University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

Reference Number CL RM/2024/024	**Version: V8**	**Status** Final	**Author:** **Karen Gourley and TV Team** **Job Title** Tissue Viability Team

Version / Amendment History	Version	Date	Author	Reason
	V1	October 2007	Kay Fawcett	Original Policy
	V2	October 2010	Director of Patient Safety	Policy review and reformat
	V3	September 2012	Tissue Viability lead nurse and TV team	Policy review and reformat
	V4	March 2016	Tissue Viability lead nurse and TV team	Policy review and reformat
	V3	March 2016	Burton Tissue Viability Team	Amendment
	V5	November 2020	Lead Nurse for Tissue Viability	Amendment, new terminology included.
	V6	October 2022	Lead Nurse for Tissue Viability	Amendment

	V7	February 2023	Tissue viability Team	Update. Please note amendment will be required to update risk assessment tools for Neonates and Paediatrics, once training in place
	V8	January 2024	Lead Tissue Viability Specialist Nurse	Amendment. Removal of sentence from Section 2. Purpose and Outcomes. 'Please refer to the additional maternity guidelines for further advice'.

Intended Recipients: All ward and Departments with University Hospitals of Derby and Burton Foundation Trust	
Training and Dissemination: Dissemination via the Trust Intranet, training is ongoing and is in line with the policy.	
To be read in conjunction with: Pressure Ulcer Guidelines, Wound Care Formulary, and Wound Management Guidelines.	
In consultation with and Date: Tissue Viability, Matrons across all 5 sites Clinical Governance April 2023	
EIRA Stage One Completed Yes / No *Delete as appropriate* **Stage Two** Completed Yes / No *Delete as appropriate*	
Approving Body and Date Approved	April Tissue Viability Group April Learning and Review Group
Date of Issue	April 2023
Review Date and Frequency	2025 every 2 years
Contact for Review	Karren Gourley, Lead Nurse for Tissue Viability
Executive Lead Signature	Director of Patient Safety and Chief Nurse

PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

1. Introduction

This policy has been drawn up in line with current guidelines set out by NICE 2018 and EPUAP 2014 and updated guidance 2019. Changes to the Patient Safety Incident Response Framework (PSIRF) (2020) which impact on governance and incident review structure have been included where they affect pressure ulcer prevention, reporting and investigation.

“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”. (NICE, 2018).

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 affected patients. (EPUAP, 2014)

This policy outlines University Hospitals of Derby and Burton Foundation Trust's approach to the prevention and management of pressure ulcers. Along with the supporting guidelines for the prevention and management of pressure ulcers, it places an emphasis on a professional nurse led, collaborative, multidisciplinary process of identifying risk factors and implementing appropriate preventative and/or treatment measures. The supporting guidelines are currently available on the TV website.

This policy promotes the provision of holistic care and incorporates the facilitation of the following guidelines:

- Revised definition and measurement, summary and recommendation (NHS Improvement, 2018)
- 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, 2010)
- 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" (NICE, 2015). 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 in adults, young people, children, infants, and neonates.

The purpose of this policy is to ensure that the Trust prevents pressure ulcers where possible and manages existing pressure ulcers effectively. This is in accordance with UHDB Tissue Viability 5-year strategy. The majority of acquired pressure ulcers are believed to be avoidable (NICE, 2014).

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 quarterly and annually.

Outcome measures:

- Sustained reduction in hospital acquired category 3 and 4 pressure ulcers.
- Overall reduction in hospital acquired category 2 pressure ulcers.

Local Indicator measures:

- Compliance and accuracy of pressure ulcer screening and risk assessment within two hours of admission or transfer to 90%.

- Compliance with skin assessment within two hours of admission or transfer to 90%
- Implementation of appropriate prevention care plan bundles within 6 hours of patient identified 'at risk' to 90%.
- Evaluation of care/management plans daily to 90%.
- Evidence of compliance with Duty of Candour undertaken; for hospital acquired harms.

3. Definitions Used

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". (NICE, 2018).

Category of Pressure Ulcer: 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.

Patient Safety Incident Response Framework (PSIRF) (2020) and Patient Safety incident Response Plan (PSIRP): Aims to improve the quality and safety of the care we provide by focusing on identification of interconnected factors and systems issue which contribute to hospital acquired pressure ulcers. These themes and trends have been identified from Post Harm Review and Serious incident evidence (Fletcher, 2022).

PSIP: Patient Safety Improvement Plan (local terminology for the review of incidents with harm identified in the care of UHDB hospitals). Following confirmation of hospital acquired Category 3 and 4 pressure ulcers, a review of care and interventions delivered is undertaken, to determine if there is to be learning from the incident. Any learning from all incidents is reviewed and used to form a quarterly thematic review.

Datix: The Datix system is an electronic incident reporting system for the reporting all incidents inherited from outside of the Trust and acquired in the Trust.

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

Learning and Review Group: Group of senior managers and nurses who examine themes and trends from pressure ulcer incidents and make recommendations to help address clinical learning.

ICB: Integrated Care Board.

aSSKINg: Acronym for preventative measures: **a**ssessment **S**urface, **S**kin assessment, **K**eep moving, **I**ncontinence, **N**utrition and **g**iving information.

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 injury in the 'at risk' patient. Risk factors such as poor nutrition, previous history of ulcers, diabetes, poor posture, mobility status 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 to ensure a consistent and standardised approach.

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 Learning and Review group

This group has the responsibility to review the clinical learning summary reports on category 3 and category 4 pressure ulcers deemed to have lapses in care. Escalating concerns and issues reported/ raised in the Tissue Viability Meeting.

4.3 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 within the corporate structure 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 all category 3 or 4 pressure ulcers or SDTI's, the Tissue Viability Team will confirm the aetiology and category of the ulcer identified on the Datix report. The Tissue Viability team will notify Risk services of patients admitted to the Trust hospitals with this level of pressure injury. The exception being, Nursing Homes, who are only notified in the event of safeguarding concerns related to the damage.

If the ulcer has developed whilst in the care of the Trust, the appropriate clinical governance team will be instructed to organise a review of care which will assess the issues that led to skin breakdown. This will be done within an agreed time standard of 10 days.

The Tissue Viability team will undertake duty of candour to inform patients with mental capacity, at the time of assessment, that a review into how they developed the pressure ulcer will be undertaken. Ward staff will be asked to do this with Next of Kin for those patients without mental capacity or altered levels of consciousness.

The Tissue Viability Team will support all inpatient areas to identify issues, develop service improvement plans and supply education materials.

The Tissue Viability Team will develop an education strategy that supports an enabling process, whereby Tissue Viability Champions are educated, supported, and empowered to deliver, disseminate, and promote quality care. Tissue Viability Champions will undertake 11.5hrs of additional Tissue Viability training annually, in addition to the essential to role training.
All members of staff will have access to the Trust Tissue Viability web site with access to educational resources and materials.

The Tissue Viability team will review completed PSIP reports within the Datix and complete the TV report review. This will be completed using a RAG system (see Appendix II) If the review identifies several or severe lapses in pressure ulcer prevention interventions, the incident will be highlighted as Red and passed on to the Safeguarding team for review.

4.4 Clinical Governance Facilitators

Clinical Governance Facilitators (CGF's) will monitor PSIPs and ensure they are completed in a timely manner.

Corporate systems such as the Tissue Viability Excellence audit 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 TV 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.

4.5 Matrons/ Sisters

The use of local monitoring systems in relation to 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.

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

Matrons will provide a monthly pressure ulcer report currently using the LOOP (Learning On One Page) format to the Tissue Viability meeting, highlighting any areas of concern and actions to be taken to address them. This is subject to minor alteration within the TV meeting to reflect any changes or developments.

The Ward Sister is responsible for investigating the development of a category 3 or 4 pressure ulcer in their area by undertaking a review of notes within 10 days of the notification to undertake the review. If this is delegated to other staff, the Ward Sister remains responsible for quality assuring the reports and ensuring the investigation is completed within the 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. The person undertaking the PSIP review will be responsible for sharing the outcome with the patient and/or Next of Kin, following consultation with any other professional person involved.

4.6 Clinical Staff

All members of staff are required to adhere to the pressure ulcer prevention policy 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. (2018)

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 pressure ulcer prevention training every two years.
- Challenge unsafe practice.
- Raise awareness of patient's pressure ulcer risk status.
- Advise patients on preventing pressure damage.

4.7 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 when surgical debridement may be required.

4.8 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 concordance. Patients will be informed to notify staff of any concerns that may develop.

4.9 Safeguarding team

The safeguarding team will review incidents where there are several or severe lapses in pressure ulcer prevention interventions based on the incident RAG rating within the PSIP review.

5. Prevention and Management of Pressure Ulcers

The Trust has incorporated the Essence of Care benchmarking standards, European Pressure Ulcer, and NICE guidelines, including a SSKIN/SKINS 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. Clinical care pathways have been introduced to promote a standardised approach to prevention and management of pressure ulcers.

All assessments and interventions are to be documented in the care bundle pathways provided, and an appropriate plan of care established in line with the risk to the patient, the patient's wishes and the medical needs of the patient.

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. Neonates (up to 6 months old) will be deemed "high risk" and appropriate interventions will be implemented throughout their hospitalisation. A paediatric risk assessment will be carried for children over 6 months.
- Risk Assessment tools will be used as an 'aide memoire' alongside clinical judgement. Please see Appendix III for Risk Assessment tools specific to clinical areas.
- Risk assessment will be undertaken by a trained healthcare professional, they are responsible for attending training updates and being familiar with the tool used in their clinical area.
- 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.
- Reassessment of risk will occur at least weekly, on transfer and on a general change in patient’s condition. The care plan will be changed accordingly.

5.2 Key Standards in Skin Assessment

- Initial skin inspection will be incorporated within the risk assessment process. This will include **all** bony prominences to identify early signs of tissue damage.
- 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 within 2hrs of admission.
- Patient skin checks will be offered as a minimum twice daily or depending on risk, at every change in position, or if the patient is unlikely to feel a problem developing.
- 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, particularly over a bony prominence.
- 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 and recorded. The skin blanching test is not reliable for patients with darkly pigmented skin, and an appropriate alternative skin assessment will be undertaken.
- Skin assessment under movable medical devices will be undertaken in accordance with the local clinical and manufacturer’s guidelines. For other devices (i.e. splints or casts), appointments for review should kept unless medically unfit, in which case alternative review will be arranged.
- All skin checks will be documented on the appropriate care pathway and signed by a trained member of staff. Untrained members of staff can document when a reposition has taken place but must escalate any deterioration in skin condition to a trained member of staff.

5.3 Repositioning for patients with a 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 who are 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.
- Specific medical needs will be considered when choosing an appropriate surface.
- Other support surfaces such as seating cushions and appropriate offloading of heels will be provided in accordance to need.
- Bariatric equipment will be sourced for those patients that exceed the manufacturers weight limits of the standard equipment.
- Staff will implement cleaning and maintenance of equipment as outlined in manufacturer's instructions and local guidelines.

5.5 Nutrition

All patients will have an assessment of nutritional status undertaken according to the Trust's agreed nutritional screening process. 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. See also current Trust Nutrition and Hydration policies.

5.6 Documentation of Pressure Ulcers

Classification.
All pressure ulcers will be categorised using the EPUAP Classification System. See Appendix I. Pressure ulcers should **not** be reverse categorised. A category 4 pressure ulcer does not become a category 3 as it heals, if the ulcer is seen

to be improving it should be described as a recovering category 4 pressure ulcer (EPUAP, 2014).

Staff must use objective and clear descriptions of the condition of the most vulnerable pressure area sites on each shift so that any early adverse changes can be more easily identifiable, reported and addressed. Staff will be trained on how to recognise 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 identified as at risk or who have pressure ulcers.

Inherited Pressure Ulcers.
All category 2, 3 and 4 pressure ulcers and SDTI's present on admission to hospital will be assessed and reported as a clinical incident on Datix. It is advisable to obtain medical photography of category 3 and 4 pressure 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. Existing pressure ulcers should be assessed within 12 hours following admission, unless infection is suspected, when they should be assessed as soon as possible. Staff must ensure appropriate preventative interventions are introduced and implemented.

Where the patient's condition is unstable, or where the patient refuses skin assessments, the ulcer should be reviewed as soon as practicable, 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 hospital-acquired, however, the circumstances of care/use of pressure relieving equipment and/or the effects of trauma prior to admission will be taken into account.

Newly Acquired Pressure Ulcer.
Category 2, 3 and 4 pressure ulcers and SDTI's acquired within the Trust will be reported on Datix and the aSSKINg 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.

Duty of Candour.
If a category 3 or 4 pressure 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, to gain an understanding as to how it occurred and explore whether there is any learning from this incident. The Tissue Viability team will provide an apology and a duty of candour patient information leaflet to the patient explaining that we will share the findings of the review with them initially however if the patient lacks capacity, responsibility falls to the ward team to inform the next of kin if they are not present. The details of who has been

informed and the details should be recorded in the medical records and on the Datix incident form. Duty of candour procedures for each division should be followed by the ward team after this initial contact.

Medical Device Related Pressure damage
Skin will be observed for signs of pressure damage caused by footwear or medical devices, this is classified as any indwelling device or device attached to a patient that comes into to contact with the skin. Please refer to individual medical device guidelines for care of the device. A pressure ulcer that has developed due to the presence of a medical device will be referred to as a 'medical device related pressure ulcer' and will be reported via Datix.

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 category 3 or 4 pressure ulcer even with optimal treatment." (NPAUP, 2014). "The pathophysiology of deep tissue injury is not fully understood, and it is unclear why some discoloured lesions progress to full thickness pressure ulcers whilst others resolve / 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". (Briggs, 2011)

NHS England has requested that this type of injury is recorded as a Suspected Deep Tissue Injury (SDTI) and these will be monitored weekly by the Tissue Viability team for signs of deterioration or improvement. If the SDTI evolves into a category 3 then the process for a newly acquired pressure ulcer is followed.

It is important that staff carefully assess the patient's 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 in a collapsed state.

5.7 Reporting Pressure Ulcers

All pressure ulcers, category 2, 3 and 4 plus SDTI's must be reported on Datix, to facilitate incidence monitoring.

Moisture lesions; Ulcers relating to incontinence or moist skin should be clearly identified as moisture lesions on a Datix report. If skin damage is caused by a combination of moisture and pressure, it will be reported based on the category of pressure damage.

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

Hospital Acquired Pressure Damage: Is any pressure ulcer that has been acquired in one of the 5 Trust sites. All pressure ulcers should be referred to the Tissue Viability Team for triage and assessment, via Datix. The Tissue Viability will endeavour to triage and give advice within 24 hours of receipt of

the referral and arrange to review all hospital acquired category 3 and 4 pressure ulcers.

Inherited Pressure Damage: Is when a patient has acquired pressure damage under another care provider such as a hospital other than that with UHDB, from home or a care home, these must be reported on Datix and triaged in the same way as Hospital Acquired pressure ulcers. Following confirmation of any category 3 or 4 pressure ulcer by the Tissue Viability team, the incident is forwarded back on to the localities for actioning by that area.

N.B. Tissue Viability is a 5 day a week service, 8.00 till 17.00. Referrals received after triage may not be picked up immediately due to the workload 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.

5.8 Patient Safety Improvement Plans (local terminology for the review of incidents with harm identified in the care of UHDB hospitals)

A review of care will be completed by the department in which the category 3 or 4 pressure ulcer developed to identify any lapses in care which may have contributed to the development of the pressure ulcer. These reviews will form the basis for service improvement plans at Trust, divisional and local levels. PSIRF Patient Safety Incident Response Framework has been developed to promote learning and improvements nationally.

5.9 Wound Management

Holistic assessment is promoted so that staff may identify and address any factors which can adversely affect wound healing. Documentation will indicate a wound assessment with recorded objectives, a care plan with dressings required to manage the wound, and the frequency of expected dressing 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, 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 the

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-vascularisation is considered to optimise 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 neglect or omissions of care then the Safeguarding Adults policy and procedures must be instigated, and a strategy discussion / meeting convened. A record should be made in the patient's notes documenting if a Safeguarding Adult referral has been made.

If the pressure damage is hospital acquired the PSIP review is rated by the Tissue Viability team and given a RAG rating, any RED rated incidents are escalated to the safeguarding team for review and investigation.

Patients have a right to make decisions that clinical staff may consider to be ill-advised regarding their care and treatment. Non-concordance with care plans will 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 concordance. Records will be kept of the person's decisions with their pressure ulcer prevention care plan.

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 (SCALE) are a reflection of compromised skin due to reduced soft tissue perfusion, decreased tolerance to external insults, and impaired removal of metabolic wastes. (EPUAP, 2009). At the end of a patient's 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 ulcer are more likely to reposition 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 pressure ulcer prevention will help provide assurances that staff are working with the patient to establish concordance.

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

For relatives who will be caring for vulnerable individuals on discharge, becoming informed of the importance of skin care and pressure ulcer prevention is vital to reduce the risk of harm to their relative. Such information will prompt carers to seek more timely medical help or advice.

5.13 Discharge/Transfer

The Registered Nurse/Nurse Associate 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. 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 MDT, patient, family members, carers and/or District Nurse to help ensure a safe discharge.

6. Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trusts Monitoring Report Template:

Monitoring Requirement :	*Quarterly report to the Learning and Review group which included data on Trust acquired Category 2, 3, 4 and SDTI pressure ulcers. This includes a thematic review of the incidents and learning* *Up dates and escalations from the TV meeting Quarterly.* *Annual thematic review to the ICB*
Monitoring Method:	*TV Excellence audit, monthly monitoring of training and report by the divisional reps to the Tissue Viability meeting*

Report Prepared by:	*Tissue Viability*
Monitoring Report presented to:	*Tissue Viability Meeting, Learning and Review Group*

7. **References**

Briggs S-L (2011) When is a grade 4 pressure ulcer not a grade 4? *British journal of Nursing* **20** (20): S4-9

Department of Health (2008) High Quality Care For All; NHS Next Stage Review Final Report. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf Accessed on 15/3/16

Department of Health (2009) Reference guide to consent for examination or treatment 2nd Edition. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf Accessed on 15/3/16

Department of Health (2010) Essence of Care. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216691/dh_119978.pdf Accessed on: 15/3/16.

Department of Health (2010) Using the Commissioning for Quality and Innovation (CQUIN) payment framework [online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123009.pdf Accessed on 15/3/16.

European Pressure Ulcer advisory Panel (2009) Skin Changes At Life's end [online] Available at: http://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf Accessed 18/3/16

European Pressure Ulcer Advisory Panel (2014) Pressure Ulcer Prevention: Quick Reference Guide. [online] http://www.epuap.org/guidelines-2014/Quick%20Reference%20Guide%20DIGITAL%20NPUAP-EPUAP-PPPIA-Jan2016.pdf Accessed 15/3/16

Fletcher, J. National Wound Care Strategy update: Pressure ulcers prevention and the PSIRF exemplar. Wounds U.K. (2022) Vol 18. No. 4 Pages: 94 -94

National Institute of Innovation and Improvement (2009) Safer Care; the leading Improvement in patient safety program. [online] Available at:

http://www.institute.nhs.uk/safer_care/leading_improvement_in_patient_safety_programme/leading_improvement_in_patient_safety_programme_(lips).html Accessed on 15/3/16

National Institute Clinical Excellence (2014) Pressure ulcers: prevention and management of pressure ulcers [online] Available at: https://www.nice.org.uk/guidance/cg179 Accessed on 15/3/16

National Institute Clinical Excellence (2015) Pressure Ulcers. NICE Quality Standard 89. [online] Available at: https://www.nice.org.uk/guidance/qs89 Accessed on 15/3/16

National Patient Safety Agency (2010) Defining avoidable and unavoidable pressure ulcers. [online] Available at: http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/PressureUlcers/Defining%20avoidable%20and%20unavoidable%20pressure%20ulcers.pdf Accessed 15/3/16

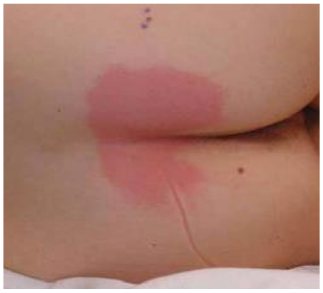
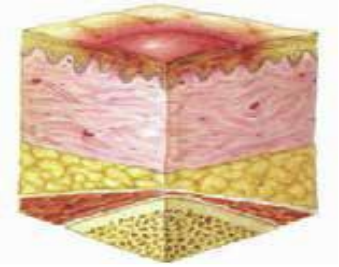
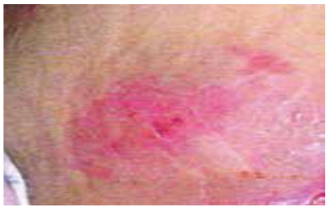
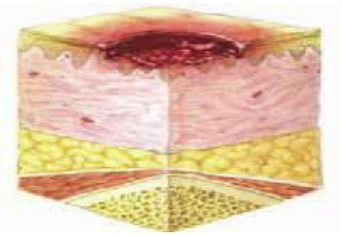
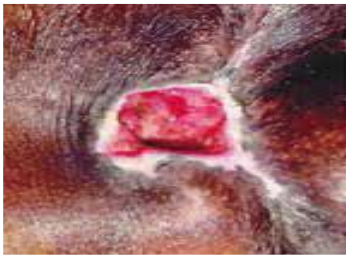
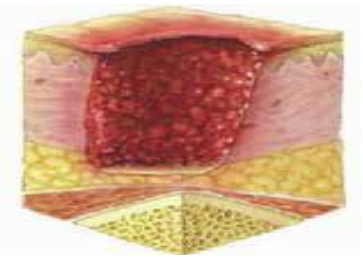
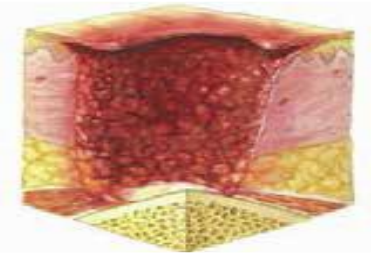
National Pressure Ulcer Advisory Panel (2014) Pressure Ulcer Prevention. [online] Available at: http://www.npuap.org/resources/educational-and-clinical-resources/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guideline/ Accessed on 15/3/16

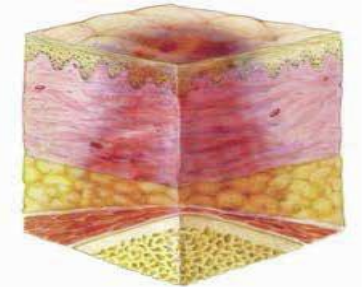
NHS Improvement (2018) Pressure ulcers: revised definition and measurement Summary and recommendations. [online] Available at: NSTPP-summary-recommendations.pdf (england.nhs.uk) Accessed 21/02/2023

Nursing Midwifery Council (2018) The Code Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

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

Non-validated tool used to improve consistence when scoring incident reviews

RAG rating	Definition	Incident Action Required	Trust Wide Action Required, for multiple incidents.

Red Scrore <30 on the TV check list Or more than 3 Level 1 lapses	There have been 3 lapses in care (Level 1), or moderate lapses in process or communication which directly or indirectly effected pressure areas management.	Safeguarding referral. Evidence of learning required. LOOP followed up in TV Meeting	Action plan for DND's, Matron's, CGF's, Senior Sisters involved. Improvement project if trend noted. Standing agenda item at PUIG for feedback
Amber Score 31-45 on TV check list Less than 3 level 1 lapses	There have been less than 3 lapses in care (Level 1) or moderate lapses in process which directly or indirectly effected pressure area	Evidence of learning required. LOOP followed up in TV Meeting	Action plan for DND's, Matron's, CGF's, Senior Sisters involved. Improvement project if trend noted. Standing agenda item at PUIG for feedback
Green Score 46-58 on TV check list No level 1 lapses	There have been no lapses in care and none or minor lapses in process, which didn't affect pressure ulcer management	Monitor trend via TV Meeting	If trend noted, review of best practice and improvement work if change required or possible.

APPENDIX III

Adult Waterlow Risk Assessment Score

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													

PLYMOUTH MATERNITY PRESSURE ULCER RISK ASSESSMENT SCORE

Risk Status **10+ At Risk 15+ High Risk 20+ Very High Risk**

Ward						**Score 10 - 15**
Date						
Time						

Skin Type (Visual Risk Areas)	Score					
Dry	**1**					
Oedematous	**1**					
Clammy (Pyrexia)	**1**					
Discoloured	**2**					
Broken/Area	**3**					
Mobility						
Restless/Fidgety	**1**					
Apathetic	**2**					
Restricted	**3**					
Inert	**4**					
Chairbound	**5**					
Continence						
Incontinent	**1**					
Ruptured Membranes	**1**					
Appetite						
Poor	**1**					
Fluids Only	**2**					
Anorexics	**3**					
Build/Weight for Height						
Above Normal (BMI 25 - 29.9)	**1**					
Obese (BMI > 30)	**2**					
Below Normal (BMI < 18.5)	**3**					
Special RIsks						
Neurological Deficit • Motor/Sensory Paraplegia inc. epidural analgesia • Peripheral Neuropathy (Diabetes/MS) • Tissue Malnutrition (Anaemia/smoking/Diabetes)	**4 - 6** **2 - 6**					
Surgery						
Casearean Section/Instrumental Birth/MROP/EUA	**4 - 6**					
All Patients Score 3		**3**	**3**	**3**	**3**	**3**
Total Risk Score						
Assessors Initials						

A Plymouth Score must be completed:

- Within **two hours** of admission/transfer to Labour Ward/314.
- If any of the trigger factors below are met,
- As / when the general condition of the patient changes during an inpatient stay.
- On **all post operative** women regardless of type of anaesthesia (until the woman is fully mobile without assistance).

Trigger factors:

- Epidural / Spinal analgesia or anaesthesia
- BMI <18 or > 35
- Existing sensory or motor neurological deficit
- Pre-existing diabetes
- Eclampsia / fulminating pre-eclampsia
- IV anticoagulant therapy or warfarin therapy
- Symphysis pubis dysfunction
- Post partum haemorrhage of more than 1litre
- Disseminated Intravascular Coagulation
- Chronic immobility

Documentation: Record position changes on partogram (labour), epidural chart if applicable, theatre care plan (in theatre) and in the Maternity Care Plan (handheld records) if ante / postnatal. Ensure any skin changes are recorded and communicated to oncoming staff at shift changes. If broken / blistered skin develops, please complete a Datix report.

Keep skin clean and dry. Offer frequent pad changes / skin hygiene if SROM or lochia present. Inspect pressure areas every 2 hours for reddening / skin discoloration / broken areas. If skin changes are noted – alter the woman's position and alleviate pressure from the site by changing her position.

Score 16 - 20+

Keep skin clean and dry. Offer frequent pad changes / skin hygiene if SROM or lochia present. Inspect pressure areas for skin changes every hour. If changes are noted alter the woman's position and alleviate pressure by changing her position. Use pressure –relieving device (e.g., Auralis) if indicated. These cannot be used on theatre tables or delivery beds. Consider using a Pressure Ulcer Prevention Care Pathway

Please record the Plymouth Score on the anaesthetic care plan (intra-operatively) or on the Special Instructions section on the partogram for women in labour.

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+

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+