Virginia Department of Behavioral Health & Developmental Services

Pressure Injury
Risk Awareness Training (RAT)

Presented by:
The Virginia Department of Behavioral Health and Developmental Services
The Office of Integrated Health
Health Supports Network

Who benefits from this training?

DSP's and caregivers- you will learn important risk factors associated with pressure injuries, learn to recognize signs and symptoms, and the importance of reporting.

Support Coordinators-you will learn important risk factors associated with pressure injuries, understand the signs and symptoms that DSP's and caregivers are going to recognize and provide in documentation, and learn diagnosis that may be associated with risk factors.

Objectives

1. Define Pressure Injury
2. Identify (3) risk factors for pressure injuries.
3. State (4) signs/symptoms of a pressure injury.
4. Identify the importance of changes in skin.
5. State (4) treatments for pressure injury.
6. List (4) prevention strategies for pressure injuries.
7. Identify (2) professional sources for help with pressure injuries.

What is a pressure injury?

A pressure injury to the skin is a result of constant pressure due to impaired mobility. The pressure results in reduced blood flow and eventually causes cell death, skin breakdown, and the development of and open wound.

Pressure injury can occur in persons who are wheelchair bound or bed-bound, sometimes even after a short time (2 to 6 hours). If the conditions leading to the pressure injury are not rapidly corrected, the localized skin damage will spread to deeper tissue layers affecting muscle, tendon, and bone.

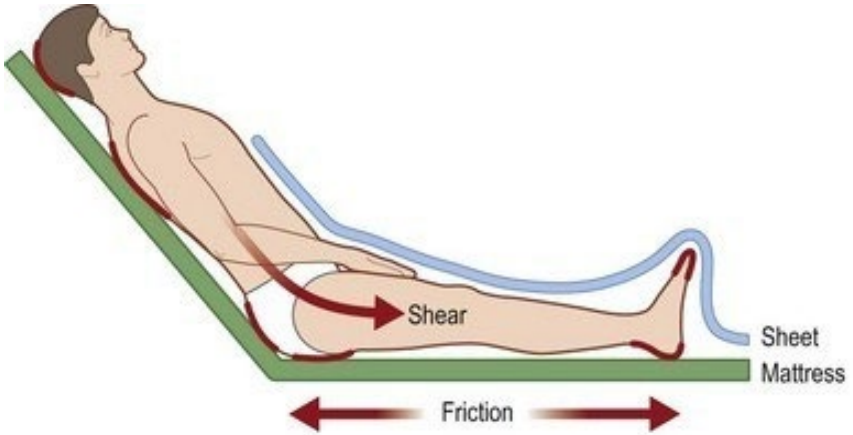
Common sites include the sacrum (tailbone), back, buttocks, heels, back of the head, and elbows. If not adequately treated, open ulcers can become a source of pain, disability, and infection.

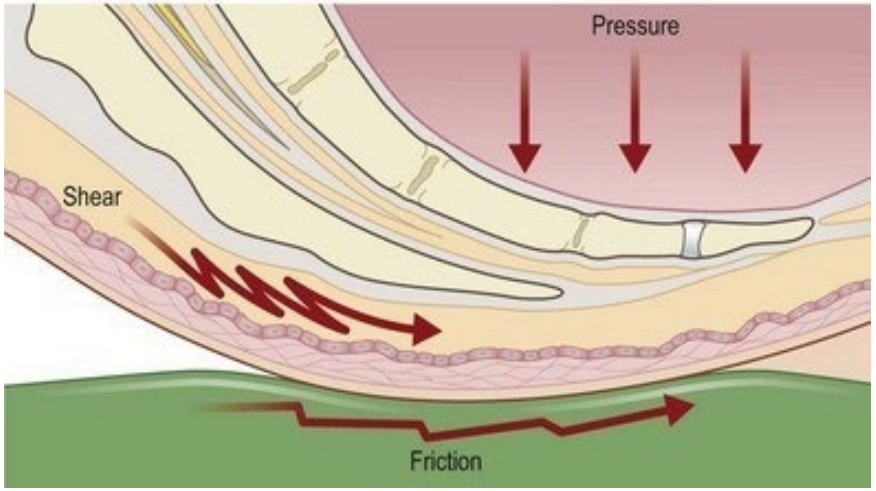
(Zeller, Lynm, & Glass, 2006)

Risk factors for pressure injury

- **Shearing and friction**
- **Moisture**
- **Decreased movement**
- **Decreased sensation**
- **Circulatory problems**
- **Poor nutrition**
- **Age**

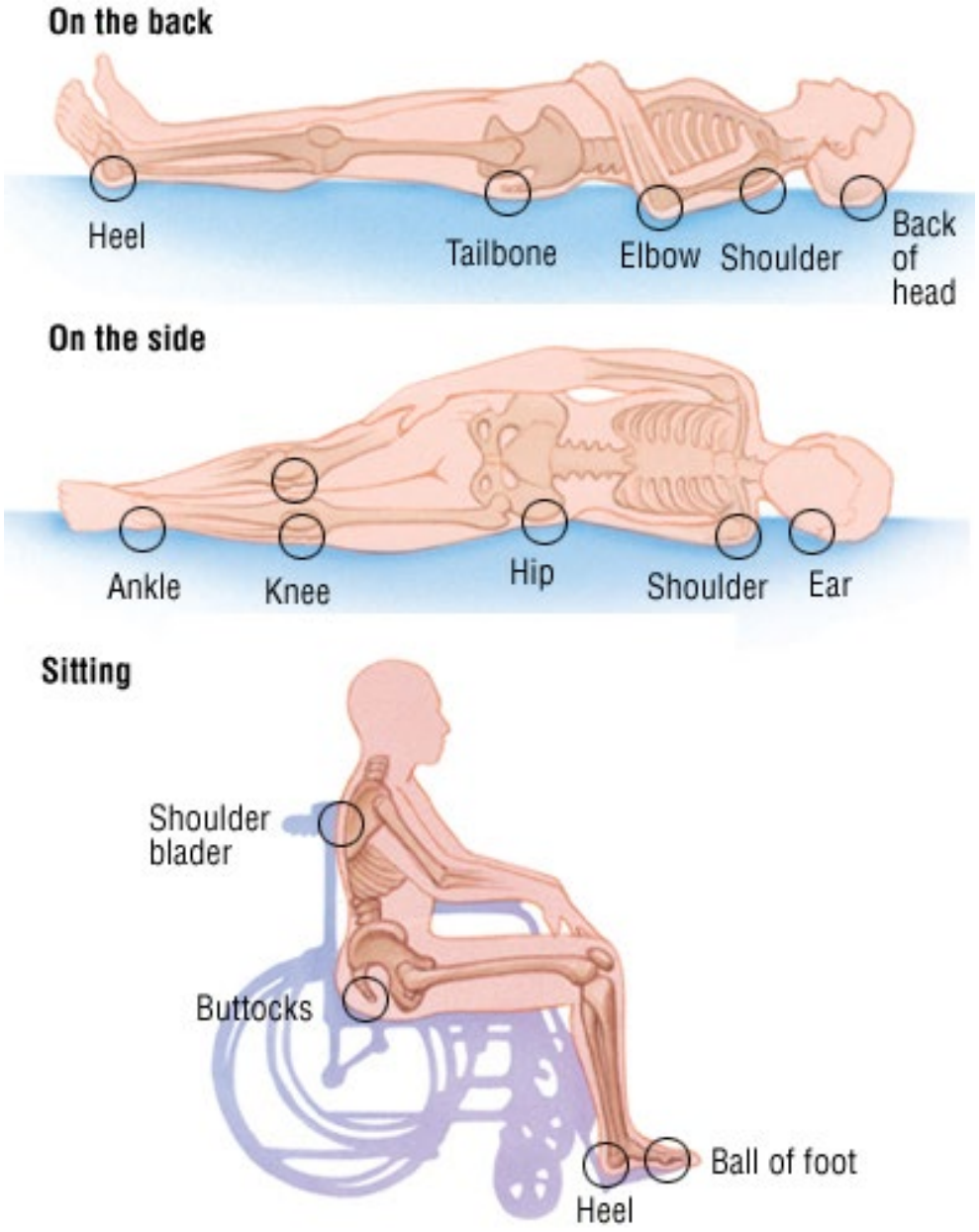
(Harvard Health Publishing)





Common sites of Pressure Injury

Any part of the body can develop pressure injuries, but most at risk are parts overlying a bony prominence.



Signs and Symptoms of a pressure injury

- Unusual changes in skin color or texture
- Swelling
- Pus-like draining
- An area of skin that feels cooler or warmer to the touch than other areas
- Tender areas

(Mayo Clinic, 2020)

❖ Changes in skin appearance should always reported to a physician as soon as possible

How pressure injuries are diagnosed ?

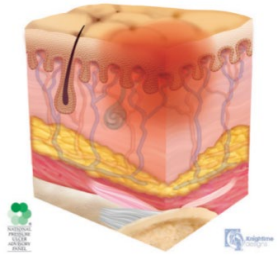
Pressure injury identification is supported by a variety of assessment tools. These tools include skin visualization techniques and risk assessment tools (Borzdynski, McGuiness and Miller, 2015).

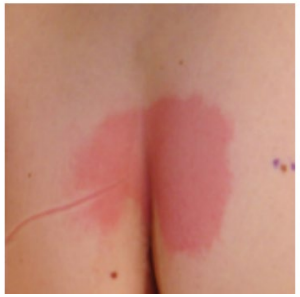
- The Braden Scale for Predicting Pressure Ulcer Risk, is a tool that was developed in 1987 by Barbara Braden and Nancy Bergstrom. The purpose of the scale is to help health professionals, especially nurses, assess a patient's risk of developing a pressure ulcer.
- The Norton risk-assessment scale which was published in 1962 as the first mean of evaluating pressure ulcers risk. The scale is used in the evaluation of pressure injury risk based on factors such as mobility or physical condition.

Healthcare professionals who can stage a PI include physicians, nurses and board-certified wound specialists. (Board certified wound specials arehealthcare professionals who have received additional training and education in order to set for a national board certification examination. (American Board of Wound Management, 2019).

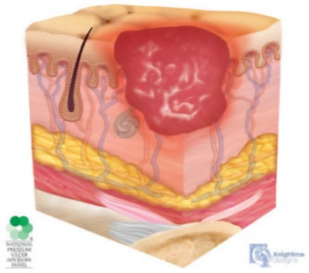
Pressure Injury Stages

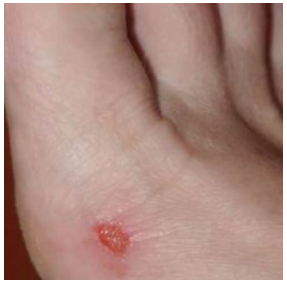
Stage 1: Skin is intact but red.



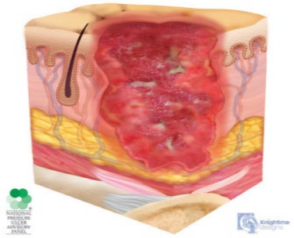


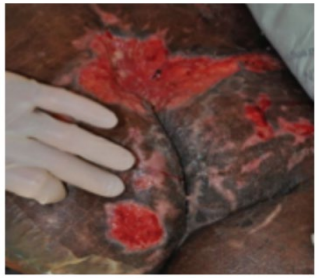
Stage 2: Skin is broken but there is no depth to the wound.



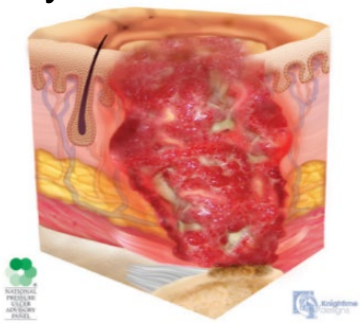


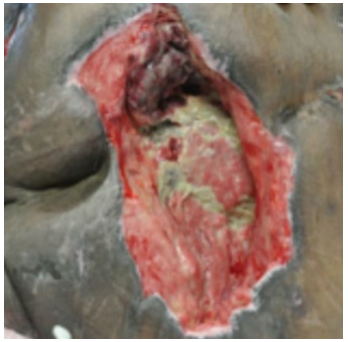
Stage 3: Skin is broken but there is obvious depth to the wound, fat tissue may be noted.



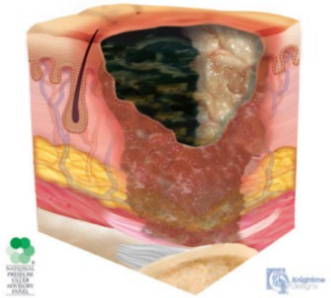


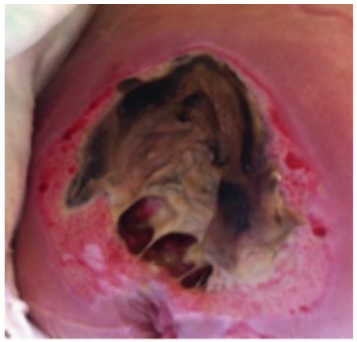
Stage 4: Skin is broken, muscle or bone may be visible.





Unstageable: Severe tissue loss is noted, wound may appear as empty hole.





Images by National Pressure Injury Advisory Council, 2019

Importance of reporting change

Many individuals with intellectual and developmental disabilities cannot report discomfort or pain. Being unable to reposition oneself or unable to ambulate is a risk factor for pressure injury. Evidence suggests non-verbal individuals are at a higher risk for under-treatment of pain. Identifying an individual is experiencing pain and treating it improves daily living, their ability to participate in enjoyed activities, and increases risk of depression (Lewis, 2011). Pain is a key sign of the presence of a pressure injury (McGinnis et al., 2014)

Any changes noted in color, temperature, or presence of skin breakdown should be reported immediately. To report a change contact the nurse. If nursing is not available, the individual should be taken to their PCP or an Urgent Care if issue is found on a weekend. Delay in seeking care can result in further injury and breakdown.

DSP's connect the dots…

Situation: Jessie reports to DS with a new pair of shoes. Today DS is goind to the dog park to put out liter bags. After the group returns at the end of the day, you notice that Jessie is frowning and limping. You ask her if something is wrong and she points to the new shoes. Jessie has diabetes.

Example only: follow your agency documentation standards.

Way to go DSP! You recognized a changed.

Example of a daily note: 4/16/20 3:00pm Returned to the DS center after an outing to refill the dog bags. Noticed that Jessie was not happy, she was frowning almost ready to cry. She indicated that her new shoes were hurting her feet. You assist her to take off her shoes, she had a large blister on the great toe of both feet, and a blister on both heels. DSP notified the DS manager.

DSP's connect the dots…

You are the boots on the ground. Based on your daily observations you may recognize a change in status that would require evaluation. If you notice any of the risk factors listed for pressure injuries, report and document them quickly.

Use the RAT tool to help staff recognize risks and prompt changes that need to occur with plans and support instructions. The RAT can assist providers to be proactive.

If the person does not meet criteria in Step 1 (above), consider if these common indicators for **pressure injury** (decubitus ulcer) occurred in the past year. (Check all that apply.):

- [ ] Regularly spends a majority of each day in a bed or chair, or wheelchair
- [x] Has experienced sensitive or fragile skin prone to injury or skin breakdown
- [ ] Has experienced an unexplained weight loss
- [ ] Has been unable to change body position independently
- [ ] Has experienced any incontinence (bowel or bladder)
- [x] Has diagnosis of diabetes
- [ ] Has the presence of any wound or skin breakdown
- [ ] Has presence of swelling of ankles or feet

Treatments for Pressure injury

Treatment begins with a physician and possible referral to a wound specialist. Each situation will be assessed individualized strategies implemented.

- ❖ Identify the source of pressure. Minimize pressure by utilizing wedges, frequent turning, and repositioning ever 2 hours.
- ❖Minimize shear and friction to reduce the damage to tissue.
- ❖Control moisture-skin should be kept clean and dry.
- ❖Pain management-pressure injuries are painful and may require oral medication for pain, especially around treatment times.
- ❖Barrier ointments should be used after incontinence episodes to protect skin.
- ❖Wound care may be required based on severity. Training for the nurse and staff on care in between appointments will be provided.

Prevention Strategies are critical!

Positioning- shifting weight at least every 2 hours

Specialty equipment- air and foam mattresses are available to redistribute weight, standers, specialized wheelchair with pressure relieving cushion.

Pillows-can assist in shifting weight and taking pressure off boney prominences.

Wedges- help with turning and repositioning and keeping boney areas off surfaces.

Keep skin clean and dry- washing the area with a product approved by the PCP or wound care. Skin should be free from urine, stool, and sweat.

Skin protectants-barrier creams and ointments help prevent breakdown in skin folds, perineum, and sacral areas. They protect skin from the corrosive nature of urine and feces.

Protocols- written by medical professionals for staff to follow to address positioning, use of DME equipment, and skin treatments.

Case Study- Meet John

Case Study

- John is a friendly and fun-loving guy. He is diagnosed with Cerebral Palsy, GERD, Diabetes insulin dependent, and chronic constipation. He is verbal and has a good sense of humor. He really loves going to his day program. John has slow movements and requires assistance to stand and pivot. If lying in the bed he can roll from side to side using the bed rails. When John becomes upset, he will wiggle out of his wheelchair onto the floor when staff are not looking. On the floor he refuses to let the staff help him back into his wheelchair. John has a behavior plan that states steps staff are to follow in the event John refuses to accept help. Today, John became very agitated when he could not go to his day program. John wiggled out of his wheelchair onto the floor. Staff tried to get him up, but he would slap at them and try to spit in their face. Finally, the staff gave up and told John to let them know when he was ready to get back in his chair.

- John sat in the floor for 3 hours. Finally, he asked for help and staff put him in on the bed. HIs clothes were wet due to incontinence. As staff provided hygiene and put on dry clothes, they noticed that John had two areas of red skin: one on his right cheek and the other on his left knee.

Apply what you've learned

Name three interventions that could have prevented John from developing pressure injury:

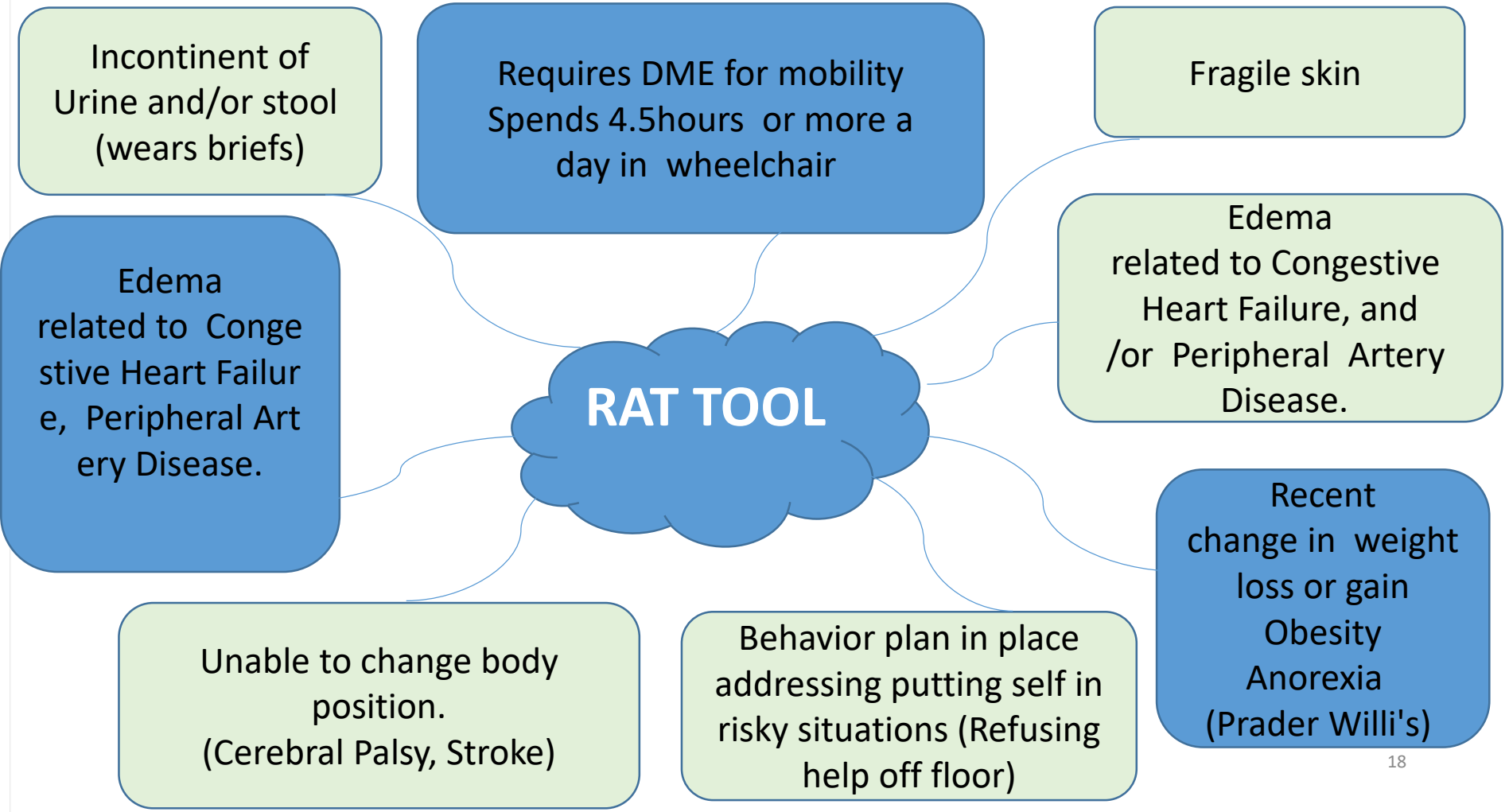
1._____
_

2._____
_

3._____
_

SC's connect the dots…

SC's- as you are completing the RAT tool keep in mind there are key diagnoses and situations you need to incorporate in discussion with providers and caregivers to ensure risk factors are being recognized.



Prior to ISP meeting, review discharge summaries, medical reports, and health history for information

Pressure Injury (decubitus ulcer) *describes injuries to skin and underlying tissue resulting from prolonged pressure on the skin.*

Step 1:

	Yes	No
The person has been diagnosed by a medical professional with a **pressure injury** (decubitus ulcer) in this past year.	☐	☐
If YES is checked above is there a plan for support? If yes, the plan for support and/or prevention must be included in the ISP. ***If YES is checked, skip Steps 2-5 and proceed to Section B - if NO is checked, complete Steps 2-5 below before proceeding to Section B.***	☒	☐

Step 2: If the person does not meet criteria in Step 1 (above), consider if these common indicators for **pressure injury** (decubitus ulcer) occurred in the past year. (Check all that apply.):

- ☒ Regularly spends a majority of each day in a bed or chair, or wheelchair
- ☐ Has experienced sensitive or fragile skin prone to injury or skin breakdown
- ☐ Has experienced an unexplained weight loss
- ☐ Has been unable to change body position independently
- ☐ Has experienced any incontinence (bowel or bladder)
- ☒ Has diagnosis of diabetes
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- ☐ Has presence of swelling of ankles or feet

Step 3: Based on the above selected risk indicators, a referral to a qualified professional is needed to evaluate and help develop a plan to reduce the risk of **pressure injury (decubitus ulcer)**. ***If no risk indicators were selected, go to Section B.***

Step 4: What qualified professional has been identified to help? _____

Step 5: Who will contact them? _____

Target Date: _____

During the ISP meeting ask all participants if they are aware of any risk factors listed in Step 2

Think about all settings: home, Day Support, Community Engagement

Pressure Injuries continued...

Who Can Help?

There are a number of healthcare professionals that can provide guidance toward reducing risk and possible adverse events. The PCP is the gate keeper to accessing other healthcare professionals.

Healthcare professionals that can assess, diagnose and prescribe treatment that include but are not limited to:

- Primary Care Practitioner (PCP)
- Registered Nurse
- Wound Care Clinic
- Board Certified Wound Specialist

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