Prevention of Pressure Ulcers and Incontinence Care Education for Nursing Assistants

Jeri Lundgren, RN, BSN, PHN, CWS, CWCN
Director of Wound & Continence Services
August 24, 2010 1:30-2:30 PM CST
Prevention of Pressure Ulcers and Incontinence Care

• Nursing Assistants are the key to a successful pressure ulcer and incontinence management program
Pressure Ulcers

• A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction
Pressure Ulcers
THE EFFECTS OF PRESSURE

nmHg  32+ mmHg  32 mm
Pressure Ulcers

MOST COMMON SITES

- Lateral (Ankle Bone)
- Heel
- Sacrum
- Ischium
Contributing Factors

Contributing factors

SHEAR
Contributing Factors: Shear
Contributing Factors: Shear
Contributing Factors: Shear

- Raise the knees of the bed a little before raising the head of the bed to prevent the resident from sliding down
- Lift, do not drag, residents when moving them in the bed or wheelchair
Prevention Interventions

• Monitor skin
  – Inspect skin daily
    • Inspect bony prominences by looking and FEELING
    • Look for discoloration or areas that feel mushy or hard
    • Look under medical devices (casts, tubes, orthoses, braces, etc).
    • Look for bruises, skin tears, rashes, etc.
    • Notify the nurse of any concerns immediately (in writing if possible)
  – Weekly skin assessment by licensed staff, typically on the bath day
Prevention Interventions

• Provide pressure-reducing surfaces when in bed and sitting
  – Overall goal of any bed or wheelchair support surface is to evenly distribute pressure over a large area
  – Residents in wheelchairs should have a cushion
  – Should be listed on Nursing Assistant assignment sheets
  – Not a substitute for turning schedules
  – Heels may be especially vulnerable, even on low air loss beds
Prevention Interventions
Prevention Interventions

Do NOT use donuts for pressure relief
Prevention Interventions

• Develop an INDIVIDUALIZED turning and repositioning schedule

• Current recommendations:
  – Turn and reposition at least every two hours when lying down
  – Reposition at least hourly in a sitting position (if residents can reposition themselves in wheelchair, encourage them to do so every 15 minutes)
  – When possible, avoid positioning on existing pressure ulcer
Prevention Interventions

• Tissue tolerance is the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects.

• An individualized turning and repositioning schedule should be done for each resident.
  – If turning intervals are not on the assignment sheet, notify the nurse.
Prevention Interventions

• Momentary pressure relief followed by a return to the same position is usually NOT beneficial (micro-shifts of 5 to 10 degrees or a 10-15 second lift)

• Off-loading is considered one full minute of pressure RELIEF
  – Done when the resident is going to return to the same position
  – If putting residents to bed from the wheelchair, place on their side
Prevention Interventions

• Pad and protect bony prominences (note: sheepskin, heel, and elbow protectors provide comfort, and reduce shear & friction, but do NOT provide pressure reduction)

• Do not massage over bony prominences
Prevention Interventions
Prevention Interventions

• Nutrition and hydration support
  – Provide protein supplements and protein intake
  – Monitor intake
  – Ensure assistance to those who can not feed themselves
  – Give fluids in small dosages throughout the day – each time you interact with the resident
Moisture
Prevention Interventions

• Keep skin clean and dry
  – Peri-care after each episode of incontinence
  – Apply a skin barrier to all incontinent residents (thick paste type of ointments should only be used with severe irritated skin)
  – 4x4s or dry cloths in between skin folds
  – Bathe with MILD soap, rinse and gently dry
  – Moisturize dry skin
  – Keep linen dry and wrinkle free
Other Considerations for Prevention Interventions

• Notify Nurse of:
  – Any pain concerns
  – If a resident refuses to allow you to do any of the interventions, notify your nurse immediately

• Explain to resident and/or family members why you are providing certain cares or special equipment

• Re-approach as appropriate
Managing Incontinence
F315 Urinary Incontinence Tips

• OVERALL GOAL of a comprehensive assessment:
  – Determine the type of urinary incontinence
  – Provide more individualized programming or interventions
  – Enhance the resident’s quality of life and functional status
Age-Related Changes in the Urinary Tract

- Bladder capacity is diminished
- Amount of urine left in the bladder after urinating may be greater
- Desire to void or urge sensation is delayed
- Involuntary contractions
- UI predominately affects 1 in 4 women

Urinary Incontinence should NOT be considered a normal part of aging!!
What is Urinary Incontinence

• Urinary Incontinence can be described as any involuntary loss of urine from the bladder, whatever the cause, that is not controlled by the individual
Complications of Urinary Incontinence

• Urinary incontinence can contribute to:
  – Falls (20-45% of incontinent women)
  – Fractures
  – UTIs
  – Depression
  – Social isolation
  – Pressure ulcers
  – Dermatitis
F315 Urinary Incontinence Tips

• Three-Day Voiding Patterns
  – Track the time, frequency, amounts of urine, and whether individuals are incontinent
  – Communicate during and at the end of each shift with the Nursing Assistant and Nurse
  – Ensure Interdisciplinary Team is aware of three-day observation
  – Overall goal is to get an ACCURATE observation
Types of Urinary Incontinence

• Types of incontinence include:
  – Urge
  – Stress
  – Mixed
  – Overflow
  – Functional
Urge Incontinence
Overactive Bladder

Failure to store related to bladder dysfunction

Common Causes:

-- Genitourinary conditions
  (UTI, Tumor, stones, cystitis)

-- CNS disorders
  CVA, Parkinson’s, spinal injury)

-- Medical condition
  (DM, ↓ fluid intake, habitual frequent voiding)

Symptoms:

-- Involuntary contractions
-- Strong urge to urinate
-- Urine loss on way to toilet
-- Timing is unpredictable
-- Key-in-lock syndrome
-- Running water
-- Nocturia
Stress Incontinence

Small to moderate amount of leakage simultaneously with physical exertion

From increase in intra-abdominal pressure

Signs and Symptoms:
Small losses of urine when:
- Coughing
- Laughing
- Exercising
- Changing positions
- Lifting/Straining
Mixed Incontinence

- Combination of Urge and Stress
- Mix of gotta go right now and small amounts of leakage with coughing, laughing, exertion
Overflow Incontinence

Urinary retention with leakage of small amounts of urine when the bladder has reached its maximum capacity

- Bladder cannot contract properly and empty normally
- Causal Factors:
  - Urethral Obstruction
  - Neurologic Condition
  - Medications

Symptoms:
- Bladder Distention
- Weak stream/hesitancy
- Dribbling
- Frequency
- Dysuria
- Nocturia
- Incomplete voiding
- PVR > 200cc
Functional Incontinence

Normal bladder control, but factors prohibit residents from getting to the toilet on time

Conditions:
- Cognitive impairment
- Functional disability (physical weakness, pain, or impaired mobility)
- Psychological impairment
- Environmental barriers
- Medications

Symptoms:
- Inaccessible toilet
- Nocturnal enuresis
- Combined fecal and urinary incontinence
Three-Day Void

• Communicate to the Nurse:
  – Dribbling
  – Dribbling with movement
  – Weak stream
  – Voiding small amounts frequently
  – Urge requests or frequent need to urinate
  – Pain with urination
Successful Programs

A successful incontinence program includes:

• Access to bathroom and appropriate equipment
• Adequate fluid intake (small amounts overtime)
• Muscle strengthening exercises
• Carefully scheduled elimination times/prompting
• Avoiding the use of incontinence briefs if possible
Treatment and Elimination Plan

• Scheduled toileting plan
  – Cognitively impaired, functionally disabled, caregiver dependent

• Check and change
  – Physically unable to sit on toilet or have behaviors making difficult to use

• Retraining
  – Oriented, able to feel sensation, able to understand and inhibit urge, toilet independently or with minimal assist

• Prompted voiding
  – Scheduled toileting, that requires the caregivers prompting; able to use the toilet
Questions?

Jeri Lundgren, RN, BSN, PHN, CWS, SWCN

📞 612-805-9703

Jeri.lundgren@pathwayhealth.com

www.stratishealth.org
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.