



# HOSPICE INSIGHTS

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In the July, 2005 *Insights* we discussed the “**skin care basics**”, which included the structure of the skin, the benefits of intact skin, the five basics for skin protection, and the nursing assistant’s role in pressure ulcers. I would like to continue by describing the different types of skin ulcers, staging definitions, and devices used for skin integrity.

**All ulcers are not pressure ulcers.** It is important to know how to determine “what” a pressure ulcer is. They are either **over a bony prominence** (heels and feet, coccyx, hip, elbows, and buttocks), **related to pressure OR sheer force** (friction), and are **sometimes caused from shoes, braces, restraints, geri-chairs, beds, bed pads, or poor wheelchair positioning.**

There are four stages of pressure ulcers. The definition of each follows:

- Stage 1 –Over a bony prominence, nonblanchable erythema, OR induration, alteration in skin temperature, tissue consistency, and sensitivity. These symptoms persist for 20 – 30 minutes and indicate tissue injury and poor “tissue tolerance”.
- Stage 2 – Partial thickness, epithelium is gone, not into subcutaneous tissues.
- Stage 3 – Through the dermis, subcutaneous fat or debris, not yet into muscle, tendons or bone.
- Stage 4 – Through the fascia and into muscle, visible bone or tendon, and into the joint space.

If the wound is covered with *eschar* it is “unstageable due to the eschar”. **NEVER stage non-pressure ulcers.**

To heal a wound caused from pressure it is best to use **moist** wound healing techniques. They consist of:

- 1) Eliminate the underlying cause of the wound,
- 2) Keep the wound bed clean,
- 3) Apply dressings that maintain proper moisture, and
- 4) Change when dressings are saturated.

The **two main choices for moist wound healing are** : ***Allevyn foam***, which is an excellent adhesive, waterproof barrier, absorbent foam, and ***Coversite/Solosite***. Solosite = hydrogel (keeps the wound moist) and coversite is a breathable, non-adhesive dressing.

There are several non-pressure causes of ulcers, especially in the legs and feet. They are as follows:

- **Arterial Disease ~**

These ulcers are slow and progressive in nature. They have the following qualities:

- *Painful when elevated.*
- *Painful when walking.*
- *Shiny, red foot.*
- *Cool, no hair.*
- *Difficult to heal open areas.*

Some ulcers are due to a sudden arterial occlusion. They have the following qualities:

- *Cold leg.*
- *Very painful.*
- *Cyanotic or blue color.*
- *Urgent action needed.*
- *Amputation is possible.*

- **Venous Stasis ~**

- *Red rash.*
- *Pain when limb is down.*
- *Wet, weeping open areas.*
- *Skin is stained with iron from blood cells.*

- **Diabetic Foot Ulcers ~**
  - *Most commonly caused by peripheral neuropathy and peripheral vascular disease.*
  - *Loss of sensation, absence of pain.*
  - *Poor circulation.*
  - *Callous formation.*
  - *Cracks and infection.*
- **Neuropathic ~**
  - *May occur in patients with diabetes, spinal cord injury, Hansen's Disease, or other conditions that result in a loss of sensation in the legs and feet.*
  - *Most commonly seen at the ankle and foot, particularly at the plantar surface and metatarsal heads.*
  - *Varied wound depth.*
  - *Even, well-defined wound margins.*
  - *Varied presence and amount of necrotic tissue or exudates.*

*The periwound and leg/foot skin may demonstrate the following changes:*

  - *A circumferential callous.*
  - *Erythema.*
  - *Maceration.*
  - *Cellulites.*
  - *Palpable pulses (usually present).*
- **Traumatic ~**
  - *Trauma to the body may result in a compromise to the arterial, venous or lymphatic systems; changes to the bony architecture of the skeleton; loss of tissue layers – epidermis, dermis, subcutaneous soft tissue, muscle, or bone; damage to body parts or organs; and/or loss of body parts or organs.*
  - *All of the above situations present different problems, all of which could lead to skin ulcers. Each condition must be evaluated separately to identify the underlying reason for that ulcer.*

There are many devices available to ensure skin integrity:

1. Beds
  - a. Standard beds.
  - b. Pressure Relief inserts for heels and hips.
  - c. Alternating pressure overlays.
  - d. Specialty beds ("Flotation" by Clinitron, and "Low Air Loss" by Kinair).
2. Footwear
  - a. Large toe box shoes.
  - b. EZ Boots (bed and wheelchair and pillows under the patient's calves).
  - c. PRAFO (ambulators).
  - d. Orthotics (inserts, custom shoes, and "surgical shoes").
3. Seating
  - a. Non-slip fabric.
  - b. Firm base pad.
  - c. Gel.
  - d. ROHO.
  - e. **Avoid "Geri-chairs"!!!**
4. Wheelchair positioning
  - a. Wedge.
  - b. Stirrups.
  - c. Bolsters.
  - d. Reclining Seats.
  - e. Custom designed .

**Summary:n**

1. **Know the 5 Basics ~ Hydration, Nutrition, Hygiene, Pressure, and Shear Injury.**
2. **Observe your resident's/patient's skin, positioning, shoes and wheelchair.**
3. **Communicate and report the condition of the resident's/patient's skin.**
4. **Get to know some of the common skin problems.**

**References:**

Hospice Skin Care presented by Dr. John Mielke, June 30, 2005 at Hospice of the Twin Cities.

[Woundinformation@aol.com](mailto:Woundinformation@aol.com)

[www.hollister.com/us/wound/resource](http://www.hollister.com/us/wound/resource)

**Mission Statement**

*Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families y providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.*