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| PRESSURE ULCER PREVENTION PROGRAM | | | | NO. | |
| It is the policy of this facility that upon admission, a licensed nurse assesses each resident for pressure area potential. The resident will then be assessed weekly times 4 weeks and quarterly at MDS and when there has been a significant change in condition.  The facility 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.   * The facility will promote the prevention of pressure ulcer development; * The facility will promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible) and lastly; * The facility 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.  A Norton Plus Pressure Ulcer Scale form or another 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.  Preventative Rounds: All residents identified as “at high risk” for skin breakdown will be reviewed at a minimum of monthly by the Interdisciplinary Wound Care Team to monitor effectiveness of preventive measures and to recommend changes to the preventative program as indicated.  Wound Care Coordinator: Role and Responsibilities:   1. Maintains a current Weekly Wound Tracking Record log of residents with pressure ulcers and ascertains that the appropriate pressure ulcer prevention protocols are implemented (i.e. pressure reduction chair cushions, etc). 2. Completes the Weekly Wound Tracking Record and distributes to the Director of Nursing, Administrator, Registered Dietician, and all members of the Interdisciplinary Wound Care Team.  * Pressure sores are to be tracked separately from vascular and other wounds.  1. Confers with the resident’s attending physician regarding treatment recommendations. Documents and transcribes all new physician orders received. 2. Confers with the facility wound consultation firm, when appropriate, and implement recommendations.   MDS Coordinator: Role and Responsibilities:   1. Completes the quarterly and significant change documentation for all residents. (on admission the admitting nurse completes the Norton Plus form within 24 hours). 2. Updates the resident care plan whenever a change occurs in the status of the wound or when the treatment plan is altered.   Norton Plus Pressure Ulcer Scale (Risk Assessment):  The Norton Scale has been selected for risk assessment at this facility (unless otherwise specified or dictated by state/federal regulation). | | | | | |
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| The Norton Scale is a descending scale. It is to be used:   1. Upon admission (within 24 hours) 2. Upon decline in residents condition 3. Quarterly 4. Return from hospital   The Norton Scale is divided into two categories:   1. Risk Factors 2. Physical Condition (rated 1 to 4) 3. Mental State (rated 1 to 4) 4. Activity (rated 1 to 4) 5. Mobility (rated 1 to 4) 6. Incontinence (rated 1 to 4) 7. Norton Plus Deductions 8. Diagnosis of Diabetes 9. Diagnosis of Hypertension 10. Hematocrit level 11. Hemoglobin level 12. Albumin level 13. Febrile >99.6 F 14. 5 (or more) medications 15. Changes in mental status to confused, lethargic within 24 hours   There are a total of 20 possible points. Residents with a score of 15 or below are at greater risk for development of pressure sores. These “at risk” residents will be place on preventive skin care protocol (Please refer to the Preventive Skin Care Program).  **HIGH RISK:**  Practice Guidelines:  When a resident has been rated “at high risk” (10 or <) for skin breakdown on the Norton Scale they will be placed on a turning and repositioning schedule. Ambulation, restorative groups, health and fitness as tolerated and as indicated on the care plan.   1. Nutritional: 2. Nutritional assessment by Dietician on admission and reviewed quarterly with MDS or with significant change in condition; 3. Develop nutritional care plan; 4. Encourage increase dietary intake (particularly protein, unless contraindicated); 5. Consider multivitamin, zinc, and/or vitamin C if appropriate; 6. Weights as ordered. | | | | | |
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| 1. Skin exposed to moisture: 2. Establish bladder/bowel program if appropriate and/or select absorbent products that wick away moisture from the skin; 3. Gently cleanse and dry skin thoroughly after each incontinent episode; 4. Apply appropriate in house skin barrier products; 5. Consider temporary use of fecal management system or urinary catheter. 6. Mobility: 7. Assessment for needs/ability referral of the IDT to the Rehabilitation Department on admission and reviewed quarterly at Care Plan, unless change in condition noted; 8. Range of motion program as ordered by attending physician or established by Physical Therapist; 9. As appropriate and per resident preference, provide a daily time for resident with pressure sores located on back, coccyx, or ischial tuberosity to be in bed to relieve pressure to that area. Position on left or right side, unless contraindicated. Some residents may require this time in the AM or PM or both; 10. Ambulation, exercise groups, health and fitness as tolerate and as indicated on the care plan. 11. Pressure relief/skin integrity measures: 12. Daily skin inspection of resident by CNA during cares, notify nurse of any findings; 13. When appropriate, teach resident to change positions frequently; 14. Licensed nurse to implement turning/repositioning schedule, if appropriate; 15. Place chair cushion in resident’s wheelchair; 16. Consider alternating pressure / low air loss beds, if appropriate.   **MODERATE RISK:**  Practice Guidelines:  When a resident has been rated “at moderate risk” (11 to 15) for skin breakdown on the Norton Scale they will be placed on a turning and repositioning schedule. Ambulation, restorative groups, health and fitness as tolerated and as indicated on the care plan.   1. Nutritional: 2. Nutritional assessment by dietician on admission and quarterly with MDS or with significant change in condition; 3. Nutritional support as established by the dietician; 4. Develop nutritional care plan as needed; 5. Weights as ordered; 6. Skin exposed to moisture: 7. Establish a bowel and/or bladder program if appropriate and/or select absorbent products that wick moisture away from the skin; 8. Gently cleanse and dry skin thoroughly after each incontinence episode; 9. Apply appropriate in-house skin care/barrier products; 10. Consider temporary use of fecal management system or urinary catheter. | | | | | |
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| PRESSURE ULCER PREVENTION PROGRAM | | | | NO. | |
| 1. Mobility: 2. Assessment for needs/ability referral of the IDT to the Rehabilitation Department on admission and reviewed quarterly at Care Plan, unless change in condition noted; 3. Range of motion program as ordered by attending physician or established by Physical Therapist; 4. Ambulation, exercise groups, health and fitness as tolerate and as indicated on the care plan. 5. Pressure relief/skin integrity measures: 6. Daily skin inspection of resident by CNA during cares, notify nurse of any findings; 7. When appropriate, teach resident to change positions frequently; 8. Licensed nurse to implement turning/repositioning schedule, if appropriate; 9. Place chair cushion in resident’s wheelchair;   **Low Risk**:  Practice guidelines:  When a resident has been rated “low risk” (16 to 20) for skin breakdown on the Norton Scale the resident will perform ambulation, exercise groups, health and fitness as tolerated and as indicated on the care plan. The facility will follow the Preventive Skin Care policy.   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 and/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 care/barrier products. | | | | | |
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