Patient Teaching Protocol for Pressure Ulcer Prevention and Management

ADDRESSOGRAPH

Outcome Standards	Met	Not Met	Date	Initials
Physiologic: Maintains optimal tissue perfusion.	❑	❑		
Psychologic: Demonstrates effective coping behaviors	❑	❑		
Cognitive: Verbalize understanding of information presented.	❑	❑		

Key Information Learning Needs Assessment	Date	Initials
Identify potential discharge needs: *(ie: home health, wound care center, support surface, prescriptions)*		
Identify barriers or enhancers to learning: *(ie: knowledge level, physical / sensory limitation, psychosocial status, language)*		

Evaluation Key

S = Successfully meets outcomes
N = Needs further instruction
U = Unable to comprehend
= See Patient Ed. Notes

Patient/Caregiver Learning Outcomes	Information to be Presented Patient/ Caregiver Learning Activities	Date	Initials	Evaluation Key
1. Verbalizes external factors in pressure ulcer development.	a. Pressure b. Friction c. Shear d. Moisture			
2. Verbalizes conditions which impact pressure ulcer development.	a. Partial or total immobility b. Excessive moisture: diaphoresis and/or incontinence c. History of previous pressure ulcer d. Impaired local and/or systemic circulation e. Impaired oxygenation f. Poor nutrition and/or hydration g. Uncontrolled diabetes h. Sepsis i. Immune suppression j. Generalized edema k. Severe trauma l. Prolonged OR time			
3. Verbalizes actions to decrease pressure.	a. Pressure redistribution mattress or overlay and/or chair cushion b. Placement of pillows, wedges, heel protectors, heel elevators or use of mattress with heel slope or greater pressure reduction over heels c. Turning and repositioning consistent with overall needs d. Pressure releases when sitting in chair, such as leaning side to side and forward (using table support as necessary) throughout day			
4. Verbalizes action to decrease friction and shear	a. Maintain HOB elevation < 300 unless contraindicated b. Maintain proper body alignment when in bed and chair c. Utilize lifting devices when repositioning or transferring patient d. Apply moisturizing creams to help keep skin soft and supple e. Encourage patient assist with repositioning using enabling devices, such as overhead trapeze or side rail. f. Avoid firm message over boney prominences g. Apply skin barrier film to heels			
5. Verbalizes measures to decrease moisture	a. Maintain clean and dry skin with use of skin cleansers b. Apply barrier creams or ointments with incontinence care c. Inspect skin folds for moisture retention d. Use only diapers and/or underpads that absorb and wick fluid for incontinence care e. Apply corn starch or similar product to skin folds as needed			

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Patient/Caregiver Learning Outcomes	Information to be Presented Patient/ Caregiver Learning Activities	Date	Initials	Evaluation Key
6. Describes skin inspection	a. Inspect skin daily b. Observe for redness or new discoloration to skin that does not resolve in 30 minutes after position change c. Observe for breaks or new openings in the skin			
7. Verbalizes importance of adequate nutrition and fluids	a. Malnourished individuals are at higher risk for pressure ulcer development and infection b. Adequate fluids are necessary to rid the body waste products and improve tissue perfusion c. Healing process requires adequate nourishment and fluids			
8. Demonstrates adequate fluid and nutritional intake	a. Drinks a minimum of eight 8 ounce glasses of fluids daily unless contraindicated by clinical condition b. Eats a minimum of 3 balanced meals per day c. Follows dietitian recommendations for diet , supplements, vitamins and minerals and fluid intake			
9. Verbalizes steps to follow if pressure ulcer or other wound occurs	a. Increase repositioning and turning schedule b. Notes size, location, drainage, odor and color of wound and surrounding tissue c. Notifies their physician of wound d. Notifies home health nurse of wound if receiving home care services			
Complete sections 10, 11, and 12 for patients with pressure ulcers				
10. Verbalizes effective pressure ulcer management	a. Type of product used for wound b. Where to obtain dressing supplies c. Where to obtain pressure redistribution surfaces d. States resources available e. Notes signs of pressure ulcer deterioration • New necrotic tissue • Wound drainage associated with odor and/or redness and induration surrounding the ulcer • A clean wound becomes larger or deeper			
11. Demonstrates effective dressing change technique	a. Uses clean technique b. Washes hands and dons clean disposable gloves c. Performs dressing change without cuing from staff			
12. Verbalizes steps to follow if pressure ulcer deteriorates	a. Increase repositioning and turning schedule b. Notifies their physician of wound deterioration c. Notifies home health nurse of wound deterioration if receiving home cares			

Teaching Tools	Date	Initials

Evaluation Key

S = Successfully meets outcomes
N = Needs further instruction
U = Unable to comprehend
= See Patient Ed. Notes

Patient Education Notes
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Initials	Signature	Title

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