**Pressure Ulcer Prevention**

**Look**
- assess risk and check the skin every day
  - conduct a pressure ulcer risk assessment:
    - on admission and at regular intervals
    - following a significant change in condition
  - skin assessment:
    - daily skin inspection - check all pressure points
    - skin checks with each turn, shower or bath

**Protect**
- against pressure, shear, friction and moisture
  - skin hygiene:
    - avoid irritating substances - use soap alternative for irritated or sensitive skin
    - treat dry or flaky skin eg. sorbolene
  - avoid sustained contact with body fluids:
    - saliva/perspiration
    - urine/faeces – use a barrier cream
  - wound drainage
  - promote continence:
    - continence training, regular toileting
    - continence products – select the appropriate product for effective containment
  - skin assessments:
    - daily skin inspection - check all pressure points
    - skin checks with each turn, shower or bath

**Position**
- change position regularly, promote activity & mobility
  - reposition regularly:
    - according to the skin's tolerance to pressure
    - avoid direct contact between bony prominences
    - chair repositioning:
      - avoid uninterrupted sitting in a chair
      - maintain correct body alignment & foot placement
    - use an adjustable reclining/tilt chair

**Communicate**
- write it down & hand it over
  - level of risk:
    - on admission
    - following a change in condition
    - at regular intervals (eg daily)
  - risk factors:
    - identified as a problem in the patient progress notes
  - presence of a pressure ulcer:
    - site and stage
    - description of the pressure ulcer(s) and surrounding skin
  - plan of care:
    - Wound Chart
      - plan of care to reduce risk factors:
        - daily skin checks
        - repositioning/positioning requirements
        - skin hygiene
        - pressure reducing/relieving support surface
        - additional equipment
      - Care Plan/Action Record
        - evaluation:
          - response to care implemented
          - Care Plan/Action Record
          - Inpatient Progress Notes

**Reference**

http://www.awma.com.au

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