VOHRA
WOUND PHYSICIANS

STRUCTURED RISK ASSESSMENT

Patients at risk for pressure ulcer development include:

- All patients with alterations in intact skin, such as dry skin, excessive moisture, or redness
- Patients with signs of altered nutritrion (including anemia, low serum albumin, decreased intake, and/or body weight)
- Patients with perfusion problems (including diabetes and/or alterations in oxygenation and blood pressure)
- Older age
- Increased friction and shear and/or altered mobility
- Decreased sensory perception

FREQUENT SKIN ASSESSMENT

Regularly assess each patient's skin for:

- Redness or change in color
- Dryness or excessive moisture
- Blanching response
- Localized heat
- Edema
- Hardness (induration)
- Areas of discomfort or pain that may be related to pressure
- Medical devices pressing on skin

SKIN CARE

- Use frequent position changes to relieve and redistribute pressure
- Avoid friction and shear (lift, don't drag)
- Reposition using the 30 degree tilted side-lying position, or the prone position
- When possible, avoid the 90 degree side-lying position or the semirecumbent position
- Use pressure-relieving surfaces
- Do not turn an individual onto a body surface that is already reddened from pressure
- Do not use massage or rubbing for pressure ulcer prevention
- Use emollients to hydrate dry skin
- Protect skin from excessive moisture with barrier cream

NUTRITION FOR PRESSURE ULCER PREVENTION

- Use a team approach for nutrition risk assessment and intervention
- If indicated for patients with nutritional risk, offer high-protein supplements between mealtimes in addition to the usual diet

MORE DETAILED PREVENTION INSTRUCTIONS MAY BE DOWNLOADED AT www.NPUAP.org

(The National Pressure Ulcer Advisory Panel)

For additional assistance:
Speak with a care coordinator: 305-866-7123 | Send us an email: info@vohraphysicians.com