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 below:

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: Near Miss

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).

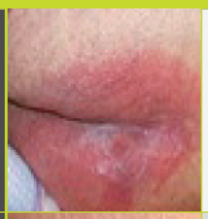
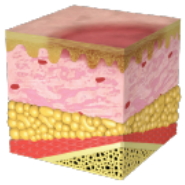
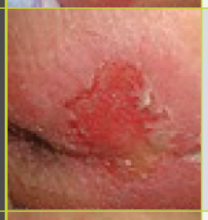
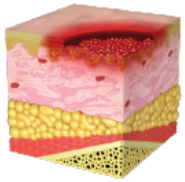
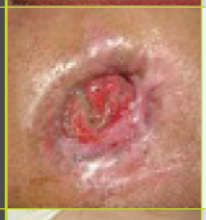
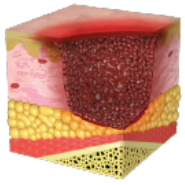
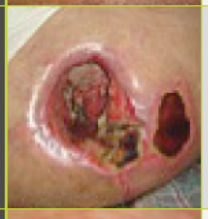
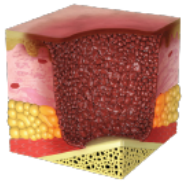
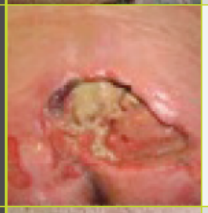
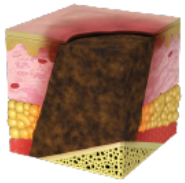
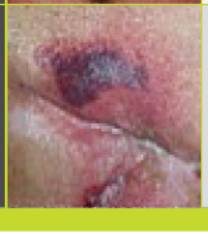
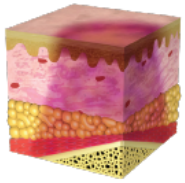
Every Time Actions

- Risk 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.
- 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"
- 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.

- 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
- Check the patient has suitable equipment for the bed and chair
- Ensure patients "at risk" have an appropriate repositioning schedule documented
- Review individual patient information each shift
- 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.
- Speak to colleagues and the Multidisciplinary Team for advice or support if necessary
- Keep yourself updated on pressure ulcer prevention and management via the e-learning modules available on My Learning Hub or visit Tissue Viability Service information at: Tissue Viability Resources
- Information on Safeguarding can be found here: Safeguarding Information

Pressure Ulcer Categorisation Guide

How to Categorise[1]

Category I		Intact skin with localised non-blanchable erythema, usually over a bony prominence. Skin discolouration, warmth, oedema, hardness or pain may be present and may differ compared to adjacent tissue. May indicate "at risk" persons.	
Category II		Partial thickness loss of dermis presenting as a shiny or dry, shallow open ulcer with a red/pink wound bed with minimal slough or bruising. Can also include intact or ruptured blisters. Does not include skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.	
Category III		Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed or directly palpable. Some slough may be present. May include undermining and tunnelling. Depth varies by location and can be shallow in areas without subcutaneous tissue eg. on the ear, or extremely deep in areas of significant adiposity.	
Category IV		Full thickness tissue loss with visibly exposed or directly palpable bone, tendon or muscle. Often includes undermining and tunnelling. Depth varies by location and can be shallow in areas without subcutaneous tissue eg. on the ear. Can extend into muscle and/or supporting structures (eg. fascia, tendon or joint capsule) making osteomyelitis likely to occur.	
Unstageable/ Unclassified		Full thickness tissue loss where actual ulcer depth is obscured by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black). True depth cannot be determined until enough slough and/or eschar is removed, but will be either a Category III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heel should not be removed until a Doppler assessment has been completed.	
Suspected Deep Tissue Injury (SDTI)		Purple or maroon localized area of discoloured intact skin or blood-filled blister due to pressure/shear damage of underlying soft tissue. May be preceded by painful, firm, boggy, warmer or cooler skin as compared to adjacent tissue. Evolution may be rapid, exposing additional tissue layers even with treatment.	

Based on International NPUAP-EPUAP-PPPIA Pressure Ulcer Classification System.[1]

NB: Injuries may be more difficult to detect in more darkly pigmented skin, and may not have visible blanching; its colour may differ from the surrounding area.

Reference: 1. NPUAP, EPUAP and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.