

All nursing staff shall be responsible for the reporting of any abnormal skin conditions.

1. During baths and personal hygiene care CNA's are to monitor carefully for any pressure or open areas.
2. The charge nurse will document in the nurse notes (following documentation procedures per facility) and report to oncoming shifts the findings of and interventions in place.

PRESSURE ULCER DOCUMENTATION:

All pressure ulcers shall be documented upon finding of pressure ulcer. Further documentation of pressure ulcer shall be completed after initial treatment and during the course of the treatment as changes occur. Documentation and measuring will be done weekly and will be done by licensed staff. CMA's are not allowed to do any documentation on the treatment sheet or notes. They can only sign that they did the treatment. Documentation shall include but not limited to:

1. Location
2. Stage
3. Size
4. Undermining / tunneling
5. Wound bed (tissue)
6. Drainage / exudate
7. Peri wound tissue (color, temp, bogginess, and fluctuation)
8. Need for debridement
9. Presence of odor
10. Type of treatment
11. Resident's tolerance to the treatment

Documentation of changes to plan of care is indicated at the time of assessment of the pressure ulcer and implementation of treatment plan.

PRESSURE ULCER TREATMENT PLAN:

NOTE: Before performing any type of wound treatment, assemble all supplies outside the room before entering (unless supplies are stored in the room for infection control purpose) If using stock supplies, use medication cups to carry an appropriate amount of the needed item into the room, then dispose the cup when the treatment is completed. These practices will help to prevent cross contamination. Also remember to wear gloves when performing any type of wound care. Remove gloves after an old dressing has been removed then apply clean gloves to apply new dressing. Dispose of wound care supplies in the proper waste receptacle making sure to use the bio-hazard red bags for dripping blood.

PREVENTION OF REOCCURRENCE:

It is the policy of Sabetha Manor to provide quality care to all residents. To prevent a reoccurrence of a pressure ulcer, preventative measures will be taken to eliminate the cause. All healed pressure areas will receive moisture barrier application as per facility (zinc oxide base or A&D) for at least 2 weeks after area is healed and will be done at least every shift.

The person responsible for doing treatments is the med aide on a daily basis. The treatment nurse or designated nurse is responsible for weekly charting and weekly measuring.

Signature of Administrator: _____

Signature of Medical Director: _____

revised 5-5-03 presulcr