Pressure Damage Prevention & Management Pathway for People Admitted to NHS Community Nursing Caseloads

NHS Lothian

1st Visit

- After 1st visit complete Waterlow within the Adult Assessment on TRAK or in the Care Rounding booklet
- 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, and under medical devices (document rationale if skin cannot be visualised and the reason why)
- Does the person have a Package of Care (POC) or receive care from family/spouse carers. If so, review whether this is adequate for person's current level of need and risk. If not discuss with person/ family, then increase POC to reflect person's needs
- Does the person have appropriate pressure relieving equipment in place? If not, assess for appropriate equipment based on District Nursing Risk Assessment and Person Centred Care bundle in conjunction with clinical judgement e.g. mattress, cushion, offloading boots, lateral turning platforms
- Document the assessment and commence District Nursing Care Rounding Chart.

Person with NO pressure damage whilst on caseload

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

Decide on frequency of completion of the District Nursing Care Rounding Chart. This is dependent on risk level, holistic assessment, person centred need, POC, carer information and clinical judgement and visit frequency.

Top to toe skin inspection completed monthly, or when care is delivered less often complete at each visit. Reassess Waterlow score 6 monthly and if the persons condition changes the Waterlow should be upgraded at this time.

Ensure that person and all care providers are checking the person's skin appropriately as per person's risk and document.

Provide education to person and relevant carers including the importance of repositioning, checking their skin, how to identify pressure damage and escalation to the District Nursing Team.

Pressure damage identified on first visit OR Pressure damage acquired whilst on caseload

Grade pressure damage as per Pressure Ulcer Grading Tool.

Frequency of assessment and care dependent on severity of damage, location of pressure damage and clinical judgement e.g.

Grade 1 & 2: Provide education regarding repositioning 2 - 3 hourly or as much as current care package allows (maximum care packages provided are four times daily).

Grade 3, Grade 4, ungradable or suspected deep tissue damage: Provide education regarding repositioning 1 - 2 hourly or as much as current care package allows.

If pressure damage is affected by sitting - sit for a maximum of 2 hours at a time only.

District Nursing team to communicate with the person and carers to assess the length of time the person can sit with pressure reducing equipment before signs of skin deterioration occur. If the persons care package does not allow for this consider bed rest.

1. Document on TRAK EPR and Adult assessment
2. Inform person and carer/relatives and provide Prevent Pressure Ulcers Patient Information leaflet (LOT 1452 via PECOS)
3. Inform Multi-Disciplinary Team (MDT)
4. Obtain clinical photographs using an NHS Lothian registered camera. Photography is recommended every 2 - 4 weeks depending on clinical judgement. Images to be emailed to Medical Photography NHS Lothian for safe storage on the Medical Image Manager (MIMs) system. Email: *medical.photography@nhslothian.scot.nhs.uk*
5. Using the Scottish Adapted European Pressure Ulcer Advisory Panel Pressure Ulcer Classification Tool for reference including those that have deteriorated to a new grade. Do not downgrade a pressure ulcer that is healing e.g. Grade 4 when improving remains a healing or healed Grade 4, never a lower grade

6. Complete a Datix Incident for all pressure ulcers (excluding Grade 1). Complete Red Day review tool, available via Tissue Viability Intranet site
7. If the skin is broken complete a Wound Assessment and Treatment Chart
8. Refer all people with Grade 3, Grade 4, Ungradable pressure damage and significant Deep Tissue Injury to Dietician
9. Refer all people with a new or complex (Grade 3, Grade 4, Ungradable pressure damage and Deep Tissue Injury of concern) to Tissue Viability
10. Share learning and any changes to practice via MDT communications, Team 'handovers' and escalate to nursing management wider teams as appropriate

If pressure damage is not identified on 1st visit (or when safe to do so)
This must be recorded as caseload acquired

Write a District Nursing Person Centred Care Plan including the person, carer and family as appropriate, using SSKIN bundle elements:

Skin Assessment (Top to Toe inspection): Check for changes in colour, moisture, temperature and deterioration of wounds. Early inspection means early detection.

Note any longstanding skin conditions such as previous pressure ulcers determined from scarring/patient history. Assess skin regions with any medical devices present e.g. splints, masks, NG tubes, catheter tube retaining straps, gastrostomy tubes, glasses, stockings etc.

Surface: Ensure the person has the correct pressure relieving/redistributing support surface, which meets their pressure needs, comfort, consent, capacity and home environment.

Consider what equipment is required, based on health status, lifestyle abilities, care need and acceptability of proposed equipment to pthe person and or carer. Fitted sheets should not be used on a dynamic mattress, use a flat bed sheet instead. No additional covers over pressure relieving cushions. Ensure bed sheets are kept clean, dry and uncreased.

Keep Moving: Assess person's 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 person in determining the repositioning regime.

Use the 30 degree, 60 degree, and 90 degree tilts to reposition. See Tissue Viability Intranet site - Pressure ulcer resources - Repositioning.

Consider patient's 24 Hour Posture Management where appropriate: Your Posture Matters - Video.

Incontinence/Increased moisture: Protect skin, manage continence. See Skin Cleansing Guideline.
Keep the skin clean, dry and at a normal temperature.

Nutrition: Ensure adequate fluids and diet to support wound healing. If high risk, advise the person / carers to keep a record of food and fluids.

Complete MUST score and refer to Dietitian for Grade 3, Grade 4, Ungradable pressure damage or Deep Tissue injury.

Evaluate Continuously

Evaluate repositioning regime, whether pressure relieving equipment is appropriate and working and if the persons care needs are being met.

Update care plan and document any changes.

Document and escalate any challenges along with any alternatives discussed.