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| **Potential risk areas**  | **Skin Assessment**  | **Surface (equipment )**  | **Keep**  **Moving**  | **Incontinence**  | **Nutrition**  |
|  |  | W:\My Documents\My Pictures\36573.jpg |  |  |  |
| **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.