



Patient Care plan Grade 4 – Full Thickness Tissue Loss

Extensive tissue destruction, exposed or palpable bone, tendon or muscle present. Slough can be present not Obscuring wound bed. Tunneling and undermining usually present.

Grade & Pressure Damage	Expected Outcome	Nursing Care Plan
<p>Grade 4 pressure ulcer to (please document site)</p> <p>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</p> <p>IR1(acute/primary) must be completed. IR1 No.....</p> <p>Care Homes complete appropriate adverse event reporting documentation.</p> <p>Complete TVS referral form and</p>	<p>To prevent further pressure damage and heal wound.</p> <p>To document evidence of skin checks/inspection to prevent any further deterioration.</p> <p>Ensure pressure damage is graded by using the Scottish Adapted European Pressure Ulcer Advisory Panel 's Grading tool and record in patients notes</p> <p>https://nhsforthvalley.com/wp-content/uploads/2019/10/GRADI-NG-AND-MOISTURE-</p>	<ol style="list-style-type: none"> 1.Complete Daily Risk Assessment and ensure treatment/re assessment is in accordance with local guidelines and patient risks (Braden/Waterlow/Must) 2.Supply Patient Pressure Area Care leaflet to Patient /Relative /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 (e.g. mattresses, heel protectors, cushions) Please state..... If mobile then please refer to Orthotics for off loading pressure relieving heel boot Date <p>https://staffnet.fv.scot.nhs.uk/departments/wp-content/uploads/sites/16/2020/11/ORTHOTIC-REFERRAL-FORM.docx</p> <ol style="list-style-type: none"> 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 must be fully and accurately completed at each dressings change (ensuring, depth, undermining and tunnelling is assessed for). Wound

<p>wound photograph sent to TVS mailbox. Date sent.....</p> <p>Patient/relatives informed of pressure injury. Date.....</p>	<p>TOOL.pdf</p>	<p>Assessment and 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</p> <p>Cleanse ulcer with Prontosan solution (irrigation/soaks 5 mins) Protect periwound skin with Cavilon barrier film (wand/spray). Examples of appropriate primary dressings: Hydrofibre eg Aquacel Extra, Urgoclean Rope (Cavity dressing) for moderate to high levels of exudates. Hydrogel eg Actiheal Hydrogel (low levels of exudate) Antimicrobial dressings – if clinically infected only for two weeks Aquacel Ag + Extra, Aquacel Ag ribbon(cavity dressing) Medihoney Apinate/L_Mesitran ointment, Flaminal Forte/Flaminal Hydro Gel.</p> <p>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) All other wounds - Secondary adhesive dressings: Low/moderate exudates: Kliniderm foam silicone border dressing (for sensitive skin only). Moderate/high exudate: Tegaderm foam adhesive or formulary equivalent. Contenance 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/Honey Ointments/Flaminal dressings remain in place.</p> <p>7. Assess and document pain score and provide analgesia as appropriate, review effects after administration</p> <p>8. Evaluate the nutritional status of your patient and record findings on local tools e.g MUST Score</p>
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