Prevention of Pressure Ulcers

Purpose
The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors.

Preparation
1. Review the resident’s care plan to assess for any special needs of the resident.
2. See policy and procedure for specific task, such as bathing, incontinence care, repositioning.

General Guidelines
1. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue.
2. The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes.
3. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected.
4. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident’s skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident’s physical and/or mental condition.
5. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident.
6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed.

Interventions and Preventive Measures: General

General Preventive Measures
1. Identify risk factors for pressure ulcer development (see procedure entitled Pressure Ulcer Risk Assessment) at admit, quarterly and any changes in status.
2. For a person in bed:
   a. Change position at least every two hours or more frequently if needed;
   b. Determine if resident needs a special mattress;
   c. If a special mattress is needed, use one that contains foam, air, gel, or water, as indicated;
   d. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments and medical necessity.
3. For a person in a chair:
   a. Change position at least every hour;
   b. Use foam, gel or air cushion as indicated to relieve pressure.
4. When repositioning, reduce friction and shear by lifting (using appropriate lifting technique and equipment) rather than dragging.
5. Do not use donut-shaped cushions.
6. Refer resident to a rehabilitation program, or a restorative nursing program, as indicated.
7. Encourage the resident to participate in active and passive range of motion exercises to improve circulation.

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Interventions and Preventive Measures: General (continued)

8. Ensure that the resident drinks plenty of fluids and eats a well-balanced diet.
9. Routinely assess and document the condition of the resident’s skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.
10. Immediately report any signs of a developing pressure ulcer to the supervisor.
11. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

Interventions and Preventive Measures: Residents with Risk Factors

1. Risk Factor – Moisture
   a. Use a moisture barrier.
   b. Use absorbent pad or adult briefs.
   c. Provide clean, unwrinkled sheets.
   d. Place resident on a minimum of a q 2 hour check and change program.
   e. Provide personal hygiene care/bath (teach staff to avoid leaving soap residue) to remove perspiration, bacteria and promote comfort. Frequency will be dictated both by facility routine and resident need. A resident who perspires profusely may need to receive more frequent care.
   f. Address causes of moisture if possible (e.g., bladder training, scheduled toileting).

2. Risk Factor – Friction and Shear
   a. Use an overhead trapeze if indicated.
   b. Allow resident to use a side rail as an enabler if indicated.
   c. Use a draw sheet to assist in moving resident from side to side and up in the bed.
   d. Provide a sitting support surface that does not cause the resident to slide.
   e. Use a draw sheet or other mechanical device for lifting.
   f. Avoid placing resident on tubing (e.g., catheter should not be placed under the resident’s leg). Nasal oxygen may need to be monitored for pressure to the ears.
   g. Monitor the placement of splints and casts to assure they are not placing friction on the resident’s skin.
   h. Positioning devices (e.g., pommel cushions) must be monitored to assure pressure is not being placed on the labia/scrotum.
   i. Shoes need to be monitored for proper fit to avoid development of blisters, corns and calloused areas.
   j. Contractures need to be addressed and managed to prevent skin integrity disruption.
   k. Skin to skin contact needs to be avoided by placement of pillows, folded sheets or clothing.
   l. Use a mechanical lift for residents who may be at risk of experiencing shearing during transfer.
   m. Protect bony prominences as needed.

3. Risk Factor – Bed-fast
   a. Change position at least every two hours and more frequently as needed.
   b. Use a special mattress that contains foam, air, gel, or water, as indicated.
   c. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments and medical necessity.
   d. Consider off-loading pressure hourly if the head of the bed is greater than 30 degrees (e.g., for residents with tube feeding or respiratory issues).
   e. Unless resident has both sacral and ischial pressure ulcers, avoid placing directly on the greater trochanter for more than momentary placement.

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4. Risk Factor – Chair-fast
   a. Postural alignment, weight distribution, sitting balance and stability should be evaluated.
   b. Residents who are able to cooperate and understand should be taught to shift weight every 15 minutes while sitting in a chair.
   c. Change position at least q 1 hour.
   d. Avoid use of wheelchairs with sling seats for prolonged periods. Consider the need for pressure relief/reducing device.
   e. Change position at least every hour and use foam, gel or air cushion as indicated to relieve pressure.
   f. When repositioning, reduce friction and shear by lifting (using appropriate lifting technique and equipment) rather than dragging.
   g. Do not use donut-shaped cushions.
   h. Refer resident to rehabilitation and/or a restorative nursing program as indicated. Coordinate care and services to encourage participation.

5. Risk Factor – Immobility
   a. See bed-fast and chair-fast.
   b. Use pillows or wedges to keep bony prominences such as knees or ankles from touching each other. Do not massage bony prominences.
   c. When in bed, every attempt should be made to “float heels” (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician.
   d. Refer resident for a therapy evaluation and/or restorative nursing program (may include range of motion, transfer and ambulation programs).

6. Risk Factor – Bowel/Bladder Incontinence
   a. Check resident for incontinence at least q 2 hours and clean skin when soiled.
   b. Assess and treat urine leaks.
   c. If moisture cannot be controlled use absorbent pads and/or briefs with a quick-drying surface and protect skin with moisture barrier.

7. Risk Factor – Poor Nutrition
   a. Dietitian will assess nutrition and hydration and make recommendations based on the individual resident’s assessment.
   b. Monitor nutrition and hydration status.
   c. Monitor laboratory values, notify physician when appropriate.
   d. Encourage proper dietary and fluid intake.
   e. If a normal diet is not possible, talk to physician about supplements.
   f. Administer vitamins, mineral and protein supplements in accordance with physician orders and dietitian recommendations.
   g. Refer resident to a dentist if needed.

8. Risk Factor – Lowered Mental Awareness
   a. Choose preventive actions appropriate to individual risk factors and adjust for cognitive impairment of the resident. For example, if the person is chair-fast, refer to the specific interventions for that risk factor, adjusting for any limitations in resident’s understanding of instructions or ability to participate in preventive actions.

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Additional Factors That Indicate Residents at Risk

The following are additional clinical conditions, treatments, and abnormal lab values that indicate that a resident is at risk for pressure ulcers:
1. Impaired/decreased mobility and decreased functional ability;
2. Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus;
3. Drugs such as steroids that may affect wound healing;
4. Impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
5. Resident refusal of some aspects of care and treatment;
6. Cognitive impairment;
7. Exposure of skin to urinary and fecal incontinence;
8. Undernutrition, malnutrition, and hydration deficits; and
9. A healed ulcer. The history of a healed pressure ulcer and its stage (if known) is important, since areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown.

Equipment and Supplies

The following equipment and supplies will be necessary when providing preventive skin care.
1. Tools for assessing skin and pressure ulcer risk:
   a. Pressure ulcer risk assessment form.
   b. Resident’s medical record, including admission assessment and MDS.
   c. Skin assessment form.
2. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Wash and dry your hands thoroughly.
2. Loosen and remove the bed covers as needed. Avoid unnecessary exposure of the resident’s body.
3. Don gloves and personal protective equipment, as indicated.
4. If the resident is incontinent, clean the resident of urine and/or feces as necessary.
5. Assess the resident’s skin, according to facility protocol.
6. Assess the resident for factors that increase the risk of developing pressure ulcers.
7. For residents with risk factors, implement preventive measures as indicated.
8. Position the resident in a comfortable position. Use supportive devices as instructed.
9. Reposition the top covers. Leave the bed covers loose so that air can circulate to all parts of the body.
10. Place the call light within easy reach of the resident.
11. Wash and dry your hands thoroughly.
12. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

Documentation

The following information should be recorded in the resident’s medical record:
1. The type of skin care given.
2. The date and time skin care was given.
3. The position in which the resident was placed.
4. The name and title of the individual who gave the care.
5. Any change in the resident’s condition.
6. The condition of the resident’s skin (i.e., the size and location of any red or tender areas).
7. How the resident tolerated the procedure or his/her ability to participate in the procedure.

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8. Any problems or complaints made by the resident related to the procedure.
9. If the resident refused the care and the reason(s) why.
10. Observations of anything unusual exhibited by the resident.
11. The signature and title of the person recording the data.
12. Documentation of advance directives (See MDS Section AA).

**Reporting**

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

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**References**

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