PRESSURE ULCERS

NHS

Ambulance staff can play an important part in early detection of pressure ulcers.

Pressure ulcers are a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.*

ASSESS

During assesment note any signs of tissue damage

IDENTIFY

Potential risks of pressure ulcers occurring using Andersen Tool

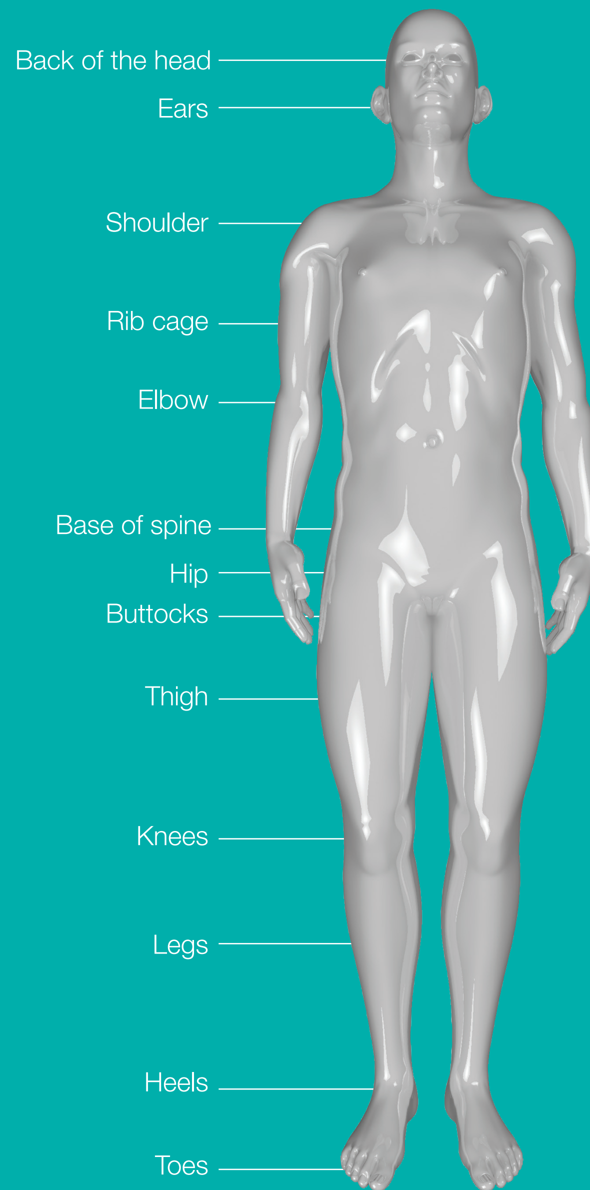
DOCUMENT

Findings and considerations

REFER

Report on handover or refer to GP/ District Nurse. Make a Safeguarding referral for any grade 3 or 4 not being treated by a health professional.

Common areas for pressure ulcers:



*European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel
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Association of the Ambulance Chief Executives and Health Education England

Scottish Adapted European Pressure Ulcer Advisory Panel (EPUAP) Grading Tool

NHS Quality Improvement Scotland

Grade	Description	Progression of a pressure ulcer
Grade 1	Non-blanchable erythema (redness) of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin	Epidermis, Dermis, Hypodermis, Bone
Grade 2	Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister	Epidermis, Dermis, Hypodermis, Bone
Grade 3	Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia	Epidermis, Dermis, Hypodermis, Bone
Grade 4	Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss	Epidermis, Dermis, Hypodermis, Bone

www.tissueviabilityonline.com/pu   Version 1 1st July 2009   Images: Colin Blain Medical Photographer Inverclyde Royal Hospital (IRH) Greenock / Science Photo Library

Scottish adapted European Pressure Ulcer Advisory Panel (EPUAP)2009

The Andersen Score is a recognised tool for identifying risk of pressure ulcers:

Absolute (Score 2)	Relative (Score 1)
Unconsciousness	Age >70
Dehydration	Restrictive mobility
Paralysis	Incontinence
	Pronounced emaciation
	Redness over bony prominence

If 2 or more scored at risk of pressure ulcer, refer to GP/ District nurses for a tissue viability assessment.

Andersen Pressure Ulcer Risk Assessment Tool (Andersen et al, 1982)

POINTS TO REMEMBER

1. Pinch-points	2. Consider padding around head / neck / shoulders if lateral
- Buckles	- Minimise time on scoop / board
- Trolley side handles	- Consider pain relief
- Arm caught under body-weight	- Consider repositioning if patient has an existing pressure ulcer

Developed by the London Ambulance Service NHS Trust and Bucks New University