

In association with: **NHS**  
Sheffield Teaching Hospitals  
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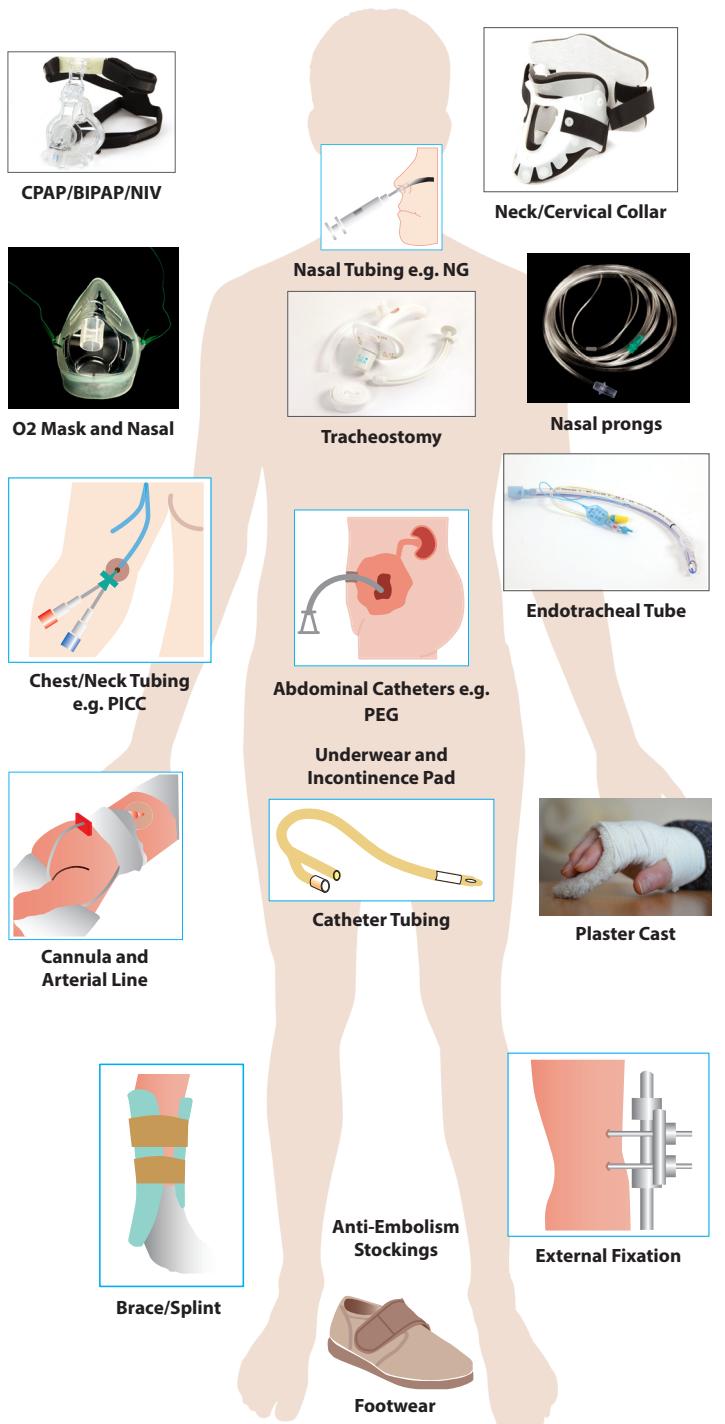
# Prevention of Medical Device-Related Pressure Ulcers (MDRPU) guidance

- Pressure Ulcers that result from the use of devices designed and applied for diagnostic and therapeutic purposes are known as MDRPU

- A significant proportion of Pressure Ulcers in critically ill and immobile patients are related to the use of devices (Black et al, 2010)

- Many devices are made of plastic, rubber or silicone, which can cause rubbing or create pressure on the soft tissues (Jaul, 2010)

- All patients with a medical device are "at risk" of developing MDRPU (NHS Improvement 2018).



If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document / Sheffield Formulary.

November 2018. Updated December 2025 in association with Sheffield. For review by July 2028

**References:** NHS Improvement (2018) Pressure ulcers: revised definition and measurement summary and recommendations. Jaul (2010) Ostomy Wound Management. Black et al. (2010) International J of Wound Care. European Pressure Ulcer Advisory Panel (2019) Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline.

## Assessment:

**SELECT** a device that has the ability to induce the least degree of pressure and/or shear, ensuring that it is correctly sized and fits appropriately.

## Management:

**REPOSITION** and/or offload the pressure from the device every two hours as a minimum in order to provide pressure relief if clinically safe to do so.

Ensure the skin beneath and around the device is kept clean and dry.

**INSPECT** the skin beneath and around the medical device three times a day.

Consider the use of barrier protectants as a preventative measure in order to minimise the risk of a MDRPU developing:

- EmFilm
- Mediderma S barrier film stick applicator
- Mediderma pro ointment
- KerraPro Silicone Pad.

## Evaluation and referral:

**ESCALATE** any skin changes to the Registered Nurse accountable for the patients care.

**Ensure** regular review of the use of barrier protectants to ensure they are clinically appropriate.

## Patient Information

If the patient and/or care giver is able to undertake self-prevention and management of a medical device provide them with recommendations following an holistic assessment for repositioning, inspection and escalation.

## REPORT all pressure ulcers via:

**DBTH** The Nerve Centre Wound Assessment Form (For the Emergency Department, Maternity and Pediatric Wards use the Skin Integrity Datix/Dashboard).

**RDaSH** Safeguarding IR1 System and the SytsmOne.

**Primary Care** SystmOne/EMIS Web.

**Sheffiled** Report all pressure ulcers via DATIX.

## DOCUMENT accordingly:

**DBTH**

- Skin Inspections
- Repositioning
- Skin Integrity Wound Assessment and Care Plan.

**RDaSH**

- SytsmOne.
- Give consideration to informed refusal and patients mental capacity to make informed choices.

**Primary Care**

- SystmOne/EMIS Web.

**Sheffiled**

- Document accordingly on the relevant electronic patient record.

**NB:** Should the patient be too unstable to have any aspects of the MDRPU prevention plan carried out, this must be documented.