CLIENT SAFETY WORKBOOK

Exercises for success in
National Patient Safety Goals

EDITION 1.0

ati NURSING EDUCATION

Lesson 7

Maintaining Skin Integrity

"Optimizing overall care and increasing attention to prevention can save patients from unnecessary harm and death"

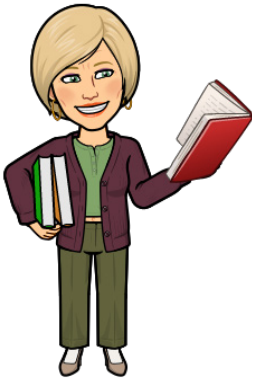
-The Joint Commission

The Objectives

1. Provide evidence-based skin care to prevent and treat skin breakdown using Agency for Healthcare Research and Quality (AHRQ) standards for practice.
2. Describe what alterations in mental status may put a client at risk for skin breakdown.
3. Evaluate the effectiveness of interventions to prevent and treat skin breakdown, and accurately document assessments and processes.
4. Identify, stage, and measure pressure injuries.
5. Self-assess individual knowledge using the Pieper Pressure Ulcer Knowledge Test.

Knowledge

In 2008, the Centers for Medicare and Medicaid Services (CMS) announced that it would not pay for additional costs incurred for hospital acquired pressure injuriess. When analyzing where healthcare dollars were spent, it was found that in the fiscal year 2006, 322,946 cases of pressure injuries as a secondary diagnosis were reported.

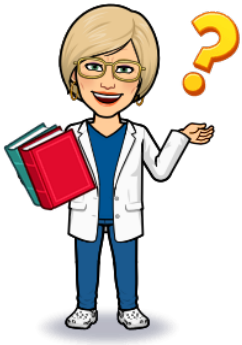


Did You Know?

Astoundingly, the average cost per hospital case PER STAY were $40,381 for a total cost of $1.3 billion. It was also found that approximately 60,000 patients die each year resulting from pressure injury complications (Fleck, 2009).

What does this have to do with nursing practice?

Lyder and Ayello (2008) claim that preventing pressure injuries has been a nursing concern for may years. Florence Nightingale (1850) purported that "If he has a bedsore, it's generally not the fault of the disease, but of the nursing." While pressure injury prevention is a multidisciplinary responsibility, the quality of nursing care seems to be directly linked with patient/client skin integrity. In 1992 the AHRQ published the first clinical practice guidelines on ways of assessing and preventing pressure injuries which served as a foundation for providing care. Ultimately, prevention of pressure injuries became a National Patient Safety Goal (Joint Commission, 2021).



What are some actions staff can take to prevent injuries in high-risk

- Avoid shear force
- Individualize nutritional support
- Use moisture barriers
- Schedule skin inspections
- Plan to maintain and increase mobility and activity level, when appropriate

Knowing that maintaining skin integrity is a key indicator of patient care quality, and understanding your roles and responsibilities to ensure that quality care is delivered safely, this chapter introduces you to

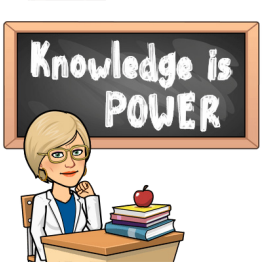
- The importance of maintaining patient skin integrity,
- Expands your resources on patient safety to include the AHRQ
- Ways of assessing skin integrity
- Appropriate documentation of skin assessment findings
- Identify, stage, and measure pressure injuries
- The Piper Pressure Ulcer Tool

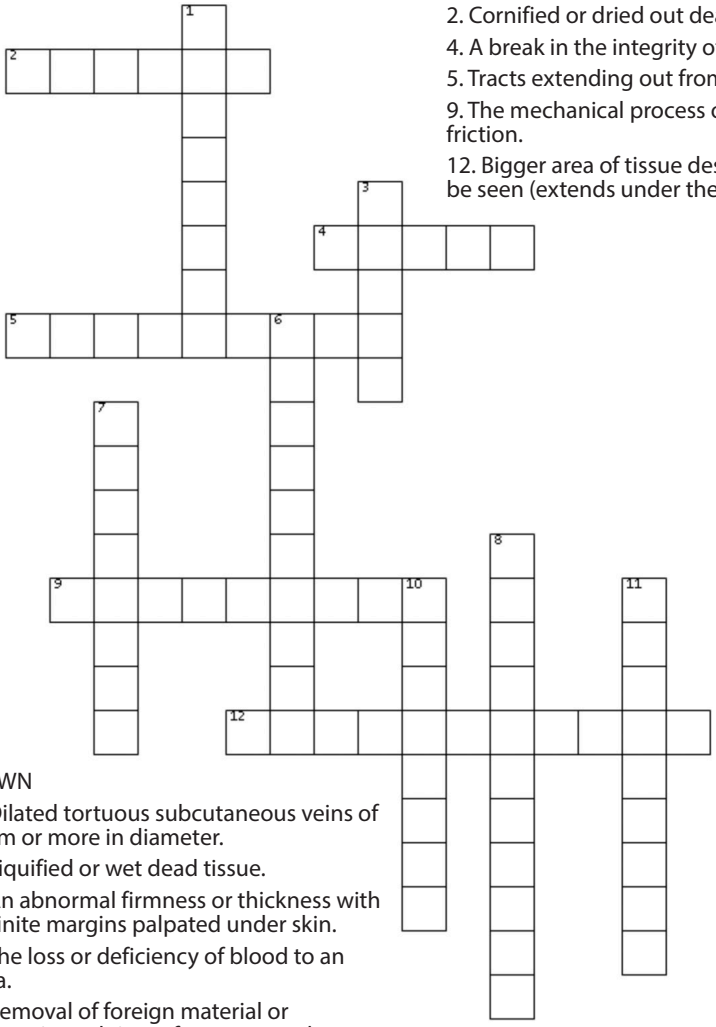
Case Study **1**

Mr. Gonzalez is a 68-year old male with a history of schizophrenia and type-2 diabetes. The home health nurse caring for Mr. Gonzalez noticed that his blood glucose has been elevated for the past few days and consults with the treatment team. The healthcare provider decides to discontinue clozapine and trial ziprasidone, another second generation anti-psychotic. Why should the nurse consider the impact of anti-histamine effects with skin integrity?

Skin Integrity
Know Your Terms

Familiarize yourself and search for important terms and definitions that will be used throughout this module.





ACROSS

2. Cornified or dried out dead tissue.
4. A break in the integrity of the skin.
5. Tracts extending out from the wound.
9. The mechanical process of wearing away by friction.
12. Bigger area of tissue destruction that can be seen (extends under the edge).

DOWN

1. Dilated tortuous subcutaneous veins of 3mm or more in diameter.
3. Liquified or wet dead tissue.
6. An abnormal firmness or thickness with definite margins palpated under skin.
7. The loss or deficiency of blood to an area.
8. Removal of foreign material or contaminated tissue from a wound.
10. Dead tissue found in the wound bed as a result of loss of blood flow.
11. The reddened area that becomes white with pressure applied.

Word

Telangiectasia

Definition

Prefix

Tel-

Root

Angie

Suffix

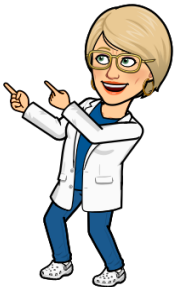
-ectasia

Clinical Scenario

Illustration

The Pieper Pressure Ulcer Knowledge Test

Designed by Pieper and Mott in 1995, this test examines various important aspects in careing for pressure injuries like prevention, staging, and wound description. Healthcare providers use this test to help understand any gaps in knowledge and better inform practice change decisions.



Interactive Concept Map

Use this QR code to explore an interactive concept map based on important national patient safety goals about pressure ulcers and injuries

1. Hot water and soap may dry the skin and increase the risk for pressure injury/ulcers.

True/False

What is the main idea of washing areas that are at risk of pressure injuries/ulcers?

What other idea can you add about washing injuries to reduce the risk for pressure injuries/ulcers?

What should the client understand about washing and pressure injuries/ulcers?

2. Hydrogel dressings should not be used on pressure injury/ulcers with granulation tissue.

True/False

What is the main idea of hydrogel dressings?

What other idea can you add about hydrogel dressing?

What should the client understand about hydrogel dressing?

3. A person confined to bed should be repositioned based on the individual's risk factors and the support surface's characteristics.

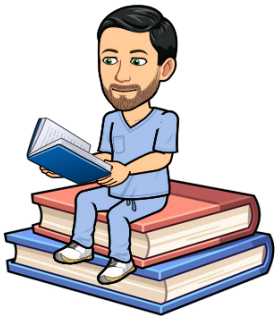
True/False

What is the main idea behind repositioning a person who is confined to a bed?

What other idea can you add to support bed repositioning?

What should the client understand about repositioning?

Skin Integrity Reading Challenge



Set a 5 and 10 minute timer on your favorite device. At the sound of each alarm, write a key point from the reading that was most memorable to you. ARTICLE SUMMARIES

1

5-min Keypoint: _____

_____

10-min Keypoint: _____

_____

_____

2

5-min Keypoint: _____

_____

10-min Keypoint: _____

_____

_____

3

5-min Keypoint: _____

_____

10-min Keypoint: _____

_____

_____

4

5-min Keypoint: _____

_____

10-min Keypoint: _____

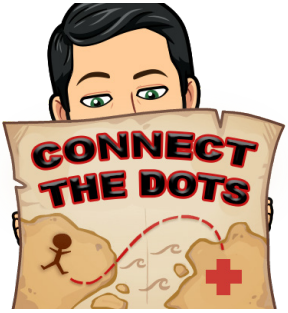
_____

_____

Skin Integrity

Active Learning Template

Set a 5-minute timer and see how much you can connect, all from memory. After, grab your readings, a different color ink, and another 5-minute timer. Challenge yourself each 10-minute round to write more from memory!



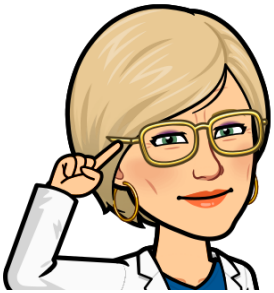
ASSESSMENT

Risk Factors	Expected Findings
Laboratory Tests	Diagnostic Procedures

PATIENT-CENTERED CARE

Nursing Care	Medications	Client Education
Therapeutic Procedures		Interprofessional Care

Skin Integrity Knowledge Quiz



Choose a word or concept in Column A and try to match it with a word or concept in Row 1.

Colum A / Row 1	Hydrocolloid Dressings	Intact Skin that has non-blanchable erythema	Shear Force	Ring Cushion	Asses Pressure Ulcer Knowledge	Dead Tissue	Alginate Dressings
Pieper Pressure Ulcer Knowledge Test							
Eschar							
Avoid this movement mechanic							
A device used to prevent injury							
Stage 1 Pressure Injury							
Ideal for dry wounds with no drainage							
Used for heavy drainage injuries.							

BONUS

Justify when each match would be considered in the nursing process. For example, A nurse can assess the risk for shear force and implement proper movement mechanis to minimize risk.

Case Study 2

A few days after coming into the health clinic, Mr. Gonzalez sustained a fall at home in his bathroom. He was transported to the ED via ambulance. My. Gonzalez had a right hip fracture and underwent hip replacement surgery 1 day ago. COVID positive confirmed through testing. States "he was in bed for 6 days, too weak to do much". Diabetic. Controlled with Metformin 2000 mg/day. No other pertinent medical history. Lives with spouse. Watch the video on the next page to view his interaction with the nurse.

Skin Integrity Clinical Application

1. Watch the clinical scenario by scanning the QR code on the right.

2. Scan the QR code below to download and use the Braden Skin Assessment Tool to predict the client's risk of developing a pressure injury.

BEGINNER

o Why is skin integrity important when providing client care?

o What information shared by Mr. Gonzalez is relevant to his potential for skin injury?

o After assessing Mr. Gonzalez's skin, what is your first priority?

DOCUMENT

Scan the QR code below to practice documenting your findings

ADVANCED

o Review the skin care protocol or standard at the healthcare organization where you are completing your clinical experience and compare it to the ARHQ tool called Assessing Screening for Pressure Ulcer (Injury) Risk (see AHRQ, n.d., pp. 109–110, in the Resources section).

o What standardized risk assessment tool is used to assess risks for pressure injuries in the inpatient population?

o According to the skin assessment protocol–standard, what is the frequency for skin inspection?

o What variables are included in the agency's skin safety plan? Is the skin safety plan clearly articulated?

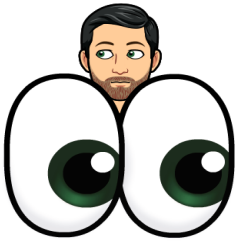
o Describe the documentation format for noting the skin assessment and skin safety plan.

o How is an increased risk of pressure injury development communicated? Who is the information shared with?

o Is the policy or standard complete? If not, add evidence-based recommendations to the existing policy or standard, and share the policy revision with your preceptor.

Scan the QR code on the right to compare your documentation with a professional

Skin Integrity Scavenger Hunt

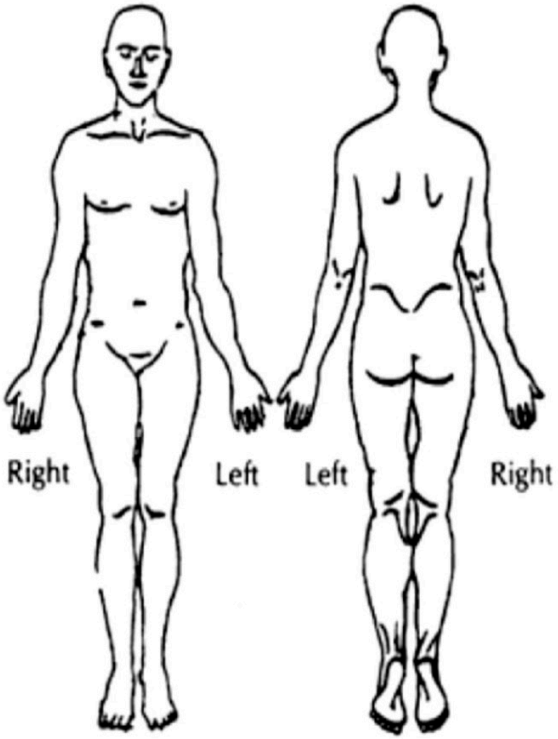


Once you have a good understanding of why and how you will manage skin integrity, the next step will be to find where these resources are in your work environment.

Item	Location
1. Moisture Barrier	
2. Cotton Underpads	
3. Assistive Lift Devices	
4. Wound Dressings	
5. Pressure Relief Devices	
6. Camera	
7. Educational Brochures	
8. Skin Cleaning Solution	
9. Footstool/rest	
10. Wound Care Clinician (Name and Contact Information)	
11. Timer	
12. How are pressure injuries measured? (Give tool/device used)	
13. Other:	

Skin Integrity Risk Visualizer

Using your assigned client, use the outline below to mark actual or at-risk areas for skin integrity considerations.



A. Skin intact (red but blanchable)
B. Stage I (red non blanchable)
C. Stage II (broken surface/epidermis)
D. Stage III (full thickness tissue loss)
E. Stage IV (bone visable)
F. Unstagable pressure ulcer
G. Venous stasis
H. Arterial stasis (necrotic toes/fingers)
I. Incisions
J. Bruising
K. Ecchymosis
L. Skin Tear
M. Excoriation
N. Abrasion
O. Scab
P. Hematoma
Q. Cyanosis
R. Jaundice
S. Edema
T. Rash
U. Deep Tissue Injury
V. Laceration
W. Other

Skin Integrity Attitudes

Beginner: What is one thing you can do to enhance the quality Mr. Gonzalez's chances of leaving the hospital without developing a pressure injury?

Advanced: Evaluate Wound Care Apps. Select one and develop an infograph that describes the app benefits.

Scan the QR codes below to hear real nurses talk about their experiences with skin integrity.

NEW GRAD

VS.

EXPERT

Social Media Outreach

Use your favorite social media platform to start, share, or participate in a global discussion about skin integrity. Choose any concept that you have learned about thus far in skin integrity. Be sure to use the hastag on the right!

Progress Report

Earn badges and keep track of your progress while you work towards becoming a National Patient Safety Goal Champion!