PRESSURE ULCER PREVENTION AND MANAGEMENT

CLINICAL PRACTICE GUIDELINE

Tissue Viability Service

December 2018

Pressure Ulcer Prevention and Management / Procedural Document

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Approved by (Sponsor Group)	Nursing Development Steering Group, Quality Group
Ratified by:	Nursing Development Steering Group
Date ratified:	March 2020
Name and Job Title of author:	Carole Taylor Clinical Lead Nurse Tissue Viability
Executive Director lead :	Ruth Bradley Director of Nursing
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1.0 Guideline Summary

This document contains guidance for clinical staff on the assessment and management of patients with or 'at risk' of, pressure ulceration. It takes into account national and international recommendations (1, 2). The document should be used in conjunction with the Wound Care Guidelines and the Wound Dressing Formulary available on the Trust intranet.

2.0 Overriding Duty of Care Statement

Should the content or operation of this guideline be challenged on any grounds whatsoever then the impact on the past, present or future duty of care to patients will be taken to be a primary factor in deciding the outcome of that challenge.

3.0 Who this Guide Applies to

The recommendations apply to all healthcare staff within East London Foundation Trust responsible for the care of patients both adults and children with or 'at risk' of developing pressure ulcers. Nursing Home, General Practice staff and Local Authority staff may also use the document where appropriate to ensure consistency and continuity in care.

4.0 Background

Pressure ulcers are common in healthcare settings and represent a significant burden of suffering for patients and carers and are costly to the NHS. As the population ages and patterns of sickness change, the prevalence of pressure ulcers is likely to increase unless preventative action is taken.

Prevention and management strategies should be provided within a **multidisciplinary framework** and should include:

- Identifying patients who are 'at risk' of developing pressure ulcers.
- Implementation of the SSKIN bundle approach to prevention and treatment
- Directing preventative measures in the form of education, manpower, equipment and other resources, towards the 'at risk' group to ensure that skin integrity is maintained.
- Measures to promote healing using the SSKIN bundle treatment plan.

5.0 Aims & Objectives

1. To provide best practice recommendations on pressure ulcer prevention and management
2. To raise awareness of pressure ulcer prevention and management strategies.
3. To provide a basis for standardised, evidence-based care in relation to patients with or 'at risk' of pressure ulcer development in East London Foundation Trust.
4. To support the development of quality care for patients in this area in line with the Trusts Quality Improvement Strategy and harm free care agenda.

6.0 Quality Assurance

This document should be used as an aid to clinical decision making and is not intended to replace professional or clinical responsibility

The principles upon which this guideline is based are:

- An individualised holistic assessment should be undertaken including a risk assessment using the recommended Trust documentation and evidence-based treatment plans commenced based on the SSKIN bundle, taking into account the underlying aetiology, patient's circumstances and wishes, the overall goals of therapy, the practitioners clinical experience, available resources and knowledge of more recent research findings.
- Those who assess, plan, implement and evaluate care for patients with or 'at risk' of pressure ulceration should be trained/educated & competent.
- The patient and their carers should be fully informed and share in the decision-making process.
- The process should be clearly documented in the patient's records and made accessible to all those caring for the patient to ensure continuity of care.
- It is essential that a collaborative, multi-disciplinary, inter-agency approach is taken to meet all the needs of the patient with or 'at risk' of developing pressure ulcers.
- **All agencies involved in the patient's care have a responsibility to report any concerns that may lead to the patient developing a pressure ulcer** (3).
- Patients, staff and carers should have access to the equipment and resources necessary to deliver quality care.
- Monitoring and development of quality initiatives should be undertaken regularly using the quality improvement methodology promoted by the Trust.

7.0 Dissemination

This guideline will be available to all staff in electronic form on the Trust Intranet site and hard copies should be kept on site in each clinical area.

Access to the online training module is available to all clinical staff to support this clinical practice guideline. In addition, Pressure ulcer assessment, prevention and management training updates will be held as part of the in-house Tissue Viability training programme as required.

8.0 DEFINITION & CAUSES OF PRESSURE ULCERS

A pressure ulcer is 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 pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful (1).

An individual's potential to develop pressure ulcers may be influenced by their body's response to variations in internal and external factors (1). All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur if:

- People are seriously ill acute/chronic/terminal illness
- The presence of vascular disease or neuropathy
- Previous history of pressure damage
- Have a neurological condition
- Impaired mobility
- Impaired nutrition
- Incontinence/Moisture to the skin
- Extremes of age
- Obesity
- Sensory impairment
- Poor posture or a deformity

The use of equipment such as casts, splints, tubing e.g. catheter & oxygen, seating or beds which are not specifically designed to provide pressure relief can contribute to the development of pressure ulcers. As pressure ulcers can arise in several ways, interventions for prevention and treatment need to be applicable across a wide range of settings including community and secondary care.

Recommendations for prevention include methods for identification and risk assessment and the preventive measures that should be applied (2). Treatment of pressure ulcers includes recommendations on wound care, adjunctive therapies and support surfaces. These guidelines should be used in conjunction with ELFT wound management guidelines and wound dressing formulary.

9.0 PRESSURE ULCER RISK ASSESSMENT

Risk assessment tools have been developed to help identify those patients most at risk, for example: Waterlow (4). For adults and the adjusted Braden for children. However, all risk assessment tools currently are limited and should be used within the context of a holistic assessment and include a full skin assessment for those identified as 'at risk' using the Trust **Pressure Ulcer Risk and SSKIN Bundle Assessment Forms** for Adults and Children (Appendix 1& 2)

9.1 Initial Risk Assessment

All patients should have a pressure ulcer risk assessment immediately upon entry to an episode of care. For all patients identified as 'at risk' initial screening should lead to further holistic assessment. Although an assessment may take time to complete, it should be commenced within **six** hours for 'in-patients' and during the **first** visit for patients who are receiving care in the community.

9.2 Adult Risk Assessment – The Waterlow Pressure Ulcer Risk Calculator

The Waterlow Pressure Ulcer Risk Calculator and skin assessment form/template should be used in adult services and a risk category assigned to each individual patient.

10 + = At risk *
15 + = High risk *
20 + = Very high risk *

The Waterlow score and skin assessment combined with clinical judgement should be used to determine the treatment plan for the patient using the SSKIN bundle.

9.3 Risk Assessment for Children - Paediatric Pressure Ulcer Risk Assessment

The **Paediatric Pressure Ulcer Risk and SSKIN bundle Form**, (Appendix 2), is recommended for use within the Children's Community Nursing Team, as it was developed for use with children. Scores of 10 or less indicate that the child is at risk of developing a pressure ulcer and interventions should be taken to reduce this risk. This should be reviewed considering any change in the child's condition.

9.4 Frequency of Risk Assessment

- All patients who have or are 'At risk' of developing pressure ulcers should be reassessed formally at least **weekly** or when their condition changes for at risk **in-patients** and **monthly** or when their condition changes for patients under the **care of Community teams.**
- Frequency of re-assessment should be dependent on any change in the patient's condition or within their environment.
- Re-assessments should be recorded on EMIS, System One or RiO. If Risk assessment forms are used these should be uploaded onto the patient's electronic records.
- Patients on in-patient units who are **'Not at Risk'** should have a pressure ulcer risk assessment recorded if their condition changes.
- Patients within the Community who are **'Not at Risk'** should be reassessed when their condition or home circumstances change.
- All relevant risk factors should be written on a **SSKIN bundle prevention** care plan with identified actions to reduce the impact of each factor.
- All patients who are using a pressure relieving/distributing support surface provided by the local provider (Appendix 3) or under rental/leasing agreements should have their on-going need for the equipment reviewed and recorded, weekly while an in-patient and monthly for those under the Community nursing teams. More frequent reviews may be required if the patient's condition changes.
- Patients requiring pressure redistributing support surfaces require on-going assessment and management and should remain under the care of staff who have undergone the appropriate training and know how to initiate and maintain correct and suitable preventative measures.

NICE Recommendations on Risk assessment (NICE 2014)

Adults	Neonates, infants, children and young people
Be aware that all patients are potentially at risk of developing a pressure ulcer. **Carry out and document an assessment of pressure ulcer risk for all adults on admission to secondary care or care home in which NHS care is provided**	**Carry out and document an assessment of pressure ulcer risk in neonates, infants, children and young people, using a scale validated for this population (for example, the Braden Q scale for children), to support clinical judgement.**
Carry out and document an assessment of pressure ulcer risk on initial contact for adults receiving NHS care which does not involve admission to secondary care or a care home (for example, care received at a GP surgery or an accident and emergency department) only if they have a risk factor, for example: • **significantly limited mobility or significant loss of sensation (for example, people with a spinal cord injury)** • **a previous or current pressure ulcer** • **the risk of nutritional deficiency** • **the inability to reposition themselves** • **a neurological condition** • **significant cognitive impairment.**	
3. Consider using a validated scale to support clinical judgement (for example, the Braden scale, the Waterlow score or the Norton risk-assessment scale) when assessing pressure ulcer risk.	
4. Reassess pressure ulcer risk if there is a change in clinical status (for example, after surgery, on worsening of an underlying condition or with a change in mobility).	
5. Develop and document an individualised care plan for adults at elevated risk of developing a pressure ulcer, taking into account: • **the outcome of risk and skin assessment** • **the need for additional pressure relief at specific at-risk sites** • **patient mobility and ability to reposition themselves** • **other comorbidities** • **patient preference.**	

10.0 SKIN INSPECTION AND ASSESSMENT

- Patients who have or are ‘At risk’ of pressure ulcer development should have a skin inspection on initial assessment, and then daily for in-patients and at each visit for those on the community nurse’s/ therapists caseload. More frequent assessment may be required if the patient's condition deteriorates.

- All bony prominence should be examined. For example, sacrum, heels, hips, ankles, elbows, ears, occiput and buttocks.
- Patients and carers should be taught to assess their own skin and take on-going responsibility if appropriate. Please use the Trusts '**Shared Care' document** (Appendix 4) to teach carers and family how to recognise and report skin integrity concerns.
- Note whether the skin is moist, dry, indurated, and unusually warm or cool in one area, broken or discoloured. Whether redness is blanching or non-blanching.
- Identifying discolouration on patients with dark skin may be difficult and care should be taken not to rely solely on visual inspection (1, 2).
- Note signs of previous pressure damage, location and circumstances surrounding occurrence and healing.
- Record evidence of pressure damage category 1-4, suspected deep tissue injury (SDTI) or unstageable pressure ulcer. (EPUAP 2014) and complete a wound assessment which should include wound measurements and evaluation on the patient's electronic records.
- All patients at risk of developing a heel pressure ulcer the heel prevention pathway should be followed (Appendix 5)
- All patients with a heel pressure ulcer should have a vascular assessment to determine the Ankle Brachial Pressure Index (ABPI) using a Doppler.
- Note the patient's level of bladder and bowel continence.
- If any moisture is found to be in contact with the skin the source should be identified and eliminated where possible.
- Moisture lesions should be distinguished from pressure ulcers. Please seek advice from the tissue viability service if clarification is required.
- Use an effective barrier film or cream to prevent maceration and excoriation. For example: Cavilon durable barrier cream/film which is on the Trust Wound Care Formulary.

NICE Recommendations on Skin assessment (NICE 2014)

Adults	Neonates, infants, children and young people
Offer adults who have been assessed as being at elevated risk of developing a pressure ulcer a skin assessment by a trained healthcare professional. The assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for: • **skin integrity in areas of pressure** • **colour changes or discoloration** • **variations in heat, firmness and moisture (for example, because of incontinence, oedema, dry or inflamed skin).**	**Offer neonates, infants, children and young people who are identified as being at elevated risk of developing a pressure ulcer a skin assessment by a trained healthcare professional. Take into account:** • **occipital area skin** • **skin temperature** • **the presence of blanching erythema or discoloured areas of skin.**
Use finger palpation or diascopy to determine whether erythema or discolouration (identified by skin assessment) is blanchable. Consider repeating the skin assessment after 2 hours in adults who have non-blanching erythema until resolved.	**Be aware of specific sites (for example, the occipital area) where neonates, infants, children and young people are at risk of developing a pressure ulcer.**

11.0 NUTRITIONAL ASSESSMENT

- All patients should be screened for 'risk of' or actual malnutrition and receive a well- balanced diet in accordance with their wishes.
- Patients considered as 'malnourished', or ‘at risk’ of malnutrition should have a full nutritional assessment and be managed according to local and national guidance Nutritional indicators such as anaemia, haemoglobin, and serum albumin levels should be undertaken in patients with pressure ulceration.
- Note any recent significant, unintentional weight loss
- Nutritionally compromised patients who have wounds may have an increased dietary need and a referral to a Dietician should be made for further assessment, advice and supplementation.
- Patients who have problems with swallowing should be referred to the Speech and Language Team (SALT) for a swallowing assessment
- Weight, height and body mass index (BMI) should be recorded at initial assessment, then weekly for in-patients and monthly for patients under the care of the community teams where possible. Use mid upper arm circumference measures if unable to weigh patient.

NICE Recommendations on Risk assessment (NICE 2014)

Adults	Neonates, infants, children and young people
Do not offer nutritional supplements specifically to prevent a pressure ulcer in adults whose nutritional intake is adequate	**Do not offer nutritional supplements specifically to prevent a pressure ulcer in neonates, infants, children and young people with adequate nutritional status for their developmental stage and clinical condition.**
Do not offer subcutaneous or intravenous fluids specifically to prevent a pressure ulcer in adults whose hydration status is adequate	**Do not offer subcutaneous or intravenous fluids specifically to prevent a pressure ulcer in neonates, infants, children and young people with adequate hydration status for their development stage and clinical condition**

12.0 MOBILITY ASSESSMENT

Suggestions to consider when assessing this are

- Can the patient turn or move independently in bed, in a chair and walking? How much assistance is required?
- Establish the patients and/or carers current level of knowledge of pressure ulcer formation and aim to improve this.
- Use moving and handling aids when repositioning the patient to reduce the effects of shear and friction forces.
- Patients/carers should be supplied with an information leaflet to reinforce any advice given verbally. Patient information leaflets are available on the Trust internet.
- Refer to physiotherapist and occupational therapists if appropriate

13.0 MENTAL HEALTH ASSESSMENT

The patient's mental status should be assessed within the context of how it affects their ability to move independently and spontaneously and to follow recommended advice for pressure ulcer prevention and management.
Is the patient:

- Alert and orientated to time, place and person?
- Confused and restless or fidgety?
- Lethargic?
- Unconscious?

Patient who are non-concordant with pressure ulcer prevention and treatment recommendations should have a mental capacity assessment carried out.

The Mental Capacity Act 2015 states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. The loss of capacity could be partial or temporary. It is possible for a person to lack capacity to make one specific decision but not about another.

14.0 PSYCHOLGICAL ASSESSMENT

Consider the following: the patient's pain level, lifestyle choices, motivational level, embarrassment, anxiety level, depression, coping strategies and any psychological impairment that may affect concordance with recommendations. For example: dementia, learning difficulties. Also detail any behavioural problems that may impact on treatment and drug/alcohol dependency. Include details of how, in the patient's view, having a pressure ulcer has affected their quality of life and what their priorities are for treatment.

14.1 Pain

Ensure effective analgesia is prescribed and administered prior to any nursing intervention. Educate patients, relatives and carers on the importance of taking regular analgesia as prescribed and its role in assisting concordance with the treatment plan.

15.0 SOCIAL ASSESSMENT

Consider the patient's hobbies, occupation, family structure, what carers or social services are involved and their ability to assist with care. Detail attitudes and any avoidance of social activities due to immobility or pressure ulceration.
The above factors should also be considered when selecting and advising on pressure ulcer care plans and equipment for patients in their own homes.

16.0 SKIN CHANGES AT LIFE'S END (SCALE)

During the end stages of life vital body systems e.g the renal, hepatic, cardiac, pulmonary, nervous system and the skin can be compromised and will eventually

cease to function (5). The skin is the largest organ of the body and during the end stages of life can become dysfunctional due to changes related to a decreased cutaneous perfusion and localised hypoxia. Other factors may also alter skin function such as a compromised immune response and in advanced cancer patients the administration of corticosteroids and other immunosuppressant agents may further affect the function of the skin.

When assessing a patient who is at the end of their life where appropriate should involve family members, carers and other health care professionals and the following considerations should be considered.

- The patient's clinical condition including co-morbidities and medication,
- Pressure ulcer risk factors and realistic expectations regarding skin integrity
- Awareness of diminished tissue perfusion leading to impaired skin oxygenation. Areas of the body with end arteries such as fingers, toes, ears and the nose may exhibit early signs of vascular compromise and display skin changes such as decreased local skin temperature, mottled discoloured skin and skin necrosis.
- Suboptimal nutrition including loss of appetite, weight loss, cachexia and wasting, dehydration, low albumin and low haemoglobin
- Significant changes and clinical interventions that are consistent with the patient's wishes
- Any concerns that impact quality of life such as pain management and psychological and emotional issues.

16.1 AIMS AND OBJECTIVES OF SCALE

The aims and objectives for end of life skin care should be clearly documented in the care plan and reflected in the patient's electronic records. Consider the 5 'P's when planning care

- Prevention – address pressure, shear, moisture, suboptimal nutrition, immobilisation
- Prescription – a pressure ulcer may heal with appropriate treatment and addressing the underlying cause
- Preservation - if wound healing is limited maintenance without deterioration should be the aim
- Palliative - provide comfort and care where healing is not an option.
- Preference - patients desires

17.0 CLASSIFICATION OF PRESSURE ULCERS

The severity of pressure ulcers should be assessed using The European Pressure Ulcer Advisory Panel Classification System (1,).

17.1 The European Pressure Ulcer Panel Classification System *

Category	Description	Picture
1	**Non blanchable erythema** Intact skin with non-blanchable redness of a localised area usually over a bony prominence. (i.e. light finger pressure applied to the site does not alter the discolouration) NB. Darkly pigmented skin may not have visible blanching but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. This category may be difficult to detect on individuals with dark skin tones. May indicate 'at risk' persons.	
2	**Partial thickness** 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 serosanguinous 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 with dermatitis, maceration or excoriation. *Bruising indicates deep tissue injury.	
3	**Full thickness skin loss** Full thickness skin loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear occiput and malleolus do not have (adipose) subcutaneous tissue and can be shallow. In contrast, areas where significant adipose tissue exists can develop extremely deep category 3 pressure ulcers. Bone or tendon is not visible but directly palpable.	
4	**Full thickness tissue loss** Full thickness tissue loss **with** exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. category 4 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	
Suspected Deep Tissue Injury (SDTI)	Purple or maroon localized 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 adjacent tissue. Deep tissue injury may be difficult to detect in 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 thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.	
Unstageable Pressure ulcer. Depth unknown	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	

This tool cannot be used to 'reverse stage' a pressure ulcer. This means that the scores cannot be counted in reverse to describe a healing pressure ulcer.
For example: A category 4 pressure ulcer does not become a category 3 as it heals.
Instead use descriptions such as: Healing category 4 ulcer

Unstageable pressure ulcers should be reviewed by a clinician with appropriate skills on a weekly basis for two weeks to help identify a definitive PU category. After two weeks DATIX will be updated to reflect the true grade.

SDTI suggests underlying tissue damage. This should be reported on DATIX and should be monitored for up to two weeks by a clinician with appropriate skills. During this time the pressure damage will be reassessed and categorised and recorded as appropriate on Datix.

For all practical purposes, evolving deep tissue injury should be provided the same level of pressure relief as a category 3 or 4 pressure ulcer. Offloading and pressure redistribution may allow reperfusion if ischemic and injured tissue, limiting the extent of dead tissue

17.2 Device related pressure ulcers
Consider both adults and children with medical devices to be at risk for pressure ulcers.

- Review and select devices available that will induce the least degree of damage from the forces of pressure and shear.
- Ensure device sized and fitted correctly to avoid excessive pressure.
- Ensure device secured appropriately to avoid dislodgement

18.0 Reporting Pressure Ulcers
All pressure ulcers assessed as being category 2-4, SDTI or unstageable should be recorded as a clinical incident (3) and reported on the DATIX system and the pressure ulcer pathway followed (Appendix 6)

18.1 Inherited pressure ulcers: Multiple category 2, category 3, category 4 and unstageable pressure ulcers
Multiple category 2, category 3 category 4, unstageable pressure ulcers and SDTI identified as acquired whilst the patient was in receipt of care outside of ELFT and where there is concern that the pressure ulcer may have arisen because of poor practice, neglect/abuse or an act of omission or if information to exclude this is not available, will require a safeguarding concern form to be completed and sent to the Local Authority (LA) safeguarding team. (4) This form should be attached to the Datix report. For guidance follow the DOH Decision Process (Appendix 8).

ELFT Governance team for Newham Community Services and Tower Hamlets Community Services to report all non ELFT pressure ulcers to the Clinical Commissioning Group (CCG) using the NHS number and external organisations name only
For Bedfordshire Community Health services this is done by the teams using the pressure alert form (Appendix 7).

18.2 ELFT Acquired pressure ulcers - Adult community services, Mental Health Services and Children and young people's services: Multiple category 2, Category 3, 4 and unstageable pressure ulcers

- Multiple category 2, category 3, category 4 and unstageable pressure ulcers acquired in ELFT care are categorised as serious incidents (SI) and must be reported on DATIX and the pressure ulcer reporting pathway followed (Appendix 6).
- If at this stage it is evident that there are safeguarding concerns or **suspected abuse or neglect or an act of omission**, identify on Datix and complete and submit a safe guarding alert form to the LA Safeguarding team – informing that a RCA is being completed and we will share outcome when finalised.
- A duty of candour (DOC) letter will be completed by the Team leader/clinical lead for all category 3 & 4 pressure ulcers acquired in ELFT care, using the DOC template and sent to the patient/carer within 10 working days.
- The Incident reporting team will liaise with the Pressure Ulcer Panel to determine if a Serious incident Review (SIR) or Investigation by Root Cause Analysis is required (RCA).
- A decision will be made by the pressure ulcer panel based on the Tissue Viability Society Consensus and NHS England Guidance..
- If when reviewing the report a safeguarding concern is identified and has not previously been reported to the LA safeguarding team a request will be made to complete one.
- The RCA will be presented to the pressure ulcer panel in Newham and Tower Hamlets and at the Skin Matters Group in Bedfordshire Community Services by the clinical lead/Team leader. Lessons learnt are discussed and actions plans are taken back to the teams for implementation. During the review the panel will consider any further evidence of safeguarding concerns. If there is evidence of neglect or abuse, and a safeguarding concern has not previously been reported to the LA safeguarding team, a request will be made to complete one.
- The finalised RCA/SIR will be shared with the LA Safeguarding team.

18.3 Deterioration of Pressure Ulcer

If the condition of the patient changes i.e further breakdown of skin, deterioration of pressure ulcer or if the patient dies, staff to report this on DATIX again regardless of this being reviewed at the Pressure ulcer panel/Skin Matters Group/SIR

18.4 Reporting Device Related Pressure Ulcers

Where pressure ulcers develop because of a device such as casts, splints, tubing e.g. catheter & oxygen, tracheostomy tubes etc, seating or beds which are not specifically designed to provide pressure relief, should be reported on DATIX under the category Device Related Pressure ulcer and categorise accordingly. The same process as above for the investigation will be followed.

19.0 Referrals

Patients with Category 2 pressure ulcers should have a SSKIN bundle treatment plan implemented and if not improving in one week referred to the appropriate specialist.

Patients with Category 3, 4 unstageable pressure ulcers or STDI should have a SSKIN bundle treatment plan implemented and referred immediately to the appropriate specialist.

AREA	REFER TO
Newham Community Services Extended Primary Care Service	Interterm referral via SPA to Pressure ulcer improvement facilitator (PUIF)
Newham East Ham Care Centre Children's Community Nursing Service Mental health in-patient units (Newham, Tower Hamlets, City & Hackney)	The Tissue Viability Service – Newham Complete referral form and email to Tissueviability.service@nhs.net
Tower Hamlets Community Nursing Service	Tissue Viability – Tower Hamlets Interterm Referral via SPA
Bedfordshire Community Nursing Services	The Team leaders of the community teams. Who will ensure appropriate equipment in place, effective repositioning schedule in place and effective wound bed preparation has been carried out. If still failing to heal refer to Tissue Viability Service via electronic referral form.

20.0 PRESSURE ULCER PREVENTION AND MANAGEMENT: REPOSITIONING

- Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every 6 hours
- Encourage adults who have been assessed as being at high risks of developing a pressure ulcer to change their position frequently and at least 4 hourly.
- If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required.
- Skin damage can be minimised by using correct positioning, transferring and repositioning techniques and the use of aids. For example: hoists, sliding sheets, pillows, bed cradles and other aids.
- Hoist slings and sliding sheets should be removed from underneath the patient after repositioning unless a 4 way sliding sheet is in use.
- Where possible patients should be taught to reposition themselves and carers should be shown how to assist.
- Repositioning should be performed in such a way as to minimise the impact on bony prominence.
- Whenever possible avoid positioning patients directly on a pressure ulcer or directly on a bony prominence unless this is contra-indicated by the general treatment objectives.
- Using the 30-degree tilt can increase the range of positions available (Appendix 9).
- Moving and handling should be in accordance with European and Trust manual handling regulations.
- The patient's need for repositioning should be assessed, planned, actioned, evaluated and documented with evidence of ongoing re-assessment. The frequency of repositioning is determined from individual assessment.
- A repositioning plan should take into consideration: existing/potential tissue damage, medical condition, comfort, patient preferences, support services, overall plan of care.

- If sitting in a chair is necessary for individuals with pressure ulcers on the Sacrum/coccyx or ischia, limit sitting to three times a day for periods of 60 minutes or less. Consult a seating specialist to prescribe an appropriate seating surface and or positioning techniques to avoid or minimize pressure on the ulcer.

NICE Recommendations Repositioning (NICE 2014)

Adults	Neonates, infants, children and young people
Encourage adults, who have been assessed as being at risk of developing a pressure ulcer, to change their position frequently and at least every 6 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required.	**Ensure that neonates and infants who are at risk of developing a pressure ulcer are repositioned at least every 4 hours.**
Encourage adults, who are at elevated risk of developing a pressure ulcer, (as identified by risk assessment) to change their position frequently and at least every 4 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required.	**Encourage children and young people who are at risk of developing a pressure ulcer to change their position at least every 4 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed.**
	Consider repositioning neonates and infants at elevated risk of developing a pressure ulcer (as identified by risk assessment) more frequently than every 4 hours. Document the frequency of repositioning required.
	Encourage children and young people who are at elevated risk of developing a pressure ulcer (as identified by risk assessment) to change their position more frequently than every 4 hours. If they are unable to reposition themselves, offer help to do so, using equipment if needed. Document the frequency of repositioning required.

21.0 PRESSURE REDISTRIBUTING SUPPORT SURFACES

21.1 Mattresses Adults

- Due to the requirement for ongoing assessment and care planning, choice of pressure redistributing support surfaces for patients should be made by a registered nurse who is trained/educated/competent in pressure ulcer risk assessment, prevention and management. Other healthcare professionals can

undertake an assessment and make recommendations; however, they should then refer to the nursing service.

- Patients with or 'at risk' of developing pressure ulcers have access to support surfaces which can be sourced from a local provider (Appendix 3).
- In Tower Hamlets Community Services refer to the Pressure ulcer passport
- Patients who are 'at risk' or who have Category 1-2 pressure ulcers should be allocated a high specification foam pressure redistributing mattress/cushion (1, 2, 3). They should also have regular observation and documented repositioning regime.
- If this is not sufficient to redistribute pressure, consider using a dynamic support surface.
- Patients with Category 3 and 4 pressure ulcers and patient at higher risk of pressure ulcer or where frequent manual repositioning is not possible should be placed on a dynamic support surface.
- Contact the provider for your area (Appendix 3) for advice on equipment selection and availability.

21.2 Mattresses – Children

- Children identified as being at risk of developing pressure ulcers should be supplied with an appropriate pressure relieving support surface. First line pressure relieving surface should be a high specification foam pressure redistributing mattress appropriate for the child's weight, cot or bed. They should also have regular observation and documented repositioning regime.
- Consider using specialist support surfaces (including dynamic support surfaces where appropriate) for neonates, infants, children and young people with a pressure ulcer, taking into account their current pressure ulcer risk and mobility
- The following issues should be taken into account before placing a child on an alternating pressure mattress whether overlay or replacement:
  - Cell size of mattress – small children can sink into gaps created by deflated cells causing discomfort and reducing efficacy
  - Position of pressure sensors within the mattress in relation to the child – small children positioned at the top of the mattress may not register as the weight sensor is positioned in the middle of the mattress, thus producing inappropriate cell calibration.
  - Lower weight restrictions of alternating pressure mattress.
  - Many alternating pressure mattresses have a permanently inflated head end which may place the occiput at risk in young children

21.3 Cushions

A seating assessment should be undertaken before allocating a pressure redistribution cushion (Appendix 10)

- Consider the seating needs of adults who have a pressure ulcer who are sitting for prolonged periods.
- Consider a high-specification foam or equivalent pressure redistributing cushion for adults who use a wheelchair or sit for prolonged periods and who have a pressure ulcer
- Assessment for wheelchair cushions should be undertaken by the Wheelchair Service.

NICE Recommendations Repositioning (NICE 2014)

Adults	Neonates, infants, children and young people
Use a high-specification foam mattress for adults who are • **Admitted to secondary care** • **At elevated risk of developing a pressure ulcer in primary care and community care (as identified by risk and skin assessment)**	**Use a high-specification foam cot mattress or overlay for all neonates and infants at elevated risk of developing a pressure ulcer (as identified by the risk assessment).**
Consider a high-specification foam theatre mattress or an equivalent pressure redistributing surface for all adults who are undergoing surgery	**Use a high-specification foam mattress or overlay for all children and young people at elevated risk of developing a pressure ulcer (as identified by the risk assessment) as part of their individualised care plan**
Consider a high-specification foam or equivalent pressure redistributing cushion for adults who use a wheelchair	**Offer infants, children and young people who are long-term wheelchair users, regular wheelchair assessments and provide pressure relief or redistribution** **Offer neonates, infants, children and young people at risk of developing an occipital pressure ulcer an appropriate pressure redistributing surface (for example, a suitable pillow or pressure redistributing pad).**
Discuss with adults at elevated risk of a heel pressure ulcer a strategy to offload heel pressure, as part of their individualised care plan	**Discuss with children and young people at elevated risk of a heel pressure ulcer a strategy to offload heel pressure**
Do not offer skin massage or rubbing to adults to prevent a pressure ulcer	**Do not offer skin massage or rubbing to neonates, infants, children and young people prevent a pressure ulcer**

21.4 Pressure Redistributing Aids and Equipment – handy tips

- **Elevating the foot of the bed** may help to reduce shear and friction forces at the sacral and heel areas by reducing the sliding movement of the patient's body down the bed.
- **Pillows** can be used to reduce the impact of pressure, particularly on the heels. If required, the pillow should be placed under the calves lengthways so that heels are elevated. Ensure that the heel is completely free from the support surface. Pillows can be used in conjunction with the patient's own mattress, static foam mattresses and alternating pressure mattress overlays and replacement systems. It is important to remember that pillows can deflate and may need checking regularly.
- **Heel Protectors** can be used to reduce the impact of pressure on the patient's heels. Foam pressure redistribution boots are available on prescription and should be issued to all patients who are in bed immobilised for 12 hours or more. **Caution in use for patients with lower limb and pedal oedema. In**

these cases consider offloading the heels with soft pillows placed lengthways. Inflatable heel protectors are also available from your local equipment provider however, as with pillows; care must be taken to assess the weight of the limb, reposition the leg and heel regularly and to ensure the device has not become deflated.

- **Electric bed frames** can be used to increase the range of positions available to a patient or carer who cannot reposition them self easily, but who could use a hand control while in bed.
- **Turning Equipment** can be used for patients who are unable to change position due to a medical complaint or pain or discomfort. These can be ordered through your local equipment provider following a full assessment from the pressure ulcer improvement facilitators in Newham or Tissue Viability team in Tower Hamlets. In Bedfordshire these are not routinely available, and an application should be made to the specials panel.

21.5 Maintenance of Equipment

- Equipment can deteriorate due to age and usage; therefore, all pressure redistributing equipment should be checked and maintained in good working order.

- The local equipment provider is responsible for delivering, setting up and maintaining loaned community equipment. Any item of equipment that contains a motor should be checked regularly, this may occur in the patient's home or on the ward if the equipment is still in use, or in the store if returned prior to its assessment date. However, it is the responsibility of the healthcare team looking after the patient using any piece of equipment to ensure that any faults are dealt with appropriately and promptly by informing the relevant authority and requesting a suitable replacement if required.
- Pressure care equipment is allocated on a named patient basis and should be returned to the local equipment provider when no longer required.

22.0 Pressure ulcer management

- All patients with a pressure ulcer should have the pressure ulcer categorised using the EPUAP (2014) classification tool
- A full and detailed wound assessment should be undertaken on first presentation of the pressure ulcer
- Wound assessments should be carried out by a registered health professional who has had training in wound assessment and management
- A wound assessment should be undertaken prior to dressing selection and should be repeated at least weekly.
- If the condition of the patient or wound deteriorates the assessment and treatment plan should be re-evaluated and patient referred to the PUIF or Tissue Viability Service.

Document the surface area of all pressure ulcers. Use a measurement technique such as photography or disposable tape measure. Record length and width

- Document an estimate of the depth of all pressure ulcers, the condition of the wound edge together with the presence of undermining and condition of the peri wound skin.
- Document the type of tissue in wound bed: necrotic, sloughy, granulating, epithelialising. The amount of each type of tissue should be estimated as a

percentage of the whole wound. This is to provide a guide to monitor increase or decrease in development of the type of tissue in the wound bed.

- Document exudate type and levels
- Note any clinical signs and symptoms of infection
- Refer to ELFT wound management guidelines

22.1 Wound Cleansing

- Cleanse wounds, if necessary, with warmed (body temperature) sterile saline or suitable tap water
- Minimal mechanical force should be used when cleansing or irrigating a wound.
- Antiseptic cleansing solutions should not be used routinely for pressure ulcer management.
- Standard Precautions should be maintained and the No Touch Wound Dressing Technique to prevent cross infection. When treating multiple ulcers on the same patient, attend to the most contaminated ulcer last. For example: peri-anal region.
- All pressure ulcers are colonised with bacteria, therefore, swabbing a wound for microbiology, culture and sensitivity (MC&S) should only be undertaken if the patient shows clinical signs of infection and is not improving.
- For Tissue samples please refer to Tissue Viability team
- When using antimicrobial dressings for local infection remember to use for 2 weeks only and refer the patient to tissue viability if not improved. Systemic antibiotics should only be used when there is evidence of systemic infection.

22.2 Debridement

Wounds can be covered by a combination of sloughy, necrotic or devitalised tissue and exudate, which can harbour bacteria and increase the risk of infection, which may delay healing by prolonging the inflammatory response. Debridement is defined as the removal of devitalised tissue from a wound, which allows assessment of wound depth and facilitates healing. When deciding whether to debride a wound the following should be considered: The condition of the patient, wound, and surrounding skin, strength of underlying blood supply, risk of adverse incidents, patient preference and pain level, availability and characteristics of equipment and dressings and the overall goals of treatment.

NICE Recommendations Debridement (NICE 2014)

Adults	Neonates, infants, children and young people
Assess the need to debride a pressure ulcer in adults taking into consideration: • **The amount of necrotic tissue** • **The category, size and extent of the pressure ulcer** • **Patient tolerance** • **Any comorbidities**	**Consider autolytic debridement with appropriate dressings for dead tissue in neonates, infants, children and young people**

Offer debridement to adults if identified as needed in the assessment • Use autolytic debridement using an appropriate dressing to support it • Consider sharp debridement if autolytic debridement is likely to take longer and prolong healing time (seek advice from the tissue viability service) • Do not routinely use larval therapy or enzymatic debridement	Consider sharp and surgical debridement by trained staff if autolytic debridement is unsuccessful (seek advice from the tissue viability service)

NB: For further advice on debridement methods please contact the tissue viability team.

22.3 Dressings and Devices

Use a dressing that promotes a warm, moist wound healing environment to treat category 2, 3, 4 and unstageable pressure ulcers. Please refer to **ELFT Wound Management Guidelines and the Wound Dressing Formulary**

NICE Recommendations Dressings (NICE 2014)

Adults	Neonates, infants, children and young people
When choosing a dressing take into account • Pain and tolerance • Position of the ulcer • Amount of exudate • Frequency of dressing change	When choosing a dressing take into account • Pain and tolerance • Position of the ulcer • Amount of exudate • Frequency of dressing change
Do not offer gauze dressing to treat a pressure ulcer adults	Do not offer gauze dressing to treat a pressure ulcer in neonates, infants, children and young people
Do not routinely offer adults negative pressure wound therapy to treat a pressure ulcer, unless it is necessary to reduce the number of dressing changes (for example, in a wound with a large amount of exudate) in adults	Do not routinely use negative pressure wound therapy to treat a pressure ulcer in neonates, infants, children and young people.

All patients regardless of the healthcare setting will have a multi-disciplinary team approach to their pressure ulcer prevention or treatment. Patients with identified risks factors may require referral to other members of the multi-disciplinary team where appropriate i.e.

- Dietitian (depending on local service agreements)
- Physiotherapist
- Continence advisor
- Tissue Viability Nurse/PUIF
- Podiatrist
- Vascular Surgeons
- Occupational Therapists
- Wheelchair Service

23.0 COMMUNICATION & DOCUMENTATION

23.1 Care planning

Patients who have or are 'at risk' of developing pressure ulcers should have an individualised **SSKIN Bundle** prevention plan which has been discussed with the patient and carer if appropriate.

SSKIN BUNDLEPREVENTION

Surface – Make sure your patients have the right support surface	**S**	• Appropriate mattress ordered and in place and being used? • Mattress calibrated to correct weight of patient if required • Appropriate cushion ordered and in place and being used? • Wheelchair user: check when last seen by wheelchair service • Patient education on use of equipment
Skin – Inspection	**S**	• Has skin assessment been completed and documented? • Check skin at each visit or daily for inpatients
Keep Moving	**K**	• Does the patient have a repositioning chart? • Does the patient have a Physiotherapy care plan if appropriate
Incontinence/ Moisture	**I**	• If patient is incontinent use of appropriate skin care • Does the patient have correct equipment to manage incontinence? • Refer to continence advisor if complex needs
Nutrition	**N**	• Is the patient eating and drinking? • If Weight loss refer to GP/Dietician for supplement advice • SALT for swallowing problems

Patients who have a pressure ulcer category 1-4, unstageable or STDI should have a **SSKIN bundle** treatment plan of care aimed at prevention of deterioration which has been discussed with the patient and carer if appropriate. The plan should include

SSKIN BUNDLE TREATMENT

Surface – Provide the right surface	**S**	• The mattress/cushion is still being used • Check at each visit equipment is in working order • Review equipment as to its effectiveness
Skin - Inspection	**S**	• Pressure ulcer categorised and reported and referred as per guidelines • Are skin assessments completed at each visit or daily for inpatients? • Wound size recorded at initial assessment and re-measured every 4 weeks • Care plan in place to guide treatment • Record pain and document effectiveness of pain relief if required
Keep – moving and repositionin g	**K**	• Repositioning schedule document in care plan • Check carers are following the repositioning schedule • Does the patient understand the need for repositioning
Incontinence	**I**	• If incontinent is this addressed in the care plan • Is treatment effective?
Nutrition	**N**	• Check weight. Measure arm circumference if bed bound or immobile • Encourage balanced diet to aid wound healing • Refer to GP/Dietician if any concerns • SALT if any swallowing problems

23.2 General Communication

- Effective communication between patients, carers and healthcare staff is essential to ensure safe, effective and patient centred care

When a patient has or is ‘at risk’ of developing a pressure ulcer, members from the multidisciplinary team together with the patient should collaborate with the aim of reducing the risk and improving the patient's condition.

- Where a patient with or ‘at risk’ of pressure ulceration is transferred from hospital into the community early liaison must take place in order that the appropriate equipment can be obtained and installed in the patient’s home. In difficult or complex cases, the community nursing team should be invited into the ward prior to discharge.
- Where a patient requires admission to hospital the community team should liaise with the Ward Manager.
- All patients transferred to/from hospitals, back to their own homes or residential/nursing homes should have information transferred with them stating:
    - Their ‘at risk’ score
    - Present condition of their pressure areas/ulcers and skin condition
    - Pressure relieving/distributing equipment
    - Current treatment of ulcers
    - Recommendation of further treatment or care.

23.3 Photography of Pressure Ulcers

National and International Guidelines (NICE 2005, 2011; 2014 EPUAP 2014 Wounds UK 2018) suggest that consideration should be given to the use of photography as a part of the management regime – it provides a tool to monitor healing over time. It is acknowledged that photography is not routinely used in all localities.

Where healthcare professionals have access to photography the following points must be considered:

- The patient’s consent should be obtained before any photograph is taken.
- Obtain written consent from the patient if the photograph is for the purpose of teaching, product evaluations or publication.
- Verbal consent for wound photography can be obtained for the purpose of wound evaluation, triage or to obtain virtual specialist advice from the tissue viability team.
- Give a full explanation to the patient as to reason for taking a photograph and gain consent as above and record in patient record
- The photographer must always check the patient understands what they have consented for and if there is any doubt Mental Capacity to be assessed
- Where the patient lacks capacity to consent. Written consent must be obtained from the next of kin or those with Lasting Power of attorney
- Tidy the area likely to be in the background of the photograph to avoid showing clothing and dressings etc.
- At all times ensure that the privacy and dignity of the patient is maintained
- Use a white pillowcase/sheet or the white drape contained in the dressing packs as background to the area being photographed.

- Always take a locater picture first to identify the part of the body involved
- Take a close up view to show the relevant detail
- All photographs must include the specific site of the body being photographed.
- The patient's initials and date of photograph should be written on the disposable tape measure and placed on the wound prior to the photograph being taken
- Upload the photographs to the patient's computerised notes
- The wound should be photographed at initial assessment and then at least monthly thereafter in order to document the healing progress. However the frequency will depend on the individual wound e.g. if the wound is deteriorating rapidly. Disposable, paper scales have limited value as a measurement tool but can be useful in terms of giving an impression of the extent of a wound, in particular over large curved surfaces (7,8)

24.0 EDUCATION & TRAINING

24.1 Staff Education & Training

All staff who care for patients with or 'at risk' of developing a pressure ulcer should ensure that their knowledge is current, and evidence based. **All clinical staff** who are in contact with patients will complete the online training module on pressure ulcer prevention and management on an annual basis

In addition, pressure ulcer, prevention and management training will be provided by the Pressure Ulcer Improvement Facilitators and Tissue Viability Service as part of their educational programme as required and will include:

- Pathophysiology of pressure ulcer development
- Risk factors and risk assessment tools
- SSKIN bundle
- Skin assessment and care
- Positioning / repositioning
- Selection use and maintenance of support surfaces and equipment
- Incident reporting
- Pressure ulcer grading / classification
- Wound care & dressing selection.

24.2 COMPETENCY ASSESSMENT

Competency assessments for pressure ulcer prevention and management are to be completed annually for all relevant nursing staff caring for patients who are at risk of developing a pressure ulcer

24.3 PATIENT AND CARER EDUCATION

Patients should be encouraged to participate in their pressure ulcer prevention and treatment care plan. They should be provided with information on how to prevent pressure ulcers and maintain skin integrity. Information should be delivered by a trained or experienced healthcare professional and include:

- the causes of a pressure ulcer

- the early signs of a pressure ulcer
- ways to prevent a pressure ulcer
- the implications of having a pressure ulcer (for example, for general health, treatment options and the risk of developing pressure ulcers in the future).
- Demonstrate techniques and equipment used to prevent a pressure ulcer.

Consider individual needs when supplying information to people with:

- degenerative conditions
- impaired mobility
- neurological impairment
- cognitive impairment
- impaired tissue perfusion (for example, caused by peripheral arterial disease).

Families and carers should be trained on how to recognise the early signs of skin damage including the 'React to Red' message (appendix 10) and the 'Shared Care' approach used to promote multi-agency working and continuity of care.

Patient information leaflets are available on the Trust intranet.

24.4 On line Training Tool

An on-line training tool is available on the Trust web site for patients and carers to access and is a useful resource for staff to use when providing patient education
.
http://share.dynamicbusiness.co.uk/2017/ELFT_PPS_2/story.html

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APPENDIX 1

PRESSURE ULCER RISK AND SSKIN BUNDLE FORM: Adult

Pressure Ulcer Risk & SSKIN BUNDLE Assessment Form

Date:	**Completed by:**

Patient's Name:	**NHS No**:

Risk Assessment:	**Waterlow Score**				
Adjusted Risk Level:	Not at Risk		**At Risk**		**At High Risk**
Comment:					

SSKIN BUNDLE ASSESSMENT

SURFACE

Equipment in place	Equipment ordered

SKIN INSPECTION

Front

Back

List signs of skin damage & pressure ulcer (s) category

KEEP MOVING

Mobility / Repositioning Issues	Repositioning regime / Mobility aids
Social Care Package	Carer(s) / Care Agency: Tel:

INCONTINENCE

Urine	Bowels
Products	Products

NUTRITION

Nutritional issues:
BMI or Estimation of BMI category from mid upper arm circumference =
Nutritional Supplement(s):

Has mental capacity to make informed decision	Yes		No	

Pressure ulcer prevention information leaflet given	Date	Signature:
Next Review Date:		

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

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

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

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

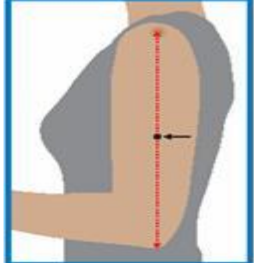
Scores can be discounted after 48 hours provided patient is recovering normally

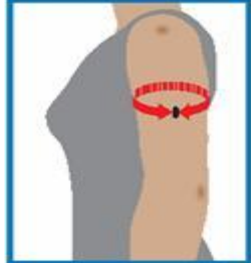
© J Waterlow 1985 Revised 2005*
Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX
* The 2005 revision incorporates the research undertaken by Queensland Health.
www.judy-waterlow.co.uk

SSKIN Bundle – Preventing Pressure ulcers

Surface	**S**	• **Static foam / alternating pressure relieving mattress** • **Mattress calibrated to correct weight of patient if required** • **Pressure relieving cushion** • **Wheelchair / cushion** • **Repose boot / pillow / Aderma dermal pad** • **Patient education on use of equipment**
Skin Inspection	**S**	✓ **Skin assessment** ✓ **Pressure ulcer categoryd and reported and referred as per guidelines** ✓ **Wound size recorded at initial assessment and re-measured every 4 weeks** ✓ **Care plan in place to guide treatment and preventive interventions** ✓ **Teach carers / family** ✓ **Complete the Shared Care Approach to Pressure Ulcer Prevention SSKIN Bundle Guidelines with carer (s) / family**
Keep Moving	**K**	○ **Regular repositioning using 30 degree tilt** ○ **Repositioning schedule regime in care plan** ○ **Check carers are following the repositioning schedule** ○ **Does the patient understand the need for repositioning**
Incontinence/ Moisture	**I**	✚ **Continence assessment / management** ✚ **Catheter** ✚ **Bowels** ✚ **Incontinent pads** ✚ **Barrier cream** ✚ **General skin care**
Nutrition	**N**	❖ **Nutritional assessment** ❖ **BMI or Estimation of BMI category from mid upper arm circumference** ❖ **Eating & drinking** ❖ **Nutritional supplements / thickened fluid** ❖ **Speech and Language Therapist / Dietician**

Estimating body mass index (BMI) category - *Measuring mid upper arm circumference*





Mid-Upper Arm Circumference (MUAC)

- Less than 23.5 cm = BMI less than 20 kg/m_2 – likely to be underweight.
- More than 32.0 cm = BMI more than 30 kg/m_2 - likely to be obese.

APPENDIX 2

PRESSURE ULCER RISK AND SSKIN BUNDLE FORM: Child

Pressure Ulcer Risk & SSKIN BUNDLE Assessment Form

Date:	Completed by:

Patient's Name:	NHS No:

Assessment: Braden Score								
Pressure Ulcer Risk Level	No Risk		At Risk		High Risk		Very High Risk	
Comment:								

SSKIN BUNDLE ASSESSMENT

SURFACE

Equipment in place	Equipment ordered

SKIN INSPECTION

List signs of skin damage & pressure ulcer (s) category

KEEP MOVING

Mobility / Repositioning Issues	Repositioning regime / Mobility aids

CONTINENCE

Passing Urine and opening Bowels Issues
Products

NUTRITION

Nutritional issues:

Pressure ulcer prevention information leaflet given	Date	Signature:
Next Review Date:		

BRAIDEN SCORE:

Notes for use:

- Look at the categories. Go across and read the acuity of illness statements in each box. Match the score to the statement that reflects your patient's current condition. Total the scores for the five categories and your patient will then have a 'at risk' score.
- Scores of 10 or less indicate your patient is at risk of developing a pressure ulcer. You will need to implement the nursing interventions that can be found overleaf.

Risk factor	Score 1	Score 2	Score 3	Score 4
Mobility	**Completely immobile** – does not make changes in body or extremity position without assistance. Patient cannot physiologically tolerate position changes.	**Very limited –** Makes occasional slight changes in body or extremity position but unable to turn self independently.	**Slightly limited** – Makes frequent changes in body or extremity position independently.	**No limitations** – Makes major changes in position without assistance.
Activity	**Bed bound** – Confined to bed.	**Chair bound** – Ability to walk is severely limited or non-existent. Cannot bear own weight. Needs help to get into chair or wheelchair.	**Walks occasionally** – Walks occasionally for short distances with or without help. Spends majority of the time in bed or chair.	**Patients too young to walk or patient walks frequently** – Walks frequently.
Sensory perception	**Completely limited** – Unresponsive to painful stimuli due to altered GCS or sedation. Inability to feel pain over most of body surface.	**Very limited** – Responds to painful stimuli. Cannot communicate discomfort verbally or has sensory impairment, limiting ability to feel pain over half of body.	**Slightly limited** – Responds to verbal commands but cannot always communicate discomfort. Has sensory impairment, limiting ability to feel pain or discomfort in 1 or 2 extremities.	**No impairment** – Responds to verbal commands. Has no sensory deficit that limits ability to feel or communicate pain or discomfort.
Moisture	**Constantly moist** – Skin is kept moist almost constantly, by perspiration, urine, drainage etc. Dampness is detected every time child is moved. Linen, nappy/pad or dressing changes are constant.	**Very moist** – Skin is often but not always moist. Linen, nappy/pad or dressing changes every 2 to 4 hours.	**Occasionally moist** – Skin is occasionally moist. Nappy/pad changes as routine. Dressing/linen changed up to 3 times per day.	**Rarely moist** – Continent. Dressing changes as routine. Linen changed as parent wishes.
Tissue perfusion	**Extremely compromised** – Hypotensive or on inotrope support. Requires mechanical ventilation. Cannot physiologically tolerate position changes.	**Compromised** – Normotensive. Oxygen saturation of <95%. Haemoglobin may be <10mg/dl. Capillary refill may be >2 seconds. Serum pH is <7.35.	**Adequate** – Normotensive. Oxygen saturation of <95%. Haemoglobin may be <10mg/dl. Capillary refill may be <2 seconds. Serum pH is normal.	**Ideal** – Normotensive. Oxygen saturation normal. Normal haemoglobin level. Capillary refill <2 seconds. Normal serum pH.

SSKIN Bundle – Preventing Pressure ulcers

Surface	**S**	• Static foam / alternating pressure relieving mattress • Mattress calibrated to correct weight of patient if required • Pressure relieving cushion • Wheelchair / cushion • Repose boot / pillow / Aderma dermal pad • Patient education on use of equipment
Skin Inspection	**S**	✓ Skin assessment ✓ Pressure ulcer categoryd and reported and referred as per guidelines ✓ Wound size recorded at initial assessment and re-measured every 4 weeks ✓ Care plan in place to guide treatment and preventive interventions ✓ Teach carers / family ✓ Complete the Shared Care Approach to Pressure Ulcer Prevention SSKIN Bundle Guidelines with carer (s) / family
Keep Moving	**K**	○ Regular repositioning using 30 degree tilt ○ Repositioning schedule regime in care plan ○ Check carers are following the repositioning schedule ○ Does the patient understand the need for repositioning
Incontinence/ Moisture	**I**	Continence assessment / management Catheter Bowels Incontinent pads Barrier cream General skin care
Nutrition	**N**	❖ Nutritional assessment ❖ BMI or Estimation of BMI category from mid upper arm circumference ❖ Eating & drinking ❖ Nutritional supplements / thickened fluid ❖ Speech and Language Therapist / Dietician

APPENDIX 3

EQUIPMENT PROVISION

EQUIPMENT PROVISION

Newham – Community	**Enabled Living Health Care Ltd** Order through Equipment co- Ordinator's based at Vicarage Lane Health Centre and East Ham Care Centre
Newham, Tower Hamlets, City & Hackney Mental Health Services	Order from Direct Mobility Telephone number: 02083707888.
Tower Hamlets	Order through Community Equipment Stores attaching page 6 of the Tower Hamlets equipment passport.
Bedfordshire – WECHS	New contract in place with Westmeria for equipment in patients' homes and residential homes and will continue to provide preventative equipment. The engineers delivering the equipment set up the equipment and provide any advice to staff in regard to how to manage the equipment. WECHS has their own equipment for inpatient areas, but this will be decontaminated by Westmeria.
Bedfordshire – SECHS	Contract in place with Westmeria to provide equipment in patients' homes and residential homes. This contract is presently being reviewed to cover preventative equipment. The engineers delivering the equipment set up the equipment and provide any advice to staff in regard to how to manage the equipment.
Bedfordshire – CHSB	Contract in place with Millbrook for equipment in patients' homes and residential homes and will continue to provide preventative equipment. The engineers delivering the equipment set up the equipment and provide any training required to the carers. Further equipment training is also provided for all staff across local authorities and community health services staff to attend.

BEDFORDSHIRE & LUTON COMMUNITY SERVICES:
PLEASE FOLLOW THE PRESCRIBER GUIDELINES AND ORDERING CRITERIA FOR PRESSURE CARE CATALOGUE ITEMS.
April 2017

APPENDIX 4

Shared Care Document

Pressure Ulcer Prevention

Shared Care Approach to Pressure Ulcer Prevention

SSKIN Bundle

Guidelines for Staff

1. Introduction

The purpose of this guideline is to provide health and social care staff working within community services with information in relation to a shared care approach to pressure ulcer prevention in the community.

Joined up health and social care is essential to improve the quality of care people receive and to ensure 'harm free care'. Pressure ulcers are a key quality indicator and all staff involved in caring for patients in the community should ensure that care is appropriate, safe and in the best interests of the person.

Health and social care in the UK is undergoing rapid change as organisations restructure the delivery of services in order to provide the most efficient and effective care to service users. This has led to not only utilising health care workers in different ways to provide additional duties of care, but also has implications for informal/ formal carers in terms of the advice they are given and specific roles they are asked to perform as part of the actual care of the patient.

East London Foundation Trust and their partners in social care are committed to working together to ensure patients do not develop avoidable pressure ulcers and have produced this document to promote best practice in pressure ulcer prevention and support an integrated approach to care.

It is recommended that the community nurse/team leader works with the patient and their carers to identify the patients risk of developing pressure ulcers and puts in place a care plan to meet the patient's needs. This will involve ensuring that patients and carers have the necessary understanding to reduce risk factors and identify the early stages of pressure ulcer development. The following checklist should be used to support the discussions and observations of practice to ensure pressure ulcers are prevented.

Pressure Ulcer Prevention: Shared care checklist

<table>
<tr><th>Please indicate with ✓ if active and date and sign</th><th>✓</th><th>Date</th><th>Carers Name receiving information</th><th>Signed
District nurse</th></tr>
<tr><td>Please ensure information and procedures specific to the patient's condition are explained, taught and observed.
All aspects of specific care plan for pressure ulcer prevention discussed and explained to patient and carers. Ensure the patient has mental capacity to make decisions regarding their care.

I have discussed with the carer:
• The importance of undertaking a full skin inspection especially over bony prominences, looking out for any redness, discolouration, localised heat, odema or induration
• The importance of regular repositioning, ensuring pressure relief
• How to check the mattress and cushion to ensure it is functional
• The importance of a healthy diet
• How to contact the team if concerned about skin integrity
• An information leaflet on prevention has been provided

The carer has observed
• The nurse undertaking a full skin inspection and what signs to look out for.
• The nurse performing the basic repositioning techniques.
• The nurse checking the mattress and cushion
• They have a good awareness of what a healthy diet entails.

• I have observed the carer performing a skin inspection and re positioning the patient. They feel competent to do this. I feel they are able to deliver this care with on-going support.</td><td></td><td></td><td></td><td></td></tr>
</table>

Review Date	Team Leader responsible	Contact details

Pressure Ulcer Prevention and treatment plan. Each patient should have an individualised care plan to address their needs. The community nurse will go through the care plan with the patient and carers following the check list below.

SSKIN BUNDLE
PREVENTION

Surface – Make sure your patients have the right support surface	**S**	• Appropriate mattress ordered from ICES and in place and being used? • Mattress calibrated to correct weight of patient if required • Appropriate cushion ordered from ICES and in place and being used? • Wheelchair user: check when last seen by wheelchair service • Patient education on use of equipment
Skin – Inspection	**S**	• Has skin assessment been completed and documented?
Keep Moving	**K**	• Does the patient have a repositioning chart?
Incontinence/ Moisture	**I**	• If patient is incontinent use of appropriate skin care • Does the patient have correct equipment to manage incontinence? • Refer to continence advisor if complex needs
Nutrition	**N**	• Is the patient eating and drinking • If Weight loss refer to GP/Dietician for supplement advice

SSKIN BUNDLE
TREATMENT

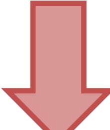
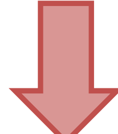
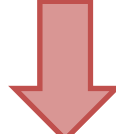
Surface – Provide the right surface	**S**	• The mattress/cushion is still being used • Check at each visit equipment is in working order • Review equipment as to its effectiveness
Skin - Inspection	**S**	• Pressure ulcer categoryd and reported and referred as per guidelines • Are skin assessments completed at each visit? • Wound size recorded at initial assessment and re-measured every 4 weeks • Care plan in place to guide treatment • Record pain and document effectiveness of pain relief if required
Keep – moving and repositionin g	**K**	• Repositioning schedule document in care plan • Check carers are following the repositioning schedule • Does the patient understand the need for repositioning
Incontinence	**I**	• If incontinent is this addressed in the care plan • Is treatment effective?
Nutrition	**N**	• Check weight. Measure arm circumference if bed bound or immobile • Encourage balanced diet to aid wound healing • Refer to GP/Dietician if any concerns

APPENDIX 5

PATHWAY FOR PATIENTS AT RISK OF DEVELOPING PRESSURE ULCERS ON THE HEELS

PATHWAY FOR PATIENTS AT RISK OF DEVELOPING PRESSURE ULCERS ON THE HEELS

Patient admitted to the case load and identified at risk of developing pressure ulcers

Patient is fully Mobile

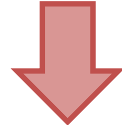
Implement SSKIN Bundle prevention care plan

Patient is in bed and immobilised for 12 hours

Implement SSKIN Bundle Prevention Care Plan

Patient Immobilised and nursed in bed continuously

Implement SSKIN Bundle Prevention Care Plan



UNIVERSAL PRECAUTIONS

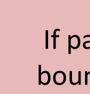
Inspect feet and heels every visit or each shift if an inpatient and advise patient/carers/relatives how to do this daily in-between visits.

Apply moisturiser such as 50% soft white paraffin and 50% liquid paraffin and follow universal heel precautions

Do not apply socks if too tight

Document condition of heels in EMIS/RIO progress notes after each visit

If patient becomes Ill and needs to be nursed in bed for 12 hours or more Follow Prevention Precautions



PREVENTION PRECAUTIONS

Follow Universal precautions, plus:

Elevate heels off the bed using Devon boots
If Oedema present offload using a soft pillow

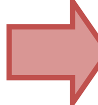
Prevent friction in agitated patients by applying loose, soft socks

Reposition 2-3 hourly

Mobilise as soon as able

Teach alert patients a range of active foot exercises to move the ankle while awake

If patient becomes bed bound follow Strict Heel precautions



STRICT HEEL PRECAUTIONS

Follow Universal and prevention precautions, plus:

Float heels in Repose, Heellift or Harvest Healthcare boots

Assess the fit of boots each visit or each shift for inpatient

Consider heel protectors to maintain the foot at 90 degrees ankle flexion if at risk of foot drop (Prevalon Boots)

If patient is able, get up out of bed into a chair at least 3 times per day. Ensuring they sit on a pressure relieving cushion

APPENDIX 6

PRESSURE ULCER REPORTING PATHWAY FOR ADULTS & CHILDREN IN THE COMMUNITY and IN-PATIENT SETTINGS (PHYSICAL & MENTAL HEALTH)

Patient presents with category 2-4 pressure ulcer

Complete Datix Incident Report
Incident reporting team liaise with PU Grading Panel who will review the Incident
If PU grading panel agree for Serious Incident Reporting (SIR) – team to complete PU report within 72 hours
Incident reporting team to share PU report with CCG within 72 hours
If PU grading panel do not agree for SIR – team to complete RCA report within 7 days
RCA presented at Pressure ulcer Panel (CHN/THCS) or Skin Matters Group (BCHS)

For **ELFT acquired** category 3 and 4 PU's, team to complete Duty of Candour within 10 working days using the DOC letter template

National criteria for serious harm in relation to pressure damage for SIR are that pressure ulcers result in:

- Loss of limb
- Loss of life
- Requiring surgery for the pressure ulcer
- Transfer for care of pressure ulcer
- Cluster of pressure ulcers in a clinical area
- At the provider organisation discretion

No: Local investigation using Root Cause Analysis (RCA) tool, evidence of best practice (SSKIN bundle) and action plan

Yes: Incident team report on STEIS and allocated for External SIR Investigation 60 days and feedback learning to team

Raise a Safeguarding concern for category 3 and 4 and multiple Category 2 pressure ulcers if the pressure ulcer has arisen as a result of **poor practice, suspected neglect/abuse or an act of omission** (DOH 2018) by completing the Local Authority (LA) Safeguarding alert form and submit electronically to LA safeguarding team and attach copy to Datix.
See DOH (2018) Decision Process Tool for guidance

RCA reviewed by the Pressure Ulcer Panel/Skin Matters Group
RCA presented by the Team Leader/Clinical lead. Lessons learnt identified and Action plans taken back to the teams for shared learning and implementation of any actions for improvement
If safeguarding concern identified and not reported in previous step raise now.
The outcome of the RCA where safeguarding concerns identified will be shared with the LA Safeguarding team

If the condition of the patient changes (i.e further skin breakdown/deterioration of PU) or the patient dies, staff to report on Datix again regardless of this being reviewed at the PU panel/ Skin matters Group

All RCAs and SI reports are uploaded on DATIX within 24 hours of completion.
Tracker report is held by the Governance Facilitator.

SIR Report to Trust Board and Commissioners.

ELFT to report all non ELFT acquired pressure ulcers to the CCG with only NHS number and the external organisations name

Appendix 7

Bedfordshire Community Services
Pressure alert Form

Pressure Alert Form

(for Pressure Ulcers acquired outside of care)

About the Incident					
Incident Ref :		Alerting organisation:	ELFT	Location e.g. name of hospital:	
Unit / Team/ Ward/ e.g.:		Date PU identified:		Date of notification:	
Was the pressure ulcer present on admission to your service? Yes No ☐ ………………..…					

Patient Details				
Name:	Address:	NHS Number:	DOB:	GP Practice:
Known to e.g. District Nurses, Mental Health, GP: Yes ☐ Which service **1..2...3...** No ☐ Unknown				

Where was patient from? Please name the residential or nursing home/ward/hospital				
Own Home ☐		Care Home	Acute Hospital ☐ (Name):	Other ☐ (Name):

Summary of the incident				
Site (e.g. Sacrum)		**Wound Size ()**	**Ulcer category**	
			3	**4**
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐

Patient information
Date of admission:
Reason for admission:
Relevant medical history including medication:

Previous services / wards the patient has used

Please explain the possible causes of the pressure ulcer

Immediate actions taken

Patient outcome at time of notification *e.g. remained in-patient, transferred, stayed at home, died:*

Alert completed by							
Name:		Role:		Telephone:		Date:	

APPENDIX 8

Safeguarding Decision Process

Decision Process to aid reporting Pressure Ulcers to Local Authority Safe Guarding Team

1. Concern is raised that a person has severe pressure damage Category 3, 4, unstageable, suspected deep tissue injury or multiple sites of Category 2 damage (EPUAP, 2014)

2. Complete adult safeguarding decision guide and raise a DATIX incident report immediately as per Trust policy.

Score 15 or higher? Concern for safeguarding

IF YES:

Discuss with the person, family and/ or carers, that there are safeguarding concerns and explain reason for treating as a concern for a safeguarding enquiry.

1. Refer to local authority via local procedure, with completed safeguarding pressure ulcer decision guide documentation.

2. Follow local pressure ulcer reporting and investigating processes.

3. Record decision in person's records.

IF NO

Discuss with the person, family and/ or carers, and explain reason why not treating as a safeguarding enquiry.
Explain why it does not meet criteria for raising a safeguarding concern with the Local Authority, but then emphasise the actions which will be taken.

1. Action any other recommendations identified and put preventative/ management measures in place.

2. Follow local pressure ulcer reporting and investigating processes.

3. Record decision in person's records.

Adapted from Pressure Ulcer Protocol: Department of Health & Social Care (2018)

Adult Safeguarding Decision Guide for people with Category 3, 4 or unstageable pressure ulcers or multiple category 2 pressure ulcers or SDTI

Patient: **NHS Number**

Q	Risk Category	Level of concern	Score	Evidence
1	Has the patients skin deteriorated to either category 3, 4, unstageable or multiple category 2 pressure ulcers from healthy skin since the last skin assessment	**YES** Record of blanching or non-blanching erythema/category 2 pressure ulcer progressing to category 2 or more	**5**	Evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		NO No previous skin integrity issues or no previous contact with health or social care services	**0**	
2	Has there been a recent change? i.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care, critical illness	**YES** Change in condition contributing to skin damage	**0**	
		No change in condition that could contribute to skin damage	**5**	

3	Was there a pressure ulcer risk assessment or reassessment with appropriate SSKIN Bundle prevention/treatment plan in place and documented? In line with Trust policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	**0**	State date of assessment Risk tool used Score / Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	**5**	What elements of care plan are in place
		No Risk assessment or incomplete risk assessment and/or care plan carried out	**15**	What elements would have been expected to be in place but were not
4	Is there a concern that the Pressure Ulcer developed because of the informal carer wilfully ignoring or preventing access to care or services	No/not applicable **YES**	**0** **15**	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk–Category/ category 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	**0**	
		Skin damage more severe than patient's risk assessment suggests is proportional	**10**	
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some		**0**	

	but not the entire care plan			
a	Was the patient compliant with the care plan having received information	Patient has not followed care plan and local concordance policies have been followed		
		Patient followed some aspects of care plan but not all	**3**	
		Patient followed care plan or not given information to enable them to make an informed choice.	**5**	
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	**0**	
		No documentation of care being undertaken in patient's best interests	**10**	
TOTAL SCORE				
HCP Assessing:				
Job Title				
Date				

If the score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and reflecting the urgency of the situation. When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes.

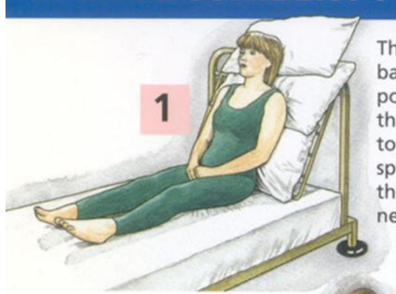
Appendix 9

30 Degree Tilt

SIMPLE....SAFE.... EFFECTIVE.... 30° *TILT*

SEMI-RECUMBENT POSITION

1



The patient's lower back should be positioned as far into the pillows as possible, to support the lumbar spine. Plump or fold the lower pillow if necessary.

2

An additional pillow is placed underneath the others. The corner is carefully positioned under the buttock to *'tilt'* the body and give clearance to the ischial tuberosities and sacrum.

3

The legs are supported as in diagram 3 and 4 of the recumbent position. Ensure that the heels are clear of the mattress and that the feet are correctly positioned.

4

The full semi-recumbent 30° *'tilt'* position.

RECUMBENT POSITION

1

Lie the patient in the centre of the bed. Use one or two pillows to support the head and neck.

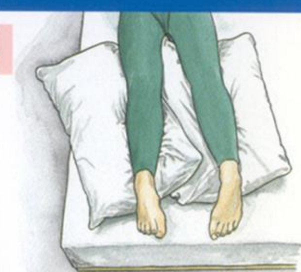
2

Use a further pillow to support the lumbar region and shoulder. This *'tilts'* the patient onto one buttock and lifts the sacrum clear of the mattress. Use your hand to check this clearance.

3

Support the full leg by placing it centrally on another pillow. Ensure that the heel overhangs the edge of the pillow.

4



An additional pillow gives further comfort to any unsupported areas of the other leg.

5

The full recumbent 30° *'tilt'* position.

POINTS TO REMEMBER

1. Illustration 6 demonstrates the necessity to use an additional pillow to prevent 'drop foot'.
2. It is important to explain the whole procedure to the patient, prior to repositioning, and to continue reassuring them.
3. Remember to ask the patient if they are comfortable and check their position at regular intervals.
4. The 30° tilt is used to promote patient comfort and reduce pressure over high risk areas. It should be used with, and not in place of, an appropriate pressure reducing support surface/mattress.

6

SUPPORT AND COMFORT

30° TILT POSITIONING TECHNIQUE - REFERENCES

Preston KW (1988) Positioning for comfort and pressure relief: the 30 degree alternative. *Care - Science and Practice* 6 (4): 116-119. **Seiler WO, Allen S, Stahelin HB (1986)** Influence of the 30 degree laterally inclined position and the 'Supersoft' 3 piece mattress on skin oxygen tension on areas of maximum pressure - implication for pressure sore prevention. *Gerontology* 32: 158-166. **Seiler WO, Stahelin HB (1979)** Skin oxygen tension as a function of imposed skin pressure - implication for decubitus ulcer formation. *J of Am Geriatric Soc* XXV11 (7): 298-301. **Colin D, Abraham P, Preault L, Bregeon C, Saumet J-L (1996)** Comparison of the 90° and 30° laterally inclined positions in the prevention of pressure ulcers using transcutaneous oxygen and carbon dioxide pressures. *Adv Wound Care* 9:3.

Medical Support Systems Limited, Nantgarw Business Park, Cardiff CF4 7QU. Tel: 01443 849200. Fax: 01443 843377

Produced by Medical Support Systems in association with:- Mr W. Haughton, CNS Tissue Viability, Wirral Hospital NHS Trust • Mrs M Fear-Price, Community Specialist, Community & District Nursing Association

APPENDIX 10

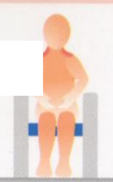
A guide to basic seating

A GUIDE TO BASIC SEATING

MSS Flo-tech
A Range of Shaped Pressure Reducing Cushions

A correctly fitted seat ensures good posture, pressure care and comfort.

ARM RESTS TOO LOW



No Support - Poor Posture
Leads to a slumped sitting position. Social interaction may be compromised.

ARM RESTS TOO HIGH

Uncomfortable - Poor Posture
High pressure under the elbows. May be difficult to eat and drink.

SEAT TOO NARROW

Difficult to Get In and Out
Allows no movement in the seat.

SEAT TOO WIDE

No Support - Poor Posture
No stability may lead to fixed spinal deformities with time.

CORRECT ARM REST HEIGHT & SEAT WIDTH

Good Posture and Support
The correct size seat provides good pressure care, good sitting posture and allows the individual to move in the seat.

CHECK AND REPLACE CUSHIONS REGULARLY.

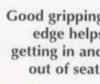
Good all-round visibility for social interaction

May need additional support under cushions to prevent seat sag.

To prevent chaffing, ensure the cushion does not have a seamed or piped front edge.

Use chair raisers for low seats.

A back cushion can be used to reduce seat length & improve comfort.



Good gripping edge helps getting in and out of seat.

CONSIDER HOW LONG A PERSON WILL BE SITTING IN ONE CHAIR OR IN ONE POSITION

A seat cushion can be used to increase height and vary the effective height of the arm rests.

Consider a pressure care cushion in place of the standard item

ENSURE REGULAR CHANGES OF POSITION OR ALTERNATIVE SEATING.

Ensure feet are correctly supported on footplates.

Always use a cushion that gives pressure care and comfort.

SEAT TOO LOW

Difficult to Get Out
Body weight is supported on a small area. This leads to high pressures under the buttocks.

SEAT TOO HIGH

Difficult to Get In
High pressures at the back of the thigh restrict blood flow. Ankle deformities may result as there is no support for the feet.

SEAT TOO SHORT

Poor Balance and Support
Body weight is supported on a small area. High pressures are produced, as the feet are being used for balance and posture.

SEAT TOO LONG

Uncomfortable
Limited knee and ankle flexion may cause poor posture and high pressures at the back of the knees and the sacrum.

CORRECT HEIGHT AND DEPTH

Good Posture and Support
The body weight is evenly distributed along the sitting area, thus reducing pressure. The feet are positioned and supported correctly.

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PROVIDING CARE & PROTECTION

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