POLICY TITLE: Pressure Ulcer Prevention and Managing Skin Integrity

POLICY:

- Nursing, in collaboration with the health care team, will assess and manage skin integrity for all patients throughout the hospital stay. Patients and families are to be encouraged by care providers to participate to the extent possible in the care and prevention of skin breakdown.
- Risk for pressure ulcer development will be evaluated upon admission to a nursing unit and on a routine basis for all adult and pediatric patients using the Braden Scale (adult) or the Braden Q (pediatric) Scales. Risk assessments (Braden scores) will be done more often when the patient condition warrants more frequent assessment.
- Skin inspections will be completed on admission and daily for all hospital patients.
- Any patient with a Braden score < 12 or when nursing assessments indicate a patient need, skin inspections will be done every 8 hours.

PURPOSE:

- To maintain the integrity of patients’ skin, a significant factor in health.
- To minimize the risks and prevent the occurrence of skin breakdown.
- To provide for early detection and intervention of all breakdown evident upon admission to the hospital.
- To promote prompt evaluation and intervention of any changes in skin integrity during the hospital stay.

OPERATIONAL DEFINITIONS

- Risk assessment: identification of the potential risk that a patient will develop skin breakdown as the result of pressure to a bony prominence or body part impacted by equipment.
- Skin Inspection: the head to toe evaluation of bony prominences and skin folds / creases when prolonged pressure may result in skin breakdown.
- Interventions: the steps taken by care providers to increase monitoring, reduce or alleviate pressure, redistribute weight, and / or eliminate friction and sheer to mitigate or eliminate the risk of skin breakdown.

PROCESS:

I. Risk Assessment
   A. Admission to the nursing unit:
      - Findings will be documented on the appropriate documentation form or screen in computerized areas. Pressure reduction interventions, based on the patient’s Braden assessment, will be implemented by nursing and documented in the patient’s medical record. 1. The RN completing the baseline admission assessment will perform a pressure ulcer risk assessment on all adults and pediatric patients for the risk for pressure ulcer development by using the:
         2. Braden Scale for Predicting Pressure Sore Risk tool for adults
         3. Braden Q for the pediatric population

II. Skin Inspection
   A. On Admission and daily:
      - The nurse (RN/LPN) completing the admission of a patient to the hospital will inspect all of the skin on the patient.
A. The focus of the examination will be on the skin over the bony prominences and in skin fold/creases. Findings will be documented in the patient medical record (paper or electronic). Skin care interventions will be implemented when appropriate and documented on the appropriate form.

B. Communication to the provider and other caregivers of a skin breakdown is essential. The WOC nurse will be consulted as needed based on patient’s skin condition and provider order.

C. If a patient refuses a full skin inspection, the patient’s refusal must be documented along with the skin areas not examined.

D. High risk patients (patients with a Braden < 12) will have skin inspections completed every shift.

B. Re-evaluation:

- **Acute Care Medical/Surgical and ICU Population**: Daily
- **Mental Health Units**: Daily, only if admission Braden is less than 19
  - Deterioration of medical status
- **Maternity Care Units**: Daily, only if admission Braden is less than 19
  - Deterioration of medical status
- **Bethesda Hospital**: Twice a week

C. Role of the NA/PCA:

- While providing routine care, the NA/PCA is to monitor the skin condition of a patient. (“Monitoring the skin” means “keeping track” or “watching”.)
- When observing an abnormal condition, the NA/PCA will notify the RN assigned to the patient so the RN can perform a thorough assessment of the condition.
- The NA/PCA will follow-through with the skin care interventions implemented for prevention and treatment of skin breakdown.

III Interventions

A. Plan of Care

- In developing a plan of care the following will be considered:
  - Patient History (previous incidence of pressure ulcer?)
    - Cognitive changes or impairment of the patient
    - Current state of skin integrity and personal hygiene practices of the patient that impact skin health
    - Any cultural practices that impact the health or integrity of the skin
    - Risk for pressure ulcer development
- Plans for the maintenance of skin integrity will include the patient and family whenever possible and may include, but are not limited to the following:
  - Daily inspections, cleansing, and moisture management as needed
  - Patient movement and activity focused on pressure redistribution of bony prominences that may result in skin breakdown
  - Recognition of early signs of skin breakdown with prompt interventions to minimize tissue damage
Identification of risk factors present or acquired that compromise skin integrity, i.e. medication, nutritional status, age, cultural practices, traumatic wounds, surgical wounds, etc.

Communication of skin care concerns so the entire healthcare team can implement interventions

Physical agents that may improve the overall integrity of the skin such as protective creams, barriers, coverings, pressure reduction devices, etc.

B. Care and interventions

- The care and intervention for any identified skin breakdown or wound will be aimed at:
  - Prevention of any further advancement of the wound, or additional skin breakdown
  - Implementation of appropriate evidence-based care indicated for the problem identified – **Note:** See Tissue Integrity Resources.
  - Collaboration with the interdependent and interdisciplinary health care teams regarding the presence of breakdown and the intervention plan
  - Close monitoring of the response to treatment
  - Referral to additional resources when indicated – Wound Care Specialist (NP or WOC), Registered Dietician, Physical Therapist, Occupational Therapist

C. Evaluation of the plan of care will include:

- Provisions for changes in the plan if progress toward expected outcomes are not evident
- Patient ability/willingness to maintain compliance with the plan
- Review during care management rounds if indicated
- Clear communication of progress to the rest of the health care team

D. Documentation

- Skin Integrity and/or conditions affecting the patient’s skin must be documented according to established procedures.
- The presence of skin breakdown/abnormal skin appearance, i.e. abrasion, blister, bruising - due to pressure, burn, denuded, erythema, hematoma, laceration, rash, skin tear and wound, will be documented upon admission and daily.
- Upon identification of a wound, a full wound assessment, including its location, size, and description of the tissue involved, will be completed.
- Interventions and progress toward outcome focused goals need regular documentation according to established procedures.
- Specific documentation that must be complete include:
  - Admission Data Base
  - Daily Skin Inspection
  - Pressure Ulcer Risk Evaluation Using the Braden Scale
  - Wound Assessment

References:

- WOCN Clinical Practice Guideline: Prevention and Management of Pressure Ulcers

Unit and Department Communication:

- All Direct Caregivers