HACKETTSTOWN REGIONAL MEDICAL CENTER
NURSING POLICIES
RISK ASSESSMENT, PREVENTION AND TREATMENT OF PRESSURE ULCERS

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Effective Date: 10/26/1989	**Policy No: 8620.048b**
Cross Referenced: old 8620.50a, 8620.223b	**Origin: HRMC Division of Nursing**
Reviewed Date: 9/2008	**Authority: Chief Nursing Officer**
Revised Date: 2/2014, 6/2015	**Page: 1 of 6**

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SCOPE
All RNs in inpatient and outpatient departments.

PURPOSE
To outline the process for screening/predicting of patients at risk for pressure ulcers and the steps for prevention and treatment of pressure ulcers development.

DEFINITIONS
Pressure Ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers. The significance of the factors is yet to be determined.

Stage I
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.

Stage II
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound-bed without slough. May also present as an intact open/ruptured serum filled blister.

Stage III
Full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of Stage III pressure ulcers vary by anatomical location,

Stage IV
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of stage IV pressure ulcers varies by location. Stage IV ulcers can extend into muscle and or supporting structures (bone, tendon or joint capsule), making osteomyelitis possible.

Suspected Deep Tissue Injury(sDTI)
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, boggy, warmer or cooler as compared to adjacent tissue. sDTI may also present as an erythemic, warm, painful area, with localized edema with skin remaining intact. The wound may further evolve, and become covered by a thin eschar. May be difficult to detect in individuals with dark skin tones. Evaluation may include a thin blister over a dark wound bed. The wound may further evolve and become covered by a thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Unstageable
Full thickness tissue loss with the base of the ulcer is covered by slough (yellow, tan, gray-green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound the true depth and therefore stage cannot be determined. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Braden Scale- The Braden Scale is an evidenced based scale designed to predict those patients at risk for the development of a pressure ulcer. It uses 6 categories to predict pressure ulcers:

- Sensory Perception (ability to respond meaningfully to pressure related discomfort)
- Moisture (Degree to which skin is exposed to moisture)
- Activity (Degree of physical activity)
- Mobility (Ability to change and control body position)
- Nutrition (usual food intake)
- Friction and Shear

POLICY

- Risk assessment using the Braden Scale will be completed during the admission process, daily and upon change in patient condition in the inpatient nursing departments, and those outpatient departments that complete the admission process.
- Patients with a **score of 18 or less** will have pressure ulcer prevention strategies implemented.
- Individuals considered high risk for pressure ulcer development (Braden Scale 12 or below), should have a physician order for low air loss or air fluidized bed to increase the degree of pressure relief in addition to prevention strategies outline in the policy.
- Wound Care nurse consultation is recommended for all pressure ulcers
- All pressure ulcers staged III, IV, unstageable or suspected deep tissue injury, and full thickness wounds require a physician order for appropriate treatment.

PROCEDURE

A. ASSESSMENT

a. Perform a risk assessment upon admission to the hospital, daily and with a change in condition or transfer to a different level of care.
b. Perform a complete skin assessment upon admission to the hospital, daily and with a change in condition or transfer to a different level of care.
c. Assess any existing pressure ulcers by evaluating the following:
    i. Location
    ii. Size- measure in centimeters (cm): length, width and depth (use sterile q-tip for depth)
    iii. Note and measure any undermining or tunneling
    iv. Stage
    v. Condition of surrounding skin
    vi. Drainage (color, amount and odor)
d. Pressure ulcers reassessed with each shift unless the pressure ulcer has a dressing. If dressing present reassess at each dressing change.
e. Pressure ulcers are measured on a weekly basis

B. PREVENTION OF PRESSURE ULCERS

1. Patients with identified risk, minimize pressure through the immediate use of pressure redistribution equipment and/or a repositioning schedule.

2. Patients who are restricted to bed with a risk assessment of mild or moderate risk:
    a. Use devices to enable independent positioning, lifting and self transfers
    b. Reposition at least every 2 hours or sooner if high risk
    c. Use pillows to avoid contact between bony prominences
    d. Use devices that totally relieve pressure on the heels (i.e. heel protection or pillows)
    e. Avoid positioning directly on the trochanter. A 30 degree turn to either side is recommended
    f. Maintain head of the bed at the lowest elevation consistent with medical conditions and restrictions in order to reduce shearing forces. A 30-degree elevation or lower is recommended.
    g. Use lifting devices to move individuals during transfer and position changes.
    h. Do not use donut type devices or products that localize pressure to a new area. Waffle cushions are available on the inpatient units.

3. Patients who are at high risk
    a. Perform all above measures
    b. Obtain an order for a specialty bed (air fluidized, low air loss, total care spO_2RT)

4. Patients who are restricted to a chair with a risk assessment of mild or moderate risk:
    a. Have the client shift weight every 15 minutes if able.
    b. Reposition at least every hour if unable to weight shift
    c. Do not use donut type devices or products that localize pressure to other areas
    d. Use an air cushion under the patient in a chair.
    e. Refer to occupational therapy/physical therapy for seating assessment and adaptations for special needs.

5. Bathe all bed-bound or ADL –dependent patients with the bed bath system.
    a. Treat the skin gently: Dry the skin by patting gently, rather than rubbing. Avoid pulling a sheet under a patient too quickly to prevent a skin tear or bruise.

6. Apply lotion to dry skin areas: The areas most likely to require lotion are the feet, hands and elbows. Do not apply moisturizer between toes. Dry skin can crack and be the beginning of an ulcer.

7. Keep skin areas that touch each other free from moisture and dry: Keep any skin areas that touch each other dry, especially in the perineal area. Any time moisture, perspiration, urine or feces is present, the skin can become macerated and prone to breakdown.

8. Turn the patient at least every two hours to relieve or redistribute pressure. A turning schedule will be kept at the bedside on the patient's bulletin board. This chart can be altered to fit

different situations. For instance, if a patient cannot be placed in a certain position, eliminate that position on the chart and rearrange the turning order.

9. Position to relieve pressure: Position the patient with supportive devices. Avoid shearing position. No vigorous massage. This will help improve the condition of the skin.

10. Massage the patient's skin gently with lotion to increase circulation. This will help improve the condition of the skin.

11. Alteration in skin integrity: **Report the first signs of skin change** - Report and document the first signs of skin change or breakdown. If you see a reddened area or any other sign of skin change, check it again in 10 to 15 minutes. If the skin has not returned to normal, it should be reported. Encourage or assist patients in wheelchairs to shift their body weight frequently (every 15 minutes whenever possible).

12. Encourage patient to maintain a well balanced diet with sufficient calories and protein for healing: oral supplements, milk shakes, fruit juices, 4 to 6 glasses of fluid per day – monitor albumin and protein levels. Nutritional consult for all stage 3, stage 4, and unstageable wounds.

13. Intra operatively: Use devices to reduce risk of pressure sores, particularly if surgical procedure is over two hours. See OR policy manual for surgical positioning.

14. Patient/family education: Educate the patient and family regarding measures to reduce or relieve pressure on bony prominences.

C. TREATMENT OF PRESSURE: Ulcers

1. Stage I
   - Cleanse skin with N/S and apply Moisturizing cream
   - No dressing required, skin is intact
   - Position patient q2h
2. Stage II (non-intact skin and require dressing to protect the underlying tissue from bacterial contamination and to provide a moist healing environment)
   - Cleanse skin with normal saline perineal skin cleanser/ or wound cleanser, dry skin well
   - Apply hydrocolloid dressing and change every 72 hours or if the dressing becomes non-adherent
   - Reposition patient every two hours
3. Stage III (ulcers may contain necrotic tissue and require debridement either autolytic, chemical, enzymatic, mechanical, or surgical.)
   - Cleanse with normal saline, perineal skin cleanser dry skin well
   - Apply the prescribed medication/dressing
   - Cover with a moist saline dressing
   - Position patient q2h
   - Consider the need for a specialty bed

- Consider surgical consult
- Consult Wound Nurse

4. Stage IV (ulcers involve deep tissue, bone and supporting structure. Bone may be visible or palpable and osteomyelitis may be present. Necrotic tissue requires debridement surgically or enzymatically)
   - Cleanse with normal saline, perineal skin cleanser, dry skin well
   - Apply dressing and medication as prescribed
   - Obtain an order for a specialty bed
   - Turn patient every 2 hours/ off load site
   - Consider surgical consult
   - Consult Wound Nurse
5. Unstageable (May require surgical intervention or chemically debridement to treat eschar)
   - Cleanse with normal saline
   - Apply a dressing as prescribed
   - Turn patient every 2 hours /off load site
   - Consider specialty bed
   - Consider consult vascular or surgical consult
   - Consult Wound Nurse
6. Suspected Deep Tissue Injury (may evolve into Stage III or IV pressure ulcers)
   - Offload area immediately and keep patient off injured area
   - No dressing required
   - Obtain order for Xenaderm or generic equivalent
   - Consider a specialty bed
   - Position patient every two hours/off load site

D. DOCUMENTATION:

1. Document values of each category in the Braden Scale and total score
2. Document Skin assessment finding and skin integrity maintenance
3. Document pressure ulcer prevention strategies
4. Document pressure ulcer treatments
5. Document any reassessment for the Braden Scale
6. Document assessment finding for any existing pressure ulcers:
   a. Location
   b. Size
   c. Undermining/tunneling (document as a position on a clock)
   d. Stage
   e. Condition of surrounding skin and drainage if presented
   f. Odor
7. Document nutritional status

REFERENCES:

NPUAP Pressure Ulcer Stages. February 2011.

WOCN Guideline for Prevention and Management of Pressure Ulcers. 2010

Bryant, R. A. Bryant, Nix D. P. Acute and Chronic Wound current management concepts 4th edition, Mosby Inc., Copyright 2012.

WOCN Society Position Statement: Pressure Ulcer Staging, April 2011

Appendix A- Braden Scale Reference

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

SENSORY PRECEPTION Ability to respond meaningfully to pressure related discomfort.	**1- Completely Limited** Unresponsive to painful stimuli, due to diminished level of consciousness or sedation OR Limited ability to feel pain over most of body.	**2- Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR Has sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3- Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR Has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4- No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to moisture.	**1- Constantly Moist** Perspiration, urine, etc keep skin moist almost constantly. Dampness is detected every time patient is moved or turned.	**2- Very Moist** Skin if often, but not always moist. Linen must be changed at least once a shift.	**3- Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately one a day.	**4- Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	**1- Bedfast** Confined to bed.	**2- Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**3- Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4- Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
MOBILITY Ability to change and control body position.	**1-Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2- Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequently or significant changes independently.	**3-Slightly Limited** Makes frequently though slight changes in body or extremity position independently.	**4- No Limitation** Makes major and frequent changes in position without assistance.
NUTRITION Usual food intake pattern.	**1- Very Poor** Never eats a completed meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2- Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR Receives less than optimum amount of liquid diet or tube feeding.	**3-Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meats, dairy products per day.) Occasionally will refuse a meal, but will usually take supplement when offered OR Is on a tube feeding or TPN regimen that probably meets most of nutritional needs.	**4- Excellent** Eats most of every meal. Never refuses a meal. Usually eats total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION & SHEARING	**1- Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheet is impossible. Frequently slides down bed or chair, requiring frequently repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2- Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good positions in chair or bed most of the time but occasionally slides down.	**3-No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	