Standard 7
Revised: 2003, 2006
Reviewed: 1991, 1994, 1997, 2000, 2009

CARE OF THE IMMOBILIZED PATIENT

OBJECTIVES:

1. To prevent complications specific to immobility.
2. To promote self care.

PROCESS STANDARDS:

1. The patient will be assessed for risk factors for alteration in skin integrity on admission and WOCN notified/consulted if indicated. This skin assessment shall be documented on the Patient History, Assessment and Discharge form.
2. The patient at risk will be reassessed for alteration in skin integrity and circulatory impairment each shift (8-12 hours).
3. The patient will be positioned utilizing proper body alignment and turned/repositioned at least every 2-3 hours unless contraindicated. (If contraindications present, document contraindications in the nurses notes).
4. Pressure reduction measures such as heel/elbow pads, specialty beds and/or skin care will be utilized, as appropriate and as ordered. Pressure devices such as foam or pillows may be placed between bony prominences to prevent direct contact.
5. The head of the bed will be maintained at the lowest degree of elevation consistent with medical conditions and other restrictions (30 degrees or less when possible). Exception: An upright position may be used during meals and one hour after eating.
6. A nutritional consult will be initiated as indicated per nutritional services policy.
7. Plastic backed incontinence pads/diapers will not be placed next to patient's skin. Pads/diapers will be assessed for moisture/soiling with each repositioning and as indicated.
8. Skin protection for the incontinent patient will be managed using available incontinent care products.
9. Deep breathing and coughing will be encouraged as needed and/or as ordered by MD.
10. Range of motion exercises will be performed daily as possible.
11. Diversionary activities such as family visitation, TV, reading, etc. will be encouraged.
12. Independence within the limitations of immobility will be encouraged.
13. The patient will be monitored for BMs daily, and MD shall be notified if no BM noted in 3 days.
14. The patient/significant other will be instructed regarding disease process and prevention of skin breakdown.

CARE OF THE IMMOBILIZED PATIENT

OUTCOME STANDARDS:

At the time of discharge:

1. The patient will be free from new skin breakdown; joint contractures, respiratory compromise, circulatory impairment and sensory/perceptual deprivation, within his/her own limitations.

2. The patient/family will demonstrate understanding of pathophysiology and prevention of skin breakdown.

3. The patient will assist in self care within his/her limitations of immobility.

HAVE I DOCUMENTED:

- Bowel movements
- I&O
- Position
  - Head of bed
  - Patient
  - Right/left side
- Skin
  - Assessment
  - Color
  - Turgor
- Circulatory assessment
  - Pulses
  - Skin temperature
  - Presence/absence edema
- Respiratory assessment
- Activity Tolerance
  - Positioning
  - Range of motion
- Patient education
  - Diet
  - Activity
  - Medications
- Interventions – Skin Care Kit, Position changes, Heel/elbow pads

At The Time of Discharge:

- Ability to resume self care
- Condition of skin
- Patient/family has understanding of home and follow-up care, and prevention of skin breakdown.

Standard 7
Revised: 2003, 2006
Reviewed: 1991, 1994, 1997, 2000, 2009

CARE OF THE IMMOBILIZED PATIENT

Reference:

1. Doenges, M., Moorhouse, M.F., and Murr, A. Nursing Diagnosis: Nurses Pocket Guide: Diagnosis, Prioritized Interventions, and Rationales-11th ed. (2008). *Impaired Bed Mobility.*Accessed 10/29/2009 AR, LA, OK Libraries - LSU - Shreveport -- Nurse's Pocket Guide: Diagnoses, Prioritized Interventions, and Rationales - 11th Ed. (2008) Philadelphia: F.A. Davis.

2. Doenges, M., Moorhouse, M.F., and Murr, A. Nursing Diagnosis: Nurses Pocket Guide: Diagnosis, Prioritized Interventions, and Rationales-11th ed. (2008). *Risk for Impaired Skin Integrity.* Accessed 10/29/2009 AR, LA, OK Libraries - LSU - Shreveport -- STAT!Ref Online Medical Database. Philadelphia: F.A. Davis.

3. National Pressure Ulcer Advisory Panel:
   Pressure Ulcer Prevention (2009) http://www.npuap.org/Final_Quick_Prevention_for_web.pdf
   Pressure Ulcer Updated Stages Revised by NPUAP 2/2007 National Pressure Ulcer Advisory Panel (NPUAP)

4. Nursing Policies:
   P-70 Pressure Ulcer Prevention and Wound Care
   http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Nursing/P-70.pdf
   E-15 Enterstomal Therapy/Wound Ostomy Continence Nurse
   http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Nursing/E-15.pdf
   WOCN Policy Manual LSUHSC - Wound , Ostomy, Continence Nursing Department

5. Wound Ostomy and Continence Nurses Society.
   Position Statements:
   Avoidable vs. Unavoidable Pressure Ulcers (2009)
   http://www.wocn.org/pdfs/About_Us/News/wocn-avoidable-unavoidable_position-3-25.pdf
   Pressure Ulcer Staging (2007)
   http://www.wocn.org/pdfs/WOCN_Library/Position_Statements/PressureUlcerStaging.pdf
   Standard of Care:
   Staging Pressure Ulcers (2006)
   http://www.wocn.org/pdfs/WOCN_Library/Position_Statements/staging.pdf