Maintain skin integrity

- skin assessment
  - daily skin inspection
    - check all pressure points
  - skin checks
    - with each turn
    - shower or bath
  - maintain skin integrity
    - avoid sustained contact with body fluids
      - saliva/perspiration
      - urine/faeces
      - wound drainage
    - treat dry or flaky skin
      - eg. sorbolene
    - avoid irritating substances
      - for irritated or sensitive skin
      - use soap alternative
    - maintain a stable skin temperature
      - avoid contact with plastic surfaces
        - avoid overheating
      - optimize nutritional status
        - maintain balance diet
        - supplement poor diet
    - ensure continence is level of continence not manageable by patient or by clinical staff
      - consult a Continence Advisor
        - select appropriate product for effective containment
      - consult a Dietitian
        - obviously underweight/frailty
          - unintentional recent weight loss
          - reduced appetite or food intake
          - mouth, teeth, swallowing or other dietary problems
PPASH: Pressure ulcer prevention pathways

Protect against pressure, friction & shear

- repositioning schedule (bed/chair)
  - avoid direct contact between bony prominences
  - chair repositioning
    - maintain correct body alignment
    - correct foot placement
    - use adjustable reclining/lift chair

- promote activity & mobility
  - mobilise where appropriate
  - employ correct patient handling techniques

- eliminate shear & friction
  - protect broken skin
  - prevent sliding down bed/chair
  - lower head of bed (as tolerated)
  - elevate heels
  - use equipment
  - monkey bar
  - pulley
  - bed poles/sticks
  - lifting machines
  - slide sheets
  - consult an occupational therapist

- reduce heel pressure
  - use an appropriate support surface
  - low risk
  - comfort equipment
  - moderate risk
  - static support surface
  - high risk
  - alternating support surface

- consult the podiatrist or wound consultant
- consult the occupational therapist or physiotherapist
- consult the wound consultant or OT

Australian Wound Management Association (2001)
PPASH: Pressure ulcer prevention pathways

1. Level of risk (low/mod/high)
   - On admission
   - Following a change in condition
   - At regular intervals

2. Risk factors
   - Identified as a problem in patient progress notes

3. Presence of a pressure ulcer
   - Site & stage
   - Description of pressure ulcer & surrounding skin
   - Plan of care

4. Plan of care to reduce risk factors
   - Daily skin checks
   - Repositioning/positioning requirements
   - Skin hygiene
   - Pressure relieving/reducing support surface
   - Additional equipment

5. Evaluation
   - Response to care implemented

6. Document & communicate

Progress Notes/Care Plan

Progress Notes

Complete a Pt Incident Form and commence a Wound Chart

Care Plan/Action Record

Care Plan/Action Record

Progress Notes

Australian Wound Management Association (2001)
Lower Limb Devices

The ideal pressure relieving device for an acute healthcare facility would:
- offload the heels;
- protect other bony prominences of the feet (malleoli, toes etc);
- allow the client to ambulate;
- remain with the client as they move around the organisation (from emergency to theatre to the ward or critical care unit... to home);
- meet Infection Control standards for cleaning and re-use;
- be affordable.

### Devices currently in use at Southern Health

<table>
<thead>
<tr>
<th>Device</th>
<th>Advantages</th>
<th>Disadvantages</th>
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</table>
| **Booties:** gel, fibre filled or sheepskin | • provide degree of comfort  
• protect bony prominences of the foot and ankle  
• may offer low level pressure redistribution  
• suitable for less active client | • difficult to keep in place  
• dangerous for mobile clients  
• often single client use only  
• difficult to retain on the ward |
| **Podiatry felt padding** | • total offloading of a localised area  
• adhesive backing ensure the pad remains fixed | • must be kept dry and is not suitable for high exudate wounds  
• not suitable for wounds with undermining, padding may increase wound edge pressure  
• application requires time and training |
| **Foam wedges, gutters and standard pillows** | • total offloading of heel for bedridden clients  
• easily cleaned (if appropriately covered)  
• large items and less likely to be lost in linen | • not often tolerated for prolonged periods of time  
• not suitable for active or restless patients  
• must be positioned so that the heel is elevated off the underlying surface |
| **Leg rolls:** fibre filled or foam | • total off loading of heel  
• useful for more active and restless clients | • can not always obtain heel clearance  
• need to be sized appropriately to prevent movement of device |
| **Foot orthosis** | • posterior offloading of heel  
• lightweight & streamlined  
• easy to clean  
• replaceable foam linings  
• reduces risk of calf contracture  
• suitable for prevention and management of heel pressure ulcers | • unable to ambulate wearing device  
• requires compliant client |
| **PRAFO (Pressure Reducing Ankle Foot Orthosis)** | • offloading of posterior heel  
• reduces the risk of contracture  
• indicated for existing pressure ulcer  
• allows patient to ambulate and progress toward rehabilitation or discharge | • requires compliant client  
• bulky with external strapping  
• risk of damage to the other limb  
• expensive |

Southern Health (2004)