Building a Pressure Injury Prevention Program in LTC

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Pressure Injuries

Pressure injuries are a continual challenge for patients and caregivers

- Cost of a hospital-acquired PU in Ontario was $44,000 – 90,000, compared with CA $11,000-18,500 for a pre-admission PU[1]
- Treating pressure injuries can increase nursing care hours by up to 50%[3]

Risk factors that can lead to pressure injuries include:

In Canada, the prevalence of pressure ulcers is estimated to be

29.9%
in Long-term Care [2]

1. https://pubmed.ncbi.nlm.nih.gov/24159655/
2. Hospital News Magazine, MARCH 2018 HOSPITAL NEWS
3. Clarke, H.F., et al (2005). Pressure ulcers: Implementation of evidence-based nursing practice . Journal of Advanced Nursing, 49(6): 578-590.

Building your healthy skin program ~ Step one
Evaluate your baseline

Assess your incidence

Audit your tools

Evaluate your team’s skill and attitude towards PIP

* International Wounds journal 2021 Attitudes of nursing staff towards pressure ulcer prevention in primary and specialised health care: A correlational cross-sectional study

Care Bundles For improved Quality of Care

- An organised set of interventions that encourages compliance with guidelines designed to improve the quality of care (1)
- Evidence based
- Helpful for making appropriate clinical decisions
- A cohesive unit of steps to complete with a focus on HOW to deliver best care
- Provides consistency in execution
- A bundle is not a checklist – it is an all-or-nothing measurement
- Skin Bundles are recommended as best practice in pressure injury prevention by the National Pressure Injury Advisory Panel (NPIAP) and the European Pressure Ulcer Advisory Panel (EPUAP)

4 https://www.ihi.org/resources/Pages/ImprovementStories/WhatIsaBundle.aspx

Building your healthy skin program ~ Step two
Design your program

Designing your bundle
What should be included

- Education
- Risk Assessment
- Skin Care and Inspection
- Activity Management
- Nutrition Management
- Moisture Management
- Support Surface Management

1) Education

Staff

- Age related skin changes
- Daily moisturizing
- Products that help and products that harm aged skin
- How and when to apply skin care products
- Friction reducing devices and how to use them

Residents

- Age related skin changed
- Daily moisturizing
- Good skin care products that are recommended by experts
- Offer a choice in hygiene and products

Family

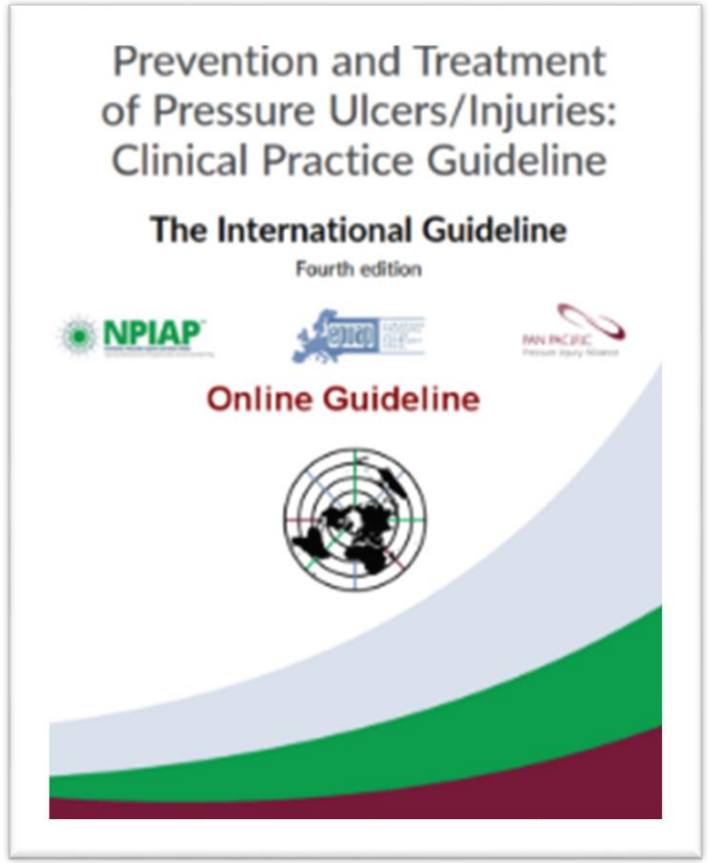
- Age related skin changes
- Daily moisturizing
- Products that help and products that harm aged skin
- Encouraging the use of skin care products
- Hygiene schedules and not over washing

Resources for educational materials

RNAO

WoundsCANADA.ca

WOUND, OSTOMY & CONTINENCE INSTITUTE
NURSES SPECIALIZED IN WOUND, OSTOMY AND CONTINENCE CANADA
NSWOC
NSWOCC



2) Risk Assessment ~ Who is At Risk?

LONG-TERM CARE

ALBERT

Ambulatory
Fully self supporting, stimulating mobility is important.

BARBARA

Mobile with some assistance
Mostly self supporting in transfers and hygiene or only guidance needed. Stimulating mobility is important.

CARL

Partially weight bearing
Able to manage standing and hygiene tasks with support. Stimulating mobility is important.

DORIS

Non weight bearing
Dependent upon caregiver for transfer and hygiene tasks. Unable to sit unsupported. Stimulating function is important.

EMMA

Completely immobile
Fully dependent upon caregiver for all transfers and hygiene tasks. Stimulating function is not a primary goal.

Skin & Tissue Assessment
NPIAP Guidelines

Recommendation 2.1: Conduct a comprehensive skin and tissue assessment for all individuals at risk of pressure injuries:

- As soon as possible after admission/transfer to the healthcare service·
- As a part of every risk assessment
- Periodically as indicated by individual's degree of PI risk
- Prior to discharge from the care service

(Good Practice Statement)

Recommendation 2.6: Consider using a sub-epidermal moisture/oedema measurement device as an adjunct to routine clinical skin assessment [4]

(strength of evidence B2, strength of recommendation ←→)

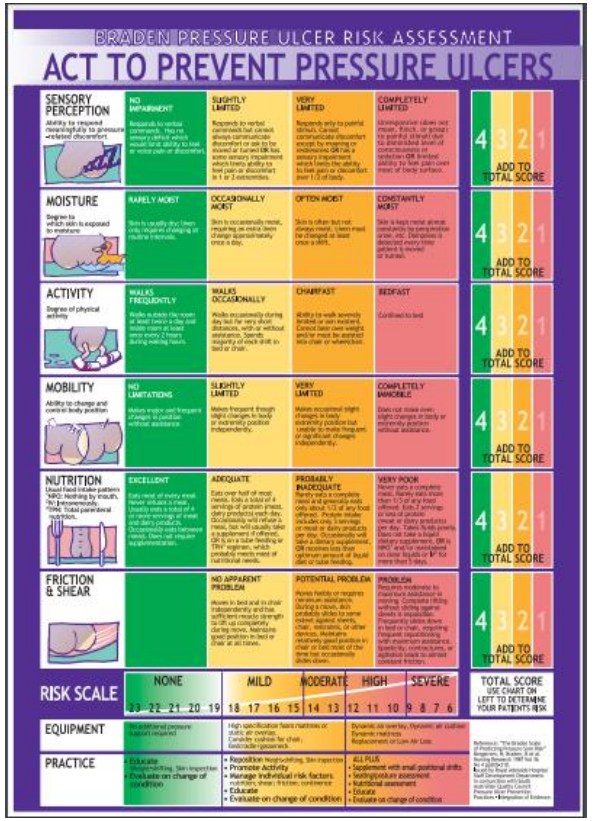
Recommendation 2.7: When assessing darkly pigmented skin, consider assessment of skin temperature and sub-epidermal moisture as important adjunct assessment strategies[5].

(strength of evidence = B2; strength of recommendation ↑)

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.

NPIAP Recommendation 1.24 Good Practice Statement: When conducting a Pressure Injury Risk Assessment

1) Use a structured approach
2) Include a comprehensive skin assessment
3) Supplement use of a risk assessment tool with assessment of additional risk factors
   - History of PI
   - Diabetes
   - Circulatory or perfusion deficits
   - Nutrition deficits
   - Oxygenation deficits
   - Increased temperature
   - Increased moisture on skin
   - Advanced age
   - Sensory perception deficits
   - Cognitive impairment



Nutrition and Pressure injuries https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5930532/#

3) Skin care and inspection

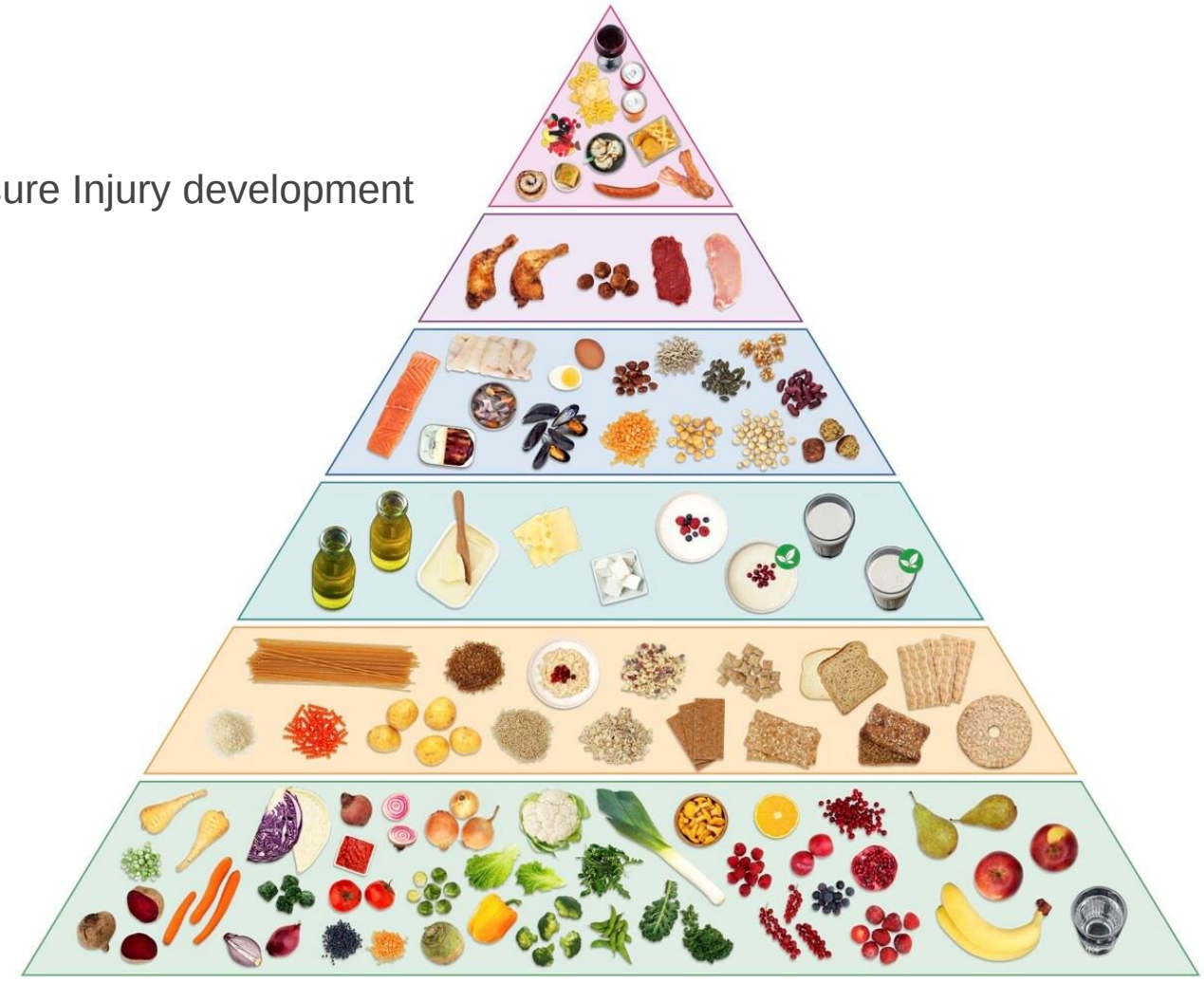
- Heat
- Turgor
- Moisture
- Edema
- Erythema (non-blanchable)

- Cleansing the skin promptly after episodes of incontinence
- Avoiding use of alkaline soaps and cleansers
- Avoid excessive rubbing
- Keeping the skin appropriately hydrated

- Protect the skin from moisture with a barrier product
- Use high absorbency incontinence products
- Use light weight breathable textiles with low friction coefficients
- Use a soft silicone multi-layered prophylactic foam dressing over bony prominences

4) Nutrition Management

- Nutritional Screening for all individuals at risk of Pressure Injury development
- Establish daily nutrition goals with dietician
- 30 – 35 kcal / kg of body weight per day
- 1.2 – 1.5 g of protein per kg of body weight per day
- Provide specialised nutrition
- Evaluate hydration
- Offer a variety of drinks at regular intervals



5) Activity management

- Positioning in bed ~ individualized schedule
  - Skin and tissue tolerance
  - General medical condition
  - Overall treatment objectives
  - Comfort and pain
- Positioning in bed
  - 30 degree side lying position
  - Head below 30 degrees
  - Auto-profiling frame
  - Micro-turns for critically ill residents
- Positioning in chair frequency
  - Tilt, recline
  - Elevate the legs
- Elevate heels pillows, foam or booties
- Do not position on area of redness

6) Moisture / incontinence management

- Limit contact of faeces and urine with skin, change body worn products right away
- Barriers should be removed and reapplied to dry skin after each episode of cleaning.
- Products containing chlorhexidine gluconate, alcohol, lanolin or fragrance should be avoided
- Limit layers of fabrics between resident and surface
- Manage perspiration
  - Low air loss surface
  - Negative pressure micro climate management surface coverlet

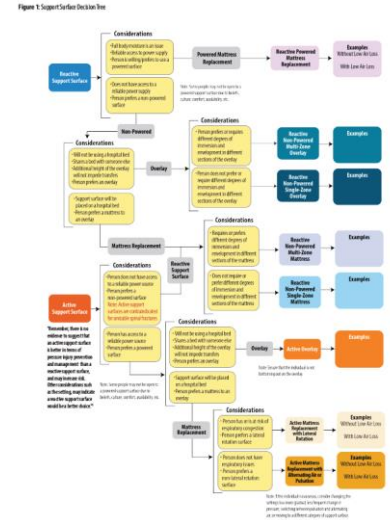
7) Support surface management

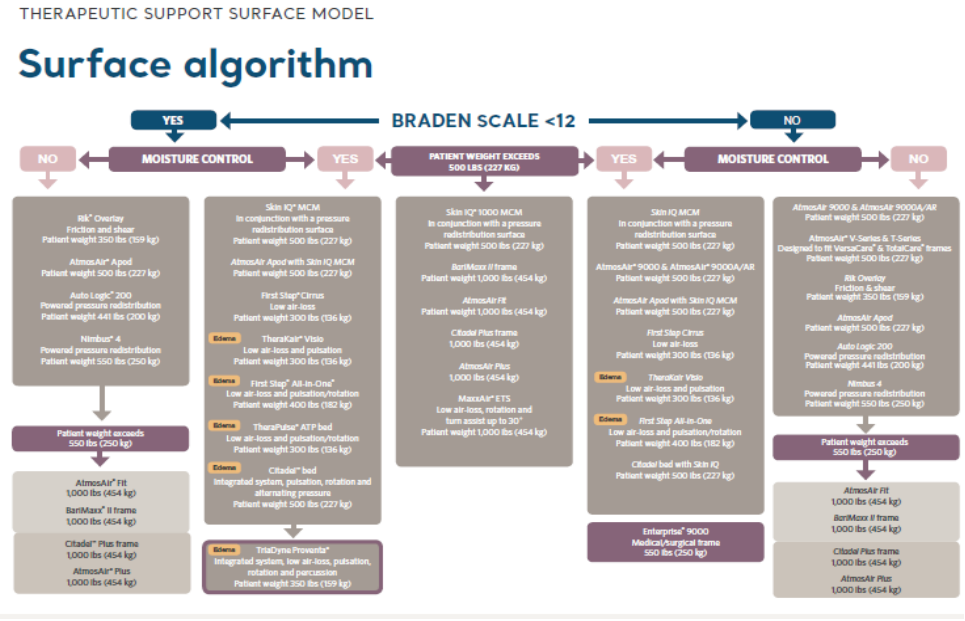
NPIAP Recommendation 7.1: Select a support surface that meets the individual's need for pressure redistribution based on the following factors:

- 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, dehydration risk
- Patient Comfort, rest and sleep

NPIAP Recommendation 7.5: Consider using a reactive air mattress or overlay for individuals at risk for developing pressure injuries.

Surface selection algorithms and Wounds Canada Product Picker tools





A skin care program is a living entity

Regularly revaluate your program

Run your data

Realign your goals

Make sure your goals are SMART

Add additional initiatives

Celebrate your success

References

- NPIAP Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide 2025
- Institute for Healthcare Improvement www.ihi.org/topics/bundles
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with people in mind