PROMOTING SKIN INTEGRITY AND PREVENTING PRESSURE SORES .....IS EVERYONE'S RESPONSIBILITY

Curriculum

Developed by The Office of Integrated Health

Virginia Department of Behavioral Health & Developmental Services

"Promoting Skin Integrity and Preventing Skin Breakdown"

Welcome to a learning opportunity offered by the Department of Behavioral Health and Developmental Services', Health Supports Network designed to help you provide new knowledge and skill development to the staff and families your organization supports so that they can provide quality care to persons with developmental disabilities.

This curriculum is designed to help your staff add to the baseline education they received during orientation and should be used in a person centered way when working with individuals you support. The information should help facilitate good discussions and aide in the development of Individual Support Plan Objectives under Health and Safety for those who are at risk of skin breakdown by promoting healthy habits for daily skin care, nutrition, hydration and movement. These quality interventions can reduce the chances for complications such as decubitus ulcers and skin infections.

Curriculum:

As participants sign in, obtain current emails and name of the provider where each participant works if not employed by your agency. Hand them the Pre-Test (Attachment 1) and ask them to complete it before the presentation starts; collect the tests before you start the program. (Remind them to place their name on the top.)
(Please forward the Sign in Sheets to susan.rudolph@dbhds.virginia.gov)

1. Welcome Participants: (Use a positive and appreciative introduction to staff and families).
2. Remind participants to hand in their Pre-tests if they have not already.
3. Introduce educators and the purpose of the seminar and how by following some simple steps they can improve the lives of people with disabilities. Discuss how **everyone** has the responsibility to provide the correct support to those in their care and ask them: Why is this important to you? (Take a few minutes to understand their motivation for being at the seminar).

Part 1: Healthy Skin Is Important; Keeping Skin Healthy; Why Do Skin Infections Happen?

Activity #1: Ask everyone to sit in the same position without moving for 5 minutes. Set your alarm on your iPhone. Continue with the presentation reminding people to remain still. When the 5 minutes is up ask them how they felt? Ask them to imagine staying in one position for an hour or more, could they do it?

Part 2: What Is A Pressure Sore? What Causes Pressure Sores? Common Pressure Points where breakdown often occurs.

Activity #2: Demonstrating the Effects of friction and Shear on the Body: Break out in to two groups and observe the proper and improper ways to move a person in a bed, and in wheelchairs. Focus on friction and shear. (See Appendix A)

Part 3: Who Is At Risk for Pressure Sores? What are Risk factors?

Activity # 3: Checking for Incontinence and Changing a Soiled Brief: Break up in to groups and demonstrate how to change a wet brief without causing shear or friction, how to apply lotions and creams. Have a few volunteers change a brief with the dummy lying in bed, use a sling for a lift and a slide board correctly. (See Appendix B)
*You could substitute a video and then practice this skill. The trainers will need to demonstrate competence with this skill.

Part 4: Complications from Pressure Sores, Severe Complications and Signs of Sepsis.

Activity # 4: Completing a skin check and reporting ALL Changes. Skit (See Appendix C).

Part 5: When Complications Happen, Stages of Pressure Ulcers

Activity #5: Professionals Commonly Involved In Healing Skin Breakdown. Complete Matching Game (See Appendix D)

Part 6: Using the Braden screening tool and Standard Measurement Tools. Demonstrate and pass examples of the tools around. Discuss how they can help with planning and prevention. (See Appendix E)

BREAK: Talk again about good nutrition and hydration and have protein rich snacks and water available.

Part 7: Prevention, Prevention Class discussion of how this care is reflected in Protocols and the I.S.P.

Part 8: Proper Skin Care

Activity # 7: How to properly wash skin; apply creams and lotions as prescribed and Barrier Ointment Demonstration. (See Appendix F)

Part 9: Proper Wheelchair and other DME care and maintenance. Demonstrate on an actual wheelchair. Have participants practice.

Part 10: Other Interventions: Nutrition and Hydration:

Part 11: Report Any Change (You cannot say this enough!)

Part 12: Document, Document. Write note together, show checklists for wheelchair care, Show examples of Intake and Output records, Diet logs, etc. Show them an example of a Part 2 of the ISP where these risks are documented and an Outcome written that addresses skin integrity.

Part 13: Answer Questions

After questions:

14. Hand out Post-tests. (Same as Pre-test)

15. Collect Post-Tests and give Certificates once they hand you the completed test. (Check to make sure name is on it)

16. Review Test Questions

17. Thank everyone for coming. Grade tests, compare pre-test grade to posttest grade and send results (See Form Attachment 6) back to Susan Rudolph, RN at susan.rudolph@dbhds.virginia.gov please.

18. Place a copy of their certificate of completion in each employee file.

References:

Berkowitz, D. et al. (2014 October). Preventing pressure ulcers in hospitals: A tool kit for improving quality care. Agency for Healthcare Research and Quality. Retrieved from: https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html

Pressure ulcers: Prevention and management of pressure ulcers. (2014) National Guideline Clearinghouse. Retrieved from: https://www.guideline.gov/search?q=pressure+ulcers

Health care protocol: Pressure ulcer prevention and treatment protocol. (march 2014). Institute for Clinical Systems Improvement. Retrieved from: https://www.icsi.org/_asset/6t7kxy/PressureUlcer.pdf

Park-Lee, E. Caffery, C. (2009, February). Pressure ulcers among nursing home residents: United States, 2004. National Center for Health Statistics. Retrieved from: www.**cdc**.gov/n*c*hs/products/databriefs/db14.htm

Sandra M. Nettina. (2010). Manual of Nursing Practice [Woltz Kluwer Health] Lippincott Williams & Wilkins · (8th ed.,rev.) Ambler Penn.

Attachment 1

Pre- Post Test

Promoting Skin Integrity and Preventing Skin Breakdown

1. The longest anyone should remain in one position is _____?

2. The largest organ in the body is the _____?

3. You should always turn a person so there ankles are touching each other when the person is on their side. ____T _____F

4. The best way to prevent bedsores or help them heal faster is with good hydration, good _____ and frequent _____.

5. Skin provides the following functions? _____,_____, _____.

5. A supervisor can stage a wound and provide guidance on wound care? ____T ____F

6. If you think someone else reported a red area on the skin, you don't have to report it, just document on it? ____T _____F

7. A Decubitus ulcer or bedsore can go all the way to the bone but it takes months for this to occur? _____T _____F

8. When helping someone move up in bed you should stand at the top of the bed and pull them up towards you. ____T _____F

9. A brief should be checked every shift for dampness or soiling and be changed. _____T _____F

10. The following areas are prone to breakdown? _____, _____.

11. Bedsores are 100% preventable? _____T _____F

12. Name 4 items you will need to give a bath in bed. _____,_____, _____, _____.

13. Barrier creams rarely work to prevent bed sores but are good for treating rashes. _____T _____F

14. Nurses are the most common professional involved in treating wounds and decubitus ulcers? _____T _____F

15. Only the nurses and supervisors are responsible for preventing bedsores/decubitus in people with disabilities. ____T _____

Attachment 2

Promoting Skin Integrity and Preventing Skin Breakdown

Pre- Post Test Answer Key

1. The longest anyone should remain in one position is ___2 hours

2. The largest organ in the body is the _Skin_____?

3. You should always turn a person so there ankles are touching each other when the person is on their side. ____T __X___F

4. The best way to prevent bedsores or help them heal faster is with good hydration, good _nutrition_____ and frequent _repositioning_____.

5. Skin provides the following functions? _is a barrier to infection, __assists with hydration, provides sensory input, protects from heat and cold, regulate temperature, stores fat and water to act as a shock absorber for the organs.

5. A supervisor can stage a wound and provide guidance on wound care? ____T _X_F

6. If you think someone else reported a red area on the skin, you don't have to report it, just document on it? ____T ___X__F

7. A Decubitus ulcer or bedsore can go all the way to the bone and it takes a short amount of time for this to occur?

__X___T _____F

8. When helping someone move up in bed you should stand at the top of the bed and pull them up towards you. ____T ____X_F

9. A brief should be checked every shift for dampness or soiling and be changed. _____T ___X__F

10. The following areas are prone to breakdown? _Boney prominences, coccyx, buttocks and hips__(Any two will be correct)

11. Bedsores are 100% preventable? __X___T _____F

12. Name 4 items you will need to give a bath in bed. __water_,__soap, __wash cloth, towel, sheet, blanket, basin, shampoo.

13. Barrier creams rarely work to prevent bed sores but are good for treating rashes. _____T ____X__F

14. Nurses are the most common professional involved in treating wounds and decubitus ulcers? ___X__T _____F

15. Only the nurses and supervisors are responsible for preventing bedsores/decubitus in people with disabilities. ____T ___X__

Attachment 3

Promoting Skin Integrity and Preventing Skin Breakdown

SIGN IN FORM

Name	Address	Phone #	E-Mail	Agency

Job Title: ❑ Direct Service Provider ❑ Nurse ❑ Administrator ❑ Other: _____

_____

How many years have you been working in the Developmental Disabilities field? _____

Please rate the following using the scale below:

SA = Strongly Agree	A = Agree	N = Neutral	D = Disagree	SD = Strongly Disagree	
Course Objectives					
As a result of participating in this course, I am better able to:					
State why skin integrity is important and three ways to promote good skin health and prevent decubitus.	SA	A	N	D	SD	N/A
Identify when there is a problem with skin and know when and how to report the issue.	SA	A	N	D	SD	N/A
Identify and/or demonstrate procedures appropriate for providing skin care while bathing and changing incontinent briefs of a person with personal care assistance needs.	SA	A	N	D	SD	N/A
Attendee Benefits					
I plan to apply this information to my daily work.	SA	A	N	D	SD	N/A
I gained an additional understanding about Skin Care and Decubitus Prevention and Treatment.	SA	A	N	D	SD	N/A
My personal objectives for attending this event were met.	SA	A	N	D	SD	N/A
Speaker					
Material was presented in a clear and understandable manner.	SA	A	N	D	SD	N/A
Course topics were well organized.	SA	A	N	D	SD	N/A
The presentation included comprehensive and current information.	SA	A	N	D	SD	N/A
I found this topic very informative:					
Promoting Skin Integrity and Preventing Skin Breakdown	SA	A	N	D	SD	N/A

Please rate the following using the scale below:

SA = Strongly Agree	A = Agree	N = Neutral	D = Disagree	SD = Strongly Disagree	
Overall Program					
The teaching methods were effective.	SA	A	N	D	SD	N/A

Attachment 6

"Promoting Skin Integrity and Preventing Skin Breakdown"

Learning Tracking Form

Date of class	Average Pre-test Score	Average Post-test Score	Difference

Send report to:

DBHDS

Office of Integrative Health

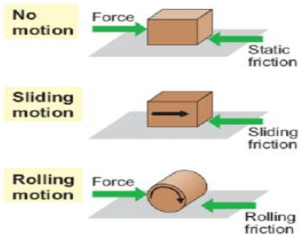
Health Supports Network

Susan Rudolph, RN at susan.rudolph@dbhds.virginia.gov

APPENDIX A

ACTIVITY # 2

DEMONSTRATION OF THE EFFECT OF FRICTION AND SHEAR ON THE BODY



Purpose: To demonstrate best practices in providing positioning for those people at risk of bedsores and to learn how to avoid common pitfalls.

(This presentation does not replace specific skills training required by licensing which meets the needs of the person served. Competency in all skills should be determined by a Registered Nurse, Occupational or Physical Therapist prior to the staff person providing care.)

Equipment needed for the purpose of demonstrating the effects of pressure, friction and shear.

- Bed, stretcher or table
- Two sheets
- Chucks if available
- First Aid Dummy. Large stuffed animal
- Pillows and wedges if available

INSTRUCTION: While one person is speaking the other helpers are demonstrating. Have two other educators demonstrate how to properly place a draw sheet and use it to move a person in bed.

Friction:

- Place a stretcher or bed made up with a model lying on a sheet on the bed.
- Instructor pulls the person up in bed showing how friction occurs. (Place arms under armpits and pull up in bed.) If possible place microphone by the sheet so the audience can hear the scraping.)
- Instructors then place a draw sheet under the person and demonstrate the proper use of the draw sheet to pull a person up in bed without causing friction and to turn them from side to side. (Arizona Medical Technical Institute)

- (Note to mention: that there is good friction when you wash your hands and rub skin with lotion but bad friction occurs when you are dragged across a surface).
- Instructors place arms under upper back and under knees and lifts person up in the bed. (Loyola University online; Proper Patient Lifting Techniques for Nurses)

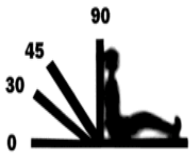
Demonstration:

- Gather Supplies: draw sheet, chux, towels, wash cloth
- Talk to the person and explain what is going to happen and receive permission if possible.
- Wash hands
- Lock the wheels of the bed
- Put up the bedrail on the opposite side of the bed
- Raise bed to hip level
- Bring Draw sheet close to the person on both sides
- Properly get in to a position of strength to lift up and then up again using the draw sheet.
- Bend top leg forward and arrange one arm across waist and the other up by the head.
- Pull draw sheet with person over on to side
- Place pillows comfortably under back and between legs

Shear:

INSTRUCTION: Demonstrate how a person sinks down in bed and skin remains stationary while the bones move down.

- Demonstrate how a person is sitting in semi fowlers position in bed without knees notched



(Upright at 90 degrees is full or high Fowler's position. Other Fowler's positions are tilted back.)

- Show how they will slowly sink down in the bed while their skin remains stationary.
- Discuss the effect this has on the skin and underlying tissue.
- Discuss how proper positioning with pillows and appropriate head elevation can prevent this from happening. Demonstrate.

Wheelchair positioning to prevent shear and friction

INSTRUCTION: Demonstrate the proper way to move a person in their wheelchair to prevent friction and shear.

- Have the instructor talk about the importance of proper movement in a wheelchair.
- Demonstrate pulling a person up their chair by placing arm around back and under knees with another person and lifting them up.
- Demonstrate proper placement of feet in the foot rest.
- Demonstrate the proper cushion placement and recognizing signs of wear.
- Demonstrate how to use the tilt in space mechanism.

Video Resources:

There are many You Tube videos on the web. Here are a few examples of You Tube videos that you may want to review and see if they meet your needs.

https://www.youtube.com/watch?v=zZ4zoIfUgc4uction:

http://cnatraininghelp.com/cna-skills/positioning-a-patient-on-their-side/

https://www.youtube.com/watch?v=Mz-akrQY3gY

https://www.youtube.com/watch?v=9VKox-wy4fU

https://www.youtube.com/watch?v=XZNtrYEN_uw

Checklist Example:

http://people.westminstercollege.edu/students/ncb0708/Program%20Files/FA%20Davis/Fundamentals%20of%20Nursing%20ESG/proc_check/pc_ch31-08.pdf

APPENDIX B

Activity # 3

Checking for a Soiled Brief and Changing a Soiled Brief for a Person in Bed.

PURPOSE: To reinforce prior learning on the reasons for keeping skin clean and dry, and maintaining proper body alignment in the prevention of decubitus ulcers.

SUPPLIES:

- Incontinent brief
- Gloves
- Cleansing Spray
- Wipes
- Pillows (4)
- Towel
- Draw Sheet

Steps:

- ✓ Gather Supplies
- ✓ Let the person know that you are going to change their brief; continue to let them know what you are going to do next throughout the process.
- ✓ Wash hands
- ✓ Put on Gloves
- ✓ Lock wheels of bed
- ✓ Put bedrail up across from you if one is there otherwise have another person on other side of bed.
- ✓ Place bed at waist height
- ✓ Using draw sheet move person closer to you
- ✓ Align the persons hips and shoulders
- ✓ Bend top knee (if possible) and move arm closest to the mattress upward if possible.
- ✓ Using draw sheet and hand on shoulder and hip turn the person on their side.

- ✓ Remove soiled diaper
- ✓ Inspect skin
- ✓ Wash skin from front to back with wet warm wash cloth and spray or wipe
- ✓ Inspect cleaned skin again
- ✓ Apply barrier cream as ordered
- ✓ Replace incontinent brief and draw sheet if soiled
- ✓ Roll the person towards you and have the person on the other side repeat the process.
- ✓ Assure all wrinkles are out of the sheets and draw sheet
- ✓ Use pillows to position the person on their side.
- ✓ Place call bell close to them
- ✓ Maintain proper bed elevation as prescribed
- ✓ Lower bed to its lowest position
- ✓ Put up bed rails if applicable
- ✓ Ask the person if they need anything
- ✓ Set timer for 15 minute checks
- ✓ Report any changes immediately to your supervisor or a health care provider
- ✓ Document

LEARNING:

- Checking briefs frequently for incontinence and changing them immediately reduces the chance of skin breakdown.
- Proper positioning while changing a person reduces friction and shear especially when the brief is already wet.
- Careful skin inspection alerts the staff to problems early so steps can be taken to reduce the chance of the issue causing a bedsore.
- Using wipes with special cleaners allows for thorough cleaning without drying out the skin.
- Barrier creams protect the skin from urine and feces
- Proper positioning protects the skin and boney prominences and contributes to the persons comfort.

APPENDIX C

ACTIVITY #4

Completing a Health Screening and Reporting All Changes

Purpose:

To identify reasons why people do not report changes and the consequences of those decisions on the person they support, their agencies and themselves.

Demonstration - SKIT:

Have three instructors and people from the audience to play out the scenarios and a model or doll as the person served.

Individual: Mary Smith
Staff #1: _____
Staff #2: _____
Supervisor: _____
Doctor: _____
Nurse: _____
Staff for home: (3) _____ _____ _____

Scene: *Mary's bedroom. Mary is on her side with a red piece of felt or paper over the hip area.*

Staff #1 is changing her brief and notices the red area on the hip. She looks at it and states "I'm sure this has been here so I'm sure someone else reported it. It will be fine."

Supervisor calls Staff #1 on the phone and lets her know the night staff called out sick and asks her to do a double shift.

Staff #1 agrees and again changes the individual and ignores the red area then allows her remain on her affected hip for the 4 hours during the night when she is not turned so she can rest per her health care providers orders.

Next morning Staff #1 is very tired and says to Mary "Have a good day Mary, I'll see you tonight." Mary is now dressed and leaves for her day program in her wheelchair. Staff #1 only charts Mary had a good night no issues, turned as prescribed. She does not report the red area to the day staff.

Staff #2: After two hours at Day Support the individual is taken in to the bathroom to be changed. The area on her hip is now red and the skin is broken.

Staff # 2 states "I need to call my supervisor immediately and we need to call her doctor". She calls her supervisor and they contact the doctor who asks for them to bring Mary in immediately.

Doctor: "We need to keep Mary off this hip; she needs to be followed by a nurse so I am ordering Home Health starting right now. She also needs to be seen by a nutritionist to increase the amount of protein in her diet and increase her fluids". Call this number to set it up and ask them to start right away. This should never have happened, who do I report this neglect too? He calls Human Rights and Adult Protective Services and reports possible neglect. He tells the supervisor how disappointed he is with her program.

Home Health Nurse arrives at the home and the Supervisor and Staff from other shifts are there with Mary.

Home Health Nurse: Nurse completes the assessment and reviews the chart (uses paper ruler) and states the Decubitus is at a Stage 2. She looks at the Protocol and is questioning why the Protocol was not followed and states "I think they must have ignored her symptoms and I need to report this as neglect. She calls Human Rights and Adult Protective Services". Mary is moaning softly as the area is cleaned and dressed. The nurse then states "thank goodness for the staff at Day Support for reporting this when she did. It could have been a much deeper wound if she hadn't". Now it will probably take three weeks to heal and be painful for a while. Please make sure Mary receives her Tylenol for pain as directed.

Supervisor calls in Staff #1 and asks about the hip area and she states she was aware but thought someone else had reported.

Staff #1: states, "she is very sad and promises never to do that again and that she will always report."

The Supervisor states "It is no longer up to us as Adult Protective Services is investigating. You are suspended until their investigation is complete. If they charge our agency with neglect you will be terminated.

Staff #1 walks out crying and says over and over "why didn't I just pick up the phone?" "I failed Mary".

Home Health Nurse to Staff from the Group Home: "Since you all will be changing Mary and providing her care, I would like to teach you how to change the dressing on her hip if it becomes soiled in between my visits. Do you think you can do this?

Staff for the Group Home agrees and the nurse demonstrates how to change the dressing, what to look for and when to call her. She writes all of the instructions down and signs off that all of the Staff except one who kept contaminating the site are competent and can change the dressing. She signs them all of on the bottom of the Protocol.

She leaves her contact information and tells the staff she will be in every other day to assess the area and give further instructions.

PROCESSING THE EVENT - Question and Answer

- Ask the audience how they feel about what happened? Put feelings up on the board.

- Was the Nurse correct that she could state what stage the decubitus was? (Yes, RN's often stage wounds and provide the care per the health care provider's prescription and write the Protocols for positioning and personal care."

- Was Staff #1 responsible? If so, what should happen to her?

APPENDIX D

Activity # 5

Professionals Involved in Wound Management including Decubitus Care

Purpose: To help recognize the members of the health care team usually associated with the treatment of decubitus ulcers.

Directions: match the discipline to the role they play on the health care team.

MATCHING

Primary Care Practitioner	**Provides guidance on mobility**
Registered Nurse	**Provides the wound care**
Certified Wound Specialist	**Guides the treatment process**
Nutritionist	**Provides guidance on ADL's**
Physical Therapist	**Provides information on diet**
Occupational Therapist	**Does surgical closure**
Wheelchair Clinic	**Prescribes the treatment**
Plastic Surgeon	**Re-fits wheelchair or seating**
DSP	**Provides daily care and reports all changes**

APPENDIX E

Activity #6

Tools

Braden Scale:

http://www.ouhsc.edu/geriatricmedicine/Education/pu/braden_scale.htm

Wound Tape Measurers

http://www.bing.com/images/search?q=wound+tape+measure+printable&qpvt=wound+tape+measure+printable&qpvt=wound+tape+measure+printable&qpvt=wound+tape+measure+printable&FORM=IGRE

APPENDIX F

Activity #7
Skin Care and Bathing

PURPOSE:

It is important to keep the skin clean and dry to reduce the risk of skin break down and pressure sores. Good bathing practices are essential to this effort.

Common Steps in Best Practices

Supplies generally needed:

Personal mild soap or prescribed skin cleanser	Gloves
Prescribed body lotion or barrier ointment	Clean clothing
Personal or prescribed deodorant	Brush or comb
Personal shampoo or prescribed medicated shampoo	Wash cloth and towel

Other toilet articles if requested or prescribed

Avoid bath oils – they make the floor slippery and increase risk of falls

Steps:

- ✓ Explain the procedure to the person and provide privacy
- ✓ Eliminate drafts as able to maintain warm room temperature
- ✓ Adjust water temperature prior to person entering shower or bath
- ✓ Wash your hands and put on gloves *(if contact with blood, body fluids, secretions or excretions is likely)*
- ✓ Wash or assist the individual to bathe starting with the face and moving to their toes (Do not use soap around their eyes – wash with warm water and a clean cloth)
- ✓ Use personal mild soap or prescribed cleanser and warm water, rinse thoroughly
- ✓ When possible, encourage the individual to wash the breast and genital area
- ✓ If preferred, gently massage their back.
- ✓ Inspect skin daily - Daily Health Checks
- ✓ Report any changes in the skin that are observed as per provider policy
- ✓ Gently pat dry (DO NOT RUB this can lead to skin breakdown)
- ✓ Apply lotion and or barrier ointments to warm dry skin as prescribed

- ✓ Use a figure 8 motion to massage and apply lotion
- ✓ Never massage over an area of skin that is reddened or where there is skin breakdown
- ✓ Remember to wash your hands when gloves are removed
- ✓ Dress or Assist the individual to dress. Assist with putting on personal incontinent product such as incontinent briefs when ordered - **never double diaper**
- ✓ Complete or Assist with hair care and grooming

Reference: excerpts from: Mosby; 2000

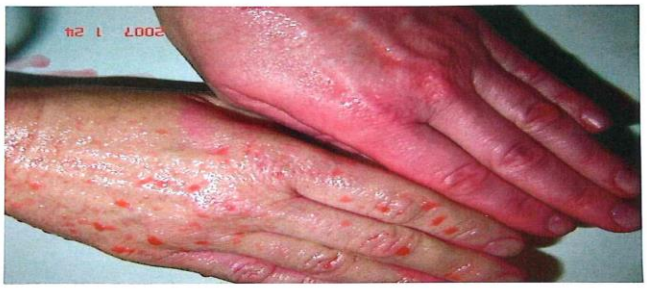
Additional Information: Giving a Patient a Bed Bath: www.youtube.com/watch?v=hYXYcOHT6aE

Barrier cream exercise: Apply barrier cream to one gloved hand and nothing to the other. Place hands in tinted water and observe how the barrier cream repels the water and the other does not.

ACTIVITY #7 **Importance of Barrier Ointments**

Both hands submerged in colored liquid:

Notice which hand had barrier ointment applied:



Source of pictures: "Meet me at the Skin Fair" Jeri Ann Lundgren, RN, CWS, CWCN

Can be found on line