Prevention and Management of Pressure Ulcers - Summary Clinical Guideline

Reference No:CG-CLIN/4208/23

- The Prevention and Management of Pressure Ulcers care pathway should be completed for all patients at risk of pressure damage and patients with existing pressure damage within 12 hours.
- A short stay pathway is available on Derby sites, for patients admitted for less than 3 days.
- In addition, a wound care pathway should be completed for all active ulceration on Derby sites and the wound assessment form should be completed on Meditech on Burton sites.
- Active pressure damage should be categorised according to EPUAP grading (Categorisation) tool.
- All SDTI's and Category 2, 3 and 4 pressure ulcers require a datix incident report.
- The Tissue Viability team will review all SDTI's and category 3 and 4 pressure ulcers following receipt of a datix incident report.
- Dressings should be selected using the wound care formulary available on Neti.
- Care and interventions should be evaluated and reassessed by trained staff at frequent intervals and as the patient's condition changes.
- Medical devices should be documented on a body map, repositioned as able and have specialist care plans.
- Plans should be made for discharge to allow continuity of care for any pressure reducing strategies and wound care if applicable.
- The 7 essential steps to preventing damage using the acronym aSSKINg are detailed in the following table:

assessment	• Qualified member of staff should undertake risk assessment within 2 hours of admission/transfer and documented.
Surface	• Support surfaces require 24-hour approach including mattresses cushions and offloading boots. • Discussion is required with consultant for spinal patients before using alternating systems. • Equipment should be cleaned as per trust policy. • Offloading boots available from site central storage location • Equipment should be downgraded if patients condition improves
Skin	• Full skin assessment by qualified staff should be undertaken within two hours of admission/ transfer, including all bony prominences, and documented. • Look for Erythema (redness), non-blanching redness, purple discolouration, blistering, localised heat, localised heat, localised oedema, localised pain, localised induration, active pressure damage. • Active pressure damage should be categorised according to EPUAP grading system. • All pressure damage should be documented within the care pathway documentation. • Skin reassessment should take place at every position change and recorded every 8 hours in care pathway. • Obtain medical photography where possible for category 3 and 4 pressure ulcers.
Keep Moving	• Individuals should be repositioned according to individual need and skin inspection. • Recommendations for repositioning are made within the Green, Amber, and Red care plans within the pressure ulcer prevention care pathway. • All repositioning activity should be logged on the daily record of repositioning within the pressure ulcer prevention care pathway. • Repositioning should match the allocated care plan.
Incontinence	• Appropriate skin wash and barrier wipes should be used for all incontinent patients as per protocol. • Catheters should be considered if necessary to maintain skin integrity. • Bowel care including management of overflow and faecal management should be considered in extreme cases
Nutrition	• MUST scores should be completed, and appropriate referrals made to dietician for nutritional support of required.
Giving information	• Patient information leaflets should be provided. • SSKIN advice sheets should be provided, particularly if patients require reiteration of need for interventions. • TVN will apologise and undertake Duty of Candour with all patients who develop category 3 or 4 pressure damage within our care.