PREVENTING PRESSURE ULCERS

Assess the patient’s risk of pressure ulcers within 2–4 hours of admittance or at least within 8 hours. Reassess the risk every time the patient’s condition changes, but at least once a week.

1. Assess the risk according to mobility and skin condition
   - **HIGH RISK**: Very limited mobility or an existing pressure ulcer. Dynamic, alternating pressure mattress or a high-risk seat cushion.
   - **MODERATE RISK**: Limited mobility or fragile skin or loss of sensation. At least a gel memory foam mattress or seat cushion.
   - **LOW RISK**: No limitations in mobility and healthy skin. New assessment when condition changes or at least once a week.

2. Check the skin condition
   - Check the skin especially on bony prominences, and near cannulas, catheters etc.
   - Assess the skin: dry/moist, changes in colour, tissue elasticity, swelling, abrasions, blisters, and changes in temperature.
   - Assess pressure ulcers classification and location.
   - Check the skin at least once per shift (8 h) – more often if the risk is increased.

3. Care for the skin and possible incontinence
   - Keep the skin clean and dry.
   - Change any moist bed linen and clothes.
   - Apply lotion on dry skin.
   - Check for incontinence: Check diapers every 2–3 hours and use protective products on skin.

4. Relieve pressure and mobilise
   - Relieve pressure from sitting patients at least once per hour, from bed patients every 2–4 hours, depending on the surface.
   - Use pressure-relieving positions/repositioning: favour the 30° tilt and mind the heels.
   - Prevent bony prominences from touching each other.
   - Keep the head of the bed at the lowest possible level, as determined by the patient’s condition.
   - Avoid friction when lifting and moving the patient.
   - Instruct and motivate the patient to move independently.

5. Assess the risk of malnutrition
   - Follow the organisation’s best practice method for assessing the risk of malnutrition.
   - Take care of nourishment according to the nutrition instructions.

6. Documentation
   - Document the class of the risk, classification and location of the pressure ulcer, prevention and treatment plan, and all the performed procedures.

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