Critical Burn Patient Skin Breakdown Prevention Protocol

Kara Kohler BSN, RN
Lehigh Valley Health Network, Kara_D.Kohler@lvhn.org

Kara Perini BSN, RN
Lehigh Valley Health Network, Kara_L.Perini@lvhn.org

Follow this and additional works at: http://scholarlyworks.lvhn.org/patient-care-services-nursing
Part of the Nursing Commons

Published In/Presented At

This Poster is brought to you for free and open access by LVHN Scholarly Works. It has been accepted for inclusion in LVHN Scholarly Works by an authorized administrator. For more information, please contact LibraryServices@lvhn.org.
Critical Burn Patient Skin Breakdown Prevention Protocol

Kara Kohler RN, BSN
Kara Perini RN, BSN
Purpose

- To develop a protocol that will aid in decreasing skin breakdown in >20% burn patients
PICO QUESTION

P: Critical Burn Patients (> 20% burn)

I: Skin breakdown prevention

C: No protocol

O: 90% compliance with designed protocol to decrease skin breakdown.
Incorporation of body wash and skin protectant brought about a decrease in skin breakdown from 68-40; statistically significant decrease in stage I and II pressure ulcer incidence; nurses evaluated interventions as effective 98% of the time.

Effectiveness of topical skin interventions was variable and dependent on the skin condition being treated. More research needed.

Multiple-barrier product inhibited the passage of the dye into the skin significantly better than the other 2 products.

Third spacing causes edema in burn patients. Fluid resuscitation increases edema.

Regularly assess your patients’ risk for pressure ulcer development.
There is currently no clear evidence of a benefit associated with nutritional interventions for either the prevention or treatment of pressure ulcers. Further trials of high methodological quality are necessary.

Some risk factors for pressure ulcer development are: pressure, infection, edema, and inflammation.

Repositioning is an integral component of pressure ulcer prevention and treatment; it has a sound theoretical rationale, and is widely recommended and used in practice. However the degree of the turn and the frequency need more research to determine the most effective approach.

People at high risk of developing pressure ulcers should use higher-specification foam mattresses rather than standard hospital foam mattresses. The relative merits of higher-specification constant low-pressure and alternating-pressure support surfaces for preventing pressure ulcers are unclear, but alternating-pressure mattresses may be more cost effective than alternating-pressure overlays.
BARRIERS & STRATEGIES

- Barriers:
  - Census
  - Compliance with the protocol
  - Lack of equipment (wedges)
  - Moist dressings
BARRIERS & STRATEGIES

Strategies to overcome:

- Education for compliance
- Checklist for compliance
- Obtaining the necessary equipment (wedges)
Expected Outcomes

• >90% compliance with protocol
• Decreased pressure ulcers
PROJECT PLANS

- Admission pictures taken of high risk areas
  - Back of head
  - Sacrum
  - Heels
- Specialty bed order placed within 24 hrs
- Nutrition consult within 24hrs
- Full skin assessment and documentation every shift
- Braden (<18 is high risk!)
- Egg crate foam under patient’s head
- Heel precautions in place
- Sling in place
- PA/MD made aware
- Dressing orders placed
PROJECT PLANS

- Disposable pads (extrasorbs) only!
- Turn/reposition patient every 2 hrs (document!)
  - Sling - to reduce friction/shearing
  - Wedge pillow
- Z-Guard application to high risk areas
  - Wash between applications with mild soap and water
- Pressure ulcer present?
  - Document only a description and do not stage until seen by ET
  - ET consult placed for staging
References

Questions or Comments?
Make It Happen