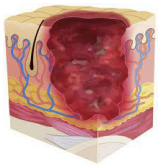
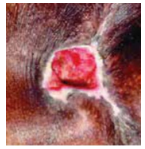
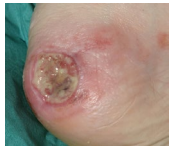

Patient care plan Grade 3 – Full thickness skin loss
Subcutaneous fat may be visible but bone, tendon or muscle is not visible or palpable **Slough may be present but does not obscure the depth of tissue loss.** May include Undermining or tunneling

Grade & Pressure Damage	Expected Outcome	Nursing Care Plan
Grade 3 pressure ulcer to ..... (please document site) **NB If pressure ulcer on foot of a diabetic patient or known PAD then will require specialist management / advice from GP/ Vascular/ Deibetologist or Podiatry** **IR1(acute/primary) must be completed. IR1 No……..** **Care Homes: complete an appropriate adverse event reporting documentation.** **Completed TVS referral form and wound photograph sent to TVS mailbox. Date sent……** **Patient/relatives informed of pressure damage. Date.....**	To prevent further pressure damage and heal the wound. 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 Daily Risk Assessment and ensure treatment/re assessment is 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 condition at each pressure area care regime with particular emphasis on bony prominences or risk areas by using the fingertip test and record any findings in clinical/nursing notes. https://nhsforthvalley.com/wp-content/uploads/2021/12/Single-Finger-Test-Pocket-Guide.pdf 4.Ensure that pressure ulcers(s) present are graded using the Scottish Adapted European Pressure Ulcer Advisory panel grading tool, and record in patients records. 5. Ensure off loading pressure relieving equipment is implemented (i.e mattresses, heel protectors, cushions) 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 6.Implementation of pressure relieving regime as per best practice/pressure area standards and document in care & comfort charts/turning charts and clinical nursing notes. https://nhsforthvalley.com/wp-content/uploads/2020/05/Pressure_Ulcer_Risk_Assessment__Prevention_Guideline-Updated-Version-1-May-2020_final.pdf 7.Wound Assessment Chart and Treatment Plan must be fully and accurately completed at each dressings change (ensuring, depth, undermining and tunnelling is assessed for). Wound treatment plans must be fully completed and update accordingly. Please refer to Wound Management Formulary and / or Quick Reference Guide for dressing choice https://nhsforthvalley.com/wp-content/uploads/2018/05/Wound-Management-Formulary.pdf Cleanse ulcer with Prontosan solution (irrigation/soaks 5 mins)

		Protect periwound skin with barrier film products. see Forth Valley Wound Management for current choice Examples of appropriate primary dressings: Hydrofibre eg Aquacel Extra or formulary equivalent (moderate to high levels of exudate) Hydrogel eg Activeheal hydrogel or formulary equivalent (low levels of exudate) Antimicrobial dressings – if clinically infected only for two weeks Aquacel Ag + Extra Medihoney apinate/ L mesitran ointment, Flaminal forte/Flaminal Hydro gel. **Secondary dressings:** Heels: absorbent dressing (soft swabs/super absorbent depending on exudate levels), protection of periwound skin with barrier films, hydration of skin with emollients, secure with Comfinette, Lantor and crepe bandage toe to knee) Secondary adhesive dressings: Low/moderate exudate Klinederm foam silicone border dressing or formulary equivalent. Moderate/high exudate: Tegaderm foam adhesive or formulary equivalent. Continence status must be considered when choosing appropriate secondary dressing, for sacral area damage then viscopaste pad can be used as an alternative in this case to secure primary dressings i.e hydrogel/L-Mesitran ointments dressings remain in place. 8. Assess and document pain score and provide analgesia as appropriate, review effects after administration 9.Evaluate the nutritional status of your patient and record findings on local tools i.e. MUST Score