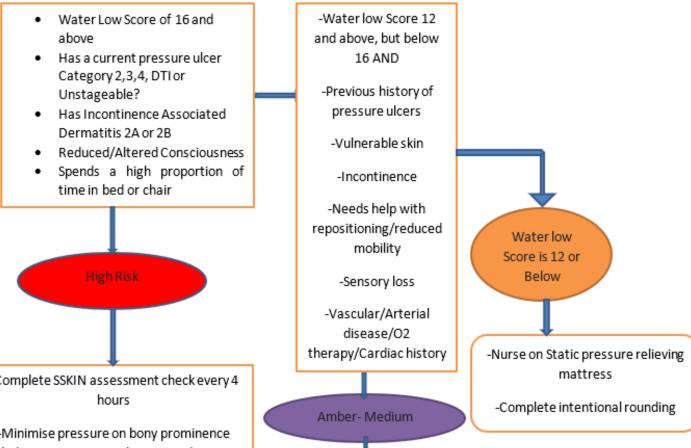


Appendix 4-Pressure Ulcer Risk Assessment Tool

This applies to all patients on admission and transfer to clinical areas. Water low Score and SSKIN assessment to take place within 4 hours of arriving on the Community Bed setting, and on the very first visit in the Community Nursing setting. WLS and MUST Risk assessment tools should be done as per Trust



- -Complete SSKIN assessment every 6 hours
 - -Commence repositioning every 3 hours during the day and 4 hourlies at night
 - -Datix and Safeguarding as appropriate, and if skin damage does occur
 - Datix/Safeguarding to be completed as per above identified skin damage/Recalculate Water low Score
 - Complete wound management chart and care plans
 - -Nurse on Alternating or Low Air Loss pressure relieving mattress and air cushion
 - -Encourage patients to mobilise
 - -Limit patients sitting out with the above pressure damage to mealtimes
 - Consider offloading heel devices

- Complete SSKIN assessment check every 4
- -Minimise pressure on bony prominence including, turning onto alternate sides, using correct slide sheets/equipment
- -Complete repositioning charts every 2 hours a day and 4 hours at night
- -Datix/Safeguarding to be completed as per above identified skin damage
- -Complete wound management chart and care plans
- -Nurse on Alternating or Low Air Loss pressure relieving mattress and air cushion
 - Encourage patients to mobilise
- -Limit patients sitting out with the above pressure damage to mealtimes
 - -Consider offloading heel devices