# PRESSURE ULCER/WOUND PREVENTION AND CARE

## INFORMATION SHEET

### 1. Initial Guidelines
- A. Identification of At Risk Individuals
- B. Early Intervention (Prevention)
- C. Treatment Stage 1 – Pressure Ulcers

### 2. Goals
- Prevention of pressure ulcer is the primary goal. Established wounds should be stabilized and further pressure injury avoided.

### 3. Pressure Ulcer
- Defined as any lesion caused by unrelieved pressure resting in damage of underlying tissue.

### 4. Assessment
- Assess surrounding skin for:
  1. color
  2. moisture
  3. suppleness

### 5. Nursing Care
- A. Documentation
- B. Follow-up
- C. Re-assessment
- D. Time frame; every shift

### 6. Admission
- Admission assessment
- Skin inspection
- Identification of at Risk/Actual Skin Breakdown

### 7. Pressure Points, Shear, and Friction
- A shear occurs because the structure in contact with the skin moves and causes the skin to be dragged; a shear precludes friction.

  In friction the goal is to protect skin from “frictional drag. The care giver should lift the patient; **sliding is not permitted.**

  The skin should be clean and dry; dressings must remain attached to the skin all times.

### 8. Managing Tissue Loads
- Defined as distribution of pressure, friction, shear.
- A. Avoid positioning patients on a pressure ulcer.
- B. Avoid use of donut- type devices.
- C. Establish a writing repositioning schedule.
- D. When possible keep head of bed (HOB) < 30 degrees.
- E. Use devices such as pillows and foam wedges to prevent direct contact between bony prominences.
PATHOLOGY OF A PRESSURE ULCER

Pressure

↓

Ischemia

↓

Edema and Inflammation

↓

Small Vessel

↓

Cell Death
HOT SPOTS

SKIN ALERT

Stop, Check, Document

Heels
Occiput
Toes
Acrum
Posterior buttock
Over bony prominences
Horacic spine
Capula
TURN SCHEDULE

LOUISIANA STATE UNIVERSITY
HEALTH SCIENCE CENTER - SHREVEPORT

0200
0400
0600
0800
1000
1200
1400
1600
1800
2000
2200
2400

Remember! Check "HOT SPOTS" & Document Turning

Left = Lt.
Right = Rt.
Back = B

Turn Every 2 Hours

Signatures: ____________________________
______________________________
______________________________

DATE:
PATIENT:

4
IMPORTANT NOTICE

All bed-bound patients must be turned unless his/her condition prevents repositioning.

Remember to document on nurses notes, every two hour turning, repositions self, unable to reposition, condition unstable, or log roll only.

KEEP UP THE GOOD WORK!!!
SKIN CARE FOR PATIENTS
Immovilized or at Risk for Pressure Ulcer Development

1. The patient shall be **turned every 2 hours**, unless contraindicated.

2. Heel/elbow protectors shall be used as appropriate *(order not required)*.

3. Pressure reduction devices (specialty beds) shall be used as ordered.

4. Positioning devices such as **foam or pillows may be placed between bony prominences** to prevent direct contact.

5. Staff shall maintain the **head of the patient’s bed at the lowest degree of elevation** consistent with medical conditions and other restrictions *(30° or less)*.
   
   **Exception:** An upright position may be used during meals and one hour after eating.

6. Staff may use one extra sheet or incontinence airflow pad as needed.

7. Use a sheet to move patient. **Lift; do not drag.**

8. Staff shall use the **skin care kit as appropriate**.

**Process Standards**

1. The patient shall be assessed for risk factors for alteration in skin integrity **upon admission**.

2. The patient shall be **reassessed** for alteration in skin integrity **every shift**.

3. Keep the **head of the bed at or below 30°** as tolerated by patient.

4. Nutritional consult shall be initiated or indicated for nutritional services policy.

5. Plastic backed incontinence pads or diapers shall not be placed on the bed next to the patient’s skin unless specifically ordered.

6. Skin protection for the incontinent patient will be managed using available incontinent products.

For additional information, refer to the following:

*Nursing Policy P-70: Pressure Ulcer Prevention and Wound Care*

*Nursing Policy P-71: Pressure Ulcer/Wound Dressing Guidelines*

*Standard of Care #7: The Immobilized Patient*
STRATEGIES ON SKIN MAINTENANCE

1. Assessment:
   Assessment of skin on admission and every shift while at risk patient is in the hospital

2. Skin Care:
   Clean, dry and moisturized.
   Protect from exudates, shear, and pressure.

3. Pressure Reduction/Relief:
   Choose appropriate mattress surface.
   Static
   Dynamic

4. Nutrition:
   Consult dietician for assessment.
   Calories
   Proteins
   Vitamins
   Fluid Intake

5. Positioning:
   Small Shifts
   Frequent Turns/Position Change

6. Patient/Family Education:
   Explanations- Discuss plan of care and involve family when ever possible.
   Discharge Planning – Begin early, preferably on admission and continue until discharged.
GUIDELINES FOR DOCUMENTATION OF PRESSURE ULCERS

1. Location
   Remember pressure ulcers occur over bony prominences.

2. Dimensions and Depth
   Always measure ulcers using centimeters.

3. Status of Wound Base:
   - Granulation Tissue
   - Epithelialization
   - Clean but not Granulating
   - Slough/Eschar

4. Presence/Absence of Undermining and/or Sinus Tract Formation:
   - Location
   - Dimensions

5. Exudates:
   - Volume
   - Character
   - Odor

6. Surrounding Tissue:

7. Indications of System Infection
   Sepsis and osteomyelitis are complications that occur from infected pressure ulcers.