Introduction
Preventing pressure ulcer has been a nursing concern for many years. Although the prevention of pressure ulcer is a multidisciplinary responsibility, nurses play a major role. The incident rate of pressure ulcer per 1000 patient bed days in our geriatric unit ranged 1.49 -1.70 (1Q 2014). Though considered largely preventable, pressure ulcer remains to be a significant potential problem in our unit. Accurate risk assessment, skin care, mechanical loading, patient and staff education could reduce the incidence of pressure ulcer. Team approach ward round was used in this program to improve the incident rate of pressure ulcer.

Objectives
1. To enhance our nursing staff on implementing effective pressure ulcer prevention practices. 2. To reduce the incident rate of hospitalized acquired pressure ulcer in our unit for 30% by 3Q2014.

Methodology
A Pressure Ulcer Prevention (PUP) team was formed in our unit since March 2014. This PUP team established some preventive strategies to improve the incident rate by replacing the pressure relief devices including foam mattress and educating nurses on pressure ulcer risk assessment to provide appropriate nursing care. PUP ward round was carried out twice weekly. Audits were conducted to ensure reliable processes in assessing skin integrity using Braden Scale for all patients on admission and it would also be reviewed regularly. Also the pressure reliving devices, such as foam mattress, heel protectors and gel cushions etc., were checked whether they were in place for all patients at risk. All nurses in our unit had completed the training on pressure ulcers prevention strategies through e-learning platform. Moreover, our
PUP team offered mentoring, guidance, and consultation for staff in addition to direct patient care.

**Result**
Fifty-four pressure ulcer prevention ward rounds were implemented by PUP team since May 2014. We found that the accuracy of Braden scale assessment and knowledge in pressure ulcer prevention of our nursing staff were insufficient. Therefore, we held provided several learning courses of Braden scale assessment, usage of pressure relieving devices and pressure ulcer assessment for our nursing staff. The ward round continued in 2014. In the latest analysis, the total number of hospital acquired pressure ulcers were reduced from 6 in 1Q2014 to 1 in 3Q2014. After correcting for the patient-bed days, the incident rate of pressure ulcer was reduced from 1.56 per thousand patient bed days in 1Q2014, to 0.27 in 3Q2014.