



Kenniscentrum Wondzorg

Decubitus in de thuissituatie

WCS congres 26 november

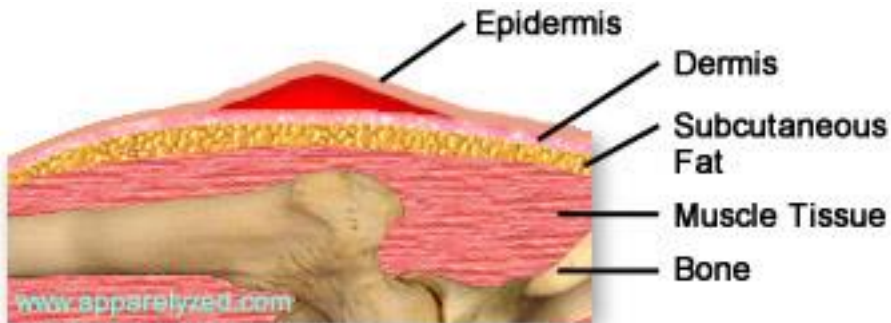
Tonny de Groot,

Transmuraal decubitusconsulent Zoetermeer

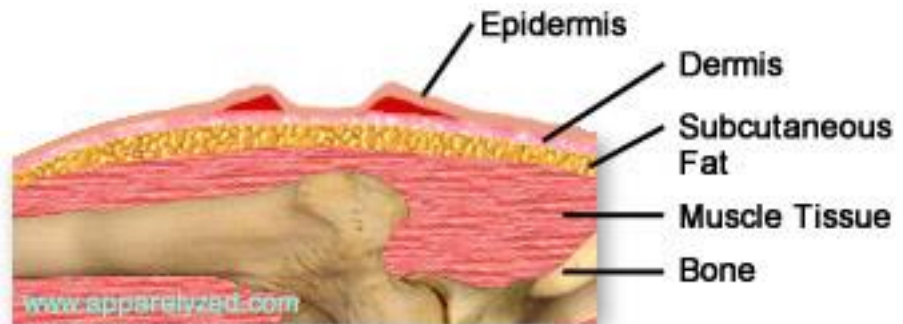
Wat is anders?

- Niet altijd 24 uurs zorg
- Niet altijd professionele zorg
- Preventieve maatregelen
- Verbandmateriaal
- Hoofdbehandelaar huisarts, ervaring?
- Hulpmiddelen
- Bij necrotectomie geen back up

Decubitus

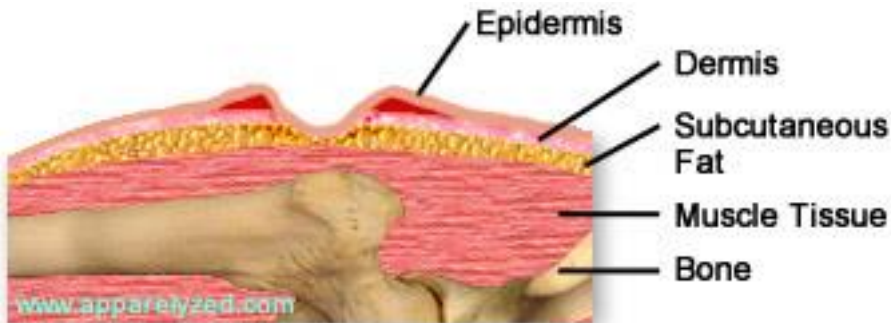


Categorie 1



Categorie 2

Decubitus



Categorie 3



Categorie 4

Incontinentieletsel

Differentiële Classificatie van decubitus, Incontinence-Associated Dermatitis (IAD) en Intertriginous Dermatitis (ITD)			
	Decubitus	IAD	ITD
Locatie	Meestal bij benig uitsteeksel of onder en medisch hulpmiddel	Peri-anaal gebied/dijen/billen	Bilnaad/liezen
Geassocieerde factoren	Verminderde mobiliteit Verminderd gevoel	Incontinentie/urine/faeces	Obesitas
Diepte	Aanvankelijk gepresenteerd als categorie 1 en 2 uiteindelijk meestal volledige huiddikte (categorie 3 en 4)	Meestal gedeeltelijke huiddikte	Meestal gedeeltelijke huiddikte
Vorm	Meestal rond, ovaal bij schuifkrachten	Onregelmatig	Lineair
Geassocieerde bevindingen	Mogelijk necrose, ondermijning en fistels kunnen aanwezig zijn	Omliggende huid gemacereerd	Omliggende huid gemacereerd

Doughty et.al; J. Wound Ostomy Continence Nurse 2012;39(3)303-315.
Vertaling: Tonny de Groot, Zoetermeer.

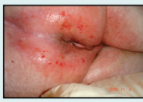
Incontinentie letsel

Incontinence-Associated Dermatitis Intervention Tool (IADIT)

Skin Care for Incontinent Persons

The #1 priority is to address the cause of incontinence. Use this tool until incontinence is resolved.

1. Cleanse incontinence ASAP and apply barrier.
2. Document condition of skin at least once every shift in nurse's notes or per organization's policy for documenting skin breakdown.
3. Notify primary care provider when skin injury occurs and collaborate on the plan of care.
4. Consider use of external catheter or fecal collector.
5. Consider short term use of urinary catheter only in cases of IAD complicated by secondary infection.

	Definition	Intervention
HIGH-RISK	Skin is not erythematous or warmer than nearby skin but may show scars or color changes from previous IAD episodes and/or healed pressure ulcer(s). Person not able to adequately care for self or communicate need and is incontinent of liquid stool at least 3 times in 24 hours. ¹	1. Use a disposable barrier cloth containing cleanser, moisturizer, and protectant.^{2,3} 2. If barrier cloths not available, use acidic cleanser (6.5 or lower), not soap (soap is too alkaline); cleanse gently (soak for a minute or two – no scrubbing); and apply a protectant (ie: dimethicone, liquid skin barrier or petrolatum). 3. If briefs or underpads are used, allow skin to be exposed to air. Use containment briefs only for sitting in chair or ambulating – not while in bed. 4. Manage the cause of incontinence: a) Determine why the person is incontinent. Check for urinary tract infection, b) Consider timed toileting or a bladder or bowel program, c) Refer to incontinence specialist if no success.⁴
EARLY IAD 	Skin exposed to stool and/or urine is dry, intact, and not blistered, but is pink or red with diffuse (not sharply defined), often irregular borders. In darker skin tones, it might be more difficult to visualize color changes (white, yellow, very dark red/purple) and palpation may be more useful. Palpation may reveal a warmer temperature compared to skin not exposed. People with adequate sensation and the ability to communicate may complain of burning, stinging, or other pain.	1. Include treatments from box above plus: 5. Consider applying a zinc oxide-based product for weepy or bleeding areas 3 times a day and whenever stooling occurs. 6. Apply the ointment to a non-adherent dressing (such as anorectal dressing for cleft, Telfa for flat areas, or ABD pad for larger areas) and gently place on injured skin to avoid rubbing. Do not use tape or other adhesive dressings. 7. If using zinc oxide paste, do not scrub the paste completely off with the next cleaning. Gently soak stool off top then apply new paste covered dressing to area. 8. If denuded areas remain to be healed after inflammation is reduced, consider BTC ointment (balsam of peru, trypsin, castor oil) but remember balsam of peru is pro-inflammatory. 9. Consult WOCN if available.
MODERATE IAD 	Affected skin is bright or angry red – in darker skin tones, it may appear white, yellow, or very dark red/purple. Skin usually appears shiny and moist with weeping or pinpoint areas of bleeding. Raised areas or small blisters may be noted. Small areas of skin loss (dime size) if any. This is painful whether or not the person can communicate the pain.	1. Include treatments from box above plus: 10. Position the person semiprone BID to expose affected skin to air. 11. Consider treatments that reduce moisture: low air loss mattress/overlay, more frequent turning, astringents such as Domeboro soaks. 12. Consider the air flow type underpads (without plastic backing).
SEVERE IAD 	Affected skin is red with areas of denudement (partial-thickness skin loss) and oozing/bleeding. In dark-skinned persons, the skin tones may be white, yellow, or very dark red/purple. Skin layers may be stripped off as the oozing protein is sticky and adheres to any dry surface.	1. Include treatments from box above plus: 10. Position the person semiprone BID to expose affected skin to air. 11. Consider treatments that reduce moisture: low air loss mattress/overlay, more frequent turning, astringents such as Domeboro soaks. 12. Consider the air flow type underpads (without plastic backing).
FUNGAL-APPEARING RASH 	This may occur in addition to any level of IAD skin injury. Usually spots are noted near edges of red areas (white, yellow, or very dark red/purple areas in dark-skinned patients) that may appear as pimples or just flat red (white or yellow) spots. Person may report itching which may be intense.	Ask primary care provider to order an anti-fungal powder or ointment. Avoid creams in the case of IAD because they add moisture to a moisture damaged area (main ingredient is water). In order to avoid resistant fungus, use zinc oxide and exposure to air as the first intervention for fungal-appearing rashes. If this is not successful after a few days, or if the person is severely immunocompromised, then proceed with the following: 1. If using powder, lightly dust powder to affected areas. Seal with ointment or liquid skin barrier to prevent caking. 2. Continue the treatments based on the level of IAD. 3. Assess for thrush (oral fungal infection) and ask for treatment if present. 4. For women with fungal rash, ask health care provider to evaluate for vaginal fungal infection and ask for treatment if needed. 5. Assess skin folds, including under breasts, under pannus, and in groin. 6. If no improvement, culture area for possible bacterial infection.

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1. Bliss DZ, Zehner C, Savik K, et al. Incontinence-associated skin damage in nursing home residents: a secondary analysis of a prospective, multicenter study. *Ostomy Wound Manage*. 2006;52:46-55.

2. Institute for Healthcare Improvement. Prevent Pressure Ulcers: How-To Guide. May 2007. Available at: <http://www.ihi.org/initiatives/Sabal851/6363-4688-se-19-be887d968580/presureulcerhowtoguide.doc>, accessed 10/21/07.

3. Gray M, Bliss DL, Ermer-Selhan J, et al. Incontinence-associated dermatitis: a consensus. *J Wound Ostomy Continence Nurs*. 2007;34:45-54.

4. Junkin J, Selekof J. Prevalence of incontinence and associated skin injury in the acute care inpatient. *J Wound Ostomy Continence Nurs*. 2007;34:260-269.

Incontinentieletsels



???



www.puclas.be

Niet altijd 24 uurs zorg



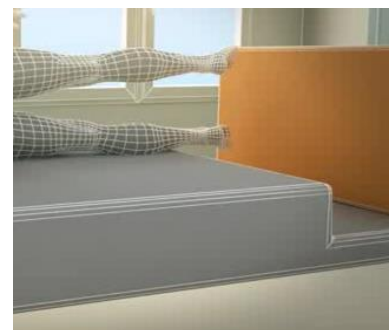
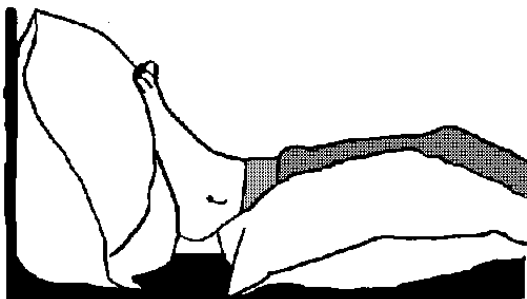
Niet altijd professionele zorg



Niet altijd professionele zorg



Preventieve maatregelen



Vervolg hielwond

- Vochtige wondbehandeling
- Na EAI start ACT i.v.m. oedeem
- Hiel vrij leggen
- Zo min mogelijk verbandwissels



Vervolg hielwond

5 maanden later:

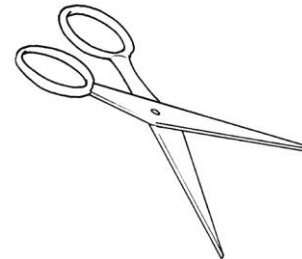
Eelt na genezen wond

Behandeling?

Ureumcreme



100



100



Hulpmiddelen

- Invloed zorgverzekeraars
- AD Indicatieverpleegkundigen leveranciers
- Frequentie herindicatie verschilt per zorgverzekeraar
-



Hulpmiddelen, CBO risico scorelijst

Mentale toestand
Neurologie
Mobiliteit
Voedingstoestand
Voeding
Incontinentie
Leeftijd
Temperatuur
Medicatie
Diabetes
Circulatie

Ieder item scoort 0-3 punten

Een score van < 8 betekent “geen verhoogd risico” - Een score van 8-12 betekent “verhoogd risico” - Een score van > 12 betekent “extra verhoogd risico”

Bij necrotectomie geen back up



Casuïstiek

Casus 1, ALTIS

- A: Decubitus
- L: Beide billen
- T: 6 maanden open/dicht
- I: Categorie 3
- S: Komt steeds terug, sinds mw minder mobiel is door MS. Schuifkrachten bij zitten in sta op stoel, incontinent van urine, hele dag uit bed



Casus 1, Time

- T: 100% rood
- I: geen
- M: vochtig
- E: onregelmatig, verweekt



Casus 1, Hulpmiddelen

- Luchtzitkussen in sta opstoel
- Rolstoel met kantel +
hoog luchtzitkussen i.p.v. sta op stoel
- Actieve tillift niet passend bij rolstoel



Casus 1, Wondbehandeling

Doel:

- Vochtige wondbehandeling
- Pijnstillend
- Wondranden beschermen



Casus 1, genezen



Casus 1, betrokkenen

- Decubitusconsulent als casemanager
- Patiënt en echtgenoot
- Huisarts is eindverantwoordelijk
- Wijkverpleegkundige
- Verzorging dagbehandeling
- Ergotherapeut
- WMO, leverancier rolstoel/tillift

Casus 2, Hypergranulatie

- 3 dagen oogzalf (Terracortril polymyxine B) en vet gaas
- Na 12 dagen het resultaat



Dank voor uw aandacht!

