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| PRESSURE ULCER PREVENTION PROGRAM | | | | NO. 226 | |
| It is the policy of Winning Wheels that upon or within 48 hours of admission, a licensed nurse assesses each resident for pressure area potential. The resident will then be assess weekly times 4 weeks and quarterly at MDS and when there has been a significant change in condition.  Winning Wheels will ensure that a resident that enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable.  Winning Wheels will promote the prevention of pressure ulcer development.  Winning Wheels will promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible) and lastly,  Winning Wheels will prevent development of additional pressure ulcers.  A pressure ulcer is defined as 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 form that evaluates and assesses the potential for pressure sores and utilizes a numerical value to determine level of risk will be used as a tool to decide which category a resident falls into. Once the risk level is determined, the appropriate preventative measures will be incorporated into the resident’s care plan and will be implemented according to the categories listed below.  High Risk Program: Current ulcer as assessed by licensed nurse and/or previous pressure sore, Stage II or higher in the past year.  Pressure Relief/Skin Integrity Measures:   1. Daily skin inspection of resident with limited mobility per CNA staff during cares. Notify nurse of findings. 2. Care inspection of high-risk areas such as occiput, sacrum, hell, coccyx, tuberosity, ischial area, or trochanter. 3. When appropriate, teach resident to change positions frequently. 4. Place resident on pressure reduction mattress, air mattress overlay, and/or chair cushion. 5. Licensed nurse to implement turning/repositioning schedule as appropriate. 6. Weekly skin check by licensed nurse. 7. Assess resident position (alignment, stability, pressure redistribution and potential pressure points including devices such as catheters.)   Shear and Friction (Secondary to reduced mobility/activity)   1. Position to avoid sliding in bed (e.g. keep HOB at lowest degree of elevation unless contraindicated). 2. Use lifting devices (e.g. turn sheets, under pads) to help move/reposition resident. 3. Assessment for needs/ability referral if the Interdisciplinary team to the Rehabilitation Department on admission and reviewed quarterly at care plan, unless change in condition noted. 4. Range of motion program as ordered by the attending physician or established by Physical Therapist. 5. Ambulation, exercise groups, health and fitness as tolerated and as indicated on the care plan. | | | | | |
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| Nutritional:   1. Nutritional assessment by Dietician on admission and reviewed quarterly wit MDS or with significant change in condition. 2. Develop nutritional care plan 3. Encourage increase dietary intake (particularly protein unless contraindicated). 4. Monitor fluid intake and output. 5. Consider multivitamin, zinc, and/or vitamin C if appropriate. 6. Weights as ordered.   Skin Exposed to Moisture:   * 1. Establish bladder/bowel program if appropriate and/or select absorbent products that wick moisture away from the skin.   2. Gently cleanse and dry skin thoroughly after each incontinent episode.   3. Apply appropriate in house skin barrier products.   4. Consider temporary use of fecal management system or urinary catheter.   Moderate Risk Program:  Pressure Relief/Skin integrity Measures:   1. Daily skin inspection of resident by CNA during cares. Notify nurse of any findings. 2. When appropriate teach resident to change positions frequently. 3. Licensed nurse to implement turning/repositioning schedule if appropriate. 4. Place resident on pressure reduction mattress, air mattress overlay and/or chair cushion.   Mobility:   1. Assessment for needs/ability referral if the IDT to the Rehabilitation Department on admission and reviewed quarterly at Care plan, unless change in condition noted. 2. Range of motion program as ordered by attending physician or established by Physical Therapist. 3. As appropriate and per resident preference, provide a daily nap for resident with pressure sores located on back, coccyx, or ischial tuberostiy. Position on left or right side, unless contraindicated. Some resident may require a nap in the AM or PM. 4. Ambulation, exercise groups, health and fitness as tolerate and as indicated on the care plan.   Nutritional:   1. Weights as ordered. 2. Nutritional support as established by the registered dietician. 3. Nutritional assessment by dietician on admission and quarterly with MDS or with significant change in condition. 4. Develop nutritional care plan as needed. | | | | | |
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| Skin Exposed to Moisture:   1. Establish a bowel and/or bladder program if appropriate and/or select absorbent products that wick moisture away from the skin. 2. Gently cleanse and dry skin thoroughly after each incontinence episode. 3. Apply appropriate in-house skin care/barrier products. 4. Consider temporary use of fecal management system or urinary catheter.   Low Risk Program:   1. Daily skin inspection of resident by CNA during cares. Notify nurse of findings. 2. Teach resident to change position frequently if cognitively able. 3. Weights as ordered 4. Nutritional assessment by dietician on admission and quarterly with MDS or with significant change in condition. 5. Develop nutritional care plan as needed. 6. Establish a bowel/bladder program if appropriate an/or select absorbent products that wick moisture away from the skin. 7. Gently cleanse and dry skin thoroughly after each incontinence episode. 8. Apply appropriate in house skin car/barrier products. | | | | | |
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