Manitoba Health

# MANITOBA HEALTH PATIENT SAFETY ALERT

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| **Date** | November 19, 2010 |
| **Sent To** | RHA Chief Executive Officers<br>RHA HPSEN Members<br>RHA Planning Network Members |
| **Subject** | **Wound Care Management** |

## Issue

The development of skin breakdown is always a potential risk in patients/residents who experience immobility or require assistance with mobility, those with chronic health conditions and/or concerns with incontinence. Aside from the obvious injury to the skin, there are a number of complications that can result. These include localized infection (at the area of skin breakdown) and systemic infection (an infection that affects the body as a whole). These can contribute to further deterioration in health status including death. Regular assessment of areas at risk for, and prompt treatment of, skin breakdown is imperative.

## Reducing the Risk

The prevention of serious injury to the skin is the responsibility of all health care providers. Wound care protocols that emphasize prevention are the first step in the prevention of skin breakdown. Sometimes in spite of our best efforts, often because of the patient's underlying overall condition, skin breakdown does occur. It is important to recognize this early and develop an individualized plan of care to achieve one of two goals: healing of the wound if this is possible or appropriate management to prevent further deterioration.

All staff involved in direct patient care should be alert for the development of:

- Any skin redness that does not disappear with repositioning. This is an early indication of a pressure ulcer developing.
- Any breaks in the skin, no matter how small they appear. Without proper care and attention, these small breaks in the skin can progress into much larger wounds.
- Any skin irritation that appears in the perineal (groin) area. This is an especially high risk area for further skin breakdown and infection due to the constant presence of moisture.

If despite treatment, the wound continues to deteriorate, staff need to have protocols outlining to whom these concerns are to be communicated. Examples might include charge nurses, physicians and/or wound care specialists.

## Recommendations

Regional Health Authorities are to ensure facilities:

1. Have detailed wound and skin care guidelines/protocols to assist staff in providing appropriate care. These guidelines/protocols should ensure that recognized "best practices" are employed in the care of these patients and should include whom to involve in wound care management.
2. Document a plan of care in the health record to address the skin breakdown that is compliant with the guidelines/protocols.
3. Report stage 3 and 4 pressure ulcers in accordance with the Manitoba Health Critical Incident Reporting Guidelines.