Pressure Ulcer Prevention Guidelines

Assessment

Assessment is crucial for prevention of pressure ulcers, it allows us to identify:

- Who is at risk
- Whether the patient has or has had any pressure damage
- The level of risk
- What action is needed to prevent damage

Assessment should be carried out using your Trust's Assessment Tool. If you need any help on how to complete the tool contact your Tissue Viability Link Nurse, Team Leader or Tissue Viability Specialist who will be able to provide you with guidance.

Assessment to determine whether a patient is at risk should be carried out:

- ✔ On admission
- ✔ At least weekly
- ✔ If their condition changes
- ✔ On discharge, transfer or return.

Action

If a patient is at risk of pressure damage, action must be taken to protect the skin. The aSSKINg Bundle can be used to guide your practice.

The patient's level of risk and skin condition will determine how often you carry out the aSSKINg Bundle, it includes:

- **Assess the risk** - carry out a risk assessment and provide a care plan appropriate to the patient's needs.
- **Skin** - check bony prominences or where devices touch the skin. Are there any early signs of pressure damage?
- **Surface** - Are they on the correct mattress and cushion? Is it working correctly? Offload heels.
- **Keep moving** - regularly help patients to reposition. This is the best way to protect the skin.
- **Incontinence** - protect the patient's skin from Incontinence Associated Dermatitis, with skin barriers and good incontinence products.
- **Nutrition** - Ensure the patient has had a nutritional assessment.
- **Give** information & share learning. Use a collaborative multidisciplinary approach, get help and advice early. Keep clear documentation.

Accountability

We all have a responsibility for protecting a patient from harm. Always document the action you have taken to protect your patients along with the condition of the skin every time the aSSKINg Bundle is carried out.

When a pressure ulcer occurs immediate action must be instigated to prevent damage getting any worse. Where possible any source of pressure must be removed and the skin protected.

The damage should be reported, on admission and or when it deteriorates, using your Trust's incident report system. The following should be included in the report:

- The pressure ulcer category
- The position of the damage
- The size of the damage
- Action taken to prevent further deterioration in the skin.

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance.
Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.

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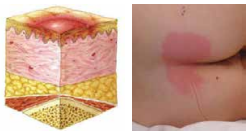
Pressure Ulcer Classification Guide

All pressure ulcers category 1-4 (EPUAP 2014) and deep tissue injury must be reported as per Trust Guidance

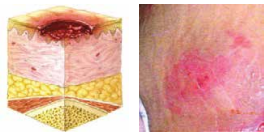
Category 1



Non Blanchable erythema:

Intact skin with non-blanchable redness over a bony prominence. Dark coloured skin may not have visible blanching - this may present as a different colour to surrounding skin. Area may be painful, firm, soft, warmer or cooler to touch than surrounding skin.

Category 2

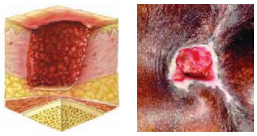


Partial thickness skin loss:

Cracked, partial thickness loss of dermis, presents as a shallow open ulcer without slough. May also present as an intact or open ruptured serum filled blister.

**Bruising indicates deep tissue injury*

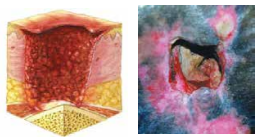
Category 3



Full thickness tissue loss:

Subcutaneous fat may be visible but underlying structures (e.g. bone, tendon, muscle) are not visible. Slough may be present but does not obscure the depth of tissue loss. Depth may vary due to anatomical location. Undermining/ tunnelling may be present.

Category 4



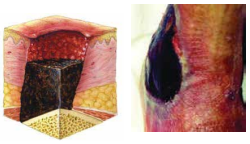
Full thickness tissue loss:

Full thickness tissue loss with exposed structure (e.g. bone, tendon, muscle)

Slough or eschar may be present; often including undermining/tunnelling. May vary due to anatomical location.

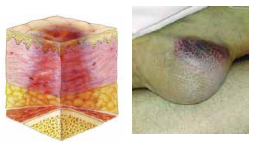
Unable/Depth unknown

Full thickness tissue loss in which the base of the ulcer is obscured by slough or necrosis. Until the base of the wound is exposed then the category cannot be determined. Note: stable, dry eschar (without fluctuance or erythema) serves as the body's natural cover and should not be removed.



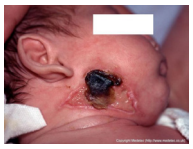
Deep tissue injury depth unknown (DTI)

Purple or maroon localised area of discoloured intact skin or blood filled blister due to damage of underlying soft tissue from pressure and /or shear. The area may be preceded by tissue that is painful firm, mushy, boggy warmer or cooler as compared with adjacent tissue. DTI may be difficult to detect in individuals with dark skin tone. Evolution may include a thin blister over a dark wound bed. The wound may evolve and become covered by a thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



Medical Device Related

Device related pressure ulcers SHOULD be reported and identified by the notation of (d) after the category.- eg category 2 PU (d) to allow their accurate measurement



Moisture-Associated Skin Damage (MASD)

Incontinence-Associated Dermatitis (IAD)

- Damaged caused by urine or faecal matter.
- Found over fatty tissue of the buttocks, perineum, inner thigh and groin (though they can occur over bony prominences.)
- Presence of erythema, skin inflammation, erosion & denudation.
- Presents with non-uniform redness in the wound bed, maceration in the surrounding skin and peri-anal redness. No necrosis.
- Has diffuse and irregular wound margins.

Intertriginous Dermatitis (ITD)

- Damaged caused by excess perspiration.
- Found in the skin folds.
- Distributed in a linear, mirror image on each side of the fold.
- Always partial thickness.
- Present as mild erythema (redness) that can quickly progress to erosion, oozing, maceration or crusting.
- Surrounding skin is often macerated and prone to bacterial and fungal infections such as candidiasis.
- Can be painful, itchy and may produce odour.

Periwound Moisture-Associated Dermatitis

- Damaged caused by wound exudate.
- Found in skin adjacent to a chronic wound.
- The condition is more common in the elderly and immunocompromised.
- Presence of erythema, inflammation and signs of erosion.
- Other causes include improper dressing selection, infrequent dressing changes, and aggressive tape removal.

Peristomal Moisture-Associated Dermatitis

- Damaged caused by urine or faecal seepage in ostomy patients.
- It begins at the stoma/skin junction, and can extend outward as much as 4 inches (10.16cm) in any direction.
- Found around any stoma, including tracheostomies, gastrostomies, urostomies, and colostomies.
- Well-defined erythema, edema, and loss of the epidermis. You may also see papules, vesicles, itching, crusting and oozing.

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