



# F-tag 686 Treatment and Services to Prevent and Heal Pressure Ulcers

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# F-TAG LEADERBOARD

1 F0884 NHSN Reporting

2 F0689 FREE OF ACCIDENTS

3 F0080 INFECTION PREVENTION

4 F0684 QUALITY OF CARE

5 F0812 FOOD STORAGE/PREP/SERVE

6 F0656 DEV/IMP COMP CARE PLANS

7 F0677 ADL CARE

8 F0761 LABEL/STORE DRUGS BIOLOGICALS

9 F0686 PRESSURE ULCERS

10 F0609 REPORTING ALLEGED VIOLATIONS

# Learning Objectives

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1. Define pressure injury
2. Recognize risk factors
3. Demonstrate signs/symptoms
4. Identify the importance of changes in skin
5. Review of various treatments
6. Comprehension of preventative strategies
7. Discuss tools and resource

# Definition

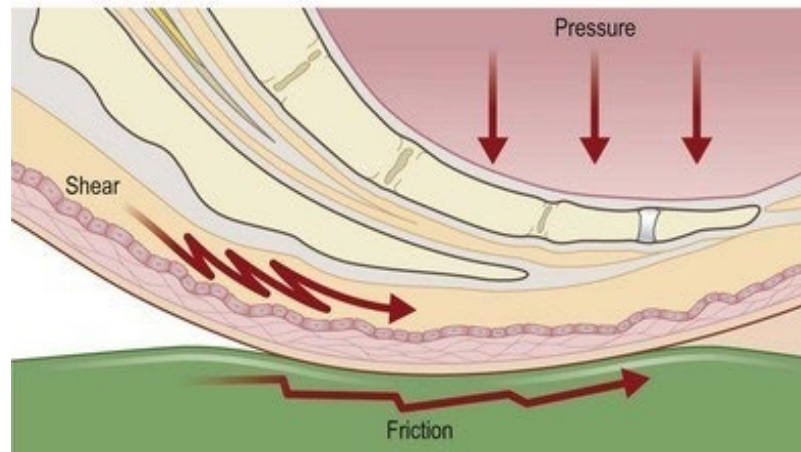
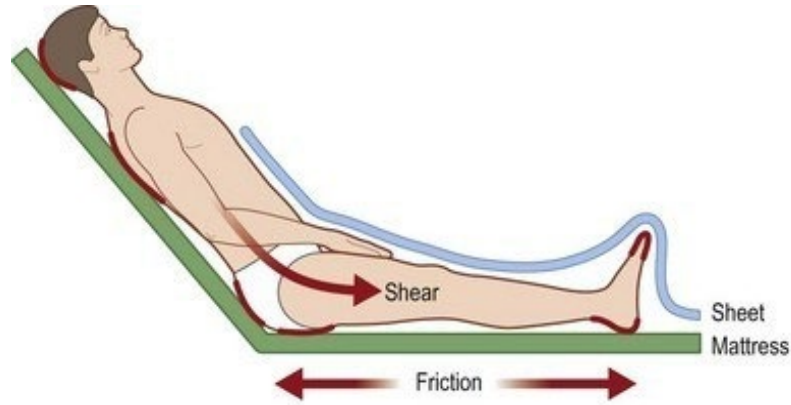
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- Pressure Ulcer/Injury:

*Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.*



# Risk Factors



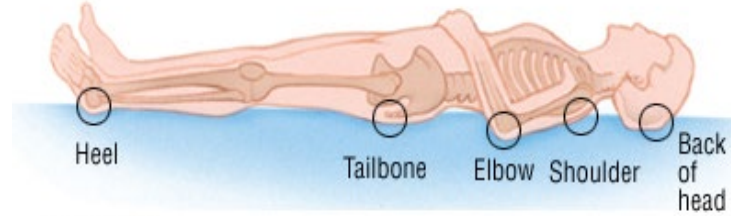
- Shearing and friction
- Moisture
- Decreased movement
- Decreased sensation
- Circulatory problems
- Poor nutrition
- Age

*(Harvard Health Publishing, 2020)*

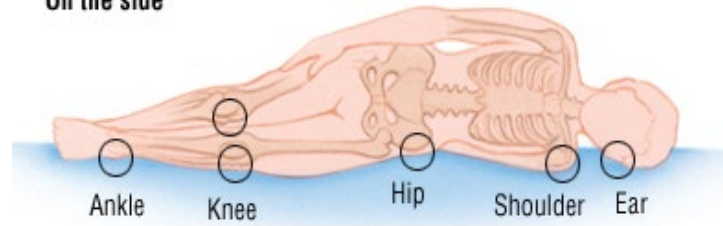


# Most Common Sites – Bony Prominence

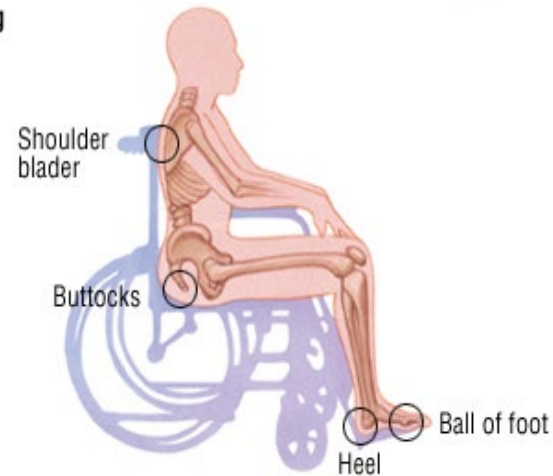
On the back



On the side



Sitting



# Signs and Symptoms

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- Changes in skin texture and/or color
- Edema
- Drainage
- Cooler or warmer to the touch
- Tenderness

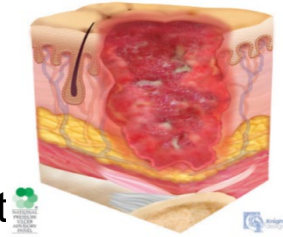
(Mayo Clinic, 2020)

# Staging

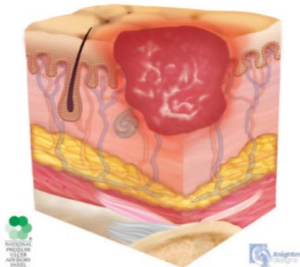
**Stage 1:** Skin is intact but red



**Stage 3:** Skin is broken  
Depth to the wound  
Fat tissue may be not



**Stage 2:** Skin is broken  
No depth to the wound



**Stage 4:** Skin is broken  
Muscle/bone  
may be visible

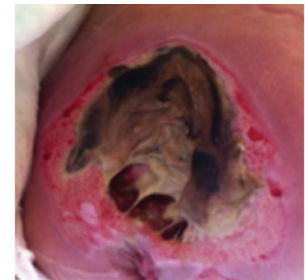


## Deep Tissue Injury:

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.



**Unstageable:** Severe tissue loss  
Wound may appear as empty hole



*Images by National Pressure Injury Advisory Council, 2019*



# Cost

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Stage I	\$1,912
Stage II	\$8,255
Stage III	\$14,240
Stage IV	\$22,222



(AHRQ, 2020)

# Back to Basics: It's All About Prevention

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- Repositioning and redistribution of weight
- Use of pressure relief surfaces:
  - Specialized cushions
  - Pillows
- Proper skin checks
- Incontinence care
  - Don't forget the barrier cream
- Assessments detect early-stages



# Back to Basics – Create a Culture

- Dietary
- Housekeeping
- Porters
- Hairdresser
- Activities
- Family
- Friends

**Stop and Watch**  
Early Warning Tool

  
Version 4.5 Tool

If you have identified a change while caring for or observing a resident/patient, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

**S** Seems different than usual; Symptoms of new illness  
**T** Talks or communicates less  
**O** Overall needs more help  
**P** Pain – new or worsening; Participated less in activities  
**a** Ate less  
**n** No bowel movement in 3 days; or diarrhea  
**d** Drank less  
**W** Weight change; swollen legs or feet  
**A** Agitated or nervous more than usual  
**T** Tired, weak, confused, or drowsy  
**C** Change in skin color or condition  
**H** Help with walking, transferring, toileting more than usual

Check here if no change noted while monitoring high-risk patient

Name of Resident/Patient \_\_\_\_\_

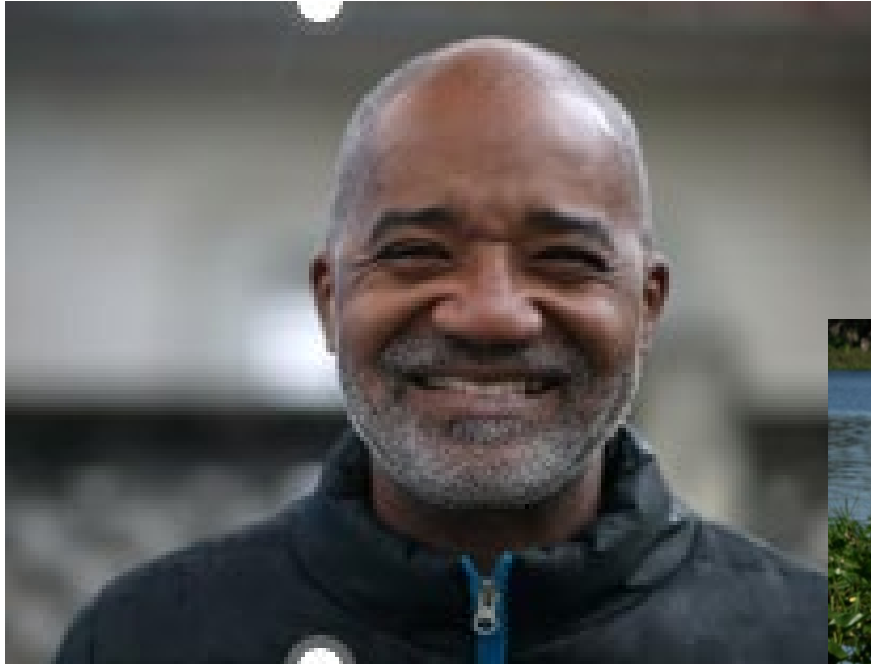
Your Name \_\_\_\_\_

Reported to	Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Nurse Response	Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM

Nurse's Name \_\_\_\_\_

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# Visual & Hands on Learning





# More Visuals Learning-



## Pressure Injury Staging is as easy as Apple P.I.E.

Follow this [Pressure Injury Explanation](#) guide to see how the state of an apple compares to the stage of a pressure injury.

<p><b>Stage 1</b></p> <p>Intact skin with a localized area non-blanchable erythema, which may appear differently in darkly pigmented skin.</p>		<p><b>Stage 2</b></p> <p>Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.</p>	
<p><b>Stage 3</b></p> <p>Full-thickness loss of skin, in which adipose (fat) is visible in the injury and granulation tissue and epibole (rolled wound edges) are present.</p>		<p><b>Stage 4</b></p> <p>Full-thickness skin and tissue loss with directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the injury.</p>	
<p><b>Unstageable</b></p> <p>Full-thickness skin and tissue loss in which the extent of tissue damage within the injury cannot be confirmed because it is obscured by slough or eschar.</p>		<p><b>Deep Tissue Pressure Injury (DTPI)</b></p> <p>Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister.</p>	

Find more skin health insights and expertise at [MedlineSkinHealth.com](https://www.MedlineSkinHealth.com)



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# Learning

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- Competencies'
- Skin Carnival
- Turn and Position (TAP)
- Certification - WOCN
- Skin Fair



# Repeat

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- Use your vendors for education
  - Peri-Care
  - Wound Care
  - Specialty Bed



# Tools and Resources

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- [I PRO QIN-QIO Resource Library](#)
- <https://qi.ipro.org/upcoming-events/>



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