CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

April 28, 2023

Congratulations to the 2023 Gold Standard Award Winners!

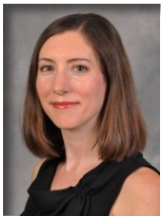
The Office of Faculty Affairs and Faculty Development is pleased to announce the

2023 Gold Standard Award Winners…

Joan Dolinak, MD
Department of Surgery, Burn Surgery

Savio John, MD
Department of Medicine, Division of Gastroenterology

Hom Neupane, MD
Department of Medicine, Division of Rheumatology and Clinical Immunology



Alicia Pekarsky, MD
Department of Pediatrics, Division of Child Abuse Pediatrics

Asalim Thabet, MD
Department of Emergency Medicine, Pediatric Emergency Medicine

Winners were honored at the Celebration of the Faculty event on March 28, 2023 in the Academic Building.

STAT Radiology Orders

By Dr. Michele Lisi, Jennifer Carey, Jennifer Caldwell

The Department of Radiology would like to remind everyone that ordering studies as "stat" should be reserved for clinical indications that require immediate results based on patient acuity. It is impossible for the radiologists to triage the indications for all studies that are ordered "stat," thus potentially deprioritizing a true medical emergency. We appreciate your cooperation with appropriately selecting an order priority.

New DEA Training Requirement

A message from Thomas W. Prevoznik, Acting Assistant Administrator, U.S Department of Justice, Drug Enforcement Administration, Diversion Control Division…

On December 29, 2022, the Consolidated Appropriations Act of 2023 enacted a new one-time, eight-hour training requirement for all Drug Enforcement Administration (DEA)-registered practitioners on the treatment and management of patients with opioid or other substance use disorders. Below is information on this new requirement.

- Who is responsible for satisfying this new training requirement? All DEA-registered practitioners, with the exception of practitioners that are solely veterinarians.

- How will practitioners be asked to report satisfying this new training requirement? Beginning on June 27, 2023, practitioners will be required to check a box on their online DEA registration form – regardless of whether a

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registrant is completing their initial registration application or renewing their registration – affirming that they have completed the new training requirement.

- What is the deadline for satisfying this new training requirement?
  - The deadline for satisfying this new training requirement is the date of a prescriber's next scheduled DEA registration submission – regardless of whether it is an initial registration or a renewal registration – on or after June 27, 2023.
  - This one-time training requirement affirmation will not be a part of future registration renewals

- How can practitioners satisfy this new training requirement? There are multiple ways that practitioners can satisfy this new training requirement:

  First, the following groups of practitioners are deemed to have satisfied this training:

  1. Group 1: All practitioners that are board certified in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, the American Board of Addiction Medicine, or the American Osteopathic Association.

  2. Group 2: All practitioners that graduated in good standing from a medical (allopathic or osteopathic), dental, physical assistant, or advanced practice nursing school within five years of June 27, 2023, and successfully completed a comprehensive curriculum that included at least eight hours of training on:

     - Treating and managing patients with opioid or other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder; or
     - Safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid and other substance use disorders.

  Second, practitioners can satisfy this training by engaging in a total of eight hours of training on treatment and management of patients with opioid or other substance use disorders from the groups listed below. A few key points related to this training:

  1. The training does not have to occur in one session. It can be cumulative across multiple sessions that equal eight hours of training.

  2. Past trainings on the treatment and management of patients with opioid or other substance use disorders can count towards a practitioner meeting this requirement. In other words, if you received a relevant training from one of the groups listed below – prior to the enactment of this new training obligation on December 29, 2022 – that training counts towards this eight-hour requirement.

3. Past DATA-Waived trainings count towards a DEA registrant's 8-hour training requirement.

4. Trainings can occur in a variety of formats, including classroom settings, seminars at professional society meetings, or virtual offerings.

- What accredited groups may provide trainings that meet this new requirement?
  - The American Society of Addiction Medicine (ASAM)
  - The American Academy of Addiction Psychiatry (AAAP)
  - American Medical Association (AMA)
  - The American Osteopathic Association (AOA), or any organizations accredited by the AOA to provide continuing medical education.
  - The American Dental Association (ADA)
  - The American Association of Oral and Maxillofacial Surgeons (AAOMS)
  - The American Psychiatry Association (APA)
  - The American Association of Nurse Practitioners (AANP)
  - The American Academy of Physician Associates (AAPA)
  - The American Nurses Credentialing Center (ANCC)
  - Any other organization accredited by the Accreditation Council for Continuing Medical Education (AACCME) or the Commission for Continuing Education Provider Recognition (CCEPR), whether directly or through an organization accredited by a State medical society that is recognized by the ACCME or CCEPR
  - Any other organization approved or accredited by the Assistant Secretary for Mental Health and Substance Use, the ACCME, or the CCEPR.

We hope this information is helpful. For information regarding the DEA Diversion Control Division, please visit www.DEAdiversion.usdoj.gov. If you have any additional questions on this issue, please contact the Diversion Control Division Policy Section at (571) 362-3260.

More information can be found online at: https://www.deadiversion.usdoj.gov/pubs/docs/index.html

As a reminder, New York State prescribers with a DEA are also required to complete at least 3 hours of course work or training in pain management, palliative care, and addiction every three years. For many, 2023 is a renewal year. The NYS DOH offers a free accredited course online through the University of Buffalo: http://pharmacy.buffalo.edu/academic-programs/continuing-education/events/opioid-prescriber-training.html

No Longer Requiring Pre-Operative COVID Testing

By Dr. Jeffrey Albright and Stacey Keefe

We have great news about the requirement for pre-operative COVID testing. Effective immediately, patients who are asymptomatic for COVID will no longer require testing prior to elective and urgent surgery. Additionally, at the current transmission level, admission testing for asymptomatic patients is also not required.

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Elective Surgery: Patients should still be asked about symptoms related to COVID in the days prior to surgery; if present, testing should be completed to determine disease status. The institution would still recommend that elective surgeries on COVID-positive patients with conditions that can safely be deferred have their surgeries delayed for 7 weeks.

- All patients who had an appointment scheduled at Upstate Community POB South Suite 1K for a COVID test have been notified via MyChart and a confirmatory phone call.

- All patients scheduled to get testing somewhere other than at Upstate Community POB South Suite 1K should be notified by your schedulers that such testing will not be needed prior to the surgery

Urgent/Emergent Surgery: Patients presenting to the Emergency Departments who demonstrate COVID-related symptoms should have COVID testing performed so that appropriate precautions may be taken (N-95 masks, isolation, etc.). If the surgical disease is urgent in a COVID-positive patient, we recommend proceeding as is the current practice. Patients without COVID-related symptoms do not require testing prior to going to the OR.

Thank you all for your ongoing diligence. The leadership of the institution are definitely happy that we have reached this milestone.

Suite 1K and 2W Covid Testing Sites Closed

The last day of operation for Suite 1K, the Covid testing site at Upstate Community Hospital, was Friday, April 14.

The rapid testing site on 2W at Upstate University Hospital also closed April 14.

Self-serve saliva Covid testing stations are still available at the following locations:

- UPD Communications Center, 1326 Upstate University Hospital
- Room 1162 Weiskotten Hall
- Health Sciences Library, Weiskotten Hall
- Security Desk, first floor of the Institute for Human Performance

Administrative supervisors and Employee/Student Health will have antigen tests on hand for staff/students who begin to feel ill while at work.

Units at all Upstate locations can request boxes of Binax antigen test kits from Stacey Keefe at KeefeS@Upstate.edu.

Staff who are mandated to test weekly will receive an email from PoolTesting@Upstate.edu with further information on the weekly testing process.

For more information about self-serve saliva Covid testing options for staff and students, visit: https://www.upstate.edu/coronavirus/intra/testing.php.

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Wound Care Diagnosis and Treatment Updates

By Dr. Matthew Glidden

The criteria for Inpatient Wound Care Consults will be changing as of May 1, 2023. To better utilize the expertise of our wound and ostomy team practitioners to focus on complex wounds and ostomies, routine wound care will no longer be within the scope of the Wound Care Team and reason for consultation. Routine wound care will be the responsibility of the primary team. Wound Care Consult criteria are as follows:

- Full thickness wounds including pressure injuries stage 3 and 4
- Evolving deep tissue injury
- Not followed by Vascular Surgery: venous stasis, arterial, and diabetic ulcers
- Any wound that is not responding to treatment or progressively getting worse
- Ostomies

Nursing will no longer be able to place wound care consults and all consults to wound care must be placed by the primary service. Tools and resources will be provided to assist in the diagnosis and management of routine wounds and skin care including a Wound Diagnosis and Treatment Guide within the EPIC Learning Home Dashboard and an Inpatient Wound Care Order Set.

Attached you will find a Wound Care Update presentation, Wound Diagnosis and Treatment Guide, Wound Care Treatment Pearls presentation, and EPIC Wound Care Order Set education.

Documenting Difficult Airway in EPIC

By Dr. Neal Seidberg

An update to Epic, planned for Monday, April 24, allows for improved documentation of patients with difficult airways. With documentation of a difficult airway, a new flag on the storyboard, "Airway Status: **Difficult Airway**", will appear in a red box to inform you that your patient has a known difficult airway.

How to document a difficult airway: There are 3 ways to document that a patient has a difficult airway. All will create the flag in the storyboard. You can use the one that is most appropriate for you.

1. **Documenting a difficult airway after intubation**. Intubation procedure notes now have a section where you can indicate airway status.

2. **Problem list**. You can add a problem of "Difficult Airway" to the problem list. For most patients, you should also make this problem a "chronic" problem. This method is best for patients with physical findings or history indicative of a difficult airway. It is also appropriate to add this problem after noting a difficult airway in an intubation note, however, the procedure note itself is enough to turn the flag on.

3. **Patient FYI**. The third option is to add a patient FYI of "difficult airway". Note that the first 2 options create the FYI automatically,

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How to remove the difficult airway flag: Should the patient no longer have a difficult airway, removing the flag by completing the difficult airway FYI is possible. This will remove the flag on the storyboard but will appropriately not remove clinical documentation in any prior intubation note. If the problem list has an entry for "Difficult Airway" you should also complete it there, however, only removing the FYI clears the storyboard flag.

How to learn more: Tip sheets are available for this change.

Removal of Monovalent COVID Vaccine Authorization

By Christopher Miller

On April 18th, the FDA removed authorization for the monovalent Pfizer and Moderna COVID vaccines. Moving forward, only the bivalent formulation of mRNA covid vaccines may be used. Adult/adolescent patients who never received their initial covid vaccine series will now receive a single bivalent vaccine dose instead of the two-dose series of monovalent vaccine. Younger pediatric patients may still receive multiple doses of bivalent vaccine depending upon their age and previous vaccine history. A summary of these changes can be found in the link below. The bivalent vaccine formulation can also be used for booster doses per FDA/CDC guidance.

To accommodate this change, all monovalent vaccines have been removed from stock and the monovalent vaccines are being removed from EPIC.

For more information, please visit: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-changes-simplify-use-bivalent-mrna-covid-19-vaccines

Clean-Up and Disposal of Liquid Anesthestic Agent Spills

By Sara LaPointe

Small volumes of liquid anesthetic agents such as halothane, enflurane, isoflurane, desflurane, and sevoflurane evaporate readily at normal room temperatures, and may dissipate before any attempts to clean up or collect the liquid are initiated. However, when large spills occur, such as when one or more bottles of a liquid agent break, specific cleaning and containment procedures are necessary and appropriate disposal is required (AANA 1992). The recommendations of the chemical manufacturer's material safety data sheet (MSDS) that identify exposure reduction techniques for spills and emergencies should be followed. Environmental Health and Safety should be contacted (regular business hours 313-464-5782/after hours or on weekends call University Police at 315-464-4000) any time there is a spill. Please see the attached tip sheet for details.

Pharmacy Shortage and Backorder Updates

By Peter Aiello and Joe Burczynski

Recent pharmaceutical supply chain disruptions have increased national drug shortages dramatically, which can compromise or delay medical treatment and increase the overall risk of medication errors. Raw material shortages,

manufacturing and quality problems, transportation delays and low profit margin product discontinuations have become routine.

The Chief Medical Officer and Upstate Pharmacy leadership are seeking to keep our Upstate clinicians informed about the most critical drug shortages affecting our organization and offer substitutions whenever possible. Sometimes substitutions are not possible due to severe supply chain constraints or sole-source manufacturers no longer producing products at all. Please ensure communication with the Pharmacy Department regarding product substitutions recommendations.

Drug	Description of Issue	Substitution Recommendations
Carboplatin	Dire Situation. Backordered, receiving sporadic shipments to maintain patient care needs. Days on hand Please contact Cancer Center pharmacy for specifics.	Carboplatin patients are being converted to cisplatin when possible. Longer infusion times & higher side effect profile.
Cisplatin	Dire Situation. Backordered, receiving sporadic shipments to maintain patient care needs. Less than 1 week on hand. Please contact Cancer Center pharmacy for specifics.	None
Cardioplegia	Currently on limited allocation	Pharmacy preparing to mix / find alternate sources.
Medical leeches	Limited allocation: ½ of normal supply still available	
Ceftriaxone 2g Premix	Backordered, receiving sporadic shipments	Pharmacy to mix patient specific / pigtail until resolves.
Aloxi syringes	Backordered, receiving sporadic shipments	Use vials as substitute until syringes return
Methylprednisolone Intravenous Formulation	Backordered across all strengths, sporadic shipments of various vial sizes are arriving.	Oral corticosteroid formulations: methylprednisolone, prednisolone, prednisone

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Hydrocortisone Intravenous Formulation	Backordered across all strengths, sporadic shipments of various vial sizes are arriving.	Oral hydrocortisone
Lidocaine with epinephrine	Remains on backorder across all strengths and formulations. There will be times when pharmacy cannot supply the requested formulation. It is imperative to communicate with the Inpatient Pharmacy if desired strength is not available.	Lidocaine without epinephrine Bupivacaine with or without epinephrine
B&O Suppositories	**No longer manufactured, pulled from the market** – ability to order has been removed from Epic as this product is no longer available across both UUH and UCH campuses.	
Ketamine	All strengths remain on backorder as of 3/23/23 with sporadic fulfillment of pending orders across all strengths.	Benzodiazepines Barbiturates Propofol Etomidate Opioids
BCG	Backordered, extremely small quantities are released on an unpredictable basis. Current supply should last until June.	
Methotrexate	Backordered, receiving sporadic shipments at this time, inventory is stable across both campuses at this time 1 month on hand	

Resolved Backorders: Pyridoxine (Vitamin B6) IV Formulation

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Clinical Documentation Improvement (CDI) Tip for April 2023

By the CDI Physician Advisory Group

To ensure consistency in communication among the care team and most accurate diagnosis reporting, it is important to ensure diagnoses that are evaluated, treated, monitored, or contribute to the patient's hospitalization are documented completely. Complete documentation includes a statement of diagnosis, etiology, evaluation, treatment or monitoring provided, and evolution of the condition. Please see the attached tip sheet for more information. For questions, please contact the CDI Hotline at 315-464-5455.

Best in KLAS

By Dr. Leslie Kohman

Enormous thanks to all who made our engagement with KLAS this year wildly successful. Nursing exceeded their target in their first year of participation. APPs exceeded their target (130%) and Physicians and Residents/Fellows each achieved 84% of target, much higher than in past years. There was great competition for % participation by faculty and residents/fellows in the academic departments, with 4 departments taking the lead by turns. In the end, Surgery pulled ahead (45%) with Urology (43%), Emergency Med (38%) and Family Med (35%) close behind.

Surgery will be awarded a $1000 Wellness Grant, and Nursing and APPs will each receive a $500 Wellness grant to recognize their achievement.

Honorable mention goes to Emergency Medicine with the largest number of participants, 48.

Chairs and Department Wellness Officers were crucial in the success of this engagement. As soon as we get results, we will be scheduling with every department faculty meeting to present the data.

I look forward to joining with you to learn how to make the Upstate experience for all clinicians better.

Peer Supporter Training

By Dr. Leslie Kohman

Last chance to receive peer support training by Dr. Jo Shapiro, a renowned expert in peer support and clinician well-being. The single 2.5-hour session is virtual and free. Those who have taken this training before are invited to re-enroll and refresh your skills and knowledge. Sessions are open to clinical staff and non-clinical staff.

Session options include:

- Monday, May 8: 11:00 am – 1:30 pm
- Thursday, May 11: 1:00 pm – 3:30 pm

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- Monday, May 15: 10:30 am – 1:00 pm

Please send a message to clinicianpeertopeer@bassett.org if you wish to enroll. You may also call 607-547-3244. Please share this opportunity widely!

Congratulations to our GEM Care Team!

By Amy Serzanin

The Upstate Community Hospital Emergency Department has received accreditation as a Level 1 Geriatric Emergency Department through the American College of Emergency Physicians (ACEP). Community is the only Level 1 Geriatric Emergency Department in New York north of New York City, and 1 of only 25 Level 1 departments in the United States. Accreditation demonstrates the organization's commitment to providing coordinated emergency care that is specifically focused on the highest standards of care for the older members of our community.

Exceptional Teacher Recipient for April 2023

By Dr. Lawrence Chin

Muslim Khan, MD, Assistant Professor of Psychiatry and Behavioral Sciences is the April 2023 recipient of the Exceptional Moments in Teaching recognition.

The Norton College of Medicine recognizes exceptional teachers with the monthly "Exceptional Moments in Teaching" program. Honorees are selected via student assessments from courses and clerkships. Recognized teachers – including medical faculty, residents, nurses and other educators – are those who challenge students and provide an exceptional learning experience.

Outstanding Physician Comments

Comments from grateful patients receiving care on the units and clinics at Upstate:

Adult Hematology Oncology: **Dr. Ian Pinto** with his positive, upbeat attitude towards the cancer and treatment I received was and is exceptional.

Breast Care Center: **Dr. Daniel Thomas** has been absolutely amazing throughout this whole process – he is an asset to Upstate and a blessing to us!

Breast Care at CC POB: I thought **Dr. Jayne Charlamb** seemed very concerned about my concerns. **Dr. Jayne Charlamb** is excellent. She has been my doctor for a number of years; she and all who work with her have given me outstanding care. **Dr. Jayne Charlamb** is SO kind and lovely to work with.

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Center for Devel., Behavior and Gen.: I've always liked seeing **Dr. Nienke Dosa**. She has a very calm demeanor, listens, and answers questions.

CC Emergency Department: **Dr. Jenica McMullen,** outstanding, thoroughness ultimately led to a medical problem I was not aware of and it needed attention! Thank you so much!

Community Campus – Virtual: **Dr. Walter Hall** is excellent. He gives you time to talk and answers all your questions. I am very happy with **Dr. Walter Hall** and his staff. Always a pleasure talking to **Dr. Ali Hazama**.

ENT at Community: **Dr. Mitchell Gore** – very quick and nice.

EU at Community: **Dr. Shahram Izadyar** was amazing and answered all my questions and showed such an impressive bedside manner.

Family Medicine: **Dr. Rahila Iftikhar** shows concern, care, and humanity in all circumstances. I hope her employer is fully supporting her and her team completely. My husband and I are both patients, and I hope my two teenage sons can also become patients as well. Sadly, **Dr. Kaushal Nanavati** is only my integrative physician and I wish he was my primary care, but grateful I'm still under his care in any capacity. He is amazing and rare in my experiences with primary care physicians. **Dr. Kaushal Nanavati** is a kind, caring, compassionate, thorough physician who takes the time to listen, explain in layman's terms my concerns and issues. Never condescending, impatient, harried or distracted. I'm grateful to him and know he makes a huge difference in my health and well-being. **Dr. Rupali Singla** is a very caring, attentive physician! **Dr. Rupali Singla** – she's wonderful and I hope she doesn't leave.

Family Medicine at Community: **Dr. Bushra Atta ur Rehman** – great doctor, she was very in depth with her questions and concerns, she took her time, which is a good asset for doctors helping people. **Dr. Bushra Atta ur Rehman** showed concern for me as a patient and is an amazing doctor. **Dr. Igor Kraev** and his team are great!! **Dr. Mary Powers** was wonderful and I look forward to having her as my PCP. **Dr. Catherine White** is always so pleasant and thorough. **Dr. Catherine White** is excellent. So glad she is my PCP. **Dr. Catherine White** was professional, kind, and concerned for my health.

GYNONC MI: **Dr. W Douglas Bunn** – excellent! **Dr. W Douglas Bunn's** appointments and chemo flush – positive experience. **Dr. W Douglas Bunn** – devoted to patients.

HEMONC CC: I am very appreciative of **Dr. Abirami Sivapiragasam's** care and concern for me. She very quickly got images after my appointment so that they could be reviewed by the Upstate team two days after my appointment. **Dr. Abirami Sivapiragasam** – good.

Joslin Center for Diabetes: **Dr. Barbara Feuerstein** was new to me. She spent a good amount of time reviewing my case. I thought she dug in to help me get good care. She will contact me next week to review my tests. Nice job so far! **Dr. Rachel Hopkins** ALWAYS provides the best most considerate care. Always impressed with **Dr. Roberto Izquierdo** these many years. He listens well, and while comprehensive and cautious, still includes me in decision making. **Dr. Ricardo Lundi** continues to do an excellent job.

Multidisciplinary Programs Cancer Center: **Dr. Lisa Lai** has a very calming presence and clearly has her patients' best interest in mind. **Dr. Gloria Morris** – knowledgeable, caring, really good at explaining and advising. **Dr. Jason Wallen** was sensitive, seemed caring, and gave me the facts straightaway. Love **Dr. Jason Wallen** from day one. He shows genuine concern and compassion and a good listener and said he's always there for me and gives great bear hugs!! I love **Dr. Joseph Valentino** and the entire office.

Nephrology Clinic: **Dr. Syed Bukhari** is highly knowledgeable with great memory *(he wrote down the names of 4 SGLT2 drugs without consulting his computer)*. He clearly explained the stage of my kidney disease. **Dr. William C. Elliott** – caring, smart, friendly, and truly cared about my health. **Dr. William C. Elliott** – you never know what you are getting with a new physician and I was pleased.

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Pediatric Cancer Center: We love **Dr. Andrea Dvorak**!

Pediatric Gastroenterology: **Dr. Aamer Imdad** – truly amazing! Excellent beyond words! **Dr. Aamer Imdad** is one of the best doctors we have ever had. He is very understanding and compassionate to the needs of child. **Dr. Aamer Imdad** is very impactful *(our child calls him Dr. Imdad several times in one visit)*. This is so honorable. We just love **Dr. Aamer Imdad**. **Dr. Christopher Justinich** has proven to be an excellent provider – very personable, knowledgeable, and great at explaining what is going on. **Dr. Christopher Justinich** is wonderful. We are so thankful that he is our child's GI provider. **Dr. Prateek Wali** is a great doctor. He takes the time to listen and he is very understanding.

Pediatric Multispecialty: We have been seeing **Dr. Christopher Fortner** and his team for a few years and they are always happy, smiling, and cheerful. They answer any questions we have with an explanation simple folk like us can understand. We love **Dr. Christopher Fortner**. He's amazing! **Dr. Zafer Soultan** is always very caring, patient, and extremely thorough.

Pediatric Surgery: **Dr. Jennifer Stanger** makes us feel important, educated, and overall very well cared for. She always takes time to answer any questions we have and we really feel that she is invested in well-being.

Peds Neph, Rheum, Integrative Med: **Dr. Scott Schurman** was an absolute delight! He came in with such a warm demeanor and had such a wonderful bedside manner. He was thorough and was so gracious to answer all of our questions, as well as provide us with information on things we hadn't thought about. He was so reassuring and eased many of our concerns. He got back to us with results from imaging in such a timely manner and his plan of action going forward is very encouraging for us. He made us feel like our son mattered, and like we mattered. I would absolutely recommend Dr. Scott Schurman to anyone. He deserves an award for his patient care. You don't find many doctors like him anymore.

Pulmonology Clinic: **Dr. Markus Gutsche** took the time to answer my questions and concerns. I never felt rushed. Very nice man. **Dr. Sanchit Panda** was very good and caring.

Rheumatology Clinic: I will miss **Dr. Hiroshi Kato**. **Dr. Hiroshi Kato** provided exceptional care evaluating a lengthy respiratory illness. **Dr. Hiroshi Kato** has been excellent and will be missed! I've seen **Dr. Hiroshi Kato** for 10+ years. Yes, I would and have recommended him. **Dr. Hiroshi Kato** always is so knowledgeable and caring. He is the best doctor I have ever been to. **Dr. Hom Neupane** is the best! **Dr. Hom Neupane** is very nice and explains procedures in a calm, reassuring manner. **Dr. Sheetal Rayancha** – excellent! **Dr. Jianghong Yu** is a great doctor. **Dr. Jianghong Yu** listens to all of your concerns.

Surgery – UH: **Dr. Moustafa Hassan** – amazing. I love you.

Surgery – UH LL022: **Dr. Kristina Go** is very informative and I would recommend her to anyone I know. **Dr. Moustafa Hassan** was extremely patient and very kind to my father. **Dr. Moustafa Hassan** was very knowledgeable and made my father feel very comfortable, very well spoken, doctor explained everything in detail clearly and kindly.

Surgical Subspecialties at CC: **Dr. MacKenzie Trovato** is amazing! She makes sure I'm heard and I understand everything. Great doctor and staff at the office!!

SUNY Upstate – Virtual: **Dr. Emily Albert** is thorough, kind, and helpful assisting with my current needs and answering or addressing concerns. I would not hesitate to recommend the Upstate Cancer Center Palliative Care Program along with **Dr. Emily Albert**. **Dr. Gennady Bratslavsky** was excellent! **Dr. Roseanna Guzman-Curtis** is great despite being up all night due to trauma. She had staff arrange for a telemedicine call which saved me from driving to Syracuse in a significant snowstorm. She and her staff arranged for testing and they scheduled a face-to-face once tests were completed. **Dr. Corey McGraw** is awesome! Overall excellent experience

with **Dr. Christopher Justinich** and the Pediatric GI team. **Dr. Christopher Justinich** is very professional, knowledgeable, and a skilled physician who provided top notch care to our daughter. He is very informative, wonderful bedside manner and demonstrates exceptional clinical skills. **Dr. Stephen Knohl** listens to my concerns, answers questions, and allows me to make decisions about my health. **Dr. Jenny Mayer** is very nice and shows genuine care and interest in her patient. **Dr. Gloria Morris** was great too!

Transplant Center: **Dr. Brian Gallay** knows his job and is very good at what he does. You guys would be lost without him.

UHCC – Neurology: I would definitely recommend **Dr. Sara Ali**. **Dr. Sara Ali** – my appointment was thorough and I feel she really listened and explained things very well. **Dr. Anuradha Duleep** is terrific! I would recommend her to everyone! **Dr. Sherif Elwan** was very kind, took his time with us and was sure to answer any questions. **Dr. Kimberly Laxton** was very understanding. I feel very lucky that **Dr. Kimberly Laxton** will be taking me on as a patient. **Dr. Jenny Meyer** is detailed and thorough. **Dr. Dragos Mihaila** is an awesome physician. Very knowledgeable and caring.

University Cardiology: **Dr. Kiran Devaraj** – knowledgeable. **Dr. Kiran Devaraj** is very professional and pleasant and I feel is taking very good care of my overall heart health. I'm very satisfied with **Dr. Kiran Devaraj's** course of treatment and his concern for my hypertension condition.

University Center for Vision Care: **Dr. Robert Fechtner** is excellent in explaining his diagnosis and treatment. **Dr. Robert Fechtner** is an exceptional doctor. He takes the time to explain things, answer any questions, and is understanding. **Dr. Preethi Ganapathy** is a very caring doctor. **Dr. Preethi Ganapathy** did not hesitate to do my laser on the other eye. Very well done. Thank you! **Dr. Katharine Liegel** explained the exam in detail as she performed, communicated her observations and impact to my eyesight. Further, she compared prior results from old office that allowed her to communicate there were no concerns, just some items to watch out for. She gave me the option of coming back in a year or longer. She is a fantastic clinician. I've referred her to many people and will continue to do so. **Dr. Katharine Liegel** made the visit stress free by their confidence, demeanor, and communications. **Dr. Stephen Merriam** – great as always, knowledgeable, caring, and accommodating! Dr. Stephen Merriam – very sweet with my three-year old. **Dr. Robert Swan** is the best doctor I have gone to for my eye problem. I have to get a shot in my eye every 2 months or so and it never hurts when he gives the shot to me. The guy is the best! I have never had a problem at **Dr. Robert Swan's** appointment.

University Internists: **Dr. Tingyin Chee** is great! **Dr. Tingyin Chee** – very caring and listened to my concerns, planned a course of action to resolve my health issues and explained it clearly to me. **Dr. Vincent Frechette** looks you in the eye when you are conversing. He also remembers previous conversations. I feel very fortunate to have him as my primary care physician. **Dr. Vincent Frechette** and his overall professionalism. **Dr. Vincent Frechette** is very knowledgeable. He is also a very compassionate individual. Highly recommend! **Dr. Vincent Frechette** is always very courteous and professional. Highly recommend! **Dr. Vincent Frechette** – compassionate, thoughtful, brilliant, kind. **Dr. Vincent Frechette** – stellar, efficient but thorough, personable, engaging, answered all my questions without rushing. **Dr. Vincent Frechette** was very interested in my condition and together we developed a plan of treatment. **Dr. Vincent Frechette** is by far a better doctor than I have seen in all my years. He is extremely knowledgeable and very thorough with his answers in a way I can understand. **Dr. George Gluz** was very helpful and informative concerning my health and my wife's. I am so happy with **Dr. Matthew Hess**. He's kind, listened to all of my concerns, and is VERY knowledgeable. The winner of the day was **Dr. Matthew Hess**. I'm very happy with his kind and courteous attention to details. Please make sure Upstate Internists treats him well! I would hate to lose him! **Dr. Matthew Hess** – courteous and understanding. **Dr. Danielle Kochen** – knowledgeable, kind, and engaged. I really enjoyed meeting Dr. Danielle Kochen. I appreciated her patience and kind down-to-earth personalities. I love **Dr. Sarah Lappin**. **Dr. Catherine White** gave me options for new medications including side effects for each and allowed me to be proactive in my medications. She also recommended a cerebral aneurysm screening due to my family history, and an aneurysm was discovered (although I had no symptoms) and successfully treated.

CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

April 28, 2023

Univ Pediatric & Adolescent Center: **Dr. Anne Sveen** is an amazing dermatologist. My child has been seeing her for the past 6 years and I feel very comfortable with her advice when it comes to dealing with my child's skin care routine. **Dr. Anne Sveen** keep up the amazing work!! **Dr. Karen Teelin** was very thorough and attentive to my child's concerns. She is very knowledgeable and shows great care for her patients. We appreciate her expertise and willingness to treat my child.

Upstate Brain and Spine Center: I feel very confident with **Dr. Ali Hazama**. He reviewed my records and I felt assured that he would be committed to addressing my ongoing back problems.

Upstate Pediatrics: **Dr. Travis Hobart** has always been and continues to be an amazing care provider, listening to my concerns, and talking with my son and ensuring he doesn't have any issues as well. I left the practice for one visit and came back immediately afterwards because the care my son receives at Upstate Peds is far superior then other practices. **Dr. Travis Hobart** is a huge part of that and I appreciate that even during his tight/busy schedule he continues to see well child visits. **Dr. Tobey Kresel** is always wonderful! **Dr. Jaclyn Sisskind** was very kind, gentle, and patient with our 2-year old. She listened to what he said and waited when it took him awhile to say it.

4North at Community: **Dr. Jeffrey Albright** was informative. **Dr. Mahesh Nepal** was wonderful.

4West at Community: **Dr. Sana Zekri** was great!

05A: **Dr. Kristina Go** saved me from having more diverticulitis attacks. I'm very grateful for her.

05B: **Dr. Joseph Valentino** was very attentive.

06I: First of all, **Dr. Richard Kelley**, deserves my recognition for his surgery that allows a maximum amount of voice (for my condition) along with a great improvement in breath, and done on short notice. He is, and has been for years, an intelligent, patient, reliable, personable physician.

08F: I feel very fortunate to have **Dr. Michael Fischi** and **Dr. Bruce Leavitt** perform the TAVR procedure.

08G: **Dr. Harish Babu** was excellent, outstanding in every way. **Dr. Harish Babu** is tremendous. **Dr. Mark Crye** and **Dr. Jason Wallen** - care was superior and I was blessed to have them take care of me. **Dr. Jason Wallen** – the man is an artist.

Vascular Surgery at Community: **Dr. Ankur Chawla** impressed me. Initially, there was some miscommunication with regards to when to stop taking Lovenox, but **Dr. Ankur Chawla** agreed to come back 12 hours later and perform the surgery. That's a long day for him and I appreciate his commitment.

Best,

Amy

ALERT — IMMEDIATE ACTION REQUIRED
ADVISORY — PRIORITY BUT NOT FOR IMMEDIATE ACTION
UPDATE — FOR INFORMATION; UNLIKELY TO REQUIRE ACTION

UPSTATE
MEDICAL UNIVERSITY
State University of New York

Inpatient Wound Care Updates

April 24, 2023

Jessica Dow, MSN, FNP-C, CWCN

Background

- Wound team staffed by 1.8 Advance Practice Providers (APP). One pending retirement June 2023, currently in the process of hiring another wound APP!
- High volume of consults not in alignment with consult criteria, leading to unmanageable volumes.
  - Skin tears, incontinence dermatitis, pressure injuries stage 1 and 2, etc
- Volumes have caused delays in care for those patients what would most benefit from an expert level wound care consult and contributed to decrease in APP job satisfaction related to not working to full scope.

- Review of Evidence Based Practice
- What are similar size Magnet Hospital doing as far as Wound care ?

Plan

- Nursing continues to complete routine skin assessment, notifies Primary team if skin breakdown.
- Minor skin breakdown managed by nursing and primary team
- 2 Wound APPs available for consult for complex wounds

Wound APP Consult

Wound consultation is provided by expert APPs to inpatients with complex wounds.

- Consults must be placed by primary team

- Inpatient wound care availability
  - Downtown and Community, Monday – Friday 0700-1530
- **Consult criteria:**
  - **Full thickness wounds including pressure injuries stage 3 and 4.**
  - **Evolving deep tissue injury.**
  - **Not followed by Vascular Surgery: Venous stasis, arterial, and diabetic ulcers**
  - **Any wound that is not responding to treatment or progressively getting worse.**

- Placing consult:
  1. Place inpatient wound consult request in EPIC.
  2. EPIC chat or call number listed in Amion.

- Consults are usually seen within 24 hours, with exception of consults placed Friday – Sunday or holidays.

Tools and Resources

- Wound Diagnosis and Treatment Guide
  - Coming soon to EPIC Learning Home Dashboard

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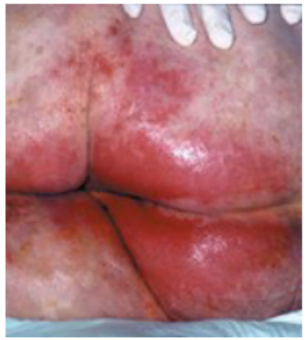
WOUND DIAGNOSIS AND TREATMENT GUIDE



Diagnosis: Incontinence Associated Dermatitis

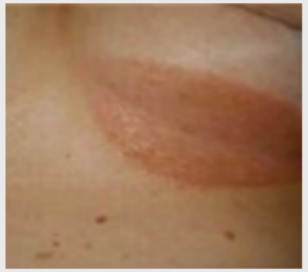
Evaluate: Assess buttock, inner thighs, and groin for skin breakdown. Is the patient incontinent of stool and or urine? How often? Recommend taking wound photo.

Findings: Redness, irritation, possible denuded partial thickness skin breakdown, often painful. Frequent incontinence of urine and or stool.

Plan:

1. Contain drainage, consider adding Flexiseal or urinary containment device.
2. Upgrade support surface, add low air loss mattress. Platinum or Bariatric Low air loss. Use Attends pad on mattress.
3. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, Attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
4. Add a barrier cream, if moist skin changes cleanse with foam cleanser. Apply Desitin oint (or Senicare) TID and prn. If dry skin changes, cleanse with foam cleanser. Apply Baza Protect TID and prn (dry skin changes).

Follow up: Assess daily, redness and irritation should resolve with treatment, will most likely need to continue treatment long term if incontinent.



Diagnosis: Intertriginous Dermatitis

Evaluate: Assess skin folds. Recommend taking wound photo.

Findings: Redness, moisture, possible malodor, possible linear slit like skin breakdown in crease.

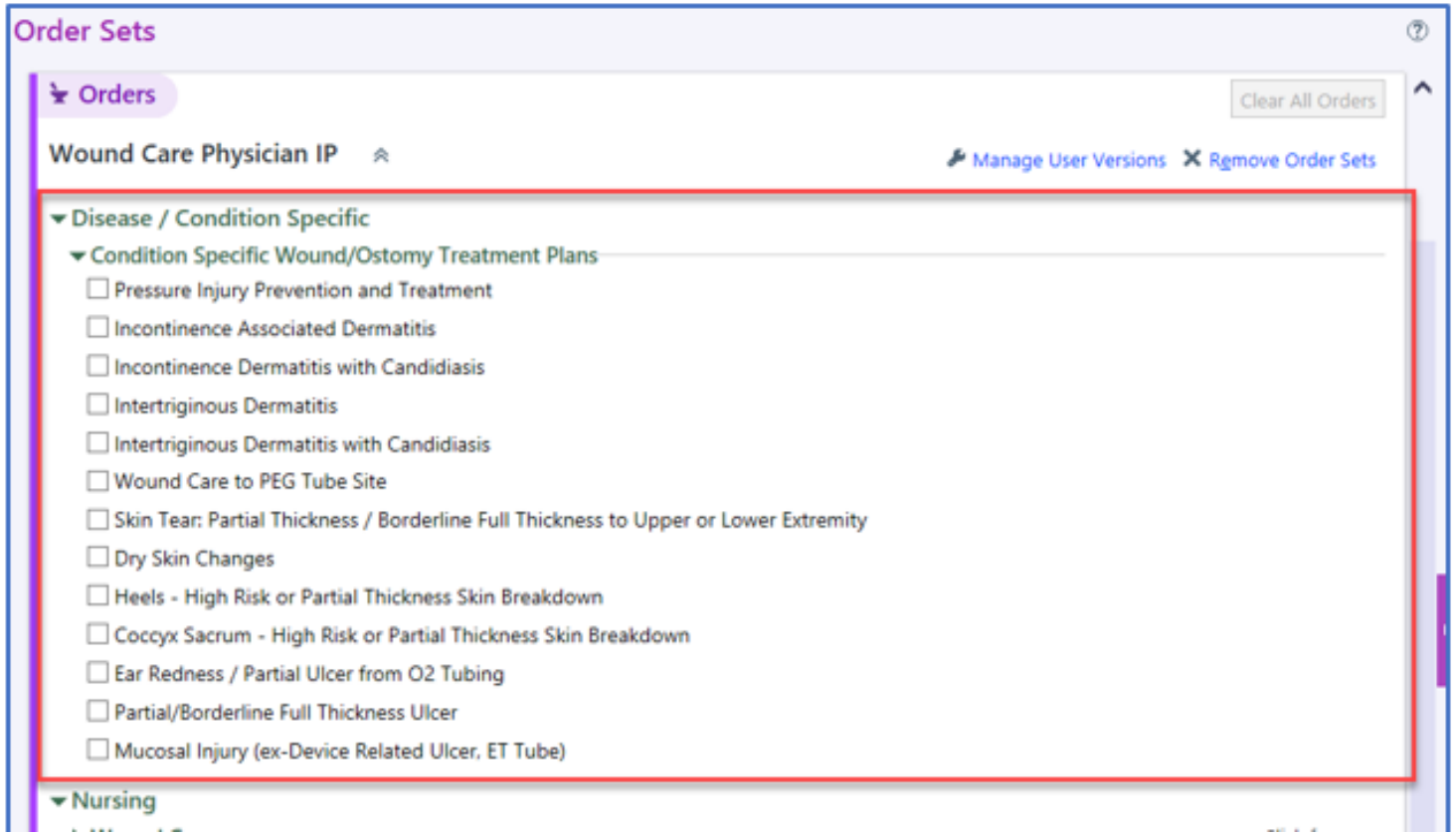
Plan:

1. Cleanse skin fold and pat dry BID and PRN.
2. Apply Interdry between skin folds (cut section long enough to extend 2 inches exposed past the fold for moisture evaporation). Remove for bathing and cleansing and can reapply fabric, change fabric when soiled. Cleanse and assess BID.

Follow up: Assess daily, if redness resolves but skin folds remain moist, recommend continuing treatment.

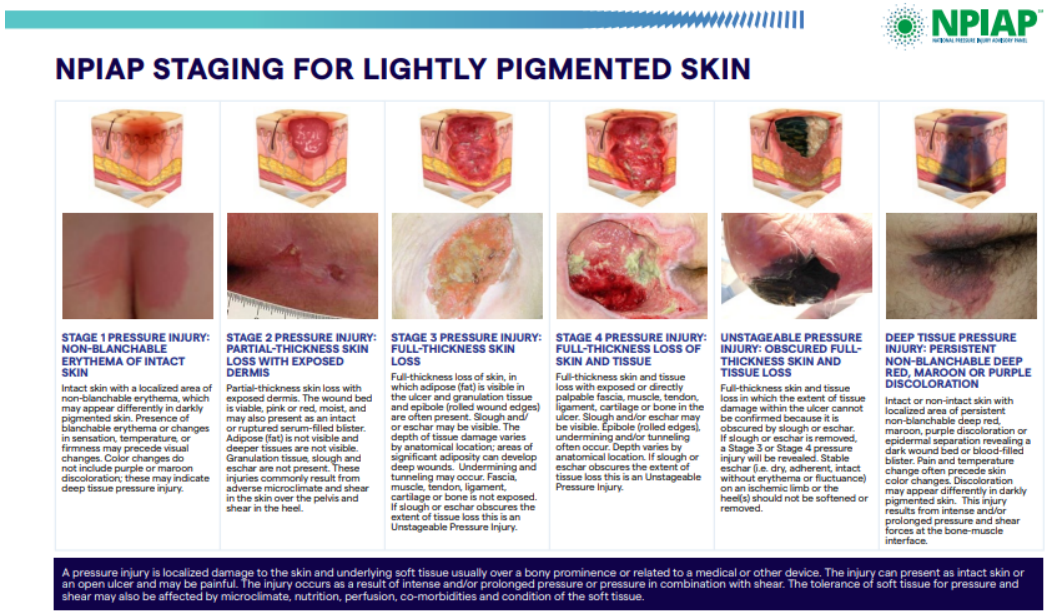
Tools and Resources

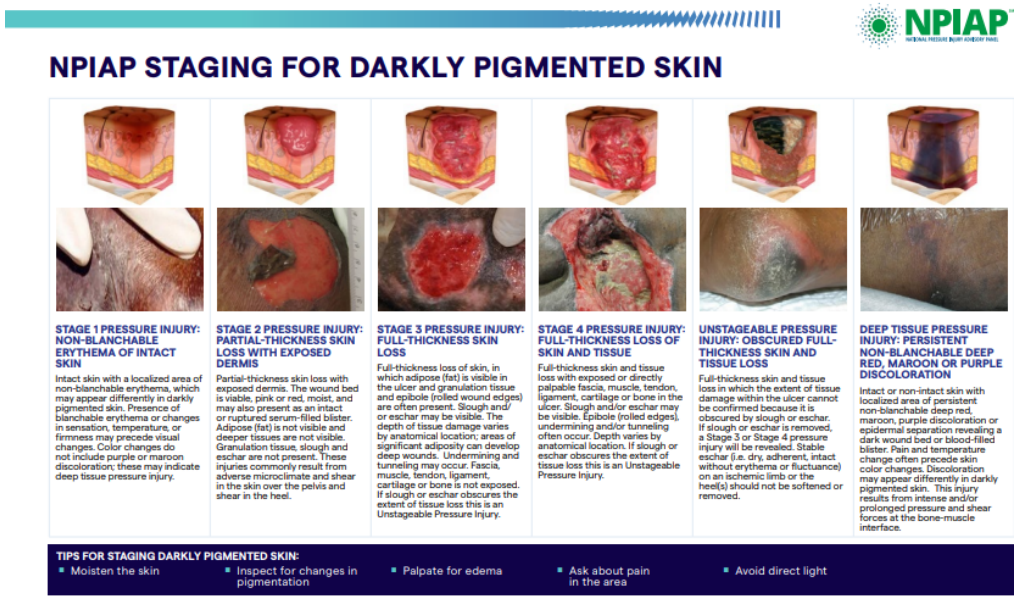
- Updated Wound Care order set
  - Wound Care Physician IP



Tools and Resources

- Wound Measure Guides
- Staging pocket cards





Tools and Resources

- Collaboration with our Wound APPs- EPIC chat or number in Amion

Terry Humez, FNP - C

Abbie Ware, FNP - C

Summary

- Primary team to initiate and provide wound care interventions for skin complications
- Wound APP Consult available for complex wounds, consult to be placed by primary team
- Wound Care Physician IP order set updated to assist the primary team with prevention injury prevention and basic wound care orders
- Wound Diagnosis and Treatment Guide available on LHD for review
- Wound APPs available for questions, clarification, and support !

Questions

Jessica Dow FNP- C, CWCN

4-5128

dowj@upstate.edu

CLEAN-UP AND DISPOSAL OF LIQUID ANESTHETIC AGENT SPILLS

Small volumes of liquid anesthetic agents such as halothane, enflurane, isoflurane, desflurane, and sevoflurane evaporate readily at normal room temperatures, and may dissipate before any attempts to clean up or collect the liquid are initiated. However, when large spills occur, such as when one or more bottles of a liquid agent break, specific cleaning and containment procedures are necessary and appropriate disposal is required (AANA 1992). The recommendations of the chemical manufacturer's material safety data sheet (MSDS) that identify exposure reduction techniques for spills and emergencies should be followed. Environmental Health and Safety should be contacted (regular business hours 313-464-5782/after hours or on weekends call University Police at 315-464-4000) any time there is a spill.

Because of the volatility of liquid anesthetics, rapid removal by suctioning in the OR is the preferred method for cleaning up spills. Spills of large volumes in poorly ventilated areas or in storage areas should be absorbed using an absorbent material, sometimes called a sorbent, that is designed for clean-up of organic chemicals. "Spill pillows" commonly used in hospital laboratories, vermiculite, and carbon-based sorbents are some of the materials commercially available and regularly used for this purpose. Caution should be exercised if broken glass bottles pose a hazard.

Employee Contamination

1. If the skin becomes contaminated with hazardous materials, wash the affected area thoroughly with copious amounts of water. If available, use the Emergency Shower for at least 15 minutes.

2. If hazardous material is splashed into the eyes, immediately use the eyewash station, and flush for at least 15 minutes.

3. Remove grossly contaminated clothing immediately. Place the contaminated clothing in a plastic bag.

4. 4. Report the spill to the Supervisor and seek medical attention.

Small Chemical Spill: defined as spills involving a small quantity of chemical that you are familiar with and can be safely handled within the work area or laboratory. Minor spills can be cleaned up by trained personnel who can contain the spill and who have access to the appropriate personal protective equipment.

1. Notify others in the area and isolate the spill.
2. Wear the appropriate personal protective equipment (PPE) to clean up the spill.
3. At a minimum, this includes gloves and protective eyewear. Depending on the size and type of spill, protective clothing, protective foot coverings and a respirator may be needed. Upstate Medical University Emergency Spill
4. Pick up any broken glass with tongs or some other mechanical device. Do not use your hands.
5. Place absorbent material over the spill, making sure not to spread the liquid.
6. Contaminated waste material in a plastic bag or other completely sealed glass or plastic container. Label the waste with the name of the hazardous material.
7. For disposal contact:
   a. Environmental Health & Safety 315-464-5782.

Large Chemical Spills: defined as a spill that cannot be quickly contained and safely managed by the person(s) involved.

1. Immediately evacuate the area and close all doors. Notify others not to enter the area.

2. Contact Environmental Health and Safety: Regular business hours 313-464-5782/ after hours or on weekends call University Police at 315-464-4000 (Downtown) University Police 315-492-5511 (Community).
   a. Inform the Office of Environmental Health & Safety of:
      - Your name
      - The location of the spill.
      - The name of the material that spilled

- The approximate quantity of spilled material.

3. Do not re-enter the area until advised by the Office of Environmental Health & Safety or Hazardous Materials Responders that it is safe to do so.

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Clinical Documentation Improvement Tip of the Month
Documenting to Secure Reporting

All diagnoses should be documented to completion, ensuring every diagnosis that is evaluated, treated, monitored, or contributes to the patient's hospitalization is accurately reported.

Conditions documented in a Problem List or specified as a 'medical history' only, that are not further discussed in the record, may likely result in query.

Documentation standards to ensure completeness is met include:

Statement of the diagnosis
Documentation of clinical evaluation establishing the diagnosis *(this cannot be assumed and must be stated by a provider)*
Etiology of condition and/or treatment provided
Measures to monitor condition
Response to treatment *(Resolved, Improving, Ruled Out)*

Example

#Acute Hypoxic Respiratory Failure, improving

- Desat to 80s on RA, no O2 at baseline
- Secondary to viral pneumonia, possible superimposed bacterial pneumonia
- On 4L, maintaining sats 92-95%, Zosyn day 2 for bacterial pneumonia
- Continuous oximetry

Reviewed & updated April 2023

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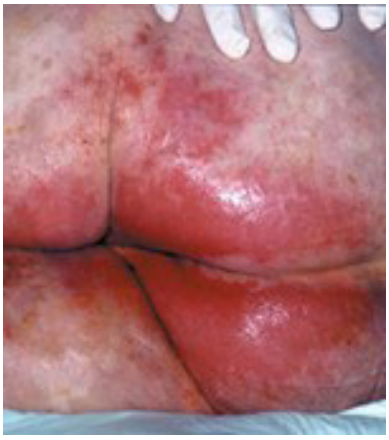
WOUND DIAGNOSIS AND TREATMENT GUIDE



Diagnosis:
Incontinence Associated Dermatitis

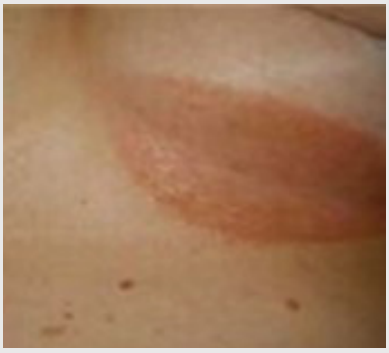
Evaluate: Assess buttock, inner thighs, and groin for skin breakdown. Is the patient incontinent of stool and or urine? How often? Recommend taking wound photo.

Findings: Redness, irritation, possible denuded partial thickness skin breakdown, often painful. Frequent incontinence of urine and or stool.

Plan:

1. Contain drainage, consider adding Flexiseal or urinary containment device.
2. Upgrade support surface, add low air loss mattress. Platinum or Bariatric Low air loss. Use Attends pad on mattress.
3. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, Attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
4. Add a barrier cream, if moist skin changes cleanse with foam cleanser. Apply Desitin oint (or Senicare) TID and prn. If dry skin changes, cleanse with foam cleanser. Apply Baza Protect TID and prn (dry skin changes).

Follow up: Assess daily, redness and irritation should resolve with treatment, will most likely need to continue treatment long term if incontinent.



Diagnosis:
Intertriginous Dermatitis

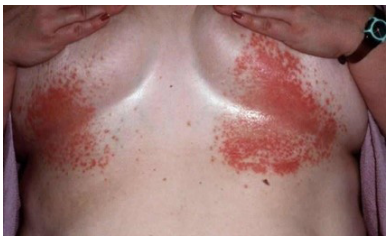
Evaluate: Assess skin folds. Recommend taking wound photo.

Findings: Redness, moisture, possible malodor, possible linear slit like skin breakdown in crease.

Plan:

1. Cleanse skin fold and pat dry BID and PRN.
2. Apply Interdry between skin folds (cut section long enough to extend 2 inches exposed past the fold for moisture evaporation). Remove for bathing and cleansing and can reapply fabric, change fabric when soiled. Cleanse and assess BID.

Follow up: Assess daily, if redness resolves but skin folds remain moist, recommend continuing treatment.



Diagnosis:
Candidiasis

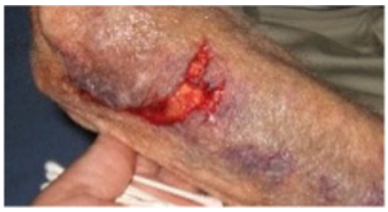
Evaluate: Assess skin folds, buttock, inner thighs, groin, moist areas. Recommend taking wound photo.

Findings: Redness, inflamed, satellite lesions, lacey margins, presence of moist environment

Plan:

1. Cleanse with foam cleanser and pat dry.
2. Under skin fold, add Nystatin powder BID and prn, if buttock, groin, or inner thighs – add Miconazole aloe vesta (dry skin changes) and Miconazole extra thick (moist skin changes) BID and prn.

Follow up: Assess daily. Continue treatment for 7- 14 days, redness and inflammation should fade.



Diagnosis:
Skin Tears – partial borderline full thickness

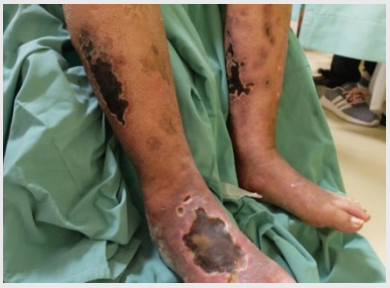
Evaluate: Predominantly on upper and lower extremities, aging skin (thins and loses elasticity), areas with dry fragile skin changes. Often related to trauma, falls, equipment, adhesive, etc. Measure skin tear in cm, length x width x depth. Recommend taking wound photo.

Findings: Usually irregular shaped, layers of skin separate or peel back, often with partially attached dermis. Can be partial or full thickness skin loss. Usually, minimal drainage unless patient also has edema. If trauma related might also have ecchymosis or purpura.

Plan:

1. Apply lotion to skin daily, limit use of adhesive directly on skin.
2. If extremity, apply single layer Vaseline gauze to open area, cover with gauze and secure with cling. Change daily. If back or abdomen, can apply single layer Vaseline gauze to open area and cover with Mepilex border 4x4. Change every two days.prn.
3. If need to use adhesive, apply Calivon skin prep to area prior to applying adhesive on skin.

Follow up: Assess daily or every other day, discontinue dressing orders once resolved. If partial thickness with minimal edema usually resolves within a week.



Diagnosis:
Arterial leg Ulcer

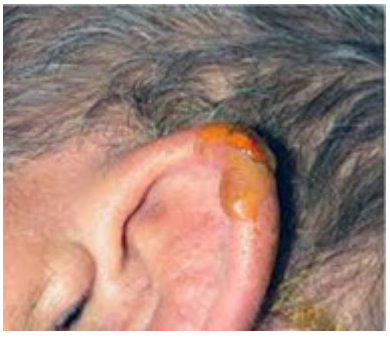
Evaluate: Found predominantly on lower legs, ankles, feet, can have diminished or absent peripheral pulses. Measure area in cm, length x width x depth. Recommend taking wound photo.

Findings: Wounds typically have punched out look, round, well defined margins, are deep, can frequently have necrotic wound bases, eschar, if wet gangrene may have foul odor. Wounds are generally painful.

Plan:

1. Wounds typically need to be kept as dry as possible to decrease risk of infection, dry gauze, Aquacel Ag or Betadine paint are frequently used until adequate perfusion can be established. Avoid use of compression stockings or SCD's.
2. Consider imaging to rule out osteomyelitis if wound is necrotic.
3. Consider venous and arterial vascular studies.
4. Vascular surgery consult if suspect gangrene, patient has known PAD or has acute ischemic changes to legs/feet.
5. Consult wound APP if above not suspected or vascular surgery suggests.
6. Nutritional therapy consult.
7. Outpatient follow up with either vascular surgery or wound care depending on plan.

Follow up: Assess daily for progress and deterioration.



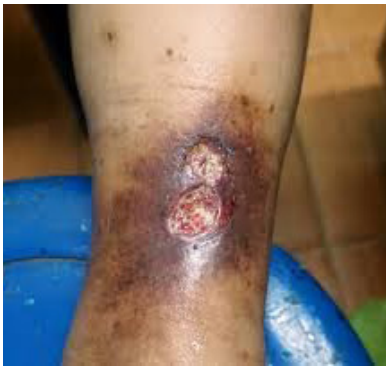
Diagnosis:
Pressure injury to ear crease/ear lobe

Evaluate: Ear lobe and crease of ear, measure area in cm, length x width x depth. Recommend taking wound photo.

Findings: Redness, partial thickness ulcers, serous filled bulla.

Plan: Wound care to ear crease or ear lobe ulcer: cleanse with Cavilon skin prep, allow to dry, leave open to air. Use foam ear protectors for O2 tubing.

Follow up: Assess daily.



Diagnosis:
Venous Stasis Ulcer

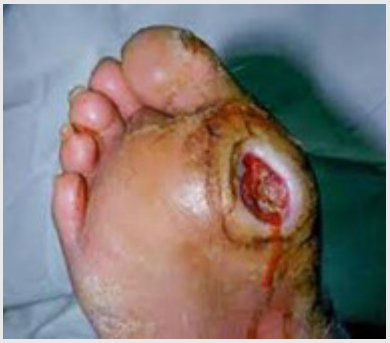
Evaluate: Predominately on the lower legs. Measure area in cm, length x width x depth. Recommend taking wound photo.

Findings: Often shallow, irregularly shaped sores, usually pink wound base. Skin surrounding ulcer may be hard and discolored. This discolored skin is called hemosiderin staining. Usually moderate dressing, LLE swelling.

Plan:

1. Apply xeroform gauze (min drainage) or Aquacel AG (moderate drainage) to ulcer. Cover with dry gauze and ABD. Wrap with kling and secure with tape. Change daily and PRN drainage.
2. Assess for pulse. Order arterial studies if concerns regarding blood flow.
3. If the patient has a strong pulse, compression should be applied. Inpatient can use tubigrip or ace wraps.
4. Order antibiotics if an infection is suspected.
5. Consult wound APP.
6. Nutritional therapy consult.
7. May need outpatient wound care follow up after discharge.

Follow up: Assess daily for progress and deterioration.



Diagnosis:
Diabetic Foot Ulcer

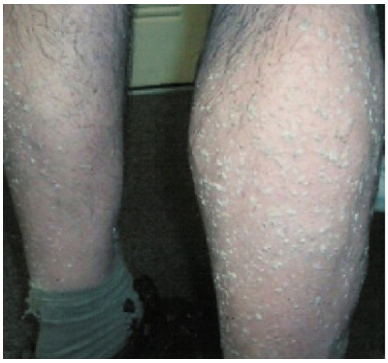
Evaluate: Feet of diabetic patients, Measure area in cm, length x width x depth. Recommend taking wound photo.

Findings: Crater in the skin bordered by thickened callused skin. Severe ulcers can be deep enough to expose tendons or bones. Possible neuropathy.

Plan:

1. Apply Aquacel AG is to ulcer, cover with dry gauze, ABD and wrap with kling. Change daily and PRN.
2. Off load wound. Patient should not walk on wound if possible or an off-loading shoe should be ordered.
3. Consider imaging to rule out osteomyelitis.
4. If osteomyelitis is present, consider consulting vascular surgery for possible debridement and/or amputation is needed.
5. Order antibiotics if an infection is suspected.
6. Consult wound APP.
7. Nutritional therapy consult.
8. Appropriate glucose monitoring and control.
9. May need outpatient wound care follow up after discharge.

Follow up: Assess daily for progress and deterioration.



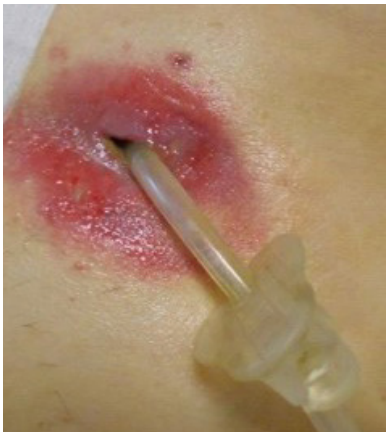
Diagnosis:
Dry skin dermatitis

Evaluate: Generalized, special attention to arms and legs. Recommend taking wound photo.

Findings: Dry, cracked flaking skin changes.

Plan: Apply lotion or Resta oint daily and prn.

Follow up: Assess daily.



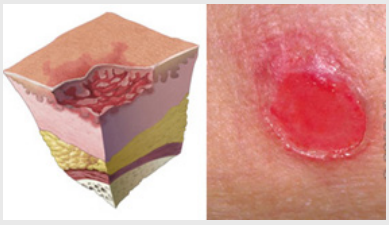
Diagnosis:
Peri tube skin changes

Evaluate: Skin immediately around tube. Recommend taking wound photo.

Findings: Red, moist, denuded skin changes related to drainage oozing around tube.

Plan: Cleanse with NS. Sprinkle light dusting of stomahesive powder (distribution) over skin breakdown, tap powder with Cavilon skin prep. Place dry drainage sponge around tube under bumper plate. Change Q8 hours and PRN. Secure tube to avoid pulling.

Follow up: Assess daily.



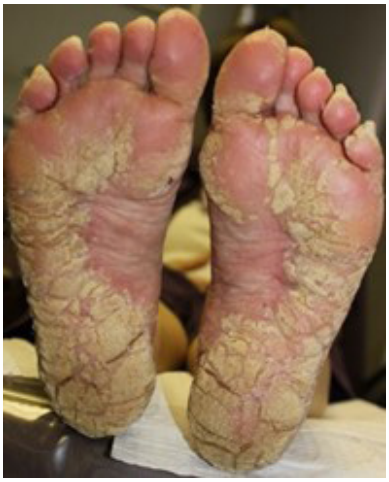
Diagnosis:
Partial / borderline full thickness ulcers

Evaluate: Buttock, back, legs, arms, etc Varity of etiologies. Measure area in cm, length x width x depth. Recommend taking wound photo.

Findings: Partial thickness-depth 0.1 cm, wound base pink, clean. No necrotic tissue. Wound base can be moist or dry. Full thickness ulcer can have undermining, tunneling, clean pink tissue, slough and or necrotic tissue, probed depth 0.2 cm or greater.

Plan: Treatment of partial / borderline full thickness ulcers depends on location and drainage. If minimal drainage, Mepilex border 4x4, change every 2 days. If moderate drainage, can add Aquacel Ag to wound base and cover with Mepilex border 4x4, change every 2 days. If dry wound base, can add single layer Vaseline gauze to wound base and cover with Mepilex border 4x4. Change every 2 days.

Follow up: Assess daily.



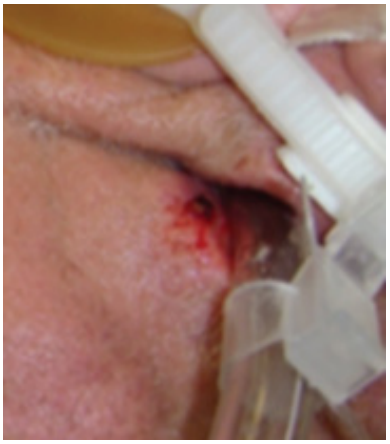
Diagnosis:
Hyperkeratotic skin changes

Evaluate: Usually lower legs and feet. Recommend taking wound photo.

Findings: Dry, thick callus like skin changes, possible odor.

Plan: Cleanse with foam cleanser. Pat dry. Apply Lac hydrin or Resta ointment BID and prn

Follow up: Assess daily. Consider Dermatology follow up after discharge.



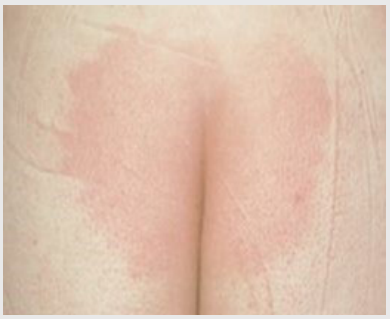
Diagnosis:
Oral Mucosal injuries. Mucosal Membrane Pressure Injuries

Evaluate: ET tube in place, assess oral cavity, lips. Measure area in cm, length x width. Recommend taking wound photo.

Findings: Injury to oral cavity and lips, pink, red, possible necrosis. Size and shape usually mirrors that of device.

Plan: Cleanse gentle with routine oral care, apply Vaseline ointment to keep lips moist, avoid placement of ET tube over wound. Reposition tube per policy.

Follow up: Assess daily.



Diagnosis:
Pressure Injury Stage 1

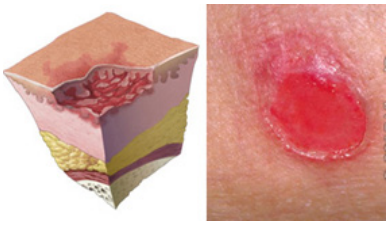
Evaluate: High risk pressure areas (heels, coccyx sacrum, etc), usually over a bony prominence. Measure in cm, length x width. Recommend taking wound photo.

Findings: Intact skin with Non blanchable redness of localized area usually over a bony prominence. Area may be painful, warmer or cooler, but usually not overly boggy or indurated.

Plan:

1. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
2. Upgrade support surface, add low air loss mattress. Platinum or Bariatric Low Ais Loss. Use Attends pad on mattress. If wound is on heels use offloading waffle boots.
3. Add Mepilex sacral, heel, or border dressing to area depending on location and size of injury. Change every two days and prn.

Follow up: Assess daily, if patient is high risk for breakdown continue treatment plan even after injury resolves.



Diagnosis:
Pressure Injury Stage 2

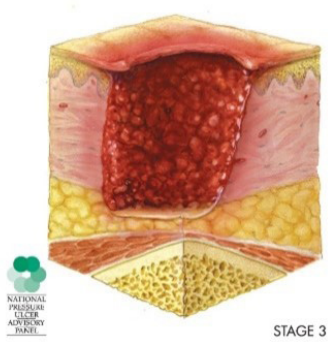
Evaluate: High risk areas of pressure, usually over bony prominence. Measure ulcer in cm, length x width x depth. Recommend taking wound photo.

Findings: Partial thickness loss of dermis, depth 0.1 cm, presents as a shallow open ulcer with redish-pink wound base without slough. May also present as intact or open / ruptured serum filled blister. Min- moderate drainage. Usually no odor.

Plan:

1. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
2. Upgrade support surface, add low air loss mattress. Platinum or Bariatric low air loss. Use Attends pad on mattress. If wound is on heels use offloading waffle boots.
3. Add Mepilex sacral, heel, or border dressing to ulcer depending on location and size of injury. Change every two days and prn. Depending on size, location, and risk- consider adding Aquacel Ag to ulcer and covering with the Mepilex (secondary dressing).

Follow up: Assess daily, if patient is high risk for breakdown continue treatment plan even after injury resolves. Discontinue Aquacel Ag if ulcer resolves.



Diagnosis:
Pressure Injury Stage 3

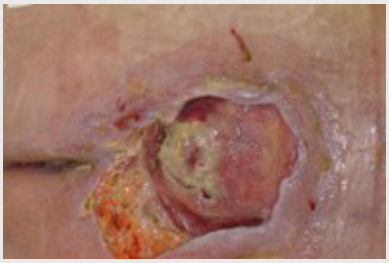
Evaluate: High risk areas of pressure, usually over bony prominence. Measure ulcer in cm, length x width x depth. Recommend taking wound photo.

Findings: Full thickness tissue loss, Subcutaneous fat may be viable. Bone, tendon, or muscle are not exposed. Slough may be present but doesn't obscure the depth of tissue loss. May include undermining and tunneling. Possible odor. Depth varies based on anatomical location (bridge of nose vs ischial tuberosity). Painful.

Plan:

1. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
2. Upgrade support surface, add low air loss mattress. Pulsate or Bariatric Low air loss Mattress. Use Attends pad on mattress. If wound is on heels use offloading waffle boots.
3. If moderate to heavy drainage- Cleanse wound with NS, gently pack wound with Aquacel Ag, cover with gauze and secure with Hypafix tape. Change daily and prn. If minimal drainage, cleanse wound with NS, gently pack wound with gauze or kerlex lightly moistened with Vashe. Cover with gauze and ABD, secure with Hypafix tape. Change BID.
4. Nutritional therapy consult.
5. Consult Wound APP.
6. Depending on progress, patient may benefit from outpatient wound clinic follow up.

Follow up: Assess daily for progress and deterioration.



Diagnosis:
Pressure Injury Stage 4

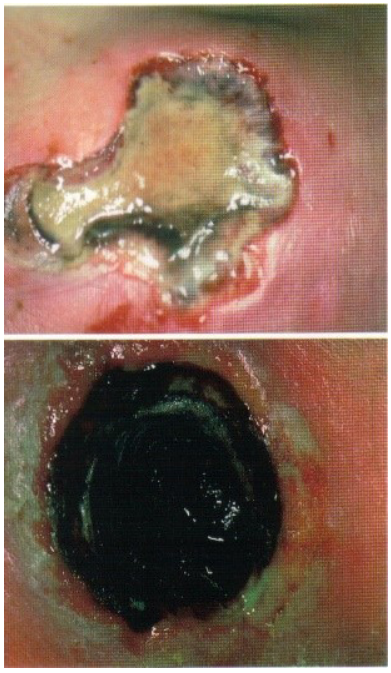
Evaluate: High risk areas of pressure, usually over bony prominence. Measure ulcer in cm, length x width x depth. Recommend taking wound photo.

Findings: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of wound bed. Often includes undermining and tunneling. Depth varies by anatomical location. Osteomyelitis possible.

Plan:

1. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
2. Upgrade support surface, add low air loss mattress. Pulsate or Bariatric Low air loss Mattress. Use Attends pad on mattress. If wound is on heels use offloading waffle boots.
3. Cleanse wound with NS, gently pack wound with gauze or Kerlex lightly moistened with Vashe. Cover with gauze and ABD, secure with Hypafix tape. Change BID.
4. Rule out/ treat for osteomyelitis- imaging, ID consult etc.
5. Nutritional therapy consult.
6. Outpatient wound clinic follow up after discharge.
7. Consult wound APP.

Follow up: Assess daily for progress and deterioration.



Diagnosis:
Pressure Injury Unstageable

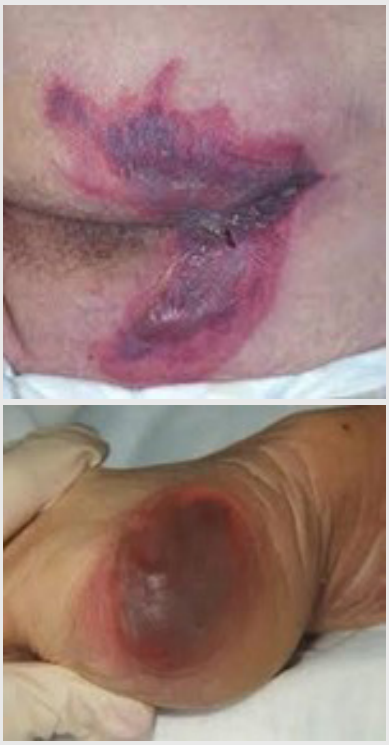
Evaluate: High risk areas of pressure, usually over bony prominence. Measure ulcer in cm, length x width x depth. Recommend taking wound photo.

Findings: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, green or brown) and or eschar (brown or black) in the wound bed. Until slough and eschar are removed to expose the base of the wound, the true depth, and therefore stage cannot be determined. Often includes undermining and tunneling. Odor.

Plan:

1. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin.
2. Upgrade support surface, add low air loss mattress. Pulsate or Bariatric Low air loss Mattress. Use Attends pad on mattress. If wound is on heels use offloading waffle boots.
3. Cleanse wound with NS, gently pack wound with gauze or Kerlex lightly moistened with Vashe. Cover with gauze and ABD, secure with Hypafix tape. Change BID. If dry necrosis on heel, leave wound dry, cover with Aquacel AG and gauze. Change daily.
4. Consider need for surgical or sharp debridement.
5. Nutritional therapy consult.
6. Depending on progress, patient may benefit from outpatient wound clinic follow up.
7. Wound APP consult.

Follow up: Assess daily for progress and deterioration, if extends to bone, rule out/ treat for osteomyelitis.



Diagnosis:
Deep Tissue Injury

Evaluate: High risk pressure areas (heels, coccyx, sacrum, etc), usually over a bony prominence. Measure area in cm, length x width. Recommend taking wound photo.

Findings: Persistent non blanchable deep red, maroon or purpuric discoloration located over a bony prominence or with known pressure source. May feel indurated or boggy. Skin can be intact or open, open wound may have dark red or purpuric wound bed. Can be an intact purpuric/blood filled bulla, seen more commonly on heels.

Plan:

1. Implement pressure injury prevention measures: Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin daily.
2. Upgrade support surface, add low air loss mattress, Pulsate or Bariatric Low Air Loss. If wound is on heels use offloading waffle boots.
3. Add Mepilex sacrum, heel, or border 4 x 4 dressing depending on location and size of wound. Change every two days and prn. If wound is an intact bulla can leave area open to air, use dry gauze and kerlix wrap or add Aquacel Ag under Mepilex to avoid rupturing the bulla. If wound is open, can add Aquacel ag if fair amount of drainage.
4. Consult wound APP.
5. Nutritional therapy consult.
6. May need outpatient wound care clinic follow up after discharge.

Follow up: Assess daily for progress and deterioration. Will need to monitor closely as wound will continue to evolve and wound care will need to be adjusted as wound may become necrotic.

UPSTATE
MEDICAL UNIVERSITY

ALAN AND MARLENE NORTON
COLLEGE OF MEDICINE

EXCEPTIONAL MOMENTS IN TEACHING

Muslim Khan, MD, an assistant professor of Psychiatry and Behavioral Sciences at the Norton College of Medicine at Upstate Medical University, is the **April 2023** recipient of the **Exceptional Moments in Teaching recognition.**

COMMENTS FROM DR. KHAN'S STUDENTS:

"Dr. Khan has more than 30 years of experience and he threw me into the ocean and believed I could swim. I guess I swam, doggy-paddled at times but I did my best. I think I was given the advantage to interview almost every patient I saw during my clerkship, even new visits. It was an amazing experience for me, and Dr. Khan's feedback was essential for my improvement and growth of my interview skills. I learned an immense amount of information in just these short five weeks, and I was happy to come to work every day."

"Dr. Khan is a great teacher, leader, and clinician, and it has been an honor to watch him interact with patients suffering from a variety of mental illnesses. He is compassionate and always knows all of the right questions to ask patients and doesn't skip a beat. I got the opportunity to interview several patients, and he provided exceptional and essential feedback to improve my interview skills. Dr. Khan took time between appointments to discuss aspects of some disorders to help information stick with me from the experiences with patients and this was extremely helpful."

The Norton College of Medicine recognizes exceptional teachers with the monthly "Exceptional Moments in Teaching" program. Honorees are selected via student assessments from courses and clerkships. Recognized teachers—including medical faculty, residents, nurses and other educators—are those who challenge students and provide an exceptional learning experience.

Inpatient Providers

Wound Care Physician IP
Order Set

TRAINING CENTER OF EXCELLENCE
UPSTATE MEDICAL UNIVERSITY

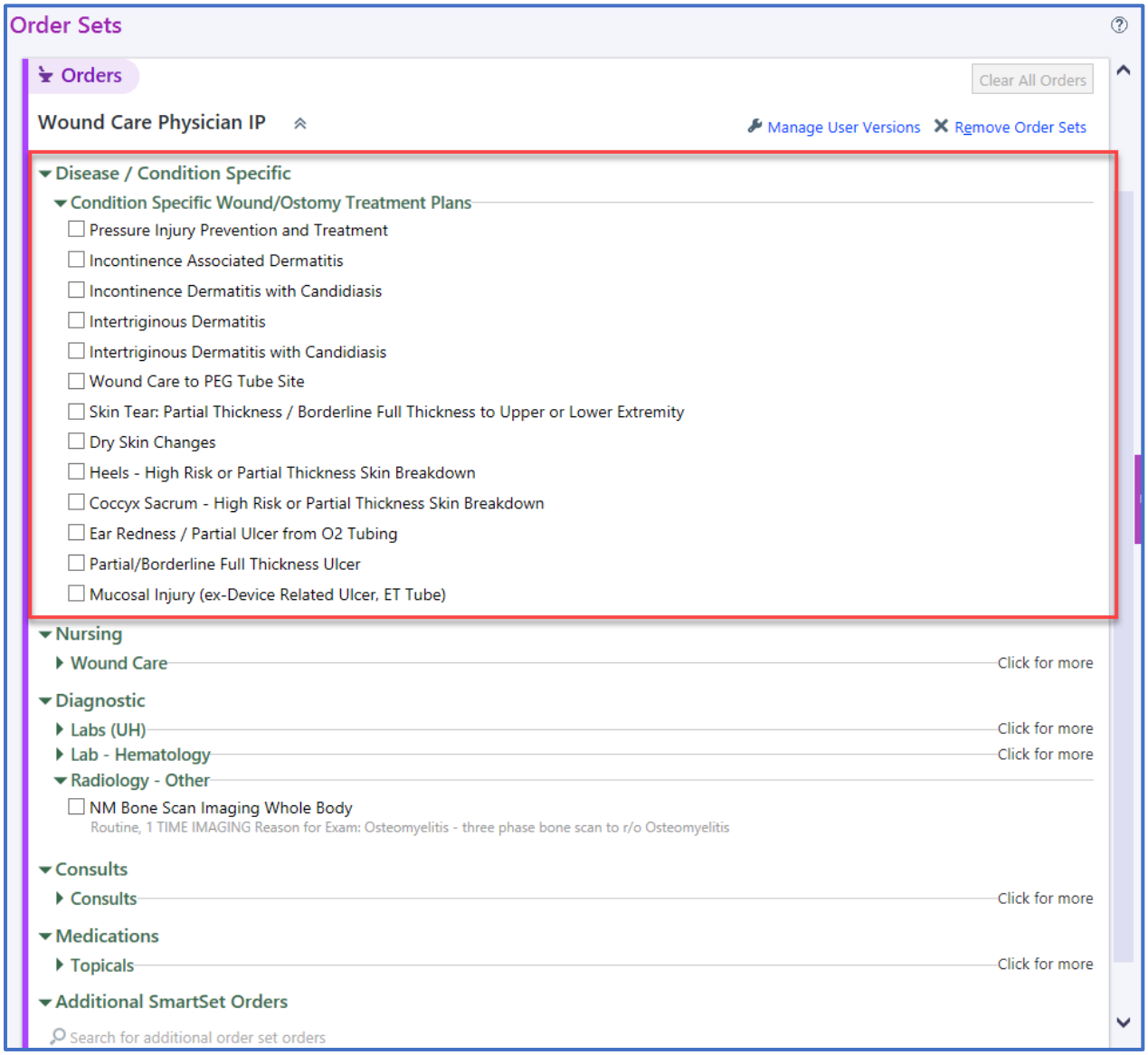
EPIC SYSTEM UPDATE

Overview of Feature / Changes

Effective Wednesday April 5, 2023: To provide guidance and improve wound care the **Wound Care Physician IP Order Set** has been updated to include condition specific treatment plan orders. Additionally, several previously preselected orders will no longer be prechecked.

Updated Content

Condition specific treatment plans have been added to the order set.



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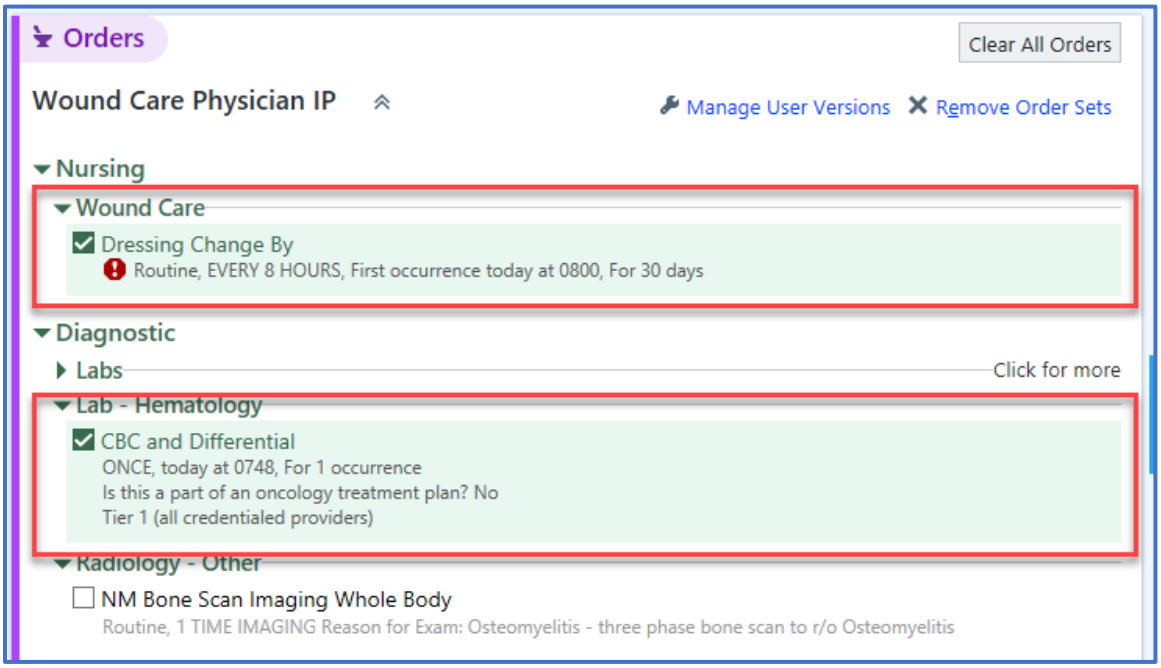
Additional Information

In the updated order set, previously preselected orders will no longer be prechecked.

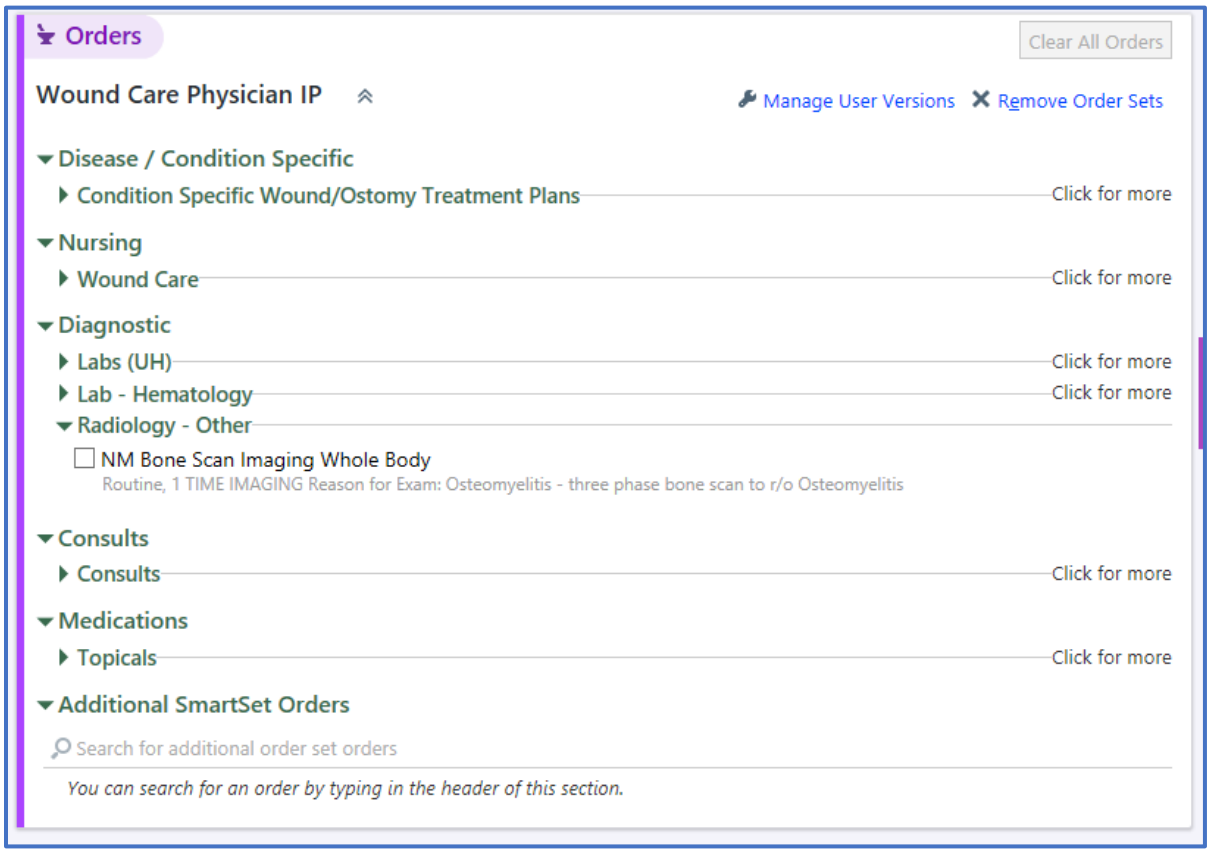
Old Version

Preselected orders:



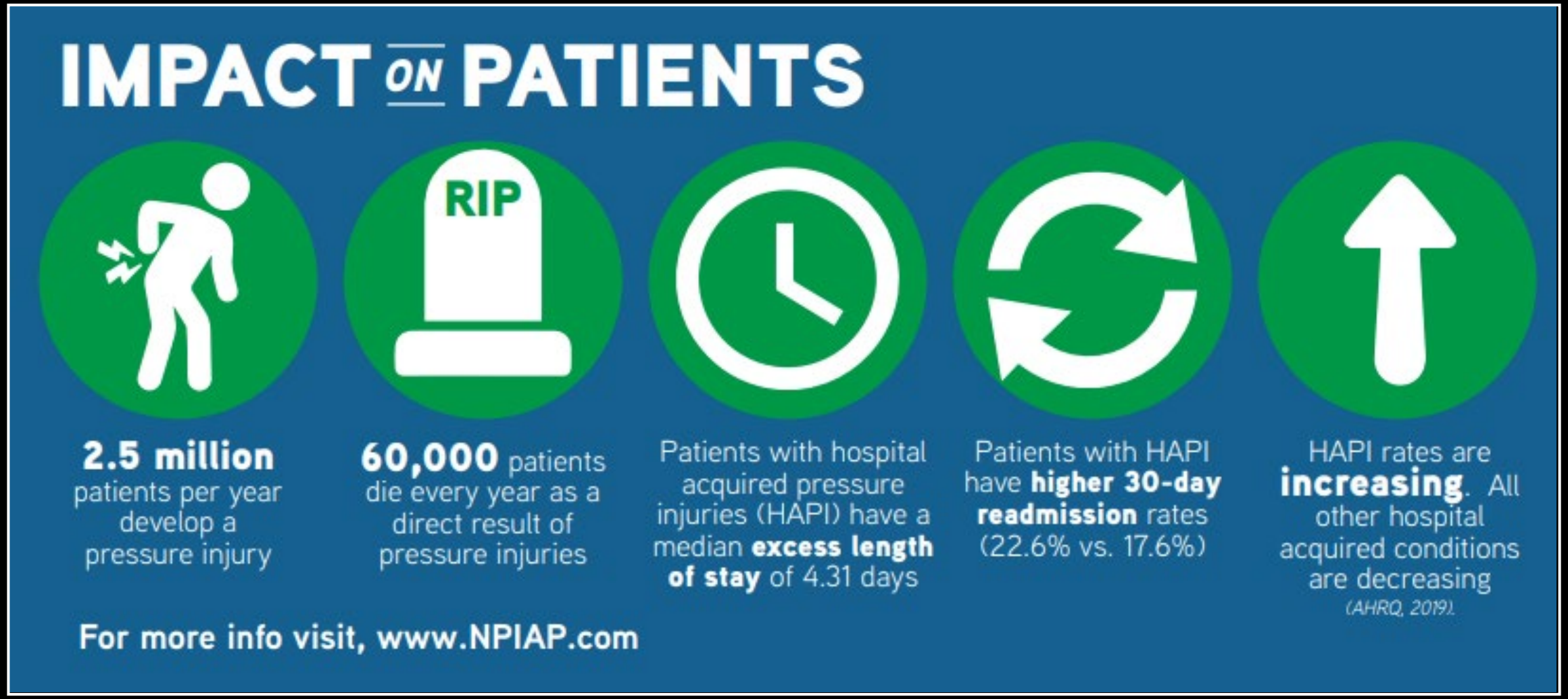
New Version

No preselected orders:



Wound Care Pearls

Jessica Dow MSN, FNP- C, CWCN



Pressure Injuries: Impact on Patients

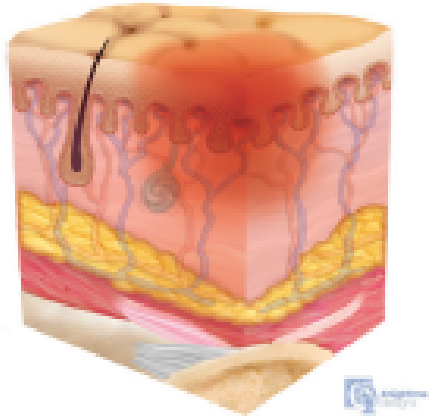
PRESSURE INJURY AND STAGES

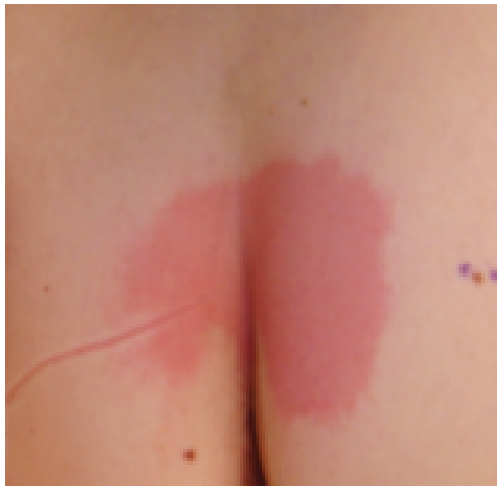
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense pressure, prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

STAGE 1 PRESSURE INJURY

Non-blanchable erythema of intact skin

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

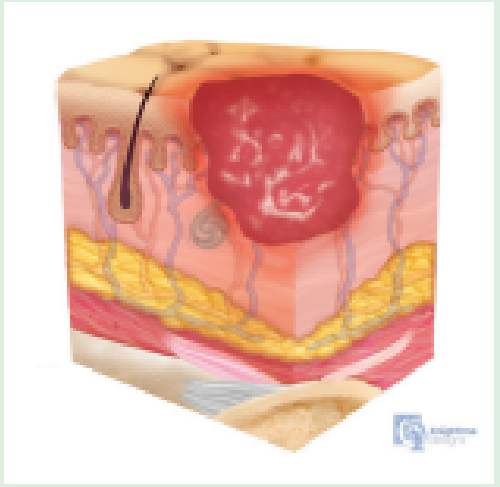


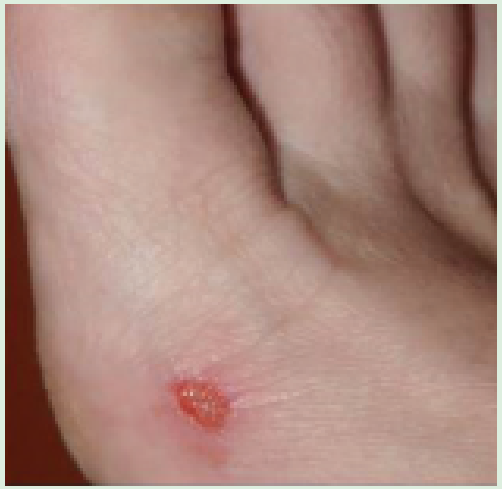


STAGE 2 PRESSURE INJURY

Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

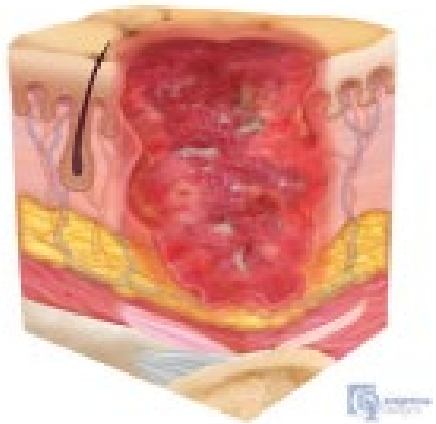


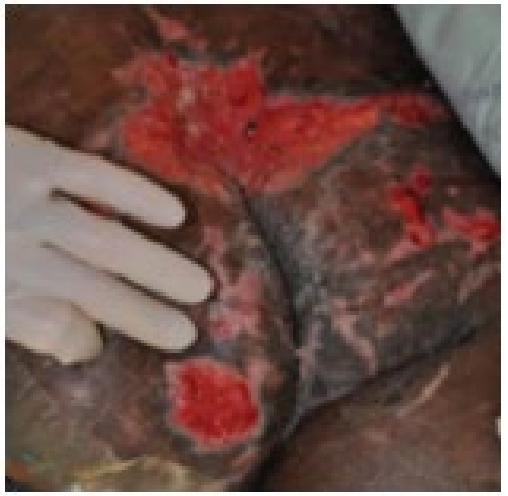


STAGE 3 PRESSURE INJURY

Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

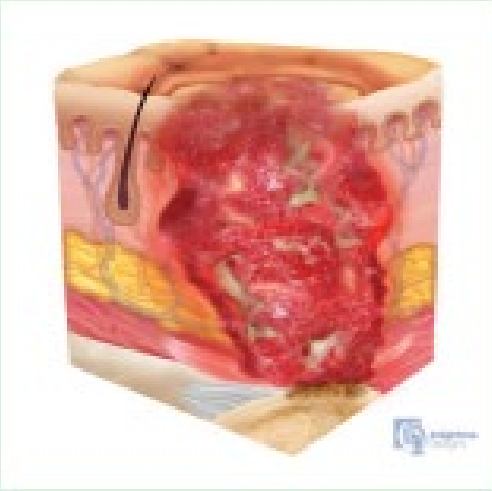




STAGE 4 PRESSURE INJURY

Full-thickness loss of skin and tissue

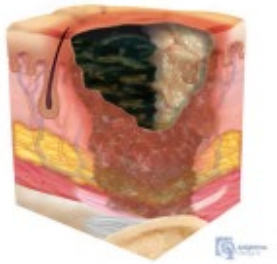
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

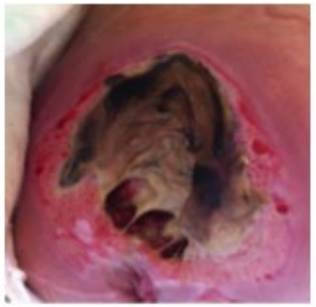


UNSTAGEABLE PRESSURE INJURY

Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable esch (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.

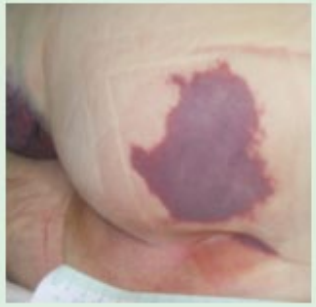




DEEP TISSUE PRESSURE INJURY

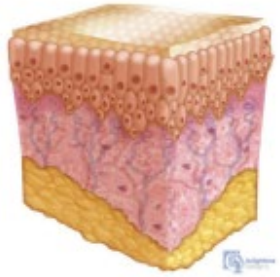
Persistent non-blanchable deep red, maroon or purple discoloration

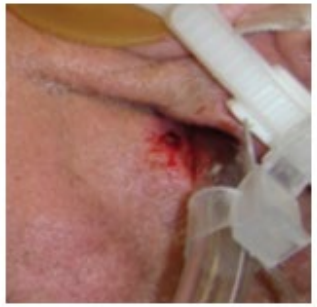
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.



MUCOSAL MEMBRANE PRESSURE INJURY

Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. These ulcers cannot be staged .

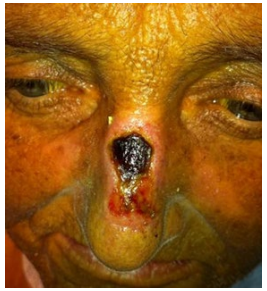




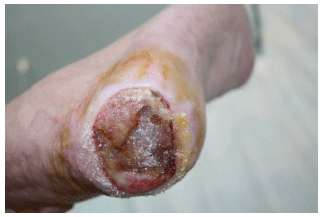
Pressure Injuries: To stage or not stage?

- Only Stage Pressure injuries
- A pressure injury must either be overlying a bony prominence or have a pressure source (ex. device related pressure ulcer).
- Do **not** stage: incontinence associated dermatitis, skin tears, bruises, leg ulcers, or blisters (unless caused by pressure).

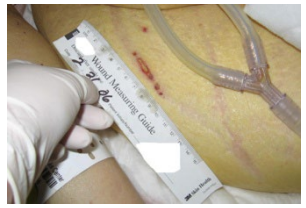
PRESSURE INJURY	NOT A PRESSURE INJURY



Device related pressure injury

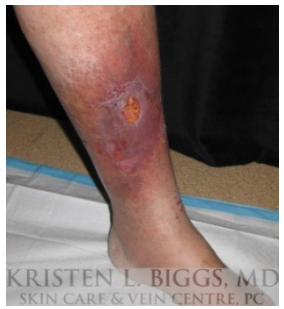


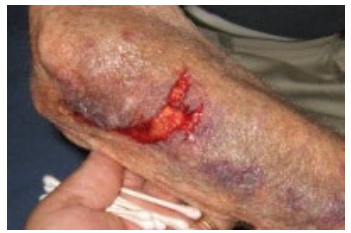
Heel pressure injury



Device related pressure injury

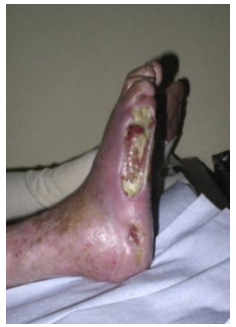
Venous ulcer

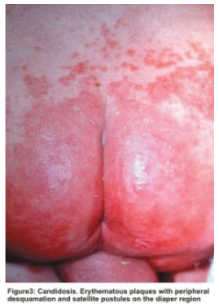




Skin tear to arm

Arterial Ulcer





Fungal rash to buttock

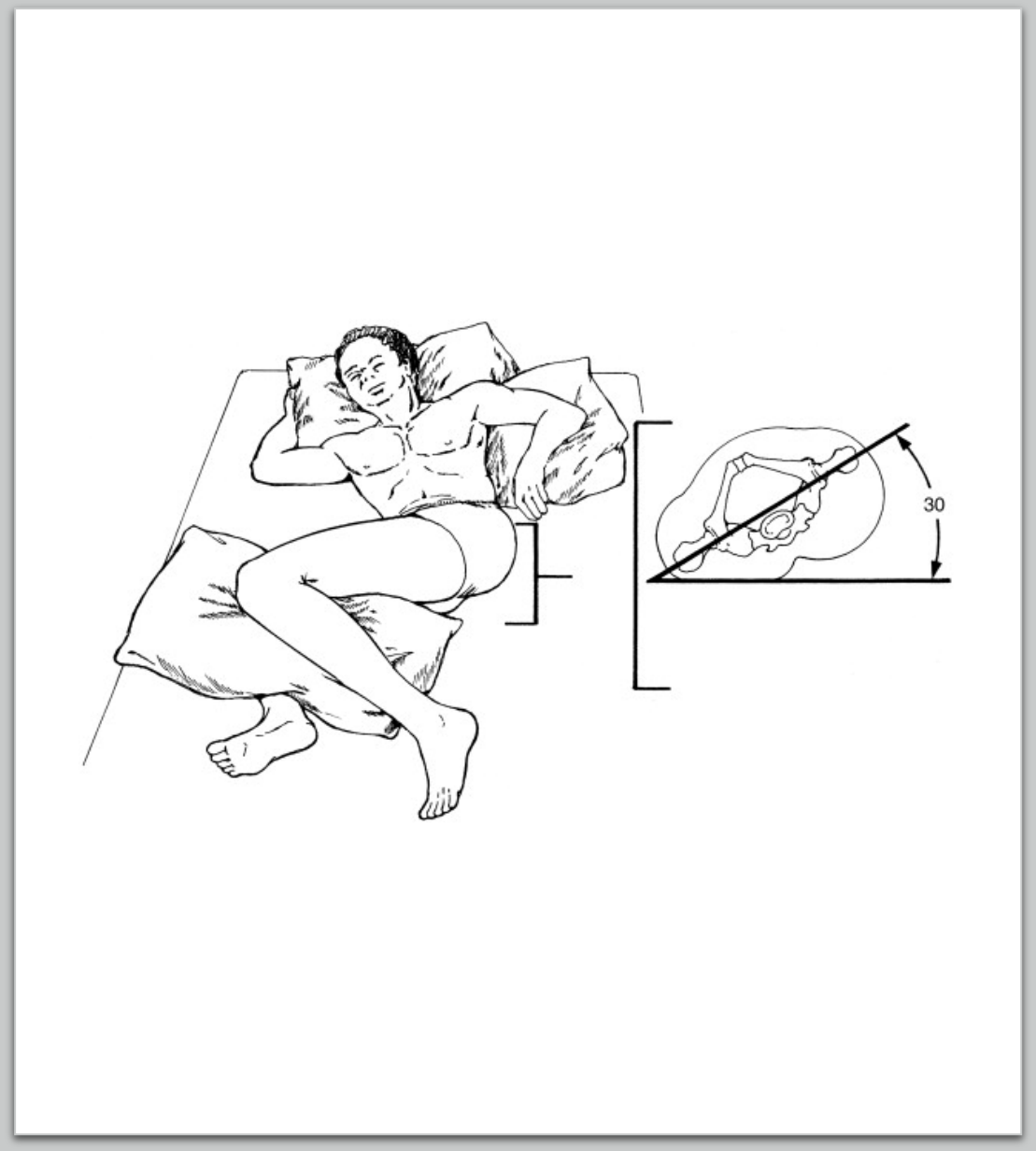
Pressure Injury Prevention

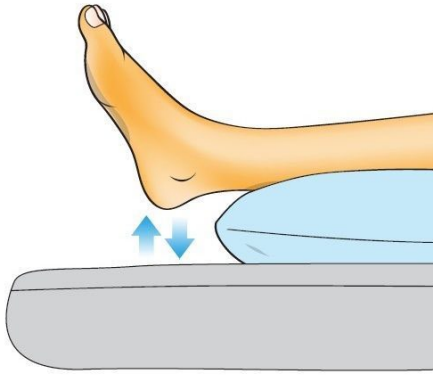
- Positioning
- Incontinence and moisture control
- Support surfaces
- Nutritional therapy
- Skin assessment
- Medical device related
- Education
- Outdated interventions

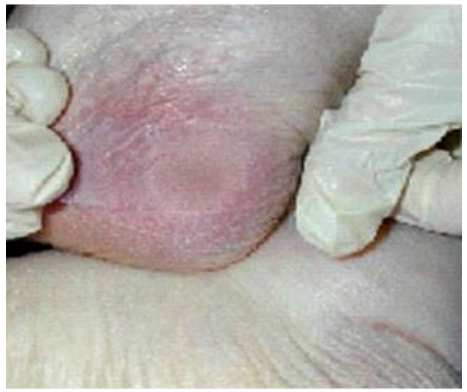
Positioning

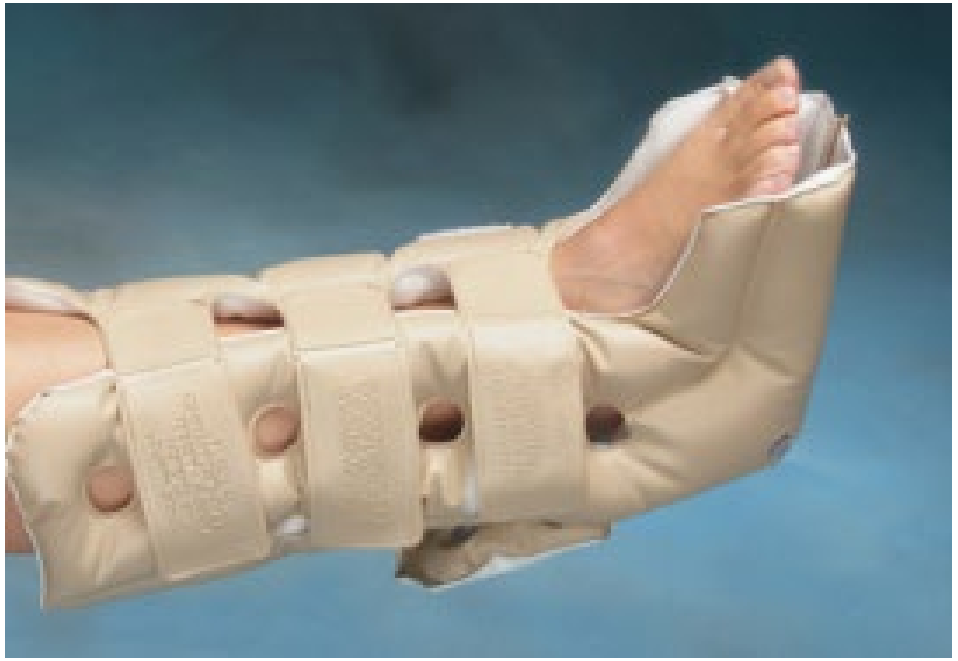
- Turn and position Q 2 hours
  - HOB elevation at 30 degrees or less
  - 30 degrees lateral position

  (keeps pressure off trochanter and off coccyx and sacrum!)
- Hemodynamically unstable patients- even small shifts /turns help !









Positioning

- Elevate heels on pillows, the heels should be “floating”
- If the patient is restless and doesn’t keep the heels up on pillows, add waffle boots

Positioning

- When OOB to chair, use pressure reducing chair cushion
- Weight shifts Q15 mins (those who are capable)
- Position changes Q 1 hour (elevating the legs or standing and reseating in the chair)
- If high risk, limit OOB time to two hours at a time

Incontinence and Moisture Control

- Incontinence cleaned as soon as possible after soiling and at intervals
- Use soaps and cleansers with neutral pH and moisturizers
- Avoid excessive friction and scrubbing
- Barrier ointments/creams
- Underpads, diapers, and briefs that wick away moisture
- Fecal management device or short-term indwelling catheter

Support Surfaces

Device that redistributes pressure, may also reduce shear, friction, and moisture.

Prevent pressure injuries or promote healing by reducing or eliminating tissue interface pressure.

Should be use for all at risk individuals.

Use in adjunct to, not a replacement for turning and positioning.

Nutritional Therapy

Normal healing requires adequate protein, fat, and carbohydrates, as well as vitamins and minerals

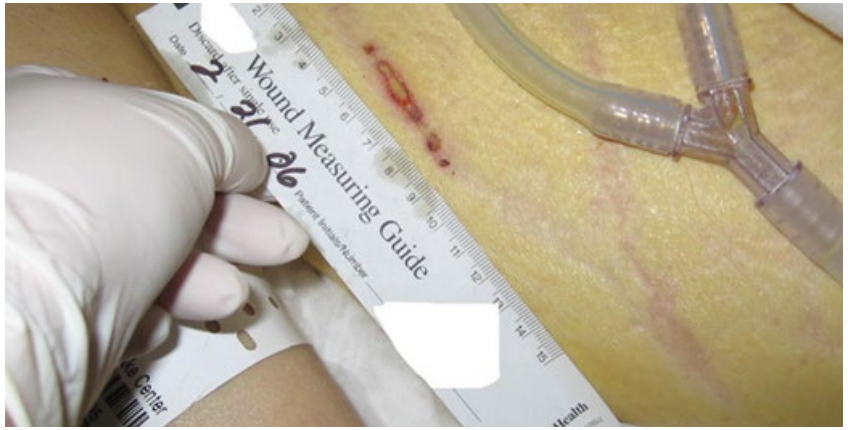
Deficiencies in any of these nutrients may result in impaired or delayed healing.

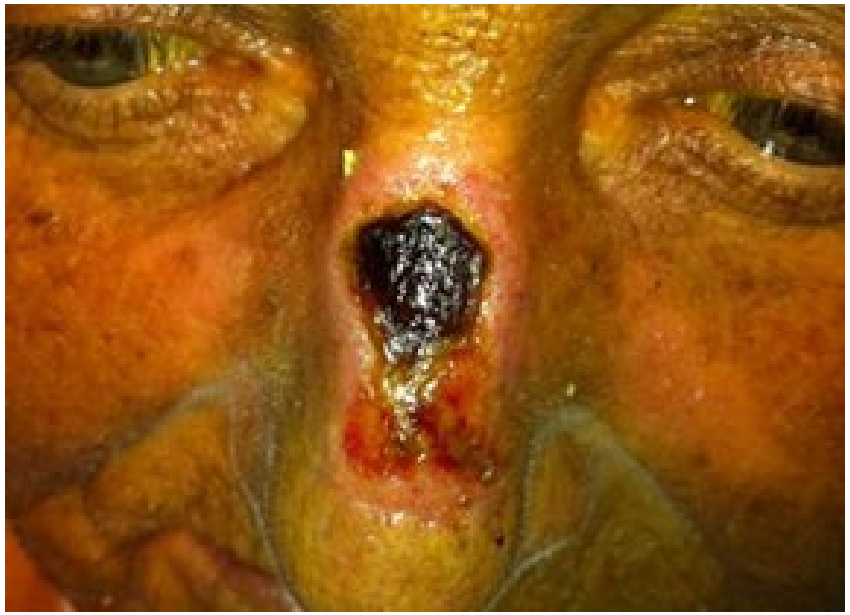
Increased protein needs for healing pressure injuries

Consider nutritional therapy/dietician referral for patients with inadequate nutritional intake.

Skin Assessment

- Patients with or without skin breakdown required comprehensive skin assessment.
- Daily skin assessment, including evaluation of integrity, temperature, texture, and presence of lesions.
- Even more frequent skin assessments if the patient is at high risk for breakdown





Medical Device Related

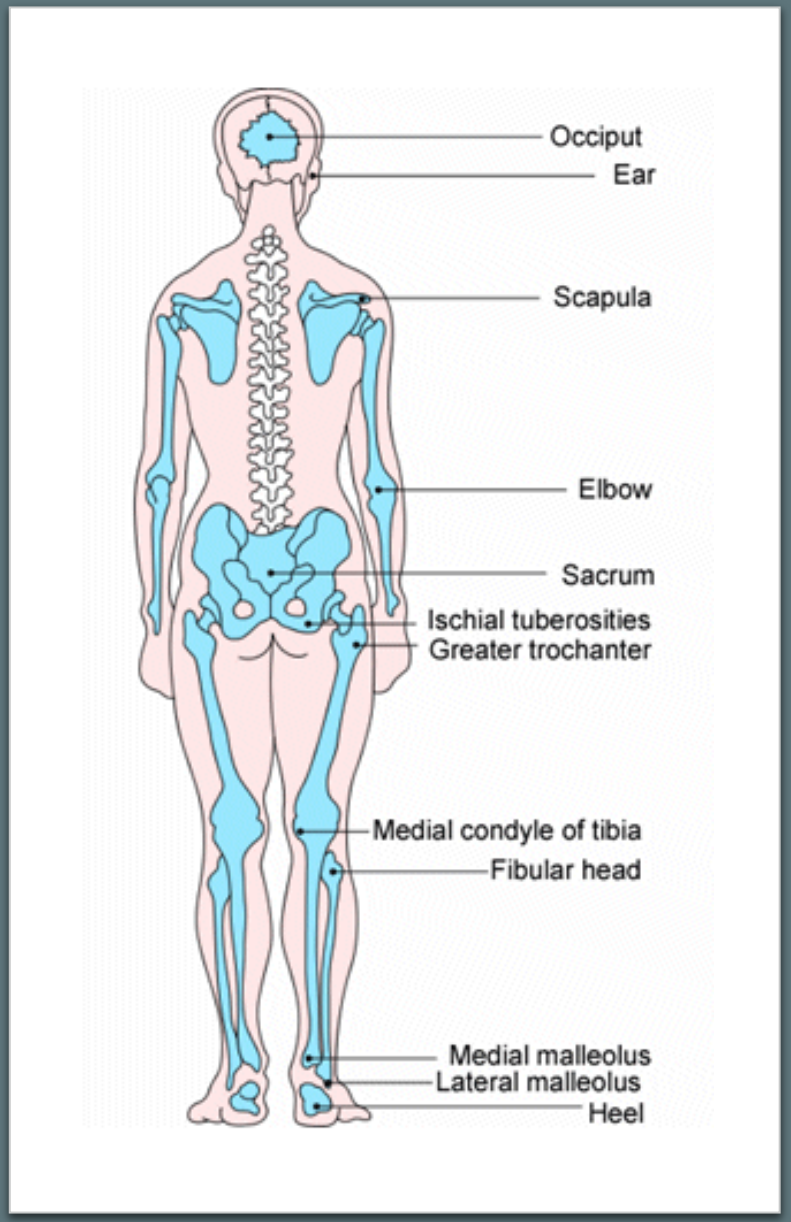
- Localized injury to skin or underlying tissue as a result of sustained pressure from a device.
- Best practices for prevention
  - Choose the best size medical device to fit the patient
  - Correctly position the device
  - Cushion/pad and protect the skin in high-risk areas
  - Remove/move the device to inspect skin that is in contact with device (if not medically contraindicated) at least once a shift
  - Avoid placement of device over sites of prior or existing pressure ulcer
  - Be aware of edema under device and potential for skin breakdown
  - In positioning make sure patient is not lying on tubing

Education

- Educate family and patient on why
- Why we reposition every two hours, why we elevate the heels off the bed surface, why we use a cushion in the chair, why it is important that we change the dressing twice a day, and reassess the skin frequently

Outdated interventions

- Vigorous massaging of pressure points
- Foam or rubber rings, “donuts”
- Sheep skin



Wound Assessment

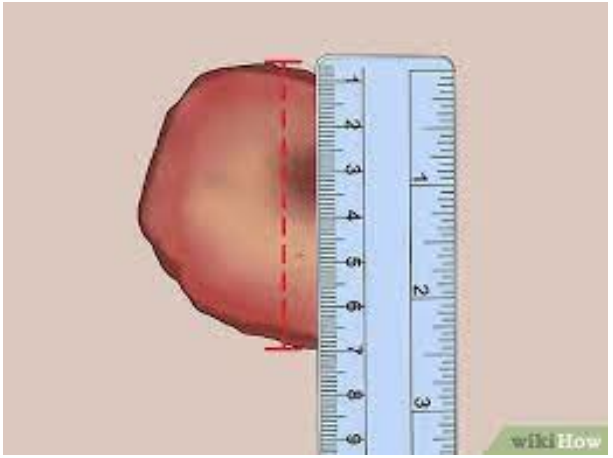
1. Location
2. Measurement
3. Appearance of the wound bed/wound margin
4. Exudate/Drainage
5. Odor
6. Presence of infection
7. Condition of periwound tissue

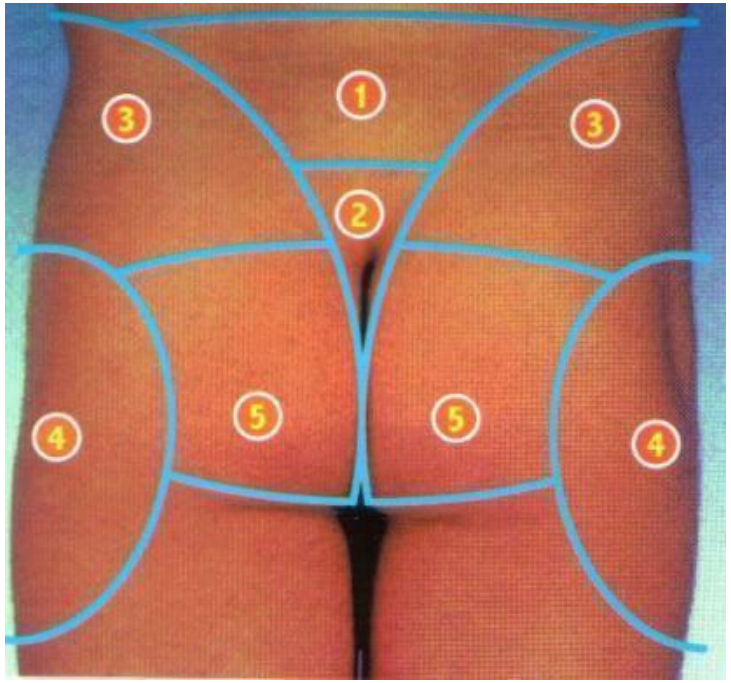
Assessing the Wound

Location: Where is the wound ? Is it over a bony prominence? Be sure to correctly identify exact landmarks when deciding where a pressure injury is.

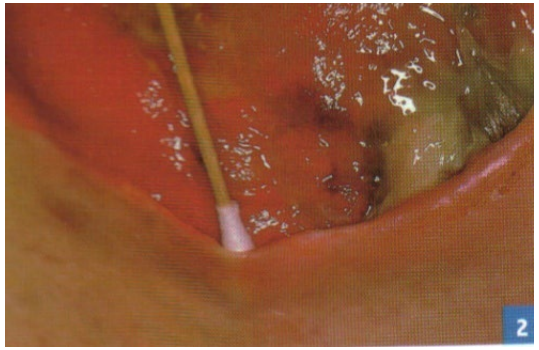
Wound measurement:

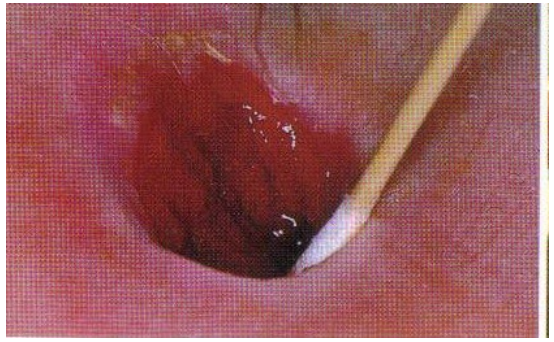
- Always measure in centimeters
- Length x width x depth
  - Example: 6 cm x 3 cm x .3cm
  - Length: Head to toe axis
  - Width: Side to side axis
  - Depth: deepest part of visible wound bed
- Imagine a clock to describe the wound
  - “12 o’clock” at the head
  - “6 o’clock” at the feet

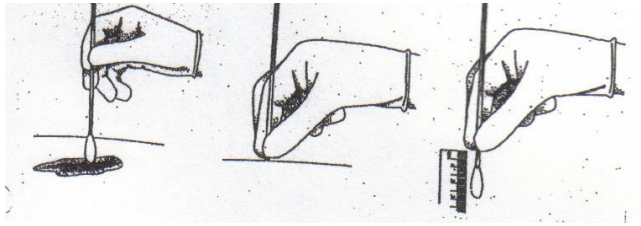




1. Sacrum
2. Coccyx
3. Iliac Crest
4. Trochanter
5. Ischial Tuberosity



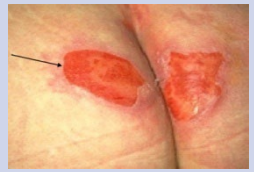
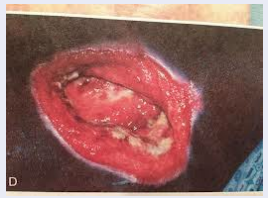
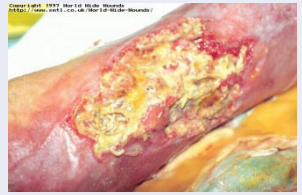
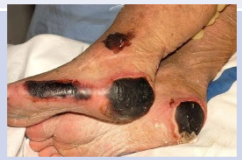
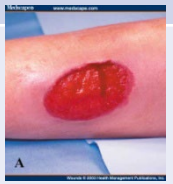


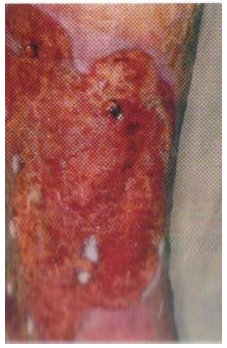


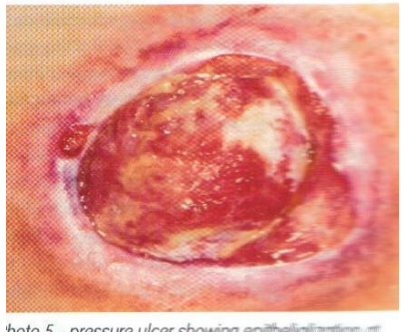
Measuring Depth, Undermining, and Tunneling

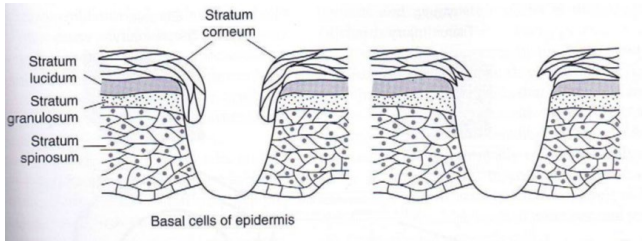
1. Depth
   - Shallow wounds
   - Deep wounds – use a sterile swab
2. Undermining: represents true size of wound
3. Tunneling/Sinus Tracts

Wound Appearance

Term	Definition	Picture
Partial Thickness Wound	Loss of epidermis and possible loss of dermis. In pressure injuries, a stage 2.	
Full Thickness Wound	Tissue destruction extending through the dermis to involve the subcutaneous layer and possibly muscle or bone. In pressure injuries, a stage 3 or 4.	
Slough	Soft, moist avascular (necrotic/devitalized) tissue; it may be white, yellow, tan, or green; it may be loose, stringy, or firmly adherent	
Eschar	Thick, leathery necrotic tissue; devitalized tissue	
Granulation Tissue	Beefy red wound bed. Indicates wound healing. Has a grainy appearance.	

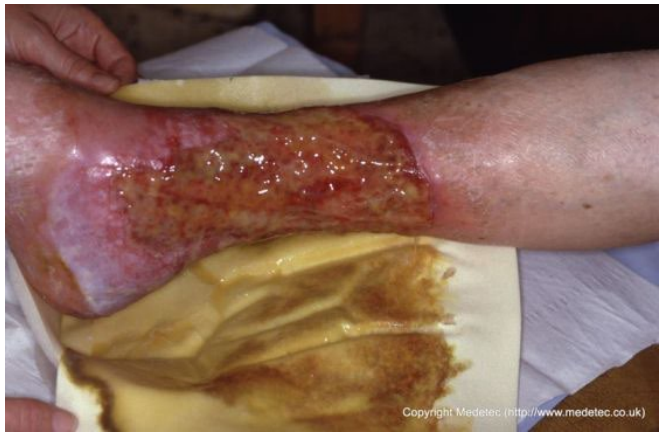






Wound Appearance

- Epithelialization:
  - Regeneration of the epidermis across a wound surface
  - Final phase of wound healing
  - Epithelial cells migrate from wound edges
    - *Or* present as small islands on the wound surface
- Wound margin:
  - Epithelializing well?

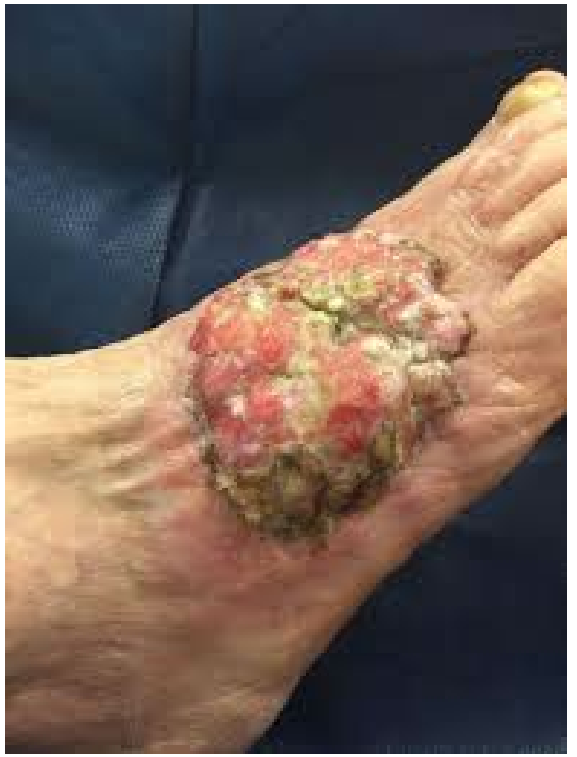


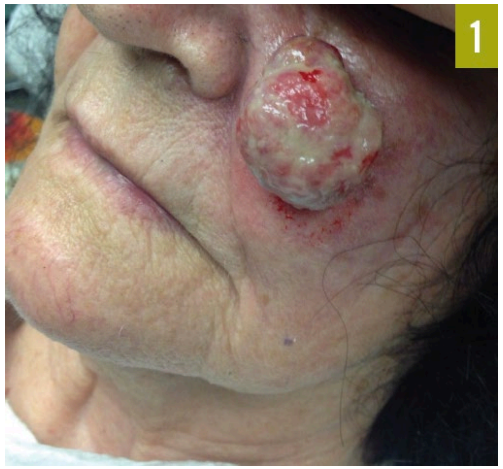
Exudate

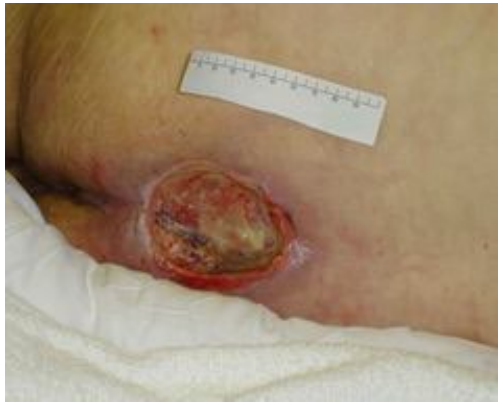
- Exudate:
  - Color
    - Serous, serosanguineous, sanguineous
  - Amount
    - Scant, moderate, large
  - Consistency
    - Thin, thick, milky, purulent
  - Odor
- Presence of heavy exudate indicates uncontrolled edema, or an increased bioburden and potential wound infection.
- Amount of exudate dictates type of dressing and frequency it is changed. If it is wet, you want to absorb it and if it is dry, you want to add moisture.

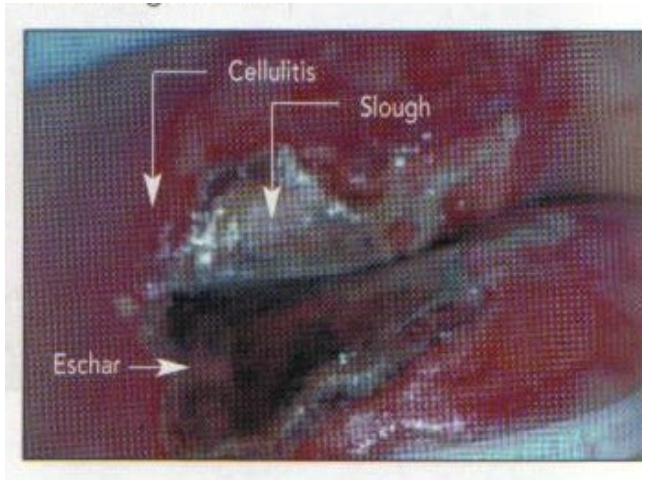
Odor

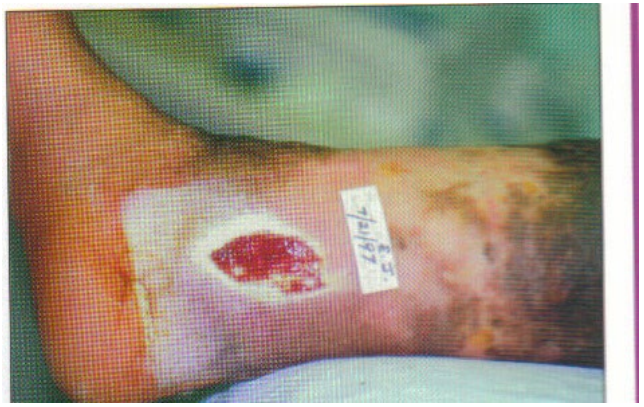
- Commonly associated with an infected wound, also with highly colonized wound such as fungating lesions or pressure injuries with necrotic debris







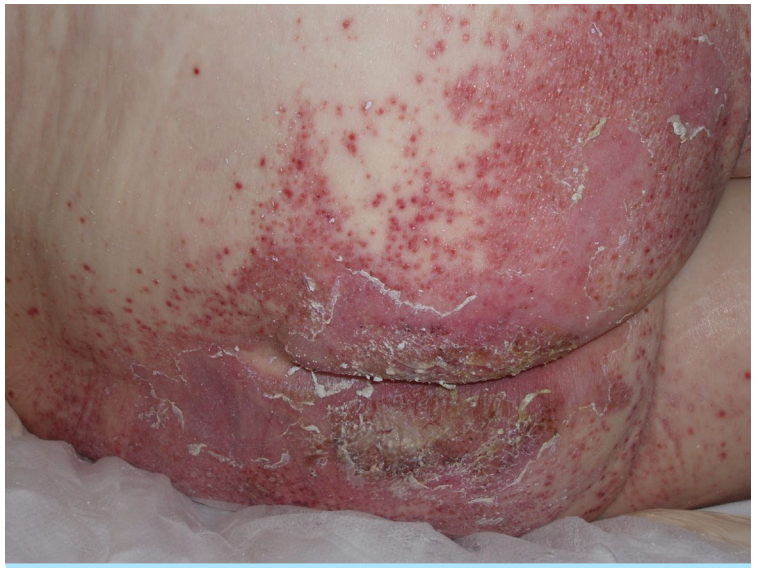




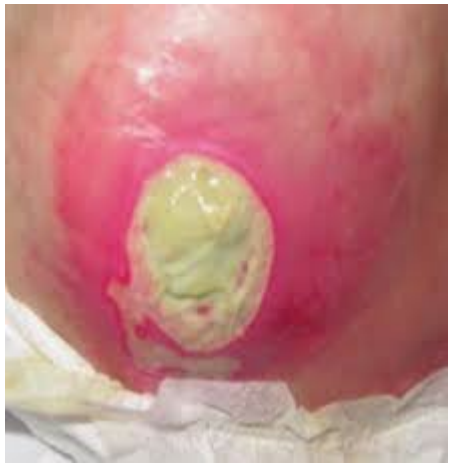
Periwound

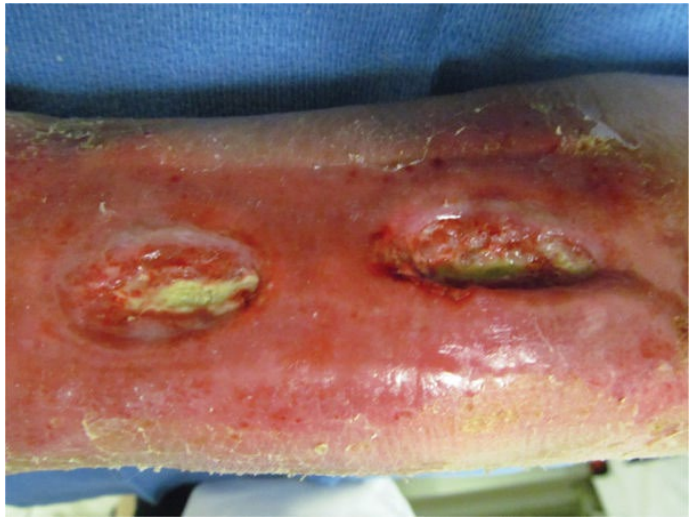
- Periwound Tissue:
  - Assess and document the condition of the skin around wound area.
    - Is it macerated?
    - Is it infected?

Periwound



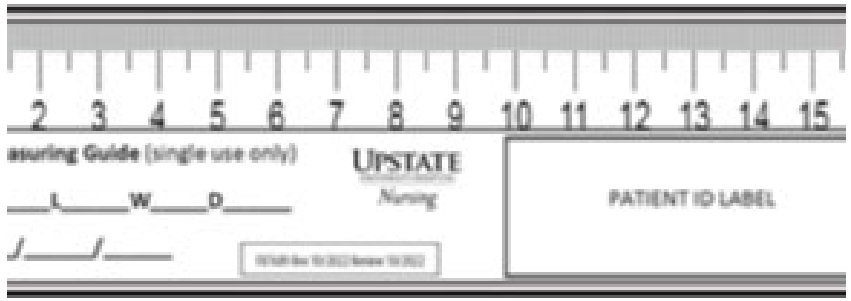
- Periwound Tissue:
  - Palpate, palpate, palpate:
    Boggy? Soft or spongy ?
    Indurated? Abnormally firm ?
    Tunnel or undermining anywhere?
    Does the wound communicate with an adjacent one?
    Temperature? Warm or cool?
    Candidal infection

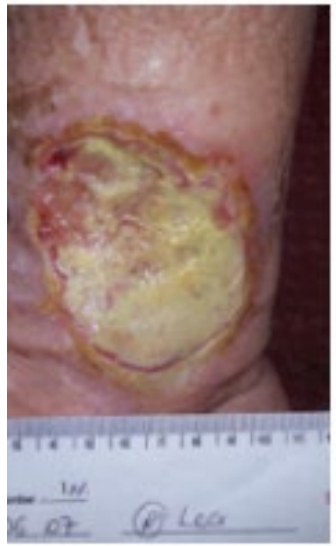


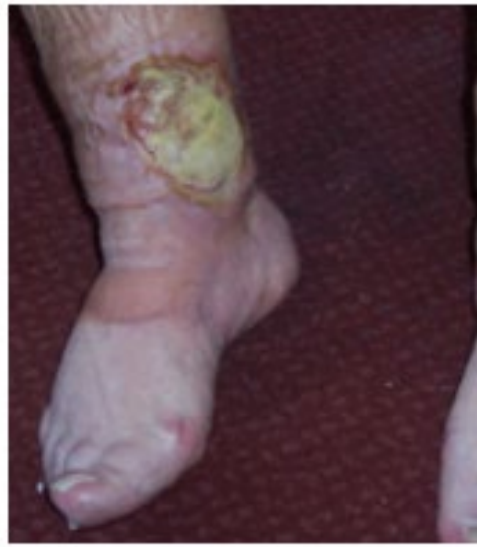


Take a Wound photo

- Use Haiku to take a photo of the wound
- Wound photography tips:
  - Clean the wound prior to the taking the photo
  - Have someone help hold the patient if needed. Can be challenging to hold the patient and get a good photo.
  - Label measure guide with date and patient initials, hold guide next to wound when taking photo
  - Title and date photo when saving ex. Right ischial 2/20/23
  - Take two photos, one up close (wound bed) and one at a distance (demonstrating the position of the wound)





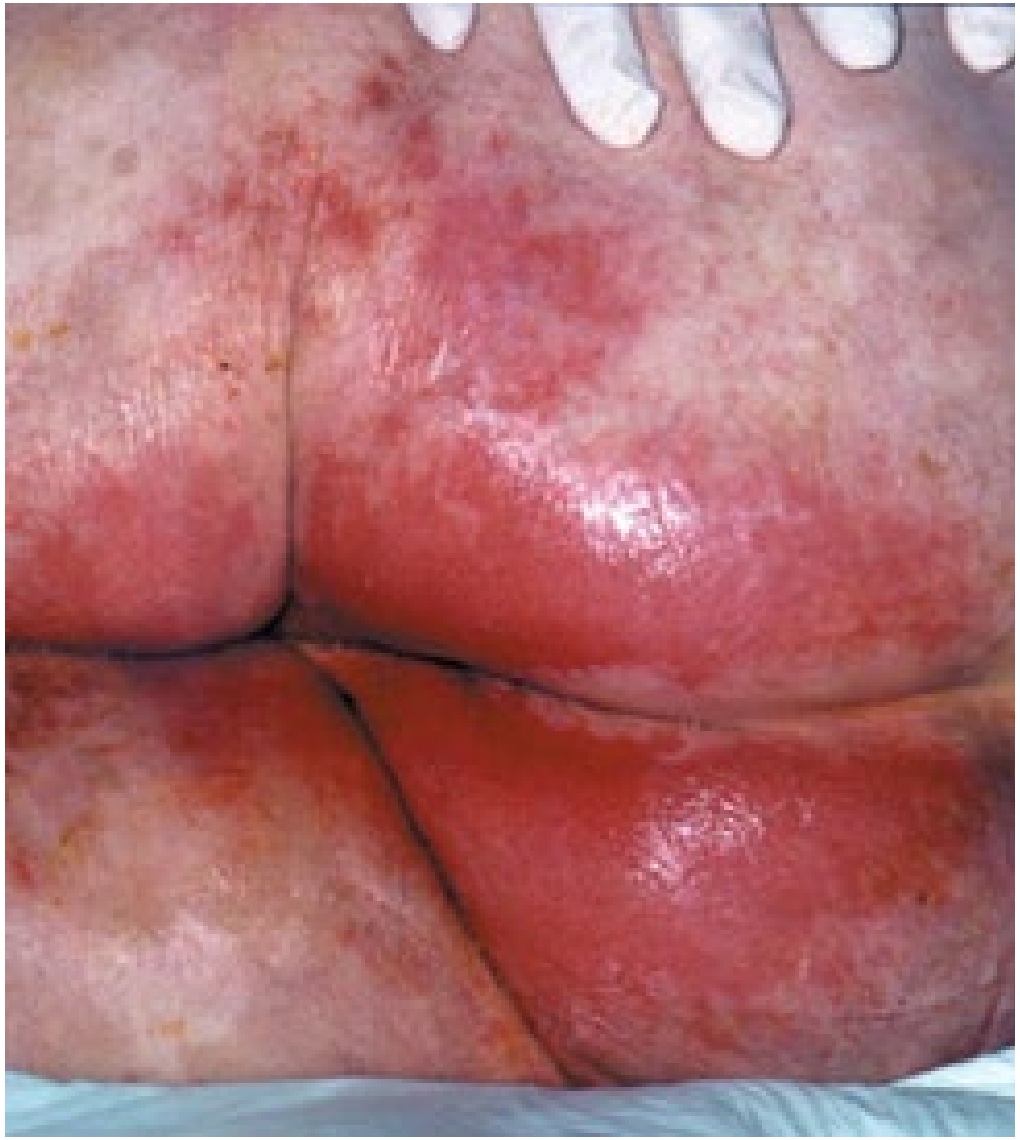


Common Wound Types

- Incontinence Associated Dermatitis
- Incontinence Associated Dermatitis with Candidiasis
- Intertriginous dermatitis
- Intertriginous dermatitis with Candidiasis
- Skin tears
- Peri tube skin changes
- Earlobe redness / ulcerations
- Dry Skin Changes
- Partial thickness ulcers
- Oral Mucosal Injuries
- Hyperkeratotic skin changes
- Pressure Injuries – Stage 1 and 2

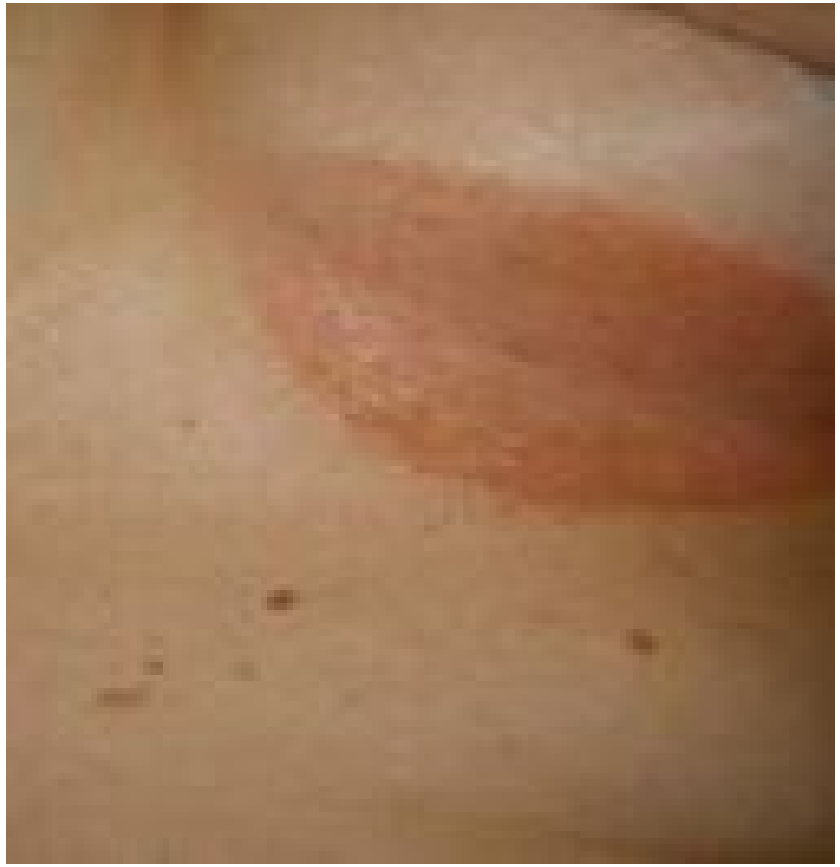
Incontinence Associated Dermatitis

- Breakdown of skin due to contact with moisture (stool, urine).
- **Treatment:**
  - Contain drainage, consider adding flexiseal or urinary containment device.
  - Upgrade support surface
    - Low air loss mattress
  - Pressure Ulcer Prevention : Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin
  - Add a Barrier cream
    - Skin care to buttock and groin : Cleanse with foam cleanser. Apply Desitin oint (or Senicare) TID and prn (moist skin changes)
    - Skin care to buttock and groin : Cleanse with foam cleanser. Apply Baza Protect TID and prn (dry skin changes)



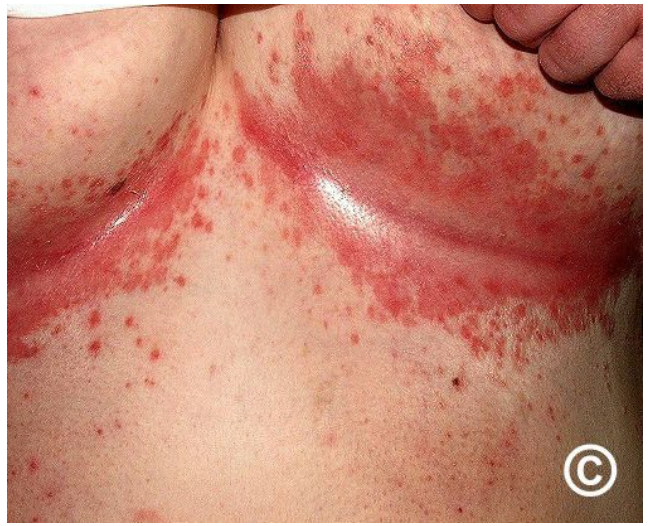
Intertriginous Dermatitis

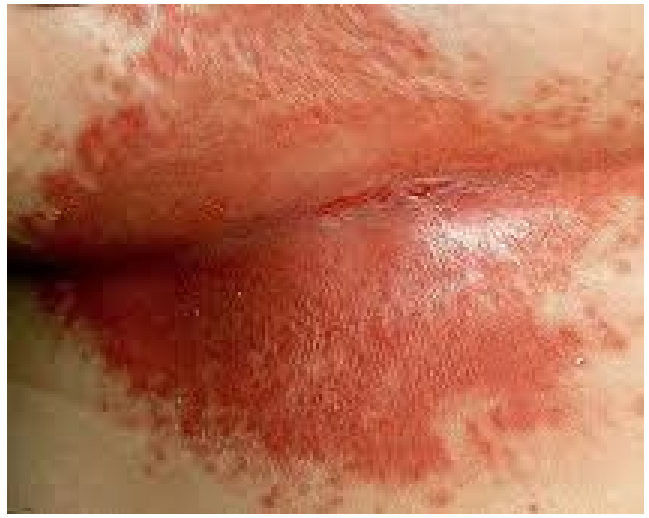
- Skin damage and inflammation in skin fold often seen under abdomen and breast, groin, etc.
- Treatment:
  - Cleanse and pat dry skin folds BID and PRN
  - Apply Interdry between skin folds (cut section long enough to extend 2 inches exposed past the fold for moisture evaporation). Remove for bathing and cleansing and can reply fabric, change fabric when soiled. Cleanse and assess BID

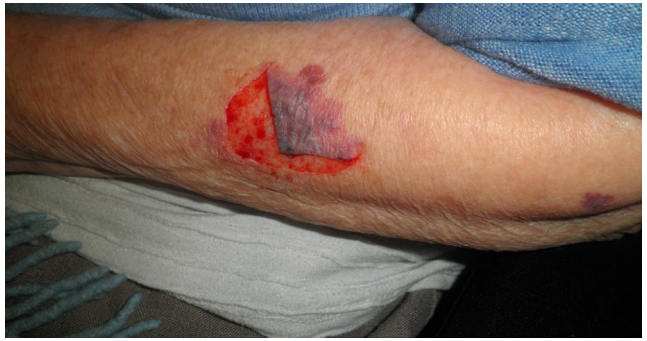


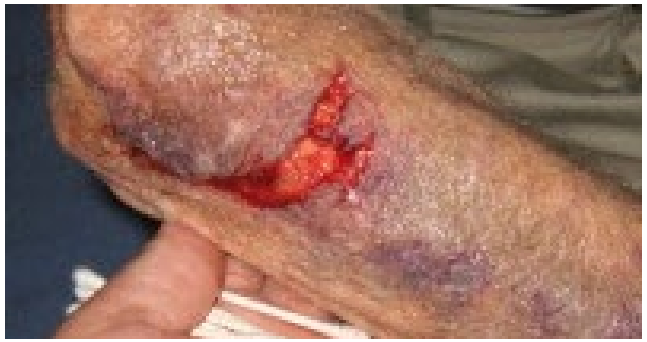
Candidiasis

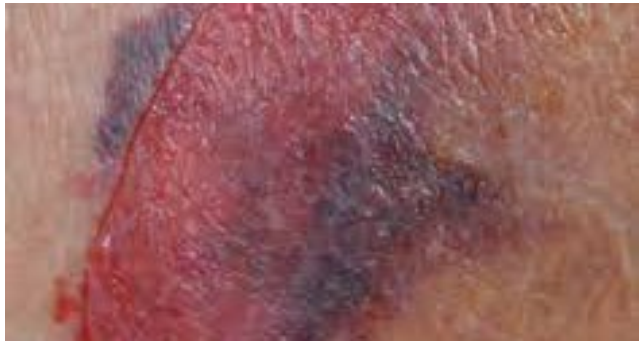
- Satellite lesions, lacey margins. Presence of moist environment – under skin folds, buttock, groin, etc
- Treatment:
  - Skin care to skin fold (under breast, abdomen, etc): cleanse with form cleanser, pat dry. Apply light dusting of nystatin powder to affected area. BID and prn
  - Skin care to buttock and groin: cleanse with foam cleanser, pat dry. Apply Miconazole extra thick oint to affected area BID and prn(moist skin changes)
  - Skin care to buttock and groin: cleanse with foam cleanser, pat dry. Apply miconazole aloe vesta oint to affected area BID and prn (dry skin changes)











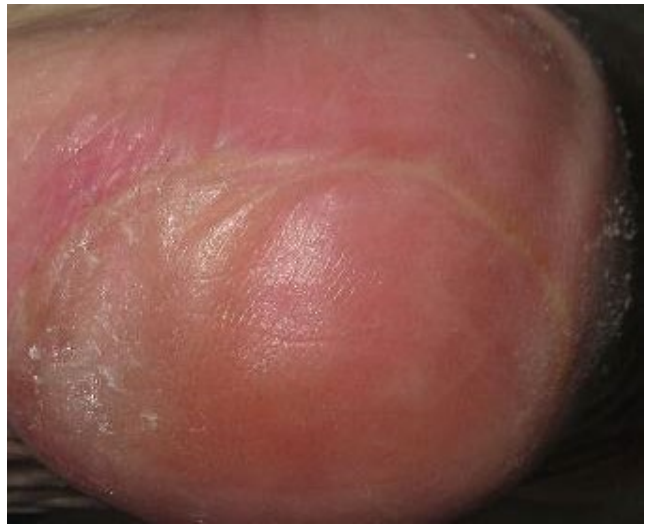
Skin Tears- Partial/borderline full thickness

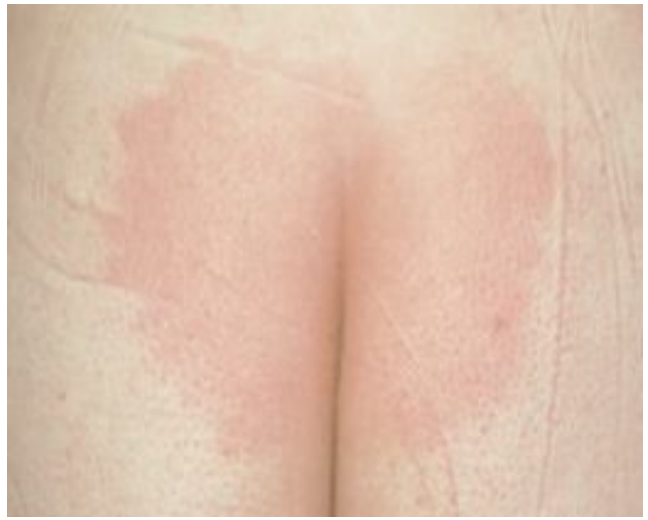
- Layers of skin separate or peel back as result of trauma, dressing changes, or washing or drying the skin harshly.
- Usually on the arms or legs
- Dry, thin, aging skin is at high risk for skin tear development
- Treatment:
  - Apply single layer Vaseline gauze to open area, cover with gauze, and secure with cling. Change daily.
  - If skin tear is on back or abdomen, can apply single layer Vaseline gauze to open area and cover with Mepilex dressing. Change every two days and prn.
  - If high risk skin tears, apply lotion to skin daily and limit use of adhesive directly on skin
  - If need to use adhesive, apply Calivon skin prep to area prior to applying adhesive on skin.

Pressure Injury: Stage 1 and 2

- Stage 1- Non blanchable redness, over a bony prominence or has pressure component.
- Is blanchable redness over bony prominence staged ? No, it would be described as blanchable redness. But it can progress to non blanchable (stage 1)
- Stage 2- Partial thickness skin loss over bony prominence or has pressure component. Can be serous filled intact or ruptured bulla.

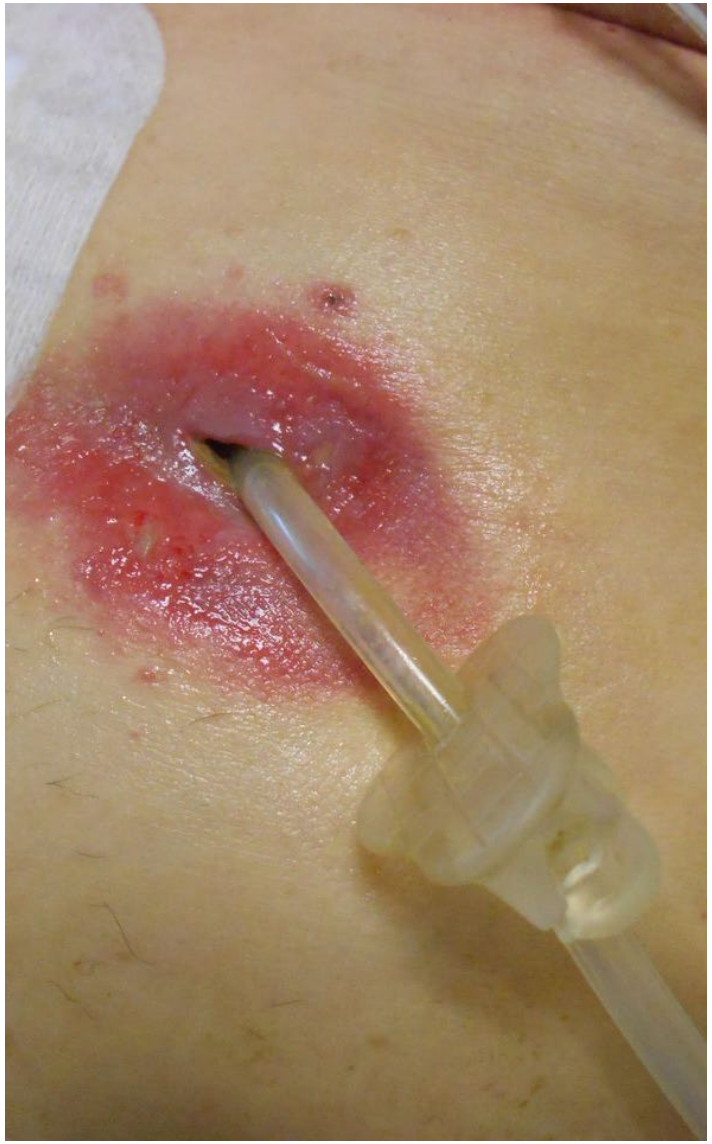
- Treatment:
  - Apply Mepilex heel, Mepilex sacrum, or Mepilex border depending on location and size of injury. Change Q2 days and prn.
  - For pressure injury stage 2- Depending on size, location, and risk- consider adding Aquacel Ag to ulcer and covering with the Mepilex (secondary dressing). Change Q2 days and prn.
  - Upgrade support surface
    - Low air loss mattress
  - Pressure Ulcer Prevention : Turn & position Q2H, OOB with static air cushion, no plaid quilted pads, attends pads, limit HOB elevation to reduce shearing, off-load heels, lotion daily to skin





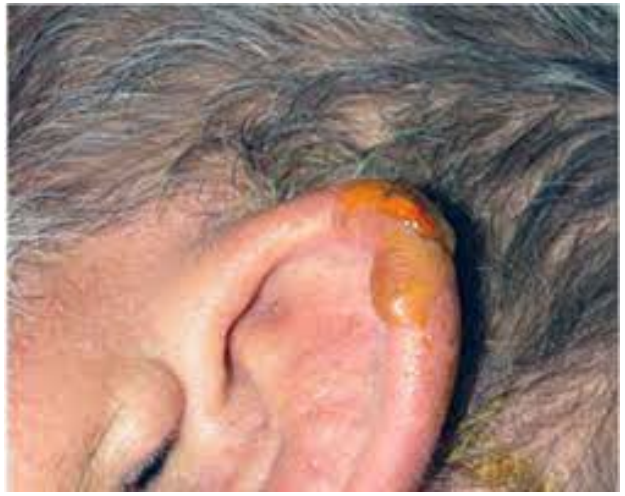
Peri tube skin changes

- Often related to drainage around tube.
- Treatment- Cleanse with NS. Sprinkle light dusting of stomahesive powder (distribution) over skin breakdown, tap powder with Cavilon skin prep. Place dry drainage sponge around tube under bumper plate. Change Q8 hours and PRN



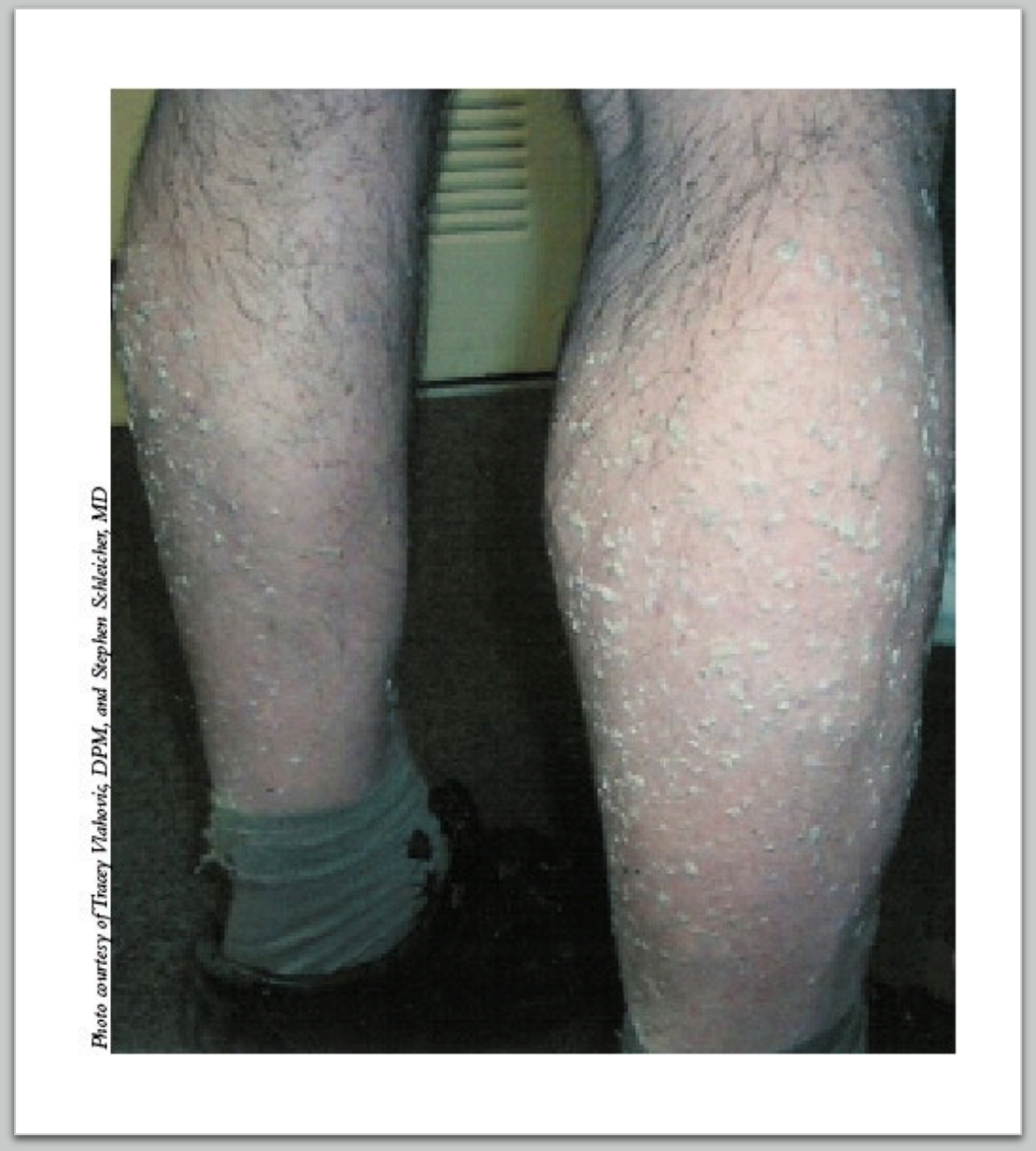
Pressure injury to ear crease/ ear lobe

- Redness or ulceration usually to ear lobe or crease of ear related to O2 tubing or positioning.
- Treatment:
  - Wound care to ear crease or ear lobe ulcer: cleanse with Cavilon skin prep, allow to dry, leave open to air. Use foam ear protectors for O2 tubing



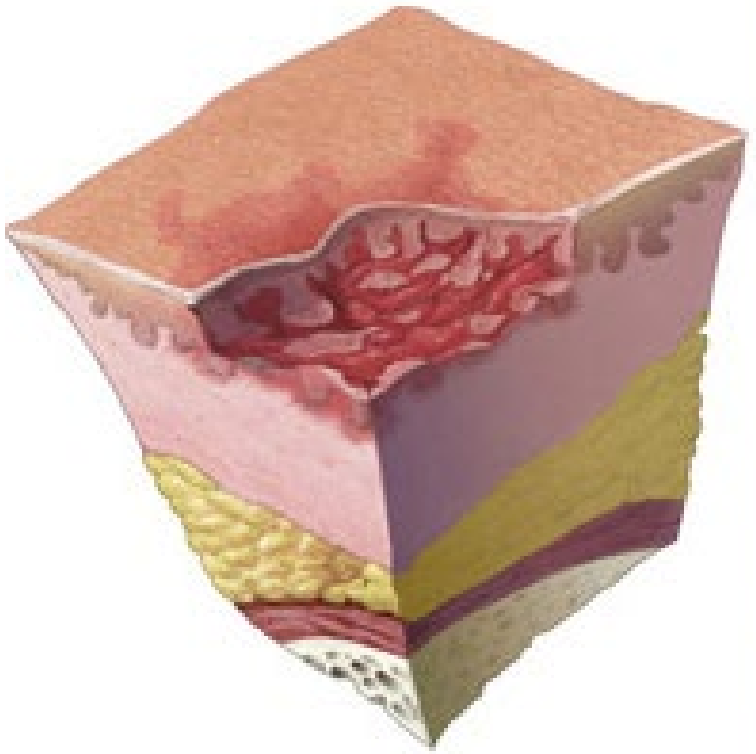
Dry Skin Dermatitis

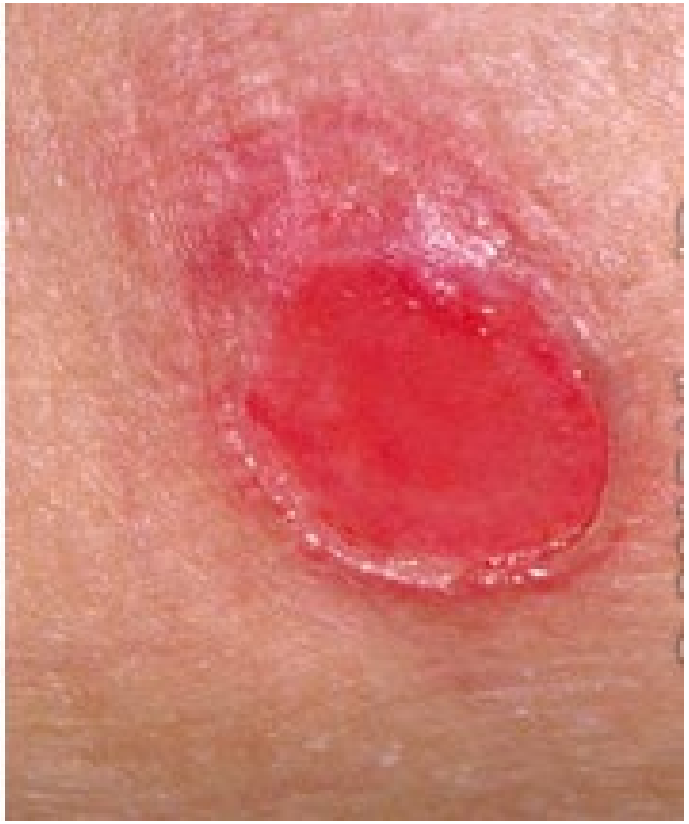
- Dry, cracked, flaking skin changes
- Treatment: Apply lotion or Resta cream daily



Partial /borderline full thickness ulcers

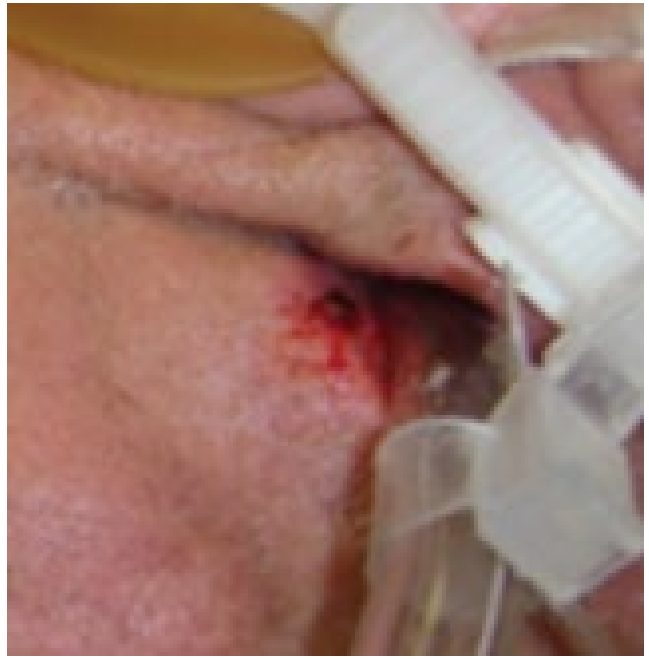
- Partial thickness skin breakdown does not penetrate below the dermis and may be limited to the epidermal layers only
- Full thickness tissue damage involves total loss of epidermis and dermis and extends into subcutaneous tissue and possibly into muscle and bone
- Treatment of partial / borderline full thickness ulcers depends on location and drainage.
    - If minimal drainage, Mepilex border 4x4, change every 2 days
    - If moderate drainage, can add Aquacel Ag to wound base and cover with Mepilex border 4x4
    - If dry wound base, can add single layer Vaseline gauze to wound base and cover with Mepilex border 4x4

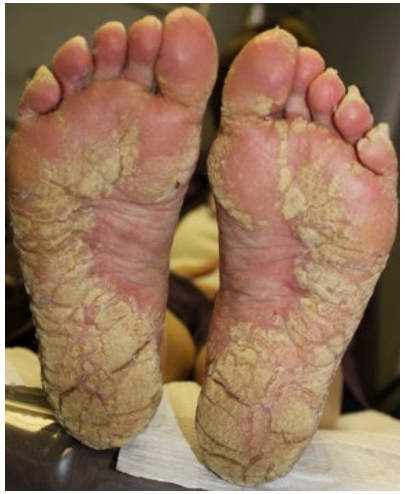


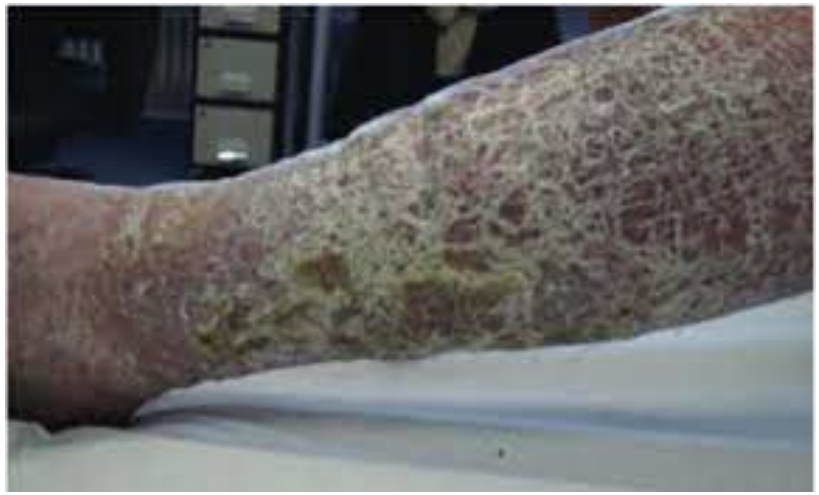


Oral Mucosal Injuries and Mucosal Membrane Pressure Injuries

- Often device related, failure to reposition ET tube timely or failed to secure appropriately
- Treatment:
  - Wound care to lip: cleanse gently with routine oral care, apply Vaseline ointment to keep lips moist, avoid placement of ET tube directly over wound. Reposition tube per policy.

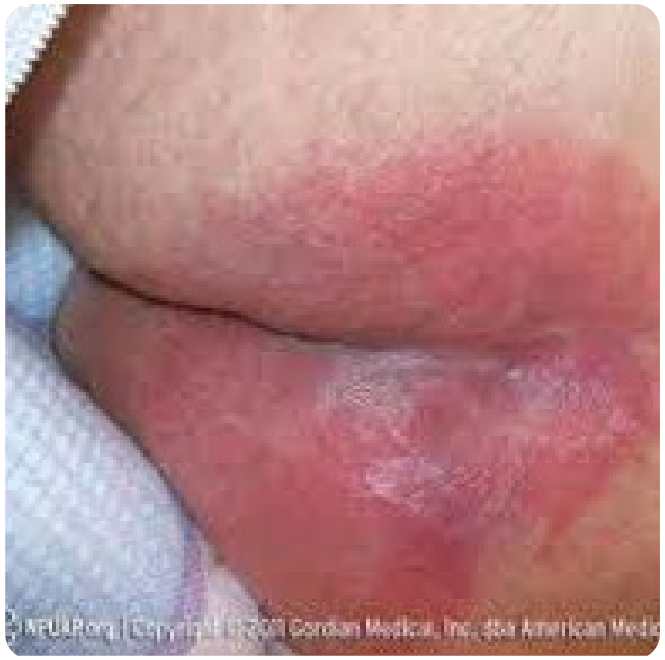


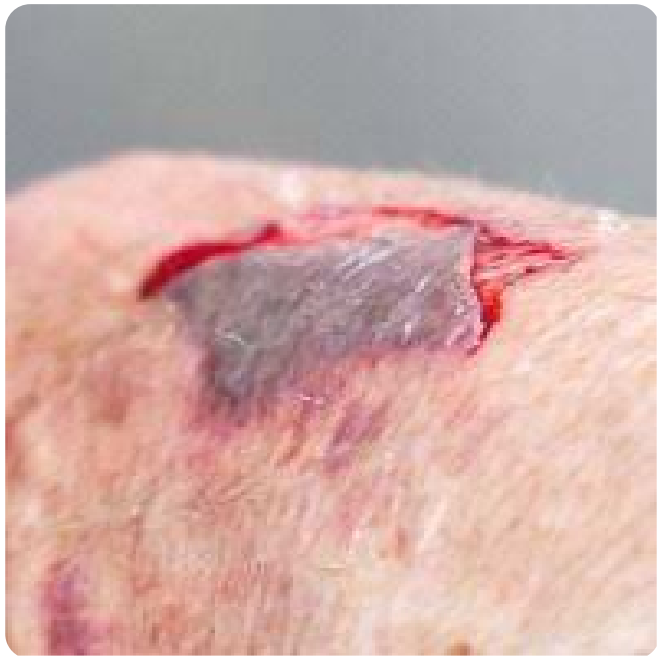




Hyperkeratotic Skin Changes

- Thickening of the outer layer of the skin. Contains a tough protective protein called keratin.
- Treatment: Cleanse with foam cleanser, pat dry. Apply LacHydrin or Resta oint BID.
- Consider Dermatology follow up after discharge





Questions ?

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