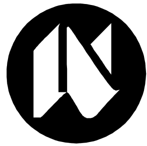

North Memorial Health Care

PROTOCOL
PRESSURE ULCER PREVENTION
Effective Date: June 24, 2005

Number: PROT0082	**Issuing Department:** PATIENT CARE SERVICES		**Supersedes:** 4/04
Submitted by: WOC	**Approved By:** (Signature on file)	**Date:** 06/2005	

Reviewed by:	**Date:**		
Wound, Ostomy Continence Nursing Service	**4/05**		
Pt Care Practice & Outcomes	**5/05**		

TITLE: Pressure Ulcer Prevention.

PERSONNEL: All accountable for patient care.

PATIENT OUTCOME:
1. Maintenance of intact skin in the patient who is at risk for breakdown.
2. Patient/caregivers verbalize knowledge of pressure ulcer risk factors, assessment, prevention and early treatment.

SUPPORTIVE DATA:
* 1. Repositioning includes small shifts of weight (e.g., shifting patient using reusable underpad to change pressure points, adjusting pillows, lowering head of bed, adjusting tilt, etc.)
2. North Memorial Nursing Philosophy, Caring Framework, and Cultural Caring Policy and Procedure
* 3. General Nursing Standards Protocol
4. Incontinence, Urinary/Fecal, Protocol
5. Specialty Beds Policy and Procedure
6. Trauma Bed Protocol
* 7. Pressure Ulcer Treatment Protocol

High Risk Diagnoses:
- Peripheral Vascular Disease
- Myocardial Infarction
- Stroke
- Multiple Trauma
- Musculoskeletal disorders/Fractures
- GI Bleed
- Spinal Cord Injury
- Paraplegia
- Neurological disorders (e.g., Guillain Barré, Multiple Sclerosis)
- Those with unstable and/or chronic medical conditions (e.g., diabetes, renal disease, cancer)
- *History of previous pressure ulcer
- Preterm neonates

Factors That Contribute To Pressure Ulcer Development:
- Age greater than 75
- Existing pressure ulcer
- Immobility
- Those having a procedure which immobilizes them for greater than one hour
- *Bed linen
- Devices (e.g., oxygen tubing, splints, TEDs stockings)
- *Sedation
- Sensory deficits
- Nutritional deficits/Weight loss
- *Excessive exposure to moisture (e.g., incontinence, excessive perspiration, wound drainage)
- Those exposed to friction and shearing

Early and ongoing assessment of patients at risk for skin breakdown is essential. Prevention involves not only identification of patients at risk but also a detailed plan of interventions which address and minimize the effects of each risk factor.

ASSESSMENT/EVALUATION	**INTERVENTIONS/KEY POINTS**
NURSING DIAGNOSIS: Potential alteration in skin integrity.	
*1. Identify patients at risk for developing a pressure ulcer upon admission and daily for at risk patients or with any change in condition.	*1. a. Refer to Risk Assessment/Screening portion of database. Determine an adult patient's risk for developing a pressure ulcer by using the Braden Risk Assessment. 1). A patient is considered at risk if their Braden score is: 15 – 18 = Mild risk 13 – 14 = Moderate risk 10 – 12 = High risk 9 or below = Very High risk 2) Advance your patient to the next risk level in the presence of: a) age over 75 b) chronic illness c) hemodynamic instability (e.g., diastolic blood pressure less than 60 mmHg). * b. Utilize the Nursing Care Plan to individualize specific prevention interventions. * c. Initiate Pressure Ulcer Treatment Protocol at the first sign of skin breakdown. d. Consult WOC nurse when current plan of care does not meet the needs of the patient.
2. Assess specific vulnerable pressure points. a. Supine: occiput, sacrum, heels b. Sitting: ischial tuberosities, coccyx c. Side-lying position: trochanters d. Reddened areas which do not fade within 30 minutes e. Dusky or cyanotic areas f. Under devices (i.e., TEDs, pneumoboots, splints, collars, tubing)	2. Inspect the skin at least every 8 hours. a. Avoid vigorous massage over bony prominences …"can injure soft tissue and capillaries" (AHCPR, 1992) b. Patients with dark pigmentation will demonstrate a cyanotic area, warmth or complain of pain over the bony prominence.

ASSESSMENT/EVALUATION	INTERVENTIONS/KEY POINTS
3. Assess skin for exposure to moisture from incontinence, wound drainage or perspiration.	3. Cleanse and dry skin at routine intervals and at the time of soiling using a low residue soap. a. Initiate the Incontinence Protocol in the incontinent patient. b. Moisturize dry skin with lotion.
4. a. Assess mobility and activity status.	4. a. 1) Maintain or increase patient's level of activity, mobility and range of motion unless contraindicated. 2) Schedule regular and frequent turning and repositioning (see definition under supportive data) at least every 2 hours (e.g., alternating supine, left lateral and right lateral positions). 3) Individualize to the patient's needs based on risk and level of mobility. 4) Refer to algorithm in the Specialty Bed/Support Surfaces Policy and Procedure when patient is immobile and/or in bed with head of bed less than 30° to determine if additional pressure reduction is necessary.
b. Identify sitting status.	b. For sitting position in bed (head of bed greater than 30°), cardiac chair or wheelchair: 1) Assist/instruct patient to shift weight at least every 15 minutes. 2) Reposition at least every 30 minutes if patient cannot independently perform pressure relief exercises every 15 minutes. 3) Consult PT/OT for assistance in seating, positioning, and wheelchair cushion options.
5. Assess nutritional status.	5. Due to increased protein needs for healing, consult Nutrition Services for a nutritional assessment and plan at the earliest sign of skin breakdown.

ASSESSMENT/EVALUATION

6. Identify factors which increase shearing, friction and/or pressure.
   a. Shearing: Tissue layers sliding against each other; e.g., sliding down in bed.
   b. Friction: Skin rubbing against other surfaces; e.g., elbows and heels rubbing against sheets.
   c. Pressure/Friction: e.g., heels resting on mattress, devices such as oxygen tubing, cervical collars, casts.

7. Assess patient/family knowledge of pressure ulcer prevention, risk factors and early treatment.

INTERVENTIONS/KEY POINTS

6. a. 1) Keep head of bed less than 30° unless contraindicated.
      2) Promote proper positioning, transferring and turning techniques.
   b. 1) Use reusable underpad, trapeze or lift sheet to lift, not drag, patient.
      2) Utilize pillows or positioning devices to prevent skin surfaces from rubbing together.
   c. 1) The immobilized patient should have heels suspended off bed by using pillows or heel suspension boots, available in dispensing.
      2) Heel and elbow protectors are best used for reducing friction and should not be used for pressure reduction.
      3) Pad devices when it is not contraindicated.

7. a. Teach patient/family about the causes and risk factors for pressure ulcer development and ways to minimize risk.
   b. The patient or caregiver, or both, should understand the importance of the following:
      1) Conduct regular inspection of skin over bony prominences. (Individuals can use a mirror if necessary to inspect their own skin.)
      2) Follow appropriate skin-care regimens.
      3) Use measures to reduce friction/shearing.
      4) Avoid vigorous massage of bony prominences or reddened area.
      5) Include routine turning, repositioning, and the use of pressure-reducing devices if patient is confined to bed and/or chair.
      6) Avoid use of donut-type devices.

ASSESSMENT/EVALUATION

INTERVENTIONS/KEY POINTS

7) Maintain adequate nutrition and fluid intake and monitoring for weight loss, poor appetite, or gastrointestinal changes that interfere with eating.
8) Program for bowel and bladder management.
9) Promptly report healthcare changes and nutritional problems to healthcare providers.

REFERENCES:

Bryant, R. (2000). *Acute and Chronic Wounds* (2nd ed.). St. Louis: (5sp) Mosby.

Frantz, R.A. (2004). Evidence-based protocol: Prevention of pressure ulcers. *Journal of Gerontological Nursing, 30*(2), 4-11.

Hobbs, B.K. (2004). Reducing the incidence of pressure ulcers: Implementation of a turn-team nursing program. *Journal of Gerontological Nursing, 30*(11), 46-51.

Makelbust, J., and Sieggreen, M. (2001). *Pressure ulcers: Guidelines for prevention and management* (3rd ed.). Pennsylvania: Springhouse.

Wound, Ostomy and Continence Nurses Society. (2003). *Guidelines for the prevention and management of pressure ulcers.* Glenview, IL

U.S. Department of Health and Human Services. (1992). *Pressure ulcers in adults: Prediction and prevention clinical practice guideline.*