

	Montana Mental Health Nursing Care Center Policy Manual	Policy Number	546
		Original Date	01/20/1998
	Department: Nursing	Revised Date	07/10/2014
	Pressure Ulcers: Prediction and Prevention		

PURPOSE:

- A. To identify at risk individuals and the specific factors placing them at risk
- B. To maintain and improve tissue tolerance to pressure in order to prevent injury
- C. To protect against adverse effects of external mechanical forces: pressure, friction and shear

PROCEDURE:

- 1. Do risk assessment with Braden Scale (Attachment #1):
 - a) upon admission or when condition changes
 - b) and quarterly with MDS
- 2. Skin should be cleansed at time of soiling and at routine intervals:
 - a) avoid hot water
 - b) use mild cleansing agent
 - c) minimize force and friction applied to the skin
- 3. Dry skin should be treated with moisturizers.
- 4. Avoid massage over bony prominences.
- 5. Minimize skin exposure to moisture due to incontinence, perspiration, or wound drainage:
 - a) when unable to control, use under-pads or briefs
 - b) use moisture barrier
- 6. Notify Food Service Supervisor as resident may need a protein supplement.
- 7. Maintain current activity level, mobility and ROM.

8. When in bed:
 - a) reposition every two hours
 - b) use positioning devices such as pillows or foam wedges to keep bony prominences from touching
 - c) when side lying position used, avoid positioning directly on hip or shoulder
 - d) elevate HOB as little and for as short a time as possible
9. Use pressure-reducing device on bed for residents assessed to be at risk.
10. When in chair:
 - a) reposition every 2 hours or more frequently
 - b) encourage resident to shift weight frequently
 - c) use pressure reducing device
11. Use a lift device to move rather than pulling during transfers and position changes
12. Inspect skin daily.
13. Monitor and document interventions and outcomes.