SKIN ULCER – WOUND

POLICY

All caregivers are responsible for preventing, caring for, and providing treatment for skin

Ulcerations.

PURPOSE

1. To identify at risk residents for potential breakdown or ulcerations
2. To prevent breakdown of tissue or ulcerations
3. To provide treatment that promotes prevention of ulcerations and healing of existing ulcerations

DEFINITION

For the purpose of this policy, a skin ulcer (wound) is defined as any open area of the skin regardless of origin. It may also include an area of discoloration that is not open if the nurse:

1. Identifies an area of concern that may potentially ulcerate and
2. Then confirms suspicion with a provider (physician/nurse practitioner/physician assistant/midlevel) for diagnosis.

Examples of this discoloration may include a Stage I pressure ulcer, a Suspected Deep Tissue Injury, a Wagner Grade 0, or other varieties of conditions that meet this criteria. It does not include areas that have resurfaced (resolved) as resurfaced areas may continue to be discolored for up to 18 months or longer in the elderly while the tissue continues to remodel after an area of previous ulceration. It also does not include areas of scar tissue formation.

RISK FACTORS

Risk factors can increase a resident’s susceptibility to develop or to not heal skin issues. Examples of risk factors as cited in F-686 are:

1. Impaired/decreased mobility and decreased ability
2. Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus
3. Drugs such as steroids that may affect wound healing
4. Impaired diffuse or localized blood flow, for example, generalize atherosclerosis or lower extremity arterial insufficiency
5. Resident refusal or some aspects of care and treatment
6. Cognitive impairment
7. Exposure of skin to urinary and fecal incontinence
8. Under nutrition, malnutrition, and hydration deficits; and
9. A healed ulcer: The history of a healed pressure ulcer and its stage (if known) is important, since areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown

ASSESSMENT

1. Licensed staff will upon admission perform a head to toe body audit within 2 hours of admission. The findings will be documented per facility protocol on the admission assessment form. Any items not documented on the admission assessment form will be charted in the nurse’s notes.
2. Licensed staff members will upon admission complete a risk scale once the head to toe body assessment is complete. The risk scale will be completed weekly for the first four weeks after admission for each resident at risk, then weekly for the first four weeks after admission for each resident at risk, then quarterly, or whenever there is a change in condition or functional ability.
3. A resident’s risk may increase due to an acute illness or condition change (i.e. upper respiratory infection, pneumonia, or exacerbation of underlying congestive heart failure) and may require additional evaluation. Therefore it is recommended to repeat a risk scale assessment if a resident has a significant change in condition.
4. Licensed staff will complete a head to toe skin assessment weekly and as needed. The skin assessment will be documented on a skin assessment form. Any unusual findings will be documented on the form with a follow up note in the nurse’s notes further describing the area of concern.

SKIN ULCER PREVENTION

1. Staff will institute a plan for any resident who has potential for skin breakdown or whose condition is deteriorating. This may include
   1. Turn and reposition every two hours as appropriate
   2. Pressure reduction surfaces for beds, wheelchairs, etc when appropriate
   3. Floating areas of concern such as heels when appropriate
   4. Separation of body prominences with a pillow or other pressure reducing device when side lying or as appropriate
   5. Use of elbow or heel protectors when appropriate
   6. Promotion of clean, dry, and well moisturized skin
   7. Avoiding powders
   8. Following Registered Dietician recommendations to promote optimum nutrition when possible
   9. Reduction of shearing force by appropriate body mechanics when moving, turning, or repositioning a resident
2. Nurse aides will complete body audits at least weekly, but preferably with every bathing opportunity. The body audits are turned in to the charge nurse for charge nurses to review for changes in skin condition. If the nurse assesses and determines there is a skin condition present, the protocol written on the licensed nurse body audit will be followed.
3. Encourage residents to change position frequently and ambulate as capable
4. Incontinent residents will be checked and changed as needed
5. Keep bed as free from wrinkles as possible
6. Nurse aides will report any clothing, shoes, braces, and splints that may not be fitting properly to the supervisor or floor nurse
7. Do not massage any areas of concern as this may cause further tissue damage and breakdown.

TREATMENT PROTOCOLS

1. Consult wound care providers when appropriate
2. Until wound care providers can assess and order treatment, the following techniques may be employed:
   1. Follow universal precautions and good hand washing techniques
   2. Provide explanation and/or instruction to the resident
   3. Provide privacy when indicated
   4. For NON-OPEN areas of concern or areas covered with STABLE eschar, apply skin prep daily and use preventative measures. On areas where skin prep is not appropriate (i.e. buttocks, etc) moisture barrier cream is adequate. Skin prep may also be used for UNRUPTURED serous filled or blood filled blisters.
   5. For all other open areas, the treatment is determined based on tissue type and drainage.
      1. For moderate to heavily draining wounds, calcium alginate is appropriate. Cover with secondary dressing to hold in place. Change as needed for soiling or drainage.
      2. For lightly exudating wounds, cover with non-adherent dressing. Change as needed for soiling or drainage.
      3. For wounds that have slough or UNSTABLE eschar present, a debridement agent is required (i.e. calcium alginate or Santyl. Keep in mind Santyl must be moist to be active so may need to be covered with Vaseline gauze or other moist dressing). Change daily and as needed for soiling or drainage.
      4. For deep or tunneling wounds, fill the open space with calcium alginate rope or other packing agent. Loosely pack. Cover with secondary dressing.
   6. All orders must be approved by a physician with 24 hours of discovering the open area or change in treatment.

FYI’s

1. Nurses may not diagnose, just describe
2. Measurements must be completed weekly by the same licensed person when at all possible
3. At the time a skin issue is discovered it must be measured. Wounds are three dimensional; therefore length, width, and depth must be documented if using measuring instrument. It is acceptable to measure using common household objects (i.e. dime size, quarter size, size of a half dollar) until actual measurements can be obtained per facility protocol.
4. Length of wound should always be measured in head to toe alignment. Width should always be measured in hip to hip or side to side alignment. Depth should always be the deepest part of the wound in perpendicular alignment.
5. If a reddened area is identified, the nurse should assess if the area is blanching. If it is not blanching, the nurse should leave for approximately 30 minutes, then return to assess if the area is blanchable. If it is blanchable, it is not a skin concern. If it is not blanching, then it should be captured on the licensed body audit report.
6. A wound assessment should be documented in the nurse’s notes (or other documentation location) with each dressing change.
7. It is recommended to chart on a TAR or other location that the dressing is intact every shift that a dressing change is not performed.

Medical Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Administrator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

DON Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_