The Case of the Hoyer Lift That Was Not Disinfected

Improving Skin Care and MDRO Prevention in Long-Term Care

The Case

A 46-year-old male resident is scheduled to be turned and repositioned. The resident is at risk for pressure injuries due to a spinal cord injury that left him with limited mobility in his arms and no use of his legs.

The Challenge

The resident is completely immobile and is therefore unable to assist with turning and repositioning. The resident requests that he be moved from the bed to the chair. The certified nursing assistant (CNA) must use a Hoyer lift to assist the transfer.

The Error

Unfortunately, the CNA doesn't realize that the Hoyer lift was not disinfected after its previous use on a resident with a MRSA-infected wound. Once in the Hoyer lift, the resident slides down the material of the chair, leading to significant shearing and friction. During the transfer, the resident's leg falls out of the sling, resulting in a small skin tear. The CNA doesn't notice the skin tear, nor do they realize that the resident's sheets have bunched up underneath him, putting pressure on his sacral region. The resident is left sitting on the sheets until his next transfer. This one transfer leads to a MRSA infection in the resident's skin tear and a stage 1 pressure ulcer in the sacral region, which goes unchecked during the next skin assessment.

Knowledge Check Questions

1. How can we prevent shearing and friction during resident transfers?

A. Use an assist of at least two people when transferring or repositioning all immobile residents.
B. Use draw sheets and slide sheets to reduce the risk of shearing and friction during transfers and repositioning.
C. Ensure proper placement of lift devices under residents to reduce the risk of injury during transfers and repositioning.
D. All of the above.

2. Who is responsible for assessing and reporting abnormalities in resident skin?

A. A Registered Nurse (RN)
B. A Licensed Practical Nurse (LPN)
C. A CNA
D. Everyone

Rationale for Each Answer

Rationale for question 1

Friction and shearing are mechanical forces that increase the risk of pressure ulcers developing. These two separate phenomena work together to create tissue ischemia and injury, which results in pressure ulcer formation.

Rationale for question 2

Everyone is responsible for observing resident skin, regardless of who is assigned to complete resident skin assessments. When abnormalities in skin are noticed, everyone should take quick action to appropriately report the observation so that interventions can take place to reduce the risk of pressure injury and other skin-related injuries and infections.

Answers to the Knowledge Check: 1=D; 2=D

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