Skin wounds | Ngā taotū kiri

Treatment should be holistic, realistic and patient-centred

Consider

- Pain
- Psychological support, eg, anxiety, depression, self-neglect
- Body image
- Independence, eg, work, financial
- Malodour and exudate
- Quality of life
- Carer stress, family/whānau
- Nutrition and hydration
- Medical history, eg, medication, co-morbidities
- Wound aetiology
- Cultural considerations.

Realistic goals of care

- Normal healing – healing proceeds as would be expected
- Hard to heal wounds – healing is prolonged, despite appropriate wound care, eg, leg ulcer, diabetic ulcers
- Palliative wounds – no healing potential
- Discuss realistic goals with resident and family
- Symptom management, rather than healing, may be the only possible outcome.

Wound bed preparation – T I M E evaluation

T	**Tissue, removal of non-viable tissue** Hydrogels, alginate, hydro fibres, cadexomer iodine, honey
I	**Infection, inflammation (bio-burden, biofilm)** Action: remove or reduce bacterial load – silver, honey, cadexomer iodine, wound solutions, polyhexamethylene biguanide (PHMB), oxidised solution
M	**Moisture balance** Action: restore moisture balance: hydrogels, hydrocolloids, foams, hydro fibres, absorbent pads
E	**Edge of wound advancement** Action: measure wound progression, photograph, measure, including undermining

Arterial and neuropathic ulcers

- Doppler assessment to assess arterial flow
- Consult with physician. Consider vascular or podiatry assessment (referral)
- Pain management
- Ischemic wounds, keep dry and protected
- Reduce bio-burden
- Raise head of bed slightly (tilt/lower the foot of the bed down)
- Remove constricting garments and keep feet warm
- Check feet and footwear. Consider orthotics or other appropriate footwear
- Encourage exercise as comfortably tolerated
- Diabetes control.

Venous ulcers

- Doppler assessment to assess arterial flow
- Compression therapy gold standard treatment
- Compression must be applied according to local policy
- Elevation
- Encourage exercise as comfortably tolerated
- Moisture balance
- Skin maintenance – ulcers may be showered; if showering consider cross-infection first
- Prevention of reoccurrence. Consider compression hosiery.

Skin tears

- Realign skin flap, where possible, without overly stretching the skin
- Consider non-adherent dressings that optimise TIME principle
- Adhesive opinion suggests that adhesive strips are no longer a preferred treatment option of choice for skin tears
- Durable dressings that do not cause trauma on removal, eg, silicone/safetec dressings
- Consider protection and care of fragile skin, eg, skin protectors, regular gentle moisturising, pH-appropriate skin cleansers
- Assess environment, eg, remove excess clutter, pad sharp edges, manage nail care
- Utilise a skin classification tool, eg, STAR or ISTAP.

Malignant wounds

- Consult with physician. Consider biopsy
- Realistic patient-centred goals
- Odour management, eg, charcoal dressing, oxidising solutions or cat litter under the bed
- Quality of life.

Incontinence-associated dermatitis

- Manage incontinence
- Implement a skin care regime
- Cleanse – pH-appropriate skin cleanser
- Protect – barrier
- Restore moisture.

Pressure injuries

- See pressure injury guide.

Wound prevention protocols

- Wound risk-screening tool; Waterlow, Braden or similar; reassess if there is a change in condition.
- Consider medication and other disease processes in care planning.
- Careful removal of skin adhesives.
- Consider alternatives such as silicone or safe tech dressings or non-adherent dressings.
- Skin protection, moisture management, hydration and nutrition, pressure off-loading, refer to the table on page 111 for bundles of care for pressure injury prevention.
- Highest level of mobility as possible.
- Do not use waterproof/incontinence sheets on mattresses as it alters the microclimate of the skin.
- Utilise a 30 degree tilt position.
- Flex knees to reduce shear of the sacrum.
- Use pillows or foam wedges to keep bony prominences apart from direct contact with each other, eg, knees and ankles.
- Use sliding sheets to reduce friction and shear.
- Multidisciplinary team – OT/PT positioning and postural assessment, seated and lying.

Care plan – pressure injury prevention

Skin assessment – head to toe

- Look, listen, feel
  - Erythema
  - Blanching response
  - Localised heat
  - Oedema
  - Induration
  - Skin breakdown, bony prominences
  - Skin breakdown under medical devices
  - Pain
- Be on the lookout.

Age-related skin changes

- Reduced pigmentation
- Reduced skin elasticity
- Reduced vascular blood
- Reduced skeletal muscle
- Reduced cellular shedding and replacement
- Thinner dermis
- Reduced sebum.

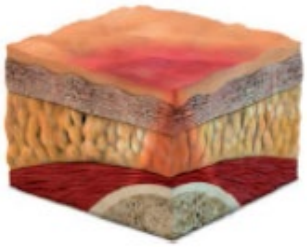
See also: SSKIN care bundle (Accident Compensation Corporation 2017).

How to classify and document pressure injuries

The NPUAP pressure injury (PI) classification system provides a consistent and accurate means by which the severity of a pressure injury can be communicated and documented.

PI identification and classification

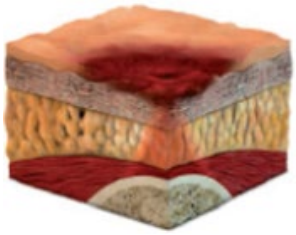
Stage I PI, non-blanchable erythema



Intact skin with non-blanchable redness of a localised area usually over a bony prominence

- Darkly pigmented skin may not have viable blanching. Its colour may differ from the surrounding area
- The area may be painful, firm, soft, warmer or cooler, compared with adjacent tissue
- May be difficult to detect in individuals with dark skin tones
- May indicate 'at-risk' persons (a heralding sign of risk)

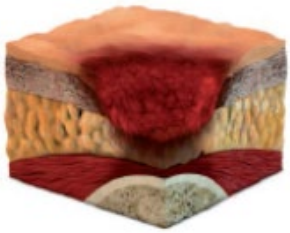
Stage II PI, partial thickness skin loss



Partial thickness loss of dermis presenting as a shallow, open wound with a red/pink wound bed without slough

- May present as an intact or open/filled serum-filled blister
- Presents as a shiny or dry shallow ulcer without slough or bruising. **Note:** bruising indicates suspected deep tissue injury
- Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation

Stage III PI, full thickness skin loss

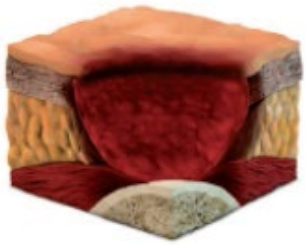


Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed

- Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling
- The depth of a stage III PI varies with anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow; in contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not viable or directly palpable

Pressure injury identification and classification continued

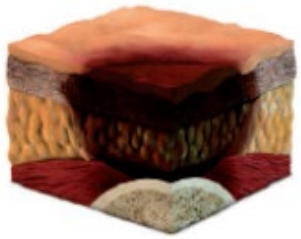
Stage IV pressure injury: full-thickness tissue loss



Full-thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed

- The depth of a stage IV PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and these PIs can be shallow.
- Stage IV PIs can be extended into muscle and/or supporting structures, eg, fascia, tendon or joint capsule, making osteomyelitis possible. Exposed bone or tendon is visibly or directly palpable

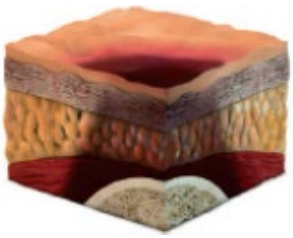
Unstageable pressure injury: depth unknown



Full-thickness tissue loss of which the bone of the PI is covered by slough (yellow, tan, grey, green or brown) and or eschar (tan, brown or black) in the PI bed

- Until enough slough or eschar is removed to expose the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed

Suspected deep tissue injury: depth unknown



Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear

- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler, compared with adjacent tissue
- Deep tissue injury may be difficult to detect in individuals with dark skin tone
- Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing other layers of tissue even with optimal treatment

Level of risk to recommended care checklist

	Not at risk Bundle A	At risk 10+ Bundle B	High risk 15+ Bundle C	Very high risk 20+ Bundle D
Initial assessment on admission within 8 hours of admission to ward	☐ Complete Waterlow or Braden risk assessment ☐ Full visual check of skin ☐ Record PIs, if present, upon admission	☐ Complete Waterlow or Braden risk assessment ☐ Full visual check of skin	☐ Complete Waterlow or Braden risk assessment ☐ Full visual check of skin ☐ Provide patient with information leaflet and discuss	☐ Complete Waterlow or Braden risk assessment ☐ Full visual check of skin ☐ Provide patient with information leaflet and discuss
Inspect skin	Weekly ☐ Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain ☐ Document outcome	Once a day during AM shift ☐ Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain ☐ Document outcome	Twice a day AM/PM shift ☐ Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain ☐ Document outcome	Once each nursing shift ☐ Check for broken areas, redness, localised heat, oedema, induration, tissue consistency and pain
Manage moisture	☐ Ensure skin remains free of excessive moisture	☐ Moisturise skin daily ☐ Manage incontinence	☐ Moisturise skin daily ☐ Manage incontinence ☐ Use barrier cream, if required ☐ Follow toileting plan	☐ Moisturise daily ☐ Manage incontinence ☐ Use barrier cream as required ☐ Check continence pad 3-hourly ☐ Attend to hygiene needs twice a day
Adequate hydration and nutrition	☐ Record patient's weight weekly	☐ Consider dietitian referral ☐ Ensure good fluid and nutritional intake ☐ Record weight weekly	☐ Make dietitian referral ☐ Ensure good fluid and nutritional intake ☐ Record fluid and food intake ☐ Record weight weekly	☐ Dietitian referral essential ☐ Ensure good fluid and nutrition intake ☐ Document fluid and food intake on each shift ☐ Record weight weekly ☐ Use supplements if indicated by dietitian. Assist with food intake
Minimise pressure	☐ Ensure patient changes position every 2 hours ☐ Ensure patient changes position every 2 hours when sitting in a chair	☐ Ensure heels are free off the surface of the bed or ☐ Use heel protectors ☐ Ensure patient changes their position every 2 hours when in bed ☐ Ensure patient changes their position every 2 hours when sat in a chair	☐ Consider the use of pressure-relieving mattress/cushions ☐ Ensure heels are free off the surface of the bed or ☐ Use heel protectors ☐ Do not turn patients onto red areas or broken skin Bed at least Individualised plan for position changes. Consider: ☐ 2-hourly change of position ☐ 3-hourly when on a pressure mattress Sitting at least ☐ 2-hourly change on chair	☐ Use pressure-reducing mattresses and cushions ☐ Ensure heels are off the bed surface or use heel protectors ☐ Discourage elevation of head of bed above 30 degrees for more than 1 hour ☐ Do not turn patients onto red areas or broken skin Bed at least Individualised plan for position changes. Consider: ☐ 2-hourly change of position ☐ 3-hourly when on a pressure mattress Sitting at least ☐ 2-hourly change on chair

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Skin wounds

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