STUDENT ORIENTATION

SKIN & WOUND & DOCUMENTATION

Revised October 2013, by Yvette Barnes
Objectives

- Pressure Ulcer (PU) prevention (6 minutes)
- Early Identification (6 minutes)
- Management of Wounds (6 minutes)
- Introduction to NYGH Documentation process
- Introduction to NYGH Medication Administration Record
Definition: Pressure Ulcer

- Localized area of tissue necrosis due to compression of soft tissue, usually between a bony prominence & external surface for a prolonged amount of time (National Pressure Ulcer Advisory Panel, 1989).
Objective 1: Prevention

- Risk Assessment using Braden Scale
- Remember “SKIN”

1. Surface selection
2. Keep tilting (30 degree tilts minimum every 2 hrs)
3. Incontinence management (barrier creams)
4. Nutrition (good nutrition prevents skin breakdown & promotes wound healing)
Surface Selection

• Eliminate “donuts” & old mattresses

• Best surface conforms to patient to displace body weight & reduce pressure points—not body conforming to surface

• for high risk patients or those with PUs choose specialty pressure reduction surfaces (within NYGH, we have Zoneaire beds)

• Use ceiling lifts to eliminate “shearing” forces
Keep Tilting

- Side-lying to eliminate direct pressure on trochanter
- Every 2 hours for full body change
- Establish a turning schedule with your preceptor or buddy
- Lateral turns not to exceed 30 degrees
- Encourage patient to shift weight q15min
- Do not drag patient up the bed (in order to eliminate shearing forces).
Incontinence management

• Toilet patients in geri-chairs regularly

• Follow bowel routines

• Get to the bottom of diarrhea! (?infection, ?feeds intolerance, ?crohn’s, speak to clinical dietitian if need be)

• Use barrier creams to prevent excoriation
Nutrition

• Good nutrition improves tissue tolerance

• Maintains fat padding

• Supports skin integrity
Objective 2: Early Prevention

- Better to prevent than treat
- Better to treat superficial than deep
- Observe and inspect patients every time you interact with patient
Objective 2: Early Prevention

• Cannot reverse staging—3 down to 2—the wound will never gain 100% of strength back and will always be prone to breakdown

• Ulcer filled with granulation tissue, not muscle or fat or dermis prior to re-epithelialization. (NPUAP 2001)

• Refer to Skin & Wound Presentation

• Use of tools such as Braden Scale
Wound classification (staging)

- Classified by the depth of the injury as a measure of the degree of tissue damage present - *Panel for the Prediction and Prevention of Pressure Ulcers in Adults, 1992*
STAGE I

- Reddened, unbroken skin
- Unresolved in 30 minutes
- Non-blanchable
- Usually but not always returns to normal within 24 hours after removal of pressure
STAGE 1
STAGE 2

- Distinct break in skin or blister
- May extend into the dermis
- Shallow
- Minimal drainage
- Painful
STAGE II
STAGE III

- Extends into subcutaneous layer
- May extend down to but not through the fascia
- Deep crater with drainage
STAGE III
STAGE IV

• Penetrates through subcutaneous layer into underlying fascia, muscle, tendon, cartilage, bone

• Undermining or sinus tracts

• Risk of infection, septicemia and osteomyelitis
STAGE IV
Unstageable

- Black eschar in wound bed or covering wound entirely.
- Unable to determine staging until wound is debrided.
Stage these wounds
STAGE ?
STAGE?
STAGE?
STAGE?
Objective 3: Management

- Management is based on your Assessment

- Remember “TIME”

1. Tissue non-viable—requires debridement
2. Infection/Inflammation
3. Moisture Imbalance
4. Edge of wound— is it undermining
5. See Condensed Pressure Ulcer Clinical Pathway & TIME handout
NYGH Documentation Systems

Emergency
• Paper documentation—Assessment forms
• Narrative notes
• Wellsoft computer system that interfaces with Cerner
• Emergency Awaiting Admission (EAA) – Cerner

L&D
• Electronic (Cerner)

Mom & Baby
• Electronic (Cerner)
NYGH Documentation System

ICU(6S)
• Electronic

Mental Health (7th Floor)
• Narrative notes
• Resident Assessment Instrument (RAI)
  1. students will not be expected to fill this out

Pediatrics (3North)
• Electronic (Cerner)

Medical/ Surgical/ Cancer Care
• Electronic (Cerner)
• Computer System is CERNER
Nursing Documentation Standards

*Documentation is:*
- An essential part of professional nursing practice (CNO standards)
- A Legal requirement
- Reflects the plan of care

*Documentation must be:*
- Accurate, true, clear, concise & patient focused
- Not contain unfounded opinions or conclusions
- Completed promptly after providing care
- Kept private and confidential
- Access patient records that you are not directly involved with
Documentation Guidelines

• What is assessed will be documented—normal & abnormal

• Powerforms are Evidence-Based & Best Practice

• Assist to guide your assessments & practice
Adult Shift Assessment Expectations

• **ONE head-to-toe** per shift (8 or 12 hour shift) performed as soon as possible within the first 3 hours of the shift

• **Re-Assessment of your patients:**

  1. Minimally Q 4 hours—regardless of the shift
  2. Any identified concerns/issues from prior assessment PLUS

Electronic Units- Use Focused Assessment powerforms from the ADHOC folder

  1. General assessment to capture LOC etc
  2. Subjective to capture pain assessments

**Note:** if there is absolutely no change in the pt condition, at a minimum capture:

  1. General assessment-- LOC etc
  2. Subjective-- pain
ADL & VS

- ADL Captures:
  
  **Activity, Hygiene, Nutrition**

  1. Can be accessed throughout your shift to capture care provision or accessed at the end of the shift

  VS—Q4 hours or as per pt condition, MD order or unit policy/standard
When Notes are required:

Notes are to be written in SOAP format

- S=Subjective data
- O=Objective data
- A=Assessment
- P=Intervention/Plan

SOAP is to be used by all Interprofessional team members including nurses

- **Narrative (chronological) Notes:**

  ***When no appropriate powerform can be found for the situation***
The Medication Administration Record (MAR) – Non-Electronic Unit

- 24 hour document
- Alphabetical order
- 3 different MARs
- Variance reports filled out for discrepancies when pharmacy not available
- Must be verified by a nurse
- D/C or changed orders stroked out initialed & dated
- New orders placed on the next available empty space
- Each separate sheet must be signed
MEDICATION ADMINISTRATION RECORD

ADMINISTRATION PERIOD: 2005-AUG-26 00:00 TO 2005-AUG-26 23:59

Name: PHARMNET, TEST
Admit: 2005-MAY-06

Unit: 3 West 339-02
Ht: 170.000 cm

MRN: 805 266
DOB: 1971-05-05
Attending Physician: Bent, Maurice A.
Wt: 65.000 kg
Age: 32 Years

Allergies: 0
Printed: 2005-AUG-25 11:44

<table>
<thead>
<tr>
<th>TR By</th>
<th>Start</th>
<th>Floor</th>
<th>Medication</th>
<th>Route/Dose/Frequency</th>
<th>Administration Time</th>
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<tbody>
<tr>
<td>CK By</td>
<td>/Stop</td>
<td>stock</td>
<td>PRN MEDS ****</td>
<td></td>
<td>00:00-07:30</td>
</tr>
<tr>
<td></td>
<td>AUG/25</td>
<td>10:00</td>
<td>Acetaminophen</td>
<td>650 mg PR every 4 to 6 hours</td>
<td>07:31-15:30</td>
</tr>
<tr>
<td></td>
<td>*SEP/24</td>
<td><em>09:59</em></td>
<td></td>
<td></td>
<td>15:31-23:59</td>
</tr>
</tbody>
</table>

PRN
**Medication Administration Record**

**Name:** PHARMACIST

**Unit:** 3 West 320

**Admit:** 2005-MAY-06

**Age:** 32 Years

**Sex:** M

**Ht:** 170.00 cm

**Wt:** 65.000 kg

**DOB:** 1973-MAY-05

**Allergies:** codeine

**Printed:** 2005-AUG-25 11:44

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### **Scheduled Meds**

<table>
<thead>
<tr>
<th>TR By</th>
<th>Start Time</th>
<th>Flooding stock</th>
<th>Medication</th>
<th>Route/Dose/Frequency</th>
<th>00:00-07:30</th>
<th>07:31-15:30</th>
<th>15:31-23:59</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUG/25</td>
<td>12:00</td>
<td></td>
<td>Acetaminophen 100 mg/1.25 mL Oral Syr</td>
<td>100 mg PO every 6 hours</td>
<td>0600</td>
<td>1200</td>
<td>1800</td>
</tr>
<tr>
<td></td>
<td><em>SEP/24</em></td>
<td></td>
<td></td>
<td>DOSE: 10-15 mg/kg/dose x 8.9 = 89 to 133.5 mg/dose</td>
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<td></td>
</tr>
<tr>
<td>AUG/25</td>
<td>09:00</td>
<td></td>
<td>Atenolol</td>
<td>12.5 mg PO daily</td>
<td>0900</td>
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<td></td>
</tr>
</tbody>
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**North York General**

*Making a World of Difference*
Single dose, stat orders, blood products
**Chemotherapy Orders**

- **Written under first column:**
- **No Dose Due:** med is not to be given daily, the time will appear when a dose is due
- **Future Dose:** administration required only on a certain date & time
  - **Hold:** MD has placed med on hold
  - **Anti-coagulants and diabetic meds** are documented on the designated sheets
Thank You