Discovering Pressure Damage… what to do next.

All pressure damage, irrespective of origin must be reported on Ulysses (Categories 1-4, Suspected Deep Tissue Injuries and Mucosal) and must be attributed to either Hospital Acquired (HAPU) or Present on Admission (POA). Consider Safeguarding concerns. Always check the patients notes to ensure an incident form has not already been submitted. For guidance on correctly categorising pressure damage (Consider other aetiologies) please see here: Pressure Ulcer Categories

Levels of Harm for any pressure damage POA: No Harm

Please indicate if the patient was transferred from another inpatient area.

Categories and guidance of assigned Level of Impact for HAPU

Category 1: Minor Impact

Category 2: Minor Impact

Category 3: Moderate Impact

Category 4: Severe Impact

Suspected Deep Tissue Injury (SDTI): Minor Impact until evolved (Tissue Viability Team will follow up)

Mucosal pressure damage: Level of Impact is associated with the level of tissue erosion – mucosal tissue erosion, usually associated with the use of a medical device, such as oxygen tubing, Catheter or Naso-gastric tube. When reporting please consider whether the damage is superficial (Minor Impact) or full-thickness (Moderate Impact).

- Complete the Ulysses form including the body location of the skin damage. A brief description of how the damage presents.
- Document any device that may be associated with the skin damage.

Every Time Actions: Follows aSSKINg Care Bundle

- **a** Assessment: Risk of developing pressure damage to be assessed within 6 hours of admission to your clinical area and if the patient's condition changes. Reassessment should be undertaken weekly at a minimum. Please use clinical judgement.
  Check that an appropriate care plan is documented that addresses the individual patient's risks.
  If the skin is broken, complete a wound assessment and wound care plan on EPR

- **S** Skin Assessment: Assess the skin of “at risk” patients on admission and each shift, including heels and other body parts in contact with external medical devices such as Catheters, Anti-embolic Stockings (AES), casts, slings or oxygen and nasogastric tubing or glasses and hearing aids.
  Document the condition of skin over these pressure points as “marked” or “unmarked” NOT “Intact”
- **S** Surface: (mattress/cushion/off-loading) Check the patient has suitable equipment for the bed and chair
- **K** Keep moving: If skin is marked, the patient or device must be repositioned, and the area checked every 2 hours (or as safe to do so) until it has resolved. Ensure patients “at risk” have an appropriate repositioning schedule documented and that interventions are undertaken.
- **I** Incontinence/moisture: Review individual patient information each shift and ensure care plans reflect care needs
- **N** Nutrition/hydration: Check assessments are accurate and actions appropriate, including care plan and monitoring
- **g** Give Information: Ensure patients are given an information leaflet about their risk of pressure damage and explanation and the care advised. Document that this has been completed. If patient has declined nursing care intervention, has this been managed/escalated appropriately

- Speak to colleagues and the Multidisciplinary Team for advice or support if necessary
- Keep yourself updated on pressure ulcer prevention and management via the Trust Policy, the e-learning modules available on My Learning Hub or visit Tissue Viability Service information at: Pressure Ulcer Prevention Resources
- Information on Safeguarding can be found here: Safeguarding Information

For Incident Managers

- Check actions above have been completed.
- Any deficits in care assessment and/or delivery need S.M.A.R.T actions to address non-compliance.