

March 2006

Educational Workshop Materials — Facilitator's Guide Assessment and Management of Pressure Ulcers



 **RNAO** Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

Based on the Registered
Nurses' Association of Ontario
Best Practice Guideline:

*Assessment and Management
of Stage I to IV Pressure Ulcers*

Acknowledgement

The Registered Nurses' Association of Ontario (RNAO) and the Nursing Best Practice Guidelines Program would like to acknowledge the following individuals and organizations for their contributions to the development of these workshops on the *Assessment and Management of Pressure Ulcers*:

- ▶ The Humber River Regional Hospital, Villa Colombo and Central Park Lodge for their role in implementing and evaluating the guideline *Assessment and Management of Stage I to IV Pressure Ulcers* through the pilot site implementation initiative and for providing leadership in the development of this resource as part of their implementation plan. This educational resource has been adapted for web dissemination by the RNAO
- ▶ The guideline development panel for *Assessment and Management of Stage I to IV Pressure Ulcers*. This best practice guideline is a foundation document for the content of this educational resource, which has been developed to support the educational needs of nurses in the implementation of this best practice guideline.

Disclaimer

While every effort has been made to ensure the accuracy of the contents at their time of publication, neither the authors nor RNAO accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of this work. Reference within this document to specific products or pharmaceuticals as examples does not imply endorsement of any of these products.

Copyright

With the exception of those portions of this document for which a specific prohibition or limitation against copying appears, the balance of this document may be produced, reproduced and published in its entirety, in any form, including in electronic form, for educational or non-commercial purposes, without requiring the consent or permission of the Registered Nurses' Association of Ontario, provided that an appropriate credit or citation appears in the copied work as follows:

Registered Nurses' Association of Ontario (2006). *Part A: Educational Workshop for RNs and RPNs: Assessment and Management of Pressure Ulcers*. Toronto, Canada: Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario (2006). *Part B: Educational Workshop for Unregulated Care Providers: Assessment and Management of Pressure Ulcers*. Toronto, Canada: Registered Nurses' Association of Ontario.

The RNAO Nursing Best Practice Guidelines Program is funded by the Government of Ontario.

Introduction: About this Workshop

This resource is intended for Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Unregulated Care Providers. It has been designed to teach these learners how to implement the recommendations outlined in the RNAO Best Practice Guideline, *Assessment and Management of Stage I to IV Pressure Ulcers*.

These materials are divided into three sections:

- ▶ “Educational Workshop Materials: Assessment and Management of Pressure Ulcers”, provides materials for two workshops. *Part A* is directed towards RNs and RPNs while *Part B* is aimed towards Unregulated Care Providers (UCP). These materials are for use by the workshop facilitator, and include a list of components, questionnaires and case studies for participants, and answer keys.
- ▶ Slideshow presentation for RNs and RPNs, in three sections:
 - “Educational Workshop for RNs and RPNs”
 - “Positioning Techniques and Devices in Wound Management”
 - “Nutritional Intervention”
- ▶ Slideshow presentation for Unregulated Care Providers

The suggested approach is as follows:

1. Provide each participant with a participant’s package and suggest that he or she completes the pre-test to identify personal learning needs. (The test is retained by the participant.) This step can be completed as participants arrive for the session.
2. After a brief introduction, begin the slide presentation relevant to the audience attending the workshop (RNs, RPNs, Unregulated Care Providers, or all three). Refer participants to the Best Practice Guideline for discussion of the evidence, where appropriate.
3. Following slide presentations, invite participants to complete the case studies provided in the package. Discuss approaches to the case study as a group.
4. Invite participants to complete the post-workshop questionnaire, to highlight the knowledge they have gained through this experience, as well as areas which may require further discussion.



The RNAO Best Practice Guideline *Assessment and Management of Stage I to IV Pressure Ulcers* is available for free download from the RNAO website at www.rnao.org/bestpractices.

Workshop Components

Part A: Educational Workshop for RNs and RPNs

A1 Pre-Workshop Questionnaire

A2 Educational Materials

Part 1 *Assessment and Management of Pressure Ulcers*

Part 2 *Positioning Techniques and Devices in Wound Management*

Part 3 *Nutritional Intervention*

A3 Post-Workshop Case Studies

A7 Post-Workshop Questionnaire

A8 Questionnaire Answers

Part B: Educational Workshop for Unregulated Care Providers

B1 Pre-Workshop Questionnaire

B2 Educational Materials

Assessment and Management of Pressure Ulcers

B3 Post-Workshop Case Study

B4 Post-Workshop Questionnaire

B5 Questionnaire Answers

FACILITATOR'S MATERIALS

Part A: Educational Workshop for RNs and RPNs
Pressure Ulcer Assessment and Management



 **RNAO** Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

Based on the Registered
Nurses' Association of Ontario
Best Practice Guideline:

*Assessment and Management
of Stage I to IV Pressure Ulcers*

Pre-Workshop Questionnaire

NAME _____

CATEGORY RN RPN

UNIT _____

DATE _____

Please answer each of the following questions by placing a **T** for *true*, **F** for *false* and **U** for *unsure*.

- ___ 1. A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Most pressure ulcers occur over a bony prominence.
- ___ 2. All individuals should be assessed for their level of risk of developing pressure ulcers using the Braden Scale on admission to hospital or long-term care facility. Braden assessments should be conducted on a weekly basis and anytime there is a change in patient/resident's health status.
- ___ 3. A high Braden score is associated with increased pressure ulcer risk.
- ___ 4. Eschar or exudates should be swabbed when obtaining a wound culture.
- ___ 5. Skin cleansers or antiseptic agents such as betadine, hygeol, hydrogen peroxide and acetic acid are the best solutions for cleaning ulcers with good tissue.
- ___ 6. A Stage I pressure ulcer is defined as blanchable erythema of intact skin.
- ___ 7. A Stage IV pressure ulcer is a full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia.
- ___ 8. Sheepskin, eggcrate mattresses, and donut devices are good choices for preventing pressure ulcers.
- ___ 9. A pressure ulcer is detrimental to a patient's quality of life and efforts should be made by caregivers to ensure that it is prevented.
- ___ 10. Documentation of the care given to prevent and treat pressure ulcers is necessary to provide baseline data that can be used to evaluate healing and the efficacy of treatment regimens.
- ___ 11. When documenting the pressure ulcer assessment, it is important to include the following: location, depth, size, odour, sinus tracts, undermining, tunneling, exudates, appearance of and visual access to the wound bed, and the surrounding skin and wound edges.
- ___ 12. Any nurse that has read the Best Practice Guideline, *Assessment and Management of Stage I to IV Pressure Ulcers*, can perform subcutaneous debridement with a scalpel.
- ___ 13. Vascular assessment (ie. Ankle/Brachial Index, Toe Pressure) is recommended for all lower extremity ulcers prior to debridement to rule out vascular compromise.
- ___ 14. Systemic antibiotics are required for pressure ulcers with only clinical signs of local infection.
- ___ 15. Management of pressure ulcers requires a multidisciplinary approach (Nurse, UCP, Dietitian, OT, PT, Pharmacist, Social Work, Physicians, and Surgeons) and patient/resident/family participation.

SCORE /15

MARKED BY _____

Educational Materials: List of Slides

The following slides can be found in the accompanying files:

Part 1: Assessment and Management of Pressure Ulcers

- ▶ Anatomy and Physiology of the Skin
- ▶ Assessing the Risk Factors for Developing Pressure Ulcers
- ▶ Preventative Skin Care
- ▶ A Multidisciplinary Team Approach to Pressure Ulcer Care
- ▶ How to Approach Pressure Ulcer Management
- ▶ Staging of Pressure Ulcers
- ▶ Treatment Goals

Part 2: Positioning Techniques and Devices in Wound Management

- ▶ Role of PT and OT in the Management of Pressure Ulcers
- ▶ Extrinsic Forces to Consider in Seating and Positioning
- ▶ Goals of Seating and Positioning
- ▶ Positioning and Seating Surfaces
- ▶ Positioning in Bed
- ▶ Seating and Positioning
- ▶ Transfers and Repositioning
- ▶ Modalities

Part 3: Nutritional Intervention

- ▶ Learning Objectives
- ▶ Role of Nutrition in a Hospital Setting
- ▶ Patients at Nutritional Risk
- ▶ Indicators of Malnutrition
- ▶ Oral Nutrition Supplements
- ▶ Nutrition Support
- ▶ Nutritional Requirements in Promoting Wound Healing

Case Study #1

NAME _____

CATEGORY RN RPN

UNIT _____

DATE _____

Mr. A is a 55 year old man admitted with Right Leg Vascular Insufficiency. He has also had an axillofemoral bypass. Four days post-op, he developed respiratory insufficiency and was intubated.

History

- ▶ CABG (9 years ago)
- ▶ Smoker until admission
- ▶ Haemorrhoidectomy
- ▶ Hypercholesterolemia
- ▶ Hypertension
- ▶ Obesity
- ▶ Diabetes (7 years ago)
- ▶ Brain Abscess (drained 2x)

Current Meds

- ▶ Humulin 30/70 Zocor
- ▶ Heparin
- ▶ Percocet
- ▶ Lasix
- ▶ Vasotec
- ▶ ECASA

Current Status

- ▶ Diarrhea x 2 days
- ▶ NPO, albumin level is 15
- ▶ He is unable to turn himself from side to side
- ▶ His Braden score is 9 out of 23
- ▶ Developed a blister on both of his heels (calcaneous)
- ▶ Black area on his left hip (trochanter)
- ▶ Has a large cavity on his sacrum measuring 9cm x 8cm with undermining of 5 cm at 9 o'clock. The wound was debrided by the plastic surgeon two weeks ago. There is minimal amount of exudate from the wound. The wound is not infected and there is some bright red tissue with a slightly bumpy appearance on the wound bed.
- ▶ Has a red unbroken area on both his elbows (olecranon)
- ▶ On his right hip (trochanter), there was a yellow area (3cm x 4cm) with large amount of purulent drainage

Questions

1. Why is Mr. A at risk for developing pressure ulcers?

2. As a nurse assigned to Mr. A:

a) Identify the stages for each of the pressure ulcers:

- i. Blisters on both heels Stage _____
- ii. Black area on his left hip Stage _____
- iii. Large cavity on his sacrum Stage _____
- iv. Red unbroken area on both his elbows Stage _____
- v. Yellow area on his right hip Stage _____

b) What type of dressing would be most appropriate to manage Mr. A's pressure ulcers?

- i. Blisters on both heels _____
- ii. Large cavity on his sacrum _____

c) What interventions will you use to prevent him from developing further skin breakdown?

3. What other health professional will you involve in Mr. A's care?

Case Study #2

NAME _____

CATEGORY RN RPN

UNIT _____

DATE _____

Mrs. D is an 80-year-old woman from a nursing home. She is admitted to the hospital for dehydration and pneumonia. Her past medical history includes CVA, dementia, and diabetes. On admission, she has a blood sugar of 30 mmol/L (Normal Values: 4-7 mmol/L), Na of 160 mmol/L (Normal Values: 135-145 mmol/L), WBC of $15 \times 10^9/L$ (Normal Values: $4-11 \times 10^9/L$), and albumin level of 10 g/L (Normal Values: 35-50 g/L). She does not speak but responds to painful stimuli by moaning. She is diaphoretic and incontinent of both urine and stool. She is immobile and requires assistance for positioning. She is not eating and she is on IV fluids and antibiotics.

Mrs. D also has a cavity on her sacrum measuring 8 cm x 6 cm x 5 cm with undermining of 3 cm at 3 o'clock. The wound is draining large amount of foul odoured greenish exudate. There is an erythema around the periwound measuring 3 cm. She also has a non-blanchable reddened area on both her hips.

Questions

As a nurse assigned to Mrs. D:

1. Complete a Braden Scale risk assessment on Mrs. D.
2. Based on Mrs. D's Braden score, what are her risk factors for developing further skin breakdown?

3. Identify the stages of each of her pressure ulcers:

a) sacrum *Stage* _____

b) reddened areas on both her hips *Stage* _____

4. Describe how you will manage Mrs. D's pressure ulcers (focus on wound cleansing, type of dressing, prevention for further skin breakdown, and health care disciplines to involve)

5. What will you include in your documentation based on your assessment of the ulcers and the interventions?

6. If Mrs. D were discharged back to the nursing home once her admitting diagnoses are resolved, what would you do to ensure that continuity of care is maintained?

Post-Workshop Questionnaire

NAME _____

CATEGORY RN RPN

UNIT _____

DATE _____

Please answer each of the following questions by placing a **T** for *true*, **F** for *false* and **U** for *unsure*.

- ___ 1. A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Most pressure ulcers occur over a bony prominence.
- ___ 2. All individuals should be assessed for their level of risk of developing pressure ulcers using the Braden Scale on admission to hospital or long-term care facility. Braden assessments should be conducted on a weekly basis and anytime there is a change in patient/resident's health status.
- ___ 3. A high Braden score is associated with increased pressure ulcer risk.
- ___ 4. Eschar or exudates should be swabbed when obtaining a wound culture.
- ___ 5. Skin cleansers or antiseptic agents such as betadine, hygeol, hydrogen peroxide and acetic acid are the best solutions for cleaning ulcers with good tissue.
- ___ 6. A Stage I pressure ulcer is defined as blanchable erythema of intact skin.
- ___ 7. A Stage IV pressure ulcer is a full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia.
- ___ 8. Sheepskin, eggcrate mattresses, and donut devices are good choices for preventing pressure ulcers.
- ___ 9. A pressure ulcer is detrimental to a patient's quality of life and efforts should be made by caregivers to ensure that it is prevented.
- ___ 10. Documentation of the care given to prevent and treat pressure ulcers is necessary to provide baseline data that can be used to evaluate healing and the efficacy of treatment regimens.
- ___ 11. When documenting the pressure ulcer assessment, it is important to include the following: location, depth, size, odour, sinus tracts, undermining, tunneling, exudates, appearance of and visual access to the wound bed, and the surrounding skin and wound edges.
- ___ 12. Any nurse that has read the Best Practice Guideline, *Assessment and Management of Stage I to IV Pressure Ulcers*, can perform subcutaneous debridement with a scalpel.
- ___ 13. Vascular assessment (ie. Ankle/Brachial Index, Toe Pressure) is recommended for all lower extremity ulcers prior to debridement to rule out vascular compromise.
- ___ 14. Systemic antibiotics are required for pressure ulcers with only clinical signs of local infection.
- ___ 15. Management of pressure ulcers requires a multidisciplinary approach (Nurse, UCP, Dietitian, OT, PT, Pharmacist, Social Work, Physicians, and Surgeons) and patient/resident/family participation.

SCORE /15

MARKED BY _____

Questionnaire Answers

- T 1.** A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Most pressure ulcers occur over a bony prominence.
- T 2.** All individuals should be assessed for their level of risk of developing pressure ulcers using the Braden Scale on admission to hospital or long-term care facility. Braden assessments should be conducted on a weekly basis and anytime there is a change in patient/resident's health status.
- F 3.** A high Braden score is associated with increased pressure ulcer risk.
- F 4.** Eschar or exudates should be swabbed when obtaining a wound culture.
- F 5.** Skin cleansers or antiseptic agents such as betadine, hygeol, hydrogen peroxide and acetic acid are the best solutions for cleaning ulcers with good tissue.
- F 6.** A Stage I pressure ulcer is defined as blanchable erythema of intact skin.
- F 7.** A Stage IV pressure ulcer is a full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia.
- F 8.** Sheepskin, eggcrate mattresses, and donut devices are good choices for preventing pressure ulcers.
- T 9.** A pressure ulcer is detrimental to a patient's quality of life and efforts should be made by caregivers to ensure that it is prevented.
- T 10.** Documentation of the care given to prevent and treat pressure ulcers is necessary to provide baseline data that can be used to evaluate healing and the efficacy of treatment regimens.
- T 11.** When documenting the pressure ulcer assessment, it is important to include the following: location, depth, size, odour, sinus tracts, undermining, tunneling, exudates, appearance of and visual access to the wound bed, and the surrounding skin and wound edges.
- F 12.** Any nurse that has read the Best Practice Guideline, *Assessment and Management of Stage I to IV Pressure Ulcers*, can perform subcutaneous debridement with a scalpel.
- T 13.** Vascular assessment (ie. Ankle/Brachial Index, Toe Pressure) is recommended for all lower extremity ulcers prior to debridement to rule out vascular compromise.
- F 14.** Systemic antibiotics are required for pressure ulcers with only clinical signs of local infection.
- T 15.** Management of pressure ulcers requires a multidisciplinary approach (Nurse, UCP, Dietitian, OT, PT, Pharmacist, Social Work, Physicians, and Surgeons) and patient/resident/family participation.

FACILITATOR'S MATERIALS

Part B: Educational Workshop for Unregulated Care Providers
Assessment and Management
of Pressure Ulcers



Pre-Workshop Questionnaire

NAME _____

UNIT _____

DATE _____

Please answer each of the following questions by placing a **T** for *true*, **F** for *false* and **U** for *unsure*.

- ___ 1. A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Most pressure ulcers occur over a bone (e.g. hips, tailbone, etc.).
- ___ 2. Sheepskin, eggcrate mattresses, and donut devices are good choices for preventing pressure ulcers.
- ___ 3. A pressure ulcer has a negative effect on a patient's quality of life and efforts should be made by caregivers to ensure that pressure ulcers are prevented.
- ___ 4. It is a good idea to massage over bony prominences that are reddened.
- ___ 5. The best position for patients/residents while in bed is keeping the head of the bed at the highest level (90 degrees).
- ___ 6. Persons with decreased mobility, incontinence, poor nutrition, altered level of consciousness and underlying diseases such as diabetes are at risk for developing pressure ulcers.
- ___ 7. Bedridden patients/residents should be repositioned twice on an eight-hour shift.
- ___ 8. All patients'/residents' skin condition should be monitored every shift and any changes must be reported to the nurse in charge.
- ___ 9. The most common pressure ulcer site is the abdomen.
- ___ 10. Management of pressure ulcers requires a multidisciplinary approach (Nurse, UCP, Dietitian, OT, PT, Pharmacist, Social Work, Physicians, Surgeons) and patient/resident/family participation.

SCORE /10

MARKED BY _____

Educational Materials

The following slides can be found in the accompanying file:

**Educational Workshop for Unregulated Care Providers:
Assessment and Management of Pressure Ulcers**

- ▶ Anatomy and Physiology of the Skin
- ▶ Assessing Risk Factors for Developing Pressure Ulcers
- ▶ Pressure Ulcer Prevention and Management
- ▶ A Multidisciplinary Team Approach to Pressure Ulcer Care

Post-Workshop Case Study

NAME _____

UNIT _____

DATE _____

Mr. D is an 80 year old man who was admitted to hospital because of severe left-sided weakness and pain. While in hospital he was diagnosed with a stroke and sent for rehabilitation. Mr. D is still severely paralyzed on his left side. He has limited ability to walk or move his left hand, arm and leg even after receiving rehabilitation. He is able to turn in bed using his right hand as leverage and has very limited movement in his left arm, hand and leg. Prior to his stroke, Mr. D was an active man who participated in many community activities. As a result, he spends a great deal of time up in his wheelchair and is often reluctant to return to bed. Mr. D's wife is very devoted. She spends most of her day sitting with Mr. D and taking him for "walks" along the street near the rehabilitation hospital.

After much deliberation and discussion with his wife, Mr. D decided to be admitted to nursing home. Two weeks after his admission, Mr. D developed a "reddened" area on his left hip. Mr. D is a baseball fan. Since the beginning of baseball season (2 weeks ago), he has spent a great deal of time lying on his left side. The TV set is on the left side of the bed and he is determined to watch the evening baseball games.

Questions

1. How would you manage the reddened area on Mr. D's left hip?

2. What would you report to the nurse that is in charge?

3. How would you prevent Mr. D from developing pressure ulcers based on his current level of activity?

4. How would you encourage Mr. D to help prevent pressure ulcers?

Post-Workshop Questionnaire

NAME _____

UNIT _____

DATE _____

Please answer each of the following questions by placing a **T** for *true*, **F** for *false* and **U** for *unsure*.

- ___ 1. A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Most pressure ulcers occur over a bone (e.g. hips, tailbone, etc.).
- ___ 2. Sheepskin, eggcrate mattresses, and donut devices are good choices for preventing pressure ulcers.
- ___ 3. A pressure ulcer has a negative effect on a patient's quality of life and efforts should be made by caregivers to ensure that pressure ulcers are prevented.
- ___ 4. It is a good idea to massage over bony prominences that are reddened.
- ___ 5. The best position for patients/residents while in bed is keeping the head of the bed at the highest level (90 degrees).
- ___ 6. Persons with decreased mobility, incontinence, poor nutrition, altered level of consciousness and underlying diseases such as diabetes are at risk for developing pressure ulcers.
- ___ 7. Bedridden patients/residents should be repositioned twice on an eight-hour shift.
- ___ 8. All patients'/residents' skin condition should be monitored every shift and any changes must be reported to the nurse in charge.
- ___ 9. The most common pressure ulcer site is the abdomen.
- ___ 10. Management of pressure ulcers requires a multidisciplinary approach (Nurse, UCP, Dietitian, OT, PT, Pharmacist, Social Work, Physicians, Surgeons) and patient/resident/family participation.

SCORE /10

MARKED BY _____

Questionnaire Answers

- T 1.** A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue. Most pressure ulcers occur over a bone (e.g. hips, tailbone, etc.).
- F 2.** Sheepskin, eggcrate mattresses, and donut devices are good choices for preventing pressure ulcers.
- T 3.** A pressure ulcer has a negative effect on a patient's quality of life and efforts should be made by caregivers to ensure that pressure ulcers are prevented.
- F 4.** It is a good idea to massage over bony prominences that are reddened.
- F 5.** The best position for patients/residents while in bed is keeping the head of the bed at the highest level (90 degrees).
- T 6.** Persons with decreased mobility, incontinence, poor nutrition, altered level of consciousness and underlying diseases such as diabetes are at risk for developing pressure ulcers.
- F 7.** Bedridden patients/residents should be repositioned twice on an eight-hour shift.
- T 8.** All patients'/residents' skin condition should be monitored every shift and any changes must be reported to the nurse in charge.
- F 9.** The most common pressure ulcer site is the abdomen.
- T 10.** Management of pressure ulcers requires a multidisciplinary approach (Nurse, UCP, Dietitian, OT, PT, Pharmacist, Social Work, Physicians, Surgeons) and patient/resident/family participation.