Pressure injury / Incontinence Associated Dermatitis why is it so different?

" You don't know what is new if you don't know what is old"
Dr George W Cherry
Chairman, Oxford international Wound Healing Foundation
Faculty of Medicine, Oxford University 2009

Ann Marie Dunk
Australian Wound and Skin Alliance
Inaugural Summer School, Melbourne 2024.

Why are Pressure Injuries still occurring?

- Acuity of our patients with complex comorbidities
- Increase of life expectancy – elderly / neonate
- Device related injuries and technologies that we need and use in practice
- Has the scientific understanding of skin failure been fully explored and blended with pressure injuries
- Has skin assessment been lost as an essential part of nursing practice
- Lost is the knowledge transfer from expert to novice

Why is Incontinence Associated Dermatitis still occurring?

- Acuity of our patients with complex comorbidities and treatments
- Increase of life expectancy – elderly and for the neonate consider inevitable
- Has the scientific understanding of IAD been fully explored and defined
- Has IAD been confused with PI historically and still is confusing







Terminology and Classficiation

- Can we classify the stage of a pressure injury and incontinence associated dermatitis
- Are we discussion and interpreting the same skin injury
- Skin assessment and risk assessment have we confused the issue
- Now screening is part of the measurable quality process
- Are we taking validated tools and adapting th
environments
- Are we understanding the validated t sing them correctly in clinical practice

Irritant Contact Dermatitis

Irritant Contact dermatitis ICD is due to friction sweating or contact with body fluids ICD-11 coding

Irritant contact dermatitis is due to friction, sweating and contact with body fluids

Irritation from body fluids may be due to high or low pH, to proteolytic enzymes or both, the irritant effect maybe aggravated or caused solely by sweating and repetitive friction of apposed skin surfaces

Moisture Associated skin damage

It is the long-term exposure of the skin surface to moisture, and multifactorial in the development of skin damage

It is multifactorial in all age groups

Chemical irritants in body fluids

Increased skin surface pH

Pathological microorganisms on the skin surface

Mechanical factors such as friction

- IAD / peristomal dermatitis /peri wound maceration / intertriginous dermatitis (intertrigo)

Quick Reference Guide
2019

INCONTINENCE-ASSOCIATED DERMA
MOVING PREVENTION FORWARD

Addressing evidence gaps

A clinical guide to pelvic skin assessment

Pressure injury and incontinence-associated dermatitis are common pelvic skin injuries. Skin assessment of the pelvic region is complex and must consider multiple factors. Pressure injury and incontinence-associated dermatitis are often misclassified, leading to inappropriate prevention and treatment strategies being implemented. This may result in poor clinical outcomes and suboptimal use of healthcare resources. This paper reports the results of an expert working party consensus process to produce a practical guide to support systematic skin assessment of the pelvic region in adults. It also provides information supporting the accurate differentiation between these commonly misclassified skin injuries.

Authors (clockwise from top left): Jill Campbell, Michelle Barakat-Johnson, Michelle Hogan, Kay Maddison, Jill McLean, Tabatha Randa, Monika Samolyk, Sarah Sage, Kate Weger and Ann Marie Dunk

Skin injuries, such as pressure injury (PI) and incontinence-associated dermatitis (IAD), continue to present challenges for patients and healthcare providers across the healthcare continuum. Maintaining skin integrity is a critical dimension of the broader imperative of keeping patients safe from harm (Campbell et al, 2016a). Appropriate evidence-based prevention and management of pelvic skin injury is underpinned by thorough holistic patient assessment, of which skin assessment is a key component. However, skin assessment — particularly of the pelvic area — is complex, requiring the consideration of multiple interrelated factors. This complexity,

This paper is targeted primarily at registered nurses who are responsible for the assessment and classification of pelvic skin injury, and for formulating, implementing and evaluating a care plan to treat any injury and prevent further injury. The information provided will also benefit any individual involved in the ca of adults at risk of pelvic skin injury. See *Te* for definitions of terms used in this pap

Pressure injury

This term was originally adopt Pacific Pressure Injury Alli recently by the Natio Advisory Panel. T Advisor

ELSEVIER journa

Kennedy terminal ulcer and other skin integrative review

Alba Roca-Biosca [a], Lourdes Rubio-Rico [a,*], María Inmaculada
Juan Francisco Martinez-Castillo [b], Pedro Luís Pancorbo-Hidalgo [c],
Francisco Pedro García-Fernández [d]

[a] Department of Nursing, Faculty of Nursing, Rovira I Virgili University, Tarragona, Spain

ances in
n&WoundCare

urnal for Prevention and Healing Volume 33 Number 2 February 2020

GEMENT EXTRA
s to Microthrombotic Wounds: A Review
nesis and Clinical Features
n Failure in the Critically Ill Adult Population:
matic Review

AL INVESTIGATION
Ears of a Hippopotamus: Quality of Venous Leg Ulcer Care
Gauteng, South Africa
A Novel Point-of-Care Solution to Streamline Local Wound Formulary Development and Promote Cost-effective Wound Care

CASE SERIES
Wounds Related to Malignancy in Postacute and Long-term Care: A Case Series

APS
Archives of Plastic Surgery

A case of acute skin failure misdiagnosed as a pressure ulcer, leading to a legal dispute

Jung Hwan Kim, Hea Kyeong Shin, Gyu Yong Jung, Dong Lark Lee
Department of Plastic and Reconstructive Surgery, Dongguk University College of Medicine, Gyeongju, Korea

It is difficult to differentiate acute skin failure (ASF) from pressure ulcer (PU). ASF is defined as unavoidable injury resulting from hypoperfusion caused by severe dysfunction of another organ system. We describe a case of ASF mistaken as PU that resulted in a legal dispute. A 74-year-old male patient was admitted to our intensive care unit with sepsis due to bacterial pneumonia. Despite the use of air cushions and regular position changes, skin ulcerations occurred over his occiput, back, buttock, elbow, and ankle. After improvement in his general condition, he was transferred to the department of plastic and reconstructive surgery. Debridement was performed immediately, followed by conservative treatment (including a vacuum-assisted closure device) for 6 weeks. The buttock and occiput wounds were treated surgically. Despite complete healing, his caregivers sued the hospital for failing to prevent PU formation. ASF is a pressure-related injury resulting from hemodynamic instability due to organ system failure. Unlike PU, ASF may occur despite the implementation of all appropriate preventive measures. Furthermore, misdiagnosis of ASF as PU can lead to litigation. Therefore, it is critical for the proper diagnosis to be made quickly, and for physicians to explain that ASF occurs despite proper preventative treatment.

Keywords Pressure ulcer / Skin / Intensive care units / Necrosis

Correspondence: Hea Kyeong Shin
Department of Plastic and Reconstructive Surgery, Dongguk University College of Medicine, 87 Dongdae-ro, Gyeongju 38067, Korea
Tel: +82-54-770-1461
Fax: +82-54-770-1469
E-mail: shinheakyeong@hanmail.net

Received: 22 Jan 2018 • Revised: 8 May 2018 • Accepted: 13 Jun 2018
pISSN: 2234-6163 • eISSN: 2234-6171 • https://doi.org/10.5999/aps.2018.00087 • Arch Plast Surg 2019;46:75-78

Case Report

INTRODUCTION

Patients in a poor medical state often develop pressure ulcer (PU) during hospitalization, and if preventive measures are inappropriate, this can be interpreted as reflecting carelessness of the medical team. However, acute skin failure (ASF) can develop despite the adoption of normal precautionary measures [1]. der to shed light on this ill-defined disease entity, so that physicians can better cope with patients who actually have ASF. The patient and the caregivers were informed about this study, and their consent was obtained before submission.

CASE

Wound Care

J Wound Ostomy Continence Nurs. 2019;46(3):187-191.
Published by Lippincott Williams & Wilkins

CE 1.5 ANCC Contact Hours

Definition and Characteristics of Chronic Tissue Injury

A Unique Form of Skin Damage

Mary F. Mahoney ◆ Barbara J. Rozenboom

ABSTRACT

BACKGROUND: The purpose of this article is to examine the evidence related to a unique phenomenon of purple-maroon discoloration of the buttocks found in homecare patients and to recommend a label for this phenomenon.

CASES: Initially, we searched the literature to identify and retrieve any evidence related to this unique form of purple-maroon discoloration of the buttocks. No evidence was found. To illustrate the condition, we compared 4 cases of what we have labeled chronic tissue injury to 6 patients with purple-maroon discoloration of the buttocks from different causes.

CONCLUSION: Chronic tissue injury is characterized by a persistent purple-maroon discoloration located on the fleshy portion of the buttocks that does not improve or deteriorate. Unlike other causes of purple discoloration such as deep tissue pressure injury, there is minimal change in the discoloration over time. Additional research is needed to further our understanding of the histopathology of this phenomenon.

KEY WORDS: Chronic tissue injury, Chronic wound, Deep tissue pressure injury, Moisture-associated skin damage, Skin failure, Venous ulcers.

INTRODUCTION

Understanding the etiology of various forms of skin damage is necessary for accurate assessment and classification. For example, pressure injury categories have clinically relevant regulatory and cost implications.[1,2] Misidentification can lead to inconsistent and inaccurate benchmarking, ineffective treatment, and inaccurate use of resources.

Through our combined 35 years of homecare nursing experience, we have reviewed thousands of homecare patients' medical records with a form of skin injury of the buttocks that did not resemble any known skin injury category. The injury was noted to be a purple-maroon discoloration of the fleshy buttocks present for a long period. The area of damaged skin sometimes included superficial abraded skin or small open le-

All clinicians must accurately identify wound type to guide management, comply with federal regulations, and achieve reimbursement.[2] Choosing the wound type may be limited by the terminology available in the organization's electronic medical record system. For example, home health clinicians must classify wounds using the Outcomes and Assessment Information Set (OASIS). We have found that clinicians typically label these unique purple-maroon lesions as Stage 1 or Stage 2 pressure injury (PI), deep tissue pressure injury (DTPI), skin failure, moisture-associated skin damage, trauma, or inflammatory lesions. The purpose of this article is to examine evidence related to chronic tissue injury, present a case series of individuals with chronic tissue injury compared to patients with similar characteristics of the buttocks, and recommend a

ed: 13 April 2021 | Revised: 3 September 2021 | Accepted: 10 September 2021
0.1111/jnu.12716

Journal of Nursing Scholarship

in injuries associated with severe life-threatening situations: new conceptual framework

ıcisco Pedro García-Fernández PhD, MSN, RN[1] |
ıvier Soldevilla-Agreda PhD, BAS, RN[2] | Manuel Rodriguez-Palma PhD, MSN, RN[3] |
ro L. Pancorbo-Hidalgo PhD, BSc, RN[1]

rtment of Nursing, Faculty of Health es, University of Jaén, Jaén, Spain
ng School, University of La Rioja, La Spain
ng Home "José Matía Calvo" of Cádiz, Spain

ıpondence
sco Pedro García-Fernández, tment of Nursing, Faculty of Health es, University of Jaén, Bldg. B3 222, Campus Las Lagunillas S/N, 3071, Spain.
fpgarcia@ujaen.es

Abstract

Purpose: To create a conceptual framework for skin injuries developing in patients whose lives are severely compromised or who are expected to die within a short period of time. To name and classify these types of skin injuries. To describe the clinical features of the different types of skin injuries that may occur in terminally ill and/or dying patients.

Design: A sequential design with several different phases (a literature review, a nominal group, and a consensus conference) was used.

Methods: Six experts with extensive knowledge of these types of injuries were selected for the nominal group. The traditional eight-phase nominal group technique was followed. The consensus conference consisted of participants voting on different options based on the statements elaborated with the expert panel summarizing the best scientific evidence available.

Findings: Using all these elements, a conceptual framework was constructed to identify *skin injuries associated with severe life-threatening situations* (SI-SLTSs), defined as unpredictable and therefore unpreventable injuries indicating a serious threat to life or even imminent death. These injuries can occur in two forms: (a) as *skin injuries associated with multiple organ dysfunction syndrome* (SI-MODSs) or (b) as *skin injuries associated with severe vasoconstriction* (SI-ESVs). SI-MODSs develop very quickly and suddenly. They progress from superficial to deep stages abruptly, even within hours. The severity of the injuries does not reflect the care provided to the patient. Individuals suffering from these injuries have an irreversible clinical condition. SI-ESVs also appear in individuals who are in a very critical, even terminal, clinical condition. They are frequently treated in the ICU and may exhibit severe vasoconstriction due to their disease process (e.g., shock), sometimes exacerbated by vasoconstriction caused by various drugs (e.g., noradrenaline).

Conclusions: We have developed a conceptual framework for skin injuries developing in patients whose lives are severely compromised or who are expected to die within

Available online at http://www.journalijdr.com
IJDR
International Journal of Development Research
Vol. 10, Issue, 10, pp. 41760-41763, October, 2020
https://doi.org/10.37118/ijdr.20306.10.2020
ISSN: 2230-9926

RESEARCH ARTICLE OPEN ACCESS

NURSING CARE FOR PATIENTS AFFECTED BY KENNEDY TERMINAL ULCER: INTEGRATIVE REVIEW

Maria Margarida Costa de Carvalho[1], Érika de Cássia Lima Xavier[2], Ivonete Vieira Pereira[3], Rayanne Bandeira Carneiro[4], Angélica Menezes Bessa Oliveira[1], Kelly Layla da Silva Guterres[1], Deliane Silva de Souza[1], Cristianne de Oliveira Arrais Saraiva[1], Alex Miranda Franco[1], Kamille Martins de Oliveira[1], José Maria dos Santos Coelho[2], Rosivalda Jacirema Cardoso Chaves[5], Laudelana de Paiva Santos[5], Amanda Ventura Félix[5], Ana Karoline Araújo[5], Jessica Lopes Quadros da Silva[5], Felipe Moreira Viegas[4], Raíza Almeida Pereira[4] and Winnie Taíse Pena Macêdo[3]

[1]Hospital Ophir Loyola; [2]Secretaria de Saúde e Meio Ambiente do Pará; [3]Universidade do Estado do Pará; [4]Instituto Nacional do Câncer; [5]Secretaria de Estado Saúde Pública do Pará; [1]Centro Universitário FIBRA

ARTICLE INFO

Article History:
Received 17th July, 2020
Received in revised form
19th August, 2020
Accepted 29th September, 2020
Published online 30th October, 2020

Key Words:
Palliative Care, Oncology Nursing, Chronic Wounds.

****Corresponding author:***
Maria Margarida Costa de Carvalho,

ABSTRACT

Objective: Describe the scientific evidence on Kennedy's ulcer as described in the literature, identifying nursing care for patients with Kennedy's ulcer. Method: Integrative review segmented in six stages. The search took place between 2010-2019 on MEDLINE, LILACS, SciVerse Scopus, ScienceDirect, CINAHL and PUBMED databases, with export to the Rayyan for Systematic Reviews program. Evidence levels were assessed according to Agency for Healthcare Research and Quality.Results: 133 publications were identified and 6 remained, with level of evidence IV, V and VI. The inevitability of Kennedy's terminal ulcer stands out, especially due to the physiological blood hypoperfusion of the skin during terminality, measures to avoid shear and pressure injuries do not reverse the situation that deserves attention and multi-professional dialogue. **Conclusion:** Kennedy's terminal ulcer serves as a marker for those involved in palliative care, giving rise to postures aimed at offering comfort and keen communication. There is still a lack of evidence in primary intervention and follow-up studies in the scientific literature.

Citation: ***Maria Margarida Costa de Carvalho, Érika de Cássia Lima Xavier, Ivonete Vieira Pereira, Rayanne Bandeira Carneiro et al, 2020.*** "Nursing care for patients affected by kennedy terminal ulcer: Integrative review*", International Journal of Development Research*, 10, (10), 41760-41763.

INTRODUCTION

Kennedy's terminal ulcer (KTU) occurs due to the collapse of the largest organ in the human body, the skin, during the death process. Karen Kennedy-Evans was the nurse responsible for describing her in 1983 at a long-term care facility while performing a study of pressure injuries. KTU has characteristics such as: predilection for the sacral region; irregular design; pear, butterfly or horseshoe shape; yellowish, black or purple color; it starts suddenly as a bubble or stage III or IV, the colors may be less indicative for, starting as red abrasion (Kennedy, 2014). The difference of these for pressure injuries comes from the time of progression, starting at times bigger and increasing in size and depth, taking days or weeks for the outcome (Kennedy, 2014; Trombley *et al*., 2012). The Skin Changes At Life End (SCALE) determines the failure of several organs at the end of life, the known systemic involvement of organs is still being studied for the skin, through quantitative models. What is known is that the physiological composition of KTU is incomplete, that it is inevitable at the end of life and that it is necessary to begin to elaborate and disseminate solid diagnostic criteria for it at the end of life (Ayello *et al*., 2019). SCALE informs about the approach of: objective changes in the skin and pain, despite the excellent care, documentation on the client's response, focusing on the patient, ideal care is implemented even without a prognosis for improvement, communication between those involved in terminality and about this biological process,

Literature Review

Understanding Skin Failure: A Scoping Review

Lizanne Dalgleish, PhD, RN; Jill Campbell, PhD, RN; Kathleen Finlayson, PhD, RN; Michelle Barakat-Johnson, PhD, RN; Amy Beath, BSN, RN; Jessica Ingleman, MSN, RN; Christina Parker, PhD, RN; and Fiona Coyer, PhD, RN

Clinical Management Extra

Acute Skin Failure in the Critically Ill Adult Population: A Systematic Review

Lizanne Dalgleish, BSN, RN, PhD Candidate, School of Nursing, Faculty of Health, Queensland University of Technology, Brisbane, Queensland, Australia
Jill Campbell, PhD, RN, Joint Appointment, School of Nursing, Faculty of Health, Queensland University of Technology, Clinical Nurse, Skin Integrity Service, Royal Brisbane & Women's Hospital, Brisbane, Queensland, Australia
Kathleen Finlayson, PhD, RN, Lecturer, School of Nursing, Faculty of Health, Queensland University of Technology, Brisbane, Queensland, Australia
Fiona Coyer, PhD, RN, Professor of Nursing, Joint Appointment, School of Nursing, Queensland University of Technology, Royal Brisbane & Women's Hospital, Visiting Professor, Institute for Skin Integrity and Infection Prevention, University of Huddersfield, West Yorkshire, England

CME
1 AMA PRA
Category 1 Credit™

CE
ANCC
1.5 Contact Hours

GENERAL PURPOSE: To present a systematic review of the literature conducted to define and extend knowledge of the risk factors, causes, and antecedent conditions of acute skin failure (ASF) in adult intensive care patients.

TARGET AUDIENCE: This continuing education activity is intended for physicians, physician assistants, nurse practitioners, and nurses with an interest in skin and wound care.

LEARNING OBJECTIVES/OUTCOMES: After participating in this educational activity, the participant should be better able to:

1. Outline the background information helpful for understanding the authors' systematic review of ASF in adult intensive care patients.
2. Summarize the results of the authors' review of the risk factors, causes, and antecedent conditions of ASF in adult intensive care patients.

Skin failure

- Ongoing debate surround the definitions of skin failure, such as acute SF (ASF) chronic SF and end-stage SF.
- Objective diagnostic markers and clinical parameters related to the integumentary system and SF are lacking
- No agreed-upon definition and related research remains inconsistent as a result
- Significant conceptual confusion surrounding ASF remains, as often labelled as PI, ASF does not require mechanical stress for PI development
- Kennedy terminal ulcer skin failure occurs as part of the dying process, 62% develop pressure injuries in their final 2 weeks of life, are they Kennedy terminal ulcers?

Table 1. SKIN FAILURE DEFINITIONS

	Definitions			
Author	**Skin Failure**	**Acute Skin Failure**	**Chronic Skin Failure**	**End-Stage Skin Failure**
Irvine[2]	A loss of normal temperature control with inability to maintain the core temperature, failure to prevent percutaneous loss of fluid, electrolytes, and protein with resulting imbalance and failure of the mechanical barrier to penetration by foreign materials			
Isaac[3]	The interference with skin function as a result of damage or loss of large areas of skin resulting in loss of barrier function, hemodynamic problems, impaired thermal regulation, and metabolic, endocrine, and hemodynamic changes			
Inamadar[4]		A state of total dysfunction of the skin resulting from different dermatological conditions		
Langemo and Brown[5]	An event in which the skin and underlying tissue die due to the hypoperfusion that occurs concurrent with severe dysfunction or failure of other organ systems	An event in which skin and underlying tissue die due to hypoperfusion concurrent with a critical illness	An event in which skin and underlying tissue die due to hypoperfusion concurrent with an ongoing, chronic disease state	An event in which skin and underlying tissue die due to hypoperfusion concurrent with the end of life
Shanks et al[6]		Pressure-related injury concurrent with acute illness as manifested by hemodynamic instability and/or major organ system compromise		
Delmore et al[7]		The hypoperfusion state that leads to tissue death that occurs simultaneously to a critical illness.		
Levine[8]	The state in which tissue tolerance is so compromised that cells can no longer survive in zones of physiological impairment that includes hypoxia, local mechanical stresses, impaired delivery of nutrients, and buildup of toxic metabolic byproducts. This includes pressure injuries, wounds that occur at life's end, and in the setting of multisystem organ failure.			

KENNEDY TERMINAL ULCER

Diagnosis

- Clinicians should be aware and know where to find the information when they need it to make a diagnosis
- Stronger definition. Probable progression with timeline?
- A tool like the Braden Scale that can quantify the skin changes that occur at the end of life.
- Better markers of multi organ failure, documentation of skin failure and what it looks like, lab tests that indicate skin failure, etc.
- Such changes need to also be coordinated with patient's cognitive condition and ability to comply with self protective measures
- We need look toward causes just like we learned Pr I vs MASD
- It is multifactorial so may need a checklist to determine if it is SCALE vs a HAPI
- Checklists that aid in diagnosis and prognosis
- Need better diagnostic criteria

Unavoidable

- Unavoidable pressure injury has to be excluded from incidence total number at the end of each month
- An appreciation that the skin is an organ and as with other organs can fail despite all medical interventions.
- Avoidable definition requires an out for clinicians that do everything "reasonable" to maintain the skins integrity in whatever setting they find themselves

Miscellaneous

- Better staffing
- Less emphasis on fear of accountability. We should make PIs simpler instead of more complicated to diagnose and therefore prevent
- Recognition of patient and family denial of processes
- Work with other specialties to individual the care
- Better support surfaces
- You simply do not have enough space here for me to pontificate

Abbreviations: KTU, Kennedy terminal ulcer; HAPI, hospital-acquired pressure injury; MASD, moisture-associated skin damage; NPUAP, National Pressure Ulcer Advisory Panel; PI, pressure injury; PrI, pressure injury; PU, pressure ulcer; RCT, randomized controlled trial; SCALE, Skin Changes at Life's End; TB-TTI, Trombley-Brennan terminal tissue injury; WOC, wound ostomy continence.

KENNEDY TERMINAL ULCER

TABLE 1. Differential Diagnosis Between Kennedy Terminal Ulcer, Deep Tissue Injury and Trombley-Brennan Terminal Tissue Injury[a]

Type of Wound	Kennedy Terminal Ulcer	Deep Tissue Injury	Trombley-Brennan Terminal Tissue Injury
Color	• Red, black, or yellow	• Purple or maroon	• Pink, purple, or maroon
Presentation	• Skin may not be intact • May begin as black speck, and size progresses rapidly	• Discolored intact skin or blood-filled blister	• Intact skin; bruise-like appearance • Sacrum may present as butterfly pattern • Bilateral injuries may mirror another
Causation	• Unknown	• Pressure and/or shear	• Unknown
Location	• Usually on sacrum	• Over bony prominences	• May or may not present over bony prominences • Noted on lower extremities and trunk
Shape	• Pear shaped	• Irregular shaped	• Butterfly shaped, linear striations
Characteristics	• Develops rapidly from blister/wound into full-thickness wound	• Tissue may be painful, firm, mushy, boggy, warmer, or cooler compared with adjacent tissue	• Does not progress to skin breakdown • Remains intact • Wounds may extend in downward trajectory • Injury appears spontaneously
Time frame	• May occur suddenly	• Discoloration may darken and intensify over time	•Occurs suddenly
Time from presentation to death	• Days to weeks	• Not related	• Hours to days

[a]From Trombley, Brennan, et al.[8] Used with permission.

FIGURE 2

A photograph of Trombley-Brennan terminal tissue injury in an adult patient.

Definitions

Incontinence Associated Dermatitis

A type of irritant contact dermatitis (inflammation of the skin found in patients with faecal and/or urinary incontinence)

Severity may be associated with superficial skin layers and/or secondary infections

Also known as

Irritant dermatitis, moisture lesion, perineal dermatitis, perineal rash, diaper/napkin/nappy dermatitis and/or rash

Pressure Injury

Is a localised damage to the skin and/ or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object.

Also known as

Pressure ulcer, pressure sore, bed sore, pressure area, decubitus ulcer

Who are we trying to teach and influence?

2023 - 453,515 RN RM EN

33% of our graduates leave in the 1st year ,and 56% leave in the 2nd year

New nurses struggle with the work environment and have difficulty in applying policies and procedures in the workplace

Assessment and accurate classification of PI and IAD is complex. PI and IAD often coexist and can be co-located

Experts' vs novice teachers

- Experts are better problem solvers because of the large amount of domain knowledge and organisation of information that reflects a deep understanding of the subject matter.
- What is the difference between expert and novice teachers?
- Experts focused on learning in the classroom and the teacher's ability to influence learning, whereas novices were more concerned with maintaining discipline and behavioural norms
- Experts notice features and meaningful patterns of information that are not noticed by novices. Experts have acquired a great deal of content knowledge that is organized in ways that reflect a deep understanding of their subject matter.

Is skin assessment lost and considered not an impo[illegible] part of fundamental nursing care and quality of care

Why is skin assessment important?

A complete skin assessment is essential for holistic care and must be completed by nurses and other health professionals on a regular basis in a systematic manner.

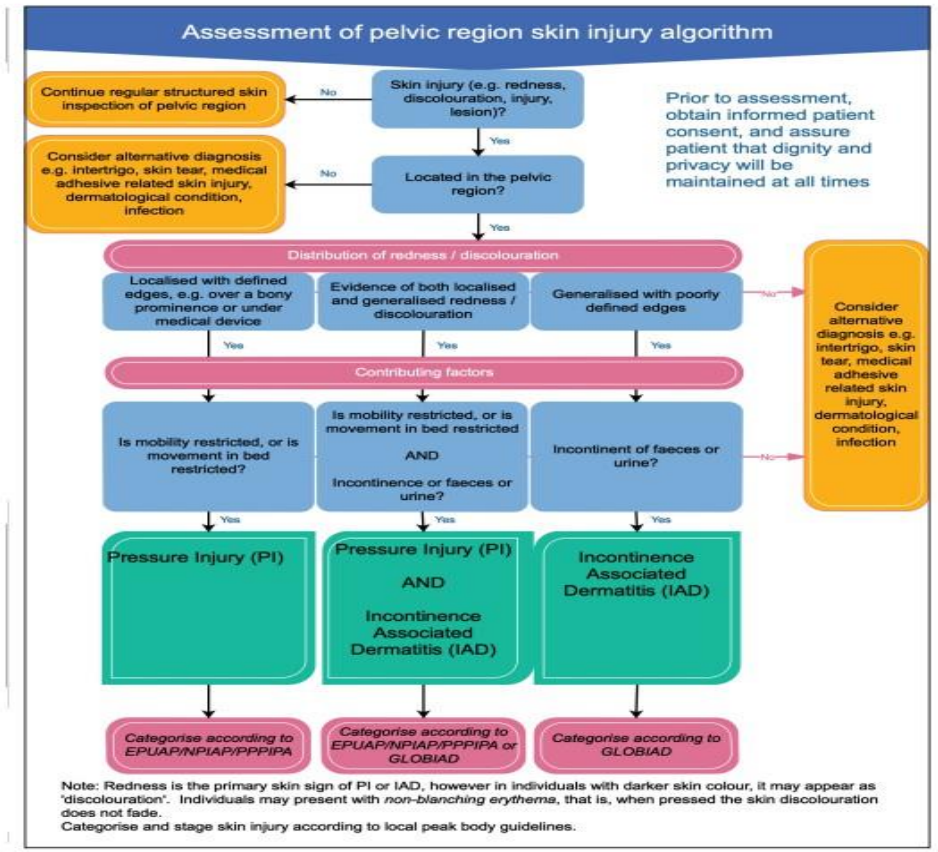
Early identification plays a critical role in maintaining skin integrity, through the timely implementation of appropriate prevention and management strategies.

Pain assessment and clues verbal and non-verbal.

Assessment should include the continuum of skin tones. Understanding of visual clues in determining severity of skin injuries.

Providing patients and relatives with information on good skin hygiene can improve skin integrity and reduce the risk of skin injuries.

Should we be building more algorithms or gui… improve clinical awareness and understand prac…



You as the experts' thoughts to **contemplate**

- Dynamic changes in healthcare systems e.g. DHR
- Systems to blame – multifactorial
- Is there a knowledge deficit senior professionals in both PI and IAD which inhibits differentiation
- As experts how can we upskill the novice teacher with terminology and classification of these skin injuries are there better ways
- Should we be talking about the relevance to clinical practice
- Have we ever mapped where the experts are in Australia and the outcomes of their wound health services
- Reporting systems in place for data collection however is there an ability to cleaning
- Explore the potential for collaborate research in Australia to understand these challenges which assist us with solutions

Thank you


Winners don't do DIFFERENT things. But they do things DIFFERENTLY.
- Unknown
boardofwisdom.com


Experts
Focus on learning
Knowledge
Understanding meaningful patterns
Deep reflection on subject matter
Novice
Concerned with maintaining behavioural norms
Have difficulty applying policies and procedures
Knowledge and expertise is lost within 2- 4 years post graduate as nurses walk away from the profession
Targeting and developing
Key clinicians and persons in roles that influence governances
Imbed information and resources into the electronic patient record system
Developing the expert clinician and
informing the governances and persons involved in policy / reporting