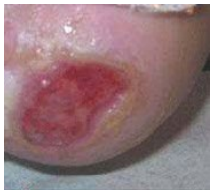

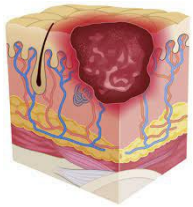

Plan Grade 2 Partial Skin Loss and Ruptured Blister

Loss of epidermis/dermis presenting as a shallow open ulcer with a red/pink wound bed without slough or bruising.

NHS Forth Valley

Grade & Pressure Damage	Expected Outcome	Nursing Care Plan
Grade 2 pressure damage to ..... (please document site) NB – Wounds on the feet of Diabetic patients can deteriorate quickly and should be referred to podiatry IR1 (acute/primary) must be completed IR1 No..... Care Homes complete appropriate adverse event reporting documentation Patient/relatives have been informed of pressure injury Date.....	To prevent any further damage and heal the pressure ulcer 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 by using finger tip test and record any findings in clinical / nursing notes (please see separate sheet for finger tip assessment) https://nhsforthvalley.com/wp-content/uploads/2021/12/Single-Finger-Test-Pocket-Guide.pdf 4.Ensure off loading pressure relieving equipment is implemented (i.e. Mattresses and heel protectors) and document what equipment 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.**For heels -** Cleanse ulcer with prontosan soaked swabs for 5-10min. 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.) **For all other areas -** Cleanse ulcer with prontosan soaked swabs for 5-10min, apply viscopaste pads and appropriate secondary dressing. (Please consider incontinence if pressure ulcer located on sacrum, query the need for secondary dressings) 8. Assess and document pain score and provide appropriate analgesia if required.