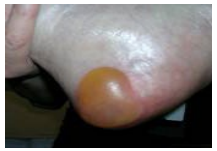

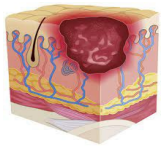

Patient care plan Grade 2 Blister to heel
Intact Blister - Partial thickness skin loss damage to epidermis/dermis

NHS Forth Valley

Grade & Pressure Damage	Expected Outcome	Nursing Care Plan
Grade 2 Blister to ..... NB – Wounds on Diabetic patient can deteriorate quickly and if any deterioration then should be referred to podiatry for further advice IR1 (acute/primary care) must be completed IR1 No..... Care Homes complete appropriate adverse event reporting documentation for their service Patient/relatives informed of pressure injury Date.....	To prevent any further damage and heal wound/area To document evidence of skin checks /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 risk assessments/ re assess 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 and around any blistered area by using finger tip test and record any findings in clinical / nursing notes (please see separate sheet for finger tip assessment) 4.Ensure off loading pressure relieving equipment is implemented (e.g. Mattresses and heel protectors) and document what equipment is utilized Please state……. If patient is mobile then please refer to Orthotics for off loading pressure reliving heel boot. Date ..... https://staffnet.fv.scot.nhs.uk/departments/wp-content/uploads/sites/16/2020/11/ORTHOTIC-REFERRAL-FORM.docx 5.Implement a pressure relieving regime as per best practice pressure area standards and document in care & comfort charts/ Turning charts and in 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.Wound Assessment Chart and Treatment Plans must be fully completed https://nhsforthvalley.com/wp-content/uploads/2018/05/Wound-Management-Formulary.pdf 7.Apply emollient to surrounding skin, apply Non Adherent wound dressing (e.g. Atrauman or formulary equivalent) soft swabs, comfinette liner and protective bandaging to secure toe to knee. Aim to redress 3 times per week (avoid using adhesive dressings on heels as this can cause trauma on removal) 8. Assess and document pain score and provide appropriate analgesia if required

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.*

- Any alteration in skin colour (redness, purple or black), increased heat or swelling may imply underlying tissue breakdown. Darkly pigmented skin does not blanch. Signs to look for include purple discolouration, skin feeling too hot or cold, swelling, hardness or pain