Enhancing Life
Jersey City Medical Center

Department of Patient Care Services

POLICY: Interventions for High Risk Patients Braden Score at or below 18	**DEVELOPED BY:** Patient Care Services
POLICY COMMITTEE: _____ Janice Kozzi MSN, RN, CNL Policy Committee Chair ❑ N/A	**APPROVED BY:** _____ Rita Smith, DNP, RN CNO, Senior Vice President Patient Care Services

Effective Date:	Revised Date:	Reviewed Date:
11/04	11/06	1/12

Distribution: All nursing unit manuals

Reference: Braden B., Bergstrom N., Laguzza, A., Adman V. The Braden Scare for Predicting Pressure Sore Risk. Nursing Research 2000, July / Aug.: 36(4): 205-210

Braden, B. and Ayello, A. 2002. *How and Why to Do Pressure Ulcer Risk Assessments?* Advances in Skin & Wound Care 15(3): 125-131

Approvals:

Professional Practice	Y ☐	N/A ☐
Nursing Education	Y ☐	N/A ☐
Critical Care	Y ☐	N/A ☐
Emergency Dept	Y ☐	N/A ☐
Peri-Op	Y ☐	N/A ☐
Trauma	Y ☐	N/A ☐
Maternal Child Health	Y ☐	N/A ☐
Behavioral Health	Y ☐	N/A ☐
Cardiac Cath Lab	Y ☐	N/A ☐
Interventional Radiology	Y ☐	N/A ☐
Med Exec	Y ☐	N/A ☐
Pharmacy/ P&T	Y ☐	N/A ☐
Pathology/Blood Bank	Y ☐	N/A ☐
Other:	Y ☐	N/A ☐
Other:	Y ☐	N/A ☐

PURPOSE: To define early interventions for prevention of pressure ulcers.

POLICY:

All patients in the inpatient med-surg and Critical Care units will be assessed upon admission. Documentation on the interdisciplinary admission assessment will be completed within 24 hours of admission. Documentation will be completed every shift on the unit specific Daily Flow Sheet.

Procedure:

Implement the following for patients with a Braden Scale Score of 18 or

less. 1. Mobility / Activity Deficit:

a. For Bed-bound individuals or those whose ability to reposition is impaired.

- Reposition every 2 hours
- Use pillows or foam wedges to keep bony prominences from direct contact with another bony prominence or hard surface
- Use devices that totally relieve pressure on the heels
- Avoid positioning directly on the trochanter
- Elevate the head of bed as little and for as short a time as possible unless more acute conditions require HOB elevation.
- Use lifting devices to move rather than drag patient during transfers and position changes. (Lift Sheet)
- Place “at risk” individuals on a pressure-reducing mattress

DO NOT USE DONUT TYPE

DEVICES b. For Chair Bound Individuals:

- Reposition at least every hour
- Have patient shift weight every 15 minutes, if

able **DO NOT USE DONUT TYPE**

DEVICES

2. Skin Care

- Inspect skin DAILY
- Remove TED Stockings daily and check heels
- Avoid hot water for bathing and use mild cleansing agent.
- Use moisturizers for dry skin.
- Avoid massage over bony prominences
- Use proper positioning, transferring and turning techniques to

prevent friction and shearing

- Use film or protective dressing over Stage I pressure ulcer site (film dressings, skin sealants, and hydrocolloids)
- Institute a rehabilitation program (encourage ambulation, active and passive range of motion exercises, physical therapy)

3. Moisture / Incontinence:

- Gentle cleansing of skin with a perineal wash at time of soiling.
- Minimize skin exposure to moisture. (Use moisture barriers)

4. Nutritional Deficit:

- Dietary Referral for Braden Score of 18 or less.
- Assist with meals as needed
- Nutritional Supplements – Record food intake accurately as determined by Dietary.

MD Communications:

5. The nurse will notify the physician of the patient's high-risk status or any changes in skin integrity and obtain appropriate orders for intervention

Patient Education:

6. The patient/s will be instructed on the following:
   - Measures to help prevent alteration in skin integrity, skin inspection, skin cleansing, skin protection, etc)
   - Importance of mobility and turning / repositioning a minimum of every 2 hours
   - Proper positioning techniques
   - Importance of nutrition and hydration
   - Encourage an active role in self-care, as appropriate

Documentation:

7. The nurse will document the following:

- Risk assessment on the Braden Scale at time of admission every shift and upon discharge

In the Nursing Progress Notes with any change of skin condition