# Prevention, treatment and management of pressure ulcers

<table>
<thead>
<tr>
<th>Lead executive</th>
<th>General Manager</th>
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<tbody>
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<td>Authors details</td>
<td>Tissue Viability Specialist Nurse - 01244 389243</td>
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<tr>
<th>Type of document</th>
<th>Guidance</th>
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<tr>
<td>Target audience</td>
<td>All CWP staff</td>
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**Document purpose**

This guideline provides guidance to Cheshire and Wirral Partnership (CWP) staff in the relation to the reduction in risk of pressure ulcer development and the assessment, planning, implementation and evaluation of pressure ulcers which have developed. The document outlines best practice standards for the prevention and management of pressure ulcers.

The ultimate aim of the guideline is to support staff to reduce the incidence of pressure ulcer development and to ensure that, should a pressure ulcer develop, it is managed in an evidenced based, effective way.

<table>
<thead>
<tr>
<th>Approving meeting</th>
<th>Clinical Practice and Standards Sub-Committee</th>
<th>Date 12-Dec-19</th>
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<tr>
<td>Implementation date</td>
<td>12-Dec-19</td>
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**CWP documents to be read in conjunction with**

- IC2 Hand decontamination standard operation procedure
- IC3 Standard (universal) infection control precautions policy
- GR1 Incident reporting and management policy
- GR26 Safe manual handling of people and loads policy
- HS1 Waste management policy
- CP3 Health records policy
- CP10 Safeguarding adults policy
- CC23 Clinical guidelines for digital photography in wound care

**Document change history**

**What is different?**

Guidance updated in accordance with the NHS Improvement Pressure ulcers: revised definition and measurement. June 2018.

**Appendices / electronic forms**

New flowchart for incident reporting.

**What is the impact of change?**

- Training requirements: No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

**Document consultation**

- Clinical Services: via policy discussion forum
- Corporate services: via policy discussion forum
External agencies

via policy discussion forum

Financial resource implications

None

External references


### Equality Impact Assessment (EIA) - Initial assessment

<table>
<thead>
<tr>
<th>Does this document affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
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<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
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<td></td>
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<tr>
<td>Gender</td>
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<td>Culture</td>
<td>No</td>
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<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
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<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
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<tr>
<td>Age</td>
<td>No</td>
<td></td>
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<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
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</tbody>
</table>

Is there any evidence that some groups are affected differently? No

If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? N/A

Is the impact of the document likely to be negative? No
- If so can the impact be avoided? N/A
- What alternatives are there to achieving the document without the impact? N/A
- Can we reduce the impact by taking different action? N/A

Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.

Was a full impact assessment required? No

What is the level of impact? Low
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Quick reference flowchart 1 for pressure ulcer prevention process
For quick reference the guide below is a summary of actions required.

Management of pressure ulcers in adults

Categorise each pressure ulcer using a validated classification tool. Use this to guide ongoing preventative strategies and management.

Document the results of categorisation each time the ulcer is assessed.

**PRESSURE REDISTRIBUTING DEVICES**
- Use a high specification foam mattress
- Insufficient to redistribute pressure?
- Consider using a dynamic support surface
- Sitting for prolonged period?
- Consider seating needs
- Consider a high specification foam or equivalent pressure redistributing cushion

**ULCER MEASUREMENT**
- Record and document the surface area of all pressure ulcers. If possible, use a validated measurement technique.
- Document an estimate of the depth of the ulcer and the pressure of undermining.

**DEBRIDEMENT**
- Assess the need to debride a pressure ulcer in adults, taking into consideration: the presence of dead tissue, patient tolerance, any comorbidities, the category, size and extent of the pressure ulcer.
- Allow autolytic debridement using an appropriate dressing.
- Likely to take a long time?
- Consider using sharp debridement.
- Sharp debridement contraindicated?
- Consider larval therapy.

**NUTRITION AND HYDRATION**
- Offer a nutritional assessment by a dietitian or other healthcare professional.
- Nutritional deficiency identified?
- Yes
- No
- Offer nutritional supplements to correct nutrition deficiency.
- Provide information and advice on how to follow a balanced diet to maintain an adequate nutritional status, taking into account energy, protein and micronutrient requirements.
- Do not routinely offer nutritional supplements unless supplements are needed to support healing.

**DRESSINGS**
- Consider using a dressing that promotes a warm, moist wound healing environment for Category 2, 3 and 4 pressure ulcers.
- Consider using a dressing to support healing.
- Consider using a dressing to promote a warm, moist wound healing environment for Category 2, 3 and 4 pressure ulcers.

**ANTIMICROBIALS**
- Is there:
  - Clinical evidence of systemic sepsis
  - Spreading cellulitis
  - Underlying osteomyelitis
- Discuss with the microbiology department which antibiotic to offer.
- Antibiotics not indicated
- Yes
- No
- Offer antibiotics

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- Use a high specification foam mattress
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- Yes
- No
- Offer antibiotics

NICE Guidance CG179 – April 2014

Do not retain a paper version of this document, always view from the website www.cwp.nhs.uk to ensure it is the correct version.
Quick reference flowchart 2 on how to report a pressure ulcer incident

1. Skin integrity check
   - Pressure ulcer ‘developed in our care’?

   - No
     - Complete care standards – ASSKIN tool on EMIS
     - Complete Datix*
     - Manager review/ Clinical Lead
     - Final approval by Clinical Governance Team

   - Yes
     - Safeguarding concern?
       - Yes
         - Referral to CWP Safeguarding Team/Local Authority
         - Complete Datix*
       - No
         - Complete care standards

2. If; moisture associated skin damage
   - Category 2
   - Category 3

   - Clinical reflection – lapse in care/good practice
   - Manager review – lessons learnt/actions taken
   - Clinical/ward manager – collate themes
     - Team learning, learn from experience/zero harm meeting

   - If suspected deep tissue
     - Referral to TVN to monitor
     - Present at Panel

3. If category 4 pressure ulcer

*How to report a pressure ulcer on Datix
1. Introduction

What are pressure ulcers?
Pressure ulcers are known by a variety of terms, these include; pressure sores, bed sores, pressure damage, pressure injuries, wound and decubitus ulcers. For the purpose of this document they will be referred to as 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.” (NHS Improvement, 2018).

1.1 Patient-centred care
Treatment and care should be individually assessed to meet the needs and preferences of each individual (see page 4). In partnership with healthcare professionals, patients’ should be given the option to make informed decisions about their care and treatment. When a patient does not have capacity to make decisions, healthcare professionals should follow the Mental Capacity Act and / or the supplementary code of practice on deprivation of liberty safeguards. (NICE, 2014)

Who is at risk of pressure ulcers?
Pressure ulcers are more likely to occur in those who:
- Are acutely ill with infections or exacerbations of pre-existing long term conditions
- Have neuropathy or lack of sensation in any part of the body
- Have impaired mobility or who are immobile
- Do not have the ability to reposition themselves
- Have a previous or current pressure ulcer
- Are nutritionally compromised, either under or over weight
- Use equipment such as seating or beds which do not provide appropriate pressure relief
- Have a spinal cord injury
- Are elderly
- Have a significant cognitive impairment

What is the impact of pressure ulcers?
For the patient:
- Pain
- Discomfort
- Inconvenience
- Increased incidence of infection including osteomyelitis
- Potential hospitalisation
- Reduced quality of life for patients, their carer’s and their families
- Prolonged and frequent contact with the health care system
- A higher risk of death in older people;

For healthcare organisations:
- The financial costs to the NHS are considered to be substantial
- Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. Finding ways to improve the prevention of pressure damage is therefore a priority. (NHS Improvement 2018)

2. Intrinsic factors
There are a number of intrinsic factors, which contribute to the development of tissue damage which should be considered during the assessment.
2.1 **Extrinsic Factors**
The extrinsic factors involved in the development of pressure ulcers include:

- Pressure
- Friction
- Shearing
- Moisture
- Medication

3. **Assessment**
All individuals who are deemed to be at risk of pressure ulcer development must have the following formal assessment to determine their level of risk of pressure ulcer development / management. The following documentation should be completed/ provided as per pressure ulcer bundle:

- Full holistic assessment (completed within 1 week of initial contact)
- Malnutrition Universal Screening Tool (MUST) assessment
- Risk assessment should be completed on admission and reassessed monthly or more frequently if the patient’s condition changes.
- Skin integrity to be assessed on admission (reassessment to be completed, dependent on the patient’s condition)
- Trust leaflet on prevention and treatment of pressure ulcers. See Trust Intranet
- Assessment and advice for pressure relieving equipment if required
- Pain assessment

A patient’s pressure ulcer care must be reviewed weekly by either a registered nurse or Assistant Practitioner who has completed the pressure ulcer competencies.

3.1 **All patients with a new or existing pressure ulcer**
The following documentation should be completed/ provided (as per pressure ulcer bundle) to determine the management of the pressure ulcer see appendix 1.

- Full holistic assessment (completed within 1 week of initial contact)
- Malnutrition Universal Screening Tool (MUST) assessment
- Risk assessment (completed monthly or more frequently if the patient’s condition changes)
- Skin integrity checklist (reassessment to be completed, dependent on the patient’s condition)
- Pressure ulcer treatment plan
- Pain assessment
- Trust leaflet on prevention and treatment of pressure ulcers. See Trust Intranet
- Assessment and advice for pressure relieving equipment if required
- Wound management plan (pressure ulcer to be reviewed weekly or more frequently if required)
- Photograph of pressure ulcer on initial assessment, any changes occur and on healing
- All pressure ulcers Category 2 and above including suspected deep tissue injuries are to be reported via the Datix system
- If the pressure ulcer has been caused by a device, the pressure ulcer should be reported as device related on the Datix.
If the pressure ulcer is Category 2 or below:

If wound is below 20mm in diameter it will be assessed without completing a full wound assessment. Staff should record wound size, wound bed appearance, pain and dressing regime in the comment section. If the patient is new, the short version of the universal assessment should be completed. At this point, the patient should be scheduled for a full review and assessment of needs in case the wound has not healed within 5 visits or 2 weeks (whichever comes first).

If they become static or deteriorate, they should be referred to the ‘Link Nurse’ initially and the Tissue Viability Service if appropriate.

3.2 Pressure Ulcer Risk Assessment

Patients who sit for more than 2 hours have an increased risk of developing pressure ulcers over their bony prominences due to body weight focusing onto these areas. Patients and carers need to be advised of implications of ‘long term seating’ (Tissue Viability Society 2009) and be educated around alternative positions in the chair / bed, fully document advice in the patients’ records. Please see Appendix 2 for NICE guidance on those patients at risk of developing a pressure ulcer.

This guidance will refer to ‘at risk’ and ‘at high risk’ to identify patients who may develop a pressure ulcer:

- Patients considered at risk of developing a pressure ulcer following assessment using the risk assessment tool or/and clinical judgement
- Patients considered at high risk of developing a pressure ulcer may have multiple risk factors such as: significant reduced mobility, nutritional risks, inability to reposition independently, significant cognitive impairment following assessment using the risk assessment tool or/and clinical judgement.

Within CWP – West Physical Community Health, the Braden risk assessment tool is utilised to identify levels of risk to identify the development of pressure ulcers.

<table>
<thead>
<tr>
<th>Levels of pressure ulcer risk using the Braden scale</th>
<th>Score</th>
<th>Level of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild risk</td>
<td>15 - 18</td>
<td>At risk</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>13 – 14</td>
<td>At risk</td>
</tr>
<tr>
<td>High risk</td>
<td>10 – 12</td>
<td>High risk</td>
</tr>
<tr>
<td>Severe risk</td>
<td>&lt; 9</td>
<td>High risk</td>
</tr>
</tbody>
</table>

It is important to remember that this is part of an holistic assessment and should not replace clinical judgement.

WATERLOW Risk Assessment – Initial clinical inpatient assessment

All ward based patients must receive a pressure ulcer risk assessment using the Waterlow risk assessment tool within six hours of admission. The pressure ulcer risk assessment MUST be undertaken by a healthcare professional who is trained and competent performing this assessment.
Waterlow Risk Assessment – Inpatient on-going clinical assessment.

Patients should have a risk assessment when leaving the ward e.g. when they are being transferred to another ward, or on discharge to the community. On arrival at a new in-patient setting a Waterlow assessment must also be completed within six hours of admission.

<table>
<thead>
<tr>
<th>Waterlow Risk Assessment Score</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td>At risk</td>
<td>10+</td>
</tr>
<tr>
<td>High risk</td>
<td>15+</td>
</tr>
<tr>
<td>Very high risk</td>
<td>20+</td>
</tr>
</tbody>
</table>

It is important to remember that this is part of an holistic assessment and should not replace clinical judgement

4. European Pressure Ulcer Advisory Panel (EPUAP) (Pressure ulcer staging guidance)

**Category 1**
- Non blanchable, redness of intact skin
- Usually over a bony prominence
- May be painful, firm, soft, warm or cool
- May be difficult to detect in individuals with darker skin
- May indicate “at risk” patients

**Category 2**
- Partial thickness skin loss
- Shallow open ulcer
- Pink / red wound bed, without slough
- May present as intact or open/erupted serum-filled blister
- Should not be used to describe: skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

* As per North West Tissue Viability Network; CWP categorise a Category 2 pressure ulcer as superficial skin loss, pink / red wound bed, maybe minimal slough, with healthy tissue evident.

**Category 3**
- Full thickness tissue loss
- Subcutaneous fat may be visible
- Bone / tendon / muscle are NOT exposed
- Slough may be present
- Depth will vary, depending on anatomical location
Category 4
- Full thickness skin loss
- Slough or eschar may be present
- Often has tunnelling and undermining
- Depth depends on anatomical location (ear/bridge of nose)
- Exposed bone/muscle/tendon or may be directly palpable

Deep Tissue Injury
- Purple or maroon localised area of discoloured intact skin or blood filled blister.
- Skin may be painful, firm, mushy, boggy, warmer or cooler
- May be difficult to detect in individuals with dark skin tones

Unstageable Pressure ulcer
- Full thickness tissue loss in which actual depth of ulcer is completely obscured by slough (yellow, tan, gray, green or brown) or eschar in the wound bed.
5. Pain Assessment
Pressure ulcers can be a great source of pain and can affect an individual’s quality of life. Pain assessment must include: the scale of the individual’s pain; the site of the pain; a description of the type of pain; what aggravates/relieves the pain. The patient’s pain must be assessed according to the individual’s needs and documented within the wound management plan. If pain is not managed effectively then discussion should take place with the patient’s GP or doctor on ward regarding adequate analgesia for pain relief. Assessment should include appropriate repositioning techniques, equipment and pressure relieving devices and any discussions or recommendation must be documented.

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Site</th>
<th>Character</th>
<th>What aggravates the Pain</th>
<th>What relieves the Pain</th>
<th>Print name &amp; sign</th>
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Scale

<table>
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<tr>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td>No pain</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>Worst pain ever</td>
</tr>
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</table>

6. Nutritional Assessment
Malnutrition is frequently cited as a risk factor for the presence, development and non-healing of pressure ulcers. Best practice entails monitoring the nutritional status of individuals as part of a holistic assessment and as an ongoing process throughout an individual’s episode of care. Patients need to be re-assessed at least monthly if shown to be at risk or earlier if the patient’s condition changes. All patients at risk of pressure ulcer development will be assessed by completing a Malnutrition Universal Screening Tool (MUST) assessment. The MUST assessment should be completed on the first visit.

Remember that the bariatric individual can be malnourished despite the appearance of being well fed.

Certain diseases and treatments such as cancer and mal-absorption syndromes, surgery, radiotherapy and chemotherapy can either reduce absorption of food or increase nutritional requirements. Hypo-albuminaemia (An abnormally low concentration of albumin in the blood) low levels of iron, vitamin A and C and zinc status can all affect the healing rates of wounds. If specialist advice is required refer to the Countess of Chester Dietetics Team. In the in-patient setting ward staff are to refer to the Dietician.

Nutritional supplements, subcutaneous or intravenous fluids should not be offered to prevent a pressure ulcer in patients whose nutritional or/fluid intake is adequate.

7. Infection Control
Chronic wounds often harbour a variety of bacteria to some degree and this can range from contamination through colonisation to infection. When a wound becomes infected it will display the characteristic signs of heat, redness, swelling, pain, heavy exudates and malodour. The patient may also develop generalised pyrexia (high temperature). However, immuno-suppressed patients, diabetic patients or those on systemic steroid therapy may not present with the classic signs of infection. Instead they may experience delayed wound healing, breakdown of the wound, presence of friable granulation tissue that bleeds easily, increased production of exudates and malodour, and increased pain.
Careful wound assessment is essential to identify potential sites for infection, although routine swabbing of the area is not considered beneficial. If infection is suspected, obtain a wound swab and await results prior to antibiotic treatment if required. Systemic antibiotics should be offered to patients with a pressure ulcer if they show signs of systemic sepsis, spreading cellulitis or underlying osteomyelitis.

Consider the use of an antimicrobial dressing if an infection is suspected. Do not routinely use topical antiseptics or antimicrobials to treat pressure ulcers in patients.

8. **Photographing of Wound**
On initial assessment of a pressure ulcer, a wound photograph must be taken, and then repeated as any changes occur. All healed pressure ulcers must be photographed prior to discharge. Photographs of the pressure ulcer will be taken using the Trust digital cameras. A copy must be uploaded onto EMIS/Care Notes. No digital images must be stored on individual computers. Health professionals must obtain consent prior to taking any photographs using the Trust consent for photography form.

9. **Dressing selection**
When making a decision about a dressing or topical agent for patients with pressure ulcers, consider using a dressing that promotes a warm, moist wound healing environment. Also take into account the following:

- Ulcer assessment
- General skin assessment
- Treatment objectives
- Previous positive effect of the dressing
- Manufacturer’s indications for use and contra indications
- Risk of adverse events
- Pain and tolerance
- Position of the ulcer
- Amount of exudate
- Frequency of dressing change
- Patients’ preference

Trust wound management formulary must be followed at all times; if an alternative dressing is required, Tissue Viability must be contacted to discuss or review the patient.

10. **Wound re-assessment**
Reassessment of the pressure ulcer should take place as a minimum weekly.

For all pressure ulcers Category 1 and above including suspected deep tissue injury, skin integrity should be checked weekly.

All pressure ulcers Category 3 and above including suspected deep tissue injuries must be referred to the Tissue Viability Specialist Team for advice and support. For pressure ulcers Category 2 and above that do not show signs of healing within 4 – 6 weeks, these also must be referred to the Tissue Viability Service.

11. **Pressure Relieving equipment**
Selection should be based on a formal assessment process. Clinical judgement remains the main basis for determining level of risk. Consideration should be given to:

- Repositioning
- Seating
- Skin inspection
For patients who have been assessed and are at high risk, pressure relieving equipment may be provided. Once the patient is deemed as not requiring this level of equipment, a reassessment of their nursing needs is required.

12. **Pressure relieving cushions**
All patients who are at risk or have an existing pressure ulcer should be supplied with a high specification foam pressure relieving cushion if deemed suitable. A seating assessment must be carried out prior to supplying a cushion. For the seating assessment guidance please see Appendix 3.

13. **Pressure relieving mattress**
All patients assessed as being at high risk should, as a minimum provision, be placed on a high specification foam mattress with pressure relieving properties (NICE, 2014). If a patient has a Category 3 or 4 pressure ulcer, an alternating airwave replacement mattress should be considered.

For Airwave mattresses or Airwave cushions, all requests must be initially approved by the Tissue Viability Specialist Nurse prior to ordering the equipment. Mattresses should be checked weekly for dipping and should be re-evaluated if the pressure ulcer heals or deteriorates.

14. **Floatation devices**
If a patient is at risk or has pressure damage to a heel, then the heel requires pressure alleviation and the heel should be floated. Consider using a pillow (length ways) to support the leg and alleviate pressure from the heel; alternatively, a purchase of a flotation device may be utilised. Recommendations can be obtained from Tissue Viability Service. You can also refer to Podiatry for Heel casting which provides pressure relief.

15. **Repositioning**
Patients at risk of pressure ulcer development are repositioned to minimise pressure friction and shearing. The frequency upon which this is done is determined by the patient’s condition, comfort and skin integrity. Evidence to support this action should be in the form of accurate documentation with explicit information utilising the re-positioning schedule (see appendix 4) or evaluation notes. The repositioning schedule should include information:
- Date
- Action / position
- Time of reposition
- Patient consent
- Results of skin inspection
- Frequency of repositioning
- Practitioners’ signature

Manual handling requirement must also be clearly documented.

Repositioning will be detailed in the patients treatment plan, outlining who will perform the task, how often and what education to carer’s has been given to conduct this safely including the 30 degree tilt. Individuals assessed at an elevated risk should consider whether sitting should be restricted to less than 2 hours per session (National Institute for Health and Care Excellence (NICE) 2014). Those patients with a pressure ulcer on their coccyx/sacrum should limit their time sitting to 60 minutes or less, three times a day (European Pressure Ulcer Advisory Panel (EPUAP) 2014). For patients who have been assessed as being at risk of developing a pressure ulcer, should change their position frequently and at least every 6 hours. For those who have been assessed as high risk, should change their position frequently and at least every 4 hours.

Repositioning is still required for pressure relief and comfort when a support surface is in use.

For palliative patients, consider the individuals choice in repositioning.
If a patient resides in a residential/nursing home then specific advice to formal carers should be documented in the shared care agreement (see appendix 5) and evidence that the Trust leaflet on ‘prevention and treatment of pressure ulcers’ has been issued to the staff involved in the patient’s care.

16. Skin care
All patients at risk of pressure ulcer development must have their skin assessed as part of the holistic assessment. This will include general assessment of the skin, but with particular attention to high-risk areas.

EUPAP (2014) recommends that when any risk assessment is carried out, this is an opportunity to carry out a full skin assessment. Pay particular attention to those patients with medical devices such as compression hosiery, oxygen tubing, catheters, as they can result in skin damage to the individual.

The assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for:
- Skin integrity in areas of pressure
- Colour changes or discolouration
- Variations in heat, firmness and moisture.

17. Skin integrity check list
Observation and management of the skin integrity will reduce the incidence of skin deterioration and breakdown. Where appropriate or clinically indicated skin inspection and findings should be assessed by a trained healthcare professional and recorded and documented using skin integrity check list. The frequency of reassessment of the patients’ pressure areas using the skin integrity checklist should be documented.

Patients who have an existing pressure ulcer or are at high risk should have their skin integrity monitored at least weekly or more often if their condition deteriorates.

Blanching erythema is an early indicator of pressure damage, with timely interventions further damage can be prevented.

Formal or informal carers should be educated on how to inspect the patient’s skin in between episodes of care proved by the community nurses. Carers should also be advised to report any problems or changes in the patient’s condition to the community nurses.

18. Examination of erythema should include:
- Apply light finger pressure to the area for 5 seconds
- Release pressure. If the area is white and then returns to the original erythema, this can indicate that the superficial circulation remains intact
- If on release of the pressure the area remains the same colour as before pressure was applied, it is an indication of pressure ulcer development and preventative strategies must be employed
- If further skin discolouration is observed by redness, purple, black or blistering with an increase in heat or swelling, this may indicate deeper tissue damage (for deep tissue damage, use core care plan). This is particularly relevant when induration or hardening of the underlying tissue is palpated. Health care professional need to be vigilant when caring for patients with darkly pigmented skin (NICE, 2014).

19. Continence management
All patients who experience urinary / faecal incontinence should undergo a continence assessment. Incontinence may increase the risk of developing pressure ulcers. The key factor is moisture to the skin, which puts it at a greater risk from maceration, friction and shearing forces. Therefore, effective management of incontinence is an essential part of skin care and fundamental to maintaining a person’s dignity and comfort.
Over use of soaps and water may undermine skin integrity when combined with urinary and/or faecal incontinence. Urine and faeces can undermine skin integrity through changes in pH and contribute to shear and friction susceptibility. Non soap based foam cleaners are an alternative e.g. Derma Pro skin cleanser. Consider using a barrier preparation to prevent skin damage in patients who are at high risk of developing a moisture lesion or incontinence associated dermatitis.

20. Manual handling
Manual handling risk assessments must be completed if required and any equipment ordered must be documented in the patients’ records and strategies to prevent further damage to the skin as outlined in the patient’s plan of care.

Lifting and manual handling techniques need to be adapted to reduce the risk of shearing and friction. Specific equipment to aid turning should be considered where appropriate, such as slide sheets, transfer board or mobile/static hoist.

21. Training
• All clinical staff involved in the assessment of risk, planning, implementation and evaluation of care relating to pressure ulcer prevention and management should receive initial training within twelve months of appointment
• All clinical staff involved in the assessment of risk, planning, implementation and evaluation of care relating to pressure ulcer prevention and management should attend mandatory training which can be booked via the team manager on ESR.

For healthcare professionals the following should be included on preventing a pressure ulcer:
• Who is likely to be at risk of developing a pressure ulcer
• How to carry out a risk and skin assessment
• How to identify pressure damage
• What steps to take to prevent new or further pressure damage
• How to reposition
• Information on pressure redistributing devices
• Who to contact for further information and for further action

22. Wound debridement
Debridement of dead tissue is vital as its presence can delay healing and encourage infection. Debridement involves the removal of dead or necrotic tissue, or other debris, from the wound to reduce the wounds biological burden. A number of terms are used to describe dead tissue in wounds, necrosis, slough, and eschar.

The natural process is known as autolytic debridement and is considered the safest way to debride. It is the method most usually undertaken by nurses without specialist debridement skills or equipment, using appropriate moist wound dressings.

Other forms of debridement are available but these must be under the supervision of the tissue viability nurses. The sharp debridement of loose, devitalised tissue must only be carried out by tissue viability specialist nurses.

On heel pressure ulcers, good arterial blood flow must be established prior to debridement. A Doppler assessment must be carried out prior to any debridement of the wound bed.

23. Residential homes
Following assessment for the management of pressure ulcers, community nurses must discuss with the residential home manager the level of care required by the residential care staff to prevent and or manage pressure ulcers in-between community nurses visits.
Community nurses must document the expected level of shared care for the patient on a shared care agreement for the residential care staff to follow; this may include advice on frequency of repositioning, manual handling and the skin integrity check list. Community nurses must review and reassess care at least weekly and document any deviations from care in the patients’ health records.

If the residential home does not deliver the agreed shared care arrangements despite discussions with the residential care manager, the community nurses will complete an incident (Datix) and refer to the safeguarding team if appropriate.

If the residential care home cannot meet the needs of the patient for the prevention and management of pressure ulcers, the community nurse will inform the residential care manager, discuss the level of care required for the patients and discuss alternative arrangement for care.

24. Delegation of care
The delegation of nursing care must be appropriate, safe and in the best interests of the patient at all times and the decision to delegate must always be based on an assessment of their individual needs (NMC, 2008). When community / ward based nurses delegate clinical tasks to non-registered health support workers, they will retain accountability and responsibility for the patient. Community / ward based nurses must only delegate clinical tasks to other members of the team whom they deem clinically competent and able to fully understand the nature of the delegated task.

NB. A patients’ pressure ulcer care must be reviewed weekly by either a registered nurse or Assistant Practitioner who has completed the pressure ulcer competencies.

25. Podiatry Service
If a patient has a non-healing pressure ulcer, a referral to this service may be appropriate. The service provides specialist podiatry diagnosis and intervention for patients at high risk of podiatric complications, e.g. people with; diabetes, peripheral vascular disease and / or neuropathy and pressure relief.

26. Reporting of Pressure Ulcers and monitoring of prevalence
All pressure ulcers including suspected deep tissue injury, Category 2 and above must be reported using the internal reporting mechanism (Datix) within 48 hours of identification. The incident report must clearly identify

- The category of the pressure ulcer
- The ulcer must be categorised as moderate ‘C’ for Category 2 and categorised as severe harm, usually category B for Category 3,4 and Unstageable pressure ulcers
- If the ulcer was acquired whilst the patient was in our care this would be classed as Developed in CWP Care and if it developed in the care of another organisation it would be classed as Not developed in CWP Care.

Any patient who has a Category 3, Category 4, Unstageable or suspected deep tissue injury must be referred to community TVN for assessment.

Category 2 pressure ulcers which have previously been reported must be reported again if they deteriorate and become a Category 3 or 4. This includes those pressure ulcers which began as Category 2 ulcers acquired whilst in hospital. This incident report should be completed within 48 hours of identification of the deterioration.

All Category 3 and 4 pressure ulcers that have developed or deteriorated within the care of CWP will require a local reflective review. This will be carried out by the Tissue Viability Team. A full root cause analysis will be undertaken for any preventable harm.

Any moisture lesions should be reported on Datix however if it is combined with pressure damage, it should only be reported as the highest harm which is pressure.
27  Safeguarding
In any situation where staff may consider the patient to be a vulnerable adult, they need to follow the Trust Safeguarding Adult Policy and discuss with their line manager and document outcomes.
Appendix 1 - Assessment and management of patients with existing or new pressure ulcers

**COMPLETE THE FOLLOWING**

Within 48 hours complete an Incident form for Category 2 or above pressure ulcers – Identify if Developed in CWP care or Not developed in CWP care

- Full holistic assessment (completed within 1 week of initial contact)
- Malnutrition Universal Screening Tool (MUST) assessment
- Risk assessment (completed monthly or more frequently if the patient’s condition changes)
- Skin integrity checklist (reassessment to be completed, dependent on the patient’s condition)
- Pressure ulcer care plan
- Pain assessment
- Trust leaflet on prevention and treatment of pressure ulcers
- Assessment and advice for pressure relieving equipment if required
- Wound management plan (pressure ulcer to be reviewed weekly or more frequently if required)
- Photograph of pressure ulcer on initial assessment, any changes and on healing
- Suspected Deep Tissue Injuries and Moisture Lesions are to be reported via the Datix system as category D as per Trust policy and referred to Tissue Viability Services.
- Category 3 or 4 to be reported via the Datix system as category B as per Trust incidence policy and referred to Tissue Viability Services.

Refer to tissue viability service if a suspected deep tissue injury Category 3 or above via EMIS
Always follow the procedure for pressure ulcer prevention and management
Appendix 2 - Prevention of pressure ulcers in adults at risk and at high risk

**RISK ASSESSMENT**

**At risk?**

- Develop an individualized care plan, taking into account the outcome of risk and skin assessment, the need for additional pressure relief at at-risk sites, the person's mobility and ability to reposition themselves, other comorbidities and patient wishes.

---

**REPOSITIONING**

- Encourage repositioning at least every 6 hours

**PRESSURE REDISTRIBUTING DEVICES**

- Use a high specification foam mattress/cushion and offloading devices

**INFORMATION**

- Take into account additional information needs for people with degenerative conditions, impaired mobility, neurological impairment, cognitive impairment and impaired perfusion.

**SKIN ASSESSMENT**

- Offer a comprehensive skin assessment by a trained healthcare professional

- Erythema identified?
  - Blanchable
  - Non-Blanchable

  Use finger palpation to identify whether the erythema is blanchable

- Increase visits accordingly

---

**REPOSITIONING**

- Encourage repositioning at least every 4 hours

**PRESSURE REDISTRIBUTING DEVICES**

- Use a high specification foam mattress

---

**Social Support / Family Carer**

- Offer trust information leaflet

**Adult is at risk of heel pressure ulcers?**

- Offer a strategy to offload pressure from their heel

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From: [NICE Guidance CG179 – April 2014](#)
Appendix 3 – Seating Assessment Guidance

GUIDANCE ON SEATING WHEN ISSUING PRESSURE RELIEVING CUSHIONS

It is important to ensure that a person is in a good supported sitting position which enables them to stand and mobilise independently. Seated stability and ease of transfer is as important to consider as the degree of pressure redistribution offered by a cushion.

<table>
<thead>
<tr>
<th>Check</th>
<th>Consequences</th>
<th>Issue identified</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>The cushion fits in the chair seat</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is there space around the cushion</td>
<td>If cushion is able to move within chair this can create an unstable sitting position</td>
<td></td>
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<tr>
<td>Is the cushion wedged into the chair</td>
<td>If cushion is not flat in chair it will not give even pressure relief.</td>
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<tr>
<td>With the combined seat and cushion height</td>
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<tr>
<td>Feet can reach and are flat on floor.</td>
<td>If not patient will be uncomfortable and may slide forwards in chair.</td>
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<tr>
<td>Hips and knees are at 90 degrees with pelvis level</td>
<td>If not person may sacral sit or slide forwards and so increase risk of pressure areas.</td>
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<tr>
<td>When sitting there is a 2.5 cm gap between back of knee and chair</td>
<td>If not there is a risk of pressure area at back of knee</td>
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<tr>
<td>The full length of persons back is supported by chair back</td>
<td>If not shoulder /neck pain can occur</td>
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<tr>
<td>Chair Armrest height with cushion in place</td>
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<tr>
<td>In sitting position person should be able to rest arms on armrests with elbows at 90 degrees</td>
<td>If armrests are too low the shoulders are unsupported and can cause neck/shoulder pain.</td>
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<tr>
<td>When person stands from chair they are able to use the armrests to push up into a standing position</td>
<td>If armrests are too low person will not be able to safely and independently stand</td>
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IF ISSUES ARE IDENTIFIED WITH A CHAIR AND CUSHION COMPATABILITY, CHECK IF THERE IS A MORE SUITABLE CHAIR WITHIN PERSONS HOME THAT COULD BE USED AND GO THROUGH CHECK LIST AGAIN.

If you are still concerned about a person’s seating and posture when you have issued a cushion please discuss further with an Occupational therapist.
# Appendix 4 - Repositioning schedule

<table>
<thead>
<tr>
<th>Patient Name</th>
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<tbody>
<tr>
<td>Date of Birth</td>
<td>NHS No</td>
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<tr>
<td>Manual handling requirements</td>
<td></td>
</tr>
<tr>
<td>☐ Hoist</td>
<td>☐ Other, please state</td>
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<tr>
<td>☐ Slide sheet</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Action / Position</th>
<th>Time</th>
<th>Patient consent given (Yes / No)</th>
<th>Results of skin inspection</th>
<th>Frequency of repositioning</th>
<th>Signature</th>
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Appendix 5 - Shared care agreement for position change and pressure relief

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>Address</td>
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</table>

The person named above needs to have their position changed regularly to reduce risk of pressure ulcer development. The district nurse has identified the position change regime below as being necessary to prevent pressure ulcer development.

<table>
<thead>
<tr>
<th>Change of position / pressure relief is required</th>
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<tr>
<td>☐ Hourly</td>
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<tr>
<td>☐ 2 hourly</td>
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<tr>
<td>☐ 3 hourly</td>
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<tr>
<td>☐ 4 hourly</td>
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<td>☐ Other, please state</td>
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The Residential/Care Home has provided:

| ☐ High Specification Foam Cushion |
| ☐ Airwave Cushion                  |
| ☐ High Specification Foam Mattress |
| ☐ Airwave Mattress                 |

This care has been jointly agreed by

Community nurse
Base
Telephone Number
Signature of Carer / Manager
Date

Jointly agree daily regime

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Failure to implement this plan of care is likely to result in the development of pressure ulcers. You are responsible for the ongoing care needs of this person. If you are unable to implement the care...