April 2016

Skin Care

Date: **Instructor:**

Description: This inservice gives information on preventing pressure ulcers and skin tears.

Objectives:
On completion of this inservice, participants will be able to:

List risk factors for skin breakdown

Describe interventions to prevent pressure ulcers

Explain what to do when finding a skin tear

List causes of skin tears

Describe interventions to prevent skin tears

Outline:

Pressure Ulcers
Risk factors
Causes of pressure
Plan of care
Pre-existing signs
Interventions for prevention

Skin Tears and Bruises
Skin changes in the elderly
Reporting
Causes
Ways to prevent

Skin Care

Lesson Plan and Speaking Notes

Federal quality of care regulations state that the agency must ensure that:

A patient who enters the home health agency's care without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

A patient having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Failure to keep a patient from acquiring a pressure sore during the agency's care, and failure to heal a pressure sore in a timely manner are both considered serious signs of neglect. These things should never happen if a patient is receiving proper care.

If the patient has a clinical condition that makes a pressure ulcer unavoidable, this is defined by the patient's physician, and documented in the patient's chart.

Risk Factors for Skin Breakdown

Impaired mobility
Nutrition or hydration deficit
Incontinence
Impaired blood flow
Skin desensitized to pain or pressure
Diseases such as Diabetes or Renal Failure
Excessive moisture on skin
Dementia
Drugs like steroids that impair wound healing
Refusal of treatment
Peripheral vascular disease
Restraint
History of skin breakdown

Causes of Pressure

Remaining too long in one position
Friction and shearing
Bad positioning in a chair
Bad positioning of braces, casts, or other devices
Ill-fitting shoes
Contractures

Can you describe the agency's policy on skin assessment and care?

Know the Patient's Plan of Care

Every patient at risk for skin breakdown has a care plan for skin care, so you should be familiar with the care plan and follow it.

Follow turning schedules carefully.

With every patient, look at skin with all care, such as dressing and bathing.

Report any signs of breakdown, redness, dryness, or irritation to the charge nurse.

The nursing assistant is in vital position to protect the integrity of the patient's skin because she sees it more than anyone else.

Pre-existing Signs of a Pressure Ulcer

Redness, Purple or dark area
Edema
Hardening of skin
Bogginess

What are some ways to prevent pressure ulcers?

Interventions to Prevent Pressure Ulcers

Provide measures to decrease pressure/irritation to skin: fleece pad, heel protectors

Keep skin clean and dry

Change incontinent pad ASAP after voiding or bowel movement

Apply protective or barrier lotion after incontinence

Avoid hot water and irritating soaps

Keep bed linen clean, dry, and free of wrinkles

Assist patient to turn and reposition every two hours

Position with pads and cushions to prevent pressure

Use a draw sheet or lifting device to move patient

Increase out of bed activity as tolerated

Keep nails short

Skin Tears and Bruises

These are recurring problems in our elderly patients due to the fragility of some of the patient's skin, their immobility, and the large number of staff members who interact with them in different situations.

Skin Changes in the Elderly

Skin becomes less elastic, less rigid, sags and doesn't snap back as quickly, so it is more easily torn by stress.

Thin skin has less of a barrier effect – loses water more easily, bacteria can get in easier. There is less of the fat layer, so less protection.

Sensory and/or cognitive impairment, poor nutrition, anticoagulants can increase incidents of tearing and bruising.

All of the patients are at risk, but more dependent patients are at a greater risk.

80% occur on arms and hands - and legs also get a lot of skin tears.

What should you do when you find a skin tear or bruise on a patient?

When You Find a Skin Tear or Bruise

Report this to the charge nurse immediately.

Skin tears are a way for infection to get in the skin. The charge nurse should be informed immediately so she can clean, dress, and treat the tear, and document it.

Larger skin tears may be difficult to heal, they are an even bigger opening for bacteria, and some may need steri-strips.

Causes of Skin Tears

Friction or shearing - This can happen with the slightest movement

During personal care:
Turning / Transfers
Dressing
Bathing
Ambulating
Changing dressings

Rubbing and bumping against objects: bed, chair, clothing, dressings, tubing, toilet, any object

What are some ways we can help to prevent skin tears?

Ways to Prevent Skin Tears

Good positioning, turning, transferring, and ambulating techniques

Positioning – use draw sheet when possible - Use two staff members so you can lift instead of pulling against sheet

Watch out for bed rails when turning

When transferring, use enough help

Make sure all wheelchair leg rests are out of the way

Make sure bed crank is not sticking out

Pad equipment when possible such as bed rails, chair arms

Dress patient in long sleeves or pants

Arm and leg protectors, stockinettes

Lotion to dry skin twice a day

Don't let arms or legs dangle – support them

Use non-adherent dressings and paper tape

Remove tape slowly and gently – you may need to soak dressings or tape with saline water before removing

Post-Test

Title: Skin Care
Name:
Date:
1. List three risk factors for skin breakdown.
2. What are two interventions to prevent pressure ulcers?
3. What should you do when you find a skin tear?
4. List two interventions to prevent skin tears.