SOP Prevention Plan For Skin Breakdown Over Pressure Points

Note: Once a client meets one of the CARE "triggers" that place him or her at highest risk for developing skin breakdown over pressure points, the following interventions will automatically print out on the case manager's assessment/service plan.

1. For Clients Who Are Primarily Bedfast:

Do's:

1. Look at the client's skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. See diagram on pressure points, and pay special attention to those areas.
2. Assist the client to change position at least every 2 hours.
3. Use pillows or other cushioning to:
    a. Keep bony pressure points from direct contact with the bed;
    b. Raise the heels off the bed; and
    c. Keep the knees and ankles from directly touching one another.
4. When the client is lying on their side, avoid placing them directly on the hipbone. Make sure that bony points are not touching one another, such as the knees and ankles.
5. Raise the head of the bed;
    a. only as much as necessary for comfort and if consistent with other medical conditions and restriction; and
    b. only as long as necessary for eating, grooming, toileting, etc.
    c. Raising the foot of the bed at the same time helps keep the client from sliding down to the bottom of the bed.
6. Lift, don't drag clients who are unable to assist during transfers or positioning,
7. Use special pressure reducing equipment for the bed when available.

Don'ts:

8. **Do not** use donut-type devices purchased at the drug store. These cause more pressure rather than reducing pressure.
9. **Do not** use heat lamps, hair dryers, or "potions" that could dry the skin out more.

Report the following changes to the appropriate person(s) when:

10. The client you are caring for has skin changes, such as redness, swelling, heat or pain, or a break in the skin over a pressure point; or
11. You notice that the heels turn hard and black, or purple and soft; or
12. You are unsure of how to provide care, or if special equipment is needed.

2. For Clients Who Are Primarily Chairfast

Do's:

1. Look at the client's skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. See diagram on pressure points and pay special attention to those areas.
2. Assist the client to change position at least every hour, if unable to shift his or her own weight.
3. Ask or help the client to shift their weight in the chair every 15 minutes for 15 seconds.
4. Use cushions, pillows or other pressure reducing devices to protect pressure points from hard surfaces.
5. Position the client in the chair for good posture and equal pressure over bony points.

Don'ts:

1. **Do not** use donut type cushions in a chair. These cause more pressure rather than reducing the pressure.

Report the following changes to the appropriate person(s) when:

1. The client you are caring for has skin changes, such as redness, swelling, heat or pain, or a break in the skin over a pressure point; or
2. You are unsure of how to provide care.

3. Under Nutrition Section--Eating and Drinking Hints:

Do's:

1. Follow the service plan for instruction on any special diet needs (food and fluids), or food and fluid preferences.
2. If the client has lost weight, or has a change in their eating habits, ask the client about the reason for the changes.
3. Offer small, frequent meals to the client if their appetite is poor. If their diet allows, encourage the client to eat foods high in protein (milk, eggs, meat, cheese, etc.)
4. Avoid beverages and foods, with caffeine, such as coffee, soda, and chocolate. Caffeine can irritate the bladder.
5. Offer plenty of water to the client. It will dilute the urine and reduce irritation to the skin and the bladder.

Report the following changes to the appropriate person(s) when:

1. The client has a major change involving weight gain or loss, appetite changes; or
2. There are new or worsening changes in the skin such as redness, swelling, a break in the skin, heat or pain over a pressure point; or
3. You are unsure of how to provide care.

4. Under Bathing--Preventing Problems With The Skin

Do's:

1. Look at the skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. Pay special attention to the pressure points.
2. Use mild soap (avoid soaps labeled "antibacterial" or "antimicrobial"). Use warm (not hot) water. Rinse and dry well (pat, don't rub).
3. Lubricate dry skin with moisturizing creams or ointments (such as Eucerin or Aquaphor).
4. Use a cushion or towel on the shower chair to help prevent bare skin from tearing
5. Protect bare skin during all transfers.

Don'ts:

1. **Do not** rub the skin over the bony pressure points

Report the following changes to the appropriate person when:

1. The client gets worse in their ability to shift weight, turn, transfer, etc.; or
2. You feel that using special equipment will help you transfer the client more safely and easily; or
3. There are problems or changes in the client's skin such as redness, swelling, a break in the skin, hear or pain over a pressure point; or
4. You are unsure of how to provide care.

5. Under Toileting--Management of Bowel and Bladder Supplies

Do's:

1. Follow the toileting schedule on the service plan.
2. If the client is unable to control their urine or stool, use incontinence products of the client's choice and assist with changing the product as soon as it is wet or soiled.
3. Gently cleanse or bathe the client after soiling from urine or stool, to keep the skin clean.
4. Apply a thin layer of one of the following waterproof creams or protective barriers: zinc oxide, A&D ointment, Desitin, Bag Balm, or Balmex to protect the skin from wetness.
5. Notify the appropriate person if you are unsure of how to provide care.

Don'ts:

1. If at all possible don't use "blue pads" (disposable waterproof underpads). They hold the moisture on the skin. A preferred and more skin "friendly" alternative is a waterproof cloth pad that can be laundered and reused.

Report to the case manager when:

1. You are not sure what incontinent products or barrier creams to use. The case manager may make a referral to have a nurse talk with the client and the caregiver.