

Pressure Area Management in Critical Care

Aim: To supplement Trust pressure area guidelines with specific guidance for Critical Care patients.

Scope: All adult patients in critical care. This Critical Care Standard Operating Procedure should be used in conjunction with Trust guidelines on pressure ulcer prevention and management.

Version 2

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On Admission to Critical Care

For All Admissions:

- Use pressure-relieving mattress unless contraindicated. Consider repose boots for diabetic or vascular patients and patients on vasopressors.
- Assess and document pressure areas within 4 hours (as Trust guidelines) at the very latest.
- Document Braden Score within 4 hours (as Trust guidelines).

If Pressure Damage is Present:

1. Inform Nurse in Charge, duty consultant
2. Create separate CIS note

3. If Grade 2, 3 or 4 pressure ulcer, complete Datix electronic incident report.*

4. If Grade 3 or 4 pressure ulcer:

- complete safeguarding alert*
- remind Nurse in Charge to contact Trust Risk Dept and begin root cause analysis process*
- inform tissue viability
- photograph and document wound fully

5. Document action plan including repositioning, aids (eg repose boots) and dressings if applicable.

*if not already completed prior to ICU admission

During Critical Care Stay

For All Patients:

- Reposition patient 3-4 hourly, increased to 2 hourly if damage present.
- Inspect all pressure areas and document skin integrity every shift.
- Complete Braden Score daily.

- inform tissue viability
- photograph and document wound fully

6. Document action plan including repositioning, aids (eg repose boots) and dressings if applicable.

If Pressure Damage Occurs:

1. Inform Nurse in Charge, duty consultant
2. Inform patient and/or relatives
3. Create separate CIS note
4. If Grade 2, 3 or 4 pressure ulcer, complete Datix electronic incident report.
5. If Grade 3 or 4 pressure ulcer:
 - inform Matron
 - complete safeguarding alert
 - remind Nurse in Charge to arrange 48 hour panel and begin root cause analysis process.

7. If any part of the action plan cannot be carried out (eg repositioning due to clinical instability or missing equipment), this must be clearly documented.

8. Bedside nurses must hand over condition of pressure areas in their patient at change of shift.


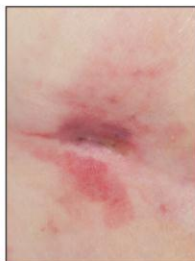






9. Nurse in Charge must hand over presence and condition of pressure ulcers in Critical Care patients at change of shift.

On Discharge from Critical Care

- Inform the receiving ward of any need for a pressure –relieving mattress at time of requesting a ward bed.
- Highlight any concerns about pressure areas on written and verbal handover- including site, grade and treatment.

Remember healed pressure areas are weak and susceptible to developing new sores.
Implement preventative action plan immediately

Grading of Pressure Ulcers

Grade/Catagory 1 	Non-blanchable erythema - Intact skin with non-blanchable redness (does not blanch under normal finger pressure) usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category or Grade 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.	
Grade/Catagory 2 	Partial thickness - Loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough or bruising*. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. This category or grade should not be used to describe tears, tape burns, incontinence associated dermatitis, maceration or excoriation. * Bruising indicates deep tissue injury. slough.	
Grade/Catagory 3 	Full thickness skin loss - Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category or Grade 3 pressure ulcer varies by anatomical location. The bridge of the nose ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category or Grade 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category or Grade 3 pressure ulcers. Bone/tendon is not visible or directly palpable.	
Grade/Catagory 4 	Full thickness tissue loss - With exposed tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of Category or Grade 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category or Grade 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.	

Grading in accordance to the European Pressure Ulcer Advisory Panel, 2009

High Risk Sites for Pressure Areas in Critical Care

- Back of head particularly spinal patients
- Nose from CPAP/BiPAP masks, NG tubes
- Mouth and neck from ET tube securing
- Chin, chest and neck from hard collars
- Ears from ET tapes, O2 mask
- Feet and legs from DVT prophylaxis devices
- Proned patients have different high-risk areas (see Proning SOP)

Preventative Measures

- Good positioning of patient and medical devices
- Regular changes of position of patient and medical devices where appropriate
- Breaks from CPAP/BiPAP if appropriate, protection for nose and other vulnerable areas

