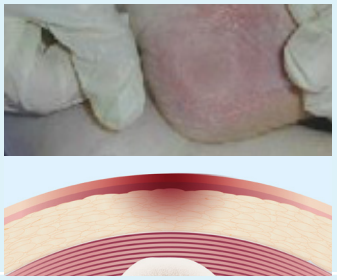
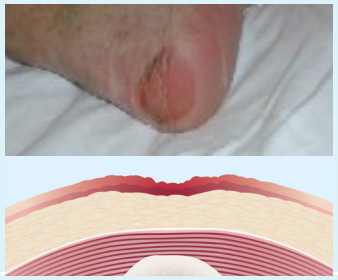
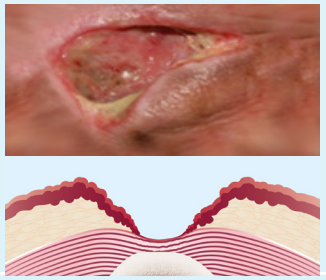
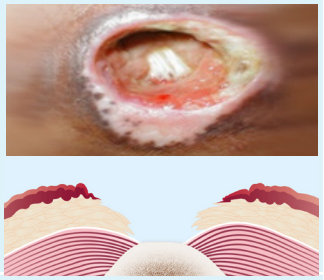
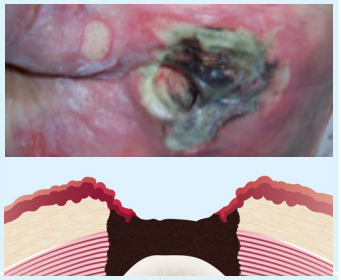
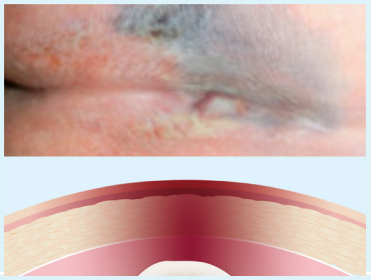
PRESSURE ULCER PATHWAY

WOUND TYPE	CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4	UNSTAGEABLE	DEEP TISSUE INJURY
IMAGE						
CLINICAL SIGNS	Discolouration of intact skin - not affected by light finger pressure (non blanching erythema.) This may be difficult to identify in darkly pigmented skin.	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled Blister.	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed often include undermining and tunnelling.	Full thickness tissue loss in which the base of the ulcer is covered by slough and, or eschar in the wound bed. Until enough slough and, or eschar is removed to expose the base of the wound, the true depth, and therefore the category / stage cannot be determined.	Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
TREATMENT AIMS AND ACTIONS	* Eliminate / reduce the cause of pressure * Utilize pressure prevention devices e.g. mattress, cushion, heel protectors * Complete nutrition assessment * Risk assessment tool e.g.: Waterlow Scale Braden Scale * Repositioning * Reposition 2 hourly avoiding damaged skin, consider 30 degree tilt * SSKIN bundle * Pressure Ulcer reporting system * Photograph area in accordance with local policy * Patient and or carer education	* Eliminate / reduce cause of pressure * Utilize pressure prevention devices. e.g. mattress, cushion, heel protectors * Complete nutrition assessment * Risk assessment tool e.g.: Waterlow Scale Braden Scale * Repositioning * Reposition 2 hourly avoiding damaged skin, consider 30 degree tilt * SSKIN bundle * Pressure Ulcer reporting sytesm *Multiple Category 2 pressure ulcer refer to safeguarding.* * Photograph area in accordance with local policy * Patient and or carer education	* Eliminate / reduce cause of pressure * Utilize pressure prevention devices. e.g. mattress, cushion, heel protectors * Complete nutrition assessment * Risk assessment tool e.g.: Waterlow Scale Braden Scale * Repositioning * Reposition 2 hourly avoiding damaged skin, consider 30 degree tilt * SSKIN bundle * Pressure Ulcer reporting system * *Refer to safeguarding* * Photograph area in accordance with local policy * Patient and or carer education	* Eliminate / reduce cause of pressure * Utilize pressure prevention devices. e.g. mattress, cushion, heel protectors * Complete nutrition assessment * Risk assessment tool e.g.: Waterlow Scale Braden Scale * Repositioning * Reposition 2 hourly avoiding damaged skin, consider 30 degree tilt SSKIN bundle * Pressure Ulcer reporting system *Refer to safeguarding* * Photograph area in accordance with local policy. * Patient and or carer education	* Eliminate / reduce cause of pressure * Utilize pressure prevention devices e.g. mattress, cushion, heel protectors * Complete nutrition assessment * Risk assessment tool e.g.: Waterlow Scale Braden Scale * Repositioning * Reposition 2 hourly avoiding damaged skin, consider 30 degree tilt * SSKIN bundle * Pressure Ulcer reporting system *When the depth of the wound is revealed, re classify and update local reporting system* * Photograph area in accordance with local policy * Patient and or carer education	* Eliminate / reduce cause of * pressure * Utilize pressure prevention devices e.g. mattress, cushion, heel protectors * Complete nutrition assessment * Risk assessment tool e.g.: Waterlow Scale Braden Scale * Repositioning * Reposition 2 hourly avoiding damaged skin, consider 30 degree tilt * SSKIN bundle * Pressure Ulcer reporting system *Regularly review and update any changes in classification* * Photograph area in accordance with local policy. * Patient and or carer education
DRESSING CHOICE	Use of **emollients** to maintain skin integrity.	**Primary Dressing:** *Consider* **ActivHeal® Hydrocolloid** **ActivHeal® Silicone Foam** (exudate) *For infection consider* **ActivHeal® PHMB foam** (exudate) **Secondary Dressing:** **ActivHeal® Silicone Foam**	*REFER TO TVN **Primary Dressing:** *Consider* **ActivHeal® Hydrocolloid** (non-infected, shallow stage 3) **ActivHeal® Alginate** (moderate to heavy exudate) **ActivHeal Aquafiber ® Extra** (moderate to heavy exudate) *For infection consider* **ActivHeal® PHMB Foam** **ActivHeal Aquafiber ® AG** (refer to local policy) **Secondary Dressing:** **ActivHeal® Silicone Foam**	*REFER TO TVN **Primary Dressing:** *Consider* **ActivHeal® Alginate** (moderate to heavy exudate) **ActivHeal Aquafiber ® Extra** (moderate to heavy exudate) *For infection consider* **Honey** **ActivHeal® PHMB Foam** **ActivHeal Aquafiber ® AG** (refer to local policy) **Secondary Dressing:** **ActivHeal® Silicone Foam**	*REFER TO TVN **Primary Dressing:** *Consider* **ActivHeal® Hydrogel** (for debridement) **Honey** (for debridement) **ActivHeal® Alginate** (moderate to heavy exudate) **ActivHeal Aquafiber ® Extra** (moderate to heavy exudate) *For infection consider* **Honey** **ActivHeal® PHMB Foam** **Secondary Dressing :** **ActivHeal® Hydrocolloid** (low exudate) **ActivHeal® Silicone Foam**	*REFER TO TVN Use of **emollients, skin protectants** to maintain skin integrity. **Primary Dressing:** **ActivHeal® Silicone Wound Contact Layer** (for broken area) **Secondary Dressing:** **ActivHeal® Silicone Foam** (skin that is broken as a protection from shearing and friction) ***NB Frequent assessment of the wound area is needed to identify and manage any changes in the status of the injury.***

References: NICE (2014) Pressure Ulcers: Prevention and Management of Pressure Ulcers. London. | NICE European Pressure Ulcer Advisory Panel (2014) Prevention and treatment of pressure ulcers: quick reference guide. Washington DC, United States of America: National Pressure Ulcer Advisory Panel. Moore,Z. Thorpe,E. (2015) Dressing for pressure ulcer prevention made easy. London: Wounds UK. Available from www.wounds-uk.com. | NHS Improvements. Pressure Ulcers: revised definition and measurement. Summary and recommendations. June 2018