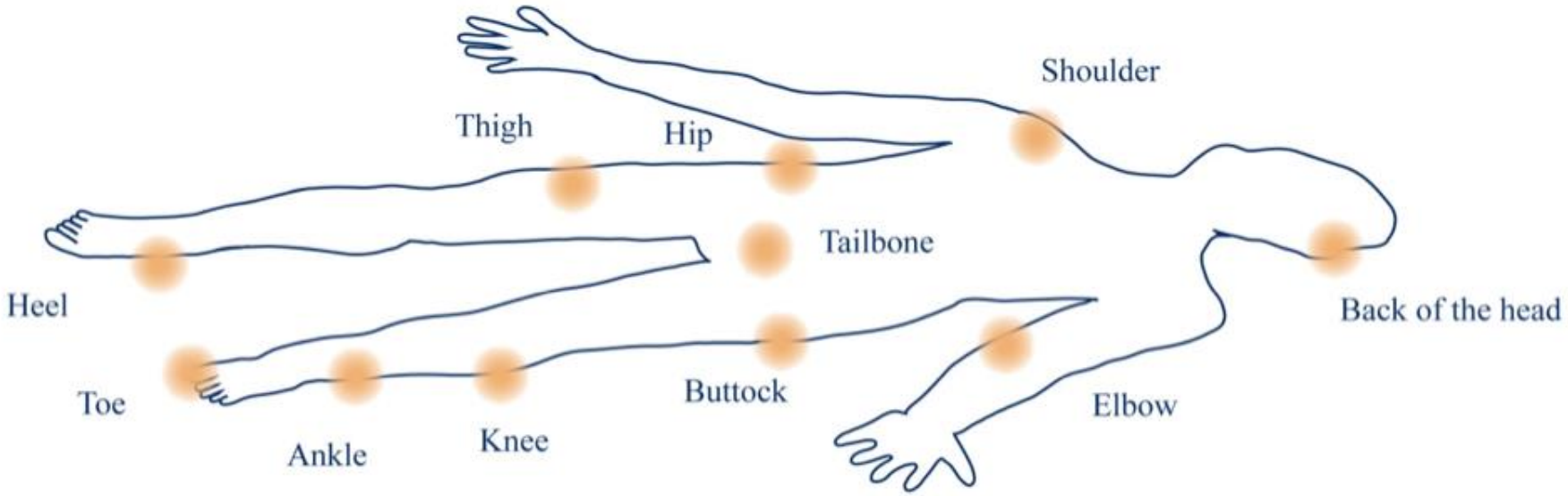
McLaren
FLINT

Skin & Wound Assessment

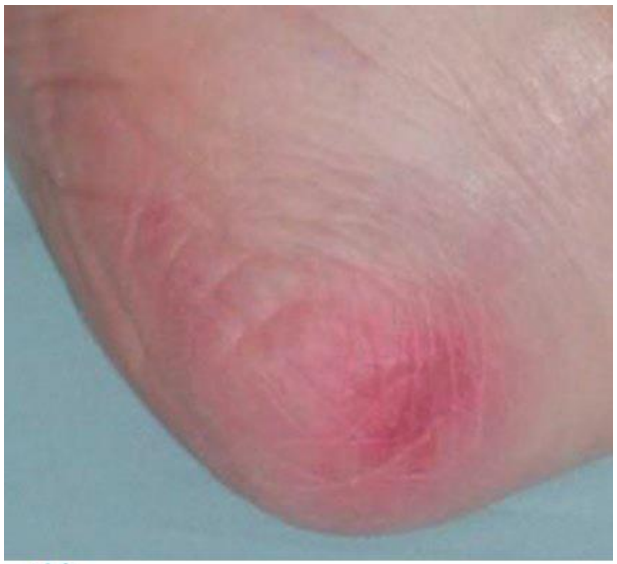
Common Pressure Points



Assess and inspect skin every 12 hours and upon admission to your unit.
Document findings in the electronic medical record

Pressure Injury Stage 1

- Intact skin with non-blanchable redness, usually over a bony prominence



AWMA Australian Wound Management Association Inc.

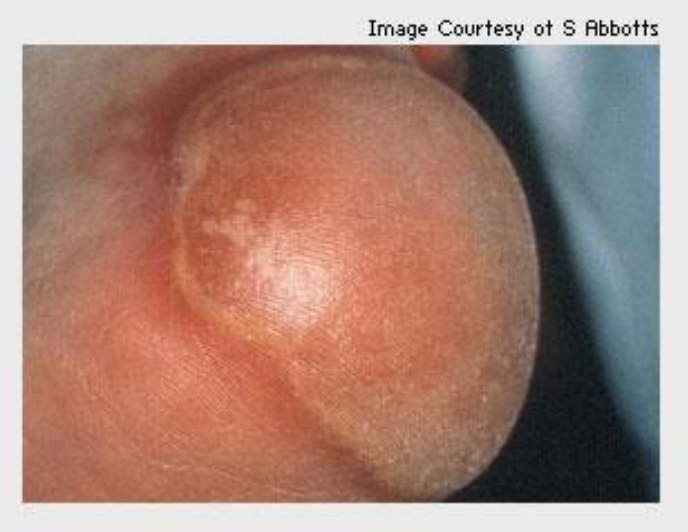
Stage 1 pressure injury

Treatment:

- ✓ Implement pressure offloading
- ✓ Turn q 2 hrs and prn
- ✓ Ensure optimal nutrition & hydration
- ✓ A non-zinc based barrier ointment can be used over the sacral/buttock area
- ✓ A foam dressing or thin hydrocolloid dressing can be applied if over a bony prominence to cushion and protect

Pressure Injury Stage 2

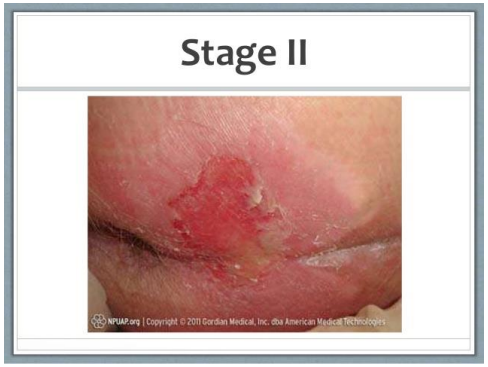
- Intact or ruptured serous blister



Treatment:

- ✓ If the blister is located in an area with a high probability of breaking, a xeroform and dry gauze dressing may be used to absorb fluid leakage, changing the dressing daily. The goal with any blister is reabsorption if possible.
- ✓ Pressure offloading
- ✓ Turn q 2 hrs and prn
- ✓ Ensure optimal nutrition & hydration

- Partial thickness loss of dermis with red or pink wound bed



Treatment:

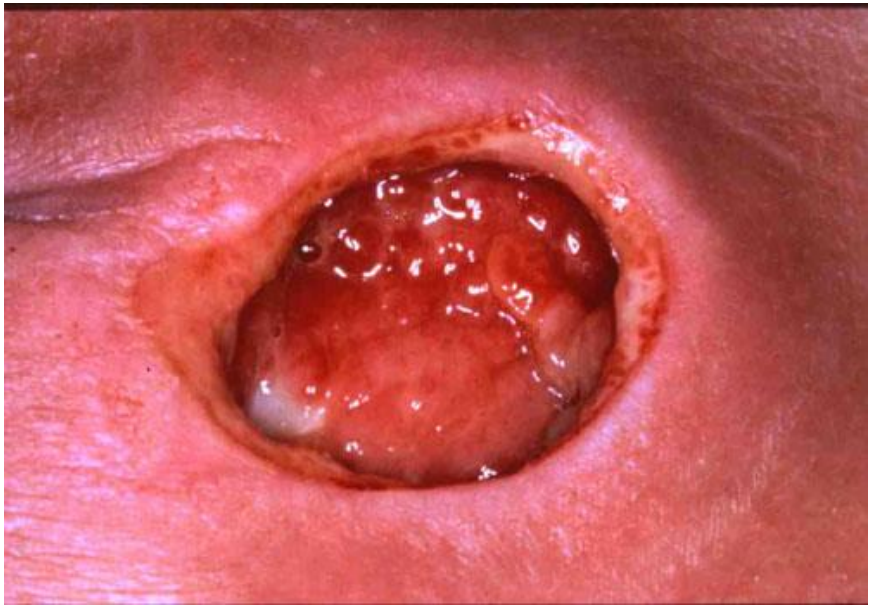
- ✓ Open wound management: Apply either a moist non-adherent dressing or hydrogel to the wound bed and cover with gauze. Change the dressing daily
- ✓ If dressing maintenance is difficult due to urinary incontinence, discontinue dressings and utilize a non-zinc based skin barrier cream to the area. Consider a zinc based barrier cream if stool incontinence is an issue
- ✓ Pressure offloading
- ✓ Turn q 2 hrs and prn
- ✓ Ensure optimal nutrition & hydration

Pressure Injury Stage 3

- Full thickness tissue loss: Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed

Treatment:

- ✓ Cleanse with normal saline
- ✓ Dressing selection is based on wound depth and amount of drainage
  - ✓ *Minimal to moderate draining wounds with moist wound bed:* Pack with hydrogel dampened kerlix with secondary foam or ABD. This dressing is changed daily or when there is strikethrough of drainage onto the secondary dressing.
  - ✓ *Heavy draining wounds:* Consider use of a hydrofiber (obtained from cart). These products may be packed in a wound dry and covered with a secondary foam or ABD. The dressing is changed daily or when there is strikethrough of drainage onto the secondary dressing.
- ✓ Pressure offloading
- ✓ Turn q 2 hrs and prn
- ✓ Ensure optimal nutrition & hydration

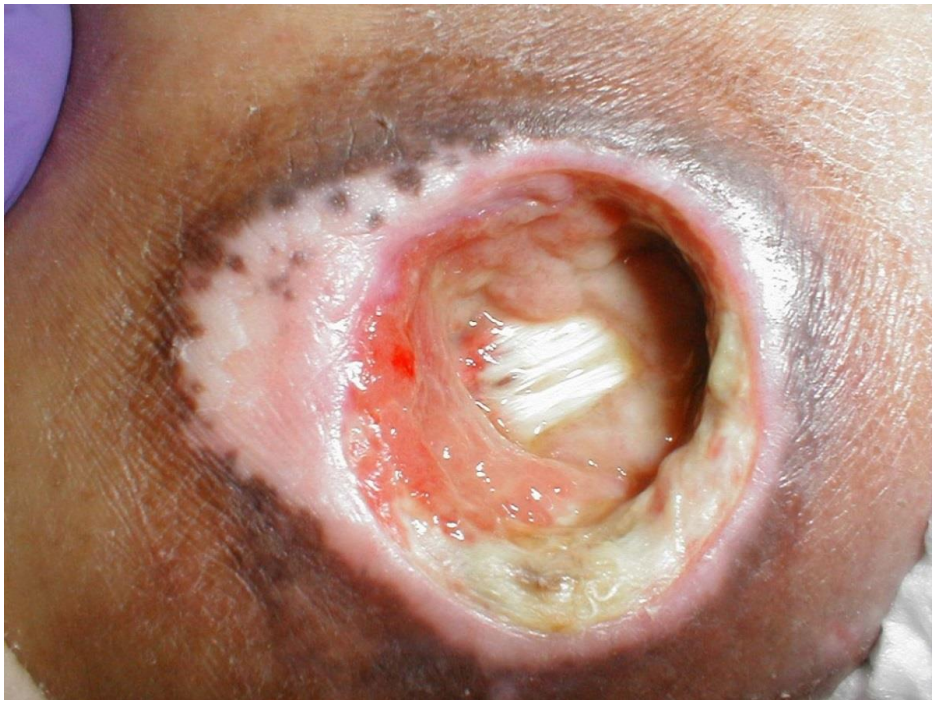


Pressure Injury Stage 4

- Full thickness tissue loss with exposed bone, tendon, or muscle

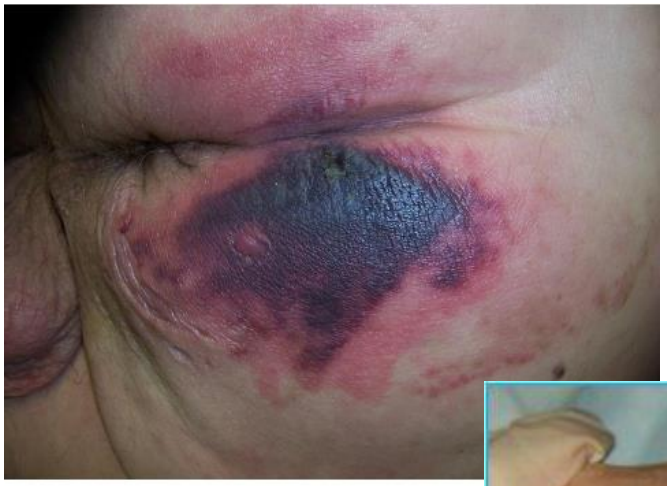
Treatment:

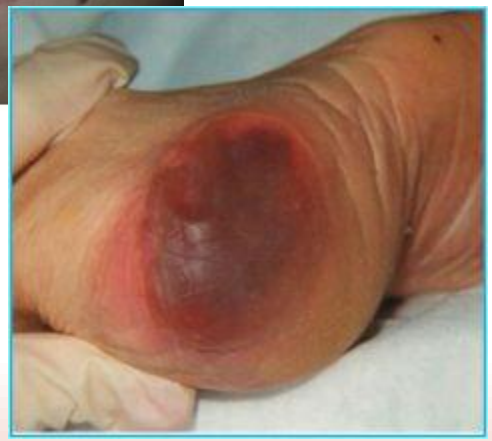
- ✓ Cleanse with normal saline
- ✓ Dressing selection is based on wound depth and amount of drainage
  - ✓ *Minimal to moderate draining wounds with moist wound bed:* Pack with hydrogel dampened kerlix with secondary foam or ABD. This dressing is changed daily or when there is strikethrough of drainage onto the secondary dressing.
  - ✓ *Heavy draining wounds:* Consider use of a hydrofiber (obtained from cart). These products may be packed in a wound dry and covered with a secondary foam or ABD. The dressing is changed daily or when there is strikethrough of drainage onto the secondary dressing.
- ✓ Pressure offloading
- ✓ Turn q 2 hrs and prn
- ✓ Ensure optimal nutrition & hydration



Deep Tissue Injury

- Purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue



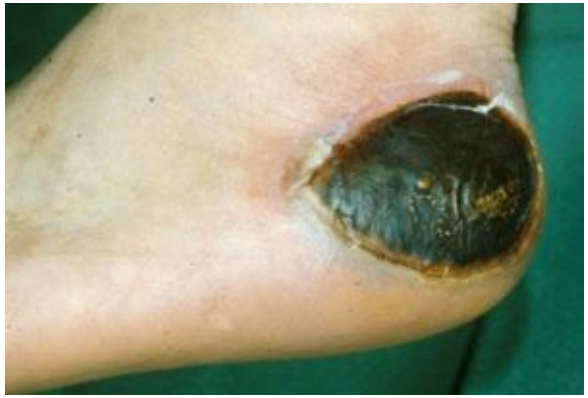


Treatment:

- ✓ **Pressure redistribution implementation is the primary course of treatment**
- ✓ Blood-filled blister: The goal with any blister is reabsorption if possible. If the blister is located in an area with a high probability of breaking: Apply xeroform and cover with a dry gauze dressing, changing daily, until the patient can be evaluated by the wound care nurse.
- ✓ If the blister breaks and an open wound is present, proceed with open wound management: Apply either a moist non-adherent dressing or hydrogel to the wound bed and cover with gauze. Change the dressing daily
- ✓ For intact tissue, a dressing may not be indicated. Utilize a moisture barrier until the patient can be evaluated by the wound care nurse.
- ✓ Monitor the tissue daily
- ✓ Turn q 2 hrs and prn
- ✓ Ensure optimal nutrition & hydration

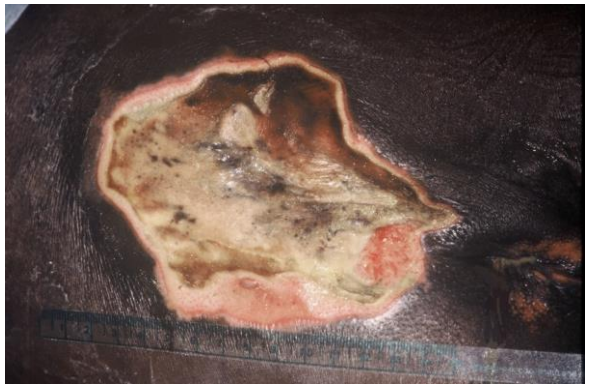
Unstageable Pressure Injury

- Full thickness tissue loss in which the base of the ulcer is covered by eschar or slough. Until enough slough or eschar is removed to expose the base of the wound, a stage cannot be determined.



Treatment:

Any dry stable eschar on the lower extremities should be kept dry!!! Do not apply a moist dressing unless instructed to do so by physician. May paint with providine iodine unless contraindicated. --
-Monitor the tissue daily
-Maintain pressure offloading & Turn q 2 hrs/PRN
-Ensure optimal nutrition & hydration

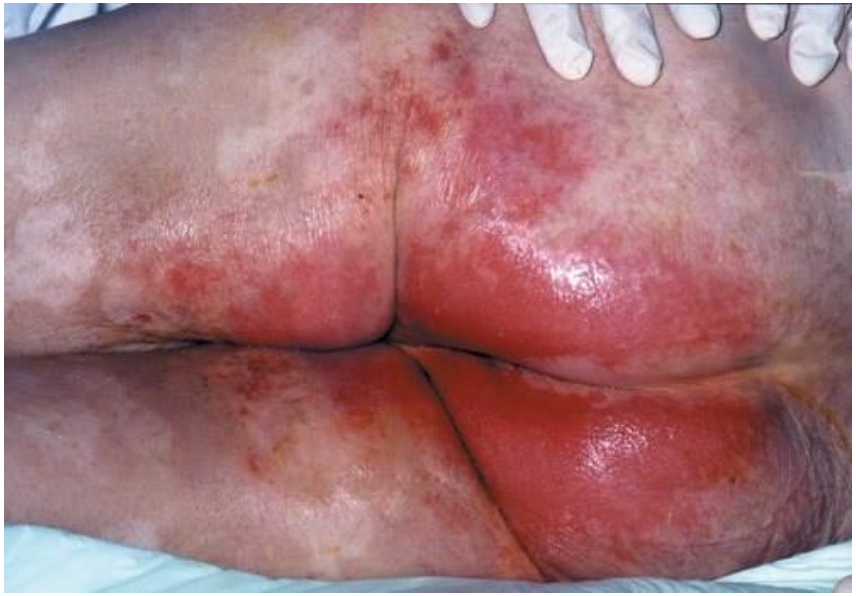


Treatment:

Moist Non-adherents or hydrogel can be used to maintain a moist wound environment in a minimally draining Unstagable pressure injury. These dressings require a secondary foam or ABD dressing. If wound depth is present, pack the wound with a hydrogel moistened gauze/kerlix dressing. A secondary foam or ABD dressing is required. Change the dressing daily & PRN
-Monitor the tissue daily
-Maintain pressure offloading & Turn q 2 hrs/PRN
-Ensure optimal nutrition & hydration

Incontinence Dermatitis

- Inflammation and excoriation of the skin caused by prolonged exposure to stool or urine



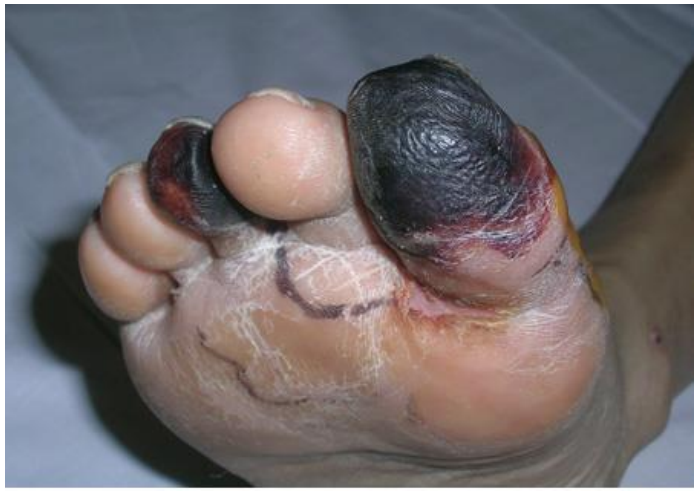
*If skin is denuded or excoriated, apply a zinc-based barrier ointment with properties to adhere to wet/weeping skin

*If superficial fungal skin infection is present, apply antifungal barrier ointment. Use as ordered by the physician or wound care team.

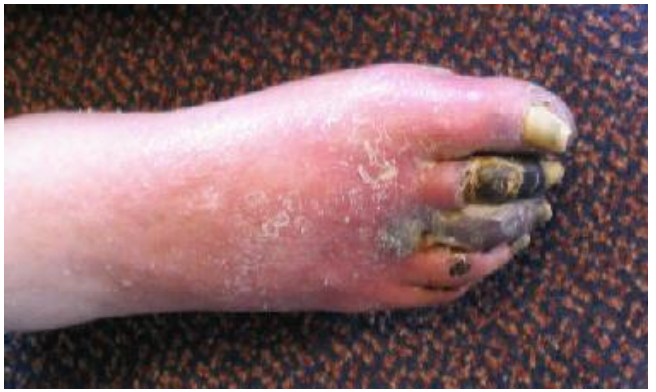
Consider a urinary and/or fecal collection device. Routinely offer assistance with toileting and check the patient frequently for incontinent episodes

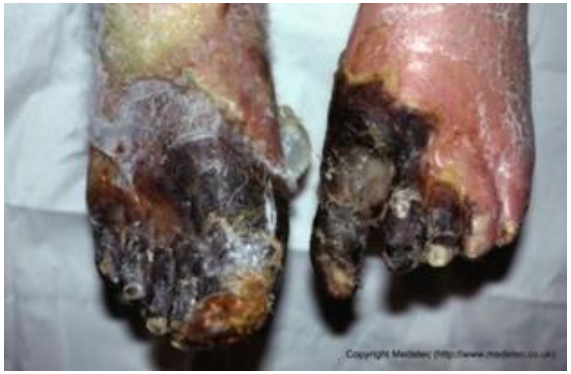
Arterial Insufficiency

- Dry or wet gangrene, purple discoloration, erythema



Source: Usatine RP, Smith MA, Mayeaux EJ Jr, Chumley H, Tysinger J: *The Color Atlas of Family Medicine*: www.accessmedicine.com



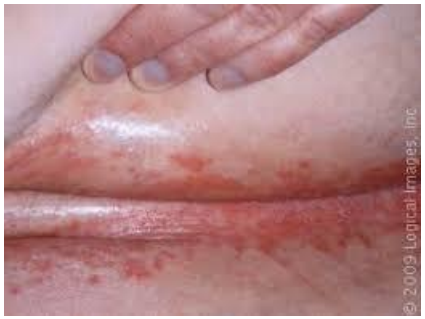


Treatment:

Keep any eschar/dry scabbing DRY!! Paint with betadine. Extremity wounds that result from or are complicated by inadequate arterial circulation should be referred to a physician for management.

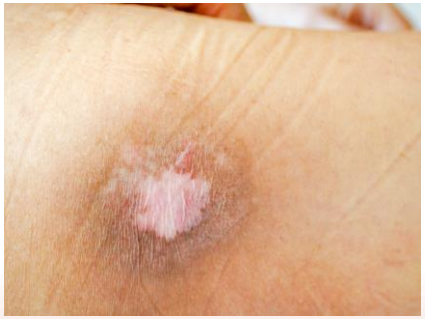
When a Wound Ostomy Care (WOC) Team consult is not required

- Rash/fungal
  - Utilize antifungal cream stocked on each unit or obtain a physician's order for antifungal powder located in pharmacy



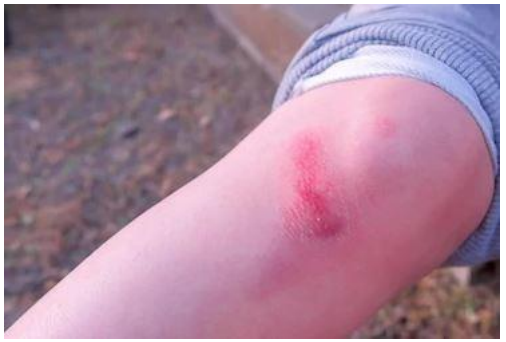
- Psoriasis/Eczema/ Dry Skin
  - Use unit-based lotion or obtain a physician's order for lac hydrin cream located in pharmacy

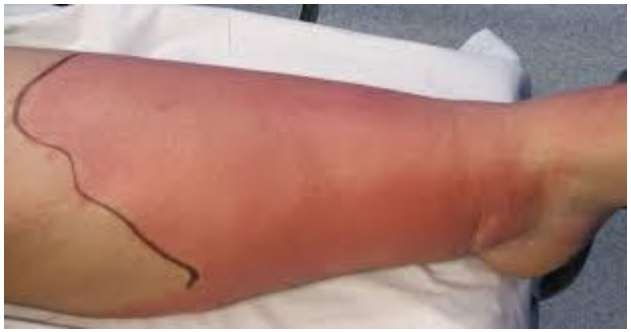
- Pigmented Scarring
  - Monitor skin integrity & implement pressure offloading. Consider protective measures such as a non-zinc based barrier cream for moisturization or foam dressing

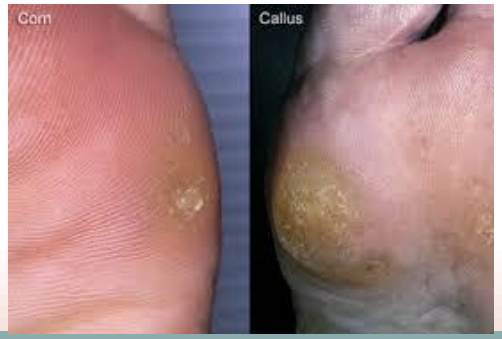


When a WOC consult is not required cont…

- Abrasions/scabs/ bruising from trauma, & skin tears
  - If tissue is open, follow the skin tear guidelines. If skin is intact, keep open to air
- Intact, non draining cellulitis
  - Notify physician. A wound consult is only needed if open & draining
- Stable callous
  - Keep clean, dry, and open to air

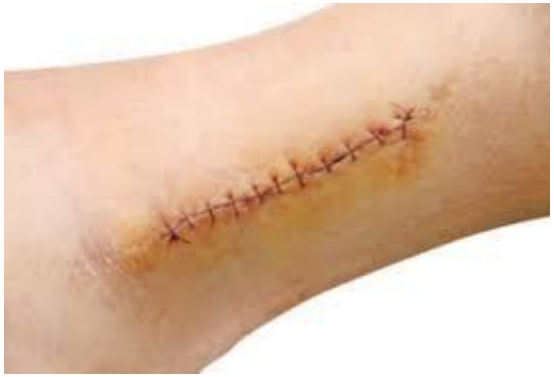






When a WOC consult is not required cont…

- Sutured/stapled intact incisions
  - Follow the surgeon's recommendations

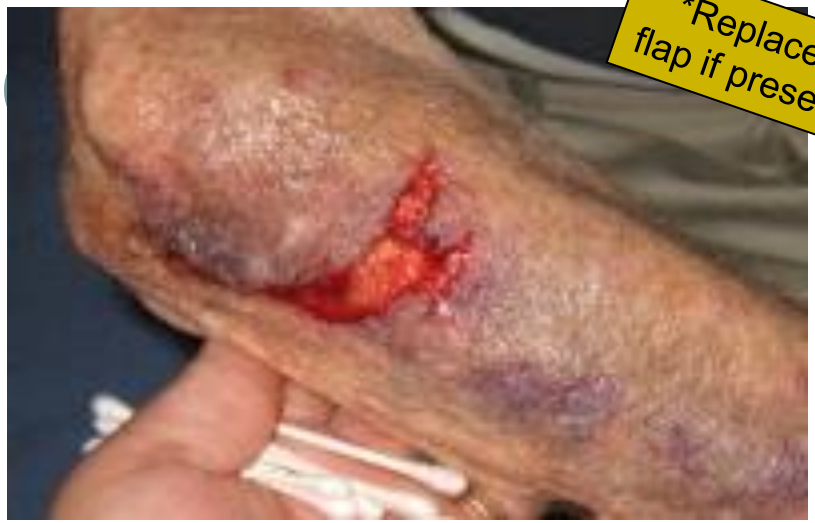


- Routine dressing changes & wounds currently under a surgeon's care

- Routine Ostomy Care
  - Bedside RN to manage routine appliance changes 1-2x per week and PRN when leaking
  - **Exception** Please consult the Wound Care Team for all NEW ostomy patients so teaching can be started

1 piece ostomy kits & paste are located on every unit and in CART. Urostomy kits, 2 piece colostomy appliances, eakin rings, and clamps are located in CART

Treatment of Skin Tears



Replace skin flap if present

Xeroform and foam dressing
if light drainage – change dressing every 2-3 days & prn

NO TAPE!!

Xeroform & kerlix Roll
for moderate to heavy drainage. Change dressing every 2-3 days & prn.

No need to consult the wound team unless infection is suspected or wound deteriorates

Pressure Offloading Devices

- Inflatable air overlay: Found in CART or on the unit. To be used for patients with braden ≤18 and/or limited mobility or discomfort
- Physician order is NOT needed

- Inflatable chair cushion: Found in CART or on the unit.
- Physician order is NOT needed

Low air loss mattress:

- Ordered by the wound team or nursing supervisor
- Typically reserved for patients with pressure injuries
- Options include McLaren owned Stryker IsoTour bed or low air loss rental

**Bariatric beds with a low air loss surface are also available. Optional trapeze is available upon request. Contact the wound team or nursing supervisor to obtain

Pressure Offloading Devices

EHOB heel offloading boot

- Found on the unit or in CART
- Physician order is NOT needed
- Use for patients with existing heel pressure injuries, or for those at risk of developing pressure injuries
- Wedge can be positioned medially or laterally to maintain foot in upright position

Prafo boot

- Obtain through a DME. Physician order is required
- Use for patients with heel ulcers or to prevent foot drop
- Monitor patient's achilles region for signs of pressure breakdown

Barrier Creams

Use for the treatment of open tissue on buttocks, or if somebody is having numerous loose stools

Use for prevention for those who are incontinent

Use for a fungal rash on buttocks, peri area, and skin folds

Product Formulary Guide

Hydrofiber with silver (Opticell AG): Obtain from unit supply room or CART

Medihoney: Obtain from pharmacy. Physician order is required

Hydrogel: Obtain from unit supply room

Silvadene Cream: Obtain from pharmacy. Physician order is required

Silvasorb Gel: Obtain in CART

Xeroform: Moist non-adherent. Obtain from unit supply room

Hydrocolloid: Obtain from unit supply room

Moisturizing Lotion: Obtain from unit supply room

Use the Wound Ostomy Care (WOC) Team for…

- Any open area to the buttocks or perineum
- Pressure Injuries (including purple discoloration suspected of being a deep tissue injury)
- Diabetic or vascular wounds that are not currently being treated by a physician
- ALL brand new ostomy patients
- For more information or questions contact a WOC nurse during normal business hours @ 22282

Find more detailed skin care information including the product formulary, pressure injury prevention tools, support surface information, and more on McLaren Flint's Intranet. (Go to: Policies and Procedures, Department policies, nursing procedure manual, then click on the integumentary tab)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