**REMEMBER TISSUE DAMAGE MAY START PRIOR TO ADMISSION, IN CASUALTY. A SEATED PATIENT IS AT RISK**
**ASSESSMENT (See Over) IF THE PATIENT FALLS INTO ANY OF THE RISK CATEGORIES, THEN PREVENTATIVE NURSING IS REQUIRED A COMBINATION OF GOOD NURSING TECHNIQUES AND PREVENTATIVE AIDS WILL BE NECESSARY**
**ALL ACTIONS MUST BE DOCUMENTED**

## PREVENTION

**PRESSURE REDUCING AIDS**

**Special Mattress/beds:**
10+ Overlays or specialist foam mattresses.
15+ Alternating pressure overlays, mattresses and bed systems
20+ Bed systems: Fluidised bead, low air loss and alternating pressure mattresses
Note: Preventative aids cover a wide spectrum of specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.

**Cushions:**
No person should sit in a wheelchair without some form of cushioning. If nothing else is available - use the person's own pillow. (Consider infection risk)
10+ 100mm foam cushion
15+ Specialist Gell and/or foam cushion
20+ Specialised cushion, adjustable to individual person.

**Bed clothing:**
Avoid plastic draw sheets, inco pads and tightly tucked in sheet/sheet covers, especially when using specialist bed and mattress overlay systems
Use duvet - plus vapour permeable membrane.

## NURSING CARE

| | |
|---|---|
| **General** | HAND WASHING, frequent changes of position, lying, sitting. Use of pillows |
| **Pain** | Appropriate pain control |
| **Nutrition** | High protein, vitamins and minerals |
| **Patient Handling** | Correct lifting technique - hoists - monkey poles Transfer devices |
| **Patient Comfort Aids** | Real Sheepskin - bed cradle |
| **Operating Table Theatre/A&E Trolley** | 100mm(4ins) cover plus adequate protection |

**Skin Care** General hygene, NO rubbing, cover with an appropriate dressing

## WOUND GUIDELINES

**Assessment** odour, exudate, measure/photograph position

## WOUND CLASSIFICATION - EPUAP

| | |
|---|---|
| **GRADE 1** | Discolouration of intact skin not affected by light finger pressure (non-blanching erythema) This may be difficult to identify in darkly pigmented skin |
| **GRADE 2** | Partial thickness skin loss or damage involving epidermis and/or dermis The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater |
| **GRADE 3** | Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia The pressure ulcer presents clinically as a deep crater with or without undermining of adjacent tissue |
| **GRADE 4** | Full thickness skin loss with extensive destruction and necrosis extending to underlying tissue. |

**Dressing Guide** Use Local dressings formulary and/or www.worldwidewounds

**IF TREATMENT IS REQUIRED, FIRST REMOVE PRESSURE**