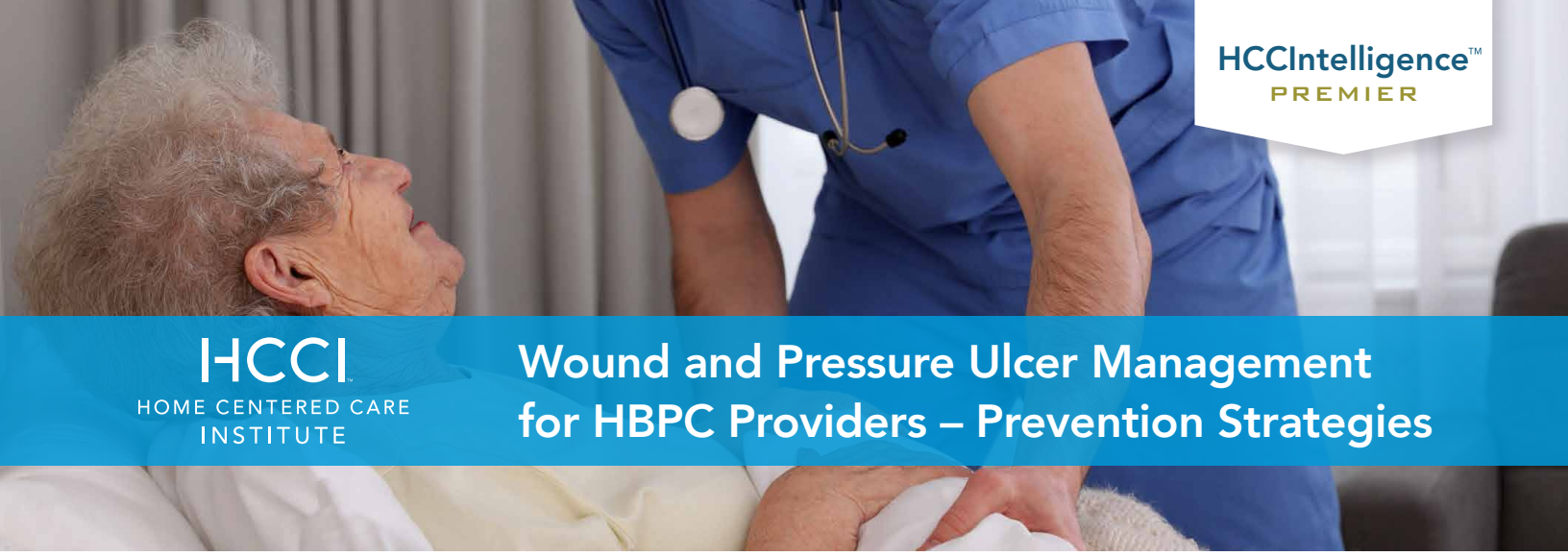

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Wound and Pressure Ulcer Management for HBPC Providers – Prevention Strategies

Purpose

Wound prevention is key in protecting your patients from unnecessary wounds. Consider the following strategies:

- ☐ **Pressure redistribution devices –** Use pressure redistribution devices to decrease force of friction, although they generally cannot completely eliminate pressure. These devices can be used anywhere the body is in contact with another surface and there is pressure. Pillows may be used to redistribute pressure. Foam, gel, or sheepskin booties can be used to provide heel protection. Mattresses are another important redistribution device, and support types can be categorized as follows:
  - **Group 1 –** These support surfaces are financially covered if the patient is completely immobile, partially immobile, or has any staged pressure ulcer and demonstrates one of the following: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status. These products commonly replace standard hospital beds or are added as an overlay. These include powered air flotation beds, powered pressure-reducing air mattresses, and non-powered advanced pressure-reducing mattresses.
  - **Group 2 –** These support surfaces are usually covered by insurance if patient has if the patient has a Stage 2 pressure injury on the trunk or pelvis, has been on a comprehensive pressure sore treatment program including a Group 1 surface for at least one month, and has wounds that worsened or remained the same over the past month. It is also covered if the patient has large or multiple Stage 3 or 4 pressure injuries on the trunk or pelvis, or has a recent myocutaneous flap or skin graft on the trunk or pelvis, and has been on a Group 2 or 3 support. These products commonly replace standard hospital beds or are used as an overlay. These include powered pressure-reducing air mattresses, and non-powered advanced pressure-reducing mattresses.
  - **Group 3 –** These support surfaces are usually covered by insurance if the patient has a Stage 3 or Stage 4 pressure injury, is bedridden or chair-bound, would be institutionalized without the use of the Group 3 support surface, is under the close supervision of a treating physician, has been undergoing conservative treatment for at least one month including the use of a Group 2 surface, a caregiver is available and willing to assist with patient care, and all other alternative equipment has been considered and ruled out. These products replace hospital beds and frames. They are complete bed systems,known as air-fluidized beds, which use the circulation of filtered air through silicone beads.
- ☐ **Incontinence care –** Use absorptive products that wick moisture away from the skin, or external catheter to manage input. Barrier creams may also be additionally used to provide a protective layer to prevent skin damage from moisture.
- ☐ **Interdisciplinary collaboration –** Consider an interdisciplinary approach to speed wound healing (e.g., home nursing, physical therapy, surgery for debridement, vascular consult if there is concern for arterial or venous disease that would impact wound healing).

- [ ] **Early detection –** Identify lower-stage pressure ulcers early to avoid progression. Research shows that individuals with darker pigmented skin tend to have greater tissue destruction from pressure injury on identification. This is thought to be due to difficulty in identifying early skin changes due to darkened skin color. For these individuals, special attention should be given to common high-pressure areas (e.g., sacral area, heels, occipital region).
- [ ] **Education –** Provide education to the patient, caregivers, and family to engage in prevention and treatment. See the online links for this course for potential resources.
- [ ] **Braden Scale –** Use this scale to identify pressure injury risks by assessing six different categories: sensory perception, moisture, activity, mobility, nutrition, and friction and shear. Overall risk is determined by adding the score in each category. When the total is 18 or less, this indicates risk (the lower the score, the greater the risk). Interventions should focus on any category scoring two or less to minimize risk. In the home, the Braden scale should be reassessed with any clinical change. (https://www.in.gov/isdh/files/Braden_Scale.pdf)
- [ ] **Weight –** Malnutrition will put patients at a greater risk for developing pressure injuries.

  Compare the patient's weight from 3 months prior and current weight. Weight loss of 10% or more is concerning and should be addressed. If you are unable to determine the patient's weight, ask the patient or their caregiver(s) about clothing fit. You may also use albumin as an indicator of nutrition over time.
- [ ] **Nutrition –** Ensure the patient is provided with adequate protein, nutrition, and hydration. Below are general guidelines for wound healing:

  - Total daily caloric requirements = 35-40 calories/kg of patient's current weight
  - Daily protein needs = 1.2-1.5 grams/kg of patient's current weight
  - Daily Fluid needs = 30 ml/kg of patient's current weight

  There is some support for additional supplements such as vitamin C and zinc to enhance wound healing.

The John A. Hartford Foundation

HCCIntelligence™ is funded in part by a grant from The John A. Hartford Foundation.

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