

# Skin Care Prevention Guidelines

Implement the following for Patients At Risk of skin breakdown:

1. Assess patient daily for reddened areas or any alterations in skin over bony prominences, feet, heels, between skin folds, contracted extremities, etc.
2. Reposition patient at least every 2 hrs while in bed. When sitting in a wheelchair, repositioning should occur every 1 hour and the patient taught to shift weight at least every 15 minutes.
3. Use positioning devices (pillow, foam wedges) to maintain 30° lateral position and separation of bony prominences.
4. Elevate calves on pillows or positioning devices to relieve heel pressure.
5. Place pressure reducing mattress on bed
6. Place pressure reducing cushion in chair.
7. Utilize draw/transfer sheet for positioning and turning. (Do not drag heels)
8. Elevate knee gatch prior to head elevation.
9. Maintain head elevation as low as possible.
10. For incontinence: Cleanse skin with ph-balanced/soapless cleanser and follow with moisturizer and moisture barrier ointment.
11. For incontinence: Consider use of briefs, pads, or external catheters. Initiate bowel and bladder program.
12. For incontinence: Assess for fluid/fiber requirement for constipation or diarrhea.
13. Assess nutritional status and dietary history. Obtain dietary consult.
14. Monitor lab values for nutritional deficit:  
Hemoglobin <12mg/dl                      Total Lymphocyte Count <1800mm<sup>3</sup>  
Serum Albumin <3.5 mg/dl                Total Protein <6.0 mg/dl
15. Weigh patient. Monitor for significant weight loss,( 5% loss in one month or 10% in six months)
16. Assess need for vitamin/mineral supplements: Multivitamin with Minerals
17. Educate patient and family regarding pressure ulcers.
18. Review plan of care with patient and family.
19. Update with care plan with prevention interventions. Initiate changes as needed.
20. Document in notes a summary of interventions and compliance, improvement, or decline.
21. Document body assessment findings weekly.