The aSSKINg Framework

	Action	Best Practice
A	**Assess risk**	■ Assess pressure ulcer risk using a validated tool to support clinical judgement and document risk status and timing of review ■ Risk assessment identifies the patient's individual risk of pressure ulcers. ■ Appropriate care and interventions can be implemented, ensuring resources are used appropriately.
S	**assessment and skin care**	■ Early inspection means early detection ■ Keep the skin clean, dry and well hydrated and perform regular skin inspections ■ Show patients and carers what to look for
S	**Surface**	■ Ensure the provision of appropriate pressure-reducing or pressure-relieving devices ■ Ensure the patient is repositioned at regular intervals, to meet their individual healthcare needs ■ Consider the impact of medical devices and their contact with the skin
K	**Keep moving**	■ Encourage mobility and regular movement to relive pressure over bony prominences. ■ Identify and understand and, where possible, address the cause of any change in mobility level ■ Identify the cause of moisture-related skin damage ie. incontinence, sweat, saliva, stoma effluent and wound leakage.
I	**Incontinence or increased moisture**	■ Keep skin clean and dry ■ This may include the use of barrier creams, incontinence products and/or emollients
N	**Nutrition**	■ Assess nutritional status using evidenced based tools such as the Malnutrition Universal Screening Tool (MUST) ■ Assess nutritional status ■ Keep patients well hydrated ■ Implement prescribed diet/nutritional supplements
G	**Give information**	■ Communicate effectively and provide information to patients, carers and the multidisciplinary team regarding pressure ulcer prevention (i.e. repositioning, equipment, nutritional/hydration).

Debrisoft® Lolly

L&R Code	PIP Code	NHS SC	Pack Size
33 224	398-5124	ELZ728	5/50

Scan the QR code to learn more about **Pressure Ulcers with Learn on Demand.**

For further information contact our Customer Services Team on **08450 606707** or email at **CustomerServices@uk.LRMed.com**

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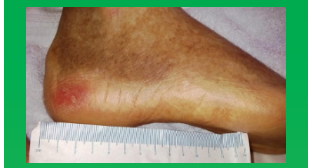
Pressure Ulcer Guide

Prepare the wound with **Debrisoft®** Lolly

www.Lohmann-Rauscher.com

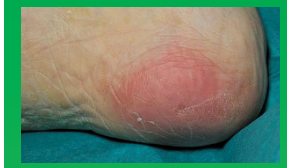
Categorisation of Pressure Ulcers*

Category 1



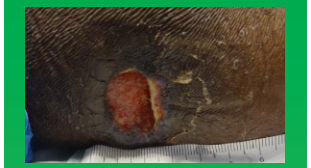
In lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but itscolour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.

Category 2



Partial thickness skin loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ ruptured serum-filled blister or present as a shiny or dry shallow ulcer without slough or bruising.

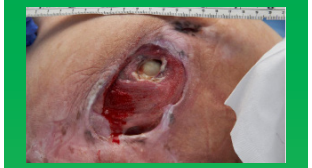
Category 3



Full thickness tissue loss where 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 tunnelling.

Consider debridement

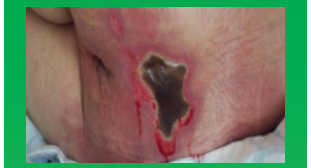
Category 4



Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. These wounds may extend beyond the skin and subcutaneous fat, causing extensive damage to supporting structures.

Consider debridement

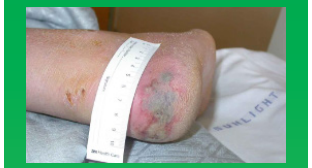
Formally known as 'unstageable



Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re recorded in the patient's records if debridement reveals category 4 pressure ulceration.

Consider debridement

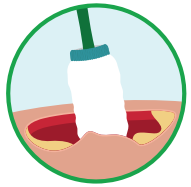
Suspect Deep Tissue Injury



Deep tissue injuries (DTIs) should not be reported as pressure ulcers unless they result in broken skin or they fail to resolve and it is evident on palpation that there is deep tissue damage present, at which point, they should immediately be categorised and reported. However, the skin change must be recorded within the clinical record.

Disclaimer: Consideration should be given to patients with wounds on the lower limb/feet where arterial or suspected arterial disease may be present, and patients where malignancy is suspected.

Prepare the wound

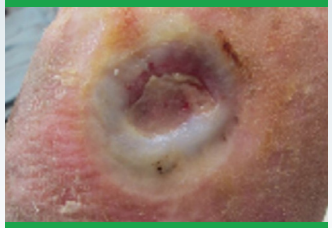
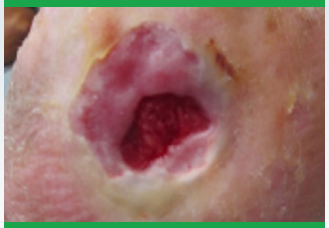


Key Benefits

- Ideal for debriding devitalised tissue and removing contamination in cavity pressure ulcers, such as sacral ulcers
- The wand of the lolly can be used for measuring the depth of pressure ulcers due to measurement indicators on the handle
- Highly effective debridement
- Rapidly visible results in 2-4 minutes
- Effective in removing biofilm
- High user satisfaction

Pressure Ulcer case study

Debridement with **Debrisoft®** revealed the true depth and extent of the wound

Pressure Damage	Pressure Damage
	
Before	After

Scan the QR code to learn more about the the **National Wound Care Strategy Pressure Ulcer Categorisation**

*National Wound Care Strategy Programme. (2023). Pressure Ulcer Recommendations and Clinical Pathway. NHS England