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Ohio's Medicare Quality Improvement Organization
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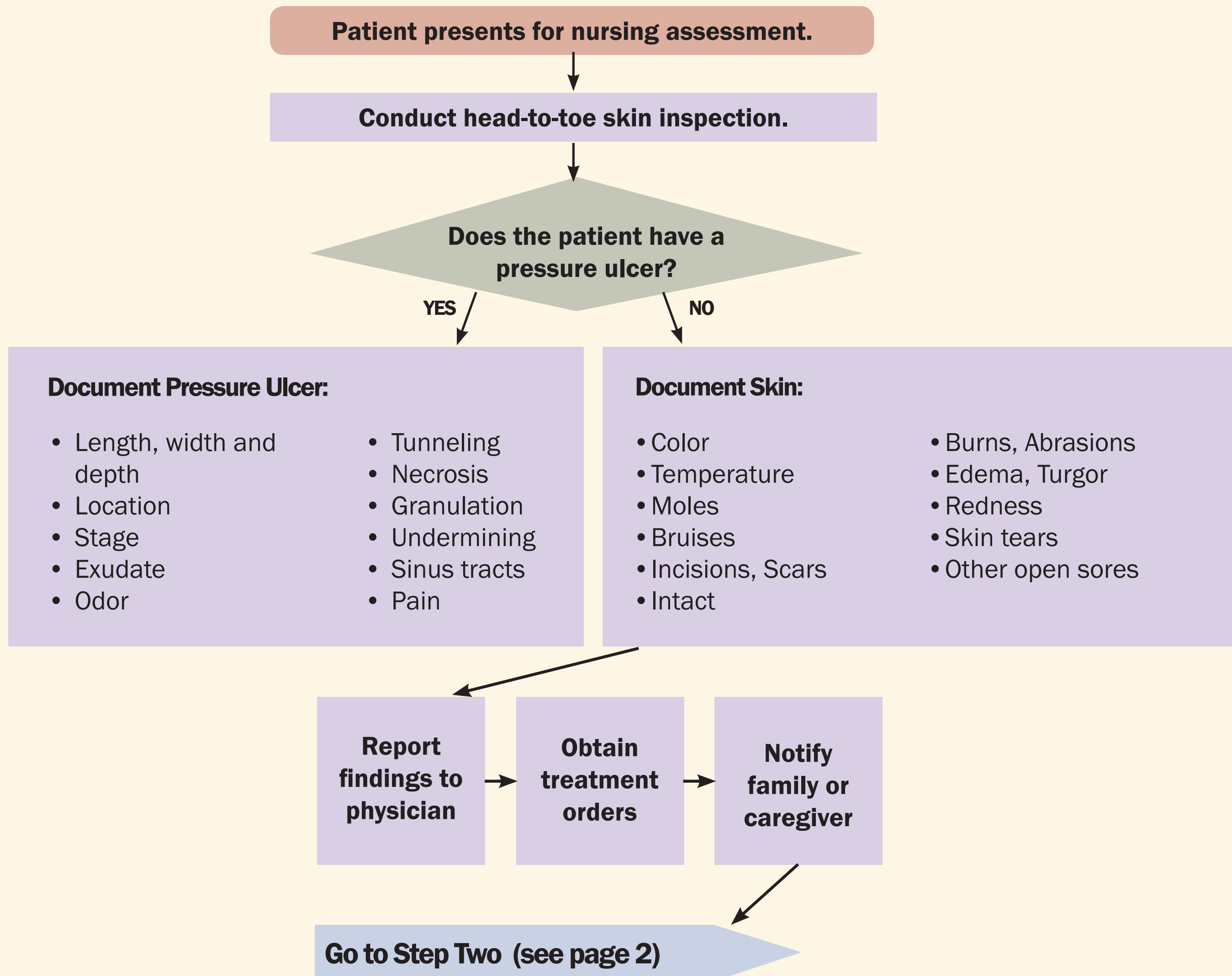
Pathway for Prediction, Prevention, and Treatment of Pressure Ulcers in Hospitals

STEP ONE: Assess skin condition.



Reminders:

Repeat Step One regularly

- Daily for all patients
- Every shift for all high-risk patientsn

If a pressure ulcer develops in-house:

- Conduct a pressure ulcer investigation
- Repeat process, beginning with Step One
- Initiate any required paperwork or tracking sheets
- Update other assessments as needed

Sources:

1. Institute for Healthcare Improvement. Five Million Lives Campaign Getting Started Kit: Prevent Pressure Ulcers, How-To Guide. Available at www.ihi.org. Accessed August 24, 2009.
2. National Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention Points. Washington DC: NPUAP; 2007.
3. The Joint Commission 2010 National Patient Safety Goals.
4. The Institute for Clinical Systems Improvement (ICSI). Skin Safety Protocol: Risk Assessment and Prevention of Pressure Ulcers. Bloomington, MN: ICSI; 2007.

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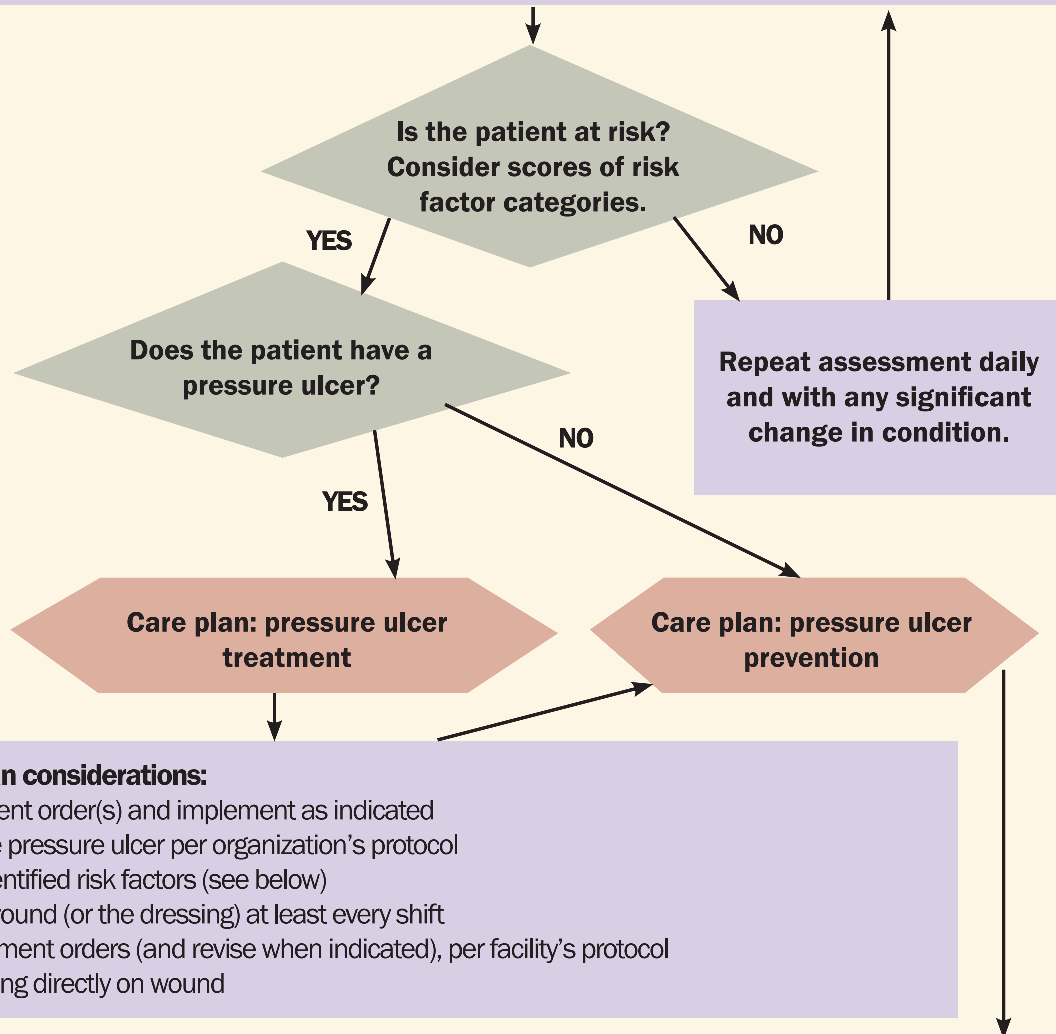
STEP TWO: Complete risk assessment to identify risk factors and care plan interventions.



Wound care plan considerations:

- Obtain treatment order(s) and implement as indicated
- Document the pressure ulcer per organization's protocol
- Address all identified risk factors (see below)
- Observe the wound (or the dressing) at least every shift
- Evaluate treatment orders (and revise when indicated), per facility's protocol
- Avoid positioning directly on wound

Preventive care plan considerations (based on risk factor categories):

Bed/chair mobility

- Adopt turn schedule of at least Q2hr in bed or Q1hr in chair; float heels
- Use pressure redistributing cushions, mattresses, gel pads, etc.
- Obtain PT/OT consult and positioning assessment
- Avoid positioning directly on trochanter

Friction and/or shear

- Use padding to prevent skin-to-skin contact; use draw sheets for turning
- Protect heels and bony prominences with boots, heel protectors, or pillows as needed avoid massage over bony prominences
- Use positioning devices; position HOB at lowest possible level

Incontinence and moisture

- Provide peri-care Q2hr or as soon as possible after incontinence
- Implement toileting program; use barrier cream, incontinent pads, briefs
- Keep skin dry with light powder; or keep moist with lotion, if dry

Nutrition and body weight

- Monitor patients' weights and labs; maintain hydration
- Obtain dietitian consult; enhance diet
- Provide dietary supplements and/or vitamin/mineral supplements
- Provide feeding assistance; monitor meal/fluid intake
- Obtain ST consult and assessment for chewing/swallowing

Other

- Address any other identified patient-specific risk factors
- Monitor patient's response to care plan and modify as needed