University Hospitals of Derby and Burton NHS Foundation Trust

CG-CLIN/4208/23

GUIDELINE FOR THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

1. Introduction

This guideline has been developed to support the Trust Policy for Prevention and Management of Pressure Ulcers. Details for: Tissue Viability (Prevention of Pressure Ulcers) - Trust Policy and Procedure › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)

The guideline applies to all staff directly involved in patient care and will identify how the Trust will aim to prevent hospital acquired pressure ulcers and manage existing pressure ulcers effectively. Successful implementation of this guidance is dependent on a competent workforce that understands how pressure ulcers develop, recognises the presence of predisposing risk factors, and implement timely and effective preventative measures to meet the individual needs of the patient.

These guidelines place an emphasis on a nurse led, collaborative multidisciplinary process of identifying risk factors and implementing appropriate preventative and/or treatment measures.

2. Aim and Purpose

The aim of this guideline is to ensure consistency of practice across the Trust for patients presenting 'at risk' of developing pressure ulcers, those patients with pressure ulcers present on admission and those acquired within the Trust. Successful prevention depends upon removing or modifying the causes of pressure ulcers and to this end the organisation has taken a zero tolerance to pressure ulcers.

3. Definitions

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

Category of Pressure Ulcer: EPUAP's (2014) description of the level of skin tissue damage caused by pressure on a scale of 1-4.

Care Bundle: a group of interventions related to a disease or condition which, when carried out together, improve care outcomes.

MUST score: Malnutrition Universal Screening Tool

Pressure Ulcer: "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).

4. Implementing care using aSSKINg and the Prevention and Management of Pressure Ulcers Care Pathway

Success in pressure ulcer prevention relies on the introduction of timely actions which are carried out simultaneously and consistently. As put forward in the Stop the Pressure campaign (2018) There are 7 essential care steps that help prevent pressure ulcers using the acronym **aSSKINg**:

The Prevention and Management of Pressure Ulcers Care Pathway should be commenced within 12hrs of identification of risk.

assessment

A qualified member of staff should undertake a pressure ulcer risk assessment, using the appropriate tool for their area, within 2 hours of admission/transfer to their clinical area, this should be documented within the appropriate document for the clinical area where the assessment is undertaken. For Derby this should be within the patient assessment and care record and on the Burton sites on the Meditech electronic notes system. It is accepted that there are additional risk factors for maternity patients. These are to be recognised, and appropriate interventions implemented to mitigate those risks (See Appendix I).

Assessment tools are available to assess adults, paediatrics, neonates, and maternity patients. These are outlined within the Trust policy for the prevention and management of pressure ulcers.

Completed risk scores, in conjunction with holistic assessment will help determine the appropriate preventative care plan category within the pressure ulcer prevention and management care pathway.

A pressure ulcer prevention and management pathway (WPH1698) should be used for all patients identified at risk of pressure ulcer development.

Patients who have active pressure ulcers should also be commenced on the Wound Management Pathway (WPH1697).

Further review, using a risk assessment tool should be recalculated weekly or with changes in patient condition.

Risk assessment should not be used in isolation, but in conjunction with the registered professional's clinical judgement.

Surface

Support surfaces require a 24hour approach and include mattresses, cushions, and offloading boots.

Guidance is provided within the care pathways; however, all inpatients, as a minimum requirement, should have a pressure redistributing foam mattress.

Alternating dynamic mattresses are available for higher risk patients. Refer to the Trust Policy and Procedures for the Management of Medical Devices for processes for arranging delivery of specialist or foam mattresses as well as troubleshooting, cleaning, and reporting faulty mattresses. opac-retrieve-file.pl (koha-ptfs.co.uk)

Discussion should take place with the individuals consultant for patients with spinal injury, that are unable to have an alternating mattress system.

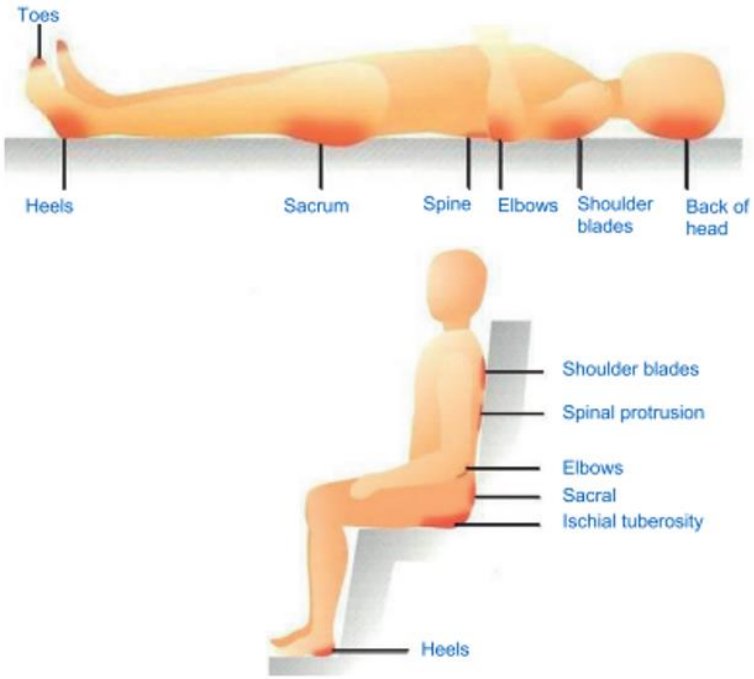
High risk static cushions are available on all wards. These should be cleaned appropriately between patient use. Chair height should be considered when selecting a pressure redistributing cushion to ensure patient safety and reduce the risk of falls.

Offloading boots are available 24 hours a day and are obtained from the equipment lockers with the use of the ward key fob. If offloading boots are not appropriate, then pillows should be used to offload heels.

Pressure reducing equipment can be downgraded as patient condition improves.

Skin

Qualified nursing staff, including Trained Nursing Associates, should assess the condition of an individual's skin within 2 hours of admission/transfer. All bony prominences should be examined. Common sites for pressure ulcers are:



Existing pressure damage should be graded using the EPUAP grading system. Vulnerable areas of skin should also be identified in addition to areas of pressure damage.

When assessing skin, changes to look for include:

Persistent erythema (redness)

Non blanching redness

Purple discolouration

Blistering

Localised heat

Localised oedema

Localised pain

Localised induration

Active pressure damage

Clinicians should be extra vigilant when assessing darkly pigmented skin, as changes are not as easily identifiable. A useful document to assist in assessing darkly pigmented skin can be found in Appendix II

All Pressure Ulcers should be documented and categorised on the body map within the care pathway.

Skin should be further assessed at every position change and recorded at least every 8 hours within the care pathway.

It is advisable to obtain medical photography to provide evidence of inherited pressure damage on admission to hospital, document any new damage and to allow accurate reassessment of pressure damage. It is also advisable to obtain images, with consent, for all hospital acquired damage of category 3 or 4 and SDTIs.

Keep moving.

Movement must be considered as being the body's first defence against pressure ulcer development. Individuals at risk will be repositioned as a response to skin inspection and according to individual need and management plan. Repositioning frequency should be determined by the individuals skin tolerance, level of activity and mobility, medical condition, support surface and patient consent. Recommendations for repositioning are made within the Green, Amber, and Red care plans.

In addition:

- 30-degree tilts are recommended to offload pressure from bony prominences.
- Slide sheets should be used to assist position changes to prevent shearing and friction to the skin.
- Patients should not be positioned onto bony prominences or where there is visible non blanching redness/existing pressure damage.
- Seating out of bed for patients with pressure ulcers to the sacrum, ischial tuberosities, spine will be restricted and planned on an individual basis.
- Bariatric equipment requirements should be discussed with the moving and handling team within the trust.
- Extra care should be taken when a patient is in the prone position. Further guidance can be found at: Pressure-ulcer-prevention-guidance-when-proning-patients-V6-5.5.20-1-2.pdf (nationalwoundcarestrategy.net)

All repositioning activity should be logged on the daily record of repositioning, including any refusal to reposition by the patient. This should be completed by all care staff and therapists.

The repositioning should match with the care highlighted in the allocated care plan.

Incontinence

An individualised care plan is developed for all at risk patients, in partnership with the patient, main carer and multidisciplinary team to help minimise risk factors such as incontinence and appropriate measures introduced to help manage patient needs.

An appropriate skin wash cream and Barrier product should be utilised for all incontinent individuals to prevent excoriation and subsequent skin damage. See appendix III for local protocol.

Urinary catheters should be considered for those patients with excessive skin damage from moisture, that can't be managed appropriately with barrier products, considering the patients individual medical needs.

Bowel care should be considered for patients with faecal incontinence. Constipation and overflow symptoms should be treated accordingly. Faecal management systems should be

considered by the medical team for those patients with excessive damage due to faecal incontinence.

Nutrition

Patients who are malnourished are highly vulnerable to pressure damage, also those who have pressure ulcer will require additional nutritional support to support healing. Staff should assess the patient's nutritional status using the MUST tool and follow Trust guidelines on the management of malnutrition and implement MUST care plans. For further guidance see Trust policy for Oral Nutrition and Hydration of Adults.

Results of search for 'oral nutrition and hydration of adults' › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)

Nutritional support/supplementation with or without the use of oral nutritional supplements should be considered. This is outlined in the medium and high malnutrition risk categories of the 'suggested advice' as documented in the Patient Assessment and Care Record. This may or may not be under the guidance of a dietitian.

giving information

Patient information leaflets for the prevention of pressure ulcers whilst in the Trust should be given to patient/carers on admission. Information leaflet: WPH2514/UHDB /P3767/17 45/03.2020NERSION2 is ordered from stores via the Saffron system.

Patient information is available in different languages please see the Tissue Viability section on Net-i. All information provided regarding pressure ulcer relief should be documented and where applicable a SSKIN advice sheet completed and signed by the patient/carer to ensure that the implications of not adhering to the advice is understood fully by them. See Appendix V for SSKIN advice sheet which is also found on the back of the Pressure ulcer pathway.

The Tissue Viability Nurse will undertake an apology and perform Duty of Candour with patients who develop a category 3 or 4 pressure ulcer within our care. In the absence of mental capacity, the clinical area staff will be asked to undertake Duty of Candour with the next of kin. The Duty of candour patient leaflet is available on Net-i.

Prevention and Management of Pressure Ulcers Care Pathway document

The pathway should be implemented for all patients identified at risk of Pressure Ulcers and patients with existing pressure damage. A Tissue Viability short stay admission pathway is available for adults not expected to exceed three days stay as an inpatient.

Using Green, Amber and Red categorisation, patients will be allocated to a care plan category, considering the following factors:

GREEN

- Your patient is **INDEPENDENTLY** mobile in hospital.
- Risk assessment score is low.
- They will reposition spontaneously and independently **without** being prompted (Paediatrics – if the patient's mobility is normal for their age).
- No evidence of pressure related skin damage on skin assessment.
- Pain is not reducing their normal activity levels.

AMBER

- Your patient has **RESTRICTED** mobility in hospital or requires **prompting** to reposition.
- Risk assessment score shows patient is at risk of developing a pressure ulcer.
- They have pressure damage or moisture lesions.
- They have a medical device in place that restricts mobility.
- They have pain, causing a reduction in normal mobility.
- Your patient has sensory impairment or unable to tell you if they are in pain (or have an epidural).

RED

- Your patient is **IMMOBILE** or requires full assistance to reposition.
- Risk assessment score is high- very high.
- They have a Category 3-4 pressure ulcer, or a pressure ulcer that is deteriorating.
- They have an altered consciousness/ cognitive impairment.
- They may have circulatory impairment.
- They may have a sensory impairment or unable to tell you if they are in pain.

SSKIN interventions should then be implemented according to category of risk as follows:

GREEN*

Your patient demonstrates the ability to spontaneously mobilise and change position in bed and in the chair, and they are able to understand the reasons for doing this. They are able to react to painful stimuli and any pain is well controlled with analgesia and is not restricting their ability to move.

- Check skin over bony prominences at this time and ensure the patient is aware that it is their responsibility to inform staff of any soreness.
- A high risk foam mattress should be sufficient.
- Risk assessment is recorded at least once per week and as the patient's condition changes.
- Inform the patient/carer that they should be repositioning regularly to prevent pressure ulcers.
- Provide an information leaflet on prevention of pressure ulcers to the patient/carer.
- Record any alteration in ability (such as short term immobility due to procedures) and upgrade patient into a different category if required until mobility returns.

PATIENTS WHO STEP DOWN ON TO A GREEN PATHWAY SHOULD BE MONITORED ON THEIR REPOSITIONING CHART FOR 24 HRS BEFORE THE PATHWAY IS DISCONTINUED.

AMBER

The patient has category 1-2 pressure ulcers, or a recovering category 3 pressure ulcer. They may have some difficulty in repositioning. They may be able to physically reposition themselves, but they require prompting to do so. They may have leg ulcers, compromised circulation or heavy limbs. Patients who have a medical device that restricts mobility may also require assistance with repositioning.

SURFACE

- If the patient is mobile or the pressure ulcer is on an area which can be effectively offloaded (e.g. heel), then a static mattress is satisfactory.
- If they require prompting or encouragement with repositioning consider an alternating mattress.
- Off load heels.
- Use a high risk cushion when patient is sat out in a chair.

SKIN ASSESSMENT

- Assess skin 3 times a day and document.

KEEPING MOVING

- Patient repositioned every 4 hours in bed and every 2 hours in a chair.
- Ensure sliding sheets are in use to reposition.
- Encourage patient to reposition independently if able (and document as witnessed repositioning).
- Consider analgesia if pain is preventing the patient from repositioning.
- Ensure an appropriate care plan is in place for any medical devices in use, and escalate any problems to the appropriate person.

INCONTINENCE/MOISTURE

- Incontinence assessment.
- Keep skin clean and provide patients with a barrier wash cream.
- Use appropriate barrier products on the skin if it is moist or patient is incontinent.
- Provide an appropriate pad/nappy for level of incontinence.

NUTRITION

- Complete MUST score; address nutrition needs and assist with eating and drinking as necessary.

GIVING INFORMATION

- Complete SSKIN advice sheet with the patient (if they have capacity), or carer so they are aware of the advice they have been given regarding the AMBER care plan.
- Provide an information leaflet on preventing pressure ulcers.

RED

The patient has a category 3 or 4 pressure ulcer, or a pressure ulcer that is deteriorating. They are unable to reposition themselves and require full assistance (this may be due to altered consciousness, cognitive impairment or a physical disability).

SURFACE

- Alternating mattress.
- Off-load heels with single use/re-usable offloading boots/pillows.

SKIN ASSESSMENT

- Pressure areas checked every time repositioned.
- Recorded at least every 8 hours unless there is a change.

KEEPING MOVING

- 2 hourly repositioning; reassess daily and record rationale in the changes to care plan section if this regime altered.
- Ensure sliding sheets are in use to reposition.
- Utilise 30 degree tilt with all limbs supported with pillows.
- If unable to alter position due to condition or pain record reasons and alternatives discussed.
- Sitting out may need to be limited or even avoided, based on an individual assessment.
- Ensure an appropriate care plan is in place for any medical devices in use and escalate any problems to the appropriate person.

INCONTINENCE/MOISTURE

- Complete incontinence assessment.
- Keep skin clean and provide patients with a barrier wash cream.
- Use appropriate barrier products on the skin if it is moist or patient is incontinent.
- Provide an appropriate pad/nappy for level of incontinence.

NUTRITION

- Complete MUST score; address nutrition needs and assist with eating and drinking as necessary.
- Refer to dietician for advice on nutrition to aid wound healing.

GIVING INFORMATION

- Complete SSKIN advice sheet with the patient (if they have capacity), or carer so they are aware of the advice they have been given regarding the RED care plan.
- Provide an information leaflet on preventing pressure ulcers.

These care plans should not replace clinical judgement and any variations needed should be monitored within the changes to care plan section within the pressure ulcer prevention care pathway.

Dressing selection

Wound evaluation should be completed on initial assessment and on every subsequent dressing change to monitor any progress or deterioration. An individualised care plan should be completed for each pressure ulcer within the wound management care pathway.

The provision of pictorial wound classification and standard wound management guidelines within the care pathways will help staff to recognise causative factors and choose dressings to help create a moist healing environment. Staff can refer to the Wound Care Formulary and guidelines for additional information. These are available on Net-i:

https://neti.uhdb.nhs.uk/download.cfm?doc=docm93jijm4n20799.xlsx&ver=52871

https://neti.uhdb.nhs.uk/download.cfm?doc=docm93jijm4n20798.pdf&ver=56421

Evaluation of care

The patient's risk status should be reassessed by trained staff, at frequent intervals and as condition changes. Reassessment may initially be undertaken daily during an acute phase of illness or in the post-operative phase. Frequency of repositioning may be reduced as the patient's condition stabilises and be reviewed at weekly intervals or as the patient's condition changes. Where adverse changes in risk factors are noted, e.g.: uncontrolled diabetes or presence of infection, staff should amend care plan to address and manage new problems.

If a patient's general condition improves, staff will reassess the need for repositioning or equipment provision to promote rehabilitation potential, e.g., downgrading alternating mattresses to foam so that the patient can move more easily and independently.

For patients compromised by immobility, pressure areas and skin condition will be evaluated on each shift and recorded on the patients repositioning chart. Any changes identified will be reported and care amended to address any new problems.

Pressure ulcers should be evaluated at least every 48 hours, or where new changes are identified, and prior to patients transfer or discharge. Characteristics will be documented on the wound evaluation form in the Wound Management Care Pathway or in Meditech V6, to review any progress or deterioration. Characteristics documented will include the wound size, depth- superficial or full thickness, category, tissue colour, exudate levels, presence of pain and ongoing progress.

Medical Devices

Medical Devices can cause pressure damage if not applied or cared for correctly.
Specialist medical devices such as casts and splints have specialist care plans available on Net-i.
Individual medical devices should be documented on the body map within the pressure ulcer prevention care pathway and repositioned according to the individual care pathway. Splint workshop plans should be followed. Reports of pain under a medical device should always be listened to and actions taken to find out the cause of the pain, and whether pressure can be relieved.

Appropriate referrals

All category 3 and 4 pressure ulcers are referred to the Tissue Viability Team by completing a Datix IR1.

The Tissue Viability Nurse will confirm the category of the pressure ulcer and, if appropriate, initiate a review of the notes for those ulcers which have developed within our care.

Where wounds fail to make expected progress or where deterioration is noted, nursing staff should seek advice from the Tissue Viability champion for the clinical area.

Tissue Viability champion nurses are based in each clinical area and will assess and suggest alternative management if the current equipment or dressing regime fails to meet the patient's needs.

If further specialist advice is required, then TV review can be sought.

Discharge planning

Prior to discharge, home equipment should be assessed and referral to community nursing teams should be made in a timely manner. If pressure ulcers are present, then a supply of dressings, should be sent home with the patients if requiring community nursing input. This would normally be enough for two days dressing changes.

The Occupational Therapist should also be included in any planning for home equipment and social care should be informed of need for regular input for individualised repositioning.

5. References

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

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

Stop the Pressure (2014) SSKIN campaign http://nhs.stopthepressure.co.uk/

6. Documentation Controls

Reference Number CG-CLIN/4208/23	**Version:** 1		**Status** Final	Final
Version / Amendment History	Version	Date	Author	Reason
	1	April 2023	Tissue Viability team	New guideline to support policy. Maternity Pressure ulcer guidelines integrated into this guideline
Intended Recipients: All clinical staff providing care for patient at risk of and with active pressure ulceration.				
Training and Dissemination: Pressure ulcer two yearly updates. TV champions clinically, Tissue Viability team. Newly qualified and overseas nurse training. Local bespoke training				
Development of Guideline: **Job Title:**				
Consultation with: Maternity, East Midlands TV group, Paediatrics, Matrons				
Linked Documents: Pressure ulcer policy, wound management guidelines, Incontinence guidelines, medical photography guidelines,				
Keywords:				

Business Unit Sign Off	**Group: Tissue Viability Meeting** **Date: 7th July 2023**
Divisional Sign Off	**Group:Trustwide Guideline Group** **Date:29 September 2023**
Date of Upload	September 2023
Review Date	September 2026
Contact for Review	Tissue viability team

7. Appendices

APPENDIX I

ADDITIONAL CONSIDERATIONS FOR THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS IN MATERNITY AND OBSTETRICS

Abbreviations

BMI	-	Body Mass Index
CTG	-	Cardiotocograph
IR1	-	Incident Report
IV	-	Intravenous

Key Responsibilities and Duties

It is the responsibility of the midwives to perform a full skin assessment, and pressure ulcer risk assessment, using the 'Plymouth maternity pressure ulcer risk assessment tool' for patients who are not fully mobile, or have any trigger factors listed in this appendix. This must be completed within **two hours** of admission / transfer to Labour Ward / 314. In addition, the Plymouth Score and skin checks are to be completed on **all post-operative** women regardless of type of anaesthesia (until the woman is fully mobile without assistance). Upon assessing the women as high risk, the 'Plymouth Score' must then be reassessed as and when their general physical condition changes. The risk assessment tool should act as an aide memoir and should not replace clinical judgement.

Ensure that those women at risk of developing pressure ulcers are educated about their risk factors and advised of measures to minimise them.

Trigger factors – tissue viability risk assessment

Women with the following trigger factors MUST have a formal risk assessment completed using the Plymouth score.

- 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 than1litre
- Disseminated Intravascular Coagulation
- Chronic immobility

Documentation

The Plymouth Risk Assessment form may be used to document the risk score.

Please ensure all assessments and individual plans of care are documented clearly in the appropriate records which may include some or all of those listed below:

- medical records
- maternity handheld records
- maternity clinical system special instructions page

Good record keeping is an integral part of nursing and midwifery practice and is essential to the provision of safe and effective care. (NMC 2009)

Risk assessment

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

- Pre labour rupture of membranes – (biggest common factor in epidural – related pressure ulcers)
- Reduced mobility or immobility.
- Sensory impairment
- Acute illness
- Level of consciousness
- Vascular disease
- Low BMI
- Raised BMI
- Severe chronic or terminal illness
- Previous history of pressure damage
- Malnutrition and dehydration
- Pressure
- Shearing
- Moisture to skin
- Medication e.g., long term steroids

Action to be taken in "at risk" women.

Risk assessments may be completed in all areas dependent upon need of the woman. Those who score 20 or above should have a **Prevention and Management of Pressure Ulcers Care Pathway** initiated**,** (WPH1698, available from Ward 209 or stores)

Any preventative action taken must be clearly recorded in the labour notes (during intrapartum care only) or in the Maternity Care Plan.

All risk assessments must be available to all members of the multidisciplinary team. A proactive care plan will then be kept according to the needs of the individual.

Skin inspection

Skin inspection should be based on an assessment of the most vulnerable areas of risk for each woman. These are typically – heels, sacrum, buttocks, ischial tuberosities, femoral trochanters, elbows, shoulders, the back of the head and toes.

Pressure and shear may result from equipment, clothing, and bed linen.

Skin changes should be documented / recorded immediately in the health record, and the care plan altered according to individual needs.
If the woman remains at risk of developing a pressure ulcer on transfer from hospital, the risk score, and plan of care must be clearly documented on discharge records. If she should still require pressure-relieving equipment, seek advice from the tissue viability department.

Positioning

All women deemed "at risk" will be individually assessed and the frequency of repositioning will be determined by skin inspection, individual needs, comfort, and the risk care plan category assigned in the **Prevention and Management of Pressure Ulcers Care Pathway** (WPH1698). *Relevant interventions must be recorded in this document.* The repositioning schedule should be agreed, recorded, and established for each woman at risk.

Positioning should ensure that prolonged pressure on bony prominences is minimised. Consider manual handling techniques to minimise friction and shear damage.

Individuals who are considered acutely at risk of developing pressure ulcers should restrict chair sitting to less than 2 hours at any one time.

Further advice can be sought from the tissue viability nurse specialists (see contact details).

Use of Aids

All patients within the University Hospitals of Derby & Burton NHS Foundation Trust maternity units are nursed on high quality foam pressure redistributing mattresses that can support up to a Category 2 pressure ulcer and a Plymouth score of 16 (High Risk).

Women in "at risk" groups should have hygiene and skin care needs assessed and care planned to meet their needs and documented.

Any aides should be used as per manufacturers' instructions and should not be left in situ after moving the woman is complete.

If a pressure ulcer develops:

In the rare event that a pressure ulcer develops in a maternity patient the following action must be taken:

- Complete **a Prevention & Management of Pressure ulcers Short Stay Care Pathway (WPH1699)** documenting all the relevant information and use the information within the document to inform dressing choice and categorise the pressure ulcer.
- Have the wound photographed via medical photography if appropriate and store within the CTG folder of the woman's medical notes.
- Complete a DATIX
- Reassess the woman's Plymouth Score and document accordingly this will also help to inform if the woman requires a different support surface on which to be nursed.
- Ensure that progress and care given is communicated clearly to the relevant primary care staff on discharge.
- Please ensure that sufficient dressing material is provided to the woman on discharge.

- The Consultant responsible for the woman's care should be informed whilst she is still an in-patient and a postnatal follow up appointment may be offered.
- Ensure that the woman, and as appropriate, her family, receive a clear explanation by a senior midwife or obstetrician, and that clear guidance on caring for the pressure ulcer and the likely course of healing is given.

Tissue Viability Contacts

TV Champion Midwife for Tissue Viability based on Labour ward

UHDB Tissue Viability team can be contacted:

Derby Sites: ext: 87043 or 86054 / Bleeps: 3128 / 3165 / 3337

Burton Sites: ext: 6293/6294 Bleeps: 461

APPENDIX II

Pan-Pacific Classification System for Dark Skin Tones

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR DARK SKIN TONES

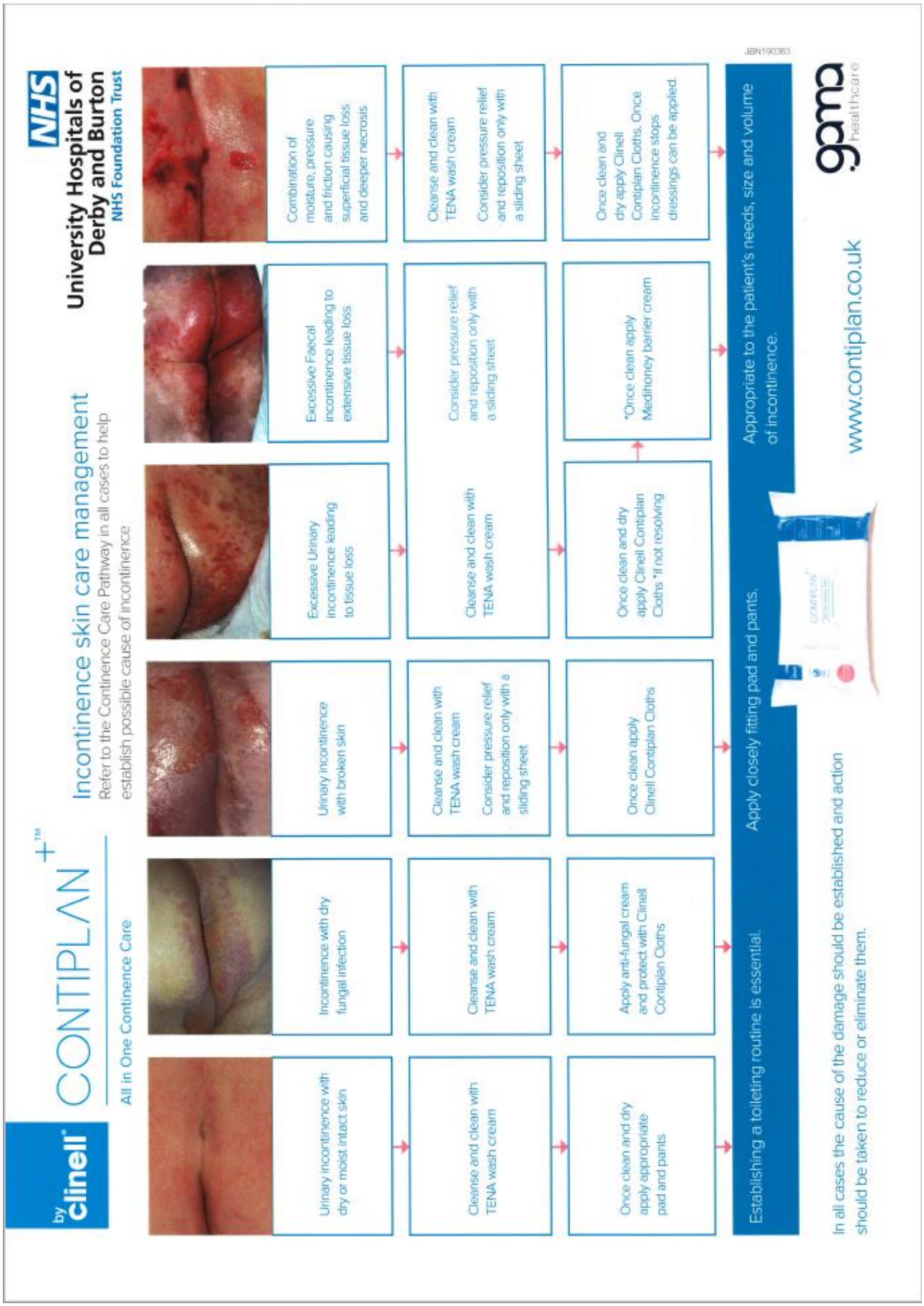
PAN PACIFIC
Pressure Injury Alliance

Text adapted from: *International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014)* published in in National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. **3D graphics:** Owned by PPPIA. **Photos:** All photos courtesy Dr Keryln Carville, used with permission. **Also available in this series:** PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults.
More information and permission for use: www.pppia.org

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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 I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).	Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

APPENDIX III

Incontinence Skin Care Management Pathway



APPENDIX IV

Patient Information Leaflet

Patient Information

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Preventing pressure ulcers in hospital

Anyone who spends a long time in one position - sitting in a chair or lying in bed, is at a larger risk of getting a pressure ulcer (also known as a pressure sore or bed sore).

You are more at risk if:

- Your walking or moving is restricted due to illness, injury, surgery or pain.
- Your skin marks easily.
- You have had a previous pressure ulcer.
- You are unable to reposition yourself in bed.
- You have a condition such as diabetes, or breathing, circulation or neurological problems.
- You are not eating and drinking as well as usual.
- You are taking medicines such as Warfarin or steroids.

What can I do to prevent pressure ulcers?

Think SKINS and tell staff your concerns straight away

S	**Skin check** Check your skin for signs of redness, pain or damage.
K	**Keep moving** Ensure you change your position regularly - whether this is moving in bed to an alternative side or getting up and going for a short walk if you are well enough. Ensure your heels are offloaded/suspended with either pillows or special boots that staff can give you.
I	**Incontinence** Moisture can increase the risk of pressure damage. If you need help with your toileting needs whilst in hospital, please speak to the staff. Excessive sweating can also increase your risk of pressure damage, please speak to the staff if this is a problem.
N	**Nutrition** You need adequate diet and fluids to maintain healthy skin.
S	**Surface** This can be your mattress or chair. If you have pressure damage, you may benefit from a specialised mattress and/or cushion for your chair, which helps to reduce pressure. However, it is still important to keep moving.

How will I know if I am getting a pressure ulcer?

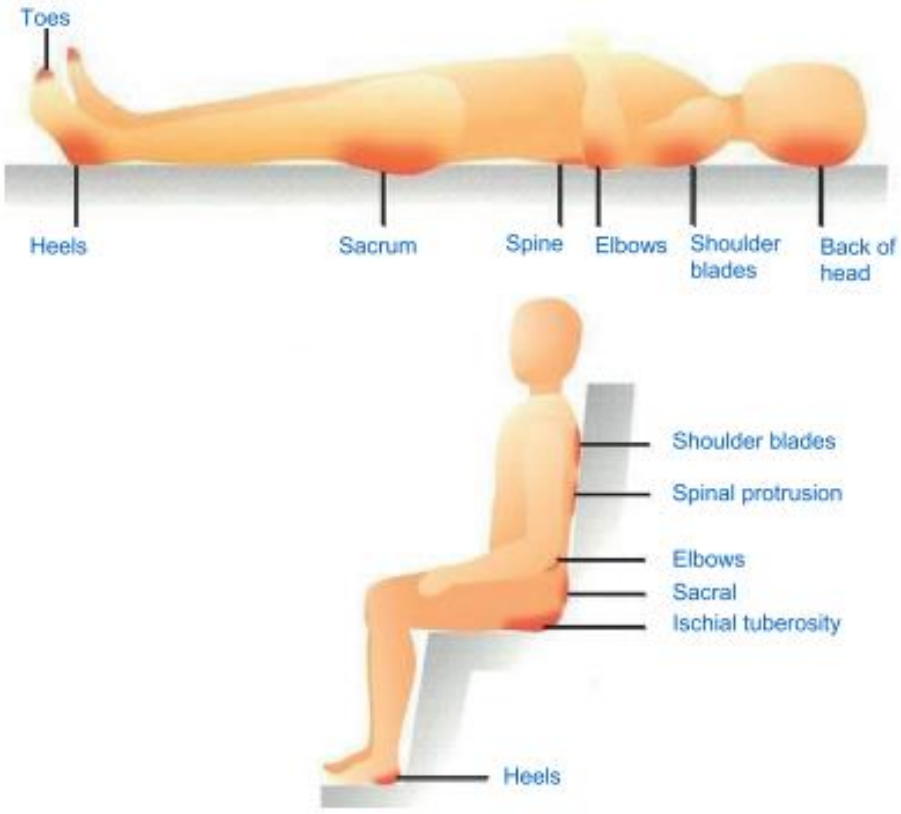
There are some key things to look out for. If you find anything, tell a staff member as soon as possible:

PAIN	e.g. heels can sometimes feel painful when resting on the bed or floor.
REDNESS OR PURPLE	this is due to interruption of blood flow in the blood vessels, due to pressure causing tissues to be starved of oxygen and nutrients.
BLISTERING	This can eventually lead to a deeper wound if pressure is not relieved.
CHANGE IN TEXTURE	e.g. spongy or harder tissue.

It is important to note that pressure ulcers can occur on bony parts of the body and sometimes under equipment such as oxygen masks, tubing, compression stocks as well as light footwear.

Checking for pressure ulcers in hospital

Nursing staff check a variety of different parts of your body. The pictures below show the areas of greatest risk.



What will happen if I have any areas of soreness on my skin?

If you have any areas of skin that are sore, red, hot or swollen **please tell your nurse as soon as possible**. If you are assessed as being at risk of developing a pressure ulcer or have started to get one, we will ask to inspect your skin for signs of damage every day. This is determined on your hospital admission and regularly throughout your stay. Your nurse will allocate you into one of the following risks groups. Ask them to tell you which group you are in.

GREEN mobile patients	If you can move yourself and do not have any existing skin damage: • Please tell staff as soon as possible if you have any soreness, especially if this is in a bony area. • Please tell staff if you need pain relief to make it easier for you to move. • Ward staff will assess the risk of your skin getting sore weekly or if anything changes in your condition.
AMBER patients with restricted mobility	If your movements are restricted, you require assistance or prompting and/or you have reduced feeling to your skin: • You will be encouraged to change position frequently. • Ward staff will check your skin three times a day for any redness or soreness, but please tell the ward staff if you feel sore. • If suitable, you will be nursed on pressure relieving equipment such as a pressure reducing cushion or special alternating air mattress. • You will be provided with pain relief to help you move more freely, if required. • Please tell the ward staff if you have any issues with incontinence, as this will increase your risk of developing a pressure ulcer. • Your dietary needs will be assessed and referral to a dietitian made if necessary. Please tell the nurse if you have any worries about not eating or drinking enough.
RED immobile patients	If you are immobile, have reduced circulation, reduced feeling to your skin and/or existing pressure damage: • You will be placed on an alternating mattress. • If your heels are at risk of pressure damage, you will be given boots to lift your heels off the bed. • Your skin will be checked every 8 hours, but please tell the ward staff if you feel sore. • You will be helped to reposition frequently. Please tell the staff if you are uncomfortable and work with them to develop a suitable repositioning plan. • You will receive an incontinence assessment and management plan, if possible please tell the ward staff if you are having incontinence.

Nurses should also be looking at areas where medical devices are, as they can cause pressure damage. Examples include:

- Catheters and catheter straps
- Oxygen masks
- Splints
- Monitoring equipment
- Feeding tubes
- Plaster casts
- TED stockings

Give it your BEST SHOT when checking your skin

B Buttocks
E Elbows and ears
S Sacrum (bottom)
T Trochanters (hips)

S Spine and shoulders
H Heels
O Occipital area (back of head)
T Toes

If in doubt, please ask your nurse or doctor for advice or information at any time. Don't wait until you have a pressure ulcer before you seek help.

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APPENDIX V

UNIVERSITY HOSPITALS DERBY & BURTON NHS FOUNDATION TRUST

SSKIN PATIENT ADVICE SHEET

PATIENT ADDRESSOGRAPH	Location Advice Given Ward: _____ Site:_____

Our Trust is working hard in order to try to reduce the risks of pressure ulcers to our patients. Our risk assessments indicates that you are at risk of pressure ulcer development or deterioration because of the following_____
_____
_____

We are providing you with this information to help ensure you understand the measures we need to introduce, in order to help reduce your risks of ulcer development. We also wish to advise you of the possible consequence i.e. development of a pressure ulcer if we are unable to consistently ensure that the following key elements of care are achieved.

In order to minimise your risks of pressure damage it is important that you and/ or you carer adhere to the following recommendations:

Skin Assessment	
Surfaces	
Keep Moving	
Incontinence	
Nutrition	

I have discussed the above risk factors with the Nurse/ Therapists and understand that the above care recommendations / advice will help reduce risks of pressure ulcer development

Date: _____ Patient Signature: _____

Date: _____ Carer Signature: _____

Date: _____ Nurse Signature: _____