Management and Preventive Strategies for Pressure Injuries and Incontinence

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Learner outcome

After this session, the learner will be able to identify strategies for the prevention and management of pressure injuries and incontinence issues.
Review of Staging:

Pressure Injury: pressure injury localized to skin and/or underlying soft tissue usually over bony prominence or related to a medical or other device.

NPUAP Classification system:

Category/Stage 1 – Intact skin with localized area of non-blanchable erythema.

Category/Stage 2 – Partial-thickness skin loss with exposed dermis. Wound bed is viable pink or red, moist and may also present as an intact or open/ruptured serum filled blister.

(Should not be used to describe skin tears, burns, abrasions, perineal dermatitis or traumatic wounds)

Category/Stage 3 – Full-thickness skin loss. Subcutaneous fat is visible in the ulcer. Slough and/or eschar may be visible but does not obscure the depth of tissue, may have undermining or tunneling. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.
Category/Stage 4 – Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough or eschar may be visible, undermining and/or tunneling often occur.

Unstageable – Obscured full-thickness skin and tissue loss in which the extent of damage cannot be confirmed because it is obscured by slough or eschar

Deep Tissue Pressure Injury – Persistent non-blanchable deep red, maroon or purple discoloration intact or non-intact skin, or epidermal separation revealing dark wound bed or blood filled blister.

(Should not be used to describe vascular, traumatic, neuropathic, dermatologic conditions)
Pressure Injury Assessment:

- Head to toe assessment
  - Over bony prominence
  - Under devices
  - Under dressing

- Identify risk factors:
  - Braden score
  - Individual risk factors
  - Contact with moisture
  - Immobility
Unavoidable risk factor:

Risk factors:
- Braden Score
- Limited Mobility
- Exposure to Moisture
- Excess Friction
- Mechanical Ventilation Longer than 72 hours
- Norepinephrine/Vasopressin infusion
- Hemoglobin less than 7mg/dL
- Cardiac Arrest
- LOS greater than 5 days
- Fecal Incontinence
- Febrile
- Obesity BMI >30
- Corticosteroid use

WOCN Society position paper: Avoidable versus unavoidable pressure ulcers (injuries). Mt. Laurel, NJ: Author
Interventions:

1. Moisture Management:
   - Prompt perineal hygiene
   - Use of under pads
   - Use of pH balanced pre-moistened wipes
   - Application of Zinc based skin barrier
   - Use urine containment device
ASSESSMENT, INTERVENTIONS, MONITOR

2. Mobility:
   - Initiate turning/repositioning schedule
   - Utilize wedges/pillows
   - Offloading of heels on heel protectors
3. **Friction/Shear Management:**
   - Apply foam dressing over bony prominence
   - Moisturize skin
   - Utilize draw sheet/lift device
   - Elevate head of bed to 30 degrees and knee elevation

4. **Device Management:**
   - Monitor and pad as necessary

5. **Identify for Special bed/Mattress:**
   - Low air Loss Mattress
   - P500 Mattress
   - Specialty Bed (Bariatric, Envella)
Monitor:
- Shift assessments are done
- Interventions are consistent
- Findings are reported
- Wound care team recommendations are being followed
- Vigilance creates awareness
Physicians:

- Depending on your Facility’s process, a timely consult to appropriate discipline to initiate care and interventions most favorable for patient outcomes.

- Documentation of skin assessment in patient’s electronic record.

- Documentation of Present on Admission pressure injuries.

- Communication with interdisciplinary departments: 
  (e.g.: Nursing, Physical/Occupational Therapy, Respiratory, Case Management, Nutrition).
Review of Definition:

- **Urinary Incontinence** – Altered ability to store urine effectively and to control the time and place for voiding; involuntary leakage of urine.

- **Fecal Incontinence** - accidental (involuntary) passage of stool (or gas) at an undesirable time or place.
Incontinence Assessment:

- Urine and stool are being contained and skin is being protected.
- Appropriate containment device is utilized.
Interventions:
- Prompt hygiene is provided
- Application of zinc oxide based products
- Appropriate nursing management approach
Incontinence Management

Avoid Incontinence Associated Dermatitis (IAD)

- Cleanse with Perineal cleanser & premoistened wipes
- Apply appropriate skin barrier

Consult WOCN for unresolved incontinence rash over 2 days.

Sequenced nursing approach

1. TOILET
2. BED SIDE COMMODE
3. URINAL
4. BEDPAN
5. Underpads
6. External Catheters OR Fecal/Urine containment devices

Always main objective
Limited mobility unable to use toilet
Limited mobility unable to use commode

Our skin is our protection: To put into perspective

The thickness of a nickel is 1.95 mm, our skin is 0.5 – 5 mm
Conclusion

Assess
Implement Intervention
Monitor

To reduce pressure Injuries
"...now apply pressure and hold it there. It's highly absorbant and will speed healing..."
References:

- WOCN Society position paper: Avoidable versus unavoidable pressure ulcers (injuries). Mt. Laurel, NJ: Author
- The Joint Commission, Division of Health Care Improvement. Issue 25 (July 2016)
Thank You