Pressure Damage Prevention and Management Pathway
For Patients in Hospital Settings

NHS Lothian

On admission

Within 6 hours of admission to your care complete formal risk assessment tool used within your area i.e. Waterlow, Glamorgan or PPURA and document findings
A holistic risk assessment must be used alongside clinical judgement and skin assessment
Check all skin top to toe especially bony prominences such as heels, hips and sacrum, etc.

Patient with NO pressure damage

If patient identified as at risk give patient and or carer the Prevent Pressure Ulcers Patient Information leaflet (LOT 1452 via PECOS)

Start Care Rounding chart

Frequency to be decided dependent on risk level and clinical judgement e.g.

- No risk 8 hourly
- Low risk 3 - 4 hourly
- High risk 2 - 3 hourly
- Very high risk 1 - 2 hourly

Pressure damage identified on admission to hospital
OR
Pressure damage acquired during hospital admission

1. Commence/update SSKIN Bundle (Care Rounding Chart) -
   Frequency to be decided depending on severity of damage and clinical judgement e.g.
   Grade 1 - 2 reposition 2 - 3 hourly
   Grade 3 - 4 reposition 1 - 2 hourly
   Ungradable or suspected deep tissue damage reposition 1 - 2 hourly
   Sitting - max 2 hourly
2. Input information onto Trak EPR
3. Inform patient and or carer/relatives and provide Prevent Pressure Ulcers Patient Information leaflet (LOT 1452 via PECOS)
4. Inform Medical Staff, Nurse in Charge/CNM and all members of multidisciplinary team of skin damage
5. Refer to Medical Photography to take images, if available to your site (repeat images every two weeks)
6. Complete a Datix Incident for all pressure ulcers (excluding Grade 1). Use the Grading tool to help you identify the correct grade if required.
7. If skin broken complete a Wound Assessment and Treatment Chart
8. Commence Food and Fluid charts
9. Refer all pressure ulcers (ungradeable, Grade 3 & 4) to Tissue Viability team and Dietitian
10. Complete the Pressure Ulcer Grade Recording Chart paper copy. When patient discharged or transferred please complete the form again (PECOS LOT 908)
11. Complete formal risk assessment once a week or more frequently if condition changes
12. If pressure damage documented within 6 hours of admission follow the Datix Reporting and Review Process for All Pressure Ulcers (on intranet)

IF PRESSURE DAMAGE IS NOT IDENTIFIED WITHIN 6 HOURS OF ADMISSION THIS MUST BE RECORDED AS HOSPITAL ACQUIRED

- All hospital acquired pressure ulcers must have a Red Day Review Tool completed and uploaded to Datix
- Share learning and any changes to practice with MDT team through safety brief and communications

Write a nursing care plan after discussion with patient and or carer which ensures continuous evaluation using SSKIN bundle elements:

Surface

Ensure the patient has the correct support surface., which meets their pressure needs, comfort, consent and capacity
Consider what equipment is required, based on health status, lifestyle abilities, care need and acceptability of proposed equipment to patient and or carer
Fitted sheets should not be used on a dynamic mattress, use a flat bed sheet instead

Skin Assessment

Check for changes in colour, moisture and temperature
Early inspection means early detection
Note any longstanding skin conditions such as previous pressure ulcers determined from scarring/patient history
Evaluate skin regions with any medical devices present e.g. splints, masks, venflons, NG tubes, catheter tubes and anti-embolism stockings, at least twice a day

Keep Moving

Assess patients mobility, if assistance to reposition is required then reposition according to risk level and skin assessment, using the most appropriate moving and handling techniques
Involve the patient in determining repositioning regime
Use the thirty degree tilt to reposition
Ensure bed sheets are kept clean, dry and uncreased

Incontinence/Moisture

Protect skin, manage continence, see Skin Cleansing Guideline
Keep the skin clean and dry
Keep skin at normal temperature

Nutrition

Ensure adequate fluids and diet
Complete the MUST score and if high risk, poor wound healing and/or grade 3 or above pressure damage, refer to Dietetics
Monitor intake with food record chart if high risk

Evaluate

Alter care in accordance with any changes and update care plan
Check pressure reducing equipment is functioning correctly daily
Evaluate repositioning regime
Is equipment meeting patients needs?
Is there patient concordance? Challenges in achieving concordance in relation to pressure ulcer management/prevention must be clearly documented along with any alternatives discussed
Ensure all interventions are evidenced fully and concisely documented

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