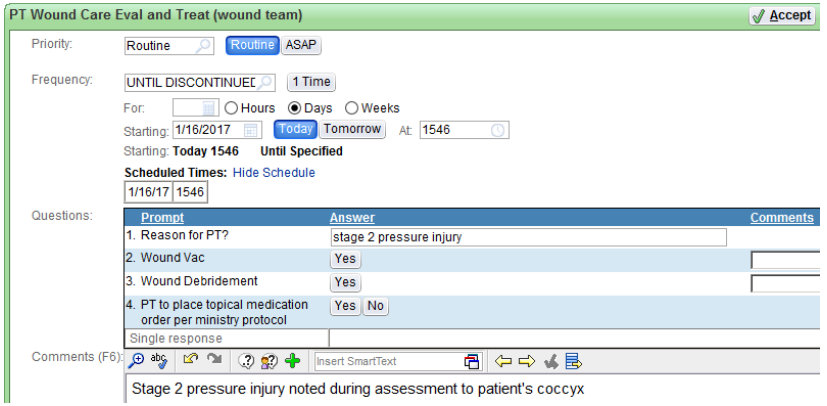


PAMC Guideline – if you find a pressure injury:

- **Cleanse** with sterile water, sterile saline, or wound cleanser
- **Stage** it using NPIAP definitions
- **Photograph** injury for EPIC chart
- **Cover** with foam dressing until wound team makes care recommendations.
- **Eliminate** source of **pressure** from injured area when possible.
- Order **Wound Consult** if stage 2 or greater
- Order **Nutrition Consult**
- Notify **Charge Nurse.**
- Notify **LIP** for all stage 2 and greater pressure injuries.
- Complete a **UOR.**
- **Document** interventions.

Wound Team

- The Wound Team is comprised of Physical Therapists with specialized wound care training.
- We have a Wound Therapist scheduled 7 days/week
- They manage:
  - Debridements
  - Complex wounds
  - Pressure injuries (stage 2 or greater)
  - Wound Vacs



- Order a wound consult with stage 2 or greater pressure injuries

Big Picture: How PAMC prevents HAPIs

- Assign NDNQI training for pressure injury staging
- Skin Integrity Council – members on each unit
- Monthly prevalence studies
- UORs
- Run at-risk reports, round on those patients more frequently
- Clinical Nurse Specialists track and report pressure injuries daily at Clinical Operations