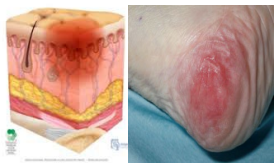
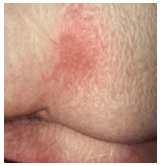

Patient care plan Grade 1

Non Blanching Erythema – intact skin with redness usually over non blanchable redness usually over a bony prominence. Darker skin tones may not have visible blanching but the colour may differ from the surrounding area. The affected area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.

GRADE & PRESSURE DAMAGE	EXPECTED OUTCOMES	NURSING CARE PLAN
Grade 1 Non Blanching Erythema pressure damage to …… Patient/relative informed of pressure damage Date……	To prevent any further damage To document evidence of skin checks – a minimum of daily inspection to prevent any further deterioration Ensure pressure damage is graded by using the Scottish Adapted European Pressure Ulcer Advisory Panel's Grading tool and record in patients notes https://nhsforthvalley.com/wp-content/uploads/2019/10/GRADING-AND-MOISTURE-TOOL.pdf	1.Complete daily skin checks/ risk assessments and skin treatment plans. Reassess in accordance with local guidelines and patient risk (Braden/Waterlow/MUST) 2. Supply Patient Pressure Area Care Leaflet to Patient / Resident / Family / Carers. https://nhsforthvalley.com/wp-content/uploads/2021/12/PAC-Patient-Information-Leaflet.pdf 3.Assess skin (as per local policies) especially over bony prominences and any areas at risk by using finger tip test and record any findings in clinical / nursing notes (please see separate sheet for finger tip assessment) 4. Continue to assess for the need for pressure relieving equipment required and provide specialist resources (e.g. Mattresses, Cushions, heel protectors) as appropriate and document what equipment utilised please state ……. 5.Implement a pressure relieving regime as per NHS Forthvalley pressure ulcer risk assessment and prevention guideline (2020) and document in care & comfort charts/ Turning charts and in patients clinical/ nursing notes https://nhsforthvalley.com/wp-content/uploads/2020/05/Pressure_Ulcer_Risk_Assessment__Prevention_Guideline-Updated-Version-1-May-2020_final.pdf 6.Apply emollient to area of damage to rehydrate, if required for further protection apply non adherent wound dressings/soft swabs and protective bandage to secure if heels/elbows but ensure these are removed daily to inspect the these areas.

Use of finger test in the prevention of pressure ulcers: a guide for skin inspectors.

- Apply light finger pressure on the area of concern with your thumb or finger
- Press and hold for 10 – 15 secs
- Look at the colour of the skin when you release your thumb or finger
- If the skin turns white (blanching) there is probably an adequate blood supply to this area and it is not a Grade 1 pressure ulcer. Daily checks are required
- If the skin remains red (non-blanching) this indicates the beginning of Grade 1 pressure ulcer.
  *Preventative measures must be taken **immediately** to remove the pressure and avoid positioning on this area until the redness has resolved. This should be documented in the notes.*