



Pressure Ulcer Prevention Points*

I. Risk Assessment

1. Consider all bed- or chair-bound persons, or those whose ability to reposition is impaired, to be at risk for pressure ulcers.
2. Use a method of risk assessment, such as the Norton Scale or the Braden Scale that ensures systematic evaluation of individual risk factors.
3. Assess all at-risk patients at the time of admission to health care facilities and at regular intervals thereafter and with a change in condition. A schedule is helpful and should be based on individual acuity and the patient care setting.
 - Acute care: assess on admission, reassess at least q 48 hrs or whenever patient's condition changes
 - Long-term care: assess on admission, weekly x 4 weeks, and then quarterly and whenever resident's condition changes
 - Home Care: assess on admission and every nurse visit.
4. Identify all individual risk factors (decreased mental status, moisture, incontinence, nutritional deficits) to direct specific preventive treatments. Modify care according to the individual factors.
5. Document risk assessment scores and implement prevention protocols based on the score.

II. Skin Care

1. Perform a head to toe skin assessment at least daily, especially checking pressure points such as sacrum, ischium, trochanters, heels, elbows, and the back of the head.

2. Individualize bathing frequency. Use a mild cleansing agent. Avoid hot water and excessive rubbing. Use lotion after bathing.
3. Establish a bowel and bladder program for patients with incontinence. When incontinence cannot be controlled, cleanse skin at time of soiling, and use a topical barrier to protect the skin. Select under pads or briefs that are absorbent and provide a quick drying surface to the skin. Consider a pouching system or collection device to contain stool and to protect the skin.
4. Use moisturizers for dry skin. Minimize environmental factors leading to dry skin such as low humidity and cold air.
5. Avoid massage over bony prominences.

III. Nutrition

1. Identify and correct factors compromising protein/calorie intake.
2. Consider nutritional supplementation/support for nutritionally compromised persons.
3. If appropriate offer a glass of water when turning to keep hydrated.

III. Mechanical Loading and Support Surfaces

1. Reposition bed-bound persons at least every 2 hours, and chair-bound persons every hour.
2. Consider postural alignment, distribution of weight, balance and stability, and pressure redistribution when positioning persons in chairs or wheelchairs.
3. Teach chair-bound persons, who are able, to shift weight every 15 minutes.
4. Use a written repositioning schedule.
5. Place at-risk persons on a pressure-redistributing mattress and chair cushion surfaces.
6. Avoid using donut-type devices and sheepskin for pressure reduction.
7. Use pressure-redistributing devices in the operating room for individuals assessed to be at high risk for pressure ulcer development.

8. Use lifting devices (e.g., trapeze or bed linen) to move rather than drag persons during transfers and position changes.
9. Use pillows or foam wedges to keep bony prominences such as knees and ankles from direct contact with each other.
10. Use devices that eliminate pressure on the heels. For short-term use with cooperative patients place pillows under the calf to raise the heels off the bed. Place heel suspension boots for long-term use.
11. Avoid positioning directly on the trochanter when using the side-lying position (use the 30° lateral inclined position).
12. Maintain the head of the bed at, or below 30° or at the lowest degree of elevation consistent with the patient's medical condition.
13. Institute a rehabilitation program to maintain or improve mobility/activity status.

IV. Education

1. Implement educational programs for the prevention of pressure ulcers that are structured, organized, comprehensive, and directed at all levels of health care providers, patients, family, and caregivers.
2. Include information on:
 - a. etiology of and risk factors for pressure ulcers
 - b. risk assessment tools and their application
 - c. skin assessment
 - d. selection/use of support surfaces
 - e. nutritional support
 - f. program for bowel and bladder management
 - g. development/implementation of individualized programs of skin care
 - h. demonstration of positioning to decrease risk of tissue breakdown
 - i. accurate documentation of pertinent data
3. Include mechanisms to evaluate program effectiveness in preventing pressure ulcers.

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