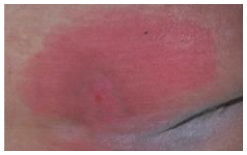
Whittington Health NHS

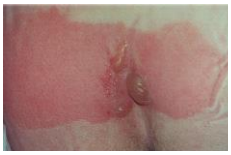
Pressure Ulcer Management Made Easy Pathway

- The use of repositioning as a preventative strategy should be considered for all patients at risk of pressure ulceration and depends upon clinical assessment
- This includes the patient's general condition, comfort, skin condition / assessment and level of mobility
- An assessment of the patient's skin over all the pressure points should be conducted

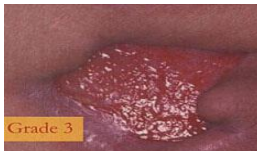
Stage / Category 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on Individuals with darker skin.



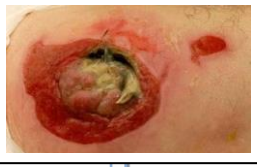
Stage / Category 2
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.



Stage / Category 3
Full thickness skin loss involving damage 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.



Unstageable

Full thickness skin or tissue loss in which the true depth of the ulcer is completely obscured by slough and / or eschar in the wound bed. Purple or maroon localized area of discoloured intact skin or blood- filled blister due to damage of underlying soft tissue from pressure and / or shear

- Complete SSKIN
- Utilise 30° tilt & side lying position
- Advice on turning / provide repositioning chart
- Restrict chair sitting as appropriate to individual needs ; high risk patients may require bed rest
- Consider pressure relieving cushion
- Utilise pillows under calves and heels to off load pressure and separate limbs
- Complete nutritional assessment, refer to dietician as appropriate
- Document in patient's care plan and educate carers and patients
- Complete wound assessment chart

Complete SSKIN
Datix
Monitor regularly

SSKIN
Datix
Complete IMR and refer to TVN as indicated

- As Stage 1 and **ADDITIONALLY**
- Give Reposition advice depending on assessment of patient's skin
- Consider anatomical location of ulcer when sitting patient for meals
- Restrict sitting to 45 minutes where possible for grades 3 & 4 (including profiling bed frame)
- Refer patients to dietician if indicated
- Educate patients and carers on repositioning regime
- If multiple stage 2-4 pressure ulcers, consider Safeguarding adults
- Base dressing selection on tissue type present and treatment aim **(utilise preferred dressing list for guidance)**
- Document on electronic computer system

Hard Necrotic Eschar:

- Refer to podiatry if heels / ankles
- Leave dry and intact
- Consider offloading with boots/pillows
- Check pedal pulses
- Obtain ABPI (community) as appropriate

Blisters:

- Apply protective dressing
- Refer to Foot health if heels and ankles
- Consider offloading

- Inform GP
- Inform TVN
- Educate carers and patients

Waterlow = or < 10

- Foam pressure relieving mattress
- Regular Turning
- Observe Pressure Areas
- Reassess Weekly

Waterlow > 10- 15

May need assistance to mobilise

- foam Mattress (Static)
- Regular turning
- Observe pressure areas
- Reassess weekly or if condition changes.
- **Complete Care Plan**

Waterlow 15 – 20

- **Medium-high risk mattress If** Weighs > 140kgs, needs dynamic mattress
- Regular turning
- Reassess weekly or if condition changes

Waterlow > 20and above2

Bed/Chair Bound – Fully dependant and /or has Pressure Ulcer

- Pressure relieving mattress + seating cushion
- Regular turning chart
- If Patient has pressure ulcer complete wound assessment and document
- Complete Care plan

Any alteration in wound characteristics may indicate a change in status and as such, wound management should be reassessed as necessary.