OUR LADY'S CHILDREN'S HOSPITAL
NURSING CARE PLAN 37
Care of a child at risk of developing / has a pressure ulcer

Care plan 37 Problem	**Goals** **Issue date: Nov 2015 Review date: Nov 2018**
…………………… is: ☐ at risk of developing a pressure ulcer ☐ has a pressure ulcer	1. Assessment and prevention of pressure ulcer 2. Early detection of changes in skin integrity 3. Initiation of pressure relieving strategies to prevent pressure ulcers 4. Management of the pressure ulcer

Commenced date, time, signature & grade	No	Nursing intervention	Discontinued, date, time, signature & grade
		Nursing intervention *Use in conjunction with Guidelines on Preventing Pressure Ulcers (to be written)*	
	1.	**Assessment of risk of developing a pressure ulcer**	

- Perform a pressure ulcer risk assessment using the Glamorgan within 6 hours of admission if _____________ has one or more of the following screening risk factors:

☐ Reduced mobility / bed rest ☐ Reduced nutritional intake / Fasting > x days
☐ Incontinence inappropriate for age ☐ Sensory / Cognitive impairment
☐ Altered tissue perfusion ☐ Other
………………………………………………………

- Repeat the risk assessment anytime the child's condition changes or as clinically indicated
- Examine child's pressure areas at least daily

Score	Glamorgan Scale
<10	At least weekly
10+	Every 12 hours
15+	Every 12 hours
20+	Every 12 hours

- **Note:** If child scores 10 due to IV Cannula **onl**y, please refer to Careplan No X

	No		
	2.	**Prevention of Pressure Ulcers Title**	

Score	Preventative strategies
<10	
10+	· Inspect skin *state frequency*. · Relieve pressure by helping child to move at least every 2 hours. · If indicated, use an age and weight appropriate pressure redistribution surface for sitting on sleeping on. · Reposition equipment/ devices at least every 2 hours.
15+	· Inspect skin *state frequency*. · Reposition child at least every 2 hours. · Relieve pressure before any skin redness develops. · Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on. · Ensure equipment / objects are not pressing on the skin.
20+	· Inspect skin *state frequency* · Move or turn if possible, before skin becomes red. · Consider using specialised pressure relieving equipment: *give details* . · Ensure equipment / objects are not pressing on the skin.

Patient Name ………………………………
HCR No ………………………………
Ward ………………………………

	3.	**Management of risk factors (please refer to individual careplans as necessary**	
		Immobility: **Nutrition:** **Medical devices:** **Incontinence (inappropriate for age):**	
	3.	**Pressure Ulcer has developed**	
		Wound care - Assess and grade pressure ulcer - Determine the specific clinical needs of the wound and choose a dressing(s) to meet these needs - Report, record and respond - Change wound dressings when clinically indicated. Please record name of dressing used and update if any changes made. **Wound 1: Plan of Care** …………………………………………………………………………… …………………………………………………………………………………………… ……………………………………………………………………………………………………	
	4	**Parent Education**	

Created June 2011

Patient Name ………………………………

HCR No ………………………………

Ward ………………………………