

Pressure Ulcer Prevention Tip Sheet

If your resident triggers at-risk upon admission, the following interventions should be implemented and documented to help avoid the formation of a pressure ulcer.

I. Activity/Mobility—(example Braden Score of 1 or 2)

Pressure Relief

- Place a pressure-reducing device (such as a specially designed foam pad or mattress) while the resident is in bed.
- Turn the resident regularly while in bed. (Refer to the resident's turning schedule.)
- Place a pressure-reducing device (chair pad or pillow) whenever the resident is out of bed and sitting down.
- Reposition the resident regularly while out of bed. (Refer to the resident's repositioning schedule.)
- Place a heel pressure-relieving device, or follow the plan for heel pressure relief.
- Check pressure-relieving devices for "bottoming out."

Shear/Friction Reduction

- Raise the head of the bed (HOB) slightly (30 degrees or less).
- Gatch knees slightly, if HOB is elevated.
- Use assistive devices for repositioning (such as a lifting sheet, overhead trapeze bar, or a thin layer of corn starch on linen).
- Apply transparent dressings to high-risk areas (bony prominences).

II. Moisture—(example Braden Score of 1 or 2)

- Protect skin from incontinence with moisture barriers such as creams.
- Use incontinence cleaners (not soap) to avoid drying the skin.
- Use incontinence supplies (such as absorbent pads, briefs, or fecal bags).
- Check for moisture every one to two hours.
- Follow an incontinence protocol.

III. Nutrition—(example Braden score of 1 or 2)

- Get a timely nutrition screen and/or consult.
- Be aware of what and how much the patient eats.
- Offer food and water or other liquid on a schedule.