Livewell Southwest

Pressure Ulceration Prevention and Management Policy

Version No. 4
Review: April 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Authors: **Tissue Viability Clinical Nurse Specialist**
Professional Lead
Matron District Nurse Treatment Clinic

Asset Number: **603**

Reader Information

Title	Pressure Ulceration Prevention and Management Policy. V.4.
Asset number	603
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document Purpose/ summary	Guidance for staff in the Prevention and Management in promoting Tissue Integrity and Preventing Pressure Ulceration The policy provides staff with a framework for assessment, intervention and reporting of patients at risk or who have Pressure Ulceration
Authors	Professional Lead Matron for the District Nurse Treatment Clinic Tissue Viability Clinical Nurse Specialist
Ratification date and group	9th December 2015. Policy Ratification Group
Publication date	28th April 2016
Review date and frequency (one, two or three years based on risk assessment)	Three years after publication, or earlier if minor changes are required.
Disposal Date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule; all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Clinical Nurse Specialist Tissue Viability
Target audience	All Livewell Southwest staff
Circulation	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☏ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation process	This policy was produced in consultation with managers from: Professional lead Matrons, Ward Managers, AHP's Director of Governance Professional practice Deputy Director of Governance Professional practice, Risk Management Team Pharmacy Manager, Infection Prevention and Control, Community Equipment Manager SH and WD staff Across Plymouth Citywide, the South Hams & West Devon.
References/sources of information	Dealey, C. (1994) The Care of Wounds. Blackwell Scientific Publications. Oxford.

	Department of Health (2012) Using the Commissioning for Quality and Innovation (CQUIN) payment framework: A summary guide. HMSO. London Department of Health (1993). Pressure Sores – A Key Quality Indicator. A Guide for NHS Purchasers and Providers. European Pressure Ulcer Advisory Panel (EPUAP) – Pressure Ulcer Prevention 2009 Hibbs, P,J. (1988) Pressure Area Care for the City and Hackney Health Authority. Identifying criteria for wound infection EWMA Position Document. (2005) www.ewma.org National Patient Safety Agency. (2010) Defining avoidable and unavoidable pressure ulcers. http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/PressureUlcers/Defining%20avoidable%20and%20unavoidable%20pressure%20ulcers.pdf (last accessed march 2012) National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel (NPUAP/EPUAP) (2009). Pressure Ulcer Treatment. Quick Reference Guide. http://www.epuap.org/guidelines/Final_Quick_Treatment.pdf (last accessed March 2012) National Patient Safety Agency (2010). 10 for 2010. http://www.nhs.npsa.resources/collections/10-for-2010/pressure-ulcers/(last accessed march 2012) NHS Institute of Innovation and Improvement (2010). High Impact Actions for Nursing and Midwifery: the essential collection. http://www.institute.nhs.uk/building_capability/general/aims/ (last accessed March 2012) NICE Guidelines – Pressure Ulcer Risk Assessment and Prevention. April 2001. NICE Guidelines – Pressure Ulcer Risk Assessment and Prevention – including the use of pressure relieving devices October 2003 & 2005

	Nursing & Midwifery Council (1992 updated 2006) Code of Professional Conduct Preston, K, W. (1988) Positioning for comfort and relief: the 30 degree alternative. Care, Science and Practice 6(4): 116-119. Tissue Viability Society (2012) Achieving Consensus in Pressure Ulcer Reporting. Waterlow, J. (2005). Pressure Ulcer Prevention Manual
Associated documentation	N/A
Supersedes document	Pressure Ulceration, Prevention & Intervention V3:5
Author contact details	By post: Local Care Centre Mount Gould Hospital, 200 Mount Gould Road, Plymouth, Devon. PL4 7PY. Tel: 0845 155 8085, Fax: 01752 272522 (LCC Reception).

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
For previous review history please contact the PRG secretary.				
3	Updated	Jan 2010	Clinical Nurse Specialist Tissue Viability	Additions from other members of staff.
3.1	Reviewed	Sept 2011	Author	Reviewed, no changes made.
3.2	Reviewed	Aug 2012	Professional lead Matron DN Treatment Clinic	Full review to include new national guidance.
3.3	Reviewed	March 2013	Tissue Viability Nurse Specialist DN Matron	Reviewed to include SSKIN bundle and revision of grading
3.4	Reviewed	May 2014	Tissue Viability Nurse Specialist	Reviewed to add copies of SSKIN bundle documents
3.5	Reviewed	Nov 2014	Tissue Viability Nurse Specialist	Appendix 10 amended in line with reporting guidelines
4	Amendments following merge with South Hams & West Devon	Aug 2015	Tissue Viability Nurse Specialist South Hams & West Devon DN Managers	LSW & Torbay & South Devon policies aligned

Pressure Ulceration Prevention and Management Policy

1. Purpose

1.1 The purpose of this document is to clarify the responsibilities and accountability of all members of the multidisciplinary team involved in the prevention and management of pressure ulcers and set out clear guidelines for staff to follow. These are not intended as a text book or training manual neither are they intended as rigid or inflexible tool.

1.2 Many pressure ulcers are preventable and those that develop are very costly to treat in both human and financial terms.

1.3 The responsibility for pressure ulcer prevention falls on all professionals in all settings and each member is accountable to the patient for his/her own practice.

1.4 The reduction of pressure ulcers developed in our care is a quality indicator.

1.5 Livewell Southwest has adopted a joint pressure ulcer strategy with the Clinical Commissioning Group (CCG), Plymouth City Council and Plymouth Hospitals NHS Trust. The strategy sets out Devon's vision (Plymouth Footprint) using the 6 core values from the Compassion in Practice document as a foundation. (DoH 2012) **See Appendix 1.**

2. Definition

2.1 The definition of a Pressure Ulcer by the National Institute for Health and Clinical Excellence (NICE 2005) is localised damage to the skin caused by disruption of the blood supply the area, usually caused by pressure, shear or friction, or a combination of any of these.

2.2 National Pressure Ulcer Advisory Panel (NPUAP 2012) defines a Pressure Ulcer 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 shearing.

2.3 Skin damage caused by incontinence and/or moisture alone, should not be recorded as a pressure ulcer. This should be documented in the patient's notes as a moisture lesion. These lesions are referred to as Incontinence Associated Dermatitis (IAD) **See Appendix 2** - Moisture Lesion Flowchart. However, on occasions patients may also develop a pressure ulcer within the moisture lesion, in which case this must be reported as a pressure ulcer identified by Category/Grade. (NPUAP 2009).

3. Background

3.1 For a long time concern has been expressed about the pain, suffering and loss of dignity for individuals and the large burden imposed on carers and the health service by pressure ulcers. Dealey (1994) defined a pressure ulcer as "localised damage to

the skin caused by disruption of the blood supply to the area, usually caused by pressure, shear or friction or a combination of any of these."

3.2 The true cost of pressure ulcers is impossible to calculate. There is untold cost in terms of pain, suffering to the patient as well as the cost to the health service. Over the years there have been various estimates ranging from £60 million to £200 million. The cost of treating a pressure ulcer in the NHS is between 1.4 and 2.4 billion pounds per year. A grade 1 pressure ulcer costs £1,214 (per episode of care) and a grade 4 pressure ulcer costs £14,108 (per episode of care). (Dealey 2012).

3.3 Pressure ulcers have a complex and multifactorial aetiology and the multidisciplinary team (MDT), patients and their families must share the responsibility of this problem. This Policy clearly sets out roles and responsibilities with regard to pressure ulcer prevention for all members of the MDT.

4. Duties and responsibilities

4.1 Chief Executive

As accountable officer, the Chief Executive has a responsibility to ensure that there are sound systems of internal control in relation to pressure ulcers and patient safety.

Responsibility with regard to the systems and processes related to pressure ulcers must be delegated to an appropriate Executive Director.

4.2 Director of Professional Practice

Is responsible for ensuring that safe clinical systems are in place with regard to the prevention and management of pressure ulcers.

This is delegated to be overseen by the Clinical Nurse Specialist for Tissue Viability. Also any national recommendations i.e. NICE are to be implemented.

4.3 Policy Ratification Group

Is responsible for approval of the Livewell Southwest Policy for the Prevention and Management of Pressure Ulcers.

4.4 Locality Manager

Is responsible for agreeing and implementing actions plans following Pressure Ulcer SIRI investigations.

4.5 Modern Matrons / Ward Nurse Manager/ District Nurse Matrons/Allied Health Care Professionals

Are responsible for the implementation of this policy at ward/Team level ensuring that all staff have read and understood the contents.

4.6 Named Nurse / Registered Nurse

The named nurse should identify those patients at risk of developing pressure ulcers by considering known predisposing and precipitating factors and then using a holistic approach in conjunction with the patient and family, plan, implement and evaluate appropriate research based care.

All grade 3 & 4 Pressure Ulcers must be referred to the Tissue Viability Service and other members of the Multi-Disciplinary Team (MDT) where appropriate.

The named nurse will be responsible for the selection of pressure relieving equipment in accordance with local policy, as well as explaining to the patient and their carer/family the purpose of the equipment and ensuring they have the correct information and skills to use the equipment appropriately.

They will also be responsible for the selection of pressure relieving equipment in accordance with local policy.

Registered nurses are accountable for the nursing care that their patients receive and should therefore ensure that nursing students and healthcare assistants are appropriately supervised in care delivery.

Registered nurses may also provide patient specific training to care home staff in relation to the prevention and management of pressure ulcers; however, it is the responsibility of the care home to ensure the staff remain competent to undertake that specific task.

4.7 Assistant Practitioners

Are responsible for ensuring that they work in line with their job description. If they are undertaking assessments this should be reported back to the caseload holder or registered nurse.

4.8 Clinical Nurse Specialist for Tissue Viability

The role of the Clinical Nurse Specialist (CNS) is to plan, implement and evaluate a strategic approach for Tissue Viability within Livewell Southwest and to identify and improve the knowledge and practice throughout Livewell Southwest.

The CNS is also responsible for co-ordinating the implementation of the policy and regularly reviewing its effectiveness towards the prevention of pressure ulcers. The Tissue Viability Team responds to ward, department and community referrals using a referral criteria.

The CNS is responsible for the auditing of the pressure ulcers.

4.9 Tissue Viability Link Nurses

The link nurse will act as a communication link with all health care professional groups in the organisation, to increase the awareness and dissemination of tissue viability information throughout the organisation.

They will also be available to ward staff in the clinical area to give advice and support and refer to the Tissue Viability Team where appropriate.

Training and support is given to the link network on a quarterly basis by the Tissue Viability Team.

Link Nurses are expected to adhere to their Link Nurse contract.

Any changes in the prevention and management of pressure ulcers relating to care homes/agencies will be disseminated via forums and the Tissue Viability website page.

4.10 Healthcare Assistant/Community Nursing Assistants/ Nursing Auxiliary

Responsible for ensuring that certain aspects of care are implemented e.g. repositioning patients for pressure relief, in accordance with the care plan prescribed by the named nurse and for reporting to the registered nurse any changes in the condition of the patient's pressure areas.

4.11 Medical Staff

The medical practitioner will have overall responsibility to plan and co-ordinate the patient's medical treatments. Specifically, doctors have responsibility to maintain the patient's optimum physiological condition especially hydration, nutrition and infection. They should consider referral to other professional disciplines in order to employ their specialist knowledge in assessing the needs of the patient.

4.12 Dietician

Is responsible for making detailed nutritional assessments of patients referred to them and identifying which particular nutrients may be insufficient in the patient's diet to provide the necessary conditions for maintaining skin integrity.

Following a nutritional screening assessment, albumin levels need to be considered as patients with a grade 3 or 4 pressure ulcer may require a high protein diet. A routine blood test should be requested via the GP to confirm this and referred to the dietician for assessment, if required.

4.13 Occupational Therapist

Occupational Therapists provide functional and vocational advice in conjunction with the provision of appropriate specialist equipment including seating and wheelchair assessments, which can be adapted for use in the home to facilitate independent living. The equipment is also provided to facilitate wound healing and

ultimately improves the patient's quality of life and reduces the risk of pressure ulceration. Their role is to teach patients, relatives, carers and health care professionals the correct use of the equipment and to ensure that written advice is available for reference.

4.14 Physiotherapist

The Physiotherapists use their knowledge and skills relating to musculoskeletal, neurological and cardiovascular systems to identify patients who are at risk of physiological changes to their posture which will pre dispose them to the development of pressure damage. Their role is to teach patients, relatives, carers and health care professionals' manual handling techniques and give advice on positioning to minimise trauma to the skin and promote recovery and mobilisation.

4.15 Podiatry

Podiatrists play a key role in the diabetic patient with foot ulceration. Podiatrists undertake full holistic comprehensive assessment to evaluate the skin, soft tissue, musculoskeletal, vascular and neurological conditions of the foot and lower limb: they identify risk factors associated with possible ulceration and lower limb amputation and develop care plans in collaboration with health care professionals involved with the patients care to standardise practice across different care settings. The Podiatry service follows national and local guidelines for the management of the diabetic foot.

4.16 Content of Policy

There are seven key principles to reducing the risk and effects of pressure ulcers. The SSKIN bundle is a collection of elements which tie together best practice to reduce the incidence of pressure ulcers.

The SSKIN bundle will be used in Livewell Southwest; it will consist of the following elements: ***Please note: Systmone should be used instead of paper copies, where available.***

- Waterlow Risk Assessment Tool – COM153 (**Appendix 3 & 3a**)
- Skin Assessment/Reassessment Tool – COM90 (**Appendix 4**)
- Wound Assessment Tool – COM88 (**Appendix 5**)
- Repositioning Chart – COM95 (**Appendix 6**)
- MUST Tool (See Livewell Southwest Intranet – Forms & Templates, where there is section titled 'Malnutrition Universal Screening Tool'.
- Patient Information Leaflet (**Appendix 7**)
- Agreement/Refusal of equipment form – COM91 (**Appendix 8**)
- Pain assessment tool (being developed) (**Appendix 9**)
- Heel ulcer leaflet (being developed) (**Appendix 10**)

South Hams & West Devon only:
SSKIN acronym to be documented at each visit.

5. Risk Assessment

5.1 Risk assessment tools should be used to support the informal assessment in all health and social care settings.

These tools enable early detection of those at risk of developing pressure ulcers and should only be used as an aid memoire and should not replace clinical judgement.

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

- Reduced mobility or immobility
- Malnutrition
- Sensory impairment
- Acute illness
- Level of consciousness
- Extremes of age
- Vascular disease
- Severe chronic or terminal illness
- Previous history of pressure damage
- Co-morbidities e.g. diabetes, obesity (NICE 2003 & 2005)

5.3 In order to identify those "at risk" of developing pressure ulcers within the wards, all patients will have a Risk Assessment carried out within 6 hours of admission to an inpatient area (NICE 2003 & 2005). Patients admitted to the Caseload in the community setting will have a risk assessment on first contact **and** within 72 hours. The timing of this will be based on each individual case.

5.4 The locally agreed risk assessment tool is the Waterlow Risk Assessment Tool (2005), (**see appendix 3 & 3a**).

5.5 Initial assessment and reassessment is the responsibility of the individual named nurse for that patient and will be undertaken at regular intervals e.g. weekly for Inpatients, or when there is a change in the Patient's clinical condition. For Patients in the Community with Long Term conditions, reassessment frequency must be determined by the District Nurse or Long Term Conditions Nurse and when the patient's clinical condition changes, for the period of time the patient remains on their caseload.

5.6 At each assessment, expected outcomes must be set and constantly evaluated to ensure that the needs and goals of each patient are being met and will always be followed by appropriate Preventive interventions, which are documented in the nursing care and embedded in the SSKIN Bundle.

6. Preventive Measures

6.1 Relief or reduction of pressure is essential to prevent pressure damage. This may be achieved by regular re-positioning of the patient in conjunction with pressure relieving equipment where necessary.

6.2 Other extrinsic risk factors such as shear and friction should be removed or diminished to prevent injury by correct manual handling and the use of hoists and slide sheets. A full skin assessment, from head to toe, using the skin assessment chart should be carried out and documented in the nursing notes European Pressure Ulcer Advisory Panel (EPUAP 2009).

6.3 High Risk Patients and those with existing Pressure damage should be ideally be moved (or encouraged to move) every 2-4 hours according to their skin integrity and tissue perfusion, and documented on a repositioning chart (**Appendix 6**). This will ensure that prolonged pressure on bony prominences is minimised. Repositioning should take into consideration other relevant matters, including the Patient's medical condition, their comfort, the over plan of care and the support surface, (Nice 2005).

Regular reassessment of the pressure areas must be made to detect any evidence of pressure damage and identify if more frequent re-positioning or equipment upgrade is required.

6.4 If a patient has an Epidural, they will be "at greater risk" of pressure ulcer formation due to the loss of sensation. Pressure areas should be checked every 2-4 hours.

6.5 A patient will still need to be repositioned when nursed on any type of dynamic pressure relieving mattress.

6.6 A referral to Podiatry for patients with diabetes and pressure ulceration should be made if a patient is diabetic and has a pressure ulcer to their foot or heel. The Podiatrist will assist with providing pressure relief to affected foot by providing an appropriate offloading device.

6.7 Diabetic foot ulcers directly attributed to Neuropathy and Ischemia must not be reported as a Pressure ulcer. However, **all heel ulcers must be** reported as pressure ulcers and incident forms raised accordingly.

6.8 An alternative to traditional "turning" of patients is the 30 Degree Tilt (Preston 1988). The patient is placed into a tilted position by the use of pillows. Once in position there is reduced pressure on the sacrum or heels (the most vulnerable areas for pressure formation). Refer to **appendix 13**.

6.9 Pillows can be used to suspend heels and between bony prominences (EPUAP 2009). Gel pads (see South & West Devon joint formulary) are a useful alternative to pillows for relieving pressure over bony prominences and where limbs are severely contracted.

6.10 Patient's presenting with pressure ulceration to the heel/heels and with associated venous disease should **not** receive compression bandages and hosiery unless assessed and agreed by the Community Tissue Viability Team.

6.11 Repositioning is one of the essential elements for caring for someone at risk of developing a pressure ulcer and it is essential for patients who already have a pressure ulcer. The time period between the positioning is dependent upon the risk factors and grade of the pressure ulcer. Patients in residential/nursing homes, in-patient units and those who are well supported within the home setting should have a repositioning chart (**Appendix 3).** Repositioning is also very important for patients whilst sitting in a chair. Ideally patients should not be positioned for more than 2 hours.

7. Grading of Pressure Ulcers

7.1 All grade 3 & 4 Pressure Ulcers must be referred to the Tissue Viability Service and other members of the Multi-Disciplinary Team (MDT) where appropriate.

7.2 All patients should have a skin inspection (using the SSKIN bundle body map (**see appendix 4**) as this helps to identify any early changes in the skin which can lead to a pressure ulcer. Check for blanching response (**Refer to 7.3**). Skin inspection should be offered to the patient within 6 hours of admission to an in-patient unit and on the first visit, or within 72 hours (according to patient's risk status) of admission to the caseload in the community.

7.3 The use of a standard system of grading pressure ulcers is essential by providing objective and accurate descriptions of pressure ulcers. It also gives a more accurate picture of the amount of tissue damage. The grading system however should also be used on conjunction with other descriptive tools such as measuring and describing the ulcers appearance.

7.4 Livewell Southwest has adopted the European Pressure Ulcer Advisory Panel Classification System of Pressure Ulcer Grades (NICE 2005, EPUAP 2009).

7.5 **EPUAP Pressure Ulcer Definition**

A pressure ulcer is 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.

7.6 **EPUAP Pressure Ulcer Classification System**

Stage 1: Non-blanchable erythema
Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones, May indicate "at risk" persons.

7.7 **Stage 2: Partial thickness**

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. *Bruising indicates deep tissue injury.

7.8 **Stage 3: Full thickness skin loss**

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

7.9 **Stage 4: Full thickness tissue loss**

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a Category/Stage 4 pressure ulcer 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/Stage 4 ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

7.10 **Additional Categories**

7.11 **Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown**

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

7.12 **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 and 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.

8 Reporting Pressure Ulcers

8.1 **Reporting process (see Appendix 14 for full details)**

Additional notes:

- All pressure ulcers of any grade should be raised as an incident within 24 hours (not including bank holidays, Saturdays and Sundays).
- All incidents will be checked by the Tissue Viability team, to ensure that the ulcer has been correctly described.
- If the clinical teams are unsure of the grading of the pressure ulcer, whether the wound is a pressure ulcer, or have any other queries the TV team will provide advice and support.
- The Tissue Viability Team will also make note of any clusters, themes or trends within the teams which may require further investigation.
- If a pressure ulcer is categorised as a grade 3 or 4 and acquired while the patient was under the care of Livewell Southwest this will also be raised in the form of an Immediate Notification of Serious Incident Requiring Investigation - 72 hour report (known as an 'Appendix A').
- The Tissue Viability (TV) team will see all grade 3 and 4 pressure ulcers to provide support and advice to the clinicians on appropriate care and interventions, as well as helping to define the ulcer if required.

8.2 All triaged pressure ulcers will brought to the Livewell Southwest Pressure Ulcer SIRI panel to ensure that the process is robust and that the decisions made are sound. All investigations will be overseen and reviewed by the SIRI panel. The panel will ensure that feedback is sent to the reporter and locality manager that actions are monitored and lessons learnt/highlighted to the organisation through SIRI newsletter, appropriate education and training and on the Pressure Ulcer page on the intranet.

All incidences of grade 3 or 4 pressure ulcers will be discussed at the Pressure Ulcer SIRI panel comprising of a group of experts from multi-disciplinary areas. SIRI's should be investigated by 2 senior healthcare professionals and presented to the panel. The Locality Managers agree and sign off an action plan and the report is sent to the commissioners for comments.

8.3 A single pressure ulcer less than 1cm in circumference, 100% sloughy – raise an incident form and report as unstageable. Wait 1-2 weeks and if the wound is healing amend report to a grade 2. If the wound deteriorates within 2 weeks, and is clearly a grade 3 pressure ulcer, complete an Appendix A and send to the Safety Systems Team.

8.4 Patients who are on the district nurse case load that are seen infrequently i.e. catheter care patients, 3 monthly medication administration etc. should have a risk assessment undertaken at each visit using the appropriate SSKIN bundle documentation. All appropriate measures must be in place to mitigate identified risk and the patient/carer must be given the relevant advice and contact details of the appropriate health care professional to inform, should deterioration occur. If the patient develops a pressure ulcer between visits it should be reported as 'inherited'. However, there must be clear evidence within the patients' records to support this.

8.5 All staff who care for patients at risk of pressure ulceration or with established pressure ulceration must comply with all standards and procedures outlined in this policy and responsible for reporting all pressure ulcers Grade 1-4.

8.6 End of life patients that have an acquired grade 3 or 4 pressure ulcer, will require triaging to determine if any harm has been caused or lessons learned. The information provided in relation to the patients last 72 hours of life will determine whether this can be investigated by a short root cause analysis or may require a full investigation. **(See - *www.epuap.org/scale-skin-changes-at-lifes-end*)**

8.7 When providing information on pressure ulcer occurrence, please ensure that adequate information is provided using SSKIN Bundle Documentation. This will enable the team investigating a SIRI to establish a Root Cause Analysis using the assessment tool for avoidable and unavoidable pressure ulcers **(Appendix 16).**

8.8 The National Patient Safety Agency (NPSA) defines severe harm as:

- a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care
- chronic pain (continuous, long term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery).
- psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days)

8.9 Pressure ulcers can be described as avoidable and unavoidable and both should be reported.

Avoidable Pressure Ulcer

"Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

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; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence.

8.10 It must be acknowledged that there are patient situations in which unavoidable pressure ulcers will occur.

8.11 Physical and social factors which may lead to unavoidable pressure ulceration are:

- Haemodynamic or spinal instability may preclude turning or repositioning.
- Patients may refuse to be repositioned.
  End of life patients may be unable to tolerate repositioning as frequently as their skin requires.
- The patient has not previously been seen by healthcare professions.
- The patient has mental capacity but refused assessment and/or treatment even when initial assessment has signs of pressure damage, or has not complied with the agreed plan of care.
- The patient is known to a healthcare professional but an acute/critical event occurs which affects mobility or the ability to reposition; for example the patient being undiscovered for a period following a fall or loss of consciousness.

8.12 The healthcare professional that identifies the Pressure Ulcer should discuss any potential safeguarding issues with the Safeguarding Lead or Risk Team and raise a safeguarding alert as appropriate according to the Safeguarding Policy.

8.13 Patients within Nursing Homes, who are assessed by Livewell Southwest Professionals, must ensure that the Manager of the Home is aware of their responsibility to report the incidence of grade 3 and 4 Pressure Ulcers to the Care Quality Commission (CQC).

8.14 Each patient/carer will be given patient educational leaflets about pressure ulcer prevention and management and will be encouraged to fully engage in all aspects of their care. The plan of care should be fully explained to the patient/carer by the health care professional implementing that care plan. If the patient/carer have concerns about the plan, or are unwilling to adhere to it, this should be clearly documented. The health care professional must ensure the patient has capacity to understand the information provided. (**See Appendix 10**)

9. The Use of Equipment

9.1 **Plymouth only** – equipment is supplied via Millbrook Healthcare.

If a patient has a Waterlow Score of 10 and above they should be nursed on one of the following pieces of equipment:-

At Risk: 10 – 14: Static overlay mattress
At High Risk: 15 – 19: Static replacement mattress
At Very High Risk: 20 with no pressure damage: Static replacement mattress
At very high Risk: 20 with risk of developing or actual pressure damage: Alternating air replacement/deep cell mattress

Refer to equipment flow chart - **appendix 11**

Livewell Southwest adheres to the Plymouth County Council Care Home Document (**see appendix 12**).

9.2 **South Hams & West Devon only –** Equipment provided by Devon County Council Community Equipment Store:

If a patient has a Waterlow Score of 10 and above they should be nursed on one of the following pieces of equipment:

At risk: 10-14 – Basic level mattress
At High Risk: 15 – 20 – Intermediate level mattress
At Very High Risk: 20+ - Critical level mattress

To view South Hams & West Devon equipment, please refer to link:

https://new.devon.gov.uk/community-equipment-service/equipment/beds-and-pressure-care

For care homes (South Hams & West Devon only), please refer to link:

https://new.devon.gov.uk/community-equipment-service/care-homes/

9.3 Other factors should be taken into consideration when selecting a piece of equipment such as Grade of pressure ulcer, length of time spent in bed/ chair, positioning / mobility e.g. Can the Patient move independently or have carers to assist movement?. It should also be considered if the patient has capacity to comply and agree to treatment.

9.4 In cases where bespoke pressure relieving equipment is required. A referral must be made to tissue viability to ensure that the patient meets the criteria for specialist equipment, before a trial is considered.

9.5 The use of equipment is a key element in the care of “at risk” patients, providing them with greater comfort and a higher level of independence, in addition to reducing their length of inpatient stay or dependence on healthcare. The use of this equipment must always be based on the Organisation’s criteria for the provision of Pressure Relieving Equipment and according to the individual patient’s needs and identified risk.

9.6 If a patient is ‘at risk’ or has Sacral/ ischial pressure damage and is a wheel chair user, a referral should be made to Millbrook Wheel chair services for a Specialist seating assessment. See: http://www.millbrookhealthcare.co.uk/images/contracts-banners/plymouth/Wheelchair_Referral_Form.pdf)

9.7 Pressure relieving equipment should be reviewed regularly and should be changed in response to altered level of risks, patient’s condition or needs.

9.8 Equipment should be checked by a health care professional at each visit to ensure that it is performing at optimal function and is being used correctly.

10. Nutrition

10.1 Patients identified at being at risk of malnutrition should be assessed and screened for malnutrition using the MUST screening tool (NICE 2005) on admission to ward/caseload. Refer to Livewell Southwest Intranet – Forms & Templates, where there is section titled 'Malnutrition Universal Screening Tool'.

10.2 Those Patients with a pressure ulcer and at risk of Malnutrition should be referred to the dietician for early assessment and intervention for nutritional problems (EPUAP 2009).

10.3 High protein mixed nutritional supplements should be given as prescribed by dietician, in addition to the usual diet, for those patients at risk of or with existing pressure ulcers.

10.4 Clinically obese and bariatric patients are at high risk of developing a pressure ulcer due to lack of movement. It should not be assumed that because they have a weight problem they are well nourished. Total protein and albumin levels should be considered and a weight management referral.

11. Discharge/Transfer of patients with pressure damage

11.1 When a patient is discharged or transferred from one care setting to another, the following information must be documented on the transfer letter to ensure that the patient receives the appropriate care and equipment in a given time frame.

The information must include:

- Referrers name and contact details
- Patients Waterlow Score
- Grade & site of pressure ulcer/s
- Current dressing regime
- Wound bed classification
- Equipment in use and equipment requested
- Time patient spends in bed
- Patient's mobility
- Patient's diagnosis

11.2 When patients are moved to other care facilities it is the responsibility of the discharging/transferring organisation to ensure that adequate pressure ulcer prevention equipment has been provided by the receiving organisation.

11.3 If a patient is discharged from the district nursing caseload because they no longer have a district nursing need, but still require a pressure relieving cushion, staff should document and demonstrate that the patient and carer have been provided

with:

- A LSW pressure ulcer leaflet.
- An explanation of how to check the cushion for signs of deterioration. A replacement cushion request can be made by the District Nurse following a reassessment.
- How to return the cushion.
- The contact number for the Team who has prescribed the cushion.
- The contact number if they have any concerns or notice any changes in their skin according to the Pressure Ulcer leaflet.

12. Dressings and Treatment

12.1 Local guidelines regarding wound management can be found within the Local Formulary available through Livewell Southwest Intranet.

13. Documentation

13.1 The Nursing and Midwifery Council 'Code of Conduct '(2015) contains professional standards that registered nurses and midwives must uphold. Refer to this link for the full code of conduct - https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

13.2 The results of the risk assessment and skin assessment should be recorded in the nursing documentation using the SSKIN Bundle on Systmone, where available.

13.3 If a pressure ulcer is present the following should be recorded:

- Site / location
- Grade
- Exudate – amount and type
- Local signs of infection
- Wound bed classification.
- Condition of surrounding skin
- Malodour
- Wound mapping and/ or photograph of the pressure ulcer

13.4 Wound photography can be used to support patient records or wounds can be mapped using the wound mapping grid. Verbal consent should be obtained and documented in the patient's record. Wounds should be measured on a monthly basis and if there is significant change. Ensure the photograph is labelled clearly with patients initials, NHS number, date and anatomical position of the wound. A disposable tape measure should be used to calibrate the size of the wound.

Photographic records made for clinical purposes form part of a patient's record. These will be used for treating or assessing a patient and must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient.

14. Education

14.1 Education is an important factor in the prevention of pressure ulcers. It is every person's responsibility involved in patient care to be kept up to date with the latest developments around pressure ulcers. All Registered Nurses involved in the care of patients at risk of developing pressure damage are required to attend an initial full mandatory Pressure Ulcer study day, followed by bi-annual half day refresher.

14.2 Ongoing education is provided through the Tissue Viability Link Nurse Group. The Link Nurses have a responsibility to disseminate this information to colleagues in their own clinical area.

14.3 All staff are required to demonstrate evidence of competency by completing the pressure ulcer competency framework (**appendix 15**).

14.4 Patient education leaflets are available (**appendix 7 & 10**)

14.5 Any changes in the prevention and management of pressure ulcers relating to care homes/agencies will be disseminated via forums and the Tissue Viability website page. See: http://www.livewellsouthwest.co.uk/services/tissue-viability

15. Monitoring effectiveness

15.1 It is essential to monitor the incidence and severity of pressure ulcers within the Organisation.

15.2 The Incidence of pressure ulcers will be recorded and an audit will be carried out. Prevalence studies will be available as part of the safety thermometer documentation.

16. Children

16.1 It is acknowledged that the pressure ulcer policy is designed for pressure ulcer prevention and management in adults (over 18 years). However, some allied health care professionals may be required to provide elements of care to children. Advice regarding pressure ulcer prevention and management maybe sought from Tissue viability if required or if this service is not covered by the Children Services.

17. Abbreviations

CNS - Clinical Nurse Specialist
CVE - Cerebral Vascular Event
CQC - Care Quality Commission
SIRI - Serious Incident Requiring Investigation
LSW - Livewell Southwest

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 20th April 2016

See Appendixes via this link

Appendixes – via hyperlink
http://pchnet.derriford.phnt.swest.nhs.uk/Staff/UsefulInformation/PressureUlcers.aspx