

Pressure Ulcer Prevention, Assessment and Treatment Policy

(Reference No. CP59 0116)

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Pressure Ulcer Prevention, Assessment and Treatment Policy
(Reference No. CP59 0414)

Version: 4

Lead Author: Kim Fenwick

Lead Director: Clare Hawkins

Who is this document is applicable to: All HCT staff

Dare Ratified: 18.08.16

Other policies that this policy should be read in conjunction with:

- Clinical Guideline 179 Pressure Ulcers: prevention and management of pressure ulcers (NICE, 2014)
- Guidelines for Pressure Ulcer Prevention and Treatment (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (NPUAP/EPUAP/PPPIA, 2014)

Scope: All patient groups seen in HCT

Statement: A policy to facilitate high standards of patient care relating to the prevention of pressure damage and the active management of patients who may have acquired pressure damage.

Purpose: To provide direction for staff in HCT on prevention, assessment and management of pressure ulcers in the community setting, based on established guidance.

General Procedure guidance:

To be followed for all patients within HCT who are at risk of pressure damage

Specific procedure for individual group:

As above

Specific training info for staff:

HCT pressure ulcer study days for all staff run by Tissue Viability service

Specific info for equipment:

Follow guidance in policy using HES ordering bundle

Key Component / Main content of the Policy:

Preventative measures – SSKIN bundles, risk factors, skin assessment, equipment, prevention of incontinence associated dermatitis, repositioning, nutrition.

Assessment of Pressure damage – classification

Incident reporting

Treatment

Governance & Escalation: If you require any guidance about the policy itself, or would like to escalate any issue please refer to Sections: [14](#) through to [18](#), and Appendixes [10](#), [13](#), and [14](#).

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1. Introduction

- 1.1 Pressure ulcers represent a major source of distress for patients in terms of physical, social and financial implications, as well as affecting quality of life for patients and their carers and families. This clinical guideline has been developed to provide direction for staff in Hertfordshire Community NHS Trust (HCT) on the prevention, assessment and management of pressure ulcers in the community setting. It is based on established guidance:
- *Clinical Guideline 179 Pressure Ulcers: prevention and management of pressure ulcers (NICE, 2014)*
 - *Guidelines for Pressure Ulcer Prevention and Treatment (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (NPUAP/EPUAP/PPPIA, 2014)*
- 1.2 This version supersedes any previous versions of this document.
- 1.3 This policy will be accessible to staff through the HCT Staff Intranet or by the issue of controlled paper copies where appropriate.

2. Purpose

- 2.1 The aim of this guideline is to facilitate high standards of patient care relating to the prevention of pressure damage and the active management of patients who may have acquired pressure damage.
- 2.2 The guidance applies to all patient groups seen in HCT. It will assist staff in holistic assessment processes and timely intervention with preventative strategies for individuals who may be at risk of pressure damage.
- The guideline promotes evidence based, cost effective care within the Trust
 - Promotes continuity of care between care settings
 - Assists in the prevention of inappropriate, detrimental or unsafe practices
- 2.3 The following key aspects of pressure ulcer prevention will be covered:
- Definitions
 - Risk assessment
 - Risk factors
 - Skin assessment
 - Pressure ulcer classification
 - Preventative measures
 - Assessment and treatment of pressure damage
 - Education
 - Safeguarding

3. Scope

- 3.1 This policy applies to all staff working for, or on behalf of the Trust (HCT).

- 3.2 This guideline should be used by all staff employed by Hertfordshire Community NHS Trust who are engaged in the prevention, assessment and management of pressure ulceration.

4. Explanation of Terms and Definitions

- 4.1 **Pressure Ulcer** – A pressure ulcer is defined as a localised injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers: the significance of these factors is yet to be elucidated. (NPUAP/EPUAP/ PPIA, 2014)
- 4.2 **Moisture Lesion** – Skin damage caused by urine and/or faeces and perspiration. This should be recorded as a moisture lesion and **not** as a pressure ulcer.
- 4.3. **Risk Assessment** - Risk assessment is the process used to identify whether a patient is vulnerable to developing pressure damage. A risk assessment tool should be used as an aide memoire, in combination with clinical judgement which is based on experience and knowledge.
- 4.4 **Skin Bundle** – The SSKIN bundle is a set of best practice interventions that will reduce the risk of patients developing pressure ulcers. The interventions are based on 5 key areas of practice (surface, skin assessment, keep moving, incontinence and nutrition). The SSKIN bundle should be applied when an individual has been identified as being at risk of developing pressure damage.
- 4.5 **Unavoidable Pressure Ulcer** – “Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person’s clinical condition and pressure ulcer risk factors. The care was planned and implemented, interventions that are consistent with the persons needs and goals, recognised standards of practice and the impact of the interventions were monitored and evaluated with revised approaches if appropriate. Or if the Individual person declined to adhere to prevention strategies in spite of education of the consequences of non-adherence (Midlands and East SHA, 2012)

5. Ownership, Roles and Responsibilities

The generic statement of roles and responsibilities of The Trust Board, Designated Committee, The Executive Team, Chief Executive Officer, Lead Executive Director, Lead Officer, Deputy Directors/ General Managers, Line Managers, All Staffs, Policy Control Officer and Communication Lead applicable to all the HCT policies/ procedural documents are in line with the HCT (Trust) GR1 0114 V.3 and attached in [Appendix 1](#). Roles and responsibilities specific to this particular policy are defined below.

5.1 Board Sub Committee (Designated Committee)

- 5.1.1 ‘Healthcare Governance Committee’ (HGC) is the Designated Committee for this policy.

- 5.1.2 A Hertfordshire Community NHS Trust Committee (HCT) Structure with regards to Line of Accountability/ Reporting is provided in [Appendix 2](#).

5.2 Lead Executive Director

- 5.2.1 The 'Director of Quality & Governance' is the identified Lead Executive Director for this policy.

5.3 Lead Officer

- 5.3.1 The identified Lead Officer for this policy is the 'Tissue Viability Specialist Nurse'.

5.4 All Staff

- 5.4.1 It is the responsibility of all staff that may have direct contact with, and make decisions concerning the treatment of, patients who are at risk of developing pressure ulcers to be familiar with the guidelines
- 5.4.2 These guidelines do not make recommendations for specific wound management. Staffs are recommended to attend the current wound management education programme and the pressure ulcer programme, and refer to the Hertfordshire Community NHS Trust Wound Care Products Formulary (2013) where applicable to ensure theoretical and practical skills are up to date.

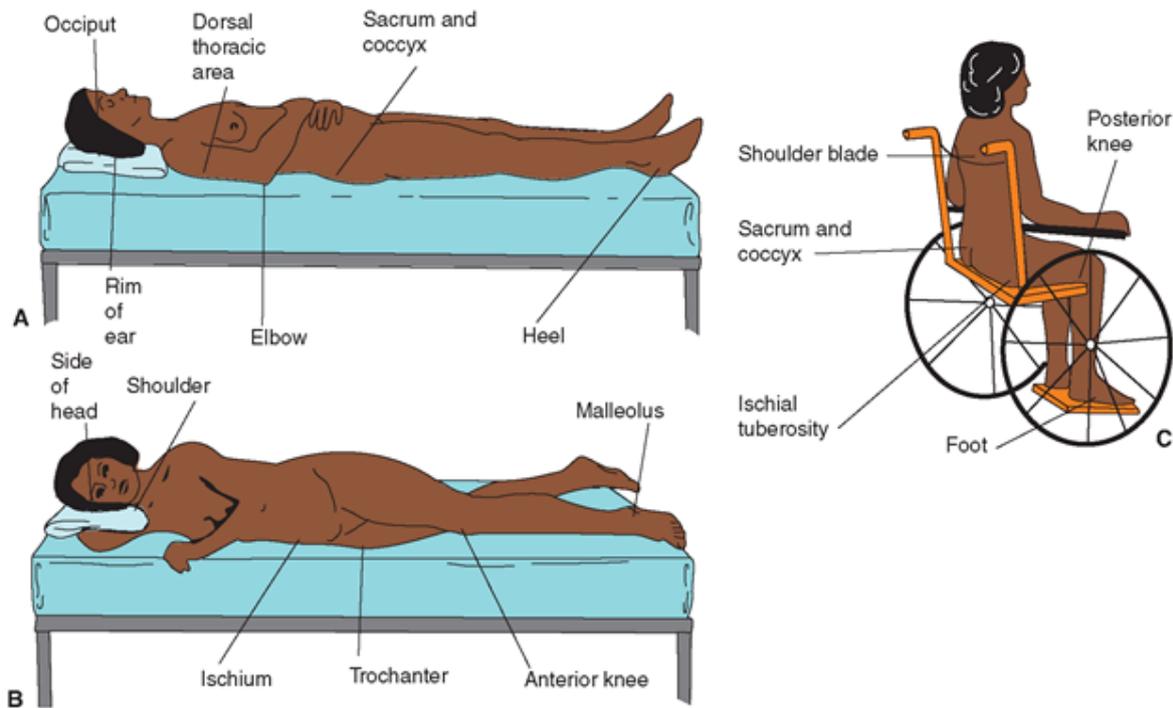
6. National Standards

- 6.1 The National Institute for Health and Clinical Excellence (NICE) provide evidence-based guidelines, Clinical Guideline 179 (National Institute for Health and Clinical Excellence, 2014) on the prevention and management of pressure ulcers in primary and secondary care.
- 6.2 High Impact Actions for Nursing and Midwifery (National Health Service Institute for Innovation, 2009) set out actions in 'Your Skin Matters' to achieve no avoidable pressure ulcers in NHS provided care.
- 6.3 The National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: (NPUAP/EPUAP/PPPIA, 2014) set out evidence based guidelines on pressure ulcer prevention and treatment.

7. Pressure Ulcers

Pressure ulcers generally develop over bony prominences, but can occur in any area of the body in certain circumstances (Ryecroft-Malone and McInnes, 2000). Typically they occur in a person who may be confined to bed or a chair by an illness and as a result they are sometimes referred to as 'bedsores' or 'pressure sores'. The most common sites for pressure ulcers are: sacrum, heels, hips, shoulders and elbows (**figure 1**) but may occur anywhere that bone and skin are in contact with another surface.

Figure1: Areas at risk of pressure damage



Tissue damage may involve skin, subcutaneous tissue, deep fascia, muscle and bone

7.1 Risk Assessment

- 7.1.1 Initial and on-going risk assessment is the responsibility of a registered healthcare professional
- 7.1.2 A risk assessment tool is a series of listed risk factors with a numerical value. The patients risk status is calculated by adding together the risk factors that are applicable. The recommended validated scale for use in HCT for adults is the Waterlow Risk Assessment Tool. (Waterlow, 2005) ([Appendix 3](#)) and for children the adapted paediatric Waterlow Tool (Waterlow, 1997; Waterlow, 1998; Willcock, J et al 2005). For infants The Glamorgan Risk Assessment tool is recommended. These assessments should be performed within 6 hours of the first episode of care (NICE, 2014) in community bed based units, and on the first assessment for patients in their own homes.
- 7.1.3 A clear statement of risk status must be formally documented, signed, and dated by the assessor. Any risk factors identified during the assessment process should be addressed in an individualised care plan to reduce the impact of those variables. Where a formal risk assessment on a patient is scored 10 or above, pressure ulcer prevention equipment for provision should be ordered using the Hertfordshire Equipment Service (HES) equipment ordering tool contained within the pressure relief ordering bundle ([Appendix 4](#)). The order should be faxed to HES where equipment will be issued according to the total clinical priority score. In community bed based units the protocol for ordering equipment in each individual unit should be followed.

7.2 Risk factors

NPUAP/EPUAP/PPPIA (2014) state a structured approach to risk assessment should be used that is refined through the use of clinical judgement and informed by knowledge of relevant risk factors. All patients are potentially at risk of developing a pressure ulcer (NICE, 2014). Development is dependent upon extrinsic and intrinsic factors which affect tissue tolerance.

7.2.1 Intrinsic factors:

Extremes of age	Reduced mobility
Acute, chronic and terminal illness	Long term conditions e.g. diabetes
Poor nutritional intake and dehydration	Major surgery
Neurological deficit	Poor oxygen perfusion
Level of consciousness	Psychological factors and cognition
Posture e.g. kyphosis fixed deformity	Previous pressure damage
Social factors	Incontinence

7.2.2 Extrinsic factors:

- **Pressure** – When sustained pressure is placed on a particular part of the body, the blood supply is occluded and can lead to tissue damage.
- **Shearing** – Strain forces the skin and upper layers away from deeper layers of the skin. This occurs when people slide down the bed or chair.
- **Friction** – Poor lifting and handling techniques can remove the top layers of the skin. Repeated friction can increase the risk of pressure ulcers
- **Moisture** – Excessive moisture presents a significant risk to the development of moisture related trauma

7.2.3 Other contributing factors

The potential of an individual to develop pressure damage may also be contributed to by the following factors: pain, other medication and changes to the patients' environment, carer or equipment. Patients at particular risk, or more susceptible to pressure damage include patients undergoing surgery, in critical care, with orthopaedic conditions or with spinal injuries.

7.3 Skin Assessment

7.3.1 A complete skin assessment should be part of the risk assessment process. Patients at risk of pressure ulcer development must have their skin assessed on admission to the service using the Trust Pressure ulcer risk and skin assessment form, available as a template on SystemOne or printed copy ([Appendix 3](#)). The skin must be physically examined. This will include general assessment of the skin, but with particular attention to high risk areas. These are typically parts of the body where pressure, friction or shear is exerted in the course of an individual's daily living activities.

7.3.2 For example: back of the head, temporal region, ears, toes, heels, elbows, shoulders, sacrum, ischial tuberosities, femoral trochanters (fig1) Frequency of re-assessment should be based on vulnerability and condition of the patient.

7.3.3 Observe the skin for damage caused by medical devices at least twice daily. This includes catheters, oxygen therapy, hoists etc.

- 7.3.4 Compression hosiery, tights/stockings and socks must be removed to inspect heels.
- 7.3.5 Individuals who are willing and able should be encouraged, following education to inspect their own skin. Individuals who are wheelchair bound should use a mirror to inspect the areas that they cannot see easily or get others to inspect them. Formal and informal carers should be educated on how to inspect the patient's skin in between episodes of care provided by their health professional. Carers should also be advised that any concerns should be reported to community nurses as soon as possible for reassessment of the patients' skin condition to prevent further trauma.
- 7.3.6 All staff should encourage patients to identify to them any areas of discomfort or pain which could be attributable to pressure damage.
- 7.3.7 Staff should be aware of the following signs of pressure damage:
- Persistent erythema (*redness*)
 - Non-blanching hyperaemia (*persistent redness that does not blanch under light finger pressure*)
 - Blisters
 - Localised heat
 - Localised oedema
 - Purplish/bluish localised areas
- 7.3.8 There is evidence that Category 1 pressure ulcers are under detected in individuals with darkly pigmented skin because areas of redness are not easily detected (NPUAP/EPUAP/PPPIA,2014). The following signs are important indicators in patients with darkly pigmented skin:
- Purplish/bluish localised areas of skin
 - Localised heat, which if tissue becomes damaged is replaced by coolness
 - Localised oedema and localised induration (*hardness*)
- 7.3.9 Skin changes should be documented and communicated to the wider team and appropriate preventative strategies must be employed immediately when an individual is found to be at risk of pressure damage.

7.4 Pressure Ulcer Classification

- 7.4.1 Categories or grades are widely used to classify pressure ulcer severity. The system adopted by the Trust is adapted from the International NPUAP/EPUAP pressure ulcer classification system (2014) and includes the NHS Midland and East pressure ulcer grading tool demonstrated pictorially in [Appendix 5](#). The term category is promoted as a '*neutral*' term that allows actual definitions of pressure damage and reflects the amount of actual visible tissue loss.
- 7.4.2 Pressure ulcers should be categorised/ graded as follows:

Superficial - Category/ Grade I: Non-blanchable erythema - intact skin with non-blanchable redness 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. Category/.Grade 1 may be difficult to detect in individuals with dark skin tones.

Superficial - Category/ Grade 2: Partial thickness skin loss - involving epidermis, dermis or both. Presenting as an abrasion or clear blister. The ulcer is superficial without bruising (bruising appearance and blood filled blister would indicate deep tissue injury).

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

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

Deep - Category/Grade 4: Full thickness tissue loss - with visible exposed bone (or directly palpable), tendon or muscle. Often includes undermining and tunnelling. The depth varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Grade 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur.

Suspected Deep Tissue Injury : Depth Unknown - 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 become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. Follow the trust flow chart ([Appendix 8](#)) when deep tissue injury is detected.

- 7.4 The pressure ulcer categorising system should not be used to describe tissue loss in wounds other than pressure ulcers.
- 7.6 All pressure ulcers should be fully documented on a Trust wound assessment chart on system 1 or paper copy in patient records.

8. Preventative Measures

8.1 **Care Planning** – the Trust adopts the NHS Midlands and East step by step Pressure ulcer Pathway care bundle SSKIN (2012) to ensure the core elements of pressure ulcer prevention are implemented and regularly reviewed.

SURFACE – Making sure patients have the right support

SKIN Inspection– Early Inspection means early detection.

KEEP Patient’s moving - Regular repositioning

INCONTINENCE - Patient’s need to be clean and dry.

NUTRITION/HYDRATION – Help patients have the right diet and plenty of fluids.

8.1.1 Where a patient has been assessed formally with a Waterlow score of 10 or above, or informally as vulnerable to pressure damage, the health professional must implement a SSKIN pressure ulcer prevention care plan ([Appendix 6](#)). This is a plan to prevent/minimise the risk factors of pressure damage occurring and includes the following:

- Frequency of risk assessment and skin inspection – In the community setting this should be performed at the initial assessment and thereafter on no less frequently than a monthly basis. Community bed based units should follow local protocol to re-assess on no less frequently than a weekly basis. Re-assessment should be sooner if there is deterioration in the patients’ self-reported condition, medical condition, skin integrity, or nutritional status. Risk assessment and skin assessment should also be performed more frequently if a patient is non-compliant with existing pressure relieving equipment or advice. When a patient has a Waterlow score of 10 or above and has minimal clinical input, for example seen on a 3 monthly basis for B12 injections or catheter care, it must be clearly documented that care is planned to be delivered at this frequency, that a pressure ulcer leaflet has been given and discussed with the patient/carer and nursing team contact details have been given in the event of any changes to the skin.
- Frequency and method of repositioning, or advice given to patient/carer regarding repositioning including any manual handling considerations
- Type of pressure care equipment in use
- Identification of patient’s risk factors with the appropriate interventions e.g. if nutritionally compromised start supplements and record food intake, start supplements.

8.1.2 Individualised care plans should be designed and implemented to address any other risk factors e.g. continence, pain etc.

8.1.3 All care planning should be developed and implemented with the patient and with their informed consent, and with their carers where this is relevant and possible.

8.1.4 All advice given and pressure care equipment discussed and issued, and the patient’s expressed consent for such, must be documented in the patient records, together with any copies of onward referrals. In the event that the patient declines to

follow the advice given, or to use the equipment supplied, this must be fully documented as well as the discussion with the patient about the risks associated with their decision and the alternatives considered and discussed. Where the patient lacks the mental capacity to make these decisions, the health professional should make and record a best interest decision using the Mental Capacity Assessment and Best Interest Decision forms available on the Staff Intranet, using the collective knowledge of the carers, relatives and multidisciplinary team to inform that decision (Department of Health, 2005).

8.2 Surface (SSKIN) provision of equipment

8.2.1 Prevention in individuals at risk should be provided on a continuous basis during the time they are at risk (NPUAP/EPUAP/PPPIA, 2014). Health care professionals need to consider all surfaces that the patient may come into contact with, e.g. mattresses, cushions, chairs etc. Pressure relieving surfaces are divided into 2 categories:

- **Continuous low pressure** – Aim to redistribute pressure over a greater surface area. These include standard foam or higher foam specification mattresses.
- **Alternating pressure** – mechanically vary the pressure beneath the patient by inflating and deflating air filled cells. The depth of the air cells, mechanical robustness, duration and sequence varies between manufacturers.

8.2.2 All pressure relieving equipment for patients in the home setting is provided by Hertfordshire Equipment Service (HES) on the basis of a full assessment following the pressure relieving equipment tool contained within the HES bundle ([Appendix 4](#)). The order form should be completed by a registered nurse or therapist, following assessment of the patient. Formal risk assessment should be performed completing the trust risk and skin assessment form ([Appendix 3](#)) and using clinical judgement taking the following factors taken into account:

- Pressure risk – what is the patient's risk level, will it stay the same, does the patient have existing pressure damage?
- Level of immobility and inactivity.
- Overall goal of care – independence, comfort, pain relief, minimal handling
- Contraindications – are there any contraindications for use e.g. spinal injured patients are not nursed on alternating mattresses
- Weight and build – is the patient's weight and build within the equipment limits, are there any manual handling issues?
- Number, severity and location of existing pressure ulcer(s)
- Safety – if bed rails are appropriate can they be used safely?
- Patient preference – comfort, noise and appearance.

8.2.3 If the Waterlow score is below 10 and an individual is considered low risk, education on pressure ulcer prevention and the trust pressure ulcer prevention leaflet should be given and regular monthly assessment planned.

8.2.4 If the Waterlow score is between 10 and 20 the pressure relieving equipment tool ([Appendix 4](#)) will determine the type of equipment suitable for ordering.

8.2.5 If the Waterlow is 21+ this may include end of life care, a deteriorating condition, and a pressure ulcer of category/grade 3 or above, extreme complex needs or severely limited mobility the patient should be nursed on an alternating pressure mattress.

8.2.6 For Plus size patients take advice from the tissue viability team at HES.

- 8.2.7 When a request falls out of the criteria included in the equipment flow chart such as Waterlow of 21+ and very high risk or the equipment is above £500.00 i.e. replacement mattresses. The supporting rationale for pressure ulcer equipment provision must be completed ([Appendix 4](#)) and sent to HES for the Tissue viability team to authorise.
- 8.2.8 Pressure relieving cushions should be provided to all patients sitting out, or for use in their wheelchairs, who are identified as being vulnerable to pressure damage as part of 24 hour pressure area management.
- 8.2.7 For individuals with at risk heels, heel offloading and/or pressure redistributing silicone/gel pads or foot protectors should be used. Pillows can be used to suspend heels and in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon. Foam wedges or pillows can be used between bony prominences.
- 8.2.9 For individuals with existing pressure damage to heels, offloading pressure redistributing aids must be used or repose foot protectors.
- 8.2.10 The following items **should not** be used as pressure relieving aids:
- Water filled gloves
 - Synthetic sheepskins or genuine sheepskins
 - Doughnut type devices
- 8.2.11 The ordering date and the delivery date of any pressure relieving equipment should be formally documented in the patients nursing record. All orders should be followed up to ensure that equipment is delivered to the patient in good time to prevent further deterioration.
- 8.2.12 Mattress settings on all alternating systems should be checked on a daily basis using the mattress setting form available on system one

8.3 Skin Inspection (SSKIN)

- 8.3.1 Over use of soaps and water may undermine the integrity of the skin when combined with urinary and/or faecal incontinence. Urine and faeces can affect skin integrity through changes in PH and contribute to shear and friction susceptibility. Non soap based cleansers are an alternative and should be considered.
- 8.3.2 Skin which is dry should be well hydrated. Emollients such as aqueous cream may be used when washing to achieve hydration.
- 8.3.3 The use of barrier creams and films such as Cavilon are very effective in giving protection from excess moisture and soiling.
- 8.3.4 Talcum powder is not advocated in the use of skin care as there is a tendency for it to 'cake' in to areas. Additionally it will not absorb moisture.
- 8.3.5 Recommend not to wear clothing made from synthetic material such as nylon that will not absorb moisture. There is an increased risk that the patient can slide down the bed or chair resulting in tissue damage or shear.

8.3.6 Pressure areas should not be rubbed or massaged as this can cause damage to the microcirculation.

8.4 Keep Patients Moving (SSKIN)

8.5.1 Patients identified at risk of pressure damage should be encouraged to, or assisted with regular repositioning.

8.5.2 Patients in the home care setting should be repositioned according to individual care packages. Changes in care packages may be required if there is an elevated risk of pressure damage and an increase in repositioning is required. This should be discussed with the patient or patients advocate and fully documented in the care record.

8.5.3 The frequency of repositioning should be determined by the results of skin inspection, the patients' medical condition, their comfort, the overall plan of care and the support surface in use and should not be a ritualistic schedule. Repositioning should still occur when patients are nursed on any pressure relieving device.

8.5.4 All patients with pressure ulcers should actively mobilise, change position or be repositioned dependant on skin tolerance.

8.5.6 Record re-positioning using an appropriate chart. Where a patient is not responding to the prescribed repositioning regime, this should be reviewed and amended accordingly.

8.5.7 Positioning of patients should ensure that prolonged pressure on bony prominences is minimised and that bony prominences are kept from direct contact with one another. Avoid positioning patients on existing pressure damage, existing erythema either from previous re-positioning or non-blanching erythema.

8.5.8 Manual handling aids should be used correctly to minimise shear and friction damage. After manoeuvring, slings, slide sheets or any other part of handling equipment should not be left under individuals.

8.5.9 Avoid positioning patients onto medical devices such as catheter tubing or bags, drains or oxygen tubing.

8.5.10 (NICE, 2005) recommend restriction of chair sitting for patients who are considered to be at risk of developing pressure ulcers to less than 2 hours per session. Minimise pressure on bony prominences until general condition improves and when sitting have an appropriate cushion instillation.

8.5.11 Wherever possible patients with existing pressure damage of category/grade 3 or above should not sit out for more than 1 hour at a time for a maximum of 3 times per day and should have an appropriate pressure relieving and contoured seating cushion.

8.5.12 Positioning of individuals who may spend long periods of time in a chair or wheelchair should take into account:

- Weight distribution
- Postural alignment
- Support of feet

- Postural safety and stability

8.5.13 In relation to seating, trained assessors, who have the acquired specific knowledge and expertise e.g. an occupational therapist or physiotherapist, should carry out seating assessments in more complex presentations.

8.5 Incontinence (SSKIN)

8.4.1 Incontinence may increase the risk of developing pressure damage. The key factor is moisture to the skin, which can put it at greater risk from maceration, friction and shearing forces.

8.4.2 It is important to understand the difference between a pressure ulcer and a moisture lesion as the treatment approaches are different. Moisture lesions **must** not be reported as pressure ulcers. A moisture lesion is defined as being caused by urine and/or faeces and perspiration which is in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft, skin folds and where skin is in contact with skin. Moisture lesions can cause superficial loss of epidermis and/or dermis which may be preceded by areas of erythema on intact skin (All Wales Tissue Viability Nurse Forum, 2014).

8.4.3 Assessment and management of incontinence is an essential part of skin care in preventing the occurrence of moisture lesions. A continence assessment should be carried out and appropriate advice given and products ordered if required. Referral to the Bladder and Bowel service should be undertaken if required.

8.4.5 Appropriate barrier films are available as a spray, wipe or foam applicator for application to broken or irritated skin to create a breathable transparent film. Barrier creams are available in sachets or tubes and can be used on intact or irritated skin but **not** on broken skin.

8.6 Nutrition (SSKIN)

8.6.1 Nutritional status has been linked to a significant influence on the development of pressure ulceration (Clark et al, 2004). Screen and assess the nutritional status of each patient at elevated risk of or with existing pressure damage using the Malnutrition Universal Screen Tool (MUST) (BAPEN, 2006). Where assessment indicates that malnutrition may be present nutritional intervention should be considered. Nutritional supplements should be provided for patients who are unable to tolerate conventional meals or who have an identified deficiency. A nutritional intake chart should be commenced (*Hertfordshire Community NHS Trust Nutrition Policy, 2014*) Screening should be performed on no less than a monthly basis or more frequently if nutrition is compromised.

8.5.2 If a patient has elevated nutritional and pressure ulcer risk status, wherever possible nutritional input should be improved with food and fortification. When the situation is deemed appropriate offer high protein oral nutritional supplements. Referral to a dietician should be undertaken if required for an individualised dietetic treatment plan.

9. Assessment of Pressure Damage

9.1 The aim of pressure ulcer assessment is to establish the severity of the pressure ulcer, assess for complications and develop a plan of care which is communicated to all health professionals who may be involved in care.

9.2 Assessment should be performed at the first scheduled visit to patients in the home care setting. For patients in community bed based units an assessment should be made in the first 24 hours of care

9.3 Assessment of the patient with a pressure ulcer includes:

▪ Holistic assessment

- Medical and social history
- Identification of factors that may delay wound healing
- The patients (and/or families) goals (aims/desires) of care
- Nutritional assessment and subsequent planning
- Patients adherence to pressure relieving manoeuvres
- Patients knowledge and beliefs concerning development and healing of pressure ulcers
- Cause
- Pain assessment, including cause, level location and management interventions
- Mental Capacity
- Consideration of safeguarding issues

▪ Wound (pressure ulcer) assessment

- Site/location
- Dimensions
- EPUAP classification
- Exudate amount and type
- Local signs of infection
- Wound appearance
- Surrounding skin
- Odour
- Consideration of undermining, tracking, sinus or fistula
- Documentation of the pressure ulcer assessment should be supported by photography wherever possible, tracings or accurate measurements with a ruler

9.4 If a photograph is to be taken of pressure damage, consent must be obtained according to the trust *Consent to Examination or Treatment Policy (Hertfordshire NHS Trust, 2014)*. A signature must be recorded on SystmOne or in the appropriate box on the Trust wound assessment chart, by the patient consenting to photography for clinical reasons and/or teaching purposes. Personal phones must not be used to take photographs. Cameras and trust phones that do not have a memory card must not be used to take photographs. In accordance with the trust *Safe Haven Policy (Hertfordshire NHS Trust, 2014)* staff must after taking a photograph secure the camera in a location for instance a laptop or similar bag. Once staff have completed taking the photograph it must be transferred at the earliest opportunity to a network drive for transfer to SystmOne. After transfer the photograph must be deleted from the device.

- 9.5 When a pressure ulcer is identified the health care professional must implement a SSKIN care plan for a patient who has developed a ulcer pressure ulcer ([Appendix 7](#)). All patients with a pressure ulcer will be reassessed and findings documented **at least weekly**. Any alterations to the treatment plan will be discussed with the patient, health professional and the rationale for this documented. This is to monitor the appropriateness of current treatment and to respond to any changes as a result of the re-assessment.
- 9.6 The pressure ulcer should be categorised/graded using the classification tool ([Appendix 5](#)) and should at no time be reverse graded.

10. Incident Reporting

- 10.1 All category/grade 2 or above pressure ulcers must be reported as an incident using the Trust's incident reporting system (Datix). Pressure ulcer incidents must be reported within 24 hours of the pressure ulcer being identified (Hertfordshire Community Trust, Incident Policy and Procedure, 2015). The Datix incident reporting system requires additional information to be provided specific to pressure ulcers; when a pressure ulcer incident is reported information fields on Datix will direct the reporter to provide the required information. Pressure ulcers that cause patients moderate or severe harm must be escalated to the Team Lead and Locality Manager, who together with the Quality Team, will consider if the incident is reportable as a serious incident. All serious incidents will be investigated and analysis will be used to identify areas of change and recommendations.
- 10.2 In the event of an incident occurring where an investigation is carried out that identifies a staff member as failing to deliver expected standards of care as per HCT guidelines. The Management of Omissions of Care by HCT staff (appendix 9) must be followed.
- 10.3 In the event of suspected deep tissue injury the Trust suspected deep tissue injury (S/DTI) process should be followed ([Appendix 8](#)).
- 10.4 If a pressure ulcer deteriorates e.g. a category/grade 2 becomes a category/grade 3 or a category/grade3 becomes a category/grade 4 a separate incident form should be completed.
- 10.5 Pressure ulcers can occur as a result of neglect and could be considered a Safeguarding Adult Concern (Hertfordshire Community Trust, Safeguarding Adults from Abuse (SAFA), 2013). The Safeguarding Adult Concern should be recorded on the incident form and discussed with the Named Nurse for Safeguarding Vulnerable Adults. It is important to note the contributing factors to establish the development of the pressure ulcer.

11. Treatment of Pressure Ulcers

- 11.1 When a pressure ulcer is identified the following wound management guidance should be implemented.

11.2 Wound management

- Where appropriate to the patient's condition, and in line with the goals of care, debride devitalised tissue from the wound bed or edge of the pressure ulcer. If debridement is required, the method should be selected according to clinical need. This may include autolytic, biosurgical (maggot therapy) or, sharp/surgical (only to be performed following a specialist referral).
- A holistic assessment should be performed and wound assessment chart completed. Both assessments will assist in selection of the most appropriate dressing, when used in conjunction with the 'Guide to Selecting the Correct Primary Dressing' found in the Trust Wound Products Formulary.
- Evaluate the effectiveness of the dressing regime at regular intervals and adjust the plan of care according to clinical need and response.
 - In the case of complex wound management or failure of management interventions to have a positive benefit to the patient, a referral to the Tissue Viability Specialist Service is advised.

All patients with pressure ulcers who are transferred to any other care setting will have their treatment regime communicated to the receiving health care professional prior to transfer. This will contribute to the continuity of patient care.

11.2 Pain management

- Assess and manage a patient's pain related to a pressure ulcer or its treatment, using a validated numerical pain scale.
- Reduce pressure ulcer pain by keeping the wound bed moist and protected with a non-adherent dressing.
- Use dressings less likely to cause pain and trauma on removal and/or a dressing that may require less frequent changes such as hydrocolloids, alginates, hydrogels, foams or soft silicone dressings. Avoid gauze or loose tulle dressing products that may adhere to the wound bed and exacerbate pain.
- If pain is related to the dressing procedure liaise with Dr/GP to prescribe analgesia prior to dressing changes.

12. Ratification of the Policy

12.1 The reviewed and revised HCT Pressure Ulcer Prevention, Assessment and Treatment Guidelines Policy once ratified by the HGC, is ready for publication.

12.2 A checklist for the guidance of Review and Ratification of this policy when submitted to the HGC for consideration is attached in [Appendix 9](#).

13. Dissemination and Access to Ratified Policy

- 13.1 The final reviewed & ratified Pressure Ulcer Prevention, Assessment and Treatment Guidelines Policy will be published on the HCT website electronically and is available to print through the Trust website – ‘Intranet Policy section’.
- 13.2 All the Trust staffs will be made aware of the revised Policy once approved and ratified; electronically via the Staff Notice board.
- 13.3 [Appendix 10](#) details the plan for dissemination of this policy.

14. Implementation and Training

- 14.1 The policy will be available for reference for all staff at all the times and the Trust (HCT) will ensure all staff implementing this policy have access to appropriate implementation tools, advice and training.
- 14.2 Ward/line Managers and Locality Managers are responsible for ensuring implementation of the policy including ensuring all relevant staff receives mandatory, highly recommended and other appropriate training both at induction and thereafter, annual competence assessment and three yearly update training.
- 14.3 Training records will be maintained. A register of staff attending is held and monitored by the identified lead and a copy kept with the learning and development department.
- 14.4 Relevant training and education is in place to improve the outcome of those patients identified as vulnerable to or have an elevated risk of pressure damage. Relevant training includes the wound management programme, pressure ulcer prevention and management programme, MUST training and moving and handling.
- 14.5 The aims and objectives of the pressure ulcer prevention and management education programme are to:
- Enhance understanding of the pathophysiology of pressure ulcer development
 - Develop skills and knowledge in skin assessment and categorising/grading pressure damage
 - Explore a range of pressure ulcer preventative measures
 - Develop skills in care planning
 - Explore problem solving strategies using case studies
- 14.6 Patient and/or carers who are able and willing should be informed and educated about risk assessment and preventative strategies.
- 14.7 Patient/carer education should include information on the following:
- The risk factor associated with them developing pressure ulcers
 - The sites that are of the greatest risk to them of pressure damage
 - How to inspect skin and recognise changes
 - How to care for skin: methods for pressure relief/reduction
 - Where they can seek further advice and assistance should they need it
 - Emphasis on the need for the referral to a health care professional should signs of skin damage be noticed

15. Monitoring Compliance and Effectiveness

- 15.1 Processes should be put in place to test that all staff especially those with specific responsibilities are compliant. Any local protocols or guidelines derived from the Incident policy and Procedure should be examined for coherence and consistency with the document.
- 15.2 Audit of compliance should be undertaken as a routine by the Lead Officer/ author, usually no less than **six months** after the policy's publication. The designated Ratifying Committee which has the responsibility for assurance may recommend the audit of specific policies and protocols as part of the Trust (HCT) internal and/ or clinical audit programmes.
- 15.3 In order to ensure that the impact of these guidelines is monitored for adherence and effectiveness the following measures are in place:
- Pressure ulcer incidence reporting
 - Root cause analysis – investigations for Category/Grade 3 & 4 pressure ulcers. These investigations specifically look at whether the correct strategies were put in place to prevent pressure damage, in line with Trust guidance.
 - Completion of relevant documentation in patient records including formal risk assessment – Waterlow and MUST, skin and wound assessment charts, care plans and regular evaluation. Evidence of standards of record keeping underpinning delivery of care will be monitored by regular record keeping audit.

16. Review and Revision Arrangements

- 16.1 The review, updating and archiving process for this policy shall be carried out in accordance with the Trust (HCT) GR1 Policy for Procedural Documents, V.3 by the identified Lead Officer.
- 16.2 Minor revision and details of amendments are recorded as per [Appendix 11](#).
- 16.3 Any revision activity is to be recorded in the version control table as part of the document control process.

17. Document Control and Archiving Arrangements

- 17.1 The version control table as listed in [Appendix 12](#) enables appropriate control of the policy with listed personnel responsible for its implementation as well the date assigned/ approved/ circulated.
- 17.3 The older version is removed from the intranet and archived at the designated location. Any copies of archived policy can be retrieved by submitting an email request to the Policy Control Officer.

18. Equality Impact Analyses (EIA)

- 18.1 The Trust (HCT) is required to have due regard to the need to:
- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010;
 - Advance equality of opportunity between people from different groups; and

- Foster good relations between people from different groups.

18.2 The completed EIA form has been undertaken by the Lead Officer ([Appendix 13](#)) before submitting the policy for ratification.

19. References

- BAPEN (2006). Malnutrition Universal Screening Tool (MUST). *Nutritional assessment tool*. www.bapen.co.uk
- Clarke, M. Schols, J. Benati, G. (2004). Pressure ulcers and nutrition: a new European guideline. *Journal of Woundcare*. 13(7), 267-272.
- Department of Health (2005) *Mental Capacity Act*. London. HMSO
- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (NPUAP/EPUAP/PPPIA) (2014) *Prevention and Treatment for Pressure Ulcers: Quick Reference Guide*. <http://www.epuap.org>
- Hertfordshire Community NHS Trust. (2014) *Nutrition Policy*
- Hertfordshire Community NHS Trust (2014) *Consent to Examination or treatment policy*.
- Hertfordshire Community NHS Trust (2015) *Incident Policy and Procedure*
- Hertfordshire Community NHS Trust. (2013) *Safeguarding Adults from Abuse (SAFA) Policy and Procedure*
- Hertfordshire Community NHS Trust (2014) *Safe Haven Policy*
- National Institute of Clinical Excellence (NICE). (2014). *Clinical Guideline 179: Pressure Ulcers: prevention and management of pressure ulcers*.
<http://www.nice.org.uk>
- All Wales Tissue Viability Nurse Forum (2014) *All Wales Best Practice Statement on the Prevention and Management of Moisture Lesions*. Wounds UK, London. www.wounds-uk.com
- Rycroft-Malone, J. & McInnes, E. (2000). *Pressure ulcer risk assessment and prevention. Technical Report*. London. Royal College of Nursing.
- Waterlow, J. (1997). Pressure sore risk assessment in children. *Paediatric Nursing*. 9(6), 21-24.
- Waterlow, J. (1998). Pressure sores in children: risk assessment. *Paediatric Nursing*. 10(4), 22-23.
- Waterlow, J. (2005). *Pressure ulcer prevention manual*. Taunton.
- Willock, J. et al (2005). Identifying the characteristics of children with pressure ulcers: results of a multi-centre survey. *Nursing Times*. 102(11), 40-43.

20. Appendices

The following appendices are attached to support this policy:

Appendix 1 - Generic Ownership, Roles and Responsibilities

Appendix 2 - Hertfordshire Community NHS Trust Committee Structure

Appendix 3 - Pressure ulcer risk and skin assessment form

Appendix 4 - Hertfordshire Equipment Ordering Bundle

Appendix 5 - Pressure Ulcer Classification Tool

Appendix 6 - SSKIN Pressure Ulcer Prevention Core Care Plan

Appendix 7 - SSKIN Pressure Ulcer Treatment Core Care Plan

Appendix 8 - Deep Tissue Injury Flow Chart

Appendix 9 - Management of Omissions of Care by HCT Staff

Appendix 10 - Checklist for the Review and Ratification of the Policy

Appendix 11 - Plan for Dissemination of the Policy

Appendix 12 - Amendment(s) Template for the Policy

Appendix 13 - Version Control Table

Appendix 14 - Equality Impact Analyses Form

APPENDICES

APPENDIX 1: Generic Ownership, Roles and Responsibilities (in line with HCT GR1 0114 V.3 Policy)

1 The Trust Board

- Are ultimately accountable for this policy to be used throughout the HCT and for ensuring that there is an approved process to manage it.
- The Board is responsible for seeking assurances via its designated Committee that the Governance framework for the development and management of this policy are robust and effective.

2 Board Sub Committee (Designated Committee)

- The Designated Committee is responsible for considering, commenting, and approving this document.
- The Designated Committee members are responsible for receiving assurance of effective implementation from The Lead Officer and formulating assurance reports to the Board as well as through the submission of minutes, advise the Board of the ratified procedural documents.

3 The Executive Team

- The Executive Team has collective responsibility for ensuring effective systems, process and resources are in place for the implementation of, and compliance with, this policy and for the ratification of agreed formal documentation.

4 Chief Executive Officer

- The Chief Executive Officer has overall responsibility for ensuring that the Trust (HCT) has appropriate 'Policy/ procedural document' in place and that robust monitoring arrangements are in place.

5 Lead Executive Director

- The Lead Executive Director is responsible for ratification, distribution, implementation and review of HCT Policy/ Procedural document along with supporting and directing the 'Lead Officer' during the progression of the policy.

6 Lead Officer

- Has the duties of monitoring compliance of this policy as well as reporting evidence of non-compliance to the Lead Executive Director (for action) and to the Designated Committee (for assurance purposes).
- The duty involves undertaking an Equality Impact Analysis, ensuring the policy is appropriately disseminated and communicated, describing how the policy will be monitored for compliance & effectiveness.
- The Lead Officer for 'each' procedural document is responsible for researching, formulating, composing, consulting on, and routing the procedural document through to the ratification and dissemination stage. Where the procedural document is a policy the Lead Officer "must" provide specialist advice and work in liaison with the Policy Control Officer in the content of the Policy being developed fully.
- The Lead Officer is also responsible for ensuring appropriate review of this policy, either in line with the relevant timescale set at the time of ratification or as a result of changes to practice, organisational structure or legislation and also for submitting the document to the Policy Control Officer for archiving when it becomes invalid.

7 Deputy Directors/ General Managers

- Deputy Directors/ General Managers through their line managers are responsible for contributing to the development of this policy including following the consultation process set out within this policy.
- Are responsible for having systems in place to monitor key performance indicators, manage non-compliance as well as manage and escalate associated risks where appropriate including resource requirements.

8 Line Managers

- Line Managers are responsible for ensuring that the policy is accessible for all of their staff and that the staff have read and understood the relevant document(s).
- Are responsible to ensure that a system is in place to identify staff training needs on the implementation of new and updated policy where relevant.

9 All Staff

- All staff have responsibility to attend all relevant training as required and directed by their line managers.
- All staff have responsibility for contributing towards the development of this policy and seek help and support from their line manager as necessary and in line with this policy
- Are responsible for following all applicable policy within their remit of working area and reporting any adverse experience/ incident or non-compliance with the policy to their line manager.

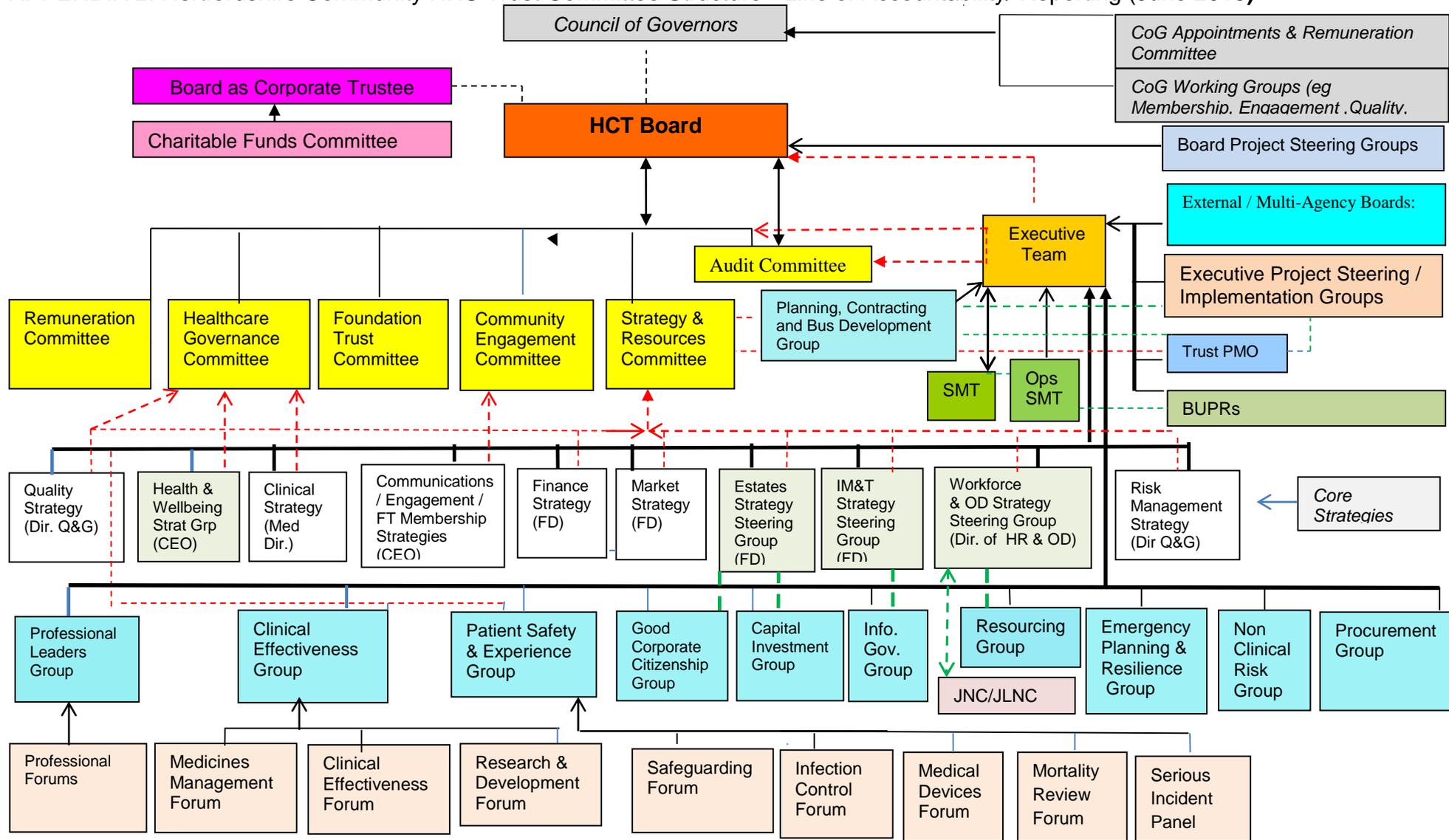
10 Policy Control Officer

- The Policy Control Officer is responsible for coordinating the procedures described in the relevant policy to enable ratification. This includes researching, formulating, composing, consulting on, and routing the procedural document through to the ratification and dissemination stage liaising with the designated Lead Officer.
- Is responsible for maintaining the policy log database, making available a copy of the approved as well as uploading the updated document and any related templates/ forms on the staff intranet with removal of the revoked versions, where appropriate.
- The Policy Control Officer will ensure archiving of a historical version of this policy; will ensure the 'Policies section' of the staff intranet is up-to-date and will notify all Trust staff via the electronic staff 'Notice board' regarding this policy.

11 Communication Lead

- Is responsible for working alongside the Policy Control Officer to upload the latest approved policy, removing revoked documents and highlighting the updated policy electronically via the staff Notice board.
- Is responsible for ensuring that there is a system in place whereby the policy, is published on the Trust's website (staff intranet).

APPENDIX 2: Hertfordshire Community NHS Trust Committee Structure - Line of Accountability/ Reporting (June 2016)



(Informal and time limited Forums, Working Groups / Project Teams)

APPENDIX 3: Pressure Ulcer Risk and Skin Assessment Form

Patients Name:	NHS No.:
Address/Ward:	Assessment Date:
GP:	Assessed by:

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY
RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT	SKIN TYPE VISUAL RISK AREAS	SEX AGE	MALNUTRITION SCREENING TOOL (MST) (Nutrition Vol.15, No.6 1999 - Australia)	
AVERAGE BMI = 20-24.9 0	HEALTHY 0	MALE 1	A - HAS PATIENT LOST WEIGHT RECENTLY	
ABOVE AVERAGE BMI = 25-29.9 1	TISSUE PAPER 1	FEMALE 2	YES - GO TO B	B - WEIGHT LOSS SCORE
OBESSE BMI > 30 2	DRY 1	14 - 49 1	NO - GO TO C	0.5 - 5kg = 1
BELOW AVERAGE BMI < 20 3	OEDEMATOUS 1	50 - 64 2	UNSURE - GO TO C AND SCORE 2	5 - 10kg = 2
BMI=W(kg)/Ht (m) ²	CLAMMY, PYREXIA 1	65 - 74 3		10 - 15kg = 3
	DISCOLOURED GRADE 1 2	75 - 80 4		> 15kg = 4
	BROKEN/SPOTS GRADE 2-4 3	81 + 5	C - PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0; 'YES' SCORE = 1	unsure = 2
				NUTRITION SCORE if > 2 refer for nutrition assessment / intervention
CONTINENCE	MOBILITY	SPECIAL RISKS		
COMPLETE/ CATHETERISED URINE INCONT. 1	FULLY 0	TISSUE MALNUTRITION	NEUROLOGICAL DEFICIT	
FAECAL INCONT. 2	RESTLESS/FIDGETY 1	TERMINAL CACHEXIA 8	DIABETES, MS, CVA 4-6	
URINARY + FAECAL INCONTINENCE 3	APATHETIC 2	MULTIPLE ORGAN FAILURE 8	MOTOR/SENSORY 4-6	
	RESTRICTED 3	SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC.) 5	PARAPLEGIA (MAX OF 6) 4-6	
	BEDBOUND e.g. TRACTION 4	PERIPHERAL VASCULAR DISEASE 5	MAJOR SURGERY or TRAUMA	
	CHAIRBOUND e.g. WHEELCHAIR 5	ANAEMIA (Hb < 8) 2	ORTHOPAEDIC/SPINAL 5	
		SMOKING 1	ON TABLE > 2 HR# 5	
			ON TABLE > 6 HR# 8	
			MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4	
# Scores can be discounted after 48 hours provided patient is recovering normally				
<p>© J Waterlow 1985 Revised 2005*</p> <p>Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX</p> <p>* The 2005 revision incorporates the research undertaken by Queensland Health.</p> <p style="text-align: right;">www.judy-waterlow.co.uk</p>				

All patients should have a risk assessment and a skin assessment on admission to caseload and on an on-going basis depending on their circumstances. The Waterlow Score should be used as an aid to clinical judgement and risk calculated accordingly.

Frequency of review:

(N.B.) In bed based units reassess weekly for **ALL** patients at risk.

In the community setting this should be monthly for "At risk" "High risk" and "Very high risk" patients or sooner if:-

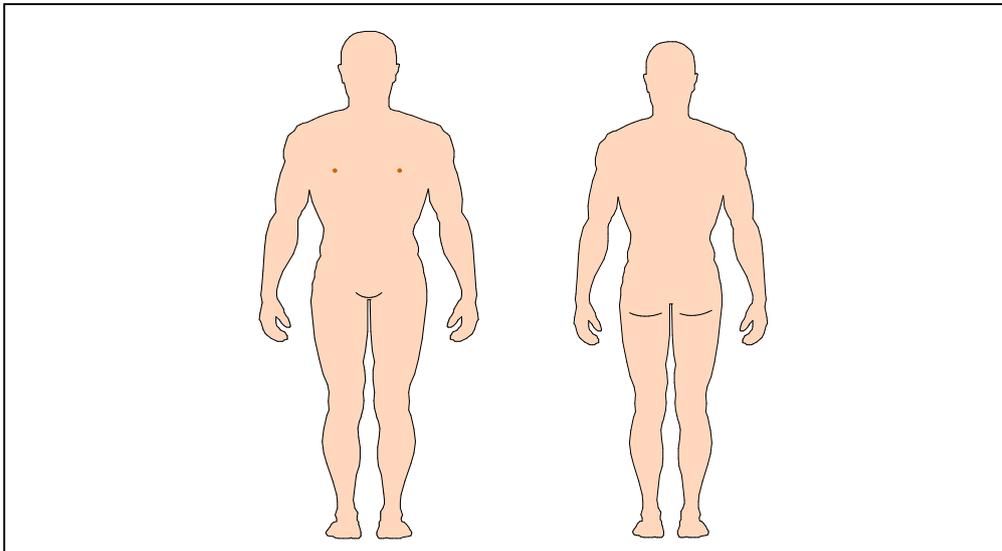
- i) The patient becomes acutely unwell,
- ii) Is there any deterioration in the patient's condition?

Date	Waterlow Score	Assessed by	Review Date

Patients Name NHS No.....

Skin should be inspected by the qualified nurse carrying out the assessment. Any pressure damage should be recorded and categorised using the EPUAP grading system.

Mark location of any area of skin damage with an "X" and number.



Tick as appropriate

Signs to look for	Signs to look for	Signs to feel for
Purplish/bluish area	Localised oedema	Hard areas
Persistent red area	Blisters	Warm areas
Area of discomfort or pain	Shiny areas	Localised coolness of tissue death occurs
Cracks, calluses, corns	Dry patches	Swollen skin over bony points

Date	Pressure ulcer present Yes/No	Category of pressure ulcer	Treatment	Equipment	Review date

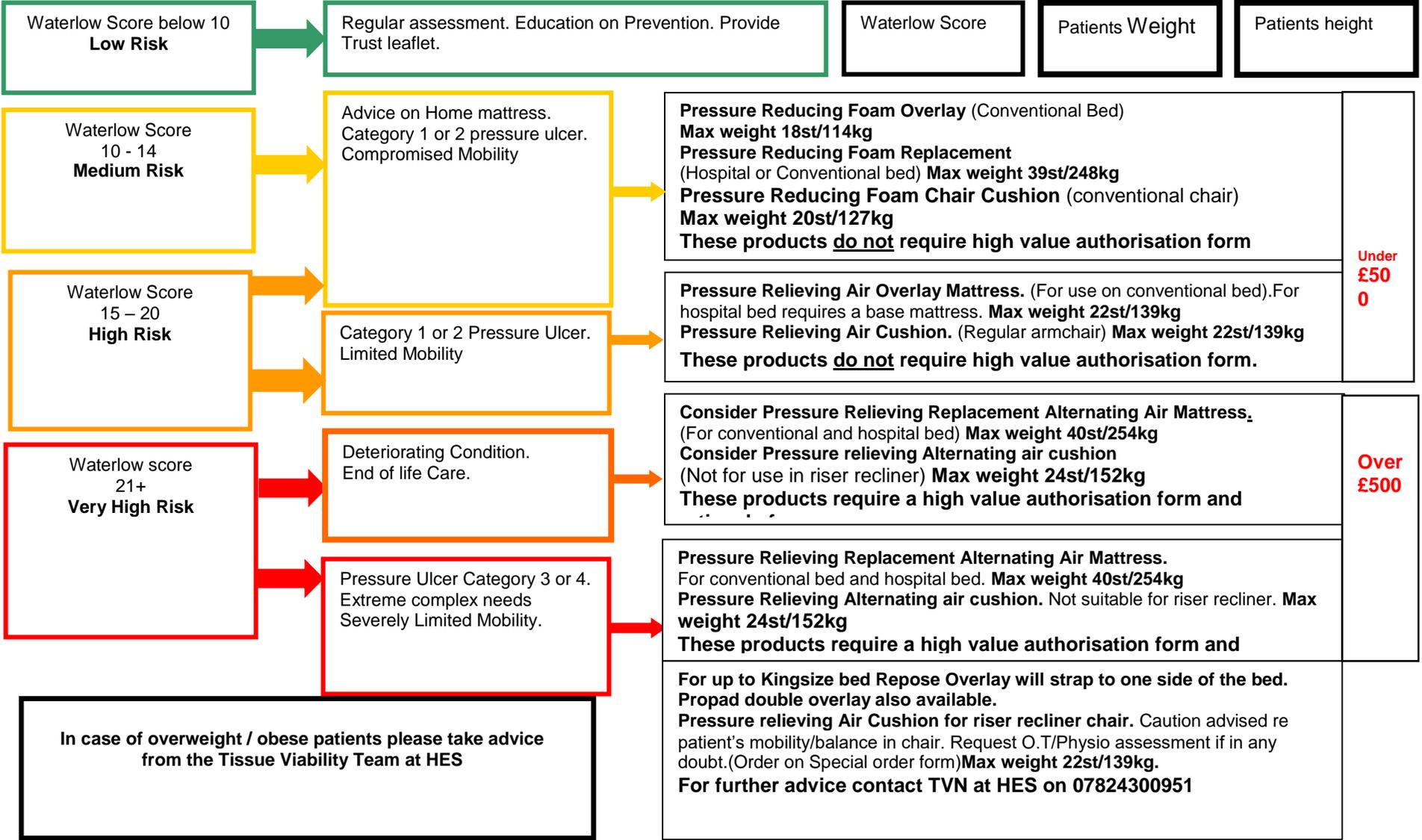
Has pressure damage of category 2 or more been identified? YES/NO (circle)

If yes, please complete incident form and insert date here _____

If pressure ulcer present, please use wound assessment chart and care plan.

APPENDIX 4: Pressure Relieving Equipment Ordering Tool

5. Complete Trust Risk and Skin Assessment Form



HERTFORDSHIRE EQUIPMENT SERVICE

Supplementary Form to be attached to HES Order Form when ordering
following high cost equipment:-

- Beds ● Alternating Air Mattresses ● Electric Hoists ● Suction Machines

PLEASE COMPLETE THIS FORM IN BLOCK CAPITAL LETTERS

HES Order Form Ref No.

Name of Patient: _____ Date Assessed: _____

Name of Prescriber: _____ Prescriber Tel No.: _____

Designation of Prescriber: _____

Diagnosis: _____

Total Clinical Priority Score from HES order form

Equipment being requested: Electric Hoist Bed
 Alternating Air Mattress Suction Machine

Please select primary reason for requesting equipment by ticking appropriate box below. If "Next Day" delivery is required please complete far right hand section of this table (see guidance notes on reverse)	NEXT DAY	3 DAY	7 DAY	<u>IMPORT NOTICE</u> HES must be advised of the potential demand at the earliest opportunity, therefore <u>you must telephone</u> and pre-book 1 and 3 day deliveries. You will be told immediately if the routes are fully booked, and the request cannot be met. You are responsible for obtaining authorisation and sending the form into HES before 13:00 pm. Equipment will NOT be delivered without an authorised referral. For 1 or 3 day delivery request it is essential to provide significant clinical evidence to underline the clinical priority score
	Please tick one box	Please tick one box	Please tick one box	
	✓	✓	✓	
Liverpool Care Pathway				
Delay transfer of care				
Rapidly deteriorating clinical needs				
Significant risk of carer breakdown				
Significant health and safety risk				
Continuing community care				
Professional Carer				
Elective surgery				
Rehabilitation				
Respite (please provide name of Care Home):- _____				

(Please tick box) - I (the prescriber) have ensured that on the day of delivery, there will be clear access from the delivery vehicle to the allocated room including stairways; and that the room where the equipment is to be delivered will be adequately cleared to enable the equipment to be installed.

Prescribers Name: Prescriber's signature:Date:

Authorisers Name: Authorisers signature:Date:

Procedure for ordering pressure relieving Equipment

Follow the mattress/cushion ordering flow chart to aid decision on which mattress/cushion to order. Complete Patients Waterlow, weight and height on flow chart this will enable technician delivering mattress to set to correct weight.

Fill in current HES order form but do not fill in clinical priority score.

Please specify the type of the mattress/cushion required. Get this by following flowchart. This will be either:-

Overlay foam mattress

Replacement foam mattress

Overlay Air Mattress

Replacement air mattress

Foam Cushion.

Air cushion.

If unsure on what product ring TVN at HES. 07824300951

For Foam overlay and foam replacement mattresses, air overlay mattresses and air cushions fill in current HES order form or order online. **No high cost form required. No rationale form required.**

For replacement alternating air mattresses and cushions fill in Order Form, High Cost form and supporting rationale and fax to usual HES number. Specify category of Pressure Ulcer if there is a pressure ulcer present.

For Special orders not covered on flow chart, please call HES TVN for advice. HES management will advise if TVN absent. If TVN on annual leave or not in, HES management will authorise. So there will be no delays.

*****For NEXT DAY/ 3 DAY DELIVERY it is ESSENTIAL to ring and follow the options and arrange with HES staff. Failure to do this will result in delayed delivery.*****

Procedure for ordering Hospital Beds.

Order beds and supplementary equipment as usual. Bed will be supplied with a Memaflex mattress unless specifically asked for on order form.

All bed orders require high cost form regardless of type of mattress ordered.

Bed orders will go through HES staff and will not be delayed if a high grade mattress is ordered with the bed.

For Pre booking delivery dates for beds please ring HES as usual to arrange with HES staff.

APPENDIX 5: Pressure Ulcer Classification Tool

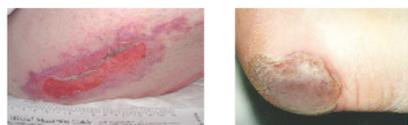
PRESSURE ULCER GRADING TOOL

EPUAP - Category/Grade 1



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

EPUAP - Category/Grade 2



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

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

EPUAP - Category/Grade 3

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



Plus: Unclassified PU – now Grade 3

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



EPUAP - Category/Grade 4

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



Moisture Lesions

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



Definition of Suspected Deep Tissue Injury - depth unknown

- 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 become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



Adapted from EPUAP/NPUAP 2009

APPENDIX 6: SSKIN Pressure Ulcer Prevention Core Care Plan

Care Plan for patients at risk of developing a pressure ulcer SSKIN CARE BUNDLE

Patient Name: _____ NHS No: _____ Care Plan Number: _____

Care Plan has been discussed and frequency of visits agreed with the patient? Yes / No

Problem / Need	Goal	Signature	Date
Patient is at risk of pressure ulcer formation due to _____	To maintain skin integrity and to help to prevent the formation of pressure ulcers		
Date/Time	Planned Care	Planned evaluation date	Date of evaluation

	<p>Surface - request appropriate pressure relieving equipment via HES if indicated. Ensure equipment is correct, in place with correct setting according to weight. Evaluate effectiveness of equipment at each visit and update care plan accordingly.</p> <p>Skin – Gain consent to complete risk assessment, inspect skin, complete Waterlow assessment, document and sign pressure ulcer risk and skin assessment form. Advise on skin management. Set date for re-assessment</p> <p>Incontinence/Moisture – adopt strategies for management of urine/bowels/sweat.</p> <p>Keep Moving -.Use of repositioning chart, advise and explain the implications of risk to patient/carer regarding repositioning at regular intervals when seated and also when laying in bed</p> <p>Nutrition - complete MUST screening tool and plan care according to level of risk Document .all advice and care given</p>		
<i>(Informal and time limited Working Groups / Project Teams)</i>			

APPENDIX 7: SSKIN Pressure Ulcer Treatment Core Care Plan

Fix patient label here

**Care Plan for patients who have developed a pressure ulcer
SSKIN CARE BUNDLE**

Care Plan Number:

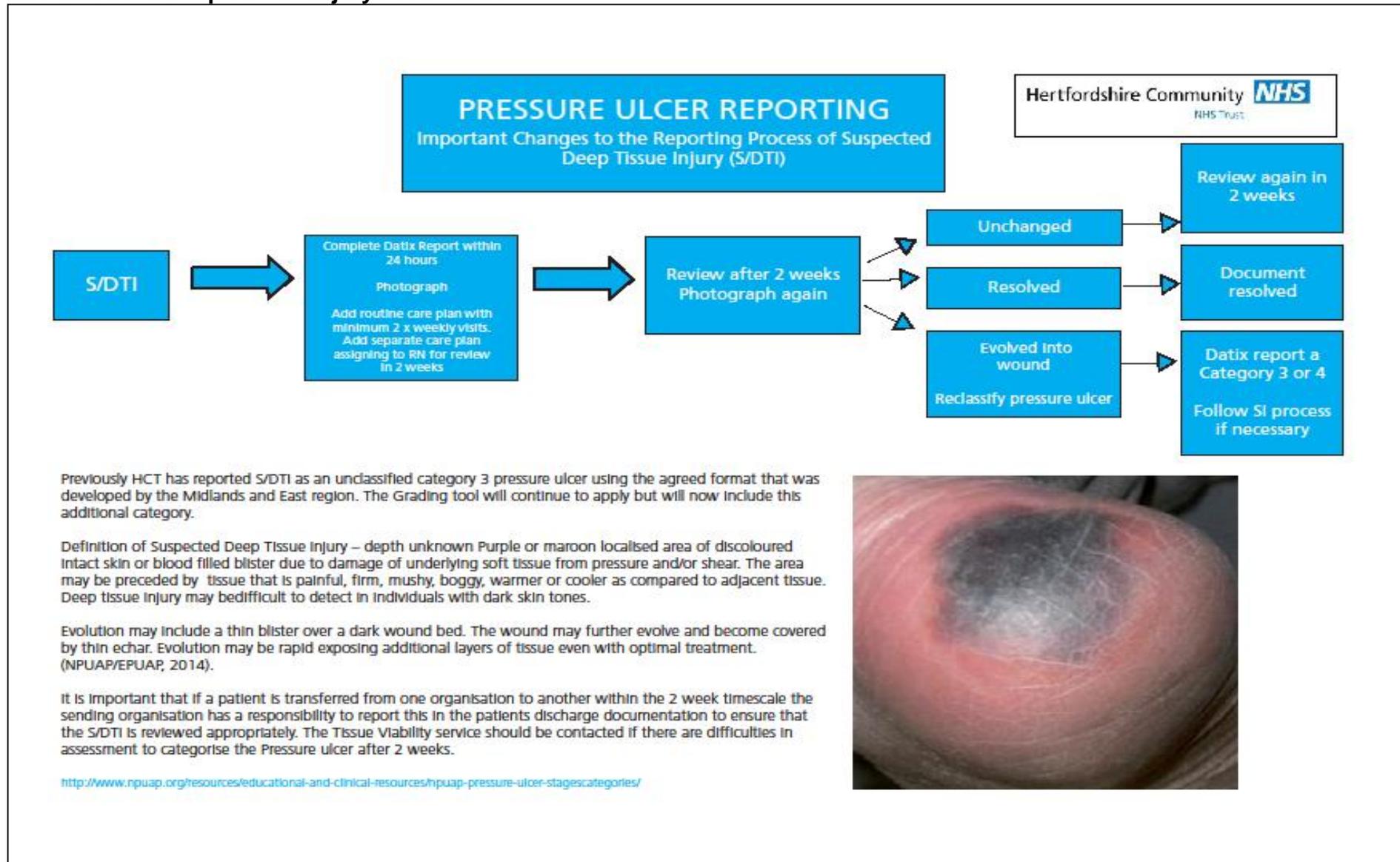
Has Care Plan been discussed with the patient? Yes / No

Completed by:

Problem / Need		Goal	Signature			Date
Patient has a pressure ulcer, category		Provide optimal healing environment and reduce the risk of further deterioration				
Date/Time	Planned Care	Action completed? Y/N	Comments	Planned evaluation date	Date of evaluation	
Surface						
	Request appropriate pressure relieving equipment via HES if indicated Ensure equipment is correct, in place and set according to weight					
Skin						
	Inspect skin and assess using Waterlow, document results on pressure ulcer risk and skin assessment chart weekly. Redress wound following wound care plan Complete wound assessment weekly, support with wound tracings, or photography with written consent from the patient					
Keep Moving						
	Use of re-positioning chart - explain to patient and carer the importance and need for regular position changes. Agree a re-positioning schedule Assess pain and level of analgesia Assess manual handling risk to prevent further shear injury					
Incontinence/Moisture						
	Adopt strategies for management of urine/bowels/sweat.					

Nutrition					
	Complete MUST assessment, and plan care accordingly – Set date for re-assessment. Advise on diet and monitor fluid intake				
Additional actions		Date			
	Incident report any pressure ulcer of category 2 or above and any subsequent deterioration				
	Evaluate effectiveness of treatment at each visit and update care plan accordingly				
	Escalate concerns to GP/TV/Safeguarding Named Nurse for Vulnerable Adults				

APPENDIX 8: Deep Tissue Injury Flow Chart



Previously HCT has reported S/DTI as an unclassified category 3 pressure ulcer using the agreed format that was developed by the Midlands and East region. The Grading tool will continue to apply but will now include this additional category.

Definition of Suspected Deep Tissue Injury – depth unknown 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.

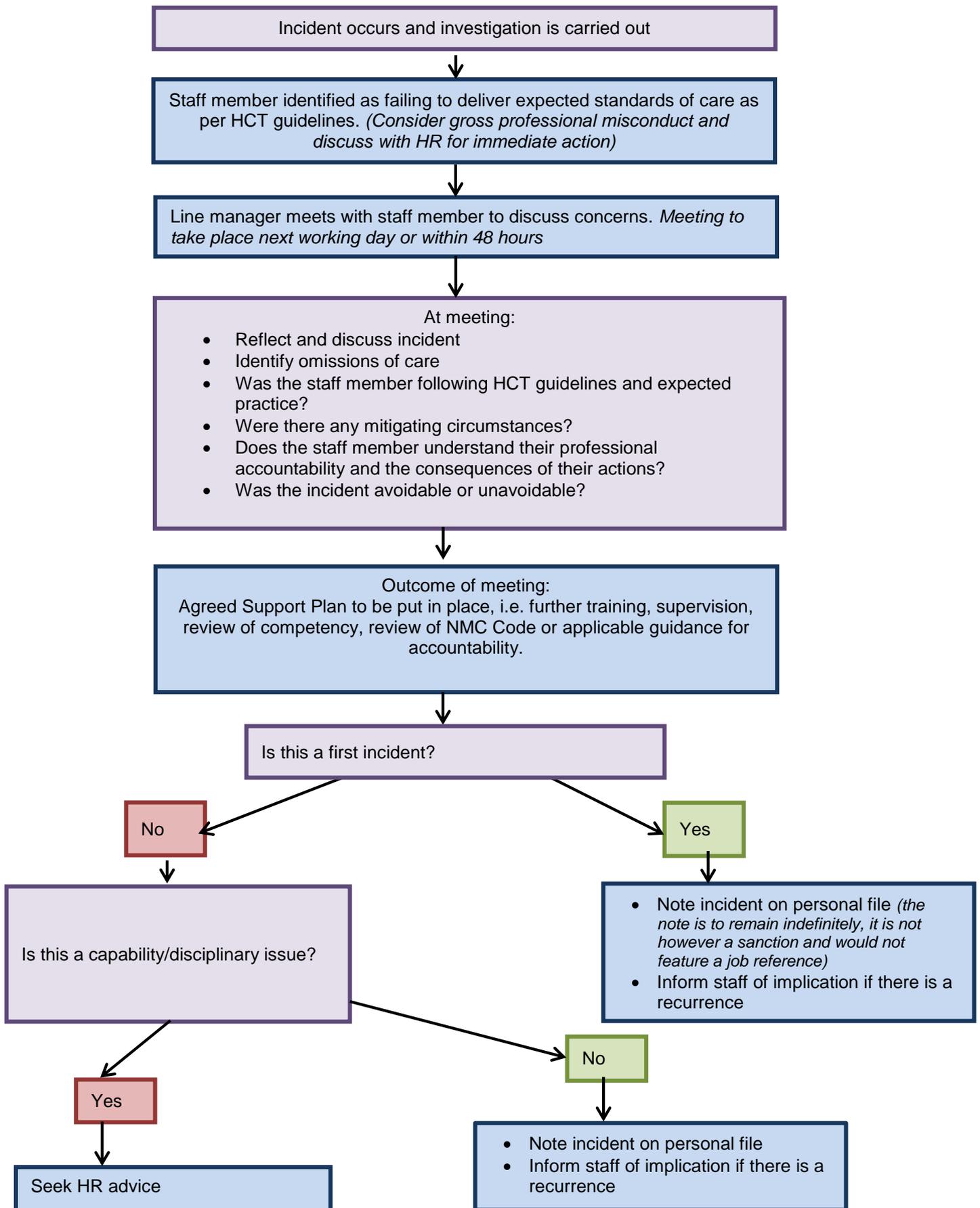
Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. (NPUAP/EPUAP, 2014).

It is important that if a patient is transferred from one organisation to another within the 2 week timescale the sending organisation has a responsibility to report this in the patients discharge documentation to ensure that the S/DTI is reviewed appropriately. The Tissue Viability service should be contacted if there are difficulties in assessment to categorise the Pressure ulcer after 2 weeks.

<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/>



APPENDIX 9: Management of Omissions of Care by HCT Staff



APPENDIX 10: Checklist for the Review & Ratification of the Policy

To be completed by the Lead Officer and attached to any document which guides practice when submitted to the appropriate committee for consideration and ratification.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	Rationale		
	Are reasons for development of the document stated?	Y	
3.	Development Process		
	Is the method described in brief?	Y	
	Are individuals involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
4.	Content		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	
	Are local/organisational supporting documents referenced?	Y	
6.	Ratification		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	Y	
7.	Dissemination and Implementation		
	Is there an outline/plan to identify how this will be	Y	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	done?		
	Does the plan include the necessary training/support to ensure compliance?	Y	
8.	Document Control		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	Y	
9.	Process for Monitoring Compliance		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Y	
	Is there a plan to review or audit compliance with the document?	Y	
10.	Review Date		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so, is it acceptable?	Y	
11.	Overall Responsibility for the Document		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Y	

Person Completing the Form			
Name	Kim Fenwick	Date	05.04.16
Designation	Tissue Viability Lead Specialist Nurse		
Committee Ratification			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Clare Hawkins	Date	
Signature			

APPENDIX 11: Plan for Dissemination of Pressure Ulcer Prevention, Assessment and Treatment Guidelines Policy

To be completed and attached to any policy when submitted to the appropriate committee for consideration and ratification.

Title of document:	Pressure Ulcer Prevention, Assessment and Treatment Guidelines Policy		
Version Number:	04		
Ratification Date:	TBC	Dissemination lead:	Kim Fenwick
Previous document already being used?	CP59 0511, V.03		
If yes, in what format (paper / electronic) and where (e.g. Directorate / Trust wide)?	Paper, electronic – trust wide		
Proposed instructions regarding previous document:	Archive the V03 version and remove it from the HCT website – Policy section page.		
To be disseminated to:	How will it be disseminated, who will do it and when?	Format (i.e. paper or electronic)	Comments:
All HCT Staff	Staff meetings, Intranet	Electronic	

Officer's Dissemination Record - to be used once document is approved – to be kept with the master document

Date document forwarded to be put on the Trust's central register / in Sharepoint:		Date document put on Directorate register (if appropriate)/ on Directorate webpage (if applicable)	
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Disseminated to: (either directly or via meetings, etc.)	By Whom?	Format (i.e. paper or electronic)	Date Disseminated:
Noticeboard	Communication Lead in liaison with Policy Control Officer	Electronic	

APPENDIX 12: Pressure Ulcer Prevention, Assessment and Treatment Guidelines Amendment(s) Template

To be completed and attached to any procedural document when submitted to the appropriate committee for ratification after doing Minor/ Technical revision(s).

Procedural Document Title: Pressure Ulcer Prevention, Assessment and Treatment Guidelines

Ref No: CP59 0414

Version: V.4

Date of Revision(s): April 2016

Summary of Amendments:

Section Heading, Paragraph Number(s)	Description of Amendment(s)	Comments
All sections, paragraphs renumbered	Whole Document amended to meet new GR1 format	New GR1 procedural document revised in January 2014
Introduction Page 3	Additional established guidance	updated
Section 7 Page 6	Change of diagram for areas of risk	updated
Section 7,1.3	information for ordering equipment	updated
Section 7.4.1	Pressure Ulcer Classification	updated
Section 8.1 - 9 Page 10 - 15	Care Planning SSKIN bundles	updated
Section 9.4 Page 15	Photographing wounds	updated
Section 10 Page 16	Incident Reporting	updated
Appendix 1	Roles and responsibilities	New appendix inserted
Appendix 2	Hertfordshire Community NHS Trust Committee Structure	Updated
Appendix 4	Hertfordshire Equipment Service ordering Bundle	New appendix inserted
Appendix 5 Appendix 6	Pressure Ulcer Classification Tool Core Care Plan for Patient at Risk of	New appendix inserted

	Developing a Pressure Ulcer	New appendix inserted
Appendix 7	Core Care Plan for a Patient who has developed a Pressure Ulcer	New appendix inserted
Appendix 8	Deep Tissue Injury Flow Chart	New appendix inserted
Appendix 9	Plan for Dissemination of policy	New appendix inserted
Appendix 10	Review and Ratification	New appendix inserted
Appendix 11	Amendment sheet	New appendix inserted
Appendix 12	Version Control table	New appendix inserted
Appendix 13	EIA form	Revised and updated

APPENDIX13: Version Control Table

Version No.	Status (Draft/ Approved)	Lead Officer (Author) Or, Identified Responsible Personnel	Date ratified (dd/mm/year) & reported Designated Committee	Comment (Key points of amendments)
V.1	Preliminary Draft	Kim Fenwick, Tissue Viability Specialist Nurse	January 2011	
V.2	Consultation Drafts	Kim Fenwick, Tissue Viability Specialist Nurse	February 2011	
V.3	Approval Draft	HGC	May 2011	

Historical Editions:

Edition/ Version and Date	Reason for archiving	Date for archiving & location
v.3 May 2011	Superseded by April 2016 V.4	<i>N:HCT/ Shared Secure/Archived Policies</i>

APPENDIX: 14 Equality Impact Analyses Form

To be undertaken, completed and attached to any procedural document when submitted to the appropriate committee for consideration and ratification.

Function or Service	Pressure Ulcer Prevention, Assessment and Treatment Guidelines Policy
Date of Equality Analysis	16.04.14
Those involved in this analysis	Kim Fenwick

Intended Outcomes	Human Rights Approach
What are the Desired Outcomes? What are the benefits?	What are patients' core rights as part of this service/function? Are there any gaps identified? What are the risks? What action is needed to mitigate risk and/or close the gap?
Facilitate high standards of patient care relating to the prevention of pressure damage and the active management of patients who may have acquired pressure damage.	None

Evidence	What are the Risks?
What evidence is being used to support and develop the service/function?	What are the risks in providing an equitable service? How can these risks be reduced, managed or justified?
NICE, DoH	

Who will be Affected?	
Identify issues in relation to each of the protected groups below:	
Race: None	Gender Reassignment: None
Disability: None	Religion or Belief: None
Gender: None	Maternity & Pregnancy: None
Age: None	Marriage & Civil partnership: None
Sexual Orientation: None	

What Workforce Issues included job role and design need to be considered?	Engagement and Involvement
Nil	Who has been involved in this analysis? Kim Fenwick

Actions Identified: None

S. No.	WHAT	WHO	WHEN	COST