DOCUMENTATION, INTERVENTIONS & PRESSURE ULCER PREVENTION

BGMC & BMDACC

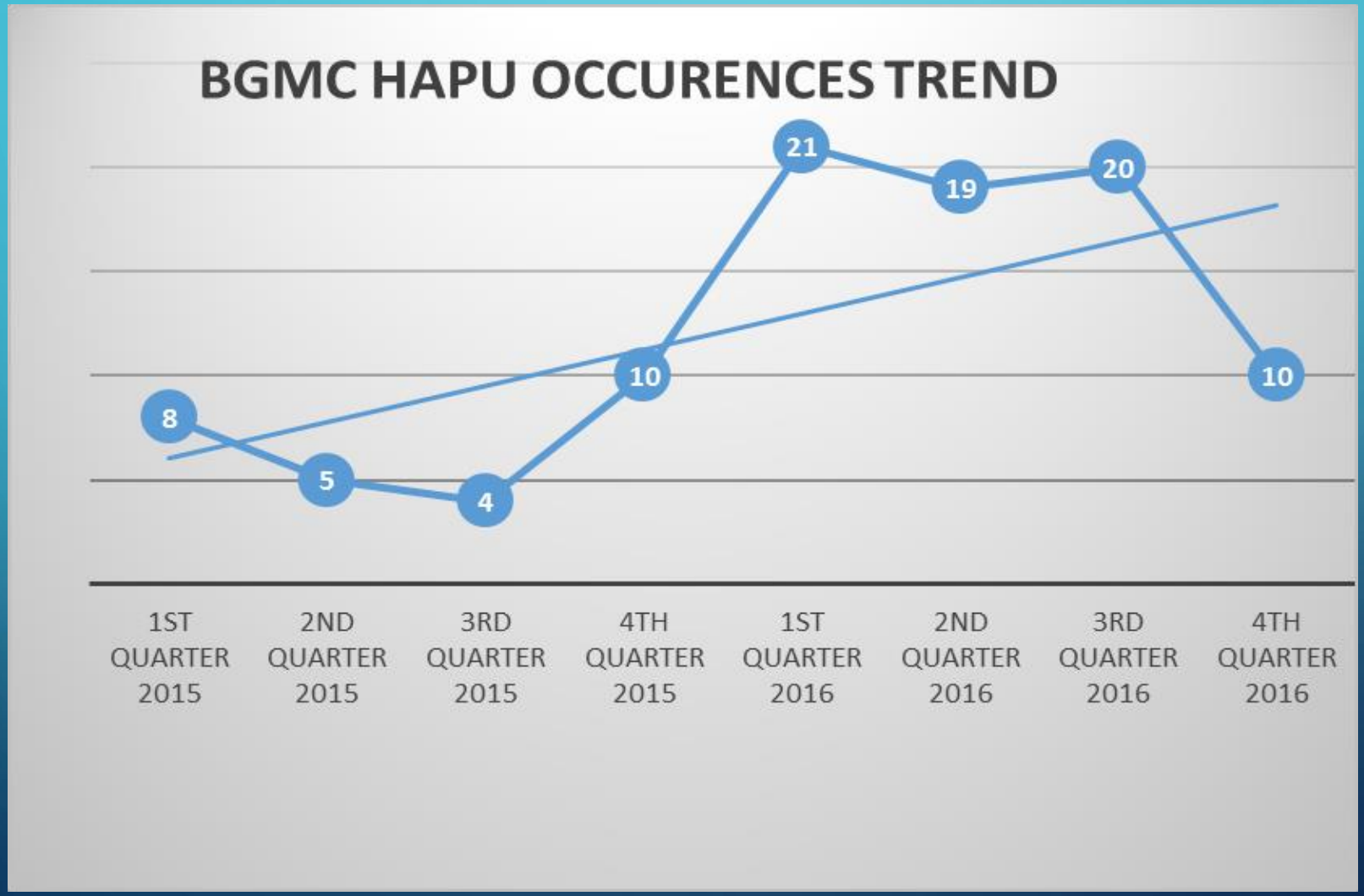
SHONA HUTTON BSN RN CWS CWOCN

MICHELLE RODRIGUEZ, BSN, RN, CWS

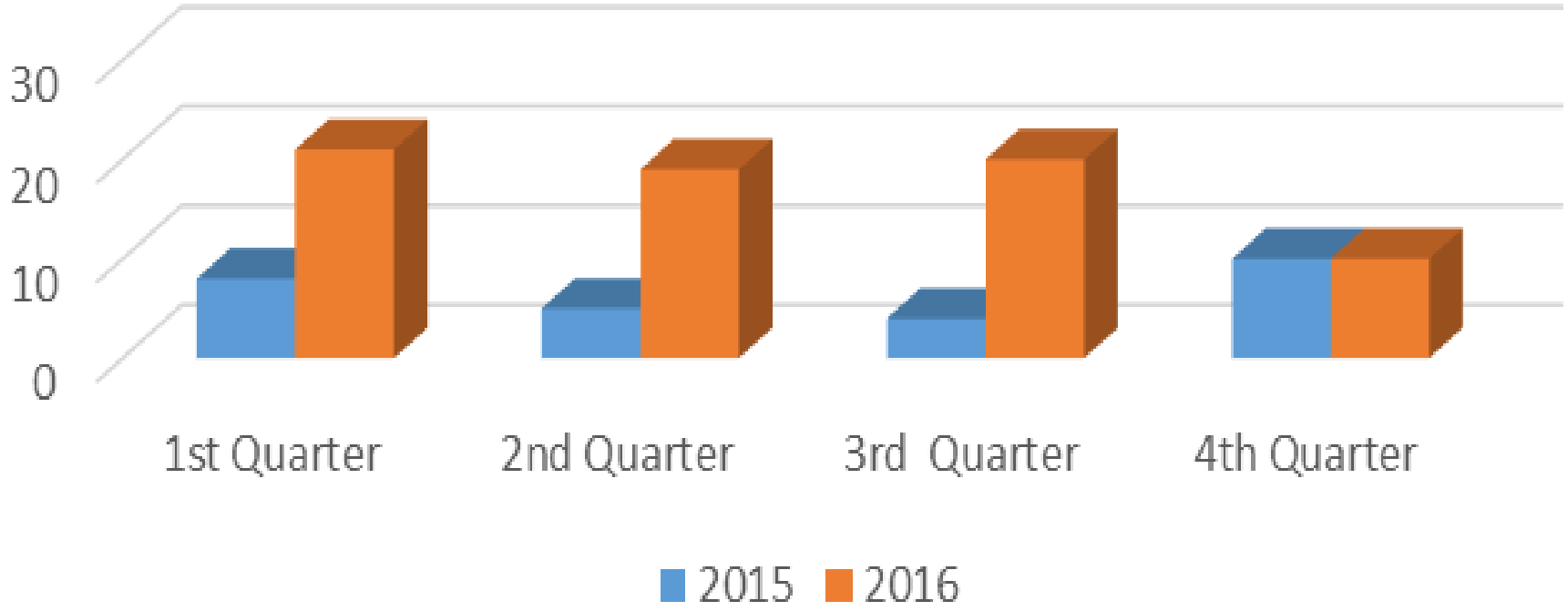
DEB SELEEN MSN, APRN, AGCNS-BC, OCN

MIRIAM JENSEN, BSN, RN, CWON

THE DOWN AND DIRTY…



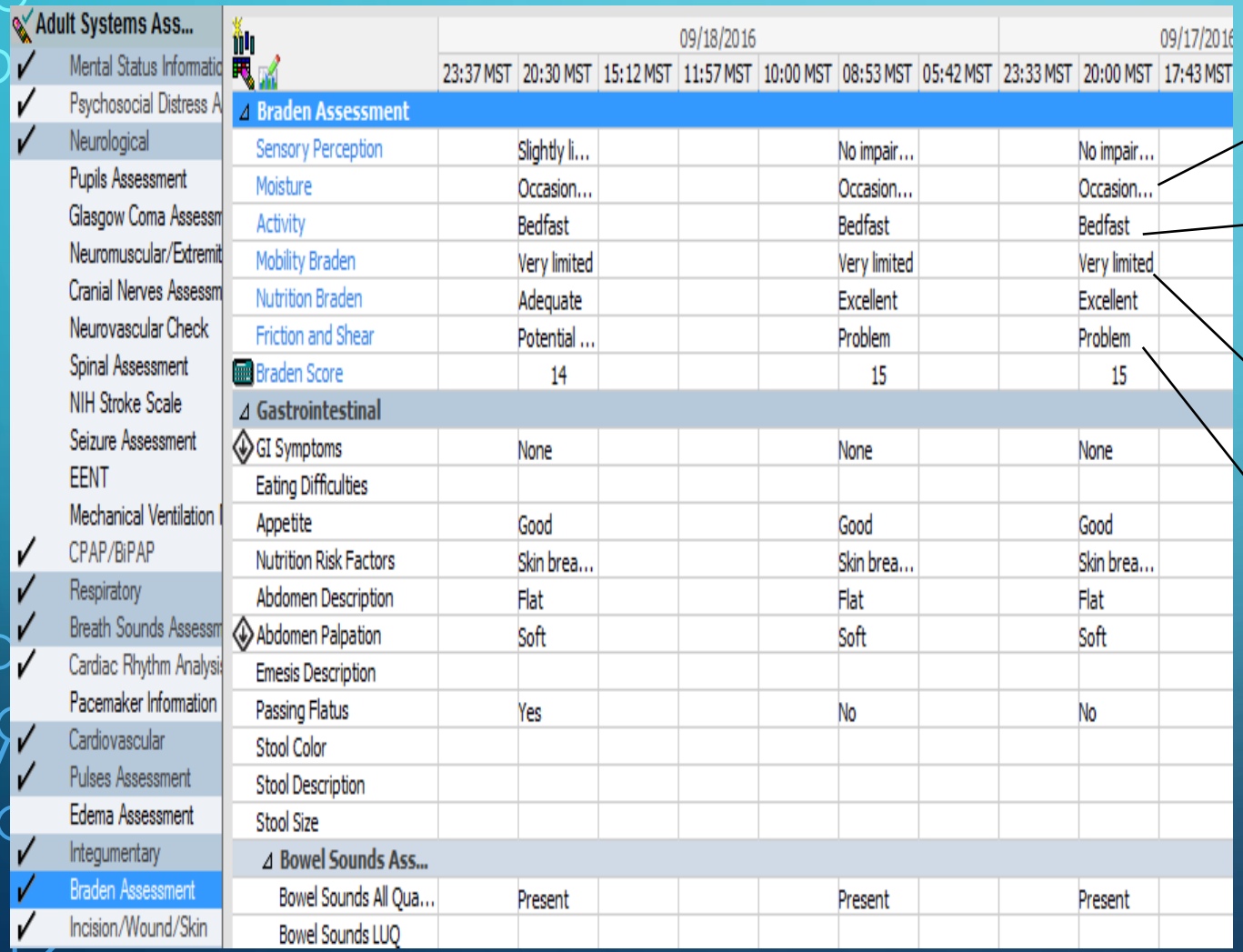
BGMC HAPU OCCURENCES 2015 to PRESENT



PRESSURE ULCER COSTS

- CMS no longer reimburses for Hospital Acquired Pressure Ulcers (HaPU)
- It is estimated that:
- > 2.5 million people develop PU's each year
- PU's cost between $9-$11 billion each year
- PU adds $43,000 to a hospital stay (2007)
- Second most common reason for lawsuits after wrongful death – 17,000/year
- **60,000** patients **die** as a result of **HAPU**

WHEN TO DOCUMENT INTERVENTIONS

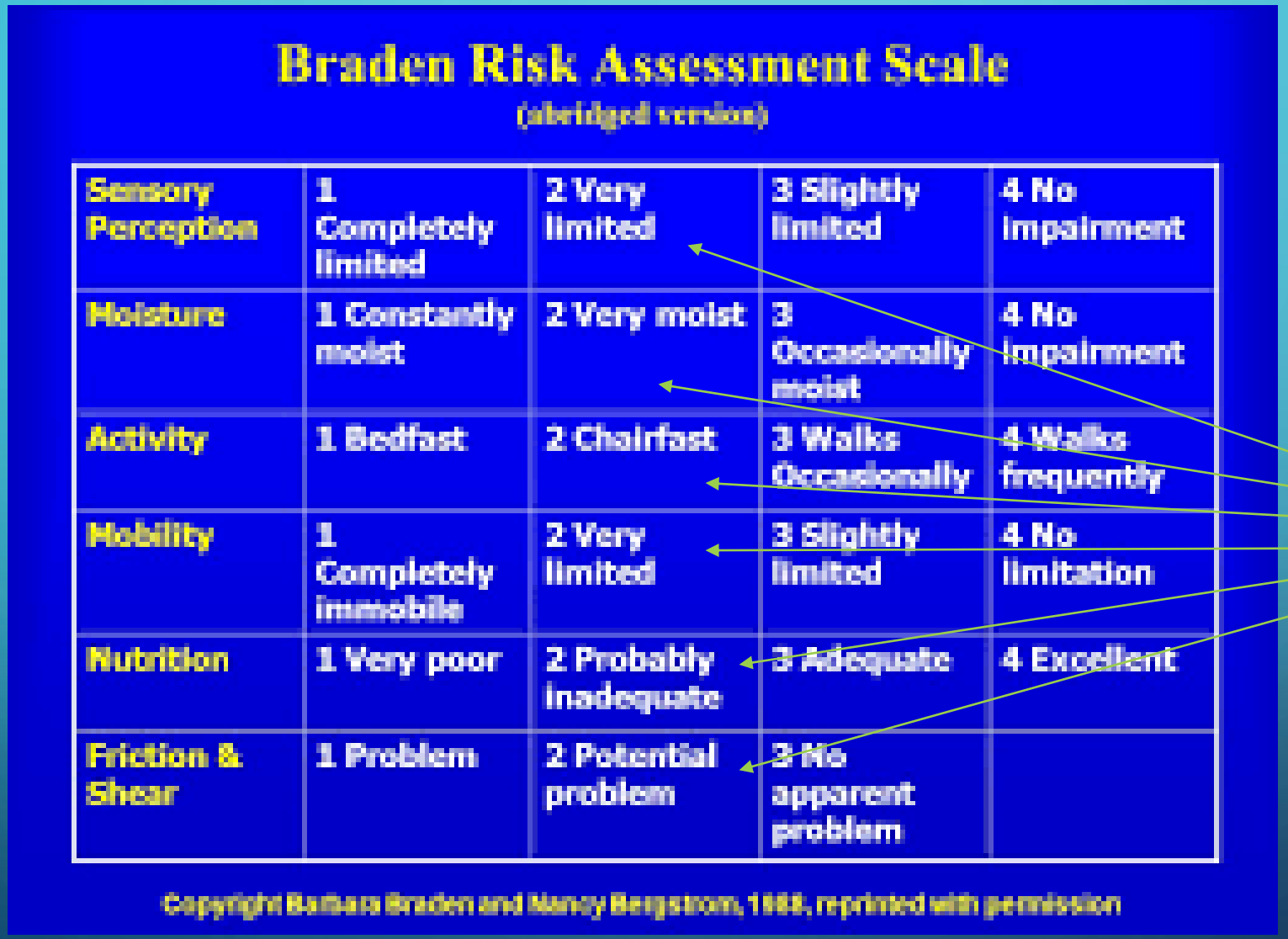


Adult Systems Ass...
- ✓ Mental Status Informatic
- ✓ Psychosocial Distress A
- ✓ Neurological
- Pupils Assessment
- Glasgow Coma Assessm
- Neuromuscular/Extremit
- Cranial Nerves Assessm
- Neurovascular Check
- Spinal Assessment
- NIH Stroke Scale
- Seizure Assessment
- EENT
- Mechanical Ventilation
- ✓ CPAP/BiPAP
- ✓ Respiratory
- ✓ Breath Sounds Assessm
- ✓ Cardiac Rhythm Analysi
- Pacemaker Information
- ✓ Cardiovascular
- ✓ Pulses Assessment
- Edema Assessment
- ✓ Integumentary
- ✓ Braden Assessment
- ✓ Incision/Wound/Skin

	09/18/2016							09/17/2016		
	23:37 MST	20:30 MST	15:12 MST	11:57 MST	10:00 MST	08:53 MST	05:42 MST	23:33 MST	20:00 MST	17:43 MST
Braden Assessment										
Sensory Perception		Slightly li...				No impair...			No impair...	
Moisture		Occasion...				Occasion...			Occasion...	
Activity		Bedfast				Bedfast			Bedfast	
Mobility Braden		Very limited				Very limited			Very limited	
Nutrition Braden		Adequate				Excellent			Excellent	
Friction and Shear		Potential ...				Problem			Problem	
Braden Score		14				15			15	
Gastrointestinal										
GI Symptoms		None				None			None	
Eating Difficulties										
Appetite		Good				Good			Good	
Nutrition Risk Factors		Skin brea...				Skin brea...			Skin brea...	
Abdomen Description		Flat				Flat			Flat	
Abdomen Palpation		Soft				Soft			Soft	
Emesis Description										
Passing Flatus		Yes				No			No	
Stool Color										
Stool Description										
Stool Size										
Bowel Sounds Ass...										
Bowel Sounds All Qua...		Present				Present			Present	
Bowel Sounds LUQ										

Critical Thinking – pt is occasionally moist – should we protect his skin??
Pt is bedfast – do we need a specialty bed, are we protecting bony prominences??
Very limited mobility – implement q 2 hr turns, if pt has pressure ulcer ensure he is kept off this surface
Problem with friction/shear – what are we doing about it???

NOTE: Use the BRADEN SCALE to determine how we can help our patients then **ensure all interventions are documented…**



Braden Risk Assessment Scale

(abridged version)

Sensory Perception	1 Completely limited	2 Very limited	3 Slightly limited	4 No impairment
Moisture	1 Constantly moist	2 Very moist	3 Occasionally moist	4 No impairment
Activity	1 Bedfast	2 Chairfast	3 Walks Occasionally	4 Walks frequently
Mobility	1 Completely immobile	2 Very limited	3 Slightly limited	4 No limitation
Nutrition	1 Very poor	2 Probably inadequate	3 Adequate	4 Excellent
Friction & Shear	1 Problem	2 Potential problem	3 No apparent problem	

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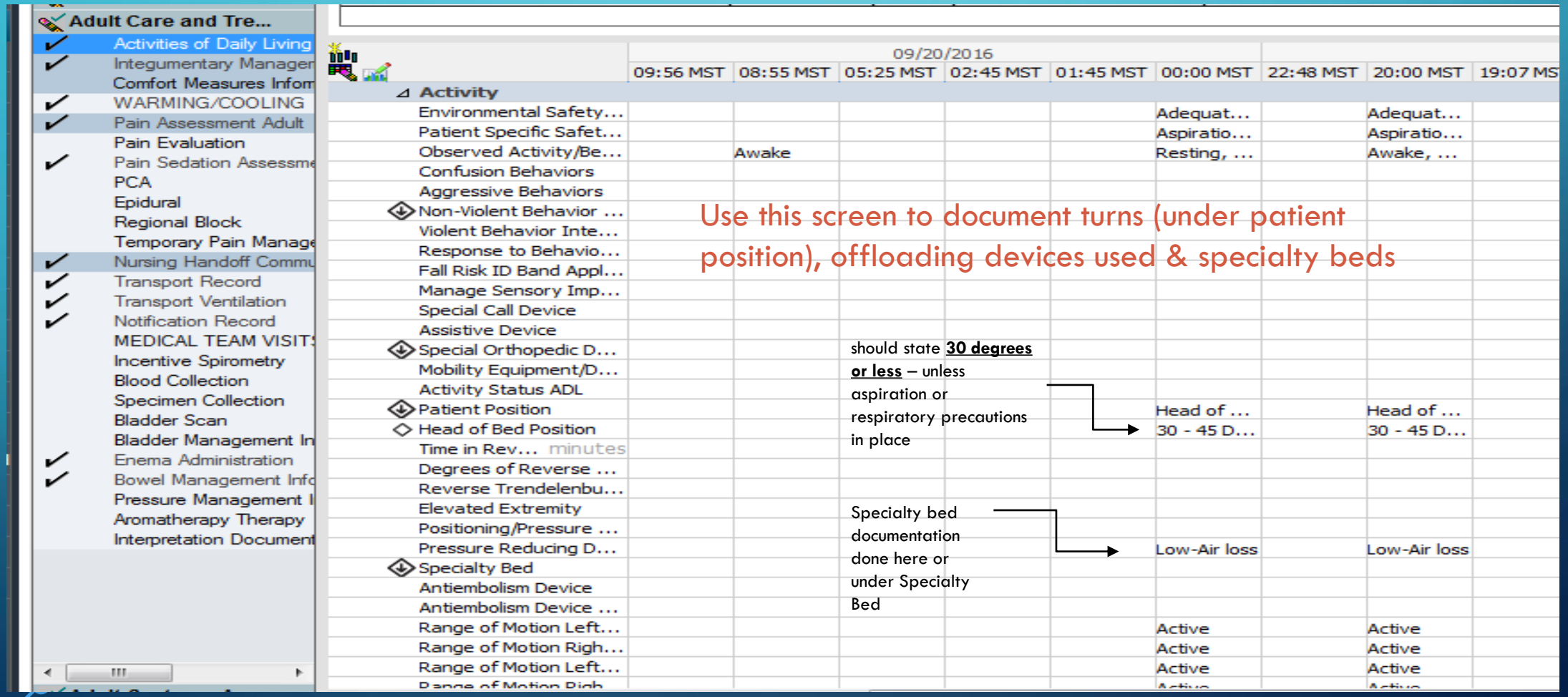
If subscale 2 or less then an INTERVENTION must be documented

SUBSCALES

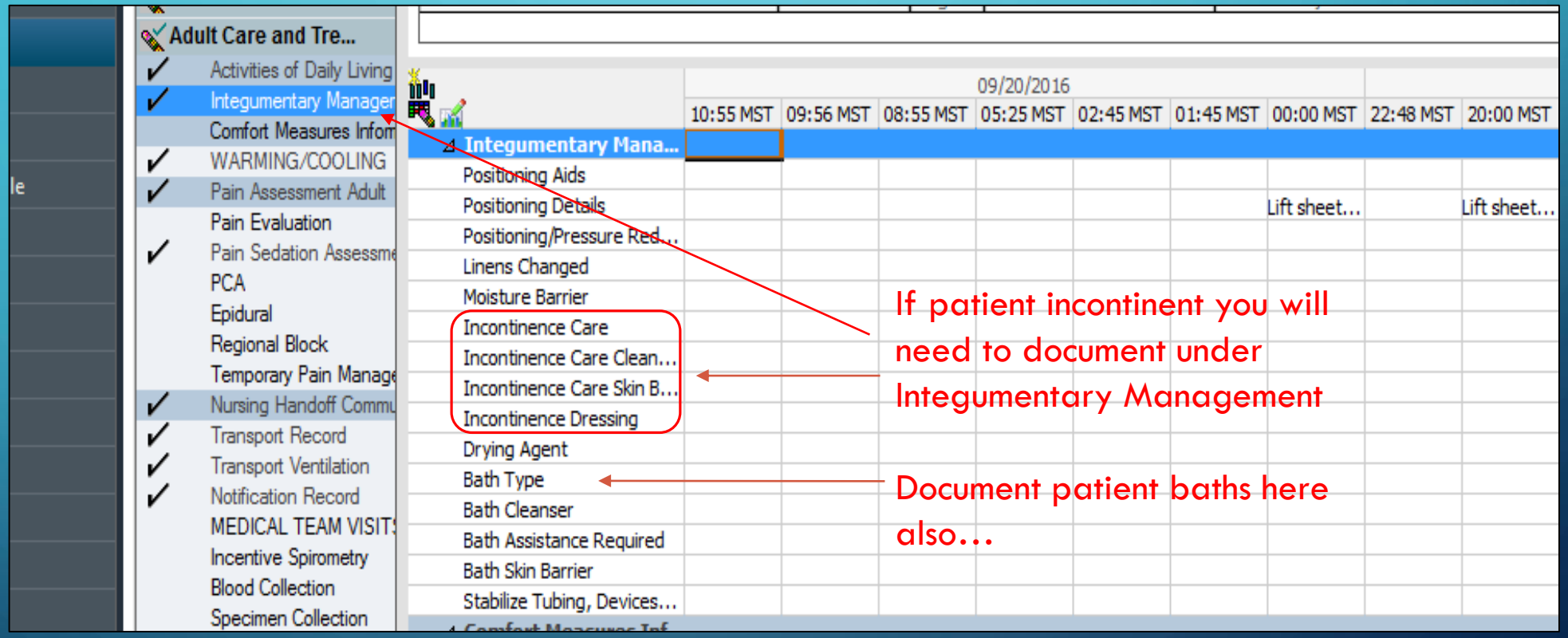
BRADEN DOCUMENTATION ISSUES

- **Document your Braden Scale** once you have seen patient eat and assessed their mobility and continence status
- DON'T document what the shift before has documented unless it is accurate
- Nightshift Staff – DON'T document the patient as being BEDFAST just because they are sleeping or that their NUTRITION status is PROBABLY INADEQUATE (unless it truly is)

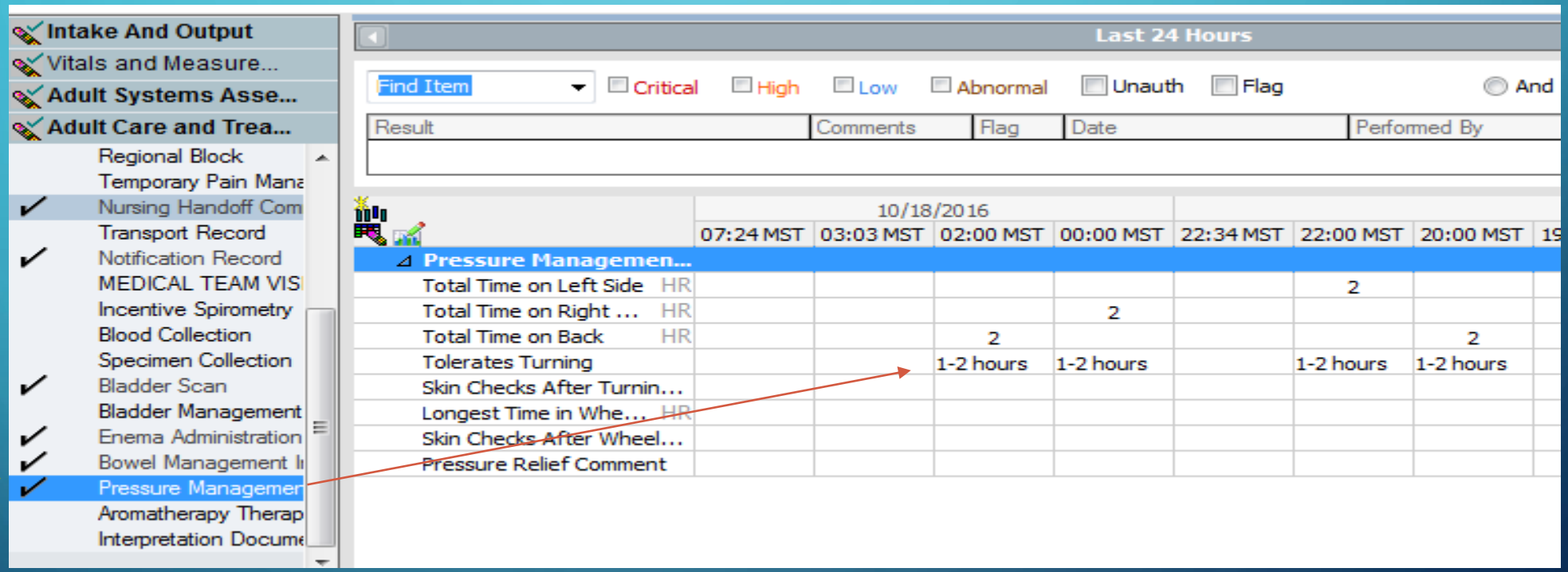
WHERE TO DOCUMENT INTERVENTIONS



WHERE TO DOCUMENT MOISTURE INTERVENTIONS



WHERE TO DOCUMENT REPOSITIONING



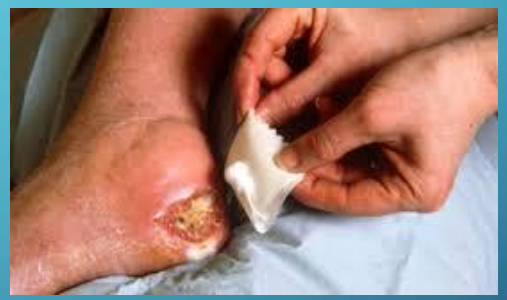
IMPORTANCE OF REPOSITIONING DOCUMENTATION

- Must document what **position** patient is lying in – **do not document** "Repositioned q 2 hours" without stating what **side** patient repositioned to
- Use the ACTIVITY screen or PRESSURE MANAGEMENT INFORMATION to document **patient position and time spent in that position**
- NOTE: Choose one of these places to document and be consistent – if orders are for q 2 hour turns or patient unable to self turn – **proof of repositioning is necessary…**

ASSESSMENT FOR SKIN BREAKDOWN

- Per Banner Policy:
  - Patient's wounds are assessed and documented on admission, when wound is identified and at time of treatment.
    - *This means all dressings should be removed at admission*

Incision/Wound/S...			
Buttock Left Inner			
Abnormality Type			Pressure ...
Abnormality Color			Pale pink,...
Dressing Type			Open to air
Topical Agent Applica...			Ointment
Pressure Point			Bony pro...
Edge			Approxim...
Cleansing			Commerci...
Wound Bed Tissue Type			Pink dermis
Pressure Ulcer Prese...			
Exudate Amount			None
Surrounding Tissue C...			Erythema
Surrounding Tissue C...			Dry, Intact
Status			Unchanged
Associated Pain			None
Non Contact Low Fre...			
Wound Specialist Con...			
Wound Comments			Castor oil...



All skin breakdown needs to be documented

ASSESSMENT/INTERVENTION

- Physicians MUST be notified of any skin breakdown
- Document Braden scale within 12 hours of admission
- Implement and document preventative measures for Braden scale of ≤ 18 and/or (subscales less than 2)
- Assess & Document skin integrity per your department protocol - must be **at the very least DAILY**

OTHER PRESSURE INJURY RISK FACTORS

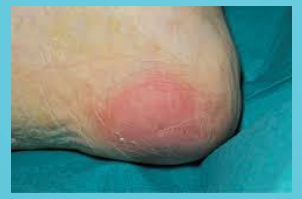
The following Risk Factors place patients at higher risk for Pressure Ulcers:

- Braden Score Less than 18
- Use of Vasopressors
- Incontinent of Urine or Feces
- Limited Self-mobility
- Age 65 or greater
- Diabetes
- Prior Recent Hospital Stay
- Shock/Sepsis
- Recent Cardiac Arrest
- Hx of Pressure Ulcers
- Going to OR or Multiple Procedures Greater than 6 hours
- Quad/ Para/ Hemiplegic
- Stroke/ Paralysis
- Obese/ Cachectic

Please Note: this list is not exhaustive

SKIN ASSESSMENT TO INCLUDE

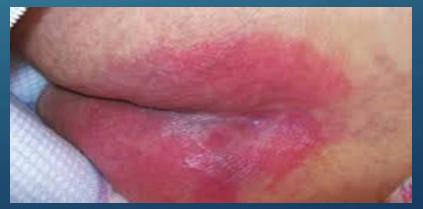
- ALL BONY PROMINENCES



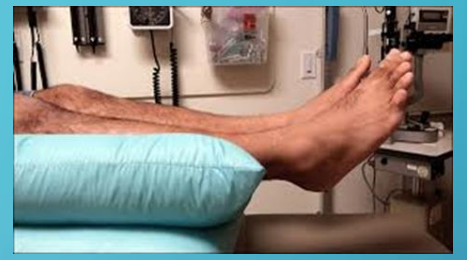
- MEDICAL DEVICES
  - Under restraints (KNOW YOUR POLICY)
  - CPAP, OXYGEN TUBING, BP CUFF'S
  - SCD's, NG, FOLEY CATHETERS etc.

- UNDER SKIN FOLDS

- PERINEUM & AXILLA



INTERVENTION



- Protect bony prominences with foam pads and offloading
- Relieve pressure under medical devices
  - If patient wearing O2+ glasses apply grey foam to O2 tubing– order via Respiratory Therapy

- Keep skin folds clean and dry (may use pillowcase but halved chux pads work better)
- Protect perineum from moisture related injury with barrier cream

PRESSURE ULCER PREVENTATIVE DRESSINGS

- Allevyn foam dressings are in use here at BGMC/BMDACC
  - SACRAL FOAM DRESSINGS COME IN TWO SIZES
- Place on heels and sacrum for PUP
- **Dressings must be peeled back every shift to assess & document skin**
- Consult or re-consult your wound care team for new findings or worsening of skin integrity.
- Call Supply chain 12090 to order
- Larger sacral dressings →

CONTINENCE CARE – WHAT TO USE AND WHEN

- EPC (extra protective cream) – 30% zinc oxide based, used in patients who are incontinent of both urine and stool multiple times a day
- Dimethicone Protectant – clear so able to visualize skin after application, use on patients occasionally incontinent of urine
- **Only one** chux pad on the bed – more than one used ONLY if patient weeping from other areas
  - Essential to use only ONE pad when patient is on a specialty bed as more than one affects the beds performance
- <u>NO BRIEFS in bed</u>, can be used when patient is OOB/mobile or if family requests their use

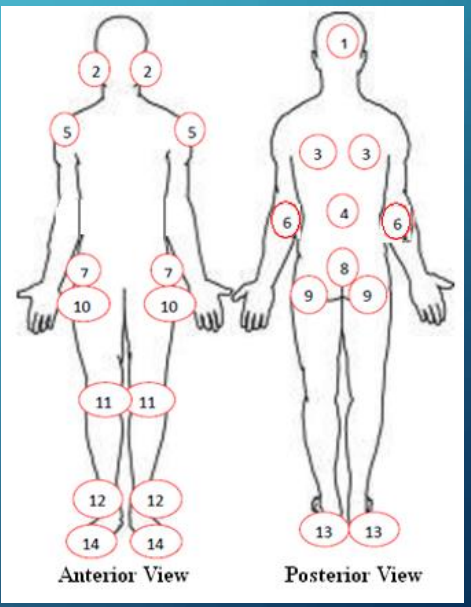
AIDS IN PRESSURE ULCER PREVENTION FOR AT RISK PATIENTS (BRADEN SCORE 18 OR LESS)

- When OOB to chair, ensure waffle cushion is placed in the chair beforehand (cover cushion with a sheet or chux pad)
  - **Reposition hourly** while in a chair and DOCUMENT position changes

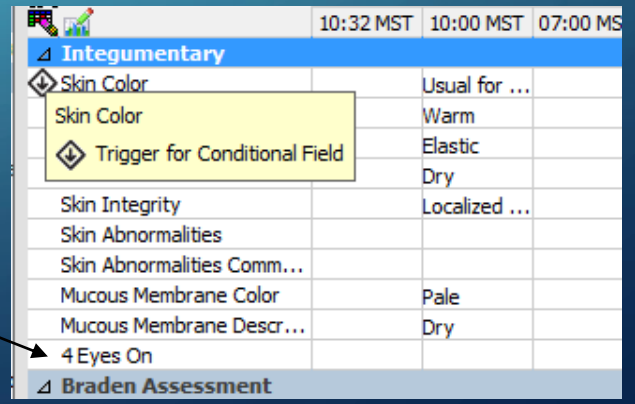
- If patient is squirming in bed use waffle boots to offload heels, use pillows lengthwise if the patient is unable to move legs

FOUR EYES DOCUMENTATION

- Complete a 4 Eyes Assessment with every new admission
  - Preferable to complete one with every transfer to a new floor as well
- A 4 Eyes Assessment is a complete skin assessment done with another licensed person looking for any potential skin issues



- Document the 4 Eyes Assessment in the Interactive View & I&O
  - Adult Systems Assessment
  - Integumentary



SPECIALTY BED ORDERING

- **Always** order a specialty bed if patient is a quadriplegic/paraplegic
  - Order via Physicians, APRN's, WOCN's & House Supervisor
  - Call Supply Chain Management on #12090 to order bed once order received
- Braden Scores of 12 or less
- Consult Wound Care RN's for patients you feel are high risk for pressure ulcer development, even if their Braden Score does not reflect this
- NOTE: CURRENTLY TRIALING EHOB OVERLAYS ON THE FIFTH FLOOR – MORE TO COME ON THIS

RENTAL BEDS MOST COMMONLY USED

HILL-ROM ENVISION ON VERSACARE FRAME

Low air loss pressure redistribution Airflow minimizes sheer, friction, and moisture.
Appropriate pressure ulcers stage II and greater
Weight Limit 400lbs

HILL-ROM COMPELLA BARIATRIC BED

Patients over 500lbs or requiring 40-50" width.
Weight limit 1000lbs
Motorized so easier to transport than the EXCEL CARE BED (now discontinued)
Width retracts to get into elevators
Built-In Low Air Loss, Percussion/Vibration
Trapeze comes as standard on rentals

TOTAL CARE BARIATRIC PLUS

Optional Low Air Loss with Turn Assist, extra wide 40" surface. Seat and foot deflate for low bed height.

Weight Limit 500lbs

BEDS OWNED BY BGMC

STANDARD BED – ACCUMAX MATTRESS ON VERSICARE FRAME

The AccuMax Quantum™ VPC Mattress is a non-powered surface that uses a system of intake and output valves to provide weight-based pressure redistribution whenever a patient moves or is repositioned. It has a top layer of visco-elastic foam for improved patient comfort.

Weight limit 500lbs

VERSICARE A.I.R. SURFACE

An 8” pressure relief mattress with turn assist functions and low bed height to help pt’s get out of bed. Can be extended to accommodate tall patients.

Weight limit 500lbs.

TOTAL CARE SPORT – ICU BED

Modules required for:
Continuous rotation therapy
Pulmonary Therapy and low air loss + coverlet
Full chair position
Built in scale

Weight limit 460/500lbs

USEFUL RESOURCES VIA THE INTRANET

- LEFT HAND SIDE OF SCREEN, CLICK ON **TEAMS AND PROJECTS**
- SCROLL ALL THE WAY DOWN TO **WOUND CARE**
- **HERE YOU WILL FIND:**
  - **ED & ACUTE CARE QUICK REFERENCE GUIDE TO SKIN CARE**
  - **BRADEN SCALE GUIDE AND TREATMENT ALGORITHM**
  - **OSTOMY CARE GUIDE AND FORMULARY –**
  - **OSTOMY APPLICATION GUIDE**
  - **ETC…**

PATIENT SCENARIO # 1

- 88 y/o female who recently underwent a laparoscopic cholecystectomy for cholecystitis.
  - Patient has been recovering at a local skilled nursing facility
  - C/O severe weakness, unable to keep food down, abdominal pain, N/V/D
  - Incontinence due to diarrhea and issues with pain when turning
  - Requires assistance with turning in bed
  - OOB with assistance of 2, but spends >90% of day in bed

WHAT IS THIS PATIENTS BRADEN SCALE SCORE?

A. 10-12
B. 16-18
C. 14-16

Braden Risk Assessment Scale

(abridged version)

Sensory Perception	1 Completely limited	2 Very limited	3 Slightly limited	4 No impairment
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Nutrition	1 Very poor	2 Probably inadequate	3 Adequate	4 Excellent
Friction & Shear	1 Problem	2 Potential problem	3 No apparent problem	

WHAT IS THIS PATIENTS BRADEN SCALE SCORE?

- The correct answer is…

A. 10-12

WHAT INTERVENTIONS SHOULD BE STARTED BASED ON THE BRADEN SCORE?

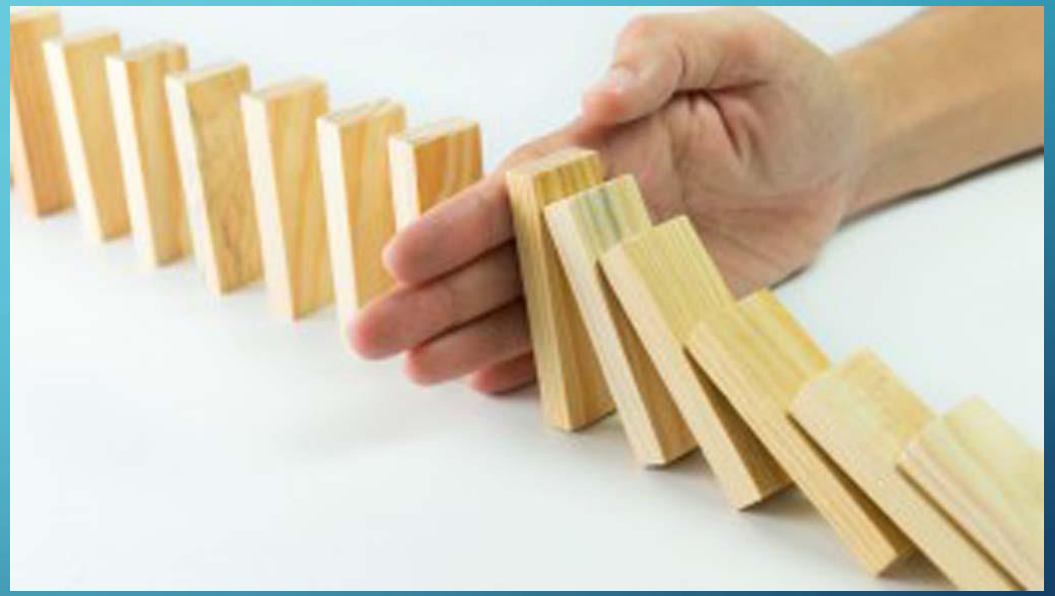
A. No interventions required

B. Dietary Consult, Wound Care Consult, Protection from Incontinence.

C. Dietary Consult, Wound Care Consult, Protection from Incontinence, Turn q 2 hrs, elevate heels, waffle cushion in chair when OOB.

WHAT INTERVENTIONS SHOULD BE STARTED BASED ON THE BRADEN SCORE?

- The correct answer is…



C. Dietary Consult, Wound Care Consult, Protection from Incontinence, Turn q 2 hrs, elevate heels, waffle cushion in chair when OOB.

USING YOUR CRITICAL THINKING - WHAT OTHER INTERVENTIONS WOULD YOU START?

A. ORDER A SPECIALTY BED, LOW AIR LOSS MATTRESS

B. MEDICATE FOR NAUSEA/VOMITING & PAIN AS ORDERED

C. CONSIDER DISCUSSING MEDICATION FOR DIARRHEA WITH PHYSICIAN

D. PHYSICAL THERAPY CONSULT

E. ALL OF THE ABOVE

USING YOUR CRITICAL THINKING - WHAT OTHER INTERVENTIONS WOULD YOU START?

- The correct answer is…

E. All of the above

HOW MANY PATIENT DIE EACH YEAR AS A RESULT OF A PRESSURE INJURY?

A. 40,000

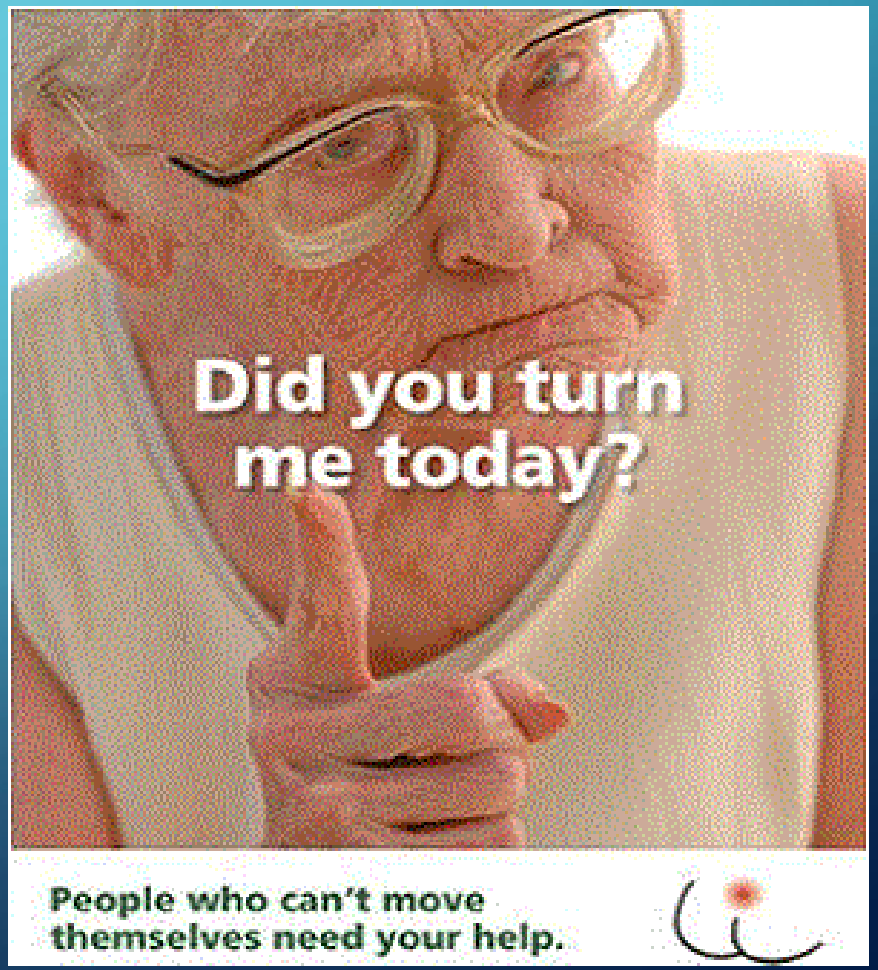
B. 85, 000

C. 60, 000

HOW MANY PATIENT DIE EACH YEAR AS A RESULT OF A PRESSURE INJURY?

- The correct answer is…

C. 60, 000



THIS IS WHAT WE ARE TRYING TO PREVENT – THANK YOU FOR BEING PART OF THE SOLUTION