Pressure Ulcer Prevention

Support Surface Table

Level of risk	Overlays	Replacement Mattress	Cushions	Heel Devices/Aids	Chairs & footstools	Protective Dressings
Low	• foam overlay • sheepskin • fibre-filled overlay • gel mats	• high-specification foam replacement mattress	• foam cushion • gel mat • fibre filled cushion • sheepskin	• sheepskin • fibre-filled booties	• padded chair • padded footstool	
Moderate	• gel mats/pads • alternating-air overlay • static-air overlay	• high-specification foam replacement mattress • static-air replacement mattress • alternating-air replacement mattress	• static-air cushion • foam cushion • wheelchair cushion (consult occupational therapy)	• fibre-filled booties • gel mat/booties • foam gutters • foam wedge • bed cradle	• consult physiotherapy or occupational therapy for appropriate chair size, height and supports for correct body alignment	• podiatry felt • polyurethane film • hydrocolloid dressing • Spenco Dermal pads
High	• alternating-air overlay	• alternating-air replacement mattress • low-air-loss replacement mattress	• static-air cushion • alternating-air cushion	• foam gutters • foam wedge • bed cradle	• tilting chair • floatation chair	• podiatry felt • polyurethane film • hydrocolloid dressing • Spenco Dermal pads
Ultrahigh		• pulsating or low-air-loss beds • air-fluidised beds		• pressure relieving ankle/foot orthosis (PRAFO) (consult podiatry)		

Common Pressure Ulcer Points

- Look
- Protect
- Position
- Communicate

Southern Health

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

  Consult a Continence Advisor
- maintain a stable skin temperature:
  - avoid contact with plastic surfaces
  - avoid overheating
- optimise nutritional status:
  - maintain a balanced diet
  - supplement a poor diet

  Consult a Dietitian
- use an appropriate support surface:
  - low risk – comfort equipment
  - moderate risk – static support surface
  - high risk – alternating support surface

  Consult Wound Consultant or Occupational Therapist

  (see Support Surface Table over page)
- reduce heel pressure:
  - elevate heels – foam wedges/gutters
  - heel protectors/heel protection
  - bed cradles

  Consult Podiatrist or Wound Consultant

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

  Consult a Occupational Therapist or Physiotherapist
- eliminate shear and friction:
  - protective dressings
  - prevent sliding down bed/chair
  - lower head of bed (as tolerated)
  - employ correct patient handling techniques:
    - promote independence – monkey bar, pulley, bed poles
    - equipment – lifting machines, slide sheets

  Consult BackSafe Coordinator or liaison nurse, Occupational Therapist or Physiotherapist
- promote activity and mobility:
  - mobilise where appropriate

  Consult a Physiotherapist

Communicate
write it down & hand it over

- level of risk:
  - on admission
  - following a change in condition
  - at regular intervals (eg daily)

  Observation Chart/Care Plan/Action Record
- risk factors:
  - identified as a problem in the patient progress notes

  Inpatient 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

look position protect communicate look

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Reference

Australian Wound Management Association (2001) Clinical Practice Guidelines for the Prediction and Prevention of Pressure Ulcers, Cambridge Publishing: West Leederville.

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