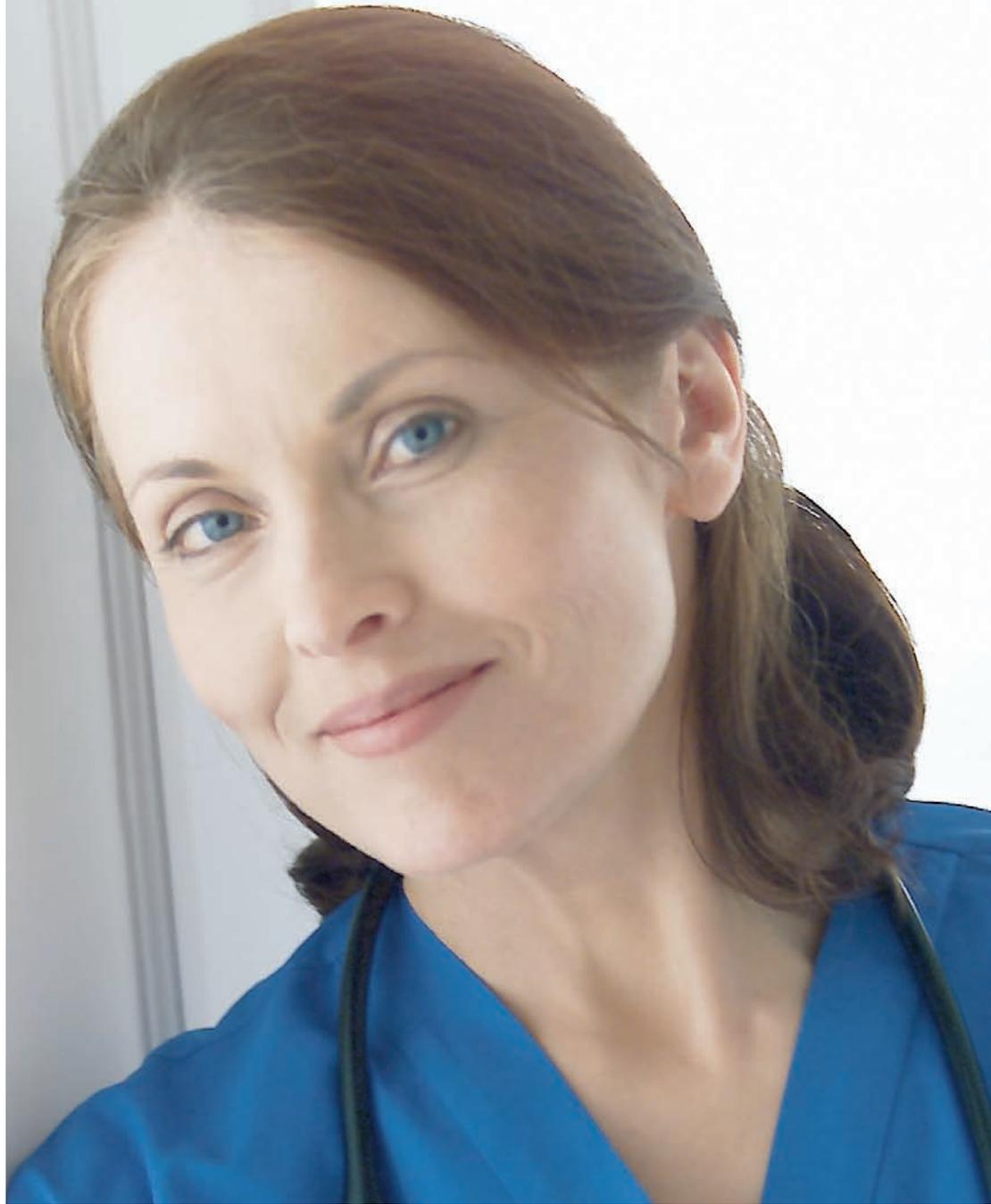


## TABLE OF CONTENTS

Urinary Incontinence Family Education	77
Skill Review Validation— Lancing for Glucose Testing	78
Monofilament Screening for Better Neuropathy Prevention	79
Monofilament Exam Instructions	81
Quality for Head of Bed Elevation	83
Pain Scales	85



# FORMS | TOOLS

This section of Healthy Skin is all about making it easier for you to do your job. It contains practical information and ideas to help you provide the best possible care for your residents while following current guidelines and standards of practice.

The charts, forms, and systems you'll find here are intended to be used. If you see something you like, feel free to tear it out and make it your own!



## Resident and Family Education

### Urinary Incontinence

*Incontinence is not a routine part of aging, despite the prevalence of incontinence in the elderly. Discovering the type of incontinence is a key to properly treating it.*

#### TYPES OF INCONTINENCE

##### **Urge Incontinence** (also called *Overactive Bladder*)

The sudden urge to urinate or the inability to reach the toilet in time is the most common type of incontinence in the elderly.

##### **Stress Incontinence**

The leakage of urine when coughing or sneezing, often due to poor muscle tone in the pelvic floor. Stress incontinence is more common in women.

##### **Overflow Incontinence**

A weak urinary stream or frequent dribbling of urine. In men, overflow incontinence is often due to an enlarged prostate.

##### **Mixed Incontinence**

This is usually a combination of urge and stress incontinence, and it is common among the elderly (especially women).

##### **Functional Incontinence**

There is no condition of the urinary tract, but some other reason such as certain medications, or inability to unfasten clothing. Getting to the root of the problem often cures this “Incontinence”.

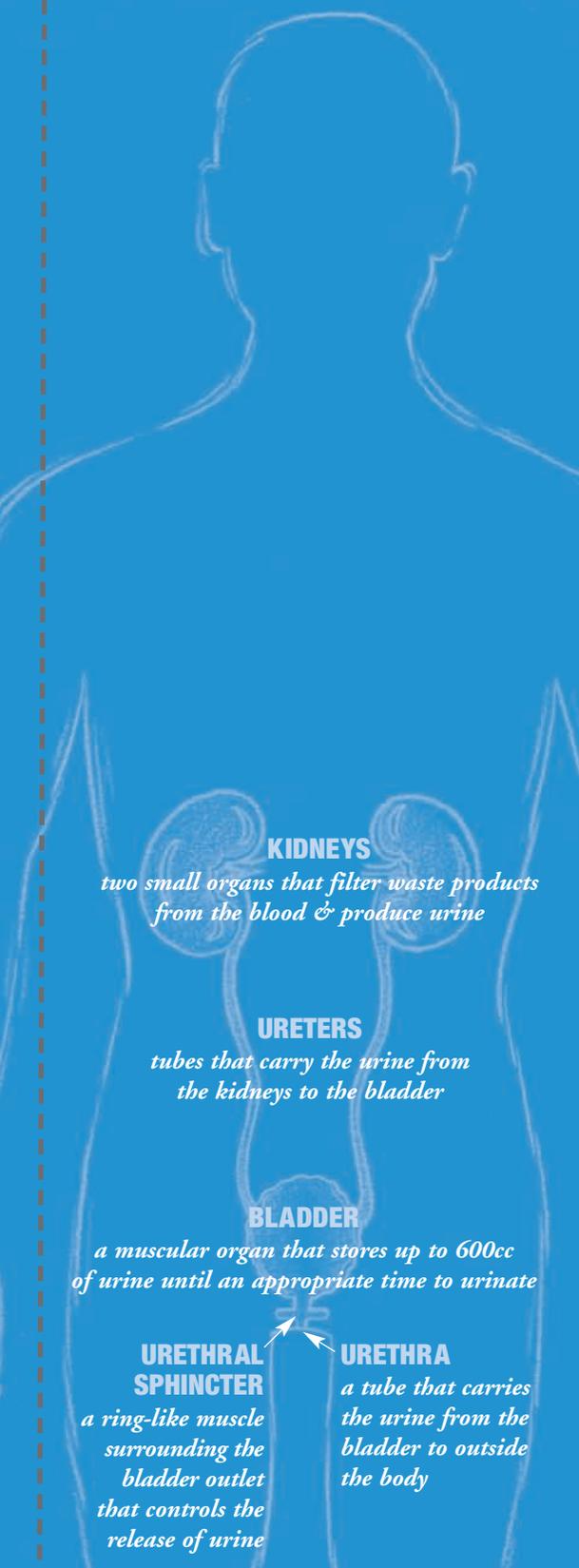
##### **Transient Incontinence**

Temporary or transient incontinence can be due to many causes, each of which has its own treatment. An example is a urinary tract infection; once the infection is resolved, so is the incontinence.

#### TREATMENT OF INCONTINENCE

To successfully treat incontinence:

- Determine the voiding pattern by keeping a diary of when the resident urinates
- Determine the type of incontinence and if it can be resolved (Functional, for example)
- Conduct a thorough assessment
  - Complete physical
  - Medical and surgical history
  - Current medications
  - Smoking and alcohol history and intake
  - Specific testing for the urinary tract
- Develop a care plan that attempts to restore as much bladder function as possible
  - Bladder training programs
  - Pelvic floor muscle exercises
  - Medications
  - Absorbent Products
- Use disposable incontinence products that are appropriate for the severity of the incontinence and the ability of the resident to use the toilet





# Skill Review Validation Form

## Lancing for glucose testing

Employee's Name \_\_\_\_\_ Date \_\_\_\_\_

Task	Reviewed Date/ Initials	Demonstrated Date/ Initials	Comments
1. Knock, identify self, wait for response, enter room			
2. Identify resident			
3. Explain the procedure to the resident			
4. Wash hands			
5. Gather necessary equipment: <ul style="list-style-type: none"><li>• lancet</li><li>• glucose meter</li><li>• testing strips</li><li>• alcohol prep</li><li>• gauze pads</li><li>• sharps container (if not mounted in room)</li></ul>			
6. Provide for privacy (pull curtain, close door)			
7. Don exam gloves			
8. Choose and prepare the selected finger (middle or ring finger, and rotate among sticks)			
9. Cleanse site with 70% isopropyl alcohol			
10. Puncture the selected finger at the side of the top of the finger			
11. Wipe away the first drop of blood			
12. Use the second drop of blood to collect the specimen			
13. Follow glucose meter manufacturer written instructions to process and read results			
14. Wipe the puncture site clean and hold pressure should excess bleeding continue			
15. Dispose of materials appropriately			
16. Document blood glucose reading and puncture site in resident's record			

Reviewer's Signature \_\_\_\_\_

# Monofilament Screening for Neuropathy

**Janet Jones, RN, BSN, PHN, ET, CWOCN, DAPWCA**

## **An Added Complication**

As if the impact of diabetes on long term care residents isn't devastating enough, neuropathy, a common complication, has proven particularly harmful. Not only is diabetes-related neuropathy the most common form, it accounts for more hospitalizations than all other diabetic complications combined.

## **A Dangerous Dilemma**

It's easy to see why screening for neuropathy is so important. But to further illustrate the problem, consider this: infections and ischemia frequently complicate neuropathy, and are the most common reasons for foot amputations. And even more shocking is that 50 percent - 70 percent of all nontraumatic amputations in the U.S. are related

to the occurrence of diabetic neuropathy with ulcers.

This is why it's vital that healthcare professionals implement programs to identify high-risk residents, including assessment and management measures for neuropathic wound prevention. And that's where monofilament screening comes in.

## **Effective Screening Tool**

Testing for protective sensation in the foot is one of the best ways to screen for neuropathy (note: sensation loss leads to callus formation, skin and nail injuries, or even skin breakdown).

You can test quickly and reliably with the Semmes-Weinstein Monofilament Exam (SWME) method. This test uses

a single, calibrated, untwisted 5.07 (10 gram) nylon monofilament (similar to strong "fishing line"), usually mounted on a plastic or cardboard holder, and is standardized to deliver a 10-gram force when pushed against an area of the foot (Pham et al., 2000).

For proper screening technique, see instructions on page 81 in the Forms & Tools Section.

## **A Beneficial Result**

Using monofilament screening to test for neuropathy can help identify the problem before it gets out of hand. And this can help to eliminate the need for drastic, life-saving measures, like foot and leg amputations. The result? A better daily existence for residents, and the hope for a better future.

**Neuropathy** is a nerve disorder that results in impaired or lost function in the tissues served by the affected nerve fibers. Peripheral neuropathy is the primary cause of diabetic foot ulcer development.



It is suggested that using the University of Texas' Subjective Peripheral Neuropathy Verbal Questionnaire, in conjunction with monofilament screening or other test, can optimize screening. It's a simple four-question evaluation:

1. Do your feet ever feel numb?
2. Do your feet ever tingle, as if electricity were traveling into your foot?
3. Do your feet ever feel as if insects were crawling on them?
4. Do your feet ever burn?



### References

1. American Diabetes Association (ADA): Consensus Development Conference on Diabetic Foot Wound Care, 7-8 April 1999, Boston, Mass. *Diabetes Care*. 1999;22(8):1354.
2. Centers for Disease Control and Prevention (CDC): National Health Interview Survey, Washington, DC: National Center for Health Statistics, 2001.
3. Pham H, Armstrong DG, Harvey C, Harkless LB, Giurini JM, Veves A. Screening techniques to identify people at high risk for diabetic foot ulceration. *Diabetes Care*. 2000;23:606-611.
4. WOCN Society: *Guideline for management of wounds in patients with lower-extremity neuropathic disease*. WOCN Clinical Practice Guideline Series #3, Glenview, IL, 2004.
5. Driver V, Lanowski MA, Madsen JL. Neuropathic Wounds: The Diabetic Wound. In: Bryant R, Nix D. *Acute & Chronic Wounds: Current Management Concepts*. 3<sup>rd</sup> ed. St. Louis, Mo: Mosby, 2007.
6. Lippincott, Williams and Wilkins, *Wound Care Made Incredibly Easy!* Ambler, PA, 2003.
7. Wunderlich, R.P., et al. "Defining Loss of Protective Sensation in the DiabeticFoot," *Advances in Wound Care* 11(3):123-28, May-June 1998.
8. Ayello E, Baranoski, S. *Wound Care Essentials Practice Principles*. Ambler, PA, 2004.

## SUDOKU Answers

O	I	T	E	D	U	N	C	A
U	E	C	N	T	A	O	I	D
D	N	A	O	C	I	U	T	E
I	T	O	U	E	N	A	D	C
E	D	U	C	A	T	I	O	N
C	A	N	D	I	O	T	E	U
N	C	I	A	O	E	D	U	T
T	U	E	I	N	D	C	A	O
A	O	D	T	U	C	E	N	I

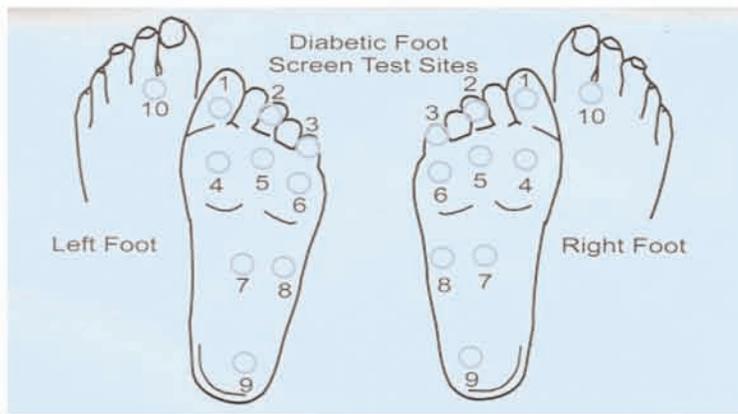
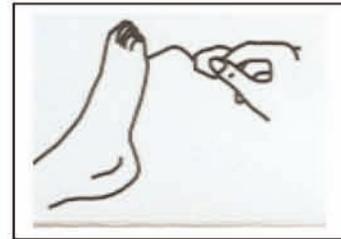
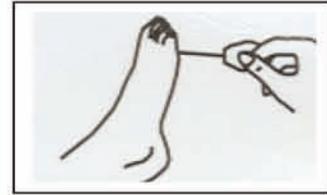
# Monofilament Exam Instructions

Resident \_\_\_\_\_ Room # \_\_\_\_\_

## Instructions

### **Procedure:** Semmes-Weinstein 5.07 (10 gram) Monofilament Examination (SWME)

1. Explain procedure to the patient.
2. Position the patient in a comfortable position, for ease of performing the exam.
3. Demonstrate the use of the monofilament on the patient's hand so that he or she will know what to expect.
4. Hold the probe by the plastic or cardboard "handle."
5. Apply the monofilament perpendicular to the skin. Apply sufficient force to cause the mono filament to buckle or bend, using a smooth, not jabbing, motion.
6. Ask the patient to respond with a "yes" each time he or she feels the monofilament touching the skin.
7. Touch the monofilament to the appropriate areas as indicated on the monofilament documentation form. (see below)
8. Apply the monofilament along the margin of a callus, ulcer, scar, or necrotic tissue; do NOT apply the monofilament over these lesions.
9. Record the results on the documentation form. Document by filling in the circle (●) if the patient felt the monofilament, and an "X" in the circle, if there is no sensation.



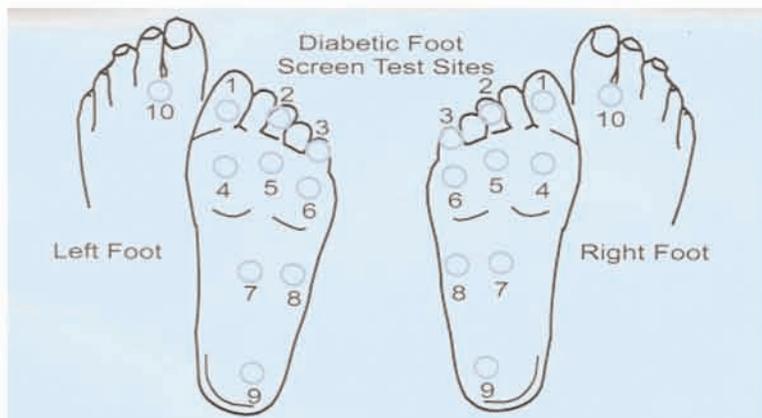
Date: \_\_\_\_\_

Assessed by: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Date: \_\_\_\_\_

Assessed by: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Quality Improvement for HEAD OF BED ELEVATION

Quality improvement is a key to success in today's health care setting. It's important to have a system in place to ensure that quality improvement programs are actually being implemented, and that you're monitoring for compliance, especially when it comes to pressure-related issues for bed bound residents.

Skin breakdown caused by unrelieved pressure is a critical concern in the health care community. Improper treatment or inadequate prevention measures can lead to large monetary fines, the cessation of government funding, denial by intermediaries of submitted claims, health care institution closures, and other punitive actions. Not to mention the affect it has on residents' quality of life.

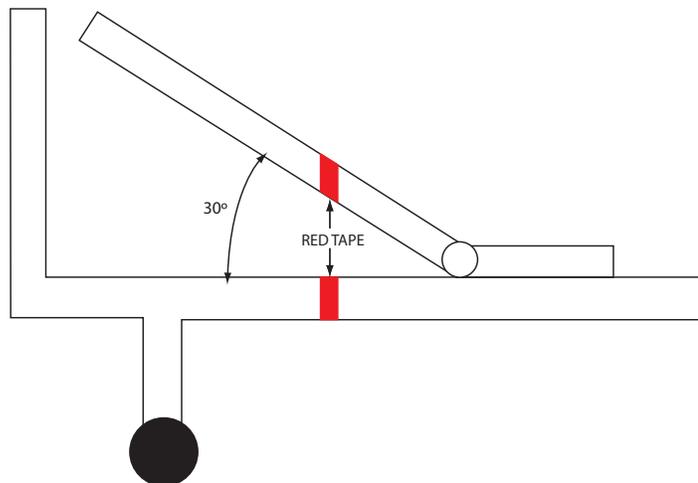
## A Challenging Issue

All bed bound residents are at risk for shearing damage. By keeping the head of the bed below a 30 degree angle, pressure is distributed more evenly over the body's surface and the sliding movement that leads to shearing is reduced.

There are those who require that the head of their beds be elevated to 30 degrees or greater (e.g. tube feeders and those with respiratory complications). These residents provide a greater challenge. But the bottom line is that any head of bed elevation greater than 30 degrees increases the risk of skin breakdown.

## A Helpful Program

So, how much of an angle is 30 degrees? And how can staff easily assess whether a resident's bed is actually elevated to 30 degrees? The good news is that there is a program your facility can adopt to allow staff to quickly and easily assess for



elevation compliance, with minimal disruption to residents.

The program is simple to implement. First, ask engineering to elevate the head of each bed to a 30 degree angle. Then ask them to use red tape (or you can use red nail polish) to mark two vertical lines, one on the stationary portion of the bed frame and one immediately above it on the part of the bed frame that elevates the head, so that when the bed is elevated at a 30 degree angle both red marks line up. And if the head of the bed is at an angle greater than 30 degrees, the red marks won't line up – alerting you that a resident is at risk for shear damage and skin breakdown.

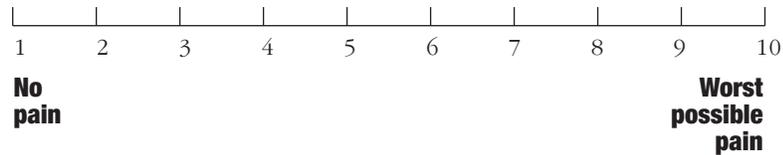
## A Beneficial Result

Following this program will help staff members quickly determine if a resident requiring 30 degree head elevation is properly elevated – just by observing the position of the red marks. It makes it easier for your facility to ensure that quality improvement measures are followed, and it makes life better for residents who need to be elevated.

# PAIN SCALES

Three common scales you can use to help residents more accurately communicate the level of pain they are in.

## Numeric Pain Intensity Scale



1. Ask resident to point to the number on the scale that represents their pain
2. Document the number the residents indicate

## Wong-Baker Faces Pain Rating Scale



1. Ask resident to point to the face on the scale that represents their pain
2. Document the number corresponding to the face the resident points to

## Visual Analog Scale



1. Ask the resident to put a mark on the line at the point that best describes his/her pain
2. To document, measure the location of the mark from left to right

Helpful Web site: [www.painconsortium.nih.gov](http://www.painconsortium.nih.gov)