NORTHUMBERLAND HILLS
HOSPITAL

Pressure Injury Prevention Protocol

Risk Assessment

- **Complete Braden Score on admission, every 24 hours, and with acute change in patient status**
- **Reevaluate patient care plan interventions with each Braden assessment**
- **Consider implementing heel boots for patients with a Braden Score of 15 or less AND two of the following co-morbidities: Age 75 or older, decreased sensation, unconscious, multi-organ system failure, on vasporessive medications, diabetes, stroke, PVD/impaired perfusion, quadraparesis, malnutrition.**

General Care Issues

- **Do not massage reddened bony prominences**
- **Do not use donut type devices**
- **Provide information for patients regarding skin health and monitoring (use Patient Information Sheet)**
- **Avoid using rolled blankets as positioning devices on bony surfaces**
- **Advanced surfaces do not substitute for turning schedules**
- **Encourage maximal activity for all patients**

Braden Score	Risk Level	Protocol
Greater than or equal to 15	**Low Risk**	Patient family education Frequent repositioning Protect heels: elevate using a pillow or apply heel boots if the patient meets criteria Manage Moisture, Nutrition, Friction and Shear (use advanced interventions for low sub-scores) Pressure redistribution support surface IF patient is bed or chair bound Advance to next level of risk if other major risk factors present or with clinical nursing judgment
13- 14	**Moderate Risk**	*Includes the above strategies PLUS:* Ensure patient repositioning q 2-4 hours. In bed ensure 30-degree lateral positioning Pressure redistribution support surface Advance to next level of risk if other major risk factors present or with clinical nursing judgment
Less than or equal to 12	**High Risk**	*Includes the above strategies PLUS:* Q 2-hour repositioning. In bed ensure 30-degree lateral positioning Required PT OT RD and SLP consult

Advanced Interventions

Moisture (sub-score 3 or less)

- Address cause if possible (fever, incontinence, wound drainage)
- Use protective cream
- Cleanse skin after each episode of incontinence
- Use absorbent pads or diapers only if incontinence persists
- Offer bedpan/urinal and glass of water in conjunction with turning schedule
- Consider implementing a toileting schedule
- Address the cause of diarrhea
- Use fragrance free moisturizing products or skin emollients with bath when appropriate
- Use warm (not hot) water for bathing
- Maintain a maximum of 3 layers between the patient and surface

Nutrition (sub-score 2 or less)

- Monitor nutritional intake
- Encourage protein intake
- Offer fluids for hydration Q2h
- Set-up and assist with meals
- Dietary consult
- Swallowing Assessment
- Perform appropriate mouth care

Friction and Shear (sub-score 2 or less)

- When in bed, maintain the head of bed at 30 degrees or less and the foot of the bed at 20 degrees or less; ensure the patient is safely positioned upright prior to oral intake and oral care (refer to NPIAP positioning guidelines)
- Maintain a maximum of 3 layers between the patient and surface
- Use appropriate techniques (Smart Moves) when repositioning
- Apply protective cream and/or protective dressings to elbows, heels and sacrum if appropriate
- Consult surface selection algorithm to determine appropriate pressure redistribution surface
- Consult PT/OT for positioning/ transfer/ mobility considerations

Pressure (sub-score of 3 or less)

- Encourage, educate and assist with frequent repositioning q 2-3hours.
- If patients cannot self-reposition, use pillows to achieve lateral turn of 30 degrees (refer to NPIAP positioning guidelines)
- Consult Surface selection algorithm to determine appropriate pressure redistribution surface
- Wound Consult if wound present
- OT consult for seating assessment