Pressure Ulcer Prevention and Management Policy and Procedure (N-050)

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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

A pressure ulcer should be defined as localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device) resulting from sustained pressure (including associated shear). The damage can be present as intact skin or as an open ulcer and may be painful (NHSI, 2018). A pressure ulcer that has developed due to the presence of a medical device should be referred to as a medical device related pressure ulcer (NHSI, 2018).

Pressure ulcers are caused when an area of skin and/or the tissues below are damaged as a result of being placed under sufficient pressure or distortion to impair its blood supply. Typically, they occur in a person confined to a bed or a chair most of the time by an illness; as a result they are sometimes referred to as 'bedsores', or 'pressure sores'. (NICE, 2015). All people are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, poor posture or a deformity, compromised skin or who are malnourished.

Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers. They can be debilitating for the patient, with the most vulnerable being over 75. Pressure ulcers can be serious and lead to life threatening complications such as sepsis or gangrene. Damage is common in many health settings, affecting all age groups, and is costly in both terms of human suffering and resources. Most pressure damage could be prevented, and it is important to have prevention and educational strategies in place based upon the best available evidence.

This policy promotes a multidisciplinary approach to the detection, prevention and management of pressure ulcers, acknowledging the physical, psychological and social impact of living with a pressure ulcer. This policy offers guidance on the prevention of pressure ulcers by outlining the essential elements of prevention which begins with an initial holistic assessment and includes risk assessments and developing a person-centred plan of care along with advice on positioning and use of equipment, with the use of support systems and the classification and management of pressure ulcers once discovered.

2. DEFINITIONS

Categories of damage: (see Appendix 1)
All pressure ulcers should be clearly documented within the records using the European Pressure Ulcer Advisory Panel categorisation system:

Category 1

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching, its colour may differ from surrounding skin.
- The area may be painful, firm, soft, warmer or cooler as compared to the adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones.

Category 2

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. It may also present as an intact open/ruptured serum filled or sero-sanginous filled blister.
- Presents as a shiny or dry shallow ulcer without slough or bruising.
- This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation
- Bruising indicates deep tissue injury.

Category 3

- Full thickness tissue loss. 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.
- It may include undermining and tunnelling.
- The depth of category 3 varies by anatomical location.
- The bridge of the nose, occiput, and malleolus do not have (adipose) subcutaneous tissue
- Category 3 can be shallow. In contrast areas of significant adiposity can develop extremely deep category 3 pressure ulcers. Bone/tendon is not visible or directly palpable

Category 4

- Full thickness tissue loss with exposed bone, tendon or muscle.
- Slough or eschar may be present.
- Often includes undermining or tunnelling.
- The depth of the category 4 pressure ulcer varies by anatomical location (see category 3).
- Category 4 pressure ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur.
- Exposed bone/muscle is visible or directly palpable.

Unstageable/Unclassified

- Full thickness skin loss in which the actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
- Until enough slough or eschar are removed to expose the base of the wound, the true depth cannot be determined, but it will be either a Category 3 or Category 4.
- Stable (dry adherent intact without erythema or fluctuance) eschar on the heels acts as the body's (biological) cover and should be removed if safe or appropriate to do so.

Suspected deep tissue injury

- Purple or maroon localised area of discoloured intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear.
- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to the adjacent tissue.
- Deep tissue damage may be more difficult to detect with individuals with dark skin tones.
- Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by a thin eschar.
- Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Device related pressure ulcers
Pressure ulcers that result from the use of devices designed and applied for therapeutic or diagnostic purposes (document as Category followed by 'd' in Datix)

Pressure ulcers should not be reverse categorised; a category 4 pressure ulcer does not become a category 3 as it heals it should be described as a healing category 4 pressure ulcer.

Moisture lesion
Caused by moisture from either sweat, wound exudate, urinary or faecal incontinence. Moisture lesions will need categorising according to the depth of damage using the EPUAP categories.

Diabetic foot ulcer – Diabetic foot ulcers are infections that can develop in the skin, muscles, or bones of the foot as a result of the nerve damage and poor circulation that is associated with diabetes.

Skin Changes at life's end [SCALE] - Are a reflection of compromised skin [reduced soft tissue perfusion, decreased tolerance to external insults and impaired removal of metabolic waste. It may become impossible to prevent skin breakdown. They are physiological changes that occur as a result

of the dying process [days to weeks], they may manifest in changes in skin colour, turgor or integrity. They may not be preventable and may occur when appropriate best practice is employed [Krasner D.L 2014].

Pressure Ulcer on Admission

- Persons admitted to any inpatient unit within Humber Teaching NHS Foundation Trust will have a pressure ulcer risk assessment (Waterlow) undertaken within six hours of admission as part of the holistic process of admission.
- There are exceptions to the 6 hour rule, for Mental health, Learning disability and General inpatient units. If it is clinically unsafe or not appropriate to undertake the Waterlow or MUST risk assessments tools. This could be due to the patient being distressed, showing disturbed behaviour or is end of life and/or not consenting.
- The Waterlow and Must should be undertaken at the next most appropriate and clinically safe time, whilst an inpatient on the unit. If the Waterlow and or MUST are not able to be assessed within the 6 hours post admission. It should be clearly documented in the patient's electronic records, the reason why the risk assessment has not been undertaken or completed and any actions put in place to navigate around the risk.
- It should be noted that the MUST is designed to be used as a risk assessment tool for those 18 years of age plus. The Waterlow is designed to be used on the 14 years and over age group.
- Persons referred to community nursing services will have a pressure ulcer risk assessment (Walsall and MUST) undertaken at the first planned contact post referral as part of the holistic process of admission. There maybe exceptions to this if a patient is admitted for end of life care and it would not be appropriate to complete all risk assessments.
- Persons will have their risk of developing pressure ulcers reassessed after a surgical or interventional procedure or after a change in their care environment following a transfer.
- Persons who have transferred into a new care environment for example residential care homes will have a personalised plan of care which will be shared with and held at the care home
- Staff will follow the Humber Sharing Information Charter when sharing information with third party colleagues.
- Persons at risk of developing pressure ulcers receive advice on the benefits and frequency of repositioning.
- Persons at risk of developing pressure ulcers, who are unable to reposition themselves will have a repositioning schedule
- Persons at high risk of developing pressure ulcers, and their carers, receive information on how to prevent them. A trust pressure ulcer prevention and management leaflet will be provided.
- Persons at high risk of developing pressure ulcers are provided with pressure redistribution devices to meet their individual risk assessment needs.

Equipment should be ordered and advice re positioning given following the first planned contact. Carers should be educated in the use of equipment and details of the care plan to maintain skin integrity and or prevent further deterioration of the pressure ulcer and or development of others.

Unattributable
A patient has developed a pressure ulcer even though staff completed the above, but the patient had a chronic health conditions, e.g. multiple sclerosis, spinal injury, peripheral arterial disease or the patient:

- Is non-concordant with advice and preventative measures offered in line with NICE guidelines and the risks of developing a pressure ulcer/s have been clearly discussed with the person or
- was admitted to the Trust with existing damage, which would be identified from the initial risk assessments

Pressure ulcers acquired in our care -

- Is a pressure ulcer that has occurred within the care of the Trust, if the community nurse is providing care and treatment to a person more than once a week or if a patient is in receipt of in-patient care.
- If a Category 3/4 or multiple category 2 ulcers developed in our care post admission an Initial Incident Review (IIR) will be requested by the Quality and Patient Safety team (please see pressure ulcer management standard operating procedure). The IIR will be undertaken by designated clinical lead.
- The aim of IIR is to identify good practice, areas of learning, any omissions in care and the potential need further action. The IIR will be presented at PURL and CRMG, reviewed and appropriate actions taken to reduce further risk.

Pressure ulcers acquired outside of our care

- If a person is NOT having contact with Humber Teaching NHS Foundation Trust's community services at least weekly then the person will be deemed as outside of our care. The pressure ulcer would NOT be attributable to Humber Teaching NHS Foundation trust.
- Any patient that is receiving infrequent care and treatment from the NCT for example the administration of Vitamin B12 which would require a visit once every three months is also deemed to be outside of our care.

All Category 3 and above pressure ulcers should be reviewed at a minimum once a week by a Registered Nurse (Band 6 and above) with appropriate tissue viability competencies.

3. SCOPE

This policy applies to clinical staff that are directly employed by Humber Teaching NHS Foundation Trust and or those who are employed on the bank or an agency, honorary contract or work experience. This policy is applicable to all clinical staff whilst they are undertaking duties on behalf of the Trust.

4. POLICY STATEMENT

This policy will provide a framework that supports professional practice in the prevention, detection and treatment of pressure ulcers with a focus upon the prevention with the assessment of all people using services within the Trust with needs articulated in the development of an individual plan of care, co-produced with the patient and or carer/s where possible, ensuring care and treatment is agreed with or in the best interests of the patient.

- All patients within the Trust will have a holistic assessment which includes risk assessments undertaken within six hours following an admission into in-patient services or at the first planned contact by the Neighbourhood Care Teams.
- All patients assessed to be at risk of developing a pressure ulcer will have evidence based preventative measures and treatments prescribed, according to the degree of risk and taking into account the wishes of the patients and or carers and medical conditions.

5. DUTIES AND RESPONSIBILITIES

Chief Executive

The chief executive is accountable for ensuring that processes are in place for the implementation of all policies for Humber Teaching NHS Foundation Trust.

Director of Nursing, Allied Health and Social Care Professionals
The director of nursing has responsibility for the strategic implementation and monitoring of this policy and evaluation of organisational learning, holding the responsibility for decision making of declaring and reporting SIs to the Clinical Commissioning Groups (CCG) or NHS England (NHSE) within two days of occurrence.

Divisional Clinical Lead and Matrons

- Will ensure that the policy is implemented within all areas within their sphere of responsibility to ensure that the focus on prevention is paramount by ensuring that all patients receive a holistic assessment at admission or first planned contact, have the skills to detect and effectively manage pressure ulcers developed within the care of the Trust.
- Lead the development of a quality improvement plan to address the issues from the Initial Incident Reviews undertaken by the clinical leads.
- Will act as the deputy chair of PURL in the absence of the Tissue Viability Lead nurse

Service managers, Neighbourhood Care Team Managers, Ward Manager, Community Clinical Leads

- Ensure that all staff within their sphere of responsibility are aware of the policy and are able to fully implement at all times
- Ensure that all staff are appropriately trained in pressure ulcer prevention and management by attending the wound care course and complete the competency assessment within three months of completion of the course.
- Monitor the training to ensure that all staff are competent to prevent, detect and manage pressure ulcers.
- Maintain records of training in conjunction with the training department
- Ensure all staff are able to undertake a holistic assessment including risk assessments at admission or first planned contact and if not to review the workload of the staff member to understand why this has not occurred as planned.
- Review the capacity and demands within the team and escalate to the clinical care director if assessments are not able to be completed within three contacts due to ongoing capacity issues within the teams
- Review the caseload of the staff member using agreed caseload management tools
- Ensure that new starters have tissue viability training as part of their induction before starting clinical work

Clinical Leads

- Work in partnership with the team managers to ensure the implementation of the policy into practice
- Undertake Initial Incident Review (IIR) investigations as requested by the Pressure Ulcer Review and Learning panel [PURL].
- Review the clinical care provided and consider use of IIR for all multiple pressure ulcers Category 2 and above when acquired in the care of Trust.
- Present the findings from the IIR for wider peer review within the PURL meeting.
- Identify the learning from the investigations and develop a quality improvement plan in partnership with the clinical care director and the community matrons.

Tissue Viability Lead Nurse

- Will attend and chair the weekly PURL meetings.

Tissue Viability Lead Nurse and Tissue Viability Specialist Nurses

- Monitor the pressure ulcer performance on the inpatient units against the CQUIN targets.
- Review all pressure ulcers reported via Datix, reviewing the category of the pressure ulcer, the level of harm, if occurred in the care of the Trust, safeguarding, requirements for duty of candour in collaboration with PURL.
- Provide quarterly, bi-annual and annual pressure ulcer reports for the appropriate groups.

Registered Practitioners working in community services and inpatient units/wards

- Adhere to all elements within this policy.
- Undertake a holistic assessment which includes a risk assessment (Walsall/Waterlow and MUST) and skin inspection within six hours of admission and or at the first planned contact within the neighbourhood care services.
- Develop a person-centred plan derived from the holistic assessment and risk assessments, making a diagnosis of skin integrity breakdown, e.g. diabetic foot ulcer, moisture lesion, pressure ulcer.
- Raise and escalate concerns to line manager if unable to complete the assessment, risk assessments and care plan as guided by this policy. Report via Datix if unable to complete at the first planned assessment.
- Provide information to patients and carers in the prevention of pressure ulcers to enable the patient and or their carer to 'react to red' and prevent the development of pressure ulcers in the care of the Trust.
- Provide advice to the patient and or carer on repositioning in order to prevent the development of the pressure ulcers.
- Provide appropriate equipment in order to prevent the development or further breakdown of skin integrity of pressure ulcers.
- Upon discovery of a pressure ulcer, clearly document within the records, category the pressure ulcer and report via Datix. Take an image of the pressure ulcer with the consent of the patient and or carer (if patient lacks capacity) and upload into the electronic records.
- Document all pressure ulcers on the body map, recording the size, length, breadth as a minimum and estimate depth.
- Raise and escalate concerns to a senior nurse when a person has more than one pressure ulcer.
- Refer to Humber Safeguarding when a person has a category 3 pressure ulcer or above or has more than one pressure ulcer of category 2 or above.
- Use the information collected at the assessment to ensure correct choice of pressure reducing/relieving equipment and use this in a safe manner assessing risk as part of patient care.
- Identify their training needs and make their managers aware of any training deficit.
- Maintain standards of record keeping in line with the Trust policy ensure adequate records are monitored at all times.
- Undertaken the ESR Pressure ulcer prevention and management module online.
- It is each person's professional responsibility to ensure their knowledge is updated accordingly as part of his/her personal professional development plan. Training should be updated at least every three years.

Safeguarding

Any patient found to have a pressure ulcer category 3 and above or having multiple pressure ulcers must be referred in the first instance to Humber Safeguarding to review if abuse or neglect has occurred. If the pressure ulcer has not occurred within the care of the Trust, the local authority must be alerted by the clinician.

Duty of Candour

Duty of candour is a statutory requirement to be open when moderate harm or above has occurred (see duty of candour policy). This requires all staff upon the discovery of a pressure ulcer, category 3 or above to be open with the relevant person (which is likely to be the patient) or their relative or carer (if the patient 'lacks capacity' and is receiving care via an agreed care plan) in their best interests.

This simply means:

- Being open with the patient and or family and inform of the pressure ulcer
- Apologising to the patient and or the persons carer (if the patient lacks capacity) that they have developed a pressure ulcer in the care of the Trust
- Documenting the discussion within the patient records

- Following up the verbal apology in writing and inform the patient and or their family of the review to be undertaken by the clinical lead (upload the copy of the letter into Datix
- Meet with the patient and or their family to discuss the findings of the review, again offer a meaningful apology
- Be open and honest about areas for learning and actions to be taken to prevent reoccurrence
- Follow up the meeting in writing, confirming the findings and areas for learning/actions to be taken following the meeting. Upload the letter into Datix

6. PROCEDURES

Assessment

A pressure ulcer risk assessment will be completed within six hours of admission to an inpatient unit.
An assessment of pressure ulcer risk will be based upon the clinical judgement of the registered professional and the use of a validated risk tool (Waterlow/Walsall) (see Appendices 6 and 7). This will also include a nutritional assessment (MUST).

A review of the risk of developing pressure ulcers (see Appendix 2 for extrinsic and intrinsic factors)
People considered to be at risk of developing a pressure ulcer are those who, after assessment using clinical judgement and/or a validated risk assessment tool, are considered to be at risk of developing a pressure ulcer. Risk factors include:

- significantly limited mobility (for example, people with a spinal cord injury)
- significant loss of sensation
- a previous or current pressure ulcer
- malnutrition
- the inability to reposition themselves
- significant cognitive impairment.

People who are at high risk of developing pressure ulcers (see Appendix 2)
People considered to be at high risk of developing a pressure ulcer will usually have multiple risk factors identified during risk assessment with or without a validated risk assessment tool. Adults with a history of pressure ulcers or a current pressure ulcer are also considered to be at high risk.

People will be risk assessed within the community nursing services at their first planned face to face assessment
It is important that every qualified and non-professionally qualified staff members initially undertake an informal risk assessment at first contact by asking the question:

> 'Is the patient at risk of getting a pressure ulcer?'

People in community care settings who have one or more risk factors for pressure ulcers and have been referred to community nursing services should have a pressure ulcer risk assessment to help identify the need for preventative action.

Risk factors include

- limited mobility
- loss of sensation
- previous or current pressure ulcers
- malnutrition
- inability to reposition themselves
- cognitive impairment

Prevention of pressure ulcer development or further skin integrity breakdown

Skin Assessment (see Appendix 3)
People have a skin assessment if they are identified as high risk of developing pressure ulcers.

Whenever a person has a pressure ulcer risk assessment that shows they are at high risk of developing pressure ulcers, a follow-up skin assessment should be carried out. A clinical assessment of the skin by a healthcare professional, taking into account any pain reported by the person, may predict the development of a pressure ulcer. The results of the skin assessment can be used to offer suitable preventative interventions to people who are at high risk of developing pressure ulcers. A skin assessment needs to be repeated whenever a person is identified as at high risk as a result of a pressure ulcer risk assessment, to take account of any changes to the skin and to ensure patient and service user safety.

Repositioning Advice
People at risk of developing pressure ulcers receive advice on the benefits and frequency of repositioning.

Repositioning, where the person moves into a different position in a chair or bed, aims to reduce or stop pressure on the area at risk. To improve patient experience, health and social care professionals should advise people at risk of developing pressure ulcers (or their carers, as appropriate) about the importance of frequent repositioning, and that it may help to prevent pressure ulcers. The frequency of repositioning advised should be appropriate for the individual person and their wishes and needs. For safety reasons, repositioning is recommended at least every six hours for adults at risk, and every 4 hours for adults at high risk. For children and young people at risk, repositioning is recommended at least every four hours, and more frequently for those at high risk.

Help with repositioning
People at risk of developing pressure ulcers, who are unable to reposition themselves, are helped to change their position.

A lack of mobility and sensation are risk factors for developing pressure ulcers. If a person is unable to reposition themselves, health and social care professionals should help them to change their position, to prevent the development of pressure ulcers. For some people, repositioning equipment may be needed. The frequency of repositioning should be appropriate for the individual and their wishes and needs. For children and young people at risk, repositioning is recommended at least every four hours, and more frequently for those at high risk.

Information on preventing pressure ulcers
People at high risk of developing pressure ulcers, and their carers, receive information on how to prevent them. This will be provided using the pressure ulcer prevention and management leaflet.

Many pressure ulcers are preventable. Much of the preventative care needed takes place in a person's own home and needs to be delivered regularly to ensure patient safety. Healthcare professionals should give information to people at high risk of developing pressure ulcers (and their carers, as appropriate) about preventative care that may stop pressure ulcers from developing. To improve patient experience, information about preventing pressure ulcers should be appropriate to the individual person and their carers. Information should include the causes and signs of pressure ulcers and how they affect health and quality of life. It should also include a demonstration of how to use equipment that may be supplied, and what people can do to help prevent pressure ulcers from developing. The trust Pressure Ulcer and prevention and management leaflet should be provided to the patient/carer [See appendix 8]

Patient Choice
Patients can only make a choice when provided with appropriate information. This should be provided in a way that is suitable for an individual’s level of understanding and reflect their needs, language and culture. Verbal and written information should be provided to patients and carers by the

healthcare professionals. Ensure the patient is aware of the risks of the not following the advice (see Appendix 8).

There may be times when a patient does not accept the treatment options; this must be clearly documented within the patient record. Assessment of capacity and discuss/review with General Practitioner. Please consider all options and make them available to the patient to make an informed choice.

Best Interests
If a person lacks the capacity to consent to any care and treatments, choice of treatments must always be considered in the context of what is in the best interests of the person. The decision maker must consult with relevant others, which could be the persons family and or carers and the GP as to the provision of treatment that is in the best interests of the person. This does not always have to be discussed in a best interest forum, however the care and treatment must be clearly documented within the care plan which will be developed following the risk, nutritional and skin assessments.

Pressure redistribution devices (see Appendix 5)
People at high risk of developing pressure ulcers are provided with pressure redistribution devices.

Pressure redistribution devices work by reducing or redistributing pressure, friction or shear forces. Devices include high-specification mattresses, pressure redistribution cushions and equipment that offload heel pressure. The type of device a person needs will depend on their circumstances, for example, their mobility, the results of the skin assessment, their level of risk, the site that is at risk, the person's weight and the person's general health. Using pressure redistribution devices as soon as possible can prevent pressure ulcers developing and help to treat them if they do arise, ensuring patient safety and improving the experience of people at high risk of pressure ulcers.

Categorise and report
All pressure ulcers discovered following the initial assessment or at any subsequent intervention must be categorised (see definitions) and reported via Datix

If the pressure ulcer is categorised at 2, reassess needs and risk assessment if not initial assessment, inspect the skin, review equipment, positioning, dressing’s, devices and emollients. Document the pressure ulcer on the body map. Report via Datix.

If the pressure ulcer is category at 3 or above, or person has multiple pressure ulcers of category 2 and above, reassess as above, report via Datix and escalate to a senior nurse/matron. Report to Humber Safeguarding.

Treatment
All treatments will be person-centred and delivered based upon the holistic individual assessment and risk assessments. Any decisions made about proposed care and treatments discussed with the person and agreed within a person-centred care plan. If a person lacks capacity to consent to treatment, this will be discussed with their family or carers or lasting power of attorney and GP and agreed that the care and treatment is in their best interests and fully documented within a person-centred care plan. All treatments will be provided in line with best practice as guided by the wound care formulary, with guidance available on TV intranet page.

Please use the wound assessment documentation on SystmOne and refer to Appendix 9, 10 and 11 in this policy for appropriate actions to be taken in the prevention and management of pressure ulcers. Please use the Tissue Viability (TV) intranet page for further guidance and access to the Wound Care Formulary and product guidance notes.
Please refer all category 3 and above and or multiple category 2 and above pressure ulcer to the TVN service via the agreed ref pathway. The pathways are on the TV intranet page

Reassessment
People have their risk of developing pressure ulcers reassessed after a surgical or interventional procedure, or after a change in their care environment following a transfer.

Pressure ulcer risk status is not constant and is likely to change during the course of care. A pressure ulcer risk assessment should be repeated if there is a change in a person's clinical status. However, changes in clinical status can be difficult to define. Specific instances where a reassessment should be carried out to ensure patient and service user safety have been identified as after a surgical or interventional procedure in hospital, and after a person's care environment changes following a transfer in any setting.

7. IMPLEMENTATION

Training
Education of healthcare professions is of paramount importance to the detection, prevention and management of pressure ulcers. All members of the healthcare team (registered and non-professionally qualified stall) will receive training targeted to their role. This training is provided by online ESR PU module, the Tissue Viability Team and the Learning Centre.

All staff working within the neighbourhood care teams and community hospitals are to undertake the Pressure Ulcer prevention and management module when starting with the trust before having face to face Pressure ulcer prevention and management training. It is each person's professional responsibility to ensure their knowledge is updated accordingly as part of his/her personal professional development plan. Training should be revisited at least every three years.

Additional financial resources
This policy requires additional financial resources to ensure that all staff are trained in wound management in order to prevent, detect and effectively manage pressure ulcers and the learning.

Protected time is agreed for every new referral (1.5 hours) to ensure that every patient who is referred into the neighbourhood care services receives a holistic assessment which includes a risk assessment (Walsall or Waterlow), a nutritional assessment (MUST) and skin assessment at the first planned contact which is developed into a person centred-plan to direct the care to be delivered and prevent where possible the development of pressure ulcers in the care of the Trust

8. MONITORING AND AUDIT

All pressure ulcers reported will be reviewed by PURL and any category 3 or above will be escalated for an Initial Incident Review if occurring within the care of the Trust. This will be undertaking by the delegated clinical lead.

All pressure ulcers escalated for investigation by the clinical lead will be reviewed by the Pressure Ulcer Review and Learning (PURL) with the outcome being, confirmation of:

- A pressure ulcer and not a moisture lesion or diabetic ulcer.
- Occurrence in the care of Trust
- Safeguarding review if neglect and or abuse may have occurred,
- Outcome from IIR
    - Consideration of escalation as a serious incident
    - Identification of the areas of learning.

A quarterly, bi-annual and annual pressure ulcer report will be provided for QPaS, CRMG, PURL and any other required meetings.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Krasner,D.L. The Scale of an expert panel [2014] SCALE Skin changes at life end: Final consensus statement. Chronic Wound care: The essentials. Malvern, PA, HMP Communications.

Chaloner DM, Franks PJ (1999) Validity of the Walsall Community Pressure Sore Risk Calculator. British Journal of Community Nursing Vol 8, no 17, pages 1142-1156.

National Institute for Clinical Excellence (2014) Pressure ulcer prevention. Clinical Guideline

NHS Improvement (2018) Pressure Ulcers: revised definition and measurement https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/

Preston KW 1988 Positioning for comfort and pressure relief: the 30 degree alternative
Todorovic V (2002) Foods & Wounds: Nutritional factors in wound information and healing Br J Community Nursing 7 (9 supp) S43-54

Seating & Pressure Ulcers: Clinical Practice Guidelines, Tissue Viability Society (2009)

Hagisawa S, Fergus Pell M (2008), Evidence supporting the use of two-hourly turning for pressure ulcer prevention Journal of Tissue Viability 17 76-81

National Institute of Care & Health Excellence (NICE) Pressure Ulcer Management CG179 http://guidance.nice.org.uk/CG179

NICE (2015) Pressure ulcers, Quality standard. http://www.nice.org.uk/guidance/qs89

10. LEGISLATION AND GUIDANCE

National Institute for Clinical Excellence – Pressure Ulcer Prevention and Pressure Relieving Devices (2014)

European Pressure Ulcer Advisory Panel – Pressure Ulcer Treatment Guideline (2014)

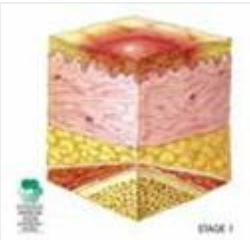
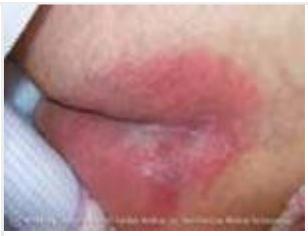
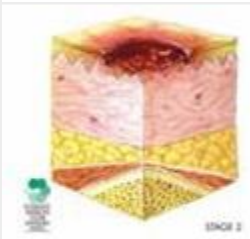
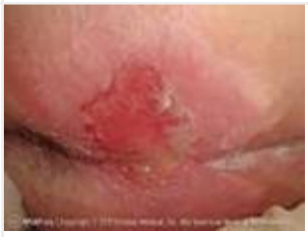
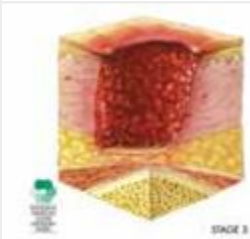
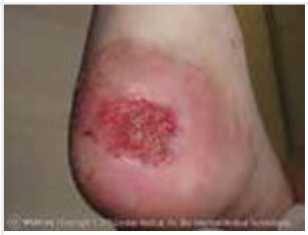
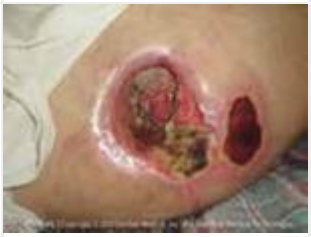
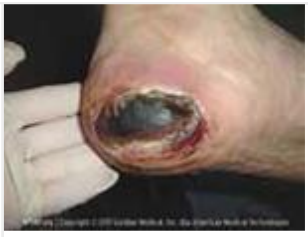
European Pressure Ulcer Advisory Panel – Nutritional Guidelines for Pressure Ulcer Prevention and Treatment (2009)

11. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Pressure Ulcer Management SOP18-003
Bed Rails Policy N-029
Consent Policy N-052
Moving and Handling Policy HR-025
Health and Safety Policy P036
Safeguarding Adults Policy
Duty of Candour Policy and Procedure

Infection Prevention and Control Arrangements Policy N-014
Consent Policy N-052
Mental Capacity Act and Best Interest Decision Making Policy M-001

Appendix 1: Pressure Ulcer Categories

		**Category / Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones1.
		**Category/ Stage II:** Partial thickness 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 or sero-sanginous filled blister1.
		**Category/ Stage III:** Full thickness tissue loss. 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 loss1.
		**Category/ Stage IV:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. Category/ Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule)1
		**Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown** Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. 1
		**Suspected Deep Tissue Injury – depth unknown** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. 1

Appendix 2: Risk Factors: Intrinsic and Extrinsic

The risk of developing a pressure ulcer can change over either a short or long period of time.

An individual's potential to develop a pressure ulcer may be influenced by the following intrinsic factors which should be considered when performing a risk assessment:

- Reduced mobility or immobility
- Sensory impairment
- Acute illness
- Level of consciousness
- Extremes of age
- Vascular disease
- Severe chronic or terminal illness
- Previous history of pressure damage
- Malnutrition and dehydration

This is not an exhaustive list. Where patients are found to have specific areas of risk, these should be documented as part of the assessment process. Many intrinsic factors affect skin health. Every patient is different and factors may change supporting the need for risk assessment to be a dynamic process that is reviewed on a regular basis. It is recognised that some intrinsic factors may not be prevented or managed and care planning should reflect this.

Information about risk factors should be given to patients/relatives/carers – see pressure ulcer prevention leaflet in Appendix 8. Improving the patients' resistance to pressure relates to the patients' intrinsic risk factors and involves an interdisciplinary approach and requires the lead healthcare professional to refer to and co-ordinate the involvement of members of the multi-disciplinary team.

Extrinsic factors

The following should be removed or reduced to prevent injury: pressure, shearing and friction

- Recognising the initial causes of redness during a skin examination is fundamental in planning preventative care. Where possible the cause of this early damage should be recognised and where possible removed.
- Pressure is the exertion of continuous force on an area; this force is usually vertical in nature resulting in a circular shaped area of damage directly over the bony prominence. Pressure damage occurs when the skin and other tissues are directly compressed between bone and another surface, the capillary blood flow is cut off and, over time, the skin will die. The relationship between pressure and tissue damage is dependent on two characteristics: the intensity of the pressure and the duration of the pressure. Prevention therefore should be targeted at removing or relieving one or other.
- Unrelieved pressure injury can first present as a hard dark red/purple area (indication of dead tissue beneath the over lying skin) but will eventually breakdown often revealing an ulcer which is very much bigger inside than out.
- Shear occurs when tissues are wrenched in opposite directions such as when reclining; external skin stays in contact with the chair but internally the tissues are sliding resulting in disruption or angulations of capillary blood vessels. Tissue damage caused by shear is usually 'teardrop' shaped caused by the pull on the skin. Better posture and avoidance is one of the key preventative measures.
- Friction occurs when the skin has rubbed against another surface. This most often produces a blister or 'scuffed' area. It may result from poor moving and handling.

The potential of an individual to develop pressure ulcers may be exacerbated by the following factors, which should be considered when performing a risk assessment: medication and moisture of the skin.

- Wet skin is more prone to damage and requires extra care.

- Excessive washing with alkaline soap should be avoided and soap with a pH of 5.5 is preferable.
- Skin barriers should be considered for prevention drugs such as steroids or anti-cancer drugs which affect skin health increase patient risk.
- Chronic long term poor nutrition and dehydration are also risk factors.

Appendix 3: Skin Inspection

- Caring for the skin is the responsibility of all clinicians caring for the patient at risk of developing a pressure ulcer.
- In order to keep it in good condition the skin needs to be protected from maceration, irritation, the removal of natural oils and accidental damage.
- Treatment of the skin depends on the state in which it is found, rather than routine procedure.
- Avoid the use of soap, especially perfumed or “strong” soap such as carbolic, use a soap substitute to wash the skin.
- Avoid the use of bubble baths and salt.
- A mild cleansing agent should be used to minimise irritation and dryness of the skin.
- Avoid rubbing the skin, pat the area dry.
- Emollients can be applied to prevent skin dehydration. They should not be rubbed into the skin, but applied in a downward direction following hair growth.
- Avoid plastic draw sheets and other non-absorbent surfaces that may increase moisture against the skin.
- Avoid talcum powder as this can “cake” and cause irritation and friction.
- DO NOT use spirit to rub onto the skin.
- Reduce the effect of moisture (incontinence, sweating and/or wound leakage) on the skin. Complete continence assessment as needed
- Barrier products which are compatible with continence aids may be applied.
- For those patients whose skin is at risk of damage caused by friction, it may be appropriate to use a film dressing. The area must be monitored closely as dictated by the risk assessment score.
- Examination of skin over bony prominences can reveal the first signs of skin damage. At this early stage ulceration may be prevented. In a patient who is recognised as at risk, skin inspection is part of the ongoing risk assessment process.

Initial and ongoing skin inspection is about recognising when something is not right, it can be done informally by patients, carers or relatives who, if suspecting a problem, should inform a health care worker who should inform a registered nurse who will carry out a formal assessment, if required.

Skin inspection should occur regularly, and the frequency determined in response to changes in the individual’s condition in relation to either deterioration or recovery.

- If a patient is considered at any risk following assessment, then skin should be inspected for signs of pressure damage at regular intervals
- Frequency of the inspection is determined by the severity of the risk assessment status, this may mean several times a day for those at high risk and those already with pressure ulcers, in this situation the location of the patient and availability of carers needs to be taken into consideration
- Carers should be encouraged to participate where necessary, following appropriate information/training
- Skin inspection should be recorded, and problems acted upon (see the pressure ulcer prevention leaflet in Appendix 8)

Skin inspection should be based on an assessment of the most vulnerable areas of risk for each patient. These are typically heels; sacrum; ischial tuberosities (parts of the body affected by anti-embolic stockings); femoral trochanters (parts of the body where there are external forces exerted by equipment and clothing); elbows, temporal region of the skull, nose, ears, shoulders, back of the head and toes. Other areas should be inspected as necessitated by the patient’s condition. Skin inspection should take place during routine care, taking into account patient consent, preferences, privacy and dignity. Refusal to allow skin inspection should be documented and the risks fully explained to the patient and carer.

Individuals who are willing and able should be encouraged, with education and training, to inspect their own skin.

- Where practicable the patient and their families/carers should be involved in the inspection process.
- Staff should provide education and training to the patient and consent to inspect their own skill gained; this should be documented within the records. Any education and training should be recorded and if possible, backed up with written information.
- The importance of reporting to the health professional any areas of concern should be stressed.

Individuals who are wheelchair users and want to inspect their own skin should be encouraged to use a mirror to inspect the areas that they cannot see easily or ask support from others to inspect them.

- Individuals and carers, who are able, should be taught how to redistribute weight and, where possible, they should be encouraged to change position every 15 minutes.
- Individuals who spend substantial periods of time in a wheelchair and are vulnerable to pressure ulcers require a seating assessment from a trained assessor
- Individuals should be supplied with a pressure reducing cushion.

Healthcare professionals should be aware of the following signs on the skin which may indicate incipient ulcer development:

- Persistent erythema
- Non-blanching hyperaemia previously identified as non-blanching erythema
- Blisters
- Discolouration
- Localised heat
- Localised oedema
- Localised indurations
- Link to TV website for TV formulary

or those with darkly pigmented skin:

- Purplish/bluish localised areas of skin
- Localised heat which, if tissue becomes damaged, is replaced by coolness
- Localised oedema
- Localised indurations

Full assessment of skin areas can often involve removal of clothing, surgical appliances and mobility aids. Assessment should not only be visual as pressure ulcers can often be ‘felt’ as hot hard areas of skin (indurations). Persistent redness (erythema) does not always lead to ulceration but must be closely observed. Other causes of skin damage and redness may be from incontinence rather than pressure – any area of abnormal skin should be examined by a registered nurse and documented.

Appendix 4: Delayed Healing

When sacral ulcers do not show signs of healing when appropriate wound dressing and appropriate pressure relief is achieved give consideration to other causative factors:

- Moisture ulcer
- History of incontinence or perspiration
- Skin appears moist and/or shiny
- Area of erythema blanches on finger pressure test
- Medication, e.g. Nicorandil
- Incontinence dermatitis – dermatitis defined as an irritant
- Underlying medical condition, e.g. renal failure
- Consequence of medical condition, e.g. cancer and peripheral arterial disease

When heel ulcers do not show signs of healing when appropriate wound dressing and appropriate pressure relief is achieved give consideration to other causative factors:

- Peripheral arterial disease (ensure Doppler – ankle brachial pressure index ABPI)
- Diabetes
- Terminal illness
- Inappropriate use of devices e.g. sheepskins and fleeces

Referral to Tissue Viability Service can be made when:

1. Patient has category 3 pressure ulcer or multiple category 2 pressure ulcers
2. Patient presents with a deteriorating pressure ulcer
3. Patient presents with a difficult to manage pressure ulcer
4. Multiple ulcerations

Appendix 5: Equipment

Pressure relieving devices for the prevention of pressure ulcers

- Devices (mattresses and cushions) come in two main types, those that reduce pressure by spreading the weight and increasing the surface area and those that relieve pressure by removing the pressure at frequent intervals.
- Pressure relieving equipment does not replace the need for repositioning and should be used as an adjunct with repositioning and a skin inspection regime that suits the patient and the circumstances.
- Pressure relieving equipment will be supplied in the community services by Mediquip and to Mental health and Learning disability inpatient units Nottingham Loan Equipment Services [NRS]. Before equipment is chosen existing support surfaces (bed, chair) should be examined for suitability – lack of support and 'bottoming out' from an old mattress or cushion could be causing the pressure damage.

Equipment provision and reassessment

The level of equipment support should be 'stepped up' when:

- The patient's skin is showing signs of pressure damage
- The patient's condition deteriorates

The level of support should be decreased when:

- The patient's condition improves
- Mobility improves

Adverse incident (Datix) reports should be raised for

- Equipment failures.
- Non-compliance with manufacturers' instructions.
- Inappropriate use of equipment, e.g. allocated equipment is not with the named patient. Prescribed pressure relief equipment is not available in a timely manner.

Decisions about which pressure redistributing device to use should be based on an overall assessment of the individual and not solely on the basis of scores from risk assessment scales.

There are three principles of action to prevent pressure ulcers:

1. Reducing/relieving pressure
2. Preventing damage to the skin
3. Improving tissue resistance

Pressure relief is the main strategy used in the prevention of pressure ulcers, this includes positioning and repositioning and the use of specialist equipment. Decisions about support surfaces should be made following a holistic assessment of a person's risk, comfort and general health state. Patient movement in and out of bed should be considered as air mattresses can restrict movement. Assessment should be ongoing throughout an individual's episode of care and the type of pressure relief support changed to suit any alteration in risk, e.g. weight loss/gain.

- Risk assessment, skin assessment and the presence and severity of any pressure ulcers.
- Location, cause and category of pressure ulcer.
- Acceptability of the proposed equipment to the patient or carer.
- General health status.
- Patient weight.
- Lifestyle and potential effects that the equipment will have on the patient or carers abilities to perform activities of daily living.
- Treatment objectives.
- Suitability for area of usage.
- Any contraindications advised by the equipment manufacturers.

- Safety of patient.
- The initial choice and subsequent changes of equipment, including the rationale should be documented.
- All surfaces used by the patient should be considered including armchair, wheelchair or toilet.
- Changes of device should reflect changes in risk status.
- Equipment for prevention should be reviewed as part of the risk assessment process taking into account that equipment can be downgraded as well as upgraded.
- Patients may choose not to use any products because of their personal circumstances this should be fully discussed with the person and documented to ensure that they are aware of the risks to their skin integrity.

Equipment choice

Foam replacement mattresses/cushions – low to moderate risk

- These consist of several layers of different foams and have a pressure reducing action because they allow the patient to 'sink in' thereby spreading the pressure over a greater surface area.
- They can be used for patients at low to moderate risk who are still relatively mobile so that they can move themselves in bed.
- They should be cared for according to the manufacturer's instructions and will require regular checks to ensure their integrity.
- They may also require rotating at intervals.
- At home a good sprung mattress should give the same sort of relief.

Alternating Pressure Overlays – moderate to high risk

- These attach to the top of the mattress – divan or foam.
- Double mattress available.
- They work on the principle of cyclic inflation and deflation of air cells over a period of time, this can be controlled by a dial or by a sensor pad which measures the patient weight and then alternates the amount of pressure to different parts of the body giving pressure relief.
- They can be used for patients at a moderate to high risk.
- The biggest consideration in choosing an overlay is the weight of the patient.
- Even moderately heavy patients can flatten the mattress when in a seated position reducing its effectiveness.
- The overall height of the bed may also increase leading to an increased risk of falling if used.

Alternating Pressure Replacement – high-risk patients or when an overlay would be inappropriate

- These replace the foam mattress and attach to the base of the bed.
- As with overlays they use cyclic inflation and deflation of air cells over a short period of time they may or may not contain sensors.
- For high-risk patients or when an overlay would be inappropriate due to falling risk or weight.
- For patients of elevated risk or presenting with heel pressure ulcers, the Nimbus is appropriate because of the special feature of heel guard cells at the foot of the system.

Constant Low Pressure Devices – moderate to high risk

- These can be either overlays or replacement mattresses
- They use a continuous flow of air and sensors to maintain a 'soft' support surface which spreads the patient's weight out therefore reducing the pressure.
- They can be used on individuals who are moderate to high risk particularly for patients who cannot tolerate the movement of an alternating product.

Electric Profiling Beds

- Electric profiling beds reduce skin damage by:
- making patient movement easier for the patient, carers and staff to perform, reducing friction and shear

- use of the knee break prevents sliding down the bed reducing friction and shear
- allowing patients to change their own position
- it is vital that an environmental check be carried out to ensure space is available as these beds are larger than a standard divan and require room to move
- if the risk to the patient is from shear and friction then a pressure reducing foam mattress may be as effective as alternating

Please check all dynamic equipment at each unit for current setting in relation to weight

NB: for individuals requiring bed rails, alternating pressure overlay mattresses should be placed on a reduced depth foam mattress or have extra high bed rails to maintain their safety

- An overlay mattress will increase the height of the bed when placed on a standard divan. If the patient is at risk of falling or bed rails are in use then a replacement mattress may be a better option.
- Care and consideration to risk front.
- Other equipment.
- Friction and shear can be minimised with the use of a slide sheet.
- Manual handling risk assessment should inform the pressure ulcer prevention care planning process.

Equipment Safety

Adherence to Trust medical/non-medical equipment policy

- If equipment is inadequately decontaminated, then there is a risk of cross infection.
- Healthcare professionals are responsible to ensure that equipment remains with the patient it was prescribed for and not transferred to another patient.
- Healthcare professionals have a duty of care to their patients when using pressure reducing/relieving equipment to ensure it is used safely and appropriately. Information
- Leaflets provided should be read and adhered to and all healthcare professionals should be able to trouble-shoot routine and minor equipment failures.
- Most pressure reducing/relieving systems are fitted with visual and/or audible alarms and informal and formal carers should be informed of who to contact should the alarms be activated.
- Prescribed equipment should be monitored for safe and effective working order at the time of reassessment of risk.
- Foam mattresses should be checked for collapse of foam (bottoming out – use both fists to lean weight on mattress and test to feel base of bed frame) and integrity of cover.
- Mattresses with a ripped/torn cover through to the foam need to be condemned and replaced due to risk of contamination to the foam.
- Pressure relief system covers that are ripped/torn also require replacement because of risk of contamination.
- Electrical equipment requires an adequate electrical supply to reduce the inherent risk associated to using electrical equipment, e.g. directly into the electrical supply socket.
- Consider trailing wire under the bed, all wires should be secure and neatly placed.
- All manual handling tasks should consider the whole picture and be assessed using the ergonomic framework of; task, individual load, environment (TILE), and equipment provision.
- Consider the environmental factors, e.g. space around the bed and mattress.

Equipment does not replace the need for repositioning and regular skin inspection.

The following should not be used as pressure relieving aids:

- Doughnut-type devices impair lymphatic drainage and therefore are likely to cause rather than prevent pressure ulcers.
- Water-filled gloves; are ineffective because their small surface area does not redistribute the pressure.

- Genuine sheepskin, synthetic sheepskin; and fibre filled overlays can be used to provide comfort at the patient's request but none will provide relief from pressure. If used, care should be taken with regard to cross infection.

Seating – further advice should be sort from the occupational therapist

- The benefits of a pressure redistributing device should not be undermined by prolonged chair sitting. Individuals who are considered to be acutely at risk of developing pressure ulcers should restrict chair sitting to less than two hours (NICE recommend restricting the time spent seated to a maximum of two hours at a time for high risk patients) until their general condition improves.
- All patients with category 4 pressure ulcers should not be 'sat out' for any length of time.
- All patients with category 3 pressure ulcers should be assessed on an individual basis to sit out.
- When sat in a chair 70% of your body weight is spread over 8% of your surface area. This means that seating increases the risk of pressure damage. Poor seating increases the risk even more.
- When planning to sit a patient out of bed consider the following points;
    - The severity and location of any pressure ulcers.
    - The patient's ability to sit comfortably in an armchair and reposition themselves.
    - Ergonomics of the chair, e.g. height, depth, width, position of armrests.
    - Ease of transfer from bed to chair and the use of appropriate moving equipment.
    - Posture, mobility, comfort and support.
    - Functions required when sitting, e.g. eating/washing.
    - Patient choice and psychological consideration.
- A patient considered a high risk who is provided with an alternating pressure mattress but who 'sits out' should also have their seating assessed and suitable equipment provided.
- Patients/carers should be advised of the risk of prolonged chair sitting so they can make informed choices about it.
- Advice should be sought from the multidisciplinary team (occupational therapists, physiotherapists, wheelchair services) if seating is a problem.

Positioning

Individuals who are at risk of pressure ulcer development should be repositioned and the frequency of repositioning determined by the results of skin inspection and individual needs not by a ritualistic schedule.

- Periodically repositioning the patient is one way of relieving pressure and transferring it to another area in order to prevent tissue damage. How often this is carried out will depend on the individual patient's skin redness, mobility, risk factors and the support system in use, e.g. mattress or cushion
- The frequency of timing and positioning must be included in the patients records
- When repositioning a patient staff should note any area of redness.
- The following procedure can be used (and taught to carers) to determine whether this redness is 'normal' or not
    - After turning the patient, lightly press with a finger the area of reddened skin the patient has been lying or sitting on. Initially the skin will go white (blanch) and then return to its normal colour. The return to normal colour (capillary refill) should take no longer than twice the length of time finger pressure was applied. If blanching does not occur or return of colour is slow, capillary damage may have occurred and a formal assessment should be undertaken including reassessment of equipment and the frequency of position changes (Simpson et al 1996).
- Continuous redness does not always lead to ulceration but should be noted and observed closely.

Consider referral to occupational therapist for seating advice.

Repositioning should take into consideration other relevant matters, including the patient's medical condition, their comfort, the overall plan of care, carer availability and capability and the support surface.

- Patient, carers and health staff should be aware of the importance of repositioning.
- Patient agreement is important to the maintenance and effectiveness of a repositioning schedule. This schedule may change depending on general health, risk status and skin condition.
- It may not always be possible to reposition patients because of their medical condition, this must be documented.
- Is there carer support available? Can the carer turn the patient safely?
- Patient and carer education should be complimented with written information.
- A repositioning schedule, agreed with the individual, should be recorded and established for each person at risk. Individuals or carers, who are willing and able, should be taught how to redistribute weight
- Where a schedule is used, carers should be encouraged to complete documentation where necessary.

Positioning of patients should ensure that: prolonged pressure on bony prominences is minimised, that bony prominences are kept from direct contact with one another and friction and shear damage is minimised.

- The use of 30° tilt has been found to be beneficial (Preston 1998). It involves the patient being positioned at a 30° angle using pillows, rather than at a ninety degree angle which would place them directly onto their hip and therefore at increased risk. Equipment that could/should be considered are the ToTo and Eko-move systems for patients that are bed bound and unable to be repositioned manually to meet the individuals repositioning needs.
- Pillows and other simple devices can be used to cushion or elevate areas (particularly heels) free from pressure, but not in combination with pressure relief system (please discuss with Tissue Viability Team).

Manual handling devices should be used correctly in order to minimise shear and friction damage.

- Carers and patients should be taught about the equipment that is being used.
- The effects of shear and friction can be minimised by:
  - correct positioning of the patient, e.g. use of profiling bed
  - using appropriate manual handling techniques and equipment
  - careful removal, when appropriate of handling equipment, e.g. slings after moving the patient

Health care professionals with recognised training in pressure ulcer management should cascade their knowledge and skills to their local health care teams.

- Formal training should be cascaded between teams Education is ongoing as each patient is different – lessons learnt must be shared.
- Many patients and carers can inform health workers on what works for them. This advice needs to be assessed against the contents of this guidance and best practice.

Training and education programmes should include:

- Risk factors for pressure ulcer development
- Pathophysiology of pressure ulcer development
- The limitations and potential applications of risk assessment tools
- Skin assessment
- Skin care
- Selection of pressure redistributing equipment

- Use of pressure redistributing equipment
- Maintenance of pressure redistributing equipment
- Methods of documenting risk assessments and prevention activities
- Positioning to minimise pressure
- Shear and friction damage including the correct use of manual handling devices
- Roles and responsibilities of inter-disciplinary team members in pressure ulcer management
- Policies and procedures regarding transferring individuals between care settings; and patient education and information giving.

Patient/carer education should include providing information on the following:

- The risk factors associated with patients developing pressure ulcers
- The sites that are of the greatest risk of pressure damage
- How to inspect skin and recognise skin changes
- How to care for skin; methods for pressure relief/reduction
- Where they can seek further advice and assistance
- Promoting the Preventing Pressure Ulcer leaflet.

Pressure Ulcer Treatment

A patient with a pressure ulcer will also require preventative care as per the recommendations.

- Assessment of the patient with a pressure ulcer should include an examination of the factors covered in the previous section, plus an assessment of the wound
- The general principles for the management of pressure ulcers are to minimise the perpetuating factors that delay healing
- To alleviate the effects of the intrinsic factors which contribute to tissue breakdown and delaying healing:
    - Malnutrition – consider referral to dietician using MUST
    - Incontinence – consider refer to bladder and bowel assessment
    - Debilitating concurrent illness – refer to specialist as required

Appendix 6: Waterlow

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE VISUAL RISK AREAS		SEX AGE	
AVERAGE		HEALTHY	0	MALE	1
BMI = 20-24.9	0	TISSUE PAPER	1	FEMALE	2
ABOVE AVERAGE		DRY	1	14 - 49	1
BMI = 25-29.9	1	OEDEMATOUS	1	50 - 64	2
OBESE		CLAMMY, PYREXIA	1	65 - 74	3
BMI > 30	2	DISCOLOURED GRADE 1	2	75 - 80	4
BELOW AVERAGE		BROKEN/SPOTS GRADE 2-4	3	81 +	5
BMI < 20	3				
BMI=Wt(Kg)/Ht (m)^2					

MALNUTRITION SCREENING TOOL (MST)
(Nutrition Vol.15, No.6 1999 - Australia

A - HAS PATIENT LOST WEIGHT RECENTLY
YES - GO TO B
NO - GO TO C
UNSURE - GO TO C AND SCORE 2

B - WEIGHT LOSS SCORE
0.5 - 5kg = 1
5 - 10kg = 2
10 - 15kg = 3
> 15kg = 4
unsure = 2

C - PATIENT EATING POORLY OR LACK OF APPETITE
'NO' = 0; 'YES' SCORE = 1

NUTRITION SCORE
If > 2 refer for nutrition assessment / intervention

CONTINENCE		MOBILITY	
COMPLETE/ CATHETERISED	0	FULLY	0
URINE INCONT.	1	RESTLESS/FIDGETY	1
FAECAL INCONT.	2	APATHETIC	2
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3
		BEDBOUND e.g. TRACTION	4
		CHAIRBOUND e.g. WHEELCHAIR	5

SPECIAL RISKS

TISSUE MALNUTRITION		NEUROLOGICAL DEFICIT	
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5	PARAPLEGIA (MAX OF 6)	4-6
PERIPHERAL VASCULAR DISEASE	5	**MAJOR SURGERY or TRAUMA**	
ANAEMIA (Hb < 8)	2	ORTHOPAEDIC/SPINAL	5
SMOKING	1	ON TABLE > 2 HR#	5
		ON TABLE > 6 HR#	8

MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4

SCORE
10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

Scores can be discounted after 48 hours provided patient is recovering normally

* The 2005 revision incorporates the research undertaken by Queensland Health.

www.judy-waterlow.co.uk

Appendix 7: Walsall Pressure Calculator

WALSALL COMMUNITY PRESSURE ULCER RISK ASSESSMENT CALCULATOR

k if a patient has a pressure ulcer present

RISK CATEGORIES	SCORE	ASSESSMENT DATES						RISK CATEGORIES	SCORE	ASSESSMENT DATES					
Level of Consciousness								Bladder Incontinence							
Alert	**0**							**None**	**0**						
Lethargic/confused	**3**							**Occasional (<2/24 hours) or catheterised**	**0**						
Semi-comatose	**3**							**Usually (>2/24 hours)**	**1**						
Comatose	**3**							**Total (no control)**	**4**						
Mobility Ambulation								Bowel Incontinence							
Moves without assistance	**0**							**None**	**0**						
Moves with limited assistance	**3**							**Occasional**	**4**						
Moves only with assistance	**8**							**Total (no control)**	**6**						
Chair fast (8 hours plus)	**8**							Special Factors							
Bedfast (12 hours plus)	**8**							**Independent for care**	**0**						
Skin Condition								**Active carers (24 hours)**	**0**						
Healthy	**0**							**Predisposing medical conditions, CVA, MS, Diabetes, Dementia, Alzheimer's, Head Injury (w)**	**2**						
Rashes/dryness	**2**														
Increase turgor/fragile	**4**							**Intermittent Care (8 hours plus) (c)**	**2**						
Redness	**4**							**Medication: Steroids/Cytotoxic/Inflammatory (w)**	**2**						
Nutritional Status								**Limited carer (3-8 hours) (c)**	**2**						
Well balanced diet/stable weight	**0**							**Occasional carer (0-2 hours)**	**2**						
Poor appetite/weight loss	**4**							Sub-total Risk Score	**2**						
Very poor fluids only/nil by month	**4**							Sub-total Risk Score (A)							
Sub-total Risk Score (A)								Total Risk Score							

- **Score each patient in one area in each risk category**

GUIDELINES
ASSESSMENT OF PRESSURE ULCER RISK

Walsall Community Pressure Sore Risk Calculator

The Pressure Ulcer Risk Calculator is used to form part of the holistic assessment when the patient is first admitted or transferred to caseload and provide a structured approach for reassessment of risk to pressure ulcer development. The columns allow for regular assessment, either at intervals indicated by the patient's level of risk as indicated in the care plan or if there is a change in the patient's condition.

The pressure ulcer risk assessment calculator assists in the identification of the main contributing factors in the development of pressure ulcers.

Score the patient in one area only in each risk category. Record the score in the appropriate column and total at the end to give the total risk score to determine the category as:

< 4	not at risk
4 – 9	low risk
10 – 14	medium risk
15	high/very high risk

A score in the shaded area denotes nursing interaction is required which leads to a negotiated care package to minimise or eliminate the risk factor, e.g. by implementation of continence programme, or by improving nutritional status.

NB: Skin condition
Increase turgor denotes skin in state of being swollen or distended.

Appendix 8: Pressure Ulcer Leaflet

What can you do to avoid pressure ulcers?

Look for signs of damage –
if you are able, check your skin regularly or ask a relative or carer to do this for you. Do not continue to put pressure on or rub reddened areas, particularly on areas at risk of skin breakdown.

Keep moving –
one of the best ways to prevent a pressure ulcer is to relieve the pressure by regularly changing your position.

This can be as simple as standing and walking on the spot for a few minutes every hour.

If you are sitting, try and lift your bottom off the seat every hour.

If you are in bed, try and change your position without digging your heels into the bed as this can cause damage.

Try not to slide down the bed as this can damage your skin.

Protect your skin –
wash your skin using warm water or pH neutral soap cleansers. Do not rub or massage your skin as this can cause damage.

Do not use heavily perfumed soap or talcum powder.

If you have continence problems, please inform your health care team.

Eat a well balanced diet –
aim to eat a balanced diet - having regular meals which include fruit, vegetables, starchy, protein and dairy foods will help achieve this. Have a variety of fluids, include at least 6-8 drinks daily. Your health care team may refer you to a Dietician for advice.

How your healthcare team can help you

Assessment –
a member of your health care team will complete a risk assessment to identify if you are at risk.

If the health care team are concerned they may refer you to the Tissue Viability Team who are clinical nurse specialists specifically trained in this area.

Surface –
following assessment pressure relieving mattresses and cushions will be provided.

Skin assessment –
you or your carer will be advised to undertake regular assessments of your skin.

Keep moving –
you will be advised about repositioning using the correct equipment.

Incontinence –
your skin will be assessed for the presence of moisture and advice will be given to help keep your skin clean and moisturised. A continence assessment may be needed to help mange your continence.

Nutrition –
your nutritional intake will be assessed and advice will be given to help you maintain a balanced diet. If you are at risk, supplements may be prescribed and a referral to a dietician will be discussed with you.

If you suspect you or the person you care for may have a pressure ulcer tell your nurse or doctor as soon as possible.

With thanks to Nottingham City Care Partnership.

Improving Health and Wellbeing

Humber NHS Foundation Trust

Preventing Pressure Ulcers

A guide for patients and carers

More information is available at:
www.your-turn.org.uk

Review date Sept 2016

What is a pressure ulcer?

A pressure ulcer (bed sore) is an area of the skin and underlying tissue which is damaged. This is due to lying or sitting in one position for too long without moving, or by rubbing causing friction.

Who is at risk?

You are at risk if you have:

Problems with movement – if your ability to move is limited, the area of skin you are lying or sitting on does not get enough oxygen and can breakdown.

Poor circulation – vascular disease and smoking reduces the blood flow to the skin.

Moist skin – caused by incontinence, sweating or a weeping wound.

Previous skin damage – scar tissue is more vulnerable to pressure as it is not as strong as normal skin making it more prone to breaking down.

Poor diet or fluid intake – lack of fluid may dehydrate your skin. Weight gain or loss can affect pressure areas and healing.

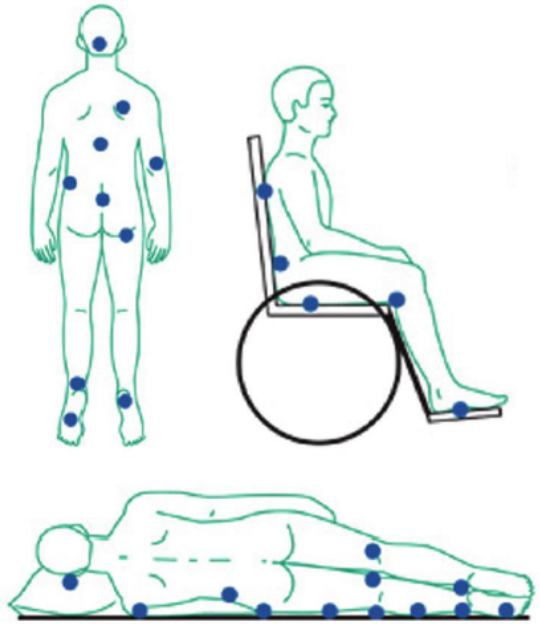
Lack of sensitivity to pain or discomfort – conditions such as diabetes, stroke and disorders which affect nerve supply and muscle movement reduce the normal sensations or feelings of discomfort that usually prompt you to move. Some treatments (e.g. Epidural pain relief, operations) reduce your sensitivity to pain or discomfort so that you may not be aware of the need to move.

Areas of the body at risk of developing a pressure ulcer

Pressure ulcers are most likely to develop over bony areas of the body. The areas most at risk are;

- heels
- buttocks and base of the spine
- elbows
- shoulders
- back of the head

What to look for – red or dark patches which do not disappear within 1- 2 hours, discomfort, pain, blistering, numbness, soreness, swelling or hardening of the skin.



Pictures of skin damage from pressure

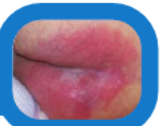
Redness is the first response to pressure

Press finger over reddened area for 15 seconds, then lift up finger. When you take your finger off the area it should turn white/pale (blanche)

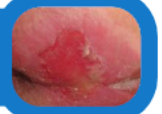
If the area blanches, it is not a pressure ulcer. If it stays red, it is a pressure ulcer.

Darkly pigmented skin does not blanche, signs to look for are purple discolouration, skin feeling too warm or cold, numbness, swelling, hardness or pain.

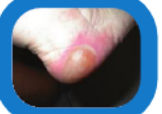
This is the beginning of a pressure ulcer



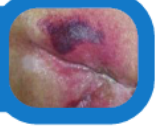
This is scuffed skin from pressure or from sliding down the chair or bed



This is heel blister caused by pressure



This is potential pressure damage that could develop into a deep sore

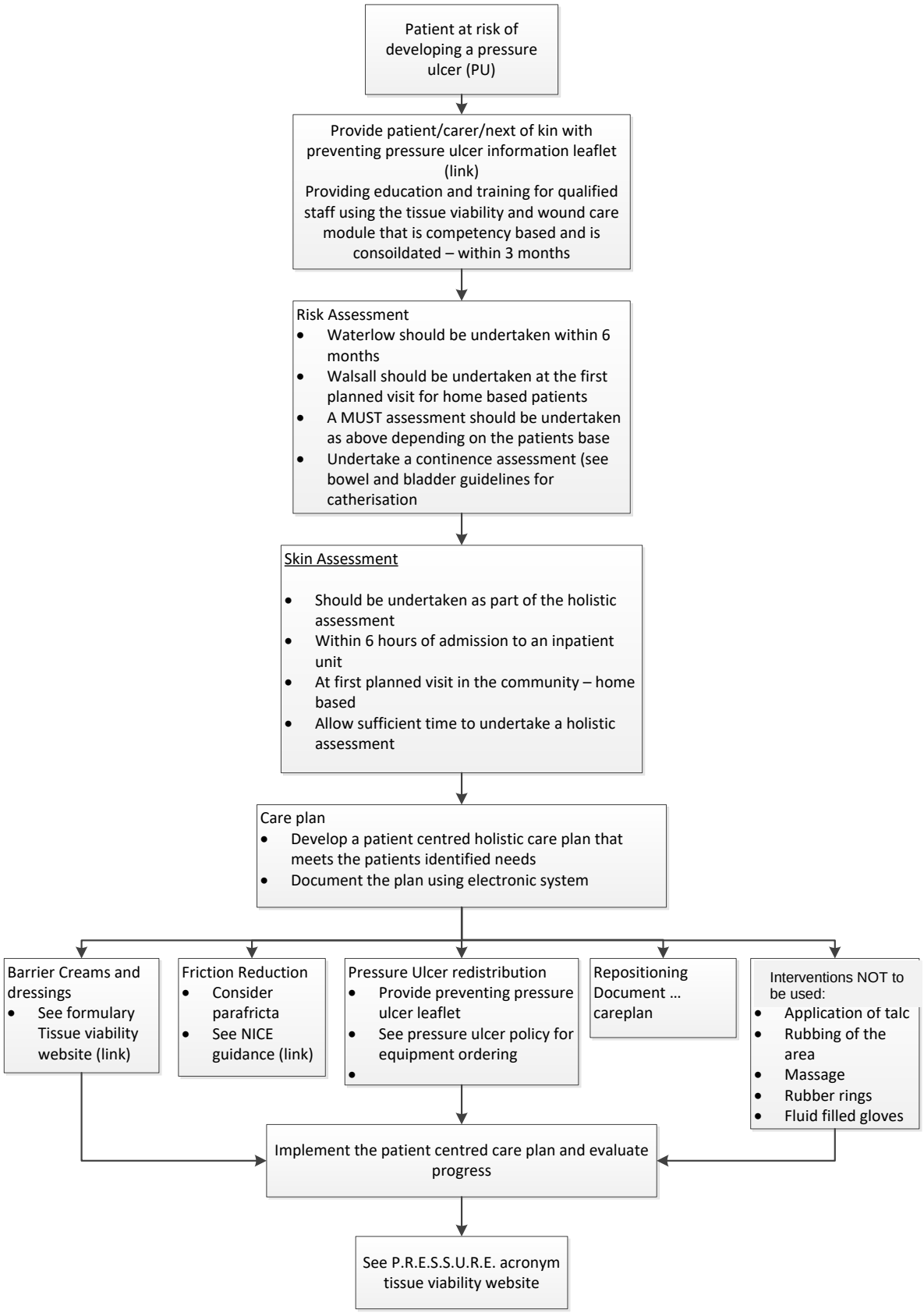


Appendix 9: Pressure Acronym

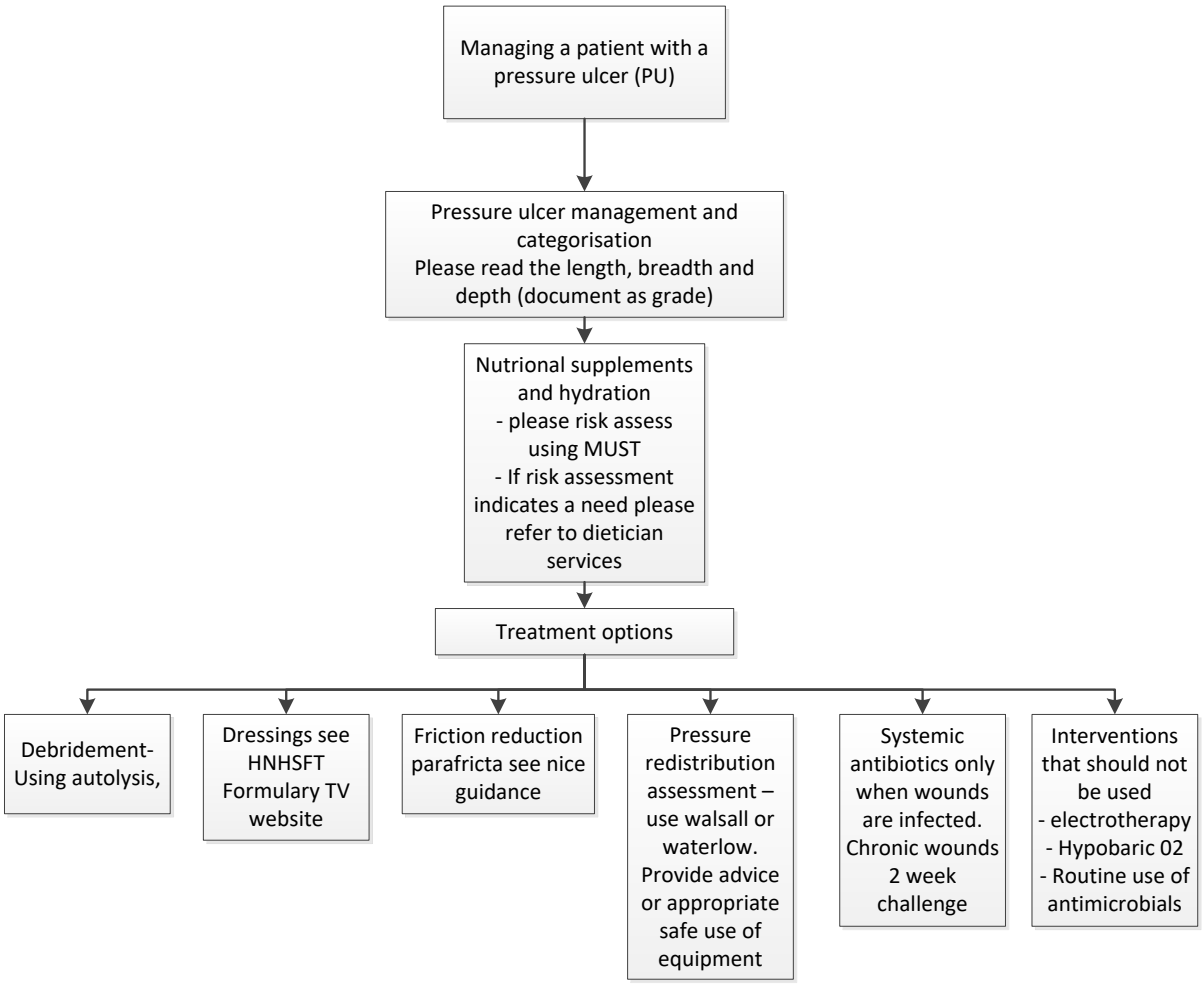
P.R.E.S.S.U.R.E. ACRONYM

P	**LAN:** Formulate an individual patient-centred clinical management plan, to include – holistic assessment, risk assessment, skin and wound assessment. Record baseline information to allow for accurate evaluation. Identify, document and Datix if the ulcer was acquired in our care (our care being Humber Teaching NHS Foundation Trust.
R	**ESOURCES:** Ensure that the appropriate equipment is offered to the patient and where accepted provided to meet the individual patient needs. If the patient declines equipment insure that you have discussed all options with the patient/carer/next of kin. Assess and document patient capacity. Consider the potential safeguarding issues. Consider referral to the multidisciplinary team in the holistic management of the patient, e.g. TVN, dietician, OT etc.
E	**VALUATE:** Regular review of the patient and the plan of care, to insure that it meets the needs of the patient and the skin integrity. Document the change in the evaluation and amend the plan of care. Compare against base line recordings of size etc.
S	**YSTEMS:** For reporting: Datix must be completed for pressure ulcers Categories 2, 3 and 4: and unstageable/unclassified and deep tissue injuries. Other reporting avenues to consider for pressure damage are – Safeguarding (Category 3 and above unless there is evidence of neglect), duty of candour (for those ulcers of Category 3 and above indicating severity of moderate or higher acquired in our care).
S	**OLVING:** Investigating the clinical and nursing issues associated with patient's who sustain pressure damage of Category 3 or above whilst in our care, through IIR. Please note nursing documentation (written and/or electronic) will be reviewed as part of the IIR.
U	**NDERSTANDING:** Why pressure damage has occurred through Lessons Learnt feedback from team leaders/matrons after an IIR has been completed. This should include training to be undertaken for continuous development of the clinician(s) and the team. This will be identified in the IIR action plan with time scales applied.
R	**EFOCUSING:** Care programme approach and changing practice in pressure ulcer management. Working together in collaboration to reduce risk and harm.
E	**STABLISH:** Gold standard of clinical practice in pressure ulcer prevention and management. Refer to the pressure ulcer policy on the intranet.

Appendix 10: Care Pathways – Patient at Risk of Developing a Pressure Ulcer



Appendix 11: Managing a Patient with a Pressure Ulcer



Appendix 12: Document Control Sheet

Document Type	Policy – Pressure Ulcer Management and Prevention Policy (N-050.2)		
Document Purpose	This policy promotes a multidisciplinary approach to the detection, prevention and management of pressure ulcers, acknowledging the physical, psychological and social impact of living with a pressure ulcer. This policy offers guidance on the prevention of pressure ulcers by outlining the essential elements of prevention which begins with an initial holistic assessment and includes risk assessments and developing a person-centred plan of care along with advice on positioning and use of equipment, with the use of support systems and the classification and management of pressure ulcers once discovered.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	October 2023	PURL	
	November 2023	QPaS	
Approving Committee:	Quality Committee	Date of Approval:	06 February 2019 (v5.0)
Ratified at:	Trust Board	Date of Ratification:	27 February 2019 (v5.0)
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below*		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:			

Document Change History:			
Version Number/Name of procedural document this supersedes	*Type of Change i.e. Review/ Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*New policy*	*April 11*	*New policy*
2.0	*Review*	*Nov 11*	*Revised with changeed in the management of pressure ulcers and harmonised*
2.1	*Review*	*July 13*	*Revised with changed to the indenfification of pressure ulcers, i.e. ungradable*
3.0	*Review*	*Jan 14*	*Reviewed with major changes* *Agreement of ungradable, avoidable and unavoidable harm with CSU (Clinical Support Unit) and discussion with RVN (Tissue Viability Nurse)*
3.1	*Review*	*Aug 14*	*Revised with minor changes* *Agreement on what constitues acuired in our care* *Two new paragraphs added Page 9 Healthcare acquired pressure ulcers*
4.0	*Review*	*Aug 16*	*Major review* *Duty of Candour* *Safeguarding* *Pathways for* • *prevention of pressure* • *Ulcer and management of pressure ulcer* *Additions of pressure acronym*

5.0	*Review*	*Nov 18*	*Major review* *Amendements to bring policy in line with pressure ulcers* *Revised definition and measurement, summary and recommendations (NHSI 2018)*
5.1	*Review*	*Jan 20*	*Reviewed with minor amendments* *The following text added following Ombudsman's review and recommendations:* *Persons who have transferred into a new care environment for example residential care homes will have a personalised plan of care which will be shared with and held at the care home* *Staff will follow the Humber Sharing Information Charter when sharing information with third party colleagues.* *Approved QPaS 22 January 2020 (minor amends)* *Date for next review to remain as Dec 2021.*
5.2	*Review*	*Jan 22*	*Reviewed with minor amendments* *Including an update the PU policy to reflect trust procedure in relation to the introduction of Skin changes at Life end [SCALE] and the roles and responsibilities. Link added to the Pressure Ulcer Management SOP (SOP18-003). Minor amendments. Approved at QPaS 10-March-22*
5.3	*Review*	*Oct-23*	*Reviewed with minor amendments including* *Schedule of reporting - PU reports* *Approved through PURL for presentation to QPaS (Oct-23)* *Approved at QPaS (11 January 2024).*

Appendix 13: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Pressure Ulcer Policy**
2. EIA Reviewer (name, job title, base and contact details): Simon Barrett, Tissue Viability Clinical Specialist simon.barrett3@nhs.net
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service To set out the Trust's policy and procedure on the prevention and management of pressure ulcers in line with NICE guidance		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma		
Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual orientation 9. Gender reassignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	This policy is applicable to all age groups, irrespective of age, to enable all people who use services to maintain their skin integrity
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**Low**	This policy is applicable to all people, irrespective of disability, to enable all people who use services to maintain their skin integrity
Sex	Men/Male Women/Female	**Low**	This policy is applicable to all genders
Marriage/Civil partnership		**Low**	This policy is applicable to all
Pregnancy/ Maternity		**Low**	This policy is applicable to all
Race	Colour Nationality Ethnic/national origins	**Low**	This policy is applicable to all
Religion or belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	This policy is applicable to all
Sexual orientation	Lesbian Gay men Bisexual	**Low**	This policy is applicable to all
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	This policy is applicable to all

Summary

Please describe the main points/actions arising from your assessment that supports your decision above This policy applies to all people, irrespective of age, disability, marital status, religion, or sexual orientation and will be applied to all who use services to ensure that prevention of pressure ulcers is a priority within the Trust, with all staff working with patients and their carers to prevent where possible, work with their preferred options but always work in the best interests of the person to maintain and or prevent further deterioration in skin integrity	
EIA Reviewer: **Simon Barrett, Tissue Viability Clinical Specialist**	
Date completed: **24 October 2023**	Signature: **S Barrett**