POLICY DOCUMENT

Burton Hospitals
NHS Foundation Trust

PRESSURE ULCER PREVENTION AND TREATMENT POLICY

Approved by:	**Trust Executive Committee**
On:	**27 April 2016**
Review Date:	**February 2019**
Corporate / Directorate	**Corporate**
Clinical / Non Clinical	**Clinical**
Responsible for Review:	**Lead Tissue Viability Nurse Specialist**
Distribution:	
• Essential Reading for:	**All Directors,** **All Clinical Directors** **All Matrons,** **All Senior Managers and Managers** **All Nursing Staff**
• Information for:	
Policy Number:	**189**
Version Number:	**3**
Signature:	**Helen Scott-South** **Chief Executive**
Date:	**27 April 2016**

Burton Hospitals NHS Foundation Trust

POLICY INDEX

Title:	**Pressure Ulcer Prevention and Treatment Policy**
Original Issue Date:	**June 2011**
Date of Last Review:	**February 2016**
Reason for amendment:	**Updated policy**
Responsibility:	**Lead Tissue Viability Nurse Specialist**
Stored:	**Trust Intranet**
Linked Trust Policies:	**Information Governance Policy** **Pressure Ulcer Prevention and Treatment Guidelines** **Clinical Photography & Video Consent Policy** **Adult Protection Policy** **Medical Engineering Equipment** **Library – Operational Policy** **Hydration and Nutrition Policy**
E & D Impact assessed?	**EIA 207**
Consulted	**Executive Directors** **Associate Directors** **Chief Nurse / Chief Operating Officer** **Deputy Chief Nurse** **Departmental Heads** **Matrons**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
3	Amendment	27/1/16	To include signs of wound infection
3	Amendment	27/1/16	Role of arterial insufficiency and diabetes in increased pressure ulcer risk.
3	Amendment	27/1/16	Consideration of reduced Mental Capacity in refusal of pressure ulcer prevention interventions.
3	Amendment	27/1/16	“Float the Heels” information
3	Amendment	27/1/16	Avoidance of tucking in sheets under alternating mattresses.
3	Amendment	27/1/16	Duty of Candour

PRESSURE ULCER PREVENTION & TREATMENT POLICY

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BURTON HOSPITALS NHS FOUNDATION TRUST

PRESSURE ULCER PREVENTION AND TREATMENT POLICY

1. BACKGROUND

1.1 Burton Hospitals NHS Foundation Trust aims to prevent and / or manage pressure ulcers with a coordinated, coherent and cohesive approach. By assessing individual's needs and circumstances, potential and actual problems can be identified and prompt action can be taken NICE (2005).

1.2 The Trust aims to ensure no avoidable hospital acquired pressure ulcers occur. To achieve this goal there needs to be a preventative approach which should be implemented as soon as the patient is admitted to avoid the pain, discomfort, psychological distress and extended hospital stay that can occur as a result of a pressure ulcer.

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and / or carer. Health care professionals must be prepared to justify any deviation from this guidance.

2. POLICY OBJECTIVES

- To ensure that the processes, preventative measures, treatment and monitoring of high quality skin care are consistent across the organisation.
- To reduce patients' risk of developing a pressure ulcer by implementing preventative measures to avoid pressure ulcer development.
- To ensure patients have a full skin assessment using the SKINS Care Bundle and Waterlow risk assessment to prevent patients from developing pressure ulcers.
- To ensure that patients with an existing pressure ulcer or who may develop an unavoidable pressure ulcer are appropriately managed.
- To assist in the delivery of high quality care and monitor through Ward Assurance, Safety Thermometer, Root Cause Analysis and Critical / Serious Incident Reporting.
- To minimise the physical, psychological and financial cost of pressure ulcers to the patient and the Trust.
- To ensure that the Trust complies with national guidance.

3. DEFINITIONS

3.1 A pressure ulcer is a localized injury and / or underlying tissue, usually over bony prominence, as result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with the development of pressure ulcers; the significance of these factors has yet to be elucidated (NPUAP / EPUAP, 2014).

3.2 Pressure ulcers are areas of tissue damage that occur in people who cannot reposition themselves; for example, the acutely ill, the older person and the malnourished. The cost of treating a pressure ulcer varies from £1214 (grade 1) to £14108 (grade 4) (Dealey et al., 2012).

3.3 **Avoidable pressure ulcers** mean that the person receiving care developed a pressure ulcer and the care provider did not provide one or more of the following:

- Evaluation of the person's clinical condition and pressure ulcer risk factors
- Plan, implement and document interventions which are consistent with the patient's needs and goals and recognised standard practice
- Monitor and evaluate the impact of interventions and revise as appropriate

The above must be evidenced in documentation.

Unavoidable pressure ulcers mean that the individual developed a pressure ulcer even though:

- The individual's condition and pressure ulcer risk had been evaluated;
- Goals and recognised standards of practice that are consistent with individual needs had been implemented;
- The impact of the preventative interventions had been monitored, evaluated and recorded; and the approaches had been revised as appropriate.

Critical illness with haemodynamic or spinal instability may preclude turning or repositioning and lead to unavoidable pressure ulcers. Patients who refuse to be repositioned or to maintain a position change may also develop unavoidable pressure ulcers but this must be documented effectively.

Patients receiving End of Life Care or who meet the criteria are deemed to be terminally ill and may not be able to tolerate repositioning at the optimum frequency for pressure ulcer prevention. In these cases, pressure damage may be an unavoidable consequence of their terminal status as the condition of skin failure does exist.

3.4 NHS Midlands and East (NHS England, 2015) identified key components to pressure ulcer prevention, which form the acronym: "S.K.I.N.S." and include:

- Skin inspection
- Keep patient moving
- Incontinence / continence
- Nutrition and hydration
- Surface

It is these components which form the basis of the Pressure Ulcer Prevention SKINS care bundle

4. SCOPE

4.1 This policy will apply to all vulnerable individuals of all age groups. The policy is intended for the use by health care professionals who are involved in the care of patients and vulnerable people who are at risk of developing pressure ulcers at Burton Hospitals NHS Foundation Trust.

4.2 The Policy supports the Essence of Care Benchmarks for Prevention and Management of Pressure Ulcers (2010); the National Institute of Health and Clinical Excellence guidance (2014) guidelines and the European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) (2014) guidelines.

5. RESPONSIBILITIES OF KEY INDIVIDUALS

5.1 Chief Executive

The Chief Executive and Board of Directors of Burton Hospitals NHS Foundation Trust are responsible for maintaining effective strategies for the prevention and treatment of hospital acquired pressure ulcers and treatment of community acquired pressure ulcers.

5.2 Chief Nurse / Chief Operating Officer

The Chief Nurse / Chief Operating Officer is responsible for ensuring and maintaining effective strategies for the prevention and treatment of hospital acquired pressure ulcers and treatment of community acquired pressure ulcers that patients may be admitted with.

5.3 Consultants

Consultants have the clinical accountability for their patient's management. The Consultant responsible for the patient's care will liaise with the ward nurse and refer to the Tissue Viability Service to agree a course of treatment that meets the needs of the individual patient.

5.4 Tissue Viability Nurse Specialist

The Tissue Viability Nurse Specialist is responsible for providing expert advice and guidance to the multi-disciplinary team on the most effective prevention strategies and treatments to meet the needs of the patient. The Tissue

Viability Nurse Specialist will monitor the effectiveness of treatment and will regularly review referred patients in a timely manner.

5.5 Head Nurses and Matrons

Head Nurses and Matrons have a vital role in assuring the Chief Nurse that all Senior Sisters and their teams implement the policy for prevention and treatment of pressure ulcers. They will monitor the delivery of any actions following an RCA / CI (Root Cause Analysis / Critical Incident) investigation. Matrons are responsible for ensuring that the RCA is completed.

5.6 Senior Sisters

Senior Sisters are responsible for the implementation of the Pressure Ulcer Prevention and Treatment Policy and are responsible for promotion of safe patient care that is effective in the treatment and prevention of pressure ulcers. Senior Sisters will be asked to complete RCAs for the pressure ulcers which develop on their ward or department.

5.7 All Staff

All staff are required to adhere to pressure ulcer policies and associated guidelines. Registered nurses are accountable for their actions and are expected to maintain accurate documentation in accordance with the NMC (Nursing and Midwifery Council) Code. Nursing assistants deliver care under the supervision of the registered nurse and are expected to inform the registered nurse of any changes in the patient's condition.

6. DELIVERY OF SAFE PRESSURE ULCER PREVENTION AND TREATMENT

6.1 SKIN ASSESSMENT

6.1.1 All patients on admission will be assessed for pressure ulcer risk using the Waterlow Risk Assessment Tool (Appendix 1) within 6 hours of admission. Results will be recorded on the HISS assessment screen by a registered nurse (excluding maternity where the risk assessment will be undertaken when there is a clinical need). An appropriate care plan will be implemented according to the Waterlow Score and the outcome of the skin assessment, using clinical judgement. The Waterlow risk assessment will be updated when a patient's condition changes, is transferred to another ward, or on a weekly basis, whichever is the sooner.

6.1.2 All inpatients or emergency patients must have an initial skin assessment, which must be documented within 6 hours of admission and take into account the following:-

- Bony prominence (e.g. sacrum, heels, hips, ankles, elbows, occiput) to identify early signs of pressure damage.

- Identify the condition of skin, erythema, maceration, excoriation, fragility, blanching responses, localised heat, oedema and induration (hardness). Individuals with darkly pigmented skin require extra vigilance as areas of redness are not easily seen. A developing pressure ulcer on darker pigmented skin may appear as a darker or purple area, or warmer, cooler or harder to touch.

- In addition, all areas of redness, pressure ulcers and other wounds must be documented within the SKINS Bundle: on change of condition (including development of new damage); on transfer; before and after theatre, and just before discharge.

6.1.3 All skin assessments must be documented, including any pain potentially related to pressure damage. Accurate documentation is essential for monitoring the progress of an individual and to aid communication between professionals.

6.1.4 Observe the skin for signs of pressure damage caused by footwear or medical devices such as ventilation tubing, anti-embolism stockings, collars, splints and catheters. Patients with a Plaster of Paris cast must have a Trust Plaster Checklist completed to monitor risk of pressure damage.

6.1.5 A documented skin assessment (using the SKINS Bundle) must be completed a minimum of twice daily for patients deemed at risk i.e. a Waterlow risk score of 15+ or greater. The frequency will need to be increased in response to any deterioration in the patient's overall condition (including skin condition). All bony areas (and those with existing pressure damage) must be documented on the SKINS Bundle at a frequency according to the individual risk level, for example 2, 3 or 4 hourly depending on how long it takes for the skin to mark. Frequency must be increased if condition and / or mobility deteriorate. Frequency can be reduced if condition and / or mobility improves, ensuring that this is not detrimental to the skin.

6.1.6 The severity of any pressure damage will be classified by the Midlands and East Guidance (2012), which grades pressure ulcers in grades / categories from 1–4 (see Appendix 2). Pressure ulcers must not be reverse graded ("retrograded"), that is, a category / grade 4 pressure ulcer does not become a grade 3 as it heals. The healing ulcer will be described as a "healing grade 4 pressure ulcer"

6.1.7 Intact skin with dark discoloured damage will be graded as a category / grade 3 or unclassified grade 3 in line with NHS Midlands and East guidelines and investigated accordingly.

6.1.8 All patients with pressure ulcers will have their pain assessed using an agreed pain assessment tool and pain management implemented.

6.1.9 If a pressure ulcer (either community or hospital acquired) is identified it will be recorded using the Midlands and East (2012) Grading System. The following needs to be done: Report as a Clinical Incident; refer to Tissue Viability Nurse for verification of grade of pressure ulcer; record on electronic patient record ,

detailing the grade, location, appearance, size, condition of surrounding skin and treatment. Commence on SKINS Bundle.

6.1.10 The optimum wound healing environment should be created by using dressings following Burton Hospitals NHS Foundation Trust Wound Care Formulary (2015) on the Trust's Tissue Viability Intranet site and documented on HISS and on the SKINS Bundle.

6.1.11 Do not massage / rub the skin for pressure ulcer prevention (EPUAP, 2014).

6.1.12 Infection in pressure ulcers can potentially lead to delayed wound healing and further complications such as osteomyelitis and bacteraemia (EWMA, 2005). Signs and symptoms of infection must therefore be identified, and, if present, a doctor and Tissue Viability Nurse informed for further assessment and advice. If there are signs of infection, a wound swab must be obtained to ascertain which antibiotics the bacteria are sensitive to in order to provide the most effective treatment. (NPUAP / EPUAP, 2014). Appropriate antimicrobial dressings, as advised by the Tissue Viability Nurse, must be applied if infection is suspected. See Tissue Viability Webpage for further information.

6.1.13 Conditions such as arterial insufficiency (e.g. caused by peripheral artery disease) or diabetes may increase risk of pressure ulcers, particularly the heels. Therefore, referral for further advice needs to be considered; for example, informing the doctor for further examination, with consideration for referral to Vascular Consultant in the case of limb ischaemia, and Diabetes Consultant if a person with diabetes has a foot wound. Signs of acute limb ischaemia are the "6 P's":

- Paraesthesia (altered sensation)
- Pain
- Pallor (mottled colouration)
- Pulselessness
- Paralysis
- Poikilothermia (coolness)

(NPSA, 2011)

6.2 KEEP MOVING

6.2.1 Patients who are at risk of developing pressure ulcers must be encouraged to move or be repositioned (to minimise pressure, shearing and friction) unless this is detrimental to their clinical condition. This must be documented on HISS and the SKINS Bundle.

6.2.2 Repositioning onto bony prominences must be minimised, and bony prominences must not be placed in direct contact with one another (NICE, 2014). Following surgery, where possible, position the patient in a different posture pre- and post–operatively from the posture adopted during surgery (EPUAP, 2014). Consider 30 degree tilt when repositioning (see Tissue Viability webpage on Trust Intranet).

6.2.3 Equipment such as slide sheets or hoists must be used where indicated, according to the patient's moving and handling assessment. **Slide sheets must be used under the body and the heels** to minimise shearing and

frictional forces. When using the profiling bed to sit a patient upright, the **knee brake control must be used first** to prevent sliding down the bed.

6.2.4 No pressure redistributing / relieving device should be relied upon as a substitute for regular changes of position.

6.2.5 Seated patients at risk of pressure ulcers, or with reduced mobility, should be prompted or assisted to stand or mobilise at least several times per hour to minimise compression of tissue and capillaries. Consider **restricting seating time** if skin on buttocks or ischial tuberosities starts to become red or damaged. Consider nursing those with severe damage (such as Grade 3 and above pressure ulcers) in bed, until there is improvement.

6.2.6 Patients and / or carers will receive verbal and written information, where appropriate, regarding the risk of pressure ulcer development and made aware of the need to move.

6.2.7 Patients with specific moving and handling requirements such as spinal injuries and bariatric patients will have a referral to a physiotherapy, occupational therapy and / or moving and handling team to assist or advise on mobility and / or position changing where appropriate.

6.2.8 Patients attending the operating theatre will have other factors examined such as: length of operation, increased hypotensive episodes intra-operatively, low core temperature during surgery, reduced mobility on post operatively. Repositioning regime must be adjusted accordingly.

6.2.9 Avoid positioning the patient directly on to medical devices e.g. drainage systems and catheters to avoid pressure damage (EPUAP, 2014).

6.2.10 A repositioning schedule will be devised, agreed with the patient, and evaluated for its effectiveness and actions taken (NICE, 2014). NICE (2014) states that patients at high risk of pressure ulcers are repositioned (prompted or assisted) **at least** every 4 hours. The following information regarding repositioning should be documented:

- Details of repositioning
- Frequency of repositioning
- Position adopted
- Assessment of the skin at each position change
- Evaluation of the effectiveness of the regime
- Amend care plan as required

6.2.11 Any refusal by the patient to have pressure relieving interventions must be documented on the SKINS Bundle at the time when offered. Explanation of the reason why the intervention needs to be made should be provided to the patient in a manner in which he / she understands. Implications of not having the intervention need to be explained to the patient. If reduced mental capacity is suspected, a Mental Capacity Assessment needs to be undertaken. If the patient lacks mental capacity and he / she is at risk of harm due to refusal of a pressure relieving intervention, then a Best Interests assessment needs to be considered. His / her wishes may

need to be overridden for Safeguarding reasons, to ensure that harm is minimised.

6.3 INCONTINENCE / MOISTURE

6.3.1 Urinary and faecal incontinence can increase the risk of pressure ulcers developing due to weakening of the skin from chemical irritation and / or inappropriate cleansing. Faeces contain proteolytic enzymes which can irritate the skin. Most soaps are alkali and can strip the skin of its natural oils, therefore low pH soap or foam skin cleanser, or plain warm tap water are recommended to cleanse the skin following episodes of incontinence. (Le Livre, 2002 and Nix, 2000).

6.3.2 All patients will receive an initial continence status assessment, if required, on admission to hospital and should be regularly reassessed for any changes in condition. Actions implemented should be documented.

Those patients incontinent of urine, faeces or both will receive interventions to prevent incontinence associated dermatitis or moisture lesions. This includes the use of emollient skin cleansers, barrier products and fitted incontinence products (NICE, 2014).

6.3.3 Incontinence associated dermatitis or moisture lesions will not be classed as pressure damage, therefore it is important to distinguish between the two (see Tissue Viability webpage). However, as **moisture damaged skin is a weakened area**, any pressure, shearing or frictional forces need to be minimised to prevent further breakdown.

6.3.4 Other sources of moisture such as sweating due to e.g. sitting on vinyl-covered chairs or wound fluid must be considered as a possible contributory factor to pressure ulcer formation. Prolonged periods sitting in the chair can exacerbate the formation of moisture on the skin, increasing pressure ulcer risk.

6.4 NUTRITION AND HYDRATION

6.4.1 Poor nutrition is a major factor in pressure ulcer development. An assessment of nutritional status must be undertaken for all patients using the Trust's agreed nutritional screening process and appropriate nutritional support implemented. See Trust Nutrition and Hydration Policy (2015).

6.5 SURFACE

6.5.1 Patients must be assessed for a suitable mattress according to their Waterlow Score; the presence of redness or pressure damage and clinical judgement. See Pressure Relieving Equipment Selection Guide on Tissue Viability webpage on the Trust Intranet.

6.5.2 If condition deteriorates or a new area of pressure damage occurs, consider upgrading the mattress (and / or repositioning frequency). If condition, skin condition and / or mobility improve, consider downgrading the mattress so that the higher specification mattress is available to those patients that need it. Follow Trust guidelines for mattress cleaning and return of equipment to the

Medical Equipment Library. (See Medical Engineering Equipment Library – Operational Policy, 2014).

6.5.3 When discharging a patient with a pressure ulcer that requires a specialised mattress for discharge please liaise with appropriate professionals such as the Discharge Team and the District Nursing Service.

6.5.4 DO NOT USE aids such as water-filled gloves, synthetic sheepskins and doughnut devices (NPUAP / EPUAP, 2014).

6.5.5 If a high risk patient is assessed as suitable to sit out in a chair, this must be of a suitable height – see Chair Nursing information on Tissue Viability webpage on Trust Intranet. An appropriate pressure redistributing support cushion will be selected and used. Please liaise with Tissue Viability Service for advice. The patient will be assisted or prompted to relieve pressure by standing or mobilising several times per hour.

6.5.6 Ensure that patients who are at risk; those with reddened pressure areas, "boggy" heels; and / or whose condition or mobility deteriorates are assisted to "Float the Heels" by using a pillow under the calves so that the heels are in the air. Consider using a pressure relieving "boot" or heel protector if a pillow is unsuitable, and the patient meets accepted criteria. Consider the **role of shearing and friction increasing heel pressure ulcer risk in patients who are restless or have tremors or spasms** due to condition. Consider referral to Tissue Viability Nurse for advice.

6.5.7 Limit the amount of pads and layers on the patient's bed, in particular, on an alternating mattress, as these may interfere with its effectiveness (NPUAP / EPUAP, 2014). **Do not tuck sheets** under alternating mattresses which may cause a "hammocking" effect (which interferes with the pressure relieving properties of the mattress).

6.6 MANAGEMENT OF EXISTING PRESSURE ULCERS

6.6.1 Pressure ulcers are likely to require a number of weeks or months to heal depending on their severity and the individual's co-morbidities. Therefore they need a clear plan of management to promote wound healing.

6.6.2 Patients presenting with pressure ulcers of any grade / category will receive initial and on-going risk and skin assessments and will have their wound assessed using the Trust's SKINS Bundle.

6.6.3 The Burton Hospitals Wound Management Guidelines and Wound Care Formulary will be used as a framework for dressing selection. This information will be recorded on the Wound Assessment Chart in the SKINS Bundle.

6.6.4 Relevant healthcare staff will be informed if a patient has developed pressure damage, so that this can be recorded in the medical notes and appropriate action taken.

6.6.5 Referral for surgical interventions will be considered if there is failure of previous conservative management interventions, or deterioration of an ulcer to involve deeper tissues. However, this will depend on the condition of the

patient (level of anaesthetic risk), skin condition and patient preference (NICE, 2014).

7 REPORTING OF PRESSURE ULCERS

7.1 All hospital acquired and community acquired grade 2, 3 & 4 pressure ulcers must be reported as a Clinical Incident. Root Cause Analysis is then undertaken; discussed at a Critical Incident meeting, and a decision is reached as to whether it is avoidable or unavoidable. Avoidable pressure ulcers are treated as Serious Incidents.

7.2 Any patient whose pressure ulcer has deteriorated must be reported as a Clinical Incident by a qualified nurse. Grades 2, 3 & 4 pressure ulcers must be referred to the Tissue Viability Service, so that these can be validated and advice given if necessary

7.3 All multiple grade 2, grade 3 and 4 pressure ulcers are to be photographed on admission to hospital (or on development where a Pressure Ulcer is hospital acquired). The photograph of the pressure ulcer requires consent to be obtained from the patient as stated in the Clinical Photography and Video Consent Policy. If the patient is unable to consent then it must be recorded in the medical notes that the photograph was taken for medical reasons.

7.4 **Duty of Candour:** Health professionals should be open and transparent with the patient about their care and treatment. If the patient develops a pressure ulcer they must tell him or her what has happened, provide support and apologise (Care Quality Commission, 2015).

8. TISSUE VIABILITY SERVICE AND FUNCTIONS

8.1 Composition

Tissue Viability Nurse Specialist: Monday to Friday 8.00am-4.00pm

Referrals: By order entry on HISS plus, if urgent, Bleep 461 or 534. See Tissue Viability Nurse Referral criteria on Tissue Viability web page.

Out of hours guidance is provided on the Tissue Viability web page on the intranet.

8.2 Functions

The Tissue Viability service provides clinical advice on:

- All grade 2, 3 & 4 pressure ulcers - hospital or community acquired
- Leg ulcers and diabetic ulcers
- Complex wounds.
- Trauma and delayed healing surgical wounds
- Infected wounds
- Advice to facilitate discharge

- Advice on equipment

See Referral Criteria on Tissue Viability Webpage on Trust Intranet.

9. TRAINING

9.1 A varied approach to Tissue Viability training will be delivered in accordance with Trust policies on pressure prevention and wound care guidelines to meet the multi-disciplinary team educational requirements and recorded in ESR.

9.2. All trained nursing staff are encouraged to complete the Pressure Ulcer Prevention E-Learning Package on the Tissue Viability website on the Trust Intranet, and complete the graded questionnaire to accompany it on ESR, every 2 years.

9.3 Tissue Viability Champions should:

- Attend regular Tissue Viability Champions meetings to maintain links with the Tissue Viability Service and to cascade any new information to staff in their area.
- Ensure they keep updated on relevant pressure ulcer prevention and tissue viability issues.
- Be expected to have obtained the Tissue Viability Degree Module at University.
- Keep a record of staff and inform the Tissue Viability Nurse of any ward based training they have undertaken with staff.
- Act as an information resource for staff so that appropriate advice can be given in the care of patients with tissue viability needs.
- Report to the Tissue Viability Nurse any tissue viability related problems encountered in their area.
- Liaise with the Senior Sister, or person responsible for ordering to ensure that stock levels of appropriate wound care products are available for staff to use with their patients.

9.4 In addition, training sessions will be delivered as required to individual departments and records sent to Learning and Development in order that individuals' training records can be maintained.

9.5 The Tissue Viability intranet site is available to provide information on:

- Pressure Ulcer Prevention Policy
- Pressure Ulcer training resource pack
- Wound Care Formulary
- Collaborative Wound Care Guidelines
- Patient Information leaflets.
- Equipment Selection Flowchart
- Quick reference guides for alternating mattresses and how they operate.
- Tissue Viability Nurse referral criteria

10. ASSURANCE FRAMEWORK

10.1 The Tissue Viability Service will act as a resource to provide evidence and information for Directorates on education on Pressure Ulcer Prevention, Pressure Ulcer adverse incident reporting, CQUINS (DH, 2009), Essence of Care (DH, 2010), NICE (2014) Prevention and Treatment of Pressure Ulcers and NICE (2008) Surgical Site Infections.

10.2 The Tissue Viability Service will monitor the Trust's performance in relation to performance indicators that are reported to the Board of Directors, including:

- Safety Thermometer pressure ulcer prevalence audit monthly
- Ward Assurance
- Root Cause Analysis incident reporting of pressure ulcers monitored monthly
- Patient outcomes
- Patient referrals
- SKINS Bundle Compliance

11. REFERENCES

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Burton Hospitals NHS
NHS Foundation Trust

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

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

BUILD/WEIGHT FOR HEIGHT	♦
AVERAGE	
BMI = 20-24.9	0
ABOVE AVERAGE	
BMI = 25-29.9	1
OBESE	
BMI > 30	2
BELOW AVERAGE	
BMI < 20	3
BMI=Wt(Kg)/Ht (m)^2	

SKIN TYPE VISUAL RISK AREAS	♦
HEALTHY	0
TISSUE PAPER	1
DRY	1
OEDEMATOUS	1
CLAMMY, PYREXIA	1
DISCOLOURED	
GRADE 1	2
BROKEN/SPOTS	
GRADE 2-4	3

SEX AGE	♦
MALE	1
FEMALE	2
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
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	♦
COMPLETE/ CATHETERISED	0
URINE INCONT.	1
FAECAL INCONT.	2
URINARY + FAECAL INCONTINENCE	3

MOBILITY	♦
FULLY	0
RESTLESS/FIDGETY	1
APATHETIC	2
RESTRICTED	3
BEDBOUND e.g. TRACTION	4
CHAIRBOUND e.g. WHEELCHAIR	5

SPECIAL RISKS

TISSUE MALNUTRITION	♦
TERMINAL CACHEXIA	8
MULTIPLE ORGAN FAILURE	8
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5
PERIPHERAL VASCULAR DISEASE	5
ANAEMIA (Hb < 8)	2
SMOKING	1

NEUROLOGICAL DEFICIT	♦
DIABETES, MS, CVA	4-6
MOTOR/SENSORY	4-6
PARAPLEGIA (MAX OF 6)	4-6

MAJOR SURGERY or TRAUMA	
ORTHOPAEDIC/SPINAL	5
ON TABLE > 2 HR#	5
ON TABLE > 6 HR#	8

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

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

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

Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX
* The 2005 revision incorporates the research undertaken by Queensland Health.

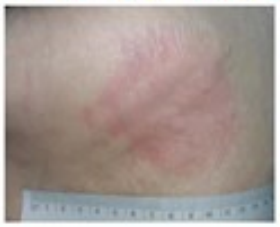
www.judy-waterlow.co.uk

NHS
Midlands and East

Pressure Ulcer Grading

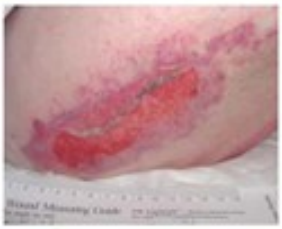
Adapted from EPUAP/NPUAP 2009

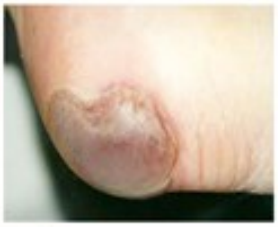
Superficial



EPUAP - Category/Grade I

- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



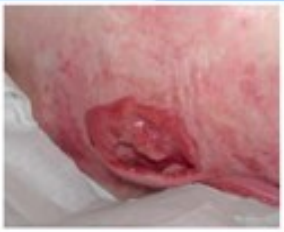


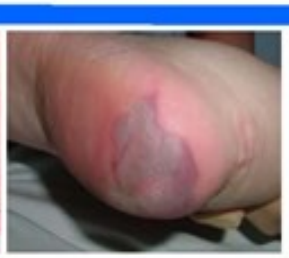
EPUAP System - Category/Grade 2

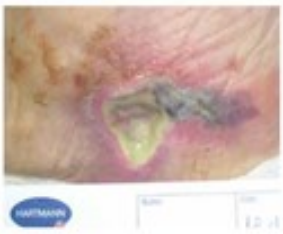
- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.

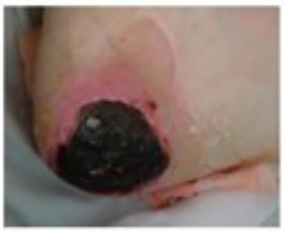
*Bruising appearance and blood filled blister would indicate deep tissue injury.

Deep







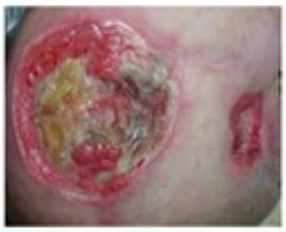


EPUAP - Category/Grade 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.

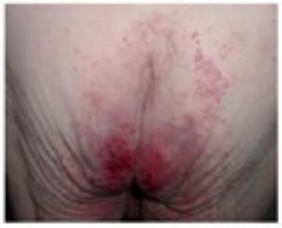
Plus: Unclassified PU – now Grade 3

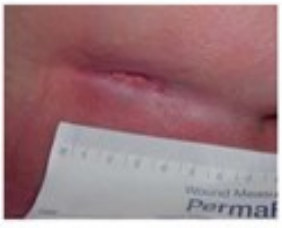
- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as 'the body natural (biological) cover' and should not be removed.
- Should be documented as grade 3 until proven otherwise.



EPUAP – Category/Grade 4

- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).





Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.