Royal Children's Hospital
Clinical Guideline (Nursing)

PREVENTING PRESSURE INJURIES

1. COMPLETE RISK ASSESSMENT

- A structured risk assessment should be completed as soon as possible to ensure early recognition of individuals at risk
- Completed on admission, daily or when a patient's condition changes, when a patient is transferred from one ward/department to another
- RCH follows the *Glamorgan Pressure Ulcer Risk Assessment scale*

Pressure Injury Risk Assessment		Score	
Mobility			
	Child cannot be moved without great difficulty or deterioration in condition/general anaesthetic	20	Select one score per section
	Unable to change his/her position without assistance /cannot control body movement	15	
	Some mobility, but reduced for age	10	
	Normal mobility for age	0	
Equipment			
	Equipment/ objects / hard surface pressing or rubbing on skin	15	

Patients with a risk score of **10 or greater** require a **Pressure Injury Prevention Plan**

2. DEVELOP A PRESSURE INJURY PREVENTION PLAN

Prevent friction & shearing forces during repositioning and transfers

- Lower bed head prior to repositioning
- Use slide sheets to move patient
- Apply skin barrier dressing

Reduce moisture

- Apply barrier cream to high risk areas
- Keep skin dry and clean
- Investigate and manage incontinence

BARRIER CREAM

Barrier creams place a physical barrier between the skin and contaminants that may irritate the skin and lead to breakdown.

PICU has a variety of barrier cream products on imprest for use:

- **Nappy goo** – contains zinc oxide which provides a protective barrier on top of the skin that protects skin from moisture and irritants
- **Calmoseptine** – also contains zinc oxide
- **Hamilton dimenthi cream** – contains a silicone polymer (Dimethicon) which is a proven water repellent

When to use?

- Prevention/treatment of nappy rash and sacral pressure injuries
- Any area of body susceptible to moisture i.e. underarms

Skin Inspection

Inspect skin of all patients on admission and at each repositioning to identify indications of pressure injury

- Patients with a pressure risk assessment score of 20+ should have their skin inspected HOURLY

Table 1 frequency of Skin Inspection

Level of Risk (Glamorgan)	Frequency of Skin Inspection
10+ At Risk	Skin should be inspected at least twice a day
15+ High Risk	Skin should be inspected with each repositioning
20+ Very High Risk	Skin should be inspected hourly

Nutrition

High risk patients should be referred to a dietician for a nutritional assessment and appropriate dietary recommendations to prevent compromise to skin integrity

Positioning & repositioning

- It is recommended that patients who are unable to reposition themselves (most PICU patients!) should be **repositioned every 2 hours!**
- Repositioning should be performed regardless of the support surface on which the patient is managed i.e. pressure mattress

Level of Risk (Glamorgan)	Positioning and Repositioning
10+ At Risk	Relieve pressure by helping the child to move and repositioning equipment and devices every 2 hours
15+ High Risk	Reposition child/ equipment/ devices at least every 2 hours
20+ Very High Risk	Reposition child/ equipment/ devices at least every 2 hours