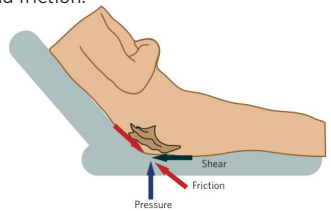
WHO IS AT RISK OF PRESSURE ULCERATION?

Assessment of an individual's risk of developing a PU should involve both informal screening tools and formal assessment procedures.

- ✓ Reduced mobility/activity
- ✓ Skin changes (redness/blanching erythema/dryness)
- ✓ History of pressure ulceration
- ✓ Impaired circulation due to diabetes, vascular problems, oedema
- ✓ Increased skin moisture (eg due to incontinence, perspiration)
- ✓ Poor nutritional status
- ✓ Age (over 65 years) in the presence of other risk factors
- ✓ Loss of sensation or ability to report discomfort due to sedatives or poor cognitive function
- ✓ Increased body temperature
- ✓ Use of sedatives, dopamine, oxygen use and postoperative steroid therapy

Pressure ulcers can occur in fit and healthy people if they are confined to bed. This is because pressure can occur at any point where the tissues are subjected to pressure, shear and friction.

Shear is an internal force caused when two adjacent surfaces slide across each other, resulting in damage to blood vessels and ischaemia.



Friction is the force that is created whenever two surfaces move or try to move across one another, causing skin abrasion

Pressure is amount of force applied at right angles to the tissues between the bone and the supporting surface

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Ref: ZJ01299

STEPS TO PRESSURE ULCER PREVENTION

A Screening and risk assessment
Aim: Identify patient at risk

1. Use appropriate risk assessment tool for patient group
2. If patient has had a previous ulcer, consider as high-risk
3. Reassess when patient's condition changes

B. Implement PU prevention care plan using SSKIN bundle
Aim: Prevent PU from developing

1. Involve the multidisciplinary team
2. Agree integrated care plan, tailored to specific risk profile for each patient.
3. Implement SSKIN
   - **Support surface** — select appropriate pressure-relieving/redistribution equipment or devices to protect vulnerable skin/bony prominences
   - **Skin inspection** — perform regular assessment of the entire skin and document any changes
   - **Keep moving** — implement turn/reposition schedule that optimises independent movement. Refer for physiotherapy/occupational therapy if appropriate
   - **Incontinence and moisture** — ensure appropriate management of incontinence, perspiration or exudate. Use skin barrier products to manage moisture next to the skin in conjunction with a skin care routine to keep skin clean and dry. Where necessary use continence and faecal management products and consult with a specialist continence advisor for patients with unresolved continence issues
   - **Nutrition and hydration** — check patient's weight and monitor any changes. Encourage patients to eat and drink regularly to maintain a good nutritional status. If appropriate, check nutritional status using assessment tool and consult with dietician for nutrition, chewing and swallowing problems.
4. Document all measures in place and communicate with multidisciplinary team
5. Provide education for patient and carers

C. Reassess and document evaluation of care bundle
Aim: Adapt the care plan for ongoing PU prevention

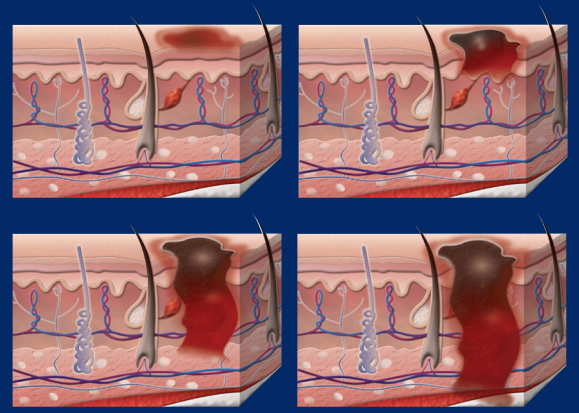
NOT ALL PRESSURE ULCERS ARE UNAVOIDABLE. IF A PRESSURE ULCER OCCURS:

1. Implement SSKIN care bundle to manage PU and optimise healing
2. Refer to multidisciplinary team for advice if necessary

For further information on SSKIN, go to: www.stopthepressure.com

QUICK GUIDE

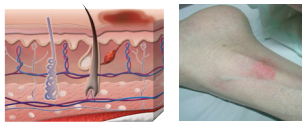
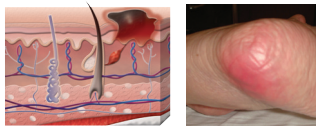
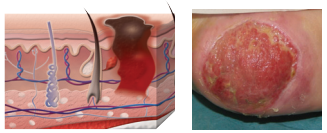
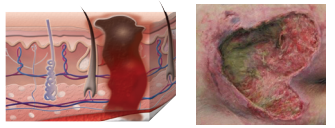
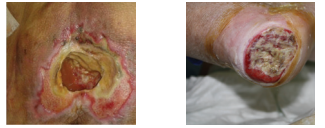
PRESSURE ULCER PREVENTION & **MANAGEMENT**



Wounds International

OPTIMISING PRESSURE ULCER MANAGEMENT

Classification of ulcer (based on EPUAP/ NPUAP, 2009)

	I	II Non-infected	III Non-infected	IV Non-infected	II–IV Infected[4]
					
Description	Non-blanchable redness of intact skin usually over a bony prominence. Discolouration of the skin, warmth, oedema, hardness or pain compared to adjacent tissues	Partial thickness skin loss or blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates deep tissue injury). Check for moisture lesion	Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss	Full-thickness tissue loss with bone, tendon or muscle visible. Slough or eschar may be present. Often includes undermining and tunnelling	Signs and symptoms of infection, such as discolouration, swelling, heat and odour. If untreated, can become life-threatening
Implement SSKIN care bundle (support, skin, keep moving, incontinence, nutrition)					
Treatment goals	• Skin protection and repair • Restore capillary function	• Provide clean wound bed for granulation tissue	• Remove slough • Provide clean wound bed for granulation tissue		• Reduce bacterial load • Manage exudate/odour • Prevent/remove biofilm
Local wound treatment					
Wound bed preparation	• Promote skin integrity using hyperoxgenated fatty acid-based products (eg Linovera®)[1] • Prevent skin breakdown due to friction or shear using skin barrier products (eg Askina® Barrier Film) • Protect against moisture (eg Askina® Barrier Cream)	Use antiseptic wound irrigation solution and/or gel (eg Prontosan® Wound Irrigation Solution, Prontosan® Wound Gel, Prontosan® Wound Gel X)[2]			
Primary dressing Factors to consider include: • Location of the wound • Extent of wound • Main tissue type in wound • Condition of periwound skin • Avoidance of pain and trauma at dressing change • Patient quality of life	DEPTH/LOCATION				
	Superficial	Absorbent/low-adherent moist dressing (eg Askina® Foam/Askina® DresSil)			Antimicrobial dressing (eg Askina® Calgitrol® Ag)[3]
	Deep		Add a cavity absorbent moist dressing (eg Askina® Absorb+/Foam Cavity)		Antimicrobial dressing (eg Askina® Calgitrol® Paste)[3,4]
	Heel	Absorbent/low-adherent moist dressing with heel shape (eg Askina® Heel/Askina® DresSil Heel)			Antimicrobial dressing (eg Askina® Calgitrol® THIN)[3,4]
	Sacrum	Absorbent/low-adherent moist dressing with sacrum shape (eg Askina® DresSil Sacrum)			Antimicrobial dressing (eg Askina® Calgitrol® Paste)[3,4]
GOAL: WOUND HEALING					

1. Recommended use as per guidelines: EPUAP, 2012 see: http://www.epuap.org
2. NOTE: As Stage IV PUs may involve exposed cartilage, special caution is required. Some products (e.g. Prontosan®) are contraindicated for the use on hyaline cartilage. In all cases, a careful risk-benefit assessment should be performed. Decisions on product use must lie with the attending physician and normal saline used instead of Prontosan® where indicated.
3. Topical antimicrobial products can be used alone in patients with local infection. They should be combined with systemic antibiotics in the presence of spreading infection and sepsis.
4. Use as a secondary dressing, an appropriate absorbent/low adherent moist dressing in flat or anatomical shape (e.g. Askina® Foam/Askina® Heel/Askina® DresSil Heel/Askina® DresSil Sacrum).