SRI LANKAN ASSOCIATION OF GERIATRIC MEDICINE

PRESSURE ULCERS - A CARE PATHWAY

STEP 1 - SCREENING → Braden Pressure Ulcer Risk Score

Parameter/Score	1	2	3	4
SENSORY PERCEPTION	Totally Inadequate	Very Inadequate	A Little Adequate	Completely Adequate
MOISTURE	Constantly Wet	Very Wet	Sometimes Wet	Rarely Wet
ACTIVITY	Bedridden	Chair Dependent	Can Sometimes Walk	Can Often Walk
MOBILITY	Completely Immobile	Very Immobile	A Little Mobile	Mobile
NUTRITION	Very Bad	Inadequate	Adequate	Very good
FRICTION & SHEAR	Problem	Potential Problem	No Problem	-

- Each factor is scored, and the total score indicates the risk level: higher scores mean lower risk.
- Modify according to each institution

STEP 2 - ASSESSMENT OF THE RISK LEVEL

DETERMINE RISK LEVEL

15-18: Mild Risk
Some risk, basic preventive measures needed.

13-14: Moderate Risk
Increased risk, more frequent monitoring and preventive measures required.

10-12: High Risk
High risk, intensive preventive measures and regular reassessment needed.

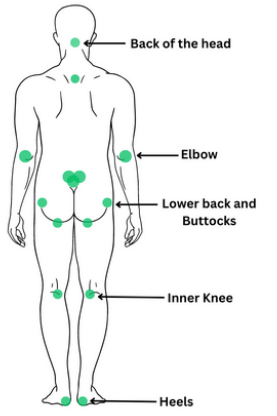
<9: Severe Risk
Very high risk, immediate and comprehensive preventive and therapeutic measures required.

Depending on risk assesment

STEP 3: CONDUCT DAILY SKIN ASSESSMENT

- Check the entire body, focusing on bony prominences.
- Look for redness, discoloration, swelling, or any signs of breakdown.
- Note any changes and report them to healthcare providers.

Common areas for Pressure sores in fixed patients



STEP 4: CLASSIFY ULCER USING NPUAP

	Stage	Description
Reversible	Stage I	Non-blanching erythema of intact skin
	Stage II	Partial thickness skin loss; ulcer extends down to epidermis and/or dermis
Graftable	Stage III	Full thickness skin loss; ulcer extends down to subcutaneous fat and fascia
non Graftable	Stage IV	Full thickness skin loss with extensive destruction and tissue necrosis; ulcer extends down to muscle, bone, tendon, or joint capsule

STEP 5: IMPLEMENT GENERAL INTERVENTIONS

To See

- Skin hygiene: *Assess for cleanliness, dryness, and moisture*
- Nutrition: *Monitor nutritional status*
- Exercise: *Observe mobility and range of movement*

To Do

- Offloading: *Reposition every 2 hours*
- Equipment: *use heel protectors, cushions, and dual system air mattresses appropriately*
- Dressings: *Simple and as needed*
- Keep dry: *Prevent bladder and bowel soiling*
- Physiotherapy: *Enhance mobility and prevent contractures*
- Nutrition: *Improve nutritional status*
- *Protect skin: by moisturizing*
- *Incorporate family and caregiver: Engage the patient's family and caregiver in the care routine.*

STEP 6: REFERRAL FOR DEFINITIVE CARE OR APPROPRIATE PALLIATIVE CARE

Not to Do

- Prolonged pressure: *Avoid long periods in one position*
- Neglect skin care: *Don't ignore skin hygiene*
- Inappropriate equipment: *Don't use unsuitable pressure relief devices.*
- Inactivity: *Don't ignore the need for physiotherapy and exercise*
- *Injurious handling: Avoid handling techniques that may cause injury.*
- *Pressure point massaging: Don't apply pressure massages that could harm vulnerable areas.*
- *Ignoring caregiver fatigue: Don't overlook the signs of caregiver exhaustion; it can impact care quality.*