Derby Teaching Hospitals NHS
NHS Foundation Trust

TRUST POLICY FOR THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

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TRUST POLICY FOR

PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

1. Introduction

Pressure Ulcers are caused when an area of skin and/or the tissues below are damaged as a result of being placed under sufficient pressure or distortion to impair the blood supply. Pressure ulcers are a complex health issue and represent a major burden on not only the patient, but also the commissioners and providers of healthcare. They can reduce quality of life, and lead to other life threatening complications for patients.

This policy outlines the Trust's approach for the prevention and management of pressure ulcers within Derby Teaching Hospitals Foundation Trust. This policy and the supporting guidelines for prevention and management of pressure ulcers, place an emphasis on a professional nurse led, collaborative multidisciplinary process of identifying risk factors and implementing appropriate preventative and/or treatment measures.
This policy promotes the provision of holistic care and incorporates the facilitation of the following guidelines:

- Essence of Care Pressure Ulcer Benchmarks. (Department of Health, 2010)
- NICE (National Institute of Clinical Excellence) Guidelines. (Department of Health, 2014)
- European Advisory Pressure Ulcer Guidelines (EPUAP, 2014)
- Commissioning for Quality and Innovation (CQUIN) framework (Department of Health,2009)
- High Impact Actions (NHS Institute of Innovation and Improvement, 2009)
- Leading improvement in patient safety (NHS Institute of Innovation and Improvement, 2009)

The implementation of "Aspiring for Excellence" aims to help health professionals and their teams understand the elements of the quality framework with regard to nursing practice. Health professionals will improve their performance against "quality at the heart of everything we do" (Department of Health, 2008).The following three domains are crucial to achieving quality in Pressure ulcer prevention and management:

- Patient Safety
- Patient Experience
- Effectiveness of Care

2. Purpose and Outcomes

This policy is intended for use for adults, young people, children, infants and neonates. Please refer to guidelines for additional advice. The purpose of this policy is to ensure that the Trust prevents avoidable pressure ulcers and manages existing pressure ulcers effectively. The majority of acquired ulcers are believed to be avoidable (NICE, 2015). This is reflected in pressure ulcers forming one of the four key elements captured within the National Patient Safety Thermometer (PST).

Successful prevention depends upon removing or modifying the causes of pressure ulcers and to this the organisation has taken a zero tolerance to pressure ulcers.

Process measures:

- Develop and facilitate effective reporting systems to monitor pressure ulcer incidence and prevalence.
- Develop and facilitate the implementation of local monitoring systems for the reporting of agreed indicators for Quarterly CQUIN reports.

Outcome measures:

- Sustained reduction in avoidable stage 3 and 4 pressure ulcers. 100% reduction from the March 2014 baseline.
- Overall reduction in stage 2 pressure ulcers by 100% from the March 2014 baseline.

Local Indicator measures:

- Increase compliance and accuracy of pressure ulcer screening and risk assessment within two hours of admission to 96% by 2018.
- Increase the implementation of appropriate prevention care plans and SSKIN bundles within 6 hours of patient identified 'at risk' to 96% by 2018.
- Increase the evaluation of care/management plans daily by 96% by 2018.
- Increase evidence of compliance with Duty of Candour.

3 Definitions Used

Pressure Ulcers: "A localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or in combination with shear" (EPUAP, 2014).

Stage of Pressure Ulcer (also known as grade or classification): EPUAP's description of the level of skin tissue damage caused by pressure on a scale of 1-4. See Appendix I for full classifications.

Avoidable Pressure Ulcer: "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the person's needs and goals; and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate." (National Patient Safety Agency, 2010)

Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the person's needs and goals; and recognised standards of

practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence" (National Patient safety Agency, 2010)

SI: Serious Incident, A report of a clinical incident where actions or omissions of actions may have led to, or contributed to the development of avoidable damage

IQAG: Incidence Quality Assurance Group containing members of the risk and quality teams who scrutinise SI reports for accuracy prior to sending to IRG group and CCG

IRG: Incident Review Group- Senior Managers and Nurses Group who review Serious Incidents and may make recommendations to help address clinical learning summarised in SI Reports.

RCA: Root Cause Analysis- investigation of all elements of care and factors present that contributed to the development of damage.

STEIS: The Strategic Executive Information System, Department of Health

CCG: Clinical commissioning Group

SSKIN: Acronym for preventative measures: **S**kin, **S**urface, **K**eep moving, **I**ncontinence, **N**utrition

ANTT: Aseptic Non Touch technique

SCALE: Skin Changes At Life's End

4. Key Responsibilities/Duties

Pressure ulcer prevention is complex, as ulcers are often caused by a combination of factors which require a multidisciplinary and holistic approach to patient care. Continuity of care is crucial for success in preventing pressure damage in the 'at risk' patient. Risk factors such as poor nutrition, previous history of ulcers, diabetes, poor posture, mobility and the presence of co-morbidities need to be included in the prevention care plan/pathway and where necessary referred to the appropriate discipline so that appropriate and timely interventions can be implemented to help minimise those risk factors.

All staff disciplines have a role to play in pressure ulcer prevention, ensuring a consistent and standardised approach to ensuring concordance to Essence of Care Standards within their care setting.

4.1 Director of Patient Experience/Chief Nurse

The director of patient experience/Chief Nurse is responsible for ensuring a proactive and systematic approach to the prevention and management of pressure ulcers.

4.2 The IQAG and IRG

These groups have the responsibility to review and sign off the SI Clinical Learning summary reports on stage 3 and stage 4 avoidable pressure ulcers.

4.3 Risk Services

In collaboration with the Clinical Governance Facilitators, Risk services will ensure stage 3 and stage 4 pressure ulcers are reported through to the commissioners, via a STEIS report in line with reporting arrangements. Risk services will also notify appropriate Matrons/ Community leaders to undertake RCA's within their area.

4.4 The Tissue Viability Team

The Tissue Viability team will act as facilitators to ensure effective pressure ulcer prevention and management becomes an underlying principle in all aspects of health care delivery systems. They will provide regular reports to raise awareness of common themes and seek support in implementing a corporate approach.

The Tissue Viability Team will strive to ensure that informed healthcare workers deliver consistently high standards of care based on the best available evidence.
Policies, procedures and guidelines will be evidence based and relevant to the activity of the Trust.

On notification of a new stage 3 or 4 pressure ulcer, the Tissue Viability Team will confirm the aetiology, severity and grade of the ulcer identified on the Datix report. The Tissue Viability team will notify Risk services of the pressure damage and identify the appropriate clinical area to compile and organise an RCA to investigate issues that led to skin breakdown within agreed time standards.
If a pressure ulcer develops whilst within the care of the Trust, the Tissue Viability team will inform patients with mental capacity, at the time of assessment, that an investigation into how they developed the pressure ulcer will be undertaken. Ward staff will be asked to discuss with Next of Kin for those patients without mental capacity.

The Tissue Viability Team will develop an education strategy that supports an enabling process, whereby, Clinical Facilitators, Link Nurses are educated, supported and empowered to deliver, disseminate and promote quality care. This will involve access to a Tissue Viability web site with access to educational resources and materials.

4.5 Clinical Governance Facilitators

Clinical Governance Facilitators will quality assure and sign off clinical learning and action plans from SI reports prior to sending to IQAG so that clinical learning trends are summarised and presented to the IRG group.

Corporate systems such as Ward Assurance audits, the Excellence audit, the Patient Safety Thermometer and Datix clinical incident reporting are available for monitoring standards in care as well as collecting incidence and prevalence data. The ward assurance tool helps monitor compliance to key standards. The Excellence audit monitors the quality of the compliance in relation to time standards and accuracy of assessments made.

Clinical Governance facilitators promote compliance to these systems and ensure the provision of services and systems locally to effectively support Tissue Viability management.

4.6 Matrons/ Sisters

Matrons and ward Sisters have a key role in promoting and facilitating the Essence of Care benchmarking standards in pressure ulcer prevention and compliance to NICE Guidelines. They will act as role models and create a culture where Tissue Viability is seen as an integral part of all clinical and professional activities. This will help ensure standardization in care for all at risk patients.

The use of local monitoring systems in relation to High Impact Actions including pressure ulcers will provide data to help influence ward teams to make necessary changes in practice. Implementation of key preventative interventions, such as risk assessments and provision of appropriate care interventions will be monitored on the Ward Assurance Tool. Incidence/Prevalence data and concordance to Essence of Care Standards will be monitored to help identify the effectiveness of the implementation of this policy.

The Ward Sister is responsible for investigating the development of a stage 3 or 4 pressure ulcer in their area by undertaking a Root Cause Analysis (RCA). If this is delegated to other staff the Ward Sister remains responsible for quality assuring the reports and ensuring the investigation is completed within time standards. The report must demonstrate factors that led to the development of damage, evidence of care provided or omissions in care and an action plan indicating measures introduced to minimise risks of reoccurrence. A pressure ulcer Root Cause Classification criteria tool is available to help staff identify where ulcers are Avoidable/Unavoidable (See Appendix II).
The completed RCA report and action should be forwarded to Risk Services and kept on file so that trends and action plans on avoidable pressure ulcers can be monitored.

4.7 Clinical Staff

Every health care professional caring for patients at risk of pressure ulcers will be accountable for ensuring that all patients are offered consistently high quality of care. Employees are responsible and will:

- Be held accountable for following the Trust pressure ulcer policy.
- Access essential to role training every two years. Level 3 for all Qualified staff and level 2 for Non-Qualified staff.
- Challenge unsafe practice.

- Raise awareness of patients pressure ulcer risk status.
- Advise patients on preventing pressure damage.

4.8 Medical Staff

Medical staff must be informed when a full thickness pressure ulcer develops in a patient under their care. Medical staff should review the pressure ulcer damage and where appropriate treat infections and organise surgical assessment where surgical debridement may be required.

4.9 The Patient

The patient plays a key role in the successful implementation of the SSKIN Bundle. Patients will be informed of their individual risks and any preventative strategies that are required in order to promote compliance. Patients need to be informed to notify staff of any problems that may develop.

5. Prevention and Management of Pressure Ulcers

The Trust has incorporated the Essence of Care benchmarking standards, European Pressure Ulcer, NICE guidelines and High Impact Actions including a SSKIN Bundle into the Local Tissue Viability Guidelines and documentation tools.

The successful implementation of this policy relies on a dynamic education and awareness programme for all staff disciplines. This will include essential training updates and awareness training for various multidisciplinary groups.

The supporting guidelines of this policy are based on evidence of effectiveness from systematic reviews of randomised control trials where available, together with published clinical evidence from respected authorities/experts. A number of protocols have been introduced to promote a standardised approach to prevention.

5.1 Key Standards in Risk Assessment

- All patients will be risk assessed within 2 hours of admission to secondary care. If the patient is too unstable to assess he/she will immediately be identified as being at high risk.
- Risk assessment is undertaken by a trained healthcare professional who is responsible for attending training updates and being familiar with the tool used in their clinical area. Appendix III contains tools used in different clinical areas.
- The clinician identifying the risk has a duty to communicate it, document it and implement preventative measures.
- All formal assessments of risk must be documented, timed, dated and made accessible to all members of the inter-disciplinary team.
- Following assessment, and identification of ‘at risk’ status, all intrinsic and extrinsic factors contributing to risk will be addressed and recorded within an individual plan of care or SSKIN bundle pathway. This is found within the pressure ulcer prevention care pathway.
- Re-assessment of risk will occur at least weekly and/or on a general change in patient’s condition.

- The individualised plan of care will be evaluated at least weekly and on changes to patients condition

5.2 Key Standards in Skin Assessment

- All people who have been assessed as being at risk of developing a pressure ulcer will be offered a skin assessment by a trained healthcare professional.
- Patients, who decline skin assessment, should be advised of the importance of assessment and monitoring. They should be advised of their responsibility for letting staff know of any pain/numbness/soreness they experience over a bony prominence.
- Patient skin checks will be offered regularly, particularly if the patient is unlikely to feel a problem developing.
- Where appropriate, patients and carers will be provided with information to enable self-skin assessment.
- During inspection of the patient's skin, the skin blanching test will be carried out on all visible red areas of skin.
- For patients with darkly pigmented skin, the skin blanching test is not reliable and an appropriate alternative skin assessment will be undertaken.
- Initial skin inspection will be incorporated within the risk assessment process. This will take into account **all** bony prominences to identify early signs of tissue damage.

5.3 Repositioning for patients with compromised ability to move

The frequency of repositioning will be reviewed regularly and determined by the results of skin inspection and the individual needs of the patient rather than by ritualistic practice. It is best practice to initially commence two hourly repositioning in the critically ill patient, but the frequency of repositioning can be reduced as skin and patient comfort tolerates and skin and general condition improves.

5.4 Support Surfaces

- Prevention in individuals 'at risk' will be provided on a continuous basis during the time that they are risk. Support surfaces will be selected based on individual patient circumstances.
- At minimum a high specification foam mattress will be provided for all individuals assessed as 'at risk'
- Patients at higher risk of pressure ulcer development, where ulcers are present, have limited movements and require frequent repositioning an active alternating support surface will be considered.
- Bariatric equipment will be sourced for those patients that exceed the manufacturers weight limits.
- Staff will implement cleaning and maintenance of equipment as outlined in manufacturer's instructions and local guidelines.

5.5 Nutrition

All patients will have a MUST nutritional score completed which will be appropriately recorded. Staff will maintain hydration to promote adequate circulatory volume and

good skin and tissue perfusion. If indicated by the nutritional assessment, nutritional intake will be monitored and 'at risk' patients will be referred to a dietician

5.6 Documentation of Pressure Ulcers

Classification;
All pressure ulcers will be staged/graded/categorised using the EPUAP Classification System. Pressure ulcers should **not** be reverse graded. A stage 4 pressure ulcer *does not* become a stage 3 as it heals; if the ulcer is seen to be improving it should be described as recovering stage 4 pressure ulcers (EPUAP, 2014).

Staff must use objective and clear descriptions of the condition of the most vulnerable pressure area sites on each shift or each client visit so that any early adverse changes can be more easily identifiable, reported and addressed.
Staff will be trained on how to recognize the various presentation of pressure damage so that they are prompted to introduce the appropriate interventions. The Trusts Prevention Care pathways and Wound Management Pathways provide prompts for staff to introduce appropriate care to manage patients at risk or who have pressure ulcers.

Inherited Pressure Ulcers;
All pressure ulcers present on admission to hospital/caseload will be assessed and reported as a clinical incident on Datix. Patient consent should be obtained for photographs of stage 3 and 4 ulcers to support documentation and facilitate evaluation of wound progress. If a patient is admitted/transferred with a pressure ulcer and the dressing is soiled, leaking or disturbed, the dressing should be removed immediately and the wound assessed and redressed. Staff must ensure appropriate preventative interventions are introduced and implemented.

Where the patient's condition is unstable or where the patient refuses skin assessments or the a dressing is clean and intact, the wound should be discussed with District Nurse, Nursing Home or referring hospital and details recorded. The ulcer should be reviewed as soon as possible usually within 24 hours and preventative interventions introduced immediately and consistently implemented to minimise the risk of deterioration. Pressure ulcers that develop after admission/ transfer will be considered as hospital-acquired however the circumstances of care/use of pressure relieving equipment and/or the effects of trauma prior to admission will be taken in to account.

Newly Acquired Pressure Ulcer;
Pressure Ulcers acquired within the Trust will be reported on Datix and the SKKIN Bundle implemented. The medical team will be informed and appropriate referrals made to the multidisciplinary team to help manage any co-morbidities. The patient and/or relatives will be notified and any proposed changes to care discussed.

Openness;
If a stage 3 or 4 ulcer is acquired under the Trust's care the patient must be informed and apologies given that the pressure ulcer developed whilst under the Trust's care. The patient should be advised that as part of the Trust's quality assurance processes

a review of their care records will be undertaken in order to gain an understanding as to how it occurred and explore whether there is any learning from this incident. A patient information leaflet will be given to the patient explaining that we will share the outcome of the review with them within an 8 week period.

Deep Tissue Damage;
Deep Tissue Damage is "a pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may result in the subsequent development of a stage 3 or 4 pressure ulcer even with optimal treatment." (NPAUP,2014). The pathophysiology of deep tissue injury is not fully understood (Briggs, 2011) and it is unclear why some discoloured lesions progress to full thickness pressure ulcers whilst others heal without complication or substantial tissue loss. The tissue may present as a deep bruise and the skin may feel mushy, boggy or hard with surface temperatures warmer or cooler than adjacent skin.
NHS England has requested that this type of injury is now recorded as a Suspected Deep Tissue Injury (SDTI) and monitored for signs of deterioration or improvement. If the SDTI evolves into a stage 3 then it is reported on to STEIS and a full RCA is undertaken. Currently a period of 3 months monitoring is being trialed however as the pathophysiology is not fully understood, this may change to reflect new evidence.
It is important that staff carefully assess the patients skin on admission to hospital and record any indicators of deep tissue injury, particularly if a patient has a history of being on the floor, or being in a collapsed state.

5.7 Reporting Pressure Ulcers

- **All pressure ulcers,** stage 2 and above, must be reported on Datix, in order to facilitate incidence monitoring.

- **Moisture lesions;** Ulcers relating to incontinence, moist skin should be clearly identified as moisture lesions on Datix report.

- **Natal cleft linear tears;** should be reported as tissue damage and are not caused by pressure.

- **Inherited Pressure Damage**; when a patient has acquired pressure damage under another Provider or Nursing Home, this must be reported to the localities Commissioners or the patients GP and Area Team in order for appropriate investigation to be undertaken.

- **Hospital Acquired Pressure Damage;** All hospital acquired stage 3 and 4 ulcers should be referred to the Tissue Viability Team for assessment. Tissue Viability will triage and give advice within 24 hours of receipt of the referral and arrange to review all stage 3 and 4 pressure ulcers.
N.B. Tissue Viability is a 5 day a week service, 7.30am till 5pm. Referrals received after triage may not be picked up immediately due to the work load already allocated that day. Referrals made late on a Friday therefore may not get triaged or seen until the Monday or Tuesday if it's a bank holiday. There is extensive pressure ulcer intervention advice contained in the Pressure Ulcer Prevention Care Pathway, and alternating mattresses are available 24 hours a

day. Wards and admission areas are encouraged to photograph ulcers with the patients consent to ensure initial damage is captured accurately.

- **Unknown Source;** if there is uncertainty as to the source of pressure damage and the patient is under the Trust's care, a joint investigation between primary and secondary care should be undertaken to establish areas of learning**.**

5.8 Serious Incident and Root Cause Analysis Reports

Root Cause Analysis Audit Tools have been revised to monitor the appropriate and timely introduction of key Essence of Care pressure ulcer standards as part of a management plan to help minimise risks to patients. Action plans will be reviewed and monitored with clinical teams providing evidence as to the changes that they have made to ensure compliance to standards. The feedback process from the RCA's and apportioning responsibility and accountability is crucial to promoting improvements in standards of care.

5.9 Wound Management

Holistic assessment is promoted so that staff may identify and address any factors which can adversely affect wound healing. Wound management includes a wound assessment form which prompts staff to record objective descriptions of damage Documentation should indicate a wound assessment form with recorded objectives, cleansing and dressings required to manage the wound, and the frequency of expected changes.

The evaluation process promotes ongoing reviews so that changes in the wound bed can be easily identifiable by staff monitoring and recording changes in wound bed such as percentage of necrotic, sloughy or granulating tissue present, the size and depth of the wound, exudate levels, presence of malodour and pain. The use of photographs to help support documentation and evaluation is recommended as it provides objective evaluations.

ANTT principles will be implemented during dressing changes and the principles of moist wound healing will be supported by the availability of an evidenced based wound care formulary. An exception to moist wound healing principles may occur in patients with compromised circulation where conservative management is appropriate until re-vascularised (where possible) so as to support potential for healing.

5.10 Safeguarding / Vulnerable Adults

There is a recognised link between pressure ulcers and safeguarding issues. Some Pressure ulcers may be the result of neglect, either deliberate or by omission. Where there are suspicions that there have been omissions of care then the Safeguarding Adults policy and procedures must be instigated and a strategy discussion / meeting convened. The Risk Department provides a summary report of all avoidable pressure ulcers to the Safeguarding Team identifying key issues and action pans.

A record should be made in the person's file documenting if a Safeguarding Adult referral has been made. If not, the reasons why a referral was not made should also be recorded.

Patients have a right to make decisions that clinical staff may consider to be ill-advised regarding their care and treatment. Non-compliance with care plans should prompt a capacity assessment and staff should explore the reasons why patients decline recommendations and where possible offer alternative solutions in an effort to gain compliance. Records should be kept of the person's compliance with their pressure ulcer prevention care plan and identified on Datix so that this can be monitored.

Where capacity to consent to treatment is impaired and interventions refused/ resisted consideration needs to be given to 'best interests' as defined by the Department of Health (2009).

5.11 SCALE

The skin, like other major organs is susceptible to failure. Skin changes at life's end are a reflection of compromised skin (reduced soft tissue perfusion, decreased tolerance to external insults, and impaired removal of metabolic wastes)(EPUAP, 2009) At the end of a patients life, tolerance to pressure may decrease to such an extent that it becomes clinically and logistically impossible to prevent skin breakdown.

5.12 Patient/ Carer Information

With an increasing elderly population, the importance of knowledge about pressure ulcer care and prevention on the part of the patient, their carers and families should not be underestimated. Patients who are informed of the risks of developing a pressure sore are more likely to move as instructed by professionals.

It is the responsibility of all healthcare professionals to impart this knowledge and empower patients to play an active role in the prevention and management of pressure ulcers. Provision of the Preventing Pressure ulcers leaflet will provide patients and/or carers with appropriate information. Recording discussions on the SSKIN information advice sheet on pressure ulcer prevention will help provide assurances that staff are working with the patient in an effort to establish concordance.

Patients will be given information regarding pressure damage, including risk factors and prevention strategies. Copies of the Pressure Ulcer Prevention guide for patients and carers will be available in all clinical areas.

For relatives caring for vulnerable individuals in the community, becoming informed of the importance of skin care and pressure ulcer prevention is vital to ensure that no harm befalls their relative. Such information will prompt carers to seek more timely medical help or advice.

5.13 Discharge / Transfer

The accountable registered nurse will inform other departments of continuing

preventative care needs when a patient with a pressure ulcer, or who is assessed as 'at risk', is transferred to another area e.g. patients requiring x-ray, physiotherapy, theatres etc.
On discharge or transfer, written information concerning risk assessment, existing pressure ulcers and current treatment will be provided to all appropriate personnel, including the receiving ward / unit, carers, community staff, patient and/ or relatives where appropriate. Equipment needs should be assessed prior to discharge and should involve discussions with the patient, family members, carers and/or District Nurse so as to help ensure a safe discharge.

6. Monitoring Compliance and Effectiveness

Monitoring Requirement :	Harm Free Care/ Aspiring for Excellence CQUIN with trajectory indicators
Monitoring Method:	Date Reports on all grade 2, 3 and 4 pressure ulcers capturing incidence of new pressure ulcers Root cause Analysis Serious Incidents Safety thermometer monitoring monthly prevalence Ward Assurance
Report Prepared by:	Dot Ward
Monitoring Report presented to:	Pressure Ulcer Prevention Group/ CQUIN Group and IRG
Frequency of Report	Quarterly

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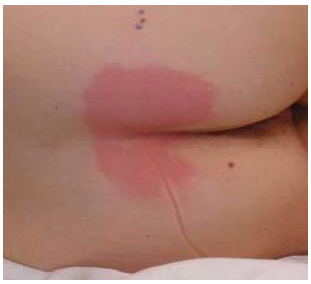
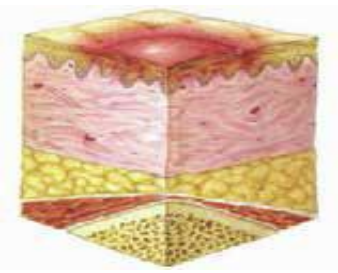
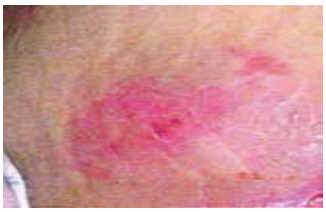
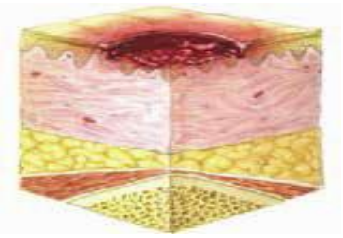
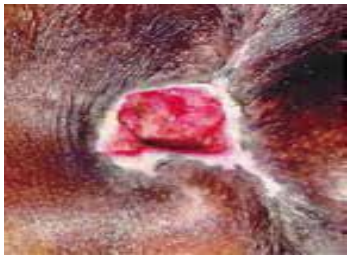
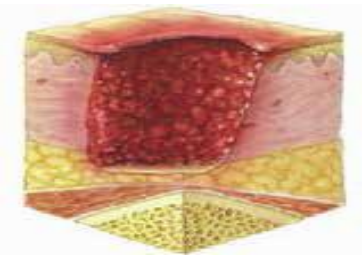
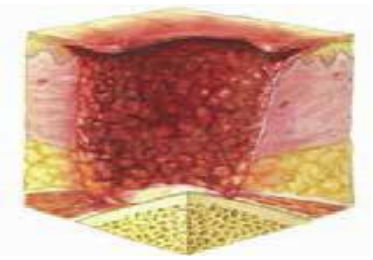
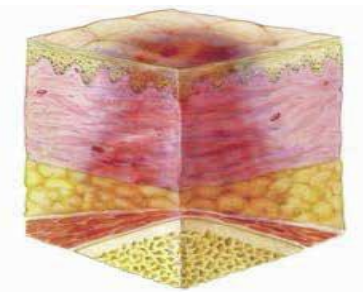
National Pressure Ulcer Advisory Panel (2014) Pressure Ulcer Prevention. [online] Available at: http://www.npuap.org/resources/educational-and-clinical-resources/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guideline/ Accessed on 15/3/16

APPENDIX I - EPUAP GRADING CLASSIFICATIONS

	**Stage 1** **Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.** **The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.**	
	**Stage 2** **Partial thickness skin loss or damage involving epidermis and/or dermis. The wound presents clinically as a superficial abrasion, blister or shallow crater. <u>If slough covers the wound bed so that the base is are difficult to see, the ulcer should be reclassified as being a grade 3</u>**	
	**Stage 3** **Full thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through the underlying fascia.** **The wound bed may be covered with necrotic tissue (hard or leathery black/brown eschar (scab) or softer yellow/cream/grey slough) which masks the true extent of tissue damage.**	
	**Stage 4** **Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling.** **The depth of a Category/Stage IV pressure ulcer varies by anatomical location**	
	**Suspected Deep Tissue Injury: Depth Unknown** **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.** **Deep tissue injury may be difficult to detect in individuals with dark skin tones.** **Evolution may be rapid exposing additional layers of tissue even with optimal treatment. Or they may resolve with no tissue**	

APPENDIX II - Pressure Ulcer Root Cause Classification Criteria

APPENDIX Unavoidable Causes	**Critical Condition leading to Peripheral Shutdown**			**Unknown to health/social service**	**Co - morbidities**	**Necessary Treatment**
	Acute Shock, Sepsis Major trauma, Hypovolaemia	Organ Failure or End of Life	Exposure to hard surface; Found on floor./Impact damage	Patient not under the care of health or social care providers	Acute Ischemia. Cord Compression	Prolonged surgery POP's Splints Traction
Contributed to Development	**Patient Contributory**		**Staff / Resource /System Contributory and/or Omissions in EOC/ NICE Standards**			
	Multiple Co-morbidities	**Concordance**	**Assessment Of Risk**	**Preventative Care**	**Equipment**	
	Combination of conditions affecting Sensory, Circulatory Motor Metabolic status	Patient Non Concordance to interventions Not tolerating repositioning/ not offloading/ not using equipment	Evidence of poor Risk assessment example risk score does not reflect co - morbidities	Evidence of key preventative measures but there are inconsistencies example patient turned 2hrly in bed but sits out for 6hrs	Delays in Access Faulty equipment not identified as deflated/ low pressure. Catheter/ tubing/ contributing to pressure damage on oedematous skin- Poor application of pop/splint/ bandage	
Contributed to Deterioration	**Patient Contributory**		**Staff Contributory Omissions of EOC , NICE, Wound Care Standards**			
	Compromising Factors/ co morbidities	Patient Non Concordance	Evidence of poor Wound Assessment	Evidence of poor evaluations	Systems, Communications/ Resources	
	Incontinence Confused/ agitated state Unstable Diabetes Anemia SOB, poor nutrition	refusing care/ interventions Not tolerating repositioning/ not offloading	Poor documentation of wound description and assessment of problem	Limited evaluations of wound progress, failing to identify deterioration and manage appropriately	Delays to make timely referrals/ escalation Evidence of poor hand over/ communications on transfer/ discharge. Access to appropriate dressings	
Preventable	**Patient Risk Status**	**Patient Concordance**	**Staff Failure To Introduce And Maintain Consistent EOC And NICE Guidelines**			
	Patient at risk with limited number of co morbidities affecting either mobility,sensation/ or circulation	*Patient is concordant and tolerates repositioning and offloading/ equipment*	*Failure to undertake Risk Assessment or risk score does not reflect risk status in illness*	*Failure to document or implement a prevention plan/ or no or inconsistent evidence of repositioning/ offloading*	*Failure to reassess/ and or recognize causative damaging factors and/ or amend care when skin changes are noted.*	

APPENDIX III – Risk assessment Tools

Neonatal Tissue Viability Score

ASSESSMENTS															
Date															
Time															
WEIGHT															
3kgs+	0														
2.5kgs - 3kgs	1														
2kgs – 2.5kgs	2														
1.5kgs – 2kgs	3														
SKIN CONDITION															
Healthy	0														
Clammy e.g. pyrexial	1														
Dry skin	2														
Oedematous	2														
Bruising	2														
Use of nasogastric tube	3														
Broken Skin	3														
Cannulation	3														
MOVEMENT															
Normal for age	0														
Restless, Fidgety,	1														
Jittery	2														

Oxygen dependent	3														
FEEDS															
Full milk feeds	0														
Additives (e.g. duocal, gaviscon)	1														
Insufficient to maintain weight (NBM/IVI)	2														
NAPPY AREA															
Normal	0														
Red	1														
Red and Rash	2														
Broken Skin	3														
Thrush (Candida)	4														
DRUGS															
Oral toxic fluids in milk (e.g. Sodium / KCL)	3														
Antibiotic Therapy	3														
Toxic Fluids: above 10% dextrose (e.g. 15% dextrose / KCL)	3														
TOTAL RISK SCORE															
ASSESSORS INITIALS															

Patient's Total Risk Score

Low risk 0-5

Medium risk 6-10

High risk 11+

APPENDIX III - Paediatric Tissue Viability Risk Assessment

ASSESSMENTS															
Date															
Time															
BUILD AND WEIGHT FOR HEIGHT															
Average	0														
Above Average	1														
Obese	2														
Below Average	3														
SKIN CONDITION															
Healthy	0														
Clammy e.g. pyrexial	1														
Dry skin, dehydrated, lack of turgor	2														
Oedematous	2														
Discoloured	2														
Broken Skin	3														
MOBILITY															
Full, normal for age	0														
Restless, Fidgety,	1														
Moves with limited assistance	2														
Dependent on Others	3														
APPETITE															

Normal for Child	0														
Insufficient to maintain weight	2														
Poor, eats and drinks little	2														
Very poor, unable or refuses	3														
ELIMINATION															
Completely continent or catheterised	0														
Occasionally incontinent	1														
Frequently incontinent	2														
Fully incontinent, no control	3														
DRUGS															
Cytotoxic drug therapy	3														
High dose steroids	3														
High dose NSAID	3														
TOTAL RISK SCORE															
ASSESSORS INITIALS															

Patient's Total Risk Score

Low risk 0-5

Medium risk 6-10

High risk 11+

APPENDIX III - Adult Waterlow Risk Assessment Score

DERBY HOSPITALS NHS FOUNDATION TRUST

ADAPTED WATERLOW RISK ASSESSSMENT

Please affix patient's sticker here	**Hospital:** **Ward:** **Date of Admission**

Several scores per category can be used: 10+ at risk – 15+ high risks – 20+ very high risk. Fill in scores within one hour of admission, whenever there is any evidence of change in the patients condition and weekly as directed in the Policy Guidelines.

SEX / AGE														
Male	1													
Female	2													
14 -49	1													
50 - 64	2													
65 - 74	3													
75 - 80	4													
81+	5													

Appetite														
Average	0													
Poor	1													
NG Tube free drainage/fluids only	2													
NBM / Anorexic	3													

Continence														
Complete	0													
Catheter / Occasional Urinary Incontinence	1													
Incontinent of Faeces	2													
Doubly Incontinent	3													

Skin – Visual Sign														
Healthy	0													
Tissue Paper / Dry	1													
Clammy / Oedematous	1													
Discoloured	2													
Previous history of pressure ulcers	2													
Broken superficial **pressure ulcer**	3													
Full thickness **pressure ulcer**	4													

Mobility														
Fully	0													
Restless / Fidgety	1													
Apathetic	2													
Restricted	3													
Inert / Traction	4													
Chair bound	5													

Build / Weight for Height														
Average	0													
Above Average	1													
Obese	2													
Below Average	3													

Cardiovascular														
Cachexia shock, organ failure Peripheral shutdown	9													
Cardiac Failure, COAD, IHD	5													
Peripheral Vascular Disease	5													
Anaemia	2													
Smoker	1													

Neurological Deficit														
Diabetes, CVA, MS, Paraplegia, Motor / Sensory **4-6**														

General Factors														
Other 4-6 critically ill, Non concordance, Systemic infection, pain , medical devices **4-6**														

Medication														
Steroids, Cytotoxic, Inotropics, Beta-blockers, Epidurals **4**														

Surgery / Trauma														
Orthopaedic–Below Waist Spinal **5**														
Any surgery more than 2 hours **5**														

Total Risk Score														
Time														
Date														
Equipment category A,B,or C														
Assessors Initials														

APPENDIX III – Maternity, Plymouth Risk Assessment Score

Appendix A

Tissue Viability Score Chart

NAME

Hospital Number

Date of Birth

PLYMOUTH MATERNITY PRESSURE ULCER RISK ASSESSMENT SCALE

ALL PATIENTS SCORE 3

SKIN TYPE VISUAL RISK AREAS		CONTINENCE		SPECIAL RISKS	
DRY	1	INCONTINENT	1	NEUROLOGICAL DEFICIT	
OEDEMATOUS	1	RUPTURED MEMBRANES	1	eg: MOTOR / SENSORY	
CLAMMY (PYREXIA)	1			PARAPLEGIA including epidural analgesia	4 – 6
DISCOLOURED	2	**APPETITE**		PERIPHERAL NEUROPATHY MS.	2 – 6
BROKEN / AREA	3	POOR	1		
		FLUIDS ONLY	2	TISSUE MALNUTRITION	
MOBILITY		ANOREXIC	3	eg: ANAEMIA	2
RESTLESS / FIDGETY	1			SMOKING	1
APATHETIC	2	**BUILD/ WEIGHT FOR HEIGHT**		UNSTABLE DIABETES	2
RESTRICTED	3	ABOVE NORMAL	1		
INERT	4	OBESE	2	SURGERY	2 – 4
CHAIRBOUND	5	BELOW NORMAL	3		

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

COMPATIBLE WITH THE WATERLOW RISK ASSESSMENT SCALE

DATE					
TIME					
Baseline score	3	3	3	3	3
Skin Type					
Mobility					
Continence					
Appetite					
Build / Weight					
Neurological deficit					
Tissue malnutrition					
Surgery					
TOTAL =					
Name of midwife					
Signature of Midwife					

7

CL/12:12/T7