Pressure Ulcer Prevention
Change Package

1. Complete head-to-toe skin assessment within four hours of admission. If pressure ulcer present:
   - Document findings
   - Obtain treatment order from physician/HCP or WCN
   - Notify family

2. Assess for intrinsic and extrinsic risk factors
   - Braden Scale (at risk)
     a. 18 or below for elderly and person with darkly pigmented skin
     b. 16 or below for other adults
   - Complete within four hours of admission to facility
   - Reassess regularly and whenever condition changes if no risk
     c. Acute care – every 24 hours
     d. Long term care – weekly (reassess every 24 hours if at risk)
     e. Home care – every RN or PT visit, whichever is applicable

3. Institute appropriate pressure ulcer prevention techniques for all patients/residents/clients over the age of 65
   - Assess skin daily
   - Clean skin at time of soiling – avoid hot water and irritating cleaning agents
   - Use moisturizers on dry skin
   - Don’t massage bony prominences
   - Protect skin of incontinent patients/clients/residents from exposure to moisture
   - Use lubricants, protective dressings and proper lifting techniques to avoid skin injury from friction/shear during transferring and turning of patients/clients/residents
   - Turn and position bed-bound patients/clients/residents every two hours if consistent with overall care goals
   - Use a written schedule for turning and repositioning patients/clients/residents
   - Use pillows or other devices to keep bony prominences from direct contact with each other
   - Raise heels of bed-bound patients/clients/residents off the bed don’t use doughnut-type devices
   - Use a 30-degree lateral side lying position don’t place patients/clients/residents directly on their trochanter
   - Keep head of the bed at lowest height possible
   - Use lifting devices (trapeze, bed linen) to move patients/clients/residents rather than dragging them in bed during transfers and position changes
   - Use pressure-redistribution devices
- Reposition chair- or wheelchair-bound patients/clients/residents every hour. In addition, if a patient/client/resident is capable, have he or she do small weight shifts every 15 minutes.
- Use a pressure-redistribution device (not a doughnut) for those who are chair-bound and
- Optimize nutrition and hydration.

4. Other care issues and interventions
- Keep the patient as active as possible, encourage mobilization
- Don’t massage reddened bony prominences
- Avoid positioning the patients/clients/residents directly on their trochanter
- Avoid drying out the patients'/clients'/residents’ skin use lotion after bathing
- Avoid hot water and soaps that are drying when bathing elderly
- Teach patients/clients/residents, caregivers and staff the prevention protocols
- Manage moisture:
  a. Determine the cause, use absorbent products/pad that wicks moisture
  b. Offer a bedpan or urinal in conjunction with turning schedules

- If the level of risk changes, consider the following:
  a. Does the patient/resident/client’s nutritional status need to be re-evaluated?
  b. Do we need to do skin reassessments more frequently?
  c. Can we get the patient/resident/client more mobile? Does the patient/resident/client need more frequent turning?
  d. Do we need to re-evaluate how we are moving/transferring the patient/resident/client?
  e. Should we use a different moisture product? Are we using the appropriate skin care products in a timely fashion?
  f. Are the heels elevated in the correct way?
  g. Are we re-assessing for risk more frequently?
  h. Does the patient/resident/client need a different category of pressure-redistribution support surface?

5. For all patients/clients/residents institute strategies to prevent skin tears
- Provide a safe environment:
  a. Do a risk assessment of all patients on admission
  b. Implement prevention protocol for patients identified as “at risk” for skin tears
  c. Have patients wear long sleeves or pants to protect their extremities
  d. Have adequate light to reduce the risk of bumping into furniture or equipment
  e. Provide a safe area for wandering
  f. Educate staff or family caregivers on how to handle patients to prevent skin tears
  g. Maintain nutrition and hydration
  h. Offer fluids between meals
  i. Use lotion twice daily, especially on dry skin on arms and legs
  j. Consider obtaining a dietary consult
k. Protect from self-injury or injury during routine care
l. Use a lift sheet to move and turn patients
m. Use transfer techniques that prevent friction or shear
n. Pad bedrails, wheelchair arms and leg supports
o. Support dangling arms and legs with pillows or blankets
p. Use non-adherent dressing on frail skin. If you must use tape, make sure it’s paper tape and remove it gently
q. Use gauze wraps, stockinettes or other wraps to secure dressings or drains/tubes rather than tape
r. Minimize use of soap and alcohol consider use of no-rinse bathing products. If soap is only cleaning system available, use an emollient soap. Don’t rub skin during bathing and pat skin dry to avoid injury and
s. Communicate with the patient/resident/client and family the plan and interventions for skin tear prevention.

For all patients/clients/residents, institute strategies to treat skin tears
a. Treat skin tears using the following protocol:
   o Continue using the prevention protocols above
   o Use the Payne-Martin classification system to document the type of skin tear (i.e. Category I, Category II or Category III)
   o Always assess the location and size of the skin tear consider doing a wound tracing
b. Perform local wound care to the skin tear as follows:
   o Gently clean the skin tear with normal saline or water
   o Let the area air dry or pat dry carefully
   o Approximate the skin tear flap
   o Apply petroleum-based ointment, steri-strips or a moist non-adherent wound dressing
   o Use caution if using film dressings as skin damage can occur when removing this dressing
   o Consider putting an arrow to indicate the direction of the skin tear on the dressing to minimize any further skin injury during dressing removal
c. Document assessment and treatment findings skin tears must be documented separately from a pressure ulcer.
Leadership Changes

6. Infrastructure
   - Senior leader WalkRounds
   - Urge leadership to adopt the unit
   - Implement culture of safety, which includes a non-punitive environment
   - Monthly senior leader report for first six months and bi-monthly for following six months and
   - Use measures to evaluate progress and improve processes/systems.

7. Partnership Level
   - Create culture of collegiality and learning between partners to enhance advocacy on behalf of patients/residents/clients
   - Establish method for regular (e.g. monthly) meetings with collaborative partners to facilitate communication and teamwork and
   - Share outcomes and lessons learned from work done as part of NJHA Collaborative.