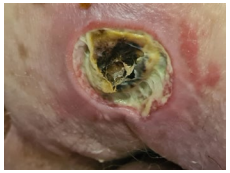
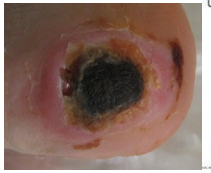
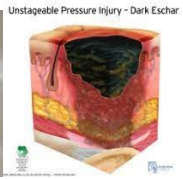

Patient care plan- Ungradable

Full thickness skin/tissue loss depth of ulcer is completely obscured due to Slough and or necrotic tissue. Until enough slough is removed to expose the base of the wound the true depth cannot be determined. When debrided the wound may become grade 3 or 4.

Grade & Pressure Damage	Expected Outcome	Nursing Care Plan
Ungradable pressure ulcer to ..... (please document site) **NB If Pressure ulcer on foot of a diabetic patient or known PAD If the tissue becomes hard and necrotic then will require IMMEDIATE specialist management / advice from GP/ Vascular/ Deibetologist or Podiatry** **IR1(acute/primary) must be completed. IR1 No……..** **Care Homes complete appropriate adverse event reporting documentation**.	To prevent further pressure damage, debride wound bed and promote wound healing. 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-	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) and document what equipment is utilised. Please state..... 6. Implementation of pressure relieving regime as per best practice / pressure area standards and document in care and 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 dressing change. Wound Assessment andTreatment 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-

Completed TVS referral form and wound photograph sent to TVS mailbox. Date sent…… **Patient/relatives informed of pressure injury. Date.....** **Ungradable heel pressure ulcer referral to orthotics for off loading foot wear. Date.....**	MOISTURE-TOOL.pdf	Formulary.pdf 8. Diabetic & Peripheral Arterial Disease ungradable heel pressure ulcers. DO NOT HYDRATE, AIM TO KEEP WOUND BED DRY UNTIL REVIEWED BY PODIATRY. APPLY INADINE ONLY TO THE ULCER If mobile and pressure damage is to Patient's heel, then please refer to Orthotics for off loading pressure relieving boot. https://staffnet.fv.scot.nhs.uk/departments/wp-content/uploads/sites/16/2020/11/ORTHOTIC-REFERRAL-FORM.docx Cleanse with Prontosan solution soaks for 5 mins. Protect periwound skin with use of barrier film during rehydration of sloughy/necrotic tissue. Examples of appropriate primary dressings to rehydrate and debride sloughy/necrotic tissue. Hydrogel eg Activheal Hydrogel Medihoney Apinate/ L-Mesitran ointment. Secondary dressings: Heels: Atruaman non adherent dressing, then apply absorbent dressing (soft swabs/super absorbent depending on exudate levels) hydration of skin with emollients, secure with Comfinette, Lantor and Crepe bandage toe to knee) Secondary adhesive dressings: Low/moderate exudate Kliniderm foam silicone border (for sensitive skin only) or formulary equivalent. Moderate/high exudate: Tegaderm foam adhesive or formulary equivalent. (advised not to use foam dressings on heels as this can cause trauma on removal) 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. 7. Assess and document pain score and provide analgesia as appropriate, review effects after administration. 8. Evaluate the nutritional status of your patient …….. and record findings on local tools e.g. MUST Score .