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| **Potential risk areas** | **Skin Assessment** | | | **Surface (equipment )** | **Keep**  **Moving** | **Incontinence** | | **Nutrition** |
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| **Intervention**  **&**  **Actions**    **OBJECTIVE To engage patient, nurses, and carers in pressure ulcer prevention** | * Check the skin at each vulnerable area at every opportunity * usually where the bones lie close beneath the skin. * Document any existing areas of skin damage including scar tissue * Apply fingertip test to any reddened / discoloured areas and check it blanches * If blanching does not occur – you have skin damage * If the skin is darkly pigmented instead of looking for reddened areas look for – * Darker areas, heat or pain, hardening of skin or overly soft skin. | | | * Have a current Waterlow score * Select equipment (mattress /cushion ) according to Waterlow score and local guides lines * Use pillows to elevate heels off the mattress and separate limbs * Check electrical equipment is plugged in and serviced. * Keep vulnerable areas or already ulcerated areas from lying on a firm resting surface * Ensure glasses, oxygen tubing, other tubing, call bells, are not causing skin damage by being rested on | * Encourage patient to self-turn/stand /walk * Explain to family, carers need for repositioning * Provide information factsheet * Use positional charts * In high risk patients chair sitting time may need to be restricted to 2 hours only or even 24 hour bed rest advised with 2 hourly positional changes * Even with air cushion and air mattress repositioning and restricted sitting time may be required in some situations * Use the 30 degree tilt to vary and change positons * Check pain is not preventing positon changes | * Encourage walking to toilet /commode * Encourage assistance and frequent support with toileting * Only use one continence pad at one time * Request a continence assessment if the pads are not suitable * Use skin barriers and creams that are transparent so the skin can be easily checked for any damage * Use the opportunity of going to the toilet to check the skin on the buttocks and back of the thighs * Encourage people to speak about any change to their bowel habit or passing urine | | * Have a current MUST/nutrition score * Encourage fluids * Provide information about importance of good balanced diet * Complete food and fluid charts if nutrition is compromised * Refer to dietician as required * Follow dietician or SALT care plans * Encourage people to say if their appetite or fluid intake levels have changed * Check the mouth/teeth and tongue are healthy * If pressure ulcers are present then encourage high fat and protein diet |
| Date of assessment | | Waterlow score | Clinicians Name | | Clinicians signature | Client/carers name | Client/signature carers | |
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NB: The care plan is to be discussed with the patient when the Waterlow reassessment has been undertaken.