POLICY TITLE: PRESSURE ULCER PREVENTION

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EFFECTIVE DATE:

MISSION STATEMENT: St. Luke Healthcare is committed to the prevention of pressure ulcers. Prevention includes not only identification of patients at risk but also a detailed plan of care.

PURPOSE: To provide a standardized approach to the prevention of pressure ulcers.

POLICY DISTRIBUTION: ACF, EMERGENCY DEPARTMENT

POLICY:

1. The level of risk for the development of pressure ulcers will be based on the Braden Scale for all patients.
2. The RN will complete a Braden Skin Assessment on admission and every shift.
3. The MD will be notified of all pressure ulcers identified and the Pressure Ulcer on Admission Orders will be initiated. Further orders will be implemented as ordered.

PROCEDURE:

A. Perform Braden Risk Assessment by assessing the following factors:

1. Sensory Perception
2. Moisture
3. Activity (the ability to ambulate)
4. Mobility(the ability to turn in bed)
5. Nutrition
6. Skin temperature
7. Skin color
8. Skin turgor
9. Skin integrity

B. Assign a numerical value from the scale to represent the patient's status in each category. Total the numerical values for each category to determine the total Braden Score.

C. Based on the Braden Score and the condition of the skin, the nurse selects the appropriate skin care prevention and/or treatment.

D. If the Braden Score is greater than or equal to 18, Universal Skin Care Practices are implemented as follows:

UNIVERSAL SKIN CARE PRACTICES

1. Use moisturizing products on dry skin.

2. For incontinent patients, use absorbent underpads/adult diapers. Limit the use of diapers whenever possible. Cleanse skin immediately after soiling and use moisture barrier products as needed on skin exposed to urine, stool, or moisture.

3. Reposition patient who is unable to effectively or adequately reposition himself frequently unless contraindicated by patients condition. (Usual interval for repositioning is every two hours while in bed, but positioning schedule will be individualized for the patient). Avoid positioning on areas of existing pressure ulcers. Do not elevate head of bed more than 30 degrees (Rule of 30's) except when medically necessary or at mealtime.

E. If the Braden score is less than 18, "At Risk" Skin Care Practices are implemented as follows:

AT RISK SKIN CARE PRACTICES

1. Continue Universal Skin Care Practices.

2. On admission, a Nutritional consult will be made for patients with prealbumin less than 10mg/dl or less than 15mg/dl if the patient has pressure ulcers. The nurse will consult the nutritionist for patients who develop pressure ulcers after admission to St. Luke's.

3. The Nutritionist will assess all patients with a length of stay of five days or more.

4. The nursing staff will monitor the patient's oral intake, offer supplements per standing order and consult the Nutritionist as needed.

5. Assure appropriate pressure redistribution sleep surfaces and other devices such as chair cushions or heel protectors are available and in use as needed.

6. May apply skin sealant such as Nutrashield Protective Barrier to friction prone areas such as elbows as needed.

7. Staff will provide pressure ulcer prevention education for patient and/or significant other.

AGE SPECIFIC CONSIDERATIONS:

These guidelines are intended for use in all patients. The physician may also be consulted for special needs of a pediatric patient.

Recording and Documentation:

The nurse will document in the medical record the Braden Score upon admission and every shift, skin assessments completed upon admission and every shift, pressure ulcer assessment initially on admission and then weekly, the treatment of these areas, positioning, and pressure ulcer prevention education and evidence of learning.