Steps		Reason and patient-centred care considerations
	Clean any equipment used as per the relevant policy every time it is used and perform hand hygiene.	
9.	Document the care provided, and if necessary any findings, on the patient's observation chart and/or in the patient's notes.	Maintains patient safety and accurate records.
10.	If any abnormalities are observed, escalate to senior nursing staff/mentor immediately.	It is vital to report abnormal findings to a registered nurse immediately so they can ensure care is escalated. Failure to do so can result in the patient's condition deteriorating, potentially leading to death.

Evidence base: Dougherty and Lister (2011); Trott (2005); WHO (2009)

Pressure related injuries – quick reference guide

☑ **Definition**

A pressure related injury is 'localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear' (EPUAP 2014).

Helpful hint – Remember that the pressure injury may not always be over a bony prominence.

☑ **Cause**

Either from pressure over bony areas or from an external source – such as a splint, collar, frame, plaster cast or occasionally friction. Pressure of any type leads to a loss of skin integrity, discolouration, reduced perfusion, skin break down, **ischaemia** and ulceration.

☑ **Grading**

1. Non-blanchable erythema.

   The ulcer appears as a red area (on lightly pigmented skin) or a red, blue or purple hue (on darker skin tones),which does not resolve 30 minutes after the pressure has been removed. Skin is intact.

2. Partial thickness.

   Skin is broken but the lesion is superficial with no measureable depth.

3. Full thickness skin loss.

   A break through the dermis of the skin and possibly including damage or necrosis of subcutaneous tissue.

4. Full thickness tissue loss.

   A break through all of the skin layers extending into muscle, tendon and bone.

   An additional category of 'unstageable' is used where the actual depth of the ulcer is not visible due to thick slough (EPUAP 2014).

Helpful hint – Remember that pressure ulcers of all stages are painful. Ensure you assess a patient's pain frequently with a pain scale that is appropriate for their cognitive level. Dressing changes can be very painful, so always ensure that analgesia has been considered if the patient finds the dressing change uncomfortable or painful, and constantly assess the pain the patient is experiencing.

☑ **Prevention**

- Assessment of patient comfort.
- Moving and handling assessment and care planning.
- Completion of tissue viability score within 6 hours of admission.
- Regular repositioning of a patient – at least 2 hourly.
- Careful moving and handling techniques – to prevent shearing of skin.
- Assessment and timely use of pressure relieving aids, such as special mattresses and cushions to help redistribute pressure.
- Ensure bed linen is dry and free from creases – to reduce risk of skin damage.
- Effective hygiene – to keep skin clean and dry.
- Ensure adequate nutrition and hydration – to promote healthy tissues.

☑ **Risk Assessment**

NICE guidelines (2014b) state that patients should have a pressure ulcer risk assessment within six hours of admission and regularly thereafter. There are a wide range of risk assessment tools. The most well-known is Waterlow (2005) although there are many others such as Braden (1997), and Norton (Schoonhoven et al., 2002). There are also tools specifically for neonates and children (Willock et al., 2009). Whilst risk assessment tools are means of achieving a structured approach to assessing a patient, clinical judgement is also vital to ensure that the correct preventative strategies are put in place.

☑ **Evidence base:** Braden (1997); EPUAP (2014); NICE (2014b); Piper et al. (2009); Schoonhoven et al. (2002); Waterlow (2005); Willock et al. (2009)