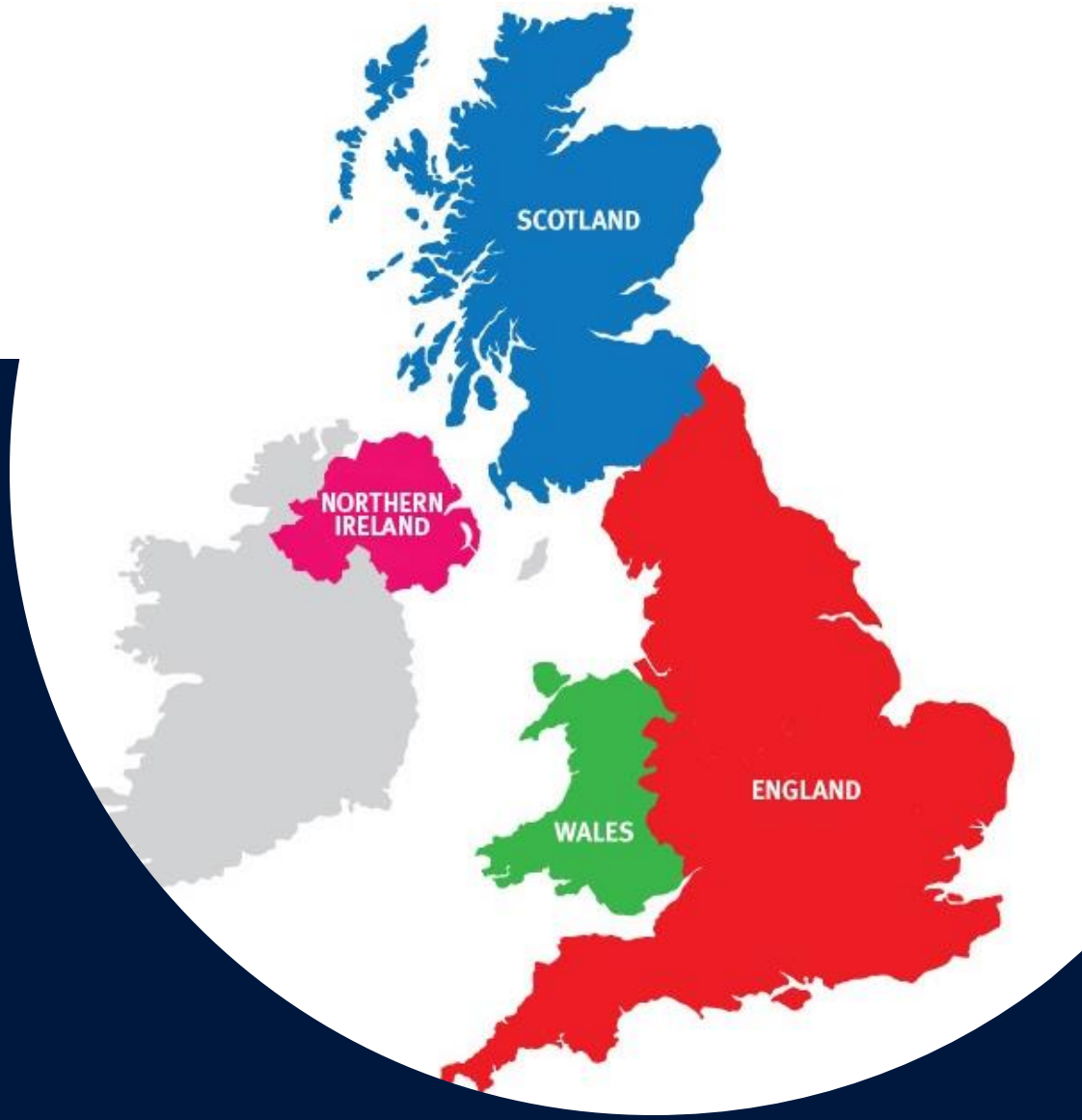
Professional
Record
Standards
Body



PRESSURE ULCER EXAMPLE

MAY 2024

Better records
for better care

Robert Pressure Ulcer Wound Example

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This an example of how the wound care standard would work for Robert.

Robert's circumstances

- Robert is a 53-year-old man
- Robert lives in a care home
- He has motor neuron disease and uses a wheelchair
- He has a category 3 pressure ulcer on his spine caused by a new wheelchair cushion which is causing his skin to deteriorate

This example shows:

- The information recorded at the 1st assessment visit and subsequent treatment visits by the community nurse.
- It also covers the referral to the wheelchair service, assessment by the wheelchair specialist
- Only the elements and information which are recorded in this example. Elements of the standard which are not relevant and would not be used for this example and the 1st check are not shown.

The standard will also enable all other contacts about wound care to be recorded along with observations, assessments, treatments, and updates/changes to her personalised care and support plan.

Wound assessment and treatment (Page 1)

Professional Record Standards Body

Contacts with Professionals

Seen by: <Name> Role: Community nurse Date: Monday 16th January 2023 Where: <anytown care home>

Baseline information

Wound classification: Pressure ulcer

Problem: Motor neurone disease,

Anatomical site: spine

Wound description: Category 3 spine pressure ulcer caused by new wheelchair cushion which is causing skin to deteriorate

Date wound occurred: 9th January 2023

First (initial) assessment of Roberts Pressure Ulcer

- Length 6cm, W 4.5cm, depth 1.5 cm, Point of ref: Spine
- Wound and surrounding skin description
  - ➢ Wound bed Tissue type: granulation
  - ➢ No undermining or tunnelling
  - ➢ Surrounding skin condition: Moist
- Image: <url for image>
- Wound complications: Local infection of wound

Wound observations

Clinical observations

- Pain score: VAS 4/10.
- Wound pain frequency: changing positions/adjusting sitting or lying position
- Signs & symptoms of infection: Overt signs of infection
- Exudate: Moderate, Serous

Person observations

- Person observations: -

	aSSKINg bundle assessment
a	Assess risk Undertake Purpose T assessment
S	Skin integrity
	○ Colour: Red
	○ Temperature: Warm
	○ Texture: Moist
	○ Integrity: Broken areas, open wound
S	The use of equipment to reduce pressure ulcers- Wheelchair cushion- but is ineffective, a dynamic pressure-relieving mattress, a wheelchair, and a hospital bed. Robert has been advised to get up for shorter periods in the day and return to bed's dynamic pressure-relieving mattress to offload pressure on wound
K	Ability to move and any aids he uses- Slight position changes occasionally, low-level mobility
I	Incontinence: Doubly Incontinent
N	How well he is eating and drinking: Well managed
g	Information provided on prevention of pressure ulcers

Wound assessment and treatment (Page 2)

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Wound and skin care treatment

- Wound care products
  - Medication/Product name: Hydro fibre dressing, adhesive foam
  - Medication trade family : <manufacturer name>
  - Form: dressing
- Procedure: Dressing change
- Adjunct additional supporting therapies: Off loading
- Consent: Consent given
- Information and advice given: advice on the prevention of pressure ulcers
- Information and advice given: Take all other prescribed medication
- Plan and requested actions
  - Professional: - Schedule of assessments: Wound is formally assessed monthly, but is reviewed every dressing change for signs of infection
  - Person: Pain management Changing positions/adjusting sitting or lying position
- Future appointments:
  - Date: 18th January 2023 and then scheduled 3 days per week (Monday, Wednesday and Friday until pressure ulcer healed
  - To see: <Name>, Community nurse
  - Location: <name>Care Home
  - Reason for appt: dressing change

Risks (for delayed healing)

- Risk (repeated for each risk)
  - Start date: -
  - End date: -
  - Risk: Local infection of the wound
  - Comment: -

Wound assessment and treatment (subsequent)

Dressing change Days 3, 5 and 8 and subsequent

- Dressings used
  - Hydro fibre dressing
  - Adhesive foam
- Any other treatments: Off loading
- Wound bed tissue type: Granulation
- Condition of surrounding skin
  - Red
  - Moist
- Exudate levels: Moderate
- Pain levels: 4/10
- Signs of infection: None
- Changes to Patient's condition: Not currently

Community nurse visit Day 5

- Referral to Wheelchair team for reassessment and body mapping

Wheelchair assessment Day 12

Performed and recorded by Wheelchair service team

- Skin inspection: Category 3 pressure ulcer
- Method of propulsion: Pushed by both arms, and or by a helper
- Assessment of sitting balance
  - Hand simulation: Neutral sitting position possible with hand support for all assessed areas of the body
  - Upright sitting posture: Fixed posture
  - Pelvis and hip posture screen
    - Can pelvis be level: yes
    - Can hip bend to neutral sitting posture: yes
    - Right hip: yes
    - Left hip: yes

Wound treatment plan (Page 1)

Robert's Treatment Plan – using a Personalised Care and Support Plan (PCSP)

A Personalised Care and Support Plan (PCSP) is created for Robert to help him manage his condition.

Person preferences and treatment objectives

- Join the local swimming group
- Previous treatment experience: -
- Previous equipment experience: -

Care & support plan

Using Robert's preferences and About Me they agree new needs, goals and actions for the PCSP. Below is just a summary of the key parts which would be added to Robert's PCSP.

- Strengths: Positive and confident person
- Needs: Alleviate pain

➢ Goal: Medication and wound care product management

➢ Goal importance: 10/10

➢ Goal status: In progress

➢ Action: Take 200-400mg of Ibuprofen

➢ Action: Continue to attend appointments for 3 times weekly hydro fibre dressing changes

➢ Action: Take 500mg Paracetamol

➢ Action: Use new wheelchair cushion

- Needs: Alleviate pain

➢ Goal: Adjust eating and drinking habits

➢ Goal importance: 8/10

➢ Goal status: In progress

➢ Action: Eat a healthy, balanced diet with high protein, fruit and vegetable intake

➢ Action: Drink 2L of water per day

- Needs: Improve strength

➢ Goal: Increase daily average movement

➢ Goal importance: 8/10

➢ Goal status: In progress

➢ Action: Frequently adjust sitting or lying positions

➢ Action: Attempt a daily stretch

➢ Goal: Take-up swimming / hydrotherapy

Wound treatment plan (Page 2)

Additional support plan

This is created to hold the wound care medical treatment plan and added to Roberts PCSP.

Regular review and monitoring of health at least 4 times a week, if unhealed at 12 weeks, detailed reassessment (ref Pressure Ulcers Recommendations - Improving Wound Care: Building on The National Wound Care Programme - FutureNHS Collaboration Platform)

Dressing changes:. Three times weekly dressing changes .

Wound bed preparation: Cleaning

Wound care products:

- Hydro fibre dressing
- Adhesive foam

Adjunct additional supporting therapies: Off loading

Pain management: Medicines prescribed by community nurse (not part of the wound care standard)

- 200-400mg of Ibuprofen every 4-5 hours if needed,
- 500mg of Paracetamol every 4-5 hours if needed

Agreed with: Robert Date: 23/01/2023

Review date: 1 month Responsible for review: Community nurse

Contingency or Escalation Plan

This is created on day 8 to show what to do should things get worse.

Triggers factors:

a) Wound not healing or improving

b) Pain management not working

c) Signs of infection showing

d) New wheelchair cushion not suitable

What should happen:

a) Switch medication to 30-60mg of Codeine every 6 hours

b) Contact wheelchair service over wheelchair cushions concerns

Who should be contacted:

a) Community nurse

b) Wheelchair service

Agreed with: Robert Date: 23/01/2023

Review date: 1 month Responsible for review: Community Nurse

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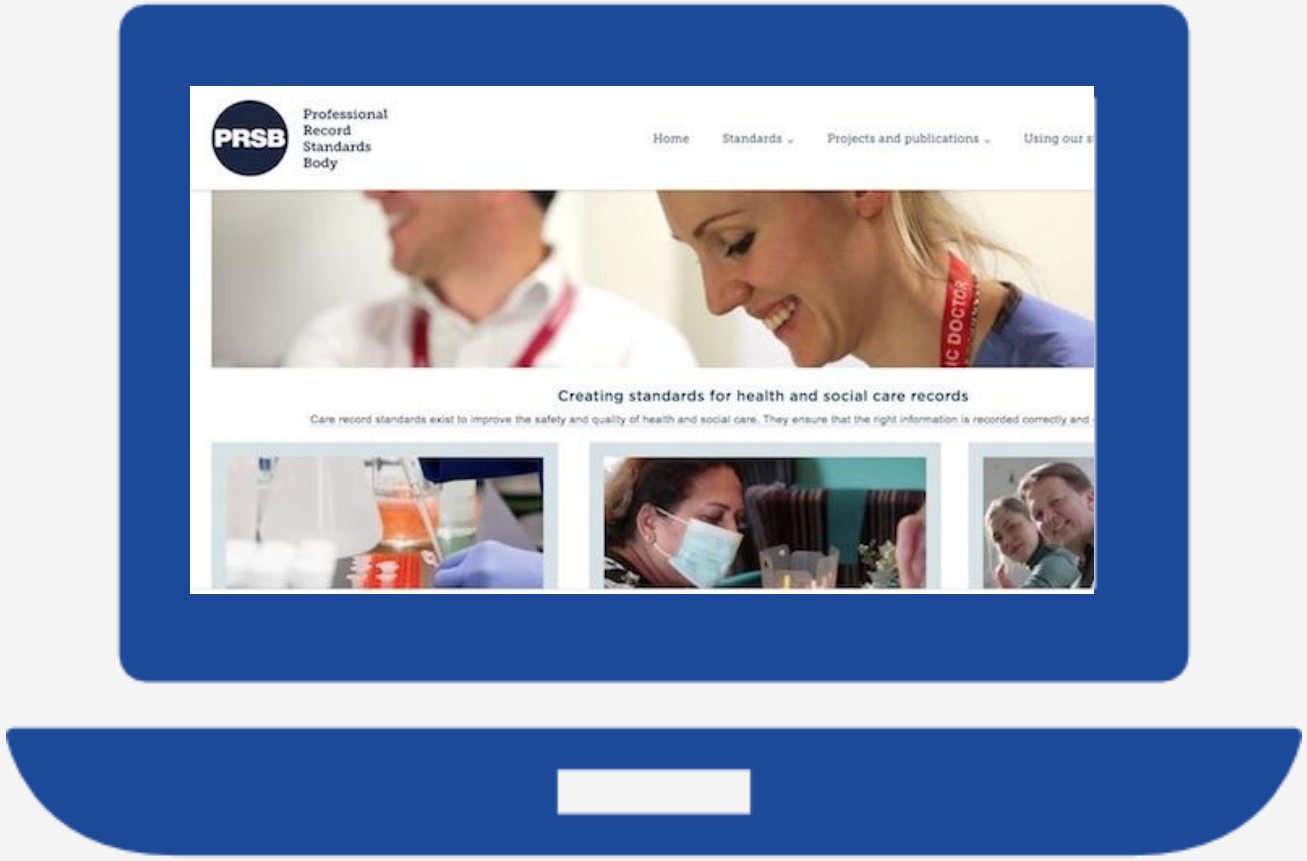

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