**Pressure Ulcer Prevention Pathway**

**IS YOUR PATIENT AT RISK OF DEVELOPING PRESSURE DAMAGE TO THE SKIN?**

**INTRINSIC FACTORS**
Something within the body that can often be influenced

**EXTRINSIC FACTORS**
Something external to the body and that can be influenced

**ASSESSMENT**

**DIAGNOSIS**

**SPECIFIC RISK FACTORS**
- Pressure
- Shearing
- Level of mobility
- Ability to reposition or transfer
- Sensory impairment
- Continence
- Level of consciousness
- Acute, chronic and terminal illness comorbidity

- Pain –(use an appropriate tool to measure it)
- Posture
- Cognition
- Psychological status, including ability to self-care
- Social factors
- Previous pressure damage
- Nutrition and dehydration
- Moisture to the skin

**SKIN ASSESSMENT**
- Regular skin assessment to detect potential pressure damage
- Assess the most vulnerable areas of risk (bony prominences such as head, elbows, shoulders, buttocks, heels, hips, ankle, sacrum, toes, knees, chest, chin or ear)

Observe signs of the following:
- Persistent erythema
- Non-blanching hyperaemia

NB. Individuals with darkly pigmented skin may present pressure ulcer development as follows:
- Purplish/bluish localised areas of skin
- Localised oedema / induration
- Localised heat which, if tissue becomes damaged, is replaced by coolness

**PATIENTS AT PARTICULAR RISK**
- Undergoing surgery
- In critical care
- With orthopaedic conditions
- With spinal injury
- With diabetes
- With peripheral vascular disease
- With a history of pressure ulcers
- At extremes of age

**PATIENT IS AT RISK OF DEVELOPING A PRESSURE ULCER**
- Foam mattress (static)
- Regular turning
- Observe pressure areas
- Reassess weekly
- Complete documentation

**PATIENT HAS A MEDIUM RISK OF DEVELOPING A PRESSURE ULCER**
- May also need assistance to mobilise
- Foam mattress (static)
- Regular turning
- Observe pressure areas
- Reassess weekly or if condition changes
- Complete documentation

**PATIENT HAS A HIGH RISK OF DEVELOPING A PRESSURE ULCER**
- If weight > 120 kg, an air mattress replacement is recommended
- Regular turning
- Reassess weekly or if condition changes
- Complete documentation

**PATIENT HAS A VERY HIGH RISK OF DEVELOPING A PRESSURE ULCER**
- Bed/Chair bound – fully dependant and/or has pressure ulcer
- High specification air mattress replacement + seating system
- Regular turning, turning chart
- Complete documentation

**PLANNING**

**COMPLETE LOCAL RISK ASSESSMENT TOOL**

The decision to adopt any particular recommendation must be made by the health care professional in light of available resources & circumstances presented by the individual patient. eg Waterlow, Braden, Norton. this will assist in identifying patients likely to develop a pressure ulcer.

**IMPLEMENTATION**

**GENERAL PREVENTION STRATEGIES**
- Reposition patient according to risk
- Utilise 30° tilt & side lying position
- Restrict chair sitting to less than 2 hours for at risk patients (sacral, ischium, spinal, buttock pressure damage)
- Consider the use of pressure relieving cushion / mattress
- Utilise heel protection devices to protect heels

**DOCUMENTATION**
- Document on turning / repositioning chart
- Complete nutritional assessment, refer to dietician as appropriate
- Ensure documentation of intended management
- Ensure documentation of any skin changes is completed describing observations and actions
- Complete local wound assessment chart as required

**EVALUATE**

**REASSESSMENT**
Pressure Ulcer Management Pathway

THE MANAGEMENT OF PRESSURE DAMAGE INCLUDES:

CLASSIFICATION OF DAMAGE
It is important to remember that pressure ulcers should not be reverse graded as they heal eg Stage 3 should be described as healing Stage 3 pressure ulcer not Stage 2.

STAGE / CATEGORY 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration particularly on individuals with darker skin

PLEASE RULE OUT SUSPECTED DEEP TISSUE INJURY* (SEE BELOW)

STAGE / CATEGORY 2
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister

STAGE / CATEGORY 3
Full thickness skin loss involving to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia

STAGE / CATEGORY 4
Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss

MANAGEMENT STRATEGIES
The decision to adopt any particular recommendation must be made by the health care professional in light of available resources & circumstances presented by the individual patient.

- Reposition every 2 – 4 hours
- Complete repositioning chart
- Utilise ‘30o lift & side lying position’
- Document on turning / repositioning chart
- Restrict chair sitting to less than 2 hours for at risk patients (sacral, ischium, spinal, buttock pressure damage)
- Consider pressure relieving cushion
- Utilise heel protection devices to protect heels
- Complete nutritional assessment, refer to dietician as appropriate
- Complete relevant documentation

- As stage / category 1 & 2 ADDITIONALLY
  - Reposition 2-4 hourly, according to risk, when in bed depending on assessment of patient’s skin condition
  - Avoid repositioning patient onto area with pressure damage
  - Complete repositioning chart
  - If multiple pressure ulcers, consider involving Safeguarding Vulnerable Adults procedure and skin damage protocol
  - Complete relevant documentation
  - Utilise pressure relieving cushion and mattress as per local policy
  - Conduct a Root Cause Analysis as per local guidelines

- As stage / category 1 & 2 ADDITIONALLY
  - Reposition at least 2 hourly depending on assessment of patient’s skin
  - Consider anatomical location of ulcer when sitting patient for meals
  - Restrict sitting to 45 minutes where possible (including profiling bed frame)
  - Refer all patients to dietician
  - Report as per local guidelines / protocols
  - If multiple stage 3-4 pressure ulcers, consider involving Safeguarding Vulnerable Adults procedure and skin damage protocol
  - Complete repositioning chart
  - Complete relevant documentation
  - Utilise pressure relieving cushion and mattress as per local policy
  - Conduct a Root Cause Analysis as per local guidelines

- As stage / category 1 & 2 ADDITIONALLY
  - Reposition 2 hourly when in bed depending on assessment of patient’s skin condition
  - *STDI - Avoid repositioning patient onto area with pressure damage
  - If multiple unstageable, suspected deep tissue injury ulcers consider involving Safeguarding Vulnerable Adults procedure and skin damage protocol
  - Report as per local guidelines / protocols
  - Complete repositioning chart
  - Document ulcer in care plan and medical notes
  - Utilise pressure relieving cushion and mattress as per local policy
  - Conduct a Root Cause Analysis as per local guidelines

WOUND CARE
Prior to dressing selection, holistic assessment of the patient is essential. Any alteration in wound characteristics may indicate a change in status and wound management should be reassessed.

- Although there is no open wound present, the integrity of the skin is compromised due to damaged blood vessels and underlying tissue
- Complete an assessment tool and care plan
- Regular monitoring of the damaged area
- Good skin care alongside the application of a durable barrier cream, will aid in the protection of skin breakdown
- Utilise 3M™ Cavilon™ Skin Care algorithm for correct product usage and application guide

- Complete an assessment tool and care plan
- Consider tissue type and treatment aim when selecting dressings
- Some areas may be challenging to dress, utilise sacral and heel deep crease (3M™ Tegaderm™ Hydrocolloid Dressing, 3M™ Tegaderm™ Foam Adhesive Dressing, 3M™ Tegaderm™ Absorbent Clear Acrylic Dressing)
- Monitor pressure ulcer for increasing levels of exudate
- Protect peri-wound area from further breakdown or maceration (3M™ Cavilon™ No Sting Barrier Film)

- Complete an assessment tool and care plan
- Base dressing choice on exudate levels (3M™ Exudate Pathway)
- Consider the potential for wound infection
- If the wound is not healing or progressing, further investigation may be required to establish co-morbidities
- Manage necrotic and sloughy tissue using dressings with autolytic qualities. This may be contraindicated in certain conditions such as diabetes and those with arterial disease
- If bone is exposed consider the risk of osteomyelitis and refer suitable health care professional
- Protect peri-wound area from further breakdown and maceration (Cavilon no sting barrier film)
- Refer to TVN Team

- Complete an assessment tool and care plan
- *STDI - Regular monitoring of the area for deterioration in condition
- Utilise wound healing continuum to assess tissue type of unstageable / unclassified pressure ulcer
- Complete an assessment tool and care plan
- *STDI - Correct dressing selection
- Base dressing choice on exudate levels (3M™ Exudate Pathway)
- Consider the potential for wound infection
- If the wound is not healing or progressing, further investigation may be required to establish co-morbidities
- Manage necrotic and sloughy tissue using dressings with autolytic qualities. This may be contraindicated in certain conditions such as diabetes and those with arterial disease
- Protect peri-wound area from further breakdown and maceration (Cavilon no sting barrier film)
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Acknowledgement of credit to K.Rajpaul, B.Byrne & H.Wormald of the Kings College Hospital NHS Foundation Trust Tissue Viability Team. Kings College Tissue Viability Team do not advocate any specific products highlighted in this pathway.
3M can support you and your clinicians with the development and provision of the following services as part of our Pressure Ulcer Care Programme:

- Training & education support for your clinical teams including classroom, practical and e-learning formats
- Care pathway creation utilising lean and six sigma methodologies
- Patient education to help improve compliance and self management of conditions
- Skin care products as a first line of skin protection
- Support tools such as pocket guides and turning clocks to support protocols and education

**BIBLIOGRAPHY**


Acknowledgement
Tissue Viability Team, Kings College Hospital, London