Tees, Esk and Wear Valleys
NHS Foundation Trust

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Assessment, Prevention and Management of Pressure Ulcers

Ref: CLIN-0084-004-v2

Status: Approved
Document type: Procedure
Overarching policy: Tissue Viability Policy

Contents

1 Purpose

Following this procedure will help the Trust to:-

- Ensure that patients at risk of developing pressure ulcers are assessed appropriately and where applicable, an individualised evidence-based and agreed prevention strategy is in place.
- Ensure all staff understand their role and responsibilities when providing care for patients who may be, or are recognised as being 'at risk' of developing pressure ulcers.
- Prevent pressure ulcers and implement pressure prevention strategies to patients who are deemed at risk of developing pressure ulcers.

2 Related documents

This procedure describes what you need to do to implement sections 3.5 and 3.6 of the Tissue Viability Policy.

The Tissue Viability Policy defines the roles, responsibilities and interventions which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ Safeguarding Adults Procedure
- ✓ Physical Health and Wellbeing Policy
- ✓ Digital Wound Photography Procedure
- ✓ Tissue Viability Policy
- ✓ Consent to Examination or Treatment
- ✓ Privacy and Dignity Policy
- ✓ Standard (Universal) Infection Prevention and Control Precautions
- ✓ Aseptic Technique Procedure (Royal Marsden Manual Online)
- ✓ Dress Code Procedure

3 Introduction

Pressure ulcers are a financial burden on the National Health Service (NHS) equating to 4% of the NHS expenditure and with an estimated cost of £1.4 - £2.1 billion annually (Bennett, Dealey, Posnett, 2004).

This procedure applies to all staff that has a role in the prevention and management of pressure ulcers. This includes all nursing, nursing support staff and members of the multidisciplinary team (MDT) who care for any patient of any age.

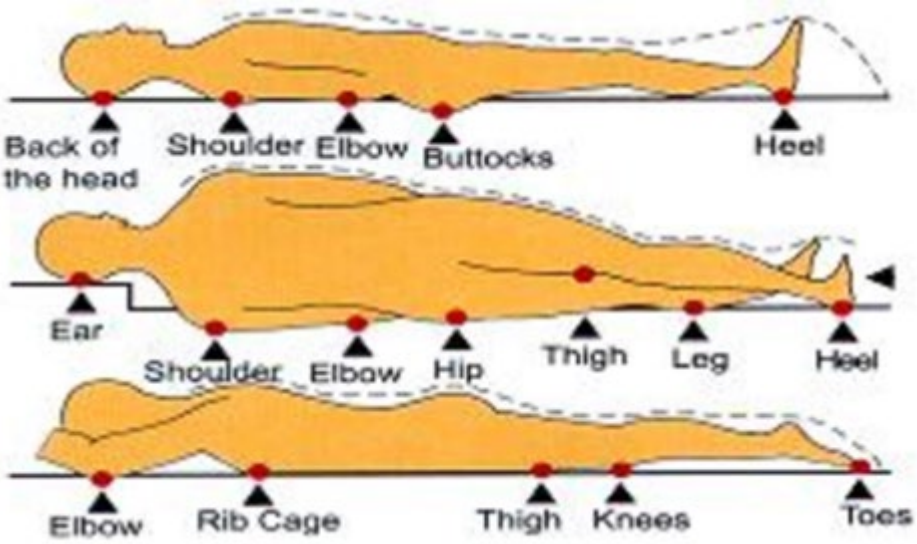
Early recognition of any damage to the skin and adequate implementation of preventative strategies can prevent skin damage altogether or reduce the significance of the ulceration.

The NHS Improvement (2018) defines pressure ulcers as ‘a localised injury to the skin and/or underlying tissue usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact or an open ulcer and may be painful.

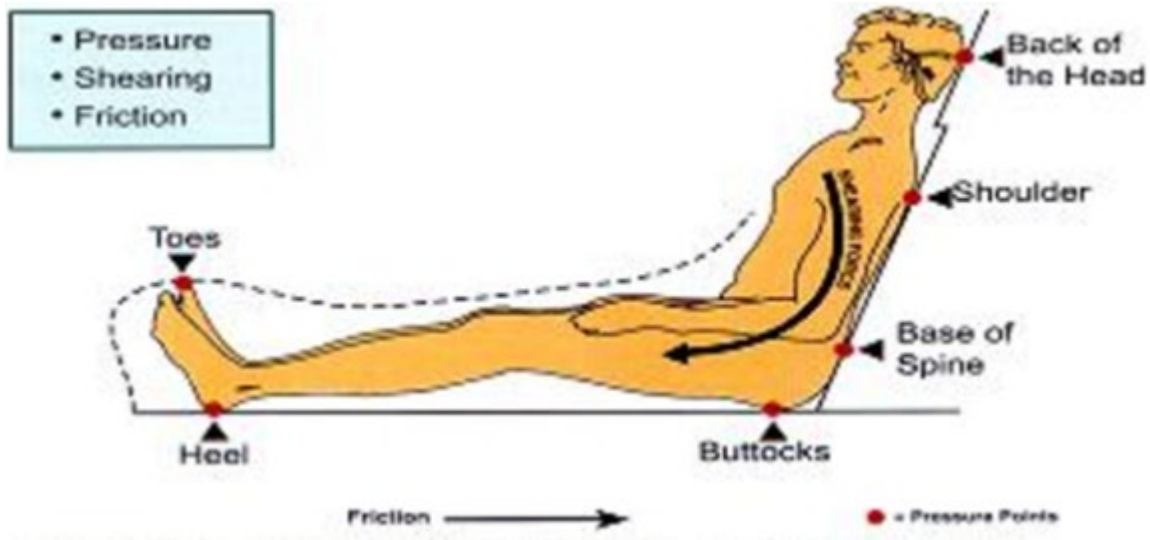
Typically pressure ulcers occur in a person confined to bed or a chair by an illness and as a result they are sometimes referred to as 'bedsores', or 'pressure sores' (NICE 2014).

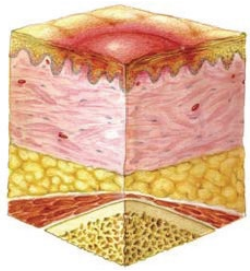
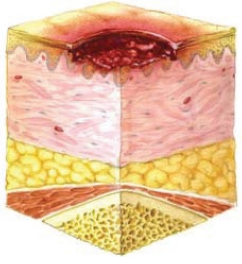
The most common sites for pressure ulcers include hips, buttocks and heels, but pressure ulcers can occur over any bony prominences (Stephen-Haynes 2006).

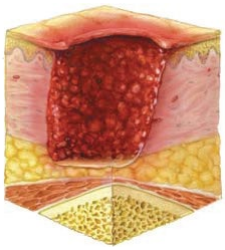
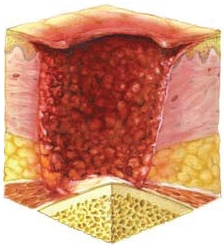
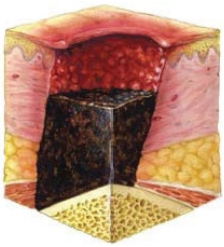
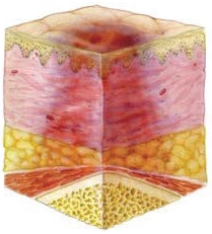
Common Sites for Pressure Ulcers



Main ways that Pressure Ulcers arise:



Term	Definition
Pressure ulcer	A localised injury to the skin and/or underlying tissue usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact or an open ulcer and may be painful.
Category 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. Category 1 may be difficult to detect in individuals with dark skin tones. This is the first sign the individual is at high risk and preventative measure must be taken. Discoloration of the skin, warmth, oedema, induration or harness may also be used as indicators, particularly those individuals with darker skin.
Category 2: Partial thickness 	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May present as an intact or open/ruptured serum filled or serosanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates deep tissue injury). This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

Category 3: Full thickness skin 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 include undermining and tunnelling. The depth of a Category 3 ulcer varied by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and so may be shallow in contrast to areas with significant adiposity which can develop deep category 3 ulcers.
Category 4: Full thickness tissue loss with exposed bone, tendon or muscle. 	Exposed bone/muscle is visible or directly palpable. Slough or eschar may be present. Often includes undermining with tunneling. The depth of a category 4 ulcer varies with anatomical position as with category 3. Those which extend through supporting structures (e.g. fascia, tendon, joint capsule) osteomyelitis is likely to occur.
Unstageable 	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.
Suspected Deep Tissue Injury 	Purple or maroon localised area of discolored 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.
Medical Device Related Pressure Ulcer	Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure ulcer generally closely conforms to the pattern or shape of the device. (NPUAP/EPUAP/PPPIA 2014b).

4 Procedure

4.1 Responsibilities

All TEWV staff must have access to the Trust policies, procedures and standards applicable to the assessment, prevention and management of pressure ulcers.

The Executive Director of Nursing and Governance is responsible for ensuring that appropriate arrangements are in place for the assessment, prevention and management of pressure ulcers.

The Head of Department/Manager is responsible for ensuring that all relevant staff have access and are aware of the recommendations set out in this procedure.

The Tissue Viability (TV) Service is responsible for maintaining their knowledge in the subject in order to offer specialist advice to staff and update this procedure in light of new evidence/guidance being published. The TV Service will also provide training if requested to support the implementation of this procedure. Likewise, expert clinical advice can also be provided to clinicians and service users regarding all areas of pressure ulcer prevention and treatment as requested. The TV Service will also investigate incidents and participate in audit and research.

Each registered nurse is responsible for understanding and using the recommendations set out in this procedure.

All members of the MDT are responsible for understanding their role in the prevention process.

4.2 Pressure ulcer risk assessment

Risk assessment is an essential part in the prevention of pressure ulcers and implementation of care. There are many pressure ulcer risk assessments that have been developed, however these represent only one part of pressure ulcer prevention.

A risk assessment tool encourages a structured approach to assessment but also complements the nurse's clinical judgement. The Waterlow Pressure Ulcer Risk Assessment Tool (Appendix 2) is the chosen formal risk assessment tool used within TEWV. Risk assessment tools should not however, be used to recommend equipment and/or treatment.

There are many external factors which predispose a patient to developing a pressure ulcer. The critical elements of pressure ulcer formation development are the duration and intensity of pressure, tissue tolerance of the skin and its structure of support for pressure, friction and shear. This includes when patients have received rapid tranquilisation in mental health.

There are two group factors that contribute to pressure ulcer development which are:

Intrinsic

- Reduced mobility
- Previous history of pressure ulcers
- Sensory impairment
- Reduced level of consciousness
- Acute illness

- Chronic long term illness
- Medication (Analgesics, sedation, anti-inflammatory)
- Pain
- Cognition
- Nutrition
- Extremes of age
- Posture
- Weight
- Incontinence
- Dehydration
- Terminal illness

Extrinsic

- External influences that cause skin distortion
- Pressure
- Shear
- Friction
- Continence
- Moisture

Those who are neurologically compromised (i.e. individuals with spinal cord injuries), seriously ill, have impaired mobility or who are immobile (including those wearing a prosthesis, or plaster cast), have contracted limbs, have reduced nutritional intake, are obese or poor posture are predominantly at risk. Older people are also very vulnerable.

All patients admitted/ transferred to inpatient **MHSOP or Eating Disorders** will have a formal pressure ulcer risk assessment completed and documented on admission/transfer and the frequency of ongoing reassessments completed will be dependent on risk score (see table 1). It is also recommended that a formal risk assessment is completed on day of discharge from inpatient services.

All patients admitted/ transferred to inpatient **Adult Mental Health or Learning Disabilities** will have a formal pressure ulcer risk assessment completed and documented on admission/transfer undertaken on admission/transfer and the frequency of ongoing reassessments completed will be dependent on risk score (see table 1). It is also recommended that a formal risk assessment is completed on day of discharge from inpatient services.

Table 1

Frequency of Ongoing Waterlow Pressure Ulcer Risk Assessments				
	Daily	**3x Weekly**	**Weekly**	**Monthly**
Assessment scores within MHSOP and Eating Disorders	**20+**	**15-20**	**2-15**	**X**
Assessments scores within Adult Mental Health and Learning Disabilities	**20+**	**15-20**	**10-15**	**2-10**

4.3 Skin Assessment

- The patient should have a body map skin integrity/assessment (see appendix 3) completed and skin condition assessed as part of the Waterlow Pressure Ulcer Risk Assessment on admission/transfer and on discharge. If this is cannot be undertaken, then a clear rationale should be documented in the patient's electronic care record.
- Early assessment of the patient's skin over bony prominences can reveal the first signs of skin damage and prevent ulcerations from developing.
- Skin inspection should occur regularly and the frequency will be determined in response to changes in the patient's condition either deterioration or recovery. Patients who are assessed as 'at risk' will have ongoing reviews as part of the reassessment process.
- Patients or relatives/carers should be encouraged to participate where necessary, following appropriate information/training. Skin inspection can be undertaken during routine care, taking into account patient consent and should be documented in the patient's electronic care record and any problems acted upon.
- Skin inspection should be based on an assessment of the most vulnerable at risk areas for each patient. Usually these areas are the heels, ischial tuberosity's (sitting bones), hip and sacrum.
- For bariatric patients, it is vital to maintain skin integrity. Those patients who are bariatric are at risk and may develop pressure ulcers in unusual sites. A comprehensive assessment should be completed and if required appropriate support equipment selected.
- Patients who decline to have a skin inspection completed should have this documented in their electronic care record and the risks fully explained to them.
- Staff should be aware that not all skin damage is related to pressure
- Diagnosing skin damage relies on an examination of the patient's history as well as their risk.
- Check the skin for:
    1. Non-blanching erythema i.e. reddening of skin that does not turn white when you press it
    2. Blisters
    3. Patches of skin over bony prominences which looks bruised
    4. Any unusual changes in skin texture that may be related to pressure damage. Common changes include the skin feeling spongy or 'boggy'
    5. Localised heat, oedema or localized coolness if tissue death occurs, may be noted in darker skin tones
    6. Any areas of pain or discomfort that may be related to pressure damage, particularly if a patient has a plaster cast/splint
    7. Skin damage that may be caused by medical devices e.g. catheters, oxygen masks, TED stockings

It is important to acknowledge the patient's personal preferences and wishes. Wherever possible these preferences need to be taken into account to promote collaborative decision making, privacy and dignity, and also, to prevent the breach of iatrogenic harm.

Further information can be obtained from the Consent to Examination or Treatment Policy and also, the Privacy and Dignity Policy- both of which are available via the Trust intranet.

4.3.1 Preventing Damage to the Skin

- All healthcare professionals, when handling patients, should take care not to damage the patient's skin. Rings (other than wedding bands) and/or watches should not be worn when

turning or repositioning patient's and fingernails should be short and free of nail varnish (see Dress Code Procedure available via the Trust intranet).

- The patient's skin should be kept well hydrated and excessive washing with an alkaline soap should be avoided. Plain water, soap with a pH of 5.5, or use of a soap substitute e.g. Hydromol should be used to cleanse the skin.
- Skin should be thoroughly dried using a patting motion, particularly over vulnerable areas. A rubbing motion must not be used when drying the patient's skin as this causes friction forces and is associated with skin damage.
- Avoid using talcum powder as this dries out the skin (increases risk of rubbing/friction) and clogs the pores increasing the risk of infection and skin damage.
- Consideration must be taken when patients are prescribed certain drugs such as steroids or anti-cancer drugs which affect the skin and increasing the risk of skin damage, however the benefit may outweigh the risks.

Skin damage can have a number of causes, some relating to the individual patient who may have be unwell, poor medical condition. However, skin damage may also be caused by external factors such as poor nursing care, lack of resources e.g. equipment and staffing. It is acknowledged and recognised that not all skin damage be prevented and patients should be reviewed on an individual basis taking into account the risk factors for that patient. Neglect may be considered for those vulnerable patients with pressure ulcers however not all pressure ulcers are a cause of neglect.

If the patient is admitted with a pressure ulcer and it is thought to have developed due to neglect then this should be reported using the Safeguarding Adults Procedure.

If the patient continues to decline to have their skin/pressure ulcer assessed and/or treated then this MUST be documented on their electronic care record. If the patient has capacity and the pressure ulcer/skin is of concern (e.g. infection, sepsis) then an MDT approach may be required for interventions to be performed.

4.3.1 Moisture Associate Skin Damage

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 (All Wales Tissue Viability Nurse Forum and All Nurse Continence Forum and Wound UK, 2014).

Moisture on the skin for any prolonged length of time weakens the skin and makes it more susceptible to friction damage, increasing the risk of pressure ulceration. All necessary steps will be taken to aid continence and manage moisture lesions.

The maintenance of skin integrity is vital for the prevention of pressure ulcers and moisture lesions. It is important to keep the skin clean and dry which can be achieved through the use of the following:

- Assess the patient and develop an intervention plan
- Washing in a soap substitute, such as Hydromol, to rehydrate skin
- Protective barrier products (i.e. Derma S barrier cream, Derma S spray or Derma pro)
- Use appropriate incontinence products, if moisture damage is due to incontinence

There is often confusion between a pressure ulcer and a moisture lesion caused by sweat, urine/faeces, and therefore, it is important to identify if a wound is a pressure ulcer or a moisture lesion since the prevention and management strategies are different.

Creams and barrier products and should be ordered via Cardea, however they may be ordered via pharmacy if there is a delay on Cardea.

4.4 Pressure Relieving Mattresses/Equipment

The standard Pentaflex Premium foam mattresses (found on the majority of beds within the Trust) are pressure relieving and can be used for all patients (unless an anti-vandal mattress is required). This includes patients with a pressure ulcer - but only up to and including a category 2.

The Atmosair 9000 mattress is a higher specification foam mattress which helps to distribute body weight and minimises pressure by automatically adjusting the internal air pressure in reaction to body movements. The Atmosair 9000 is intended for those individuals at a higher risk of developing pressure ulcers (e.g. patients within Eating Disorder or MHSOP inpatient services).

Both Pentaflex Premium and Atmosair 9000 mattresses can be purchased via Cardea.

Dynamic (air flow) pressure relieving equipment (e.g. mattresses and cushions) should only be used for the treatment of a category 3 or category 4 pressure ulcer (or on the recommendation from the Tissue Viability Service). Currently, the ranges of dynamic equipment available are:

- Nimbus 3 mattress
- Breeze mattress
- Aura cushion

No other equipment should be ordered unless discussed with the Tissue Viability Service.

The Tissue Viability Service must be contacted prior to ordering any dynamic pressure relieving equipment. This is to ensure that the equipment is suitable for the individual needs of the patient

The following **should not** be used as pressure relieving devices:

- water filled gloves
- synthetic sheepskins
- genuine sheepskins and doughnut-type devices

4.5 Positioning

- Patients, where possible, should be encouraged to reposition independently and redistribute their own weight.
- If a patient is unable to reposition independently, healthcare professionals should assist the patient in order to prevent the development of pressure ulcers. If needed, appropriate moving and handling equipment should be used.
- Patients who are identified as at being at risk of developing pressure ulcers or have existing pressure ulcers should be repositioned or encouraged to independently reposition. The frequency of repositioning must be determined by the skin assessment and the individual patient's needs, rather than by a ritualistic schedule (NICE 2014, Moore et al, 2011).
- Repositioning is recommended **at least** every 4 hours for patients identified at risk.

- Repositioning of the patient should be undertaken in a way that minimises the pressure on bony prominences (e.g. 30 degree tilt) and any existing pressure ulcers (see appendix 4). Pillows can be used effectively to relieve pressure from the heels by placing the pillow under the patient's calf to raise the heels from the surface below.
- Care should be taken to ensure that when repositioning the patient the effect of shear and friction forces are reduced by using, if needed, appropriate equipment (e.g. slide sheet, hoist).
- A repositioning schedule should be agreed with the patient and documented on their electronic care record. A positional change chart (see appendix 5) must be used if a patient requires assistance with repositioning.
- When a patient is repositioned, any areas of redness or skin damage must be documented on the positional change chart and documented on their electronic care record.
- If a patient declines to be repositioned, this must be clearly documented in their electronic care record. It may not always be possible to reposition patients because of their medical condition but this should be clearly documented and if the issue is around pain management, then this must be addressed which may increase the concordance. The staff must clearly document any advice given to the patient regarding repositioning and the potential risks for the patient in declining care.
- Patients who spend a significant amount of time seated should have their seating and sitting assessed by a trained assessor who has specific knowledge and expertise, i.e. Physiotherapists/ Occupational Therapists.

Patients at risk of developing pressure ulcers and who cannot relieve their own pressure independently should restrict sitting in a chair to a **maximum of 2 hours** at any one time.

4.6 Nutrition

Inadequate dietary intake and poor nutritional status have been identified as key risk factors for both the development of pressure ulcers and prolonged wound healing.

Patients at risk of malnutrition:

- Elderly
- Chronic illnesses
- Neurological disorders
- Physical disabilities
- Learning difficulties
- Inflammatory bowel disease
- Mental health illness

To prevent occurrence of pressure ulcers we must:

- Provide nutritional support to patients identified of having an inadequate dietary intake and poor nutritional status
- Complete a nutritional assessment and referral to the dietician for nutritional recommendations, if required

All patients with Category 3 or Category 4 Pressure Ulcer must be referred for a Dietetic review.

4.7 Reporting of Pressure Ulcers and Moisture Associated Skin Damage

Pressure ulcers must be categorised using the EPUAP guidance (2014). See section 3 for category definitions of Pressure Ulcers.

All pressure ulcer incidents are reviewed by the TV Service and if needed the patient will be assessed by the TV Team. Patients who have a category 2 pressure ulcer do not need referring to the TV Service unless there are concerns or advice required.

A patient who presents with several pressure ulcers requires only one report and the highest category of the pressure ulcers should be recorded under the 'grade of pressure ulcer' section on the Datix report with a full description of all pressure ulcers in the description.

- All pressure ulcers category 2, 3 & 4 (and unstageable) must be reported via the Trust's Datix recording system and documented within the patient's electronic care record
- All Moisture Associated Skin Damage (MASD) must be reported via the Trust's Datix recording system and documented within the patient's electronic care record

All suspected deep tissue injuries, category 3 or 4 and unstageable pressure ulcers must be reported via the Trust's Datix recording system and should be referred to the TV Service (via email: tewv.tissueviability@nhs.net). Alternatively, if there is immediate staff concern regarding the severity of the injury, the patient should be transferred to the local Acute Trust Emergency Department.

Any category 3 or 4 pressure ulcers that are not present on admission/caseload must be categorised as a Serious Incident (SI) and the SI process should be followed.
The purpose of the SI is to ascertain how the patient has developed the pressure ulcer and/or if any lessons can be learned.

Pressure ulcer grading must not be used for other wounds types.

Pressure ulcers must not be retro-graded i.e. a healing category 4 ulcer does not become a category 3 then category 2 etc., but must always be described as a healing category 4 pressure ulcer as this indicates the extent of damage that has occurred. Scar tissue is never as strong as 'normal' tissue.

4.8 Monitoring of Pressure Ulcers

An essential element of measuring good practice and quality of care delivered is to collect and review the data regarding the number of pressure ulcers identified. Often, the collection of data can determine where improvements can be made and/or highlights excellent care where there are no incidents of pressure ulcers identified.

There are two ways the TV Service measure pressure ulcers.

Incidence

- Is the percentage of patients developing a new pressure ulcers while an inpatient in a given time period
- The risk status of the given population affects incidence

Prevalence

- Is the percentage of patients having a pressure ulcer while an inpatient at a specific point in time e.g. the first day of the month which is known as a point prevalence.
- Patients admitted to inpatient areas with existing pressure ulcers, have delayed healing rates affects prevalence

Information from both the incidence and prevalence is used to improve patient care i.e. through future training sessions etc.

5 Pressure Ulcer Wound Assessment and Treatment

- Assessment of a patient with a pressure ulcer should include an assessment of the wound along with the completion of the Waterlow Pressure Ulcer Risk Assessment and body map skin integrity/assessment chart. A digital wound photograph (see Digital Wound Photography Procedure)should also be obtained for the purpose of referral to the TV Service and/or evidence as part of any safeguarding issues/concerns
- Factors that may affect wound healing should be recorded
- If the cause of the pressure ulcer is recognised this should be removed and included in the intervention plan
- Dressing selection from the Wound Dressings Formulary (available via the Trust intranet) should follow a holistic assessment and completion of a wound assessment and management chart (appendix 6). Dressings should be ordered via Cardea.
- The TV Service can offer specialist advice and support if needed
- On discharge, the patient should be given a supply of dressings and a copy of the intervention to ensure continuity of pressure ulcer management. If the patient is being discharged to their own home or a care home then a referral to the District Nurses must be made to ensure the patient can receive ongoing care for their pressure ulcer
- If a pressure ulcer is not healing, this may indicate the patient may have a wound infection or osteomyelitis (infection/inflammation within the bone or bone marrow). If osteomyelitis is suspected then the patient may require an xray/MRI scan

6 How this procedure will be implemented

• This procedure will be published on the Trust's intranet and external website.
• Line managers will disseminate this procedure to all Trust employees through a line management briefing.
• Each team/ward will ensure that the staff's training needs are met in accordance with the Trust's Training needs analysis.
• Each registered nurse is responsible for his or her own professional development and individual needs should be addressed through appraisal and training needs analysis.
• An education programme, which incorporates pressure area management, will be available for

all healthcare workers across the Trust.
• Patients and their relatives/carers who are able and willing should be educated about risk assessment and prevention strategies.

7 How the implementation of this procedure will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Pressure Ulcer Point Prevalence	Annually	Clinical Effectiveness Group
2	Waterlow Pressure Ulcer Risk Assessment	Annually	Clinical Effectiveness Group

8 References

All Wales Tissue Viability Nurse Forum and All Nurse Continence Forum and Wound UK, 2014. *All Wales Best Practice Statement on the Prevention and Management of Moisture Lesions.* Wounds UK, London.

Bennett, G, Dealey, C and Posnett, J (2004) The cost of pressure ulcers in the UK. *Age Ageing,* 33, pp.230-235.

EPUAP International Pressure Ulcer Guidelines, 2014 http://www.epuap.org/guidelines-2014/Quick%20Reference%20Guide%20DIGITAL%20NPUAP-EPUAP-PPPIA-Jan2016.pdf

http://www.epuap.org/wp-content/uploads/2011/03/EPUAP-Grading-tool.pdf

Moore, Z, Cowman, S and Conroy, R.M (2011) A randomized controlled trial of repositioning, using 30 degree tilt, for the prevention of pressure ulcers. *Journal of Clinical Nursing,* 20, pp. 2633-2644.

NHS Improvement (2018). *Pressure ulcers: revised definition and measurement. Summary and recommendations.*NHS Improvement. https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_2.pdf

NICE (2014) Pressure ulcers: prevention and management.

Stephen-Haynes, J (2006) Implementing the NICE pressure ulcer guidelines. *British Journal of Community Nursing in association with Wound Care Society.* Wound Care, pp. 16-18.

9 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	01 April 2021	
Next review date:	22 January 2024	
This document replaces:	CLIN-0084-004-v2 Procedure for the Assessment, Prevention and Management of Pressure Ulcers	
This document was approved by:	Name of committee/group	Date
	Virtual meeting of the IPC/Physical Health group	V2 - 22/01/2021 V2.1 - 01/04/2021
This document was ratified by:	Name of committee/group	Date
	Virtual meeting of the IPC/Physical Health group	V2 - 22/01/2021 V2.1 - 01/04/2021
An equality analysis was completed on this document on:	13/01/2021	
Document type	Public	
FOI Clause (Private documents only)	n/a	

Change record

Version	Date	Amendment details	Status
1	27 Mar 2017	New procedure	Withdrawn
1.1	May 2018	Minor amendment to Waterlow score tool Appendix 2 (current version numbering)	Withdrawn
1.2	28 May 2019	Minor amendment of adding new category of pressure ulcers, frequency of waterlows and pressure ulcer definition updated.	Withdrawn
1.2	23 April 2020	Review date extended from 27 March 2020 to new date of 27 September 2020	Withdrawn
2	11 January 2021	Full Review of Procedure undertaken. Updates and references added.	Published
2.1	1 April 2021	Added Appendix 7 Pressure relieving equipment protocol	Published

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Nursing and Governance/Tissue Viability Service					
Policy (document/service) name	Assessment, Prevention and Management of Pressure Ulcers					
Is the area being assessed a…	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			√	Code of practice	
	Other – Please state					
Geographical area covered	Trust-wide					
Aims and objectives	To support clinical staff in the assessment, prevention and management of pressure ulcers.					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	13/01/2021					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	13/01/2021					

You must contact the EDHR team if you identify a negative impact. Please ring the Equality and Diversity team on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

Trust, staff and patients.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s

No – Please describe any positive impacts/s

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	√	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership
Yes – Please describe the engagement and involvement that has taken place
This is an updated review of a previous procedure that was circulated via the Physical Health and Wellbeing Group. The updated procedure will be reviewed and discussed at the IPC/Physical Health Teams Group prior to approval
No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?	
Yes	Training will be delivered to Trust staff to implement and embed the standards of the procedure across the Trust.
A training need has been identified for;	

Trust staff	Yes	Service users	Yes	Contractors or other outside agencies	Yes

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046

Appendix 2 - Waterlow Pressure Ulcer Risk Assessment Chart

WATERLOW CONTINUOUS ASSESSMENT CHART									
SEVERAL SCORES PER CATEGORY CAN BE CALCULATED					**ID LABEL**				
Categories			**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Body Mass Index (kg/m^2)		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Average	20-24.9	**0**							
Above Average	25-29.9	**1**							
Obese	>30	**2**							
Below Average	<20	**3**							
Continence		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Complete/Catheterised		**0**							
Incontinence of urine		**1**							
Incontinent of faeces		**2**							
Doubly incontinent		**3**							
Mobility		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Fully mobile		**0**							
Restless/Fidgety		**1**							
Apathetic		**2**							
Restricted		**3**							
Bed bound		**4**							
Chair Bound		**5**							
Nutrition **A – Has patient lost weight recently**									
Yes	**Go to B**								
No	**Go to C**								
Unsure	**Go to C and score 2**	**2**							
B – Weight Loss Score		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
0.5 – 5kg		**1**							
5 – 10kg		**2**							
10 – 15kg		**3**							
>15kg		**4**							
Unsure		**2**							
C – Patient eating poorly or lack of appetite		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
No		**0**							
Yes		**1**							

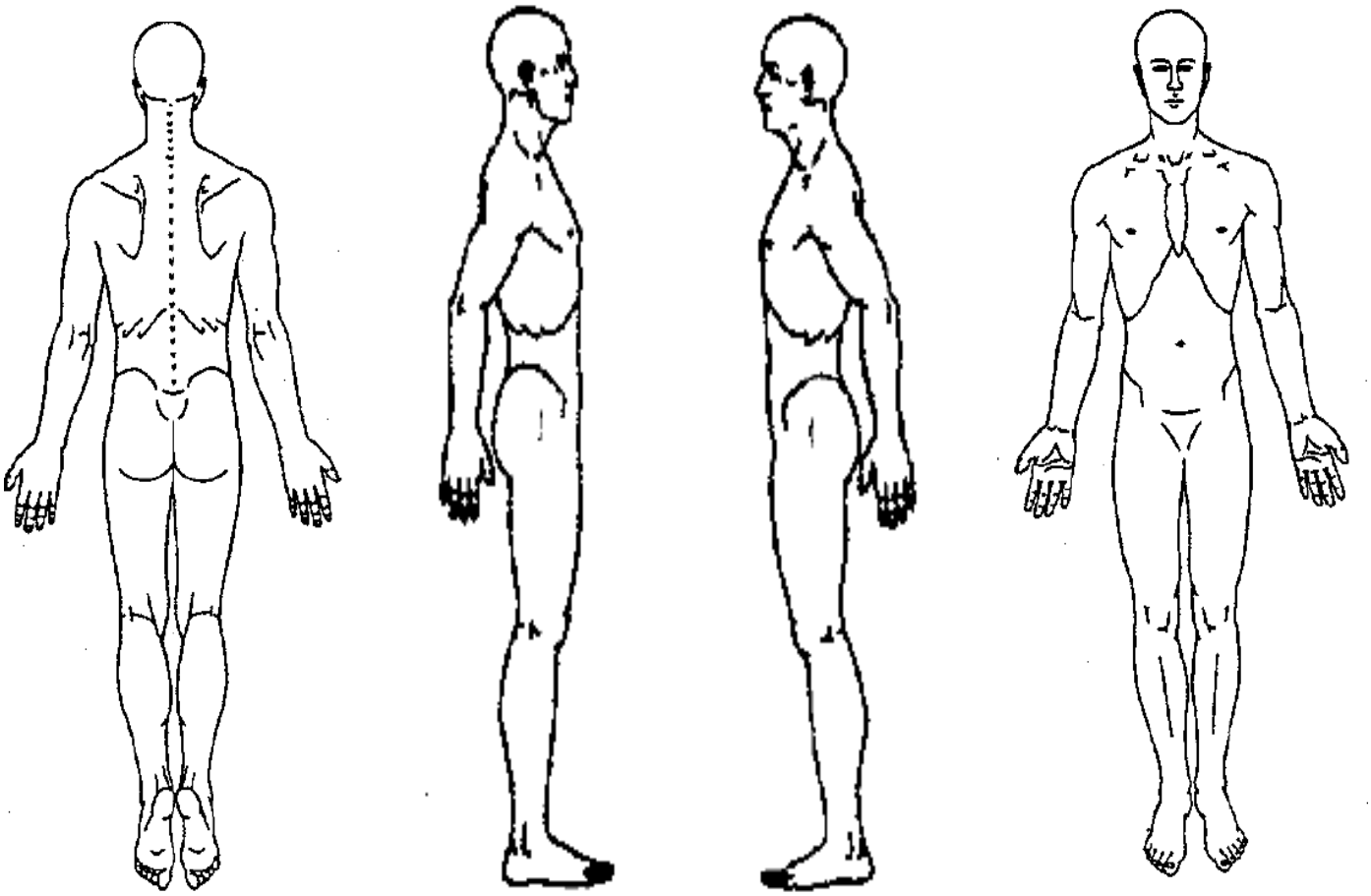
Categories		Date	Date	Date	Date	Date	Date	Date
Skin type visual risk areas	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Healthy	**0**							
Tissue Paper	**1**							
Dry	**1**							
Oedematous	**1**							
Clammy/pyrexia	**1**							
Discoloured – stage 1	**2**							
Pressure Ulcer – stage 2-4	**3**							
Sex/Age	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Male	**1**							
Female	**2**							
14 to 49	**1**							
50 to 64	**2**							
65 to 74	**3**							
75 to 80	**4**							
81 plus	**5**							
Tissue Malnutrition	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Eg terminal Cachexia	**8**							
Single Organ failure	**5**							
Multiple organ failure	**8**							
Peripheral vascular disease	**5**							
Anaemia (HB<8)	**2**							
Smoking	**1**							
Neurological deficit	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Diabetes	**4-6**							
Multiple Sclerosis	**4-6**							
Motor/sensory paraplegia	**4-6**							
Cerebro vascular accident	**4-6**							
Major surgery/Trauma	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
On table >2 hrs (past 48hrs)	**5**							
On table >6 hrs (past 48 hrs)	**8**							
Orthopaedic spinal	**5**							
Medication	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Cytotoxics	**Max 4**							
Steroids (Long term high dose)	**Max 4**							
Anti-inflammatory	**Max 4**							
Total								
Risk Category **10+ At risk** **15+ High Risk** **20+ Very high risk**								
Signature								

Appendix 3 - Body Map Skin Integrity Assessment Sheet

Body Map Skin Integrity Assessment Sheet

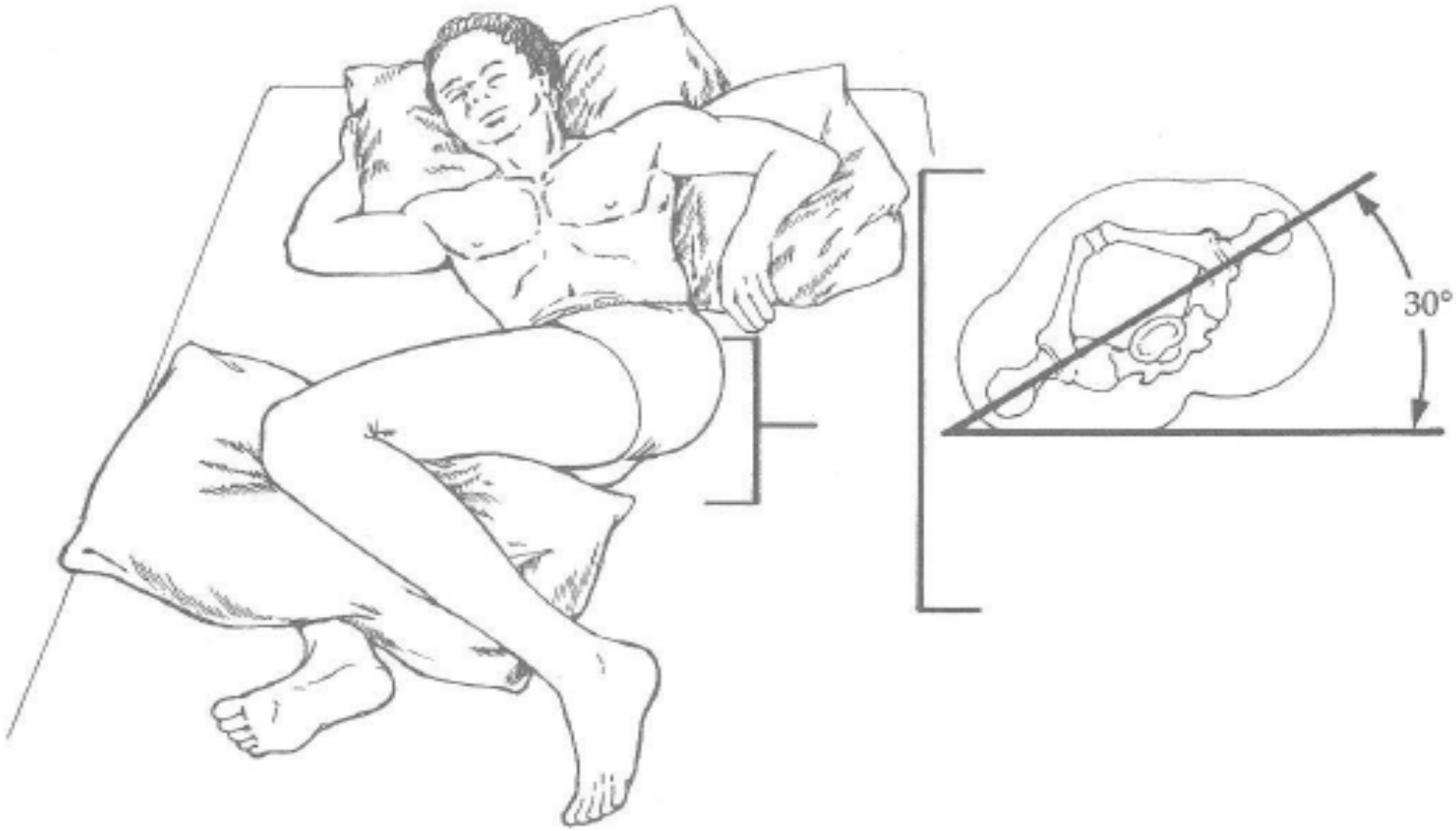
Patient Name:	PARIS ID Number:
Completed by:	Designation:

Please see diagram to illustrate location of any skin damage including pressure ulcers, abrasions, rashes, wounds and red/darkened areas.



The body map skin integrity assessment sheet should be completed in conjunction with the advice and guidance outlined in the relevant policy and/or procedure (Skin Tear Prevention and Management Procedure, Tissue Viability Policy and the Assessment, Prevention and Management of Pressure Ulcers Procedure)

Appendix 4 - 30 Degree Tilt Diagram



Appendix 5 - Positional Change Chart

Positional Change Chart

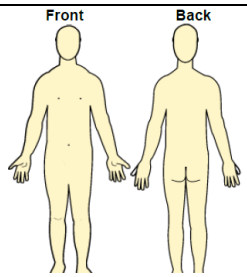
PATIENT NAME:	HOSPITAL NUMBER:
WARD	PLAN- FREQUENCY OF POSITIONAL CHANGES AS PER CARE PLAN

Date & Time	Time position changed	Patient position	Skin condition	SIGNED

Appendix 6 - Wound Assessment and Management Chart

Wound Assessment and Management		
Patients Name:		**DOB:**
Ward:	**Consultant**	**Hospital No/CRN:**
Nutritional Assessment: **Waterlow Score:**		**Pressure Aid:**
Reason for admission: **Predisposing Factors:**		

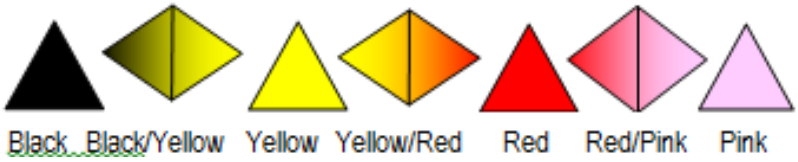
Initial Assessment

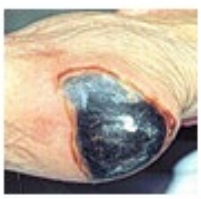


Mark location of each wound and number each wound

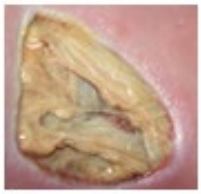
Type of wound	
Leg ulcer	☐
Surgical wound	☐
Diabetic	☐
Rheumatoid	☐
Malignant lesion	☐
Cellulitis	☐
Pressure Ulcer	☐

Colour of wound

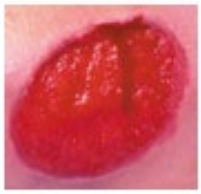




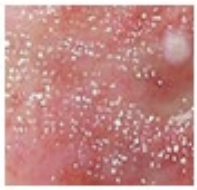
Necrotic



Slough



Granulating



Epithelisation

	Date Assessed: Wound 1	Date Assessed: Wound 2	Date Assessed: Wound 3
Site			
Type of wound			
Size of wound			
Depth of wound			
Pain			
Odour			
Exudate (How much? What colour?)			
Surrounding skin (What colour is it? Does it look healthy? Is it intact?)			
Wound tissue: (Granulating, Sloughy, Necrotic, Infected Other)			

Reassessment of treatment plan should be considered at least weekly

Date & Time	Wound Number	Treatment choice	Size of wound	Signature
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**
Date & Time	**Wound Reference**	**Treatment choice**	**Size**	**Signature**

Appendix 7 - Pressure Relieving Equipment Protocol