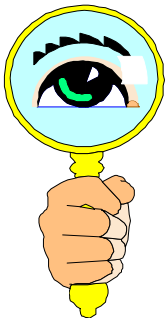

Pressure Ulcer Prevention Best Practices

Prevention is part of every aspect of wound care, regardless if a wound exists or not. Many recommended practices regarding pressure ulcer prevention are nothing more than "good old common sense". Prevention requires a holistic approach from all members of the health care team.

Interventions	Reason
Get resident out of bed if condition allows. Residents with skin breakdown, should be up a maximum of 2 hrs at a time.	Redistributes weight bearing sites and minimizes the risks of immobility.
Teach and encourage resident to shift weight every 15 minutes, assisting as necessary, while up in chair.	Prevents pressure points from developing and allows blood flow to return. Helps prevent pressure ulcers from developing on the lower portion of the buttocks.
Assist or provide resident with devices to maintain mobility, i.e., passive ROM, splint, hand cones	Lessens resident's risk for development of a pressure ulcer or contracture.
Turn and/or reposition non-ambulatory residents every 2 hrs minimum.	Rotates the sites of pressure and allows blood flow to return to an area where blood blow had been restricted.
• Lift resident off bed, do not drag when moving, especially heels and sacrum. • Use a draw sheet to help when moving or turning resident. • Place socks or heel protectors on resident. • Place pajama top or elbow protectors on resident to protect elbows.	Minimizes shear and friction which can tear the skin and damage the capillaries supplying blood to the skin.
Elevate heels by placing a pillow lengthwise under the residents calves.	Decreases pressure on the heels and may decrease shear and friction.
Place resident on pressure reducing mattress.	Reduces effects of pressure.
Place resident on pressure reducing cushion in chair.	Reduces effects of pressure.
Use maximum of 2 incontinent pads under resident in bed.	Too many layers of linen between resident and pressure reducing mattress, will decrease the effectiveness of mattress.
Avoid incontinent pads over wheelchair cushion, use drawsheet or pillowcase for cover.	Incontinent pads reduce effectiveness of pressure reduction provided by cushion.
Inspect resident's skin during bath, when changing clothes, etc.	Identify any redness or skin break so that appropriate treatment or prevention measures can begin immediately.
Apply lotion to bony prominences, back, and dry, flaky skin at bath time and prn.	Keeps skin soft and supple.
Apply moisture barrier ointment to the skin of an incontinent resident.	Helps prevent incontinence from making the skin soft and prevents burning of the skin.
Report frequent incontinence to ensure that appropriate methods of containment or treatment will be promptly implemented.	Decreases the chance of complications from incontinence.
Encourage resident to drink prescribed supplements and adequate amounts of water between and/or with meals. Report if resident refuses supplements.	Helps maintain and/or improve nutritional status and hydration.
Keep linen neat and wrinkle free.	Helps prevent shear and friction.