

CNAs/Techs Skin Champions of Downstate



Just keeping things together

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SUNY DOWNSTATE MEDICAL CENTER

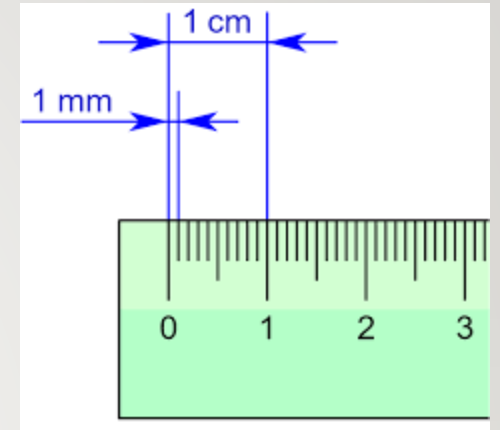
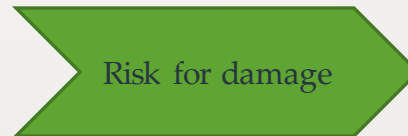
WOUND CARE X 3708

718-938-5451

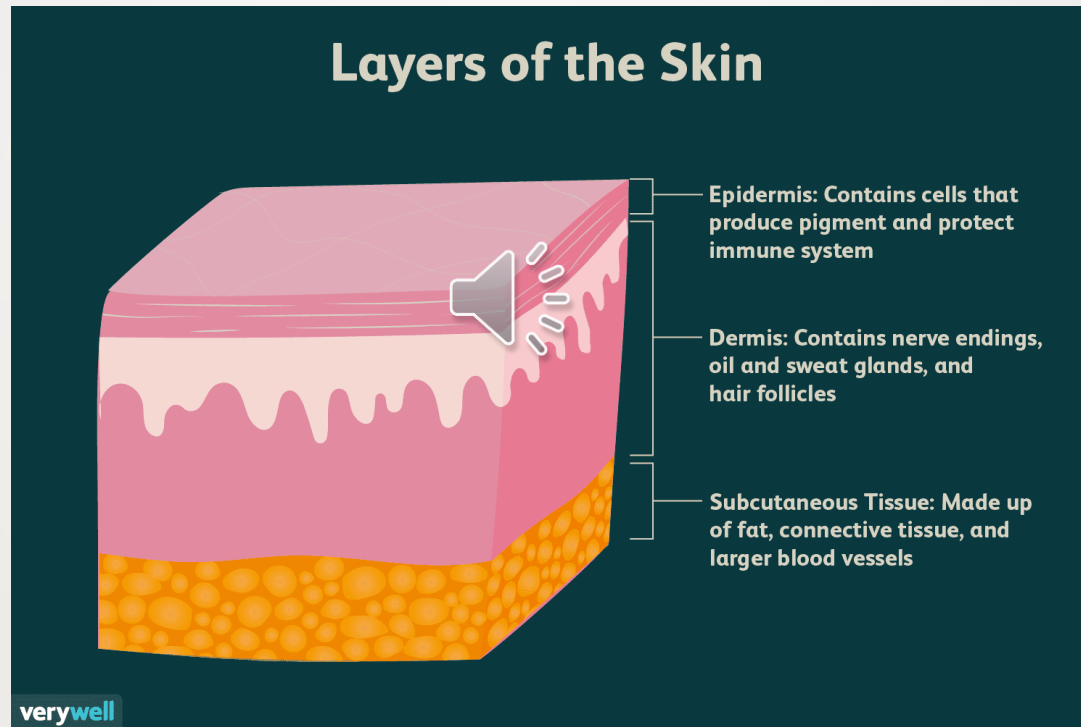
What is SKIN



- Skin is the largest organ
- Skin is needed for survival
- Skin is dry, supple and slightly acidic
- Skin is about 2 mm thick
- If skin is too dry the cells shrink
- If the skin is too wet it swells



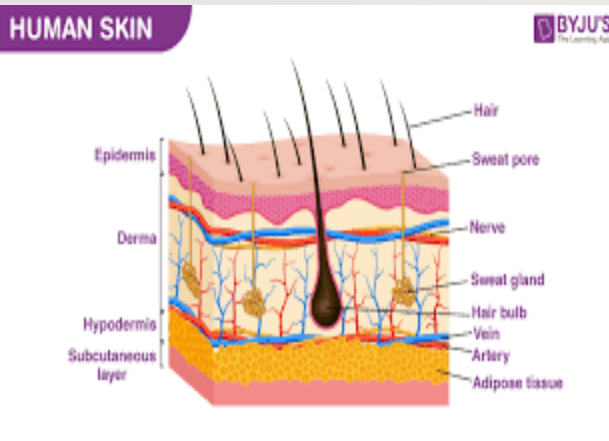
Layers of the Skin



- Epidermis
 - Regenerates
 - Outer Layer
 - Protects
- Dermis
 - Strength and elasticity
 - Nourishes epidermis
 - Does not regenerate or reproduce
 - Scar formation



- Subcutaneous
 - Fat
 - Padding and protection
 - Critical to prevent skin breakdown
 - Cannot regenerate or reproduce
 - Not a skin layer
 - Helps distribute pressure
- Muscle
 - Most vulnerable to prolonged pressure
 - Cannot regenerate
 - Replaced with scar tissue



Functions of the Skin

- Primary
 - Protection against pathogens
 - Loss of fluids and electrolytes
- Secondary
 - Heat regulation
 - Sensory perception
 - Excretion
 - Synthesis of Vitamin D
 - Body Image



Epidermal Regeneration

- In young adults skin regenerates every 21 days
- >35 turnover time ↑ to 42 days
- The **LONGER** to **REPLACE** skin also means **LONGER** to **REPAIR**
- Additionally, steroid use ↓ epidermal regeneration



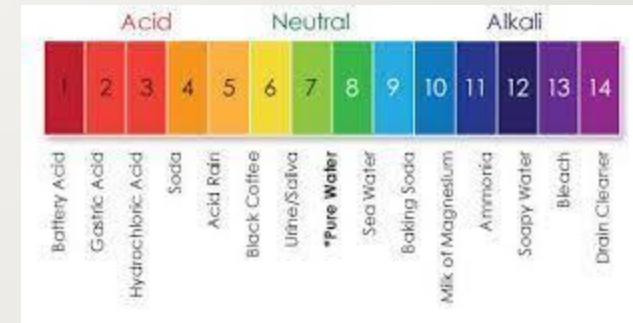
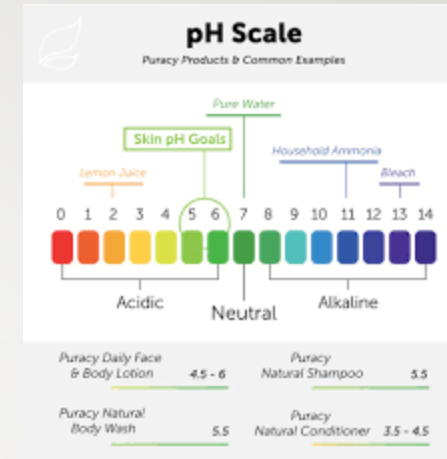
Elderly Changes

- Epidermal thinning
- ↑ risk for skin tears
- Dry
- ↓ sensory
- ↓ fatty tissue
- ↓ immunocompetency
- ↓ blood flow
- Cellular senescence



Healthy Skin for the Elderly

- pH balanced no rinse cleansers
- Gentle technique
- Frequency of bathing
- Temperature of water at bath time
- Liberal use of moisturizers
- Apply moisturizers to damp skin



Darker Skin Tones (DST) Assessment

- By 2050, individuals with darker skin tones will make up approximately 50% of the U.S. population
- Wounds normally noted late because of DST
- When a wound is identified it is usually found at a higher stage (3-U)
- There is an ↑ in incidence and severity of pressure injury
- There is an ↑ risk of death from pressure injuries in DST (9.1% vs. 1.8%)

Challenges of Early Detection in DST



LIGHT SKIN

- Early injury presents as erythema
- Presents as distinct color difference from surrounding skin
- Blanches easily



DARKER SKIN

- No erythema
- May present as subtle discoloration from surrounding skin (purple, blue)
- Injury to skin may appear as a Δ in pigmentation (hypo/ hyper) w/o redness



Early Injury Detection in DST

- Temperature may be different between areas of suspected change.
- Skin temperature may be warmer or cooler at are of suspected insult
- Patient may also c/o pain, itchiness, or Δ in sensation
- Area of insult may be firm or boggy
- Area requires a more hands on (ungloved and back of hand) assessment
- Pay attention when providing care because moistened skin improves visual ability to see changes

External Factors Causing Skin Loss

- Friction
- Moisture
- Shear



Prevention for Friction Damage of Skin


- Gentle skin care
- Routine incontinence care with protective barrier
- Protective dressings to vulnerable areas – make sure dressing does not get balled up
- Frequent examination for skin integrity with protective dressing use
- Measures to reduce sliding (draw sheets)

Shear


- Skeleton goes one way and the skin goes the other
- Causes undermining and tunneling



Moisture Associated Skin Damage (MASD)


- Skin that has too much moisture creates increased vulnerability to friction, irritants, pathogens and pressure
- Causes
 - Incontinence associated skin damage (IASD) 
 - Intertriginous Dermatitis (ITD)
 - Damage due to wound drainage or tube leakage – periwound MASD

Incontinence Associated Skin Damage (IAD)

- Characteristics
 - Exposure to urine and feces
 - Superficial skin loss
- Prevention and Management 
 - Toileting program if possible
 - Containment (closed fecal system, condom catheter, purwick, FC)
 - Incontinence care (Check and Change) q2h
 - Use of barrier creams and ointments



A few words about barriers

- Zinc should only be used in cases of diarrhea
- When using zinc oxide, all does not have to be removed when cleaning
- Removal of the soiled and reapplication is okay
- Can cause damage if too aggressive 
- When applying an antifungal to the skin, apply the antifungal first and then apply moisture barrier on top of antifungal



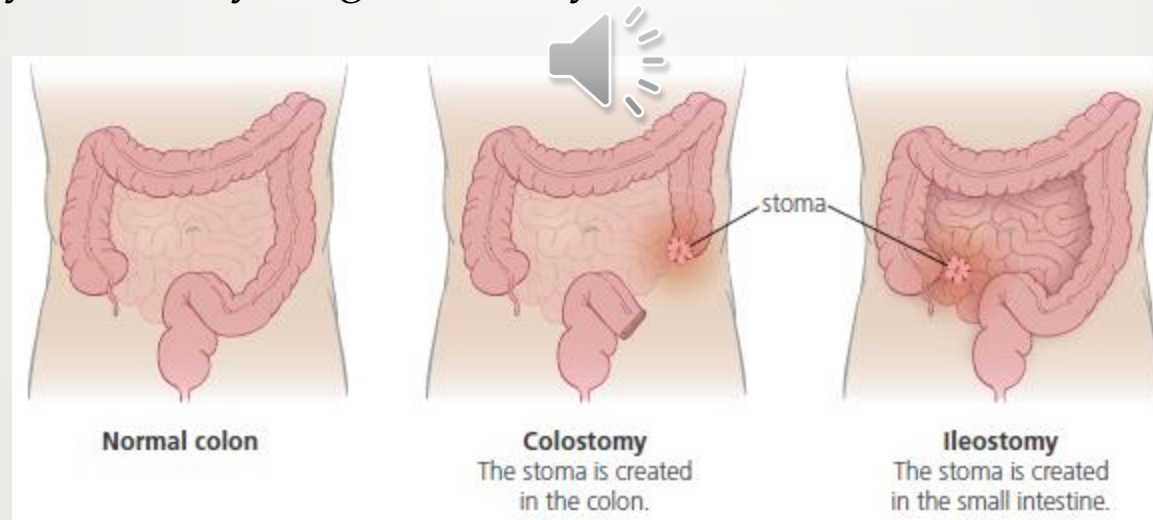
Intertriginous Dermatitis (ITD)

- Caused by trapped moisture in skin folds
- Normally have linear breaks or kissing lesions
- Prevention and management
 - Absorptive or wicking dressings between body folds
 - Moisture barriers between folds
 - Support surfaces with air flow to control microclimate



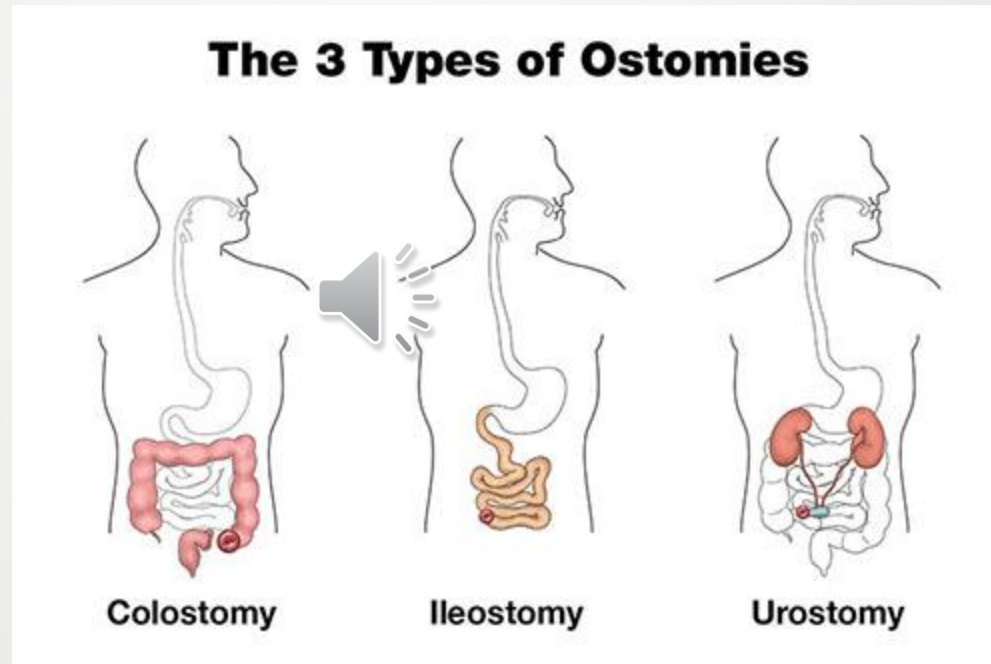
Ostomy Care

- What is an ostomy?
 - An artificial opening in an organ of the body, created during an operation such as a colostomy, ileostomy, or gastrostomy; a stoma.



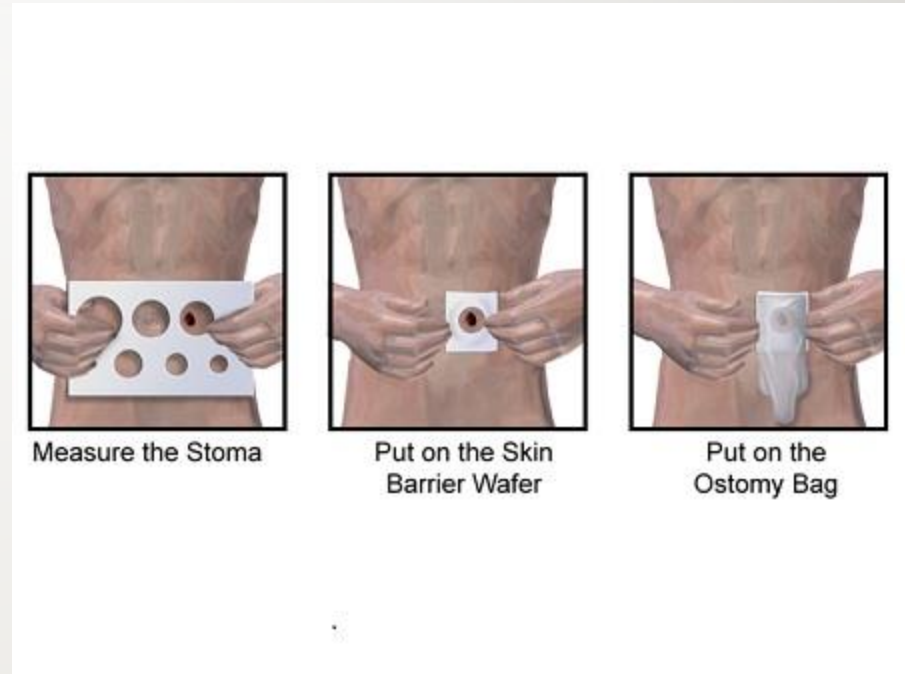
Types of ostomies

- Colostomy
- Ileostomy
- Urostomy



Steps to pouch an ostomy

- Remove system
- Check peristomal skin
- Clean and pat dry
- Measure stoma
- Apply skin prep
- Apply appliance/wafer
- Apply pouch
- Make sure sealed and closed



User Testing:
HOW TO PUT ON AN OSTOMY BAG



Trim

1

First measure the size of stoma; then trim skin barrier to proper size



Peel

2

Take off the protection layer for adhesive



Fit

3

Fit skin barrier around stoma and securely attach barrier to skin.



Snap

4

Connect pouch to skin barrier with pressure fit snap ring.



Adjust

5

Adjust overall pouch and skin barrier position.



Cover

6


Tuck it in jeans and cover with shirt.

Putting it All Together

- So what happens when a patient comes in with a wound or a new wound is found on an existing patient?
 - Notify nurse immediately
 - Do not massage area
 - If redness, apply protective dressing
 - Offload if on the heels, position off of area if on the sacrum, hip or buttock using positioning aids



Recap Pearls

- If you see something please report it immediately and have nurse look and document it
- Use containment when at all possible
- Use positioning aids to keep patients turned 
- HOB between 30-45 degrees
- If patient cannot lift their heels off of the bed or move themselves from side to side, place protective dressings on sacrum and heels
- Elevate heels off of bed
- If using heel pads ensure proper placement

Remember.....



You are one of the most valuable members of
the nursing team. We are thanking you in
advance for your service!!