Queen Elizabeth Hospital Birmingham
Part of University Hospitals Birmingham NHS Foundation Trust

Pressure Ulcer Prevention Plan (PUPP)

Date: _____ **Time:** _____

Registered Nurse Print name: _____

Registered Nurse Signature: _____

Patient ID sticker label

Skin Inspection Plan (Document inspections on "Skin Inspection and Assessment Tool")

Frequency of Skin inspection if more than daily inspection is required: **2hr** ☐ **4hr** ☐ **6hr** ☐ **8hr** ☐ **other**: ____ ☐

AES/Bandages/Devices need to be removed for skin check **Yes** ☐ **No** ☐ **N/A** ☐

Detail any vulnerable areas to check

Patient/family educated to inspect own skin and report changes **Yes** ☐ **No** ☐ **N/A** ☐

Information leaflet provided **Yes** ☐ **No** ☐

Reassessment

Planned frequency of Waterlow reassessment:

a minimum of weekly if not at elevated risk on initial assessment (i.e. Waterlow<10).
prior to discharge. This information must then be communicated to the community/referring hospital.
React to RED implemented if Waterlow score is 20+ or red areas are identified. **Yes** ☐ **No** ☐ **N/A** ☐

Repositioning Regime (Must be based upon the results of skin inspection, individual comfort and ability to move. Patients must be repositioned even if they are nursed on pressure relieving equipment.)

Planned frequency of repositioning: This must be prescribed on PICS.

Positioning restrictions:
eg unable to lie on left side

Plan for sitting out:
(Include type of equipment)

Manual handling aids in use **Yes** ☐ **No** ☐ Details:

Any devices/lines to consider when positioning the patient?
eg O_2 tubing, urinary catheters, AES, collar, splint, POP

Please state

Pressure relieving equipment (If appropriate order and utilise as detailed in the Equipment Selection Flowchart)

Foam mattress ☐ Air mattress ☐
Integral cushion ☐ Air cushion ☐ Aderma ☐
Gel pads ☐ Leg trough ☐ Heel protector ☐

Changes made

Seating (refer to patient seating guide) Confirm suitable width/ depth: ☐ Confirm suitable height (feet on floor) ☐
Detail specialist seating Therapy Services involved **Yes** ☐ **No** ☐

Continence risk factors

Continence assessment completed **Yes** ☐ **No** ☐ Wash regime:
Detail continence aids in use: Barrier cream in use:

Nutritional risk factors

MUST assessment completed. **Yes** ☐ **No** ☐ **Supplements**
Are nutritional requirements being met? **Yes** ☐ **No** ☐ **Dietician ref:**

If you have answered 'no' to any of the questions above document details overleaf.

Individualised Care:

This document should be updated as the patient's condition and plan of care changes. Initial any changes unless document becomes unclear then rewrite. It must also be completed on discharge with an updated Waterlow score and copied for Specialist Nursing Teams.

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Record any change to planned care and detail reason for this and actions taken		
Date & Time	What happened? What did we do?	Registered health care practitioner's signature, name and designation