

SKIN CARE

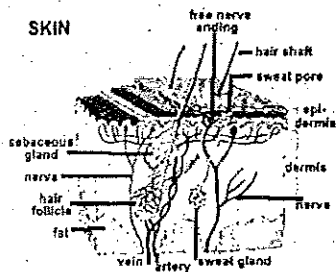
Franklin Square Hospital Center
Baltimore, MD

12/2007

Objectives

- > 1. List the three categories in the Braden Scale.
- > 2. List three prevention strategies to use for a patient at risk for skin breakdown.
- > 3. Describe 3 areas that need to be documented on a wound assessment.

Layers of Skin



Assessment

Risk Factors

WOUND CARE

Assessment

Ethics

Prevention

Wound Dressing

Risk Factors

- > Braden Scale
 - Nutrition
 - Friction/Shear
 - Moisture
 - Activity
 - Mobility
 - Sensory Perception

Risk Factors

- > What does your patient's Braden score mean?



Risk Factors

- Sensory Perception
 - Pain Assessment
 - Assessment of LOC

Risk Factors

- Moisture
 - Incontinent of bowel and/or bladder
 - Barrier Creams
 - Fecal Incontinent Pouch
 - Use of diapers?
 - Diaphoretic
 - Management of fever
 - Draining Wound
 - Management of drainage

Risk Factors

- Activity
 - Rehabilitation Consultation
 - Individualized turning program

Risk Factor

- Nutrition
 - Albumin, prealbumin
 - Tube Feeding
 - Supplements
 - Nutrition Consult
 - Needs to be fed
 - Encourage family to bring in foods
 - Disease states affecting nutrition

Risk Factors

- Friction & Shear
 - Draw sheet under patient
 - Do not leave HOB > 30°
 - Eliminate number of pads under patient

Skin Assessment

- Head to toe assessment on admission
- Head to toe assessment daily
- Braden score daily



Prevention

- Follow the Pressure Ulcer Guidelines



Assessment

- What do you do if you find wound on admission?



Assessment

- What to do if you find wound after first 24 hours?



Assessment of Wound

- Size of wound
 - Use cm
 - Head to toe
 - Wound tracings
 - Photography



Assessment of Wound

- Location
- Type
- Size
- Odor
- Drainage/exudate
- Wound bed
- Undermining/tunneling
- Periwound skin
- Pain

Bacterial Burden

Bioburden: metabolic load imposed by bacteria in tissue, often a cofactor in impaired repair

Stenility: absence of microbes

Contamination: presence of microbes but little active growth

Colonization: growth and death of microbes kept at safe level by host immune response (Healthy Balance)

Critical Colonization: host defenses unable to maintain healthy balance- either too many microbes or too many species in wound base

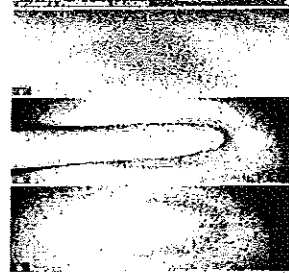
Infection: host defenses overwhelmed, local cellulitis (might lead to bacteremia, septicemia and death)

Assessment of Wound

- > Type of wound
 - Pressure Ulcer
 - Venous Ulcer
 - Arterial Ulcer
 - Diabetic Ulcer
 - Partial Thickness
 - Full Thickness

Pressure Ulcer

- > Stage I



Pressure Ulcer

- > Stage II



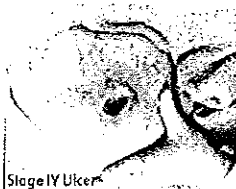
Pressure Ulcer

- > Stage III

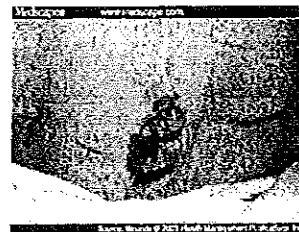


Pressure Ulcer

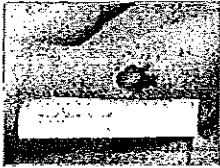
- > Stage IV



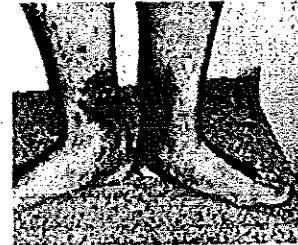
Deep Tissue Injury



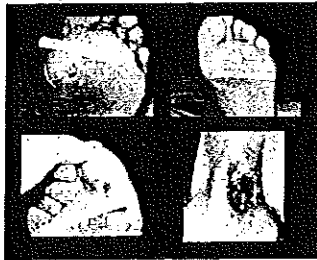
Arterial Ulcer



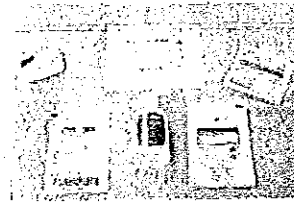
Venous Ulcer



Diabetic Ulcers



Dressing Options



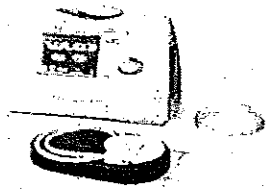
Dressing Options

- Basic Rules for selecting a dressing
 - If the wound is **dry**, **WET** it.
 - If the wound is **wet**, **DRY** it.
 - If the wound is **shallow**, **COVER** it.
 - If the wound is **deep**, **FILL** it.

Dressings

- Hydrocolloids
- Hydrogels
- Alginates
- Foams
- Gauze
- Hydrofiber
- Transparent film
- Antimicrobials
- Topical Creams
- Enzymatic Debriders
- Compression
- Wound VAC

Wound VAC



Considerations for Dressings

- › Ease of application
- › Caregiver's ability
- › Cost
- › Pain level
- › Environment of Care

Wound Care Consults

When should you ask for a
Wound/Skin
consult?

Consults

- › Enter into SMS
 - Consults → Enterstomal Therapy Nurse → Wound Skin Consult

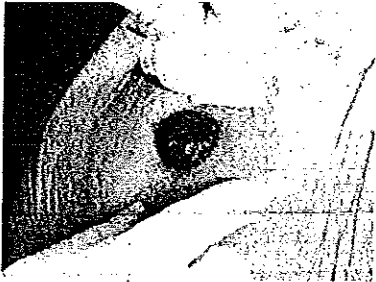
When Wound VAC is ordered:
SMS → Consults → Specialty Bed → select
Wound VAC

Specialty Bed/Bariatric Bed

- › Approval to order must come from Wound/Ostomy Nurse.
- › Need physician order for bed.
- › Bed must be entered into SMS
- › All specialty beds & bariatric beds come from Hill-Rom



Ostomy Care



Ostomy Care

- Stoma: an artificial permanent or temporary opening especially in the abdominal wall made in surgical procedure

Colostomy

- Colostomy
 - End Stoma



Colostomy

- Double Barrel

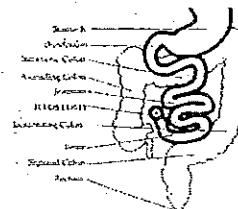


Colostomy

- Loop

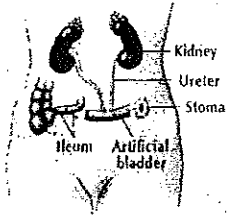


Ileostomy



Urostomy

- Ileal Conduit

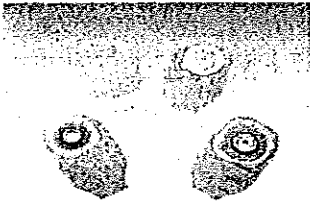


Goals of Pouching

- Contain stool/urine
- Prevent leakage
- Protect peristomal skin
- Compatible with patients/caregivers self-care ability (KISS principle)
- Suitable to patient's lifestyle
- Provide physical and psychological security

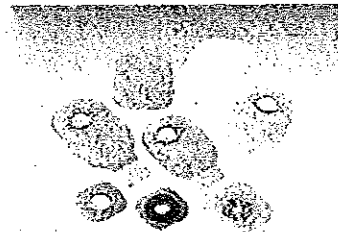
Colostomy Pouch

- One piece



Colostomy Pouch

- Two Piece System



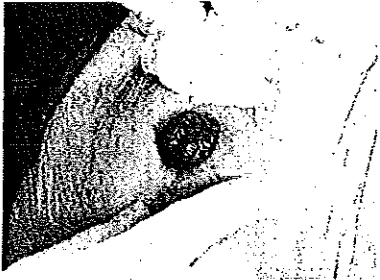
Urostomy Pouch



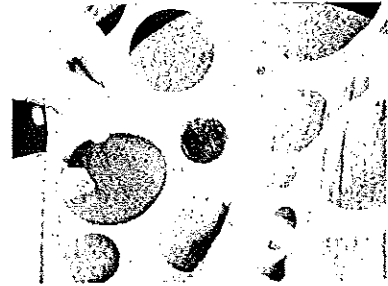
Supplies

- Pouch
- Scissors
- Clamp/Adapter
- Measuring Guide
- Soap and water

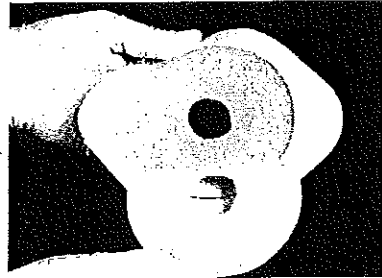
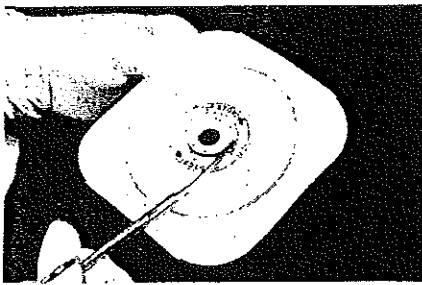
Cleaning skin



Measuring Stoma



Cutting Wafer/Flange



Attaching Pouch



Other Supplies

- > Paste
- > Skin prep
- > Powder
- > Adhesive remover
- > Paste Strips
- > Eakin seals
- > Adapt rings

> When to use?

Consults

- > Office number 443-777-7970
- > Pager number 410-932-6536
- > Enter into SMS

