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Wound, Ostomy Continence	8/08	
Nursing Service		
Pt Care Practice & Outcomes	9/08	

PERSONNEL: All accountable for patient care.

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

- SUPPORTIVE DATA:
- 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.)
 - North Memorial Nursing Philosophy, Caring Framework, and Cultural Caring
 - General Nursing Standards Protocol
 - Incontinence, Urinary/Fecal, Protocol
 - Specialty Beds Policy and Procedure
 - Trauma Bed Protocol
 - Pressure Ulcer Treatment Protocol
 - Preventing Pressure Ulcers Patient and Family Information
 - * Cervical Collar Hard 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 years
- Existing pressure ulcer
- Immobility
- Procedure which immobilizes patient for greater than one hour
- Devices (e.g., oxygen tubing, splints, TED stockings, pneumo boots)
- Sedation
- Sensory deficits
- Nutritional deficits/Weight loss
- Excessive exposure to moisture (e.g., incontinence, excessive perspiration, wound drainage)
- Those exposed to friction and shearing

*Indicates change

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 Clinical Flowsheet, Braden Scale in electronic medical record (EHR). 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 Zynx Plan of Care: Pressure Ulcer - Risk of
 - * c. Initiate Pressure Ulcer Protocol when skin integrity is impaired.
 - * d. Consult WOC nurse when patient identified at very high/high risk, i.e., Braden Score less than 12.
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, pneumoboosts, splints, collars, tubing)
2. Inspect the skin at least every 8 hours.
 - a. Avoid vigorous massage over bony prominences.
 - b. Patients with dark pigmentation will demonstrate a cyanotic area, warmth or complain of pain over the bony prominence.
 - * c. Remove TEDs, pneumo boots, splints collars every shift, evaluate skin and document; (see protocol Cervical Collar, Hard).

*Indicates change

ASSESSMENT/EVALUATION

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

INTERVENTIONS/KEY POINTS

7.
 - 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.
8.
 - a. Teach patient/family about the causes and risk factors for pressure ulcer development and ways to minimize risk. Provide Preventing Pressure Ulcers Patient and Family Information handout. Provide patient info, preventing pressure ulcers via patient care standards.
 - 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.

*Indicates change

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.

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- Frantz, R.A. (2004). Evidence-based protocol: Prevention of pressure ulcers. *Journal of Gerontological Nursing*, 30(2), 4-11.
- Griffin, B., Cooper, H., Horak, C. (2007). Best-practice protocols: Reducing harm from pressure ulcers. *Nursing Management*, 38 (9), 29-32.
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Attachment A:
Pressure Ulcer Prevention Algorithm and Strategies

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