

POLICY AND PROCEDURE FOR WOUND CARE AND PRESSURE ULCERS:

POLICY:

It is the policy of Sabetha Manor that residents admitted to our facility without pressure ulcers will not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable. Further policy indicates that nursing personnel will identify residents at risk for development of pressure ulcers and implement interventions for the prevention of pressure ulcers at the earliest time.

OBJECTIVES:

1. Identify at risk residents by using the MCS scale.
2. Intervene, maintain and improve tissue tolerance to pressure.
3. Protect against adverse effects of pressure, friction, and shearing.
4. Prevent and reduce the development of pressure ulcers through education and supervision.

PROCEDURE:

1. The MCS Scale shall be completed by the licensed personnel upon admission of the resident to the facility, quarterly (at care plan time), and any time a significant change in the resident's condition occurs.
2. The MCS scale will identify risk based on physical condition, incontinence, activity nutrition, mobility, and agility of the patient.
3. 8 or above in the MCS scale indicates the resident at high risk for breakdown.
4. Residents at high risk shall have interventions in place to minimize potential for pressure ulcers (i.e. turn schedules, pressure reduction mattress, encourage adequate nutrition/ hydration, skin care ect.)
5. Photos may be taken of pressure ulcers
6. Pressure ulcer management shall be discussed in weekly therapy meeting to keep entire team advised of status and minutes of meeting shall be posted of the meeting so all licensed personnel are well advised of them.

EARLY INTERVENTION AND PREVENTION METHODS:

Preventive measures will be implemented as soon as the resident is identified as at risk.

The interventions listed are not all-inclusive.

1. **Turning:-** individualized repositioning will be done for the resident by the staff (unless the resident is able to reposition themselves).
Monitoring of turning is the responsibility of the licensed nursing personnel.
2. **Proper positioning:-** use of pillows, wedges, and padding devices. OT and PT will be advised if necessary if any special positioning and or seating is needed. Orders will be obtained if necessary.
3. **Application of pressure reduction devices:-** special mattress, air overlays, gel pads, or specialty bed.
Specialty beds must have a physician's order and administrator's approval.
4. **Skin care and reduction of excess moisture:-** bathing schedule, monitoring of incontinence episodes, toileting program if possible, peri care with use of moisture barrier as indicated, use of clean dry linens that are wrinkle free. If incontinence is felt to be a contributing factor to a pressure ulcer, and all other attempts to maintain/improve skin integrity have been exhausted, the physician will be consulted for further instructions.
5. **Maintaining of nutritional status:** All pressure ulcers will have a dietary consult with either the dietary