Oxford University Hospitals
NHS Foundation Trust

# aSSKINg Pressure Ulcer Prevention Care Bundle: Guide to What and Why

| aSSKINg | What you can do | Why? |
|---|---|---|
| **Assessment of Risk**<br>CLICK HERE for more information | Pressure ulcer risk assessment should be completed within 6 hours of admission.<br>Use clinical judgment alongside risk assessment tools.<br>Reassessed risk if any change in the patient's condition/ mobility, or weekly as minimum. | Risk assessment is an essential component in the prevention of pressure ulcers and implementation of appropriate care.<br>*Patients with an active or pre-existing/ healed pressure ulcer are high risk of further development* |
| **Surface**<br>CLICK HERE for more information | All patients, following a pressure ulcer risk assessment, should be cared for on an appropriate mattress and cushion.<br>*Remember equipment does not replace the need to reposition to patient* | Surface selection is important in pressure ulcer prevention by helping to reduce the amount of pressure over a bony prominence. |
| **Skin Inspection**<br>CLICK HERE for more information | Skin inspections should be undertaken and documented within 6 hours of admission to all clinical areas.<br>Regularly assess pressure areas and under devices for discolouration or changes in the skin condition.<br>Assess skin at least once per shift, and if your patient is at risk of pressure damage at each position change. | Regular skin inspection will identify any potential problems with the skin such as early signs of pressure damage.<br>You can then put preventative measures in place to optimise care and reduce the risk of pressure ulcer development. |
| **Keep Moving**<br>CLICK HERE for more information | Patients should be assisted or encouraged to reposition on a regular basis.<br>The frequency of repositioning should be guided by the individual's risk assessments and findings of the skin inspections.<br>Avoid positioning a patient onto an area with pressure damage. | Repositioning is key to preventing pressure damage as prolonged periods of unrelieved pressure can result in skin damage, even in a relatively short time, including under devices. The length of time before damage occurs will vary from individual to individual. |
| **Incontinence and moisture**<br>CLICK HERE for more information | Ensure patients are kept clean and dry.<br>Use appropriate products to manage continence needs. Do not leave procedure sheets under patients.<br>Use barrier products to protect vulnerable skin before it becomes irritated.<br>Use pH balanced cleansers.<br>Consider referral to continence team | Increased moisture caused by incontinence, sweating, wound exudate or bleeding can weaken and irritate the skin, making it more vulnerable to break down.<br>pH balanced cleansers reduce risk of irritation and drying of the skin. |
| **Nutrition and hydration**<br>CLICK HERE for more information | Complete a nutritional risk assessment on admission and on a weekly basis.<br>Provide assistance and encouragement to meet nutritional and hydration needs.<br>Refer to a dietician if nutritional needs are not being met. | Nutrition and hydration are vital to skin health. Optimisation of nutrition and hydration is also important to wound healing. |
| **Giving Information**<br>CLICK HERE for more information | Whenever possible, offer appropriate advice, information, and psychological support to enable patients/carers to participate in the care programme.<br>Provide an education leaflet on pressure ulcer prevention to patients available on the Trust website.<br>Utilise members of the MDT to help in the prevention and treatment of pressure ulcers. | Involvement of MDT (i.e., TVN, Podiatry, Dietitian, etc) can positively impact the prevention and management of pressure ulcers. |