Best Practice Statement – Prevention of Pressure Ulcers (PU)

(For non-digital wards still using SSKIN Pressure Ulcer Risk Assessment)

This best practice statement is designed to prompt staff with interventions to plan care for inpatients with a **SSKIN** +ve PU Risk Assessment

Skin

1. Pressure ulcer risk assessment must be completed within 4 hours of admission, and **reassessed daily** - highlight at handover – any PU risk.
2. Skin condition should be assessed daily - minimum and documented in their personal care record or SSKIN Care Bundle.
3. If patient self-caring, have daily discussion about their skin.
4. Discuss with patient/carer if they have any history of PU or skin concerns.
5. Provide the NHS Grampian leaflet "Preventing Pressure Ulcers - Information for patients and carers". Ensure this is discussed with them and the conversation documented.
6. If skin shows any signs of pressure related damage – highlight at handover.

- Follow Datix guidance – all new PU require a Datix report.
- Follow Wound Referral Guide for further advice and support, as required.

Surface

1. Assess the suitability of pressure redistributing support surfaces (mattress, cushions, heel protectors, etc.). If patient is very tall a mattress extender should be added to **head end of bed frame**, to increase length of mattress.
2. Is a higher risk surface required? - refer to guidance.
3. If equipment unavailable this should be Datix reported.
4. Document the make and model of all pressure redistributing equipment and date implemented on Skin Care Bundle.
5. Reassess pressure ulcer risk and equipment requirements daily.
6. Document any refusal or non-concordance of equipment (remember there are alternative support surfaces to offer patients e.g. OSKA lateral tilt).

Keep Moving

1. Ask if and how the patient is able to reposition themselves independently to prevent pressure damage. Encourage and enable patient to change position independently as able.
2. Promote and ensure the use of equipment for repositioning as appropriate (glide sheet, hoist, bespoke seating, patient turning systems etc).
3. If PU to sacrum/buttocks up to sit for maximum 1 hour (e.g. meal times) on a pressure relieving cushion/chair, returning to bed for minimum 2 hours.
4. Ideally patient is nursed semi-recumbent 30 degree tilt to offload pressure from sacrum when in bed. Consider using knee break to prevent slipping down bed.
5. Document position changes (and rationale for any omissions) within patient's SSKIN Care Bundle.
6. Assess pain levels and offer analgesia as prescribed.

Incontinence (and/or Moisture)

1. Discuss the patient's normal pattern of elimination.
2. Seek advice from bladder and bowel specialists as required.
3. Consider other potential causes if moisture related skin damage (i.e. perspiration) and follow the relevant Moisture Associated Skin Damage (MASD) Pathway.
4. If Incontinence/Moisture Related Dermatitis follow Incontinence skin care pathway - **Do not apply Hydrogel**

Nutrition

1. Discuss patient's normal diet/fluid intake. Encourage varied diet and hydration.
2. Complete MUST score and act upon findings, liaise with Dietician as appropriate.
3. Review blood chemistry if there are any concerns/indications of malnutrition.
4. Follow nutritional care plan, where relevant.