Prevention of Pressure Injuries

A) Purpose

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

B) Preparation

Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.

C) Risk Assessment

1. Assess the resident on admission (within eight hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.
2. Conduct a comprehensive skin assessment upon admission, including:
    a. Skin integrity – any evidence of existing or developing pressure ulcers or injuries;
    b. Tissue tolerance – the ability of the skin (and supporting structures) to endure the effects of pressure; and
    c. Areas of impaired circulation due to pressure from positioning or medical devices.
3. Use a screening tool to determine if resident is at risk for under-nutrition or malnutrition.
4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs.
    a. Identify any signs of developing pressure injuries (i.e., nonblanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency;
    b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.);
    c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser;
    d. Moisturize dry skin daily; and
    e. Reposition resident as indicated on the care plan.

D) Prevention

Moisture

1. Keep the skin clean and free of exposure to urine and fecal matter.

Nutrition

1. Monitor the resident for weight loss and intake of food and fluids.
2. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan.

Mobility/Repositioning

1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences.
2. At least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more.
3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning.
4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort.
5. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions.

Support Surfaces and Pressure Redistribution

Select appropriate support surfaces based the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors.