Keele University Teaching Trust

NHS
North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/25051
Date: 26th February 2025

Nicola Griffiths
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
ST4 8HH

Reception: 0300 123 1535

Dear

Freedom of Information Act Request
I am writing in response to your e-mail of the 3rd February 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
I am writing under the Freedom of Information Act 2000 to request data on bed sore-related death reports and complaints made to this trust.

- Please provide any trust guidance on pressure care (for the care and prevention of pressure sores, pressure ulcers, or bed sores) issued to administrators and/or hospital staff in the past 24 months. **Please see Appendix 1 attached.**

- For the following years, please provide the number of patients within the trust treated for bedsores (classified as ICD-10 code L-89), as filed in Datix, Ulysses or other relevant reporting systems:

Year	2022	2023	2024
No of Patients	**13**	**7**	**5**

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

North Staffordshire Combined Healthcare NHS Trust

Document level: Policy
Code: 1:82
Issue number: 3

Pressure Ulcer Prevention and Management

Lead executive	Executive Director of Nursing and Quality
Authors details	Head of Infection Prevention and Control and Tissue Viability Nurse Specialist

Type of document	Policy
Target audience	All clinical Staff
Document purpose	To ensure all staff dress and present themselves in a manner that inspires professionalism, public trust and confidence in the organisation.

Approving meeting	Quality Committee Trust Board	Meeting date	4th May 2023 11th May 2023
Implementation date	31st May 2023	Review date	31st May 2026

Trust documents to be read in conjunction with	
IPC1	Infection Control Policies and associated standard operating procedures
1.24	Nutrition Support Guidelines
5.01	Incident Management Policy
4.25	Consent Policy

Document change history		Version	Date
What is different?	Review and update in line with NICE Guidance	V3	03.2023
Appendices / electronic forms	Reviewed and update in line with new NICE Guidance	V3	03.2023
What is the impact of change?	Clearer guidance for staff	V3	03.2023

Training requirements	None Identified

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	None identified

External references
1. Dowsett C, Allen L(2013) Moisture-associated skin damage: *wounds UK made easy* 9(4):1-4 2. European Pressure Ulcers Advisory Panel (EPUAP)), National Pressure Ulcer Advisory Panel (NPUAP), Pan Pacific Pressure Injury Alliance (PPPIA) (2014) – prevention and treatment of pressure ulcers: quick reference guide 3. Moore Z, Van Etten M, (20015) Preventing pressure ulcer when seated *wounds* uk 11(3), 2: 18-23 4. National Institute for Health and Clinical Excellence (NICE) (2014) – *pressure ulcers: prevention and management* Clinical guidelines (cg179) 5. Stang D, Ballard-Wilson A, (2015) The role of innovation in heel pressure ulcer prevention, *Wounds uk* 11(4): 1-5 6. Yates S, (2012) Differentiating between pressure ulcers and moisture lesions. *Wounds essentials* 2:16 – 22 **With thanks to MPFT for allowing use of their policy in support of NSCHT TV policy**

Monitoring compliance with the processes outlined within this document	A copy of this policy will be available on the Trust intranet and all staff involved will be expected to make themselves aware of the policy requirements. Staff reporting for duty in dress or appearance outside of this policy may be asked to return home to change into appropriate clothing or footwear / to remove jewellery etc. In such cases staff will be required to pay back any time lost to the service. Repeated noncompliance with this policy will be followed up by the line manager through 1:1 discussions with the member of staff and may result in action under the Trusts disciplinary policy. This policy will be reviewed 3 yearly or earlier in light of new national guidance /other significant changes. Compliance with this policy will be monitored. Where compliance is deemed to be insufficient and the assurance provided is limited, an action plan will be developed to address the gaps; progress against the action plan will be monitored at the specified group / committee

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favourably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)		
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? - Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No - N/A	

Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	Yes / No
What is the level of impact?	Low / medium / high

Contents

Appendices

1. Executive Summary

This policy applies to all clinical Trust employees, staff working for and on behalf of the Trust including students, locums and agency staff.

The Purpose of the policy is to provide guidance on pressure ulcer prevention and management within Mental Health in-patient and community setting. Pressure ulcer prevention and management play a crucial role in the care and treatment of patients in all Health Care settings.

2. Introduction

The term "Trust" throughout this policy refers to North Staffordshire Combined Healthcare Trust (NSCHT)

Pressure ulcers are caused when an area of skin/and or the underlying tissues is damaged as a result of being placed under sufficient sustained pressure or distortion to impair its blood supply. It is recognised that many pressure ulcers are preventable and when they do occur they can have a profound impact on the overall well-being of the person affected. Being painful, debilitating and in some instances life-threatening. In addition to the human cost, they pose a significant National financial burden. Treating pressure ulcers costs the NHS more than £3.8million every day.

The NHS has been mandated to adopt a zero tolerance to pressure ulcer development. To help achieve this, the 'Stop the Pressure Campaign' and **SSKIN** bundle have been updated to help raise awareness about pressure ulcers and the 7 simple steps to prevent them. SSKIN bundles were originally developed by NHS Midlands and East but are now managed by NHS improvements and are being rolled out nationally.

3. Scope

3.1 This policy applies to all clinical Trust employees, staff working for and on behalf of the Trust including contractors, voluntary workers, students, locums and agency staff.

3.2 The purpose of the policy is to provide a standardised structured approach for the prevention and management of pressure ulcers.

4. Purpose

The Purpose of the policy is to provide guidance on pressure ulcer prevention and management within Mental Health settings. Pressure ulcer prevention and management play a crucial role in the care and treatment of patients in all Health Care settings. The aim of the policy is to reduce the amount of pressure ulcers developing for patients accessing the Trust services, ensure there is a standardised and robust procedure for identifying, reporting and investigating pressure ulcers, so that any missing elements of care that might have contributed to the pressure ulcer developing are highlighted and lessons are learnt.

All Staff – All staff are responsible for being aware of and complying with this policy at all times, failure by staff to comply with the policy may result in disciplinary action.

5. Roles and responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust, including ensuring that the Trust's procedural documents comply with all legal, statutory and good practice requirements. The Chief Executive is responsible for ensuring that there are safe and effective systems in place to deliver high quality care to the persons who use our services.

5.2 Executive Directors

The Executive Directors are responsible for identifying and implementing procedural documents that are relevant to their area of responsibility.

5.3 Director of Nursing and Quality

The Director of Nursing will take the lead responsibility for the development and implementation of this policy, with the support of the Head of Infection Prevention and Control and Physical Health.

5.4 Head of Infection Prevention and Control and Physical Health

Oversee the implementation and impact of this policy and make recommendations for change.

Provide assurance to the Board that the systems are in place and the correct policies and procedures are adhered to across the organisation to ensure safe effective care.

5.5 Tissue Viability Team (TVT)

The TVT will have a pivotal role in ensuring all aspects of this policy are effectively implemented, risk managed and evaluated across the Trust. The TVT will have the responsibility to respond to national initiatives, guidance publications and evidence base relating to pressure ulcer prevention and management and to report to the Physical health Group meetings within the Trust.

Contribute to the Trust's training programmes including mandatory and statutory training programmes.

Support health and social care professionals in providing education and guidance assessing and managing pressure ulcer and pressure ulcer prevention.

5.6 All Employees

Pressure ulcer prevention and management is the responsibility of all clinical staff within the Trust.

All staff must ensure that they –

- Are aware of how to access the Trust Policy on The Prevention and Management of Pressure ulcers
- Be able to demonstrate an understanding of Trust policies on the Prevention and Management of Pressure ulcers

- Follow Trust policy on assessing patients risk level for developing a pressure ulcer, and take appropriate measures to minimise the risks that may lead to a pressure ulcer occurring for all patients under their care
- Provide education to the patient, carer and family on prevention of skin damage.
- Report pressure ulcers via the incident reporting system when a pressure ulcer is first identified
- Understand and act on the requirements for Duty of Candour
- Follow Trust policy regarding the treatment of pressure ulcers
- Assist the investigating officer with completing an RCA if required

5.7 Service Managers

Service managers, team leaders and ward managers must ensure that all new staff are made aware of the Trust's Pressure Ulcer Prevention and Management Policy during their induction into the practice area. Introduction of new and amended policies should be raised and recorded at the next appropriate team meeting. Appropriate resources will need to be made available to carry out the policy effectively.

Service managers are responsible for supporting the Investigating officer (IO) in all Root Cause Analysis (RCA) relating to pressure ulcer (appendix 1). The IO will require the team leader to provide access to all clinical records, and ensure they take part in the review. The team leader will be required to produce an action plan following the RCA and ensure that it is signed off when completed.

Learning from RCA's across the whole Trust will be communicated through shared learning alerts via the Patient and Organisational Safety Team (POST). It is the service manager's responsibility to share the information with all team members and change practice within the team accordingly.

5.8 Risk and Investigations Team

The POST Team are responsible for processing incidents within the Trust. Any incidents associated with pressure ulcer will be processed and co-ordinated by POST.

Where required, an initial Duty of Candour letter will be sent out by the directorate service manager. The service manager will then liaise with the investigating officer to complete and present the RCA to ensure the documents are completed in a timely manner.

NHS England require all pressure ulcers developed within an episode of NHS providers care and identified as causing moderate harm be reported as a Serious Incident through the adverse incident system.

5.9 Incident Review Group

The Incident Review Group is made up of a group of peers, operational leads, professional leads, internal trust group and clinical experts. It is the group's responsibility to determine the underlying cause that led to the pressure ulcer development, to decide if there were any lessons to be learnt and shared across the Trust.

6. Explanation of Terms

Patient/service user	For the purpose of this policy a patient is considered to be any person in receipt of healthcare from North Staffs Combined Healthcare Trust regardless of age or care setting.
Pressure ulcer	An area of localised damage to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.
Medical device related pressure ulcer	Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes. Device related pressure ulcers should be reported and identified by the notion of (d) after the report e.g. category 2 pressure ulcer (d)
Prevalence	Prevalence is defined as a cross-sectional count of the number of cases at a specific time, or the number of persons with a pressure ulcer who exist in a population at a particular moment in time (Defloor et al 2002). Both prevalence and incidence are used to measure disease frequency. While both have been used to record the number of people with pressure ulcers, they provide different perspectives on the scale of the problem (EPUAP 2014).
Incidence	Incidence is defined as the number of persons who develop a new pressure ulcer, within a particular time period in a particular population (Defloor et al 2002). Incidence can be captured within the in-patient setting per 1000 bed days, or based on percentage rate of admissions, and within the community per 10,000 populations.
Pressure ulcers on admission (POA)	Pressure ulcers which are observed during the first skin assessment on admission to that service. These will need to be incident reported via the Trust's safeguard system under the appropriate category and as a pressure ulcer on admission
Acquired pressure ulcer	Patients that develop a pressure ulcer whilst receiving care within the Trust. These will need to be incident reported via the Trust's safeguard system under the appropriate category as Trust acquired.
Verification/ confirmation	All Trust acquired unstageable, category 3 pressure ulcers that are over 1cm x1cm, and category 4 pressure ulcers need to be confirmed by Tissue viability or an appropriately trained member of the ward staff. A photograph taken with consent may also be useful as evidence of the category.
Duty of Candour	Duty of Candour is a legal requirement. It places a formal requirement on providers of health or social care to be open with their patients when they suffer moderate harm related to care or treatment. Please refer to the Duty of Candour Standard Operating Procedure.
RCA	Root Cause Analysis. Comprehensive investigation of records to ascertain the "what, why, how and when" relating to the development of a pressure ulcer
Incident Review Group	Meeting held weekly by clinical leads, team leaders, Tissue viability and nursing peers to enable presentation of RCA's and to determine if the incident is reportable as a serious incident and what lessons may be learnt and shared
High risk	High Risk patients are individuals who usually have multiple risk factors (such as complex medical conditions leading to significant limited mobility, nutritional deficiency, inability to reposition themselves, significant cognitive impairment), or patients' with a history of a pressure ulcer or a current pressure ulcer. (NICE 2014)

Moisture Lesions/ Moisture Associated Skin Damage (MASD)	Sustained presence of moisture can damage skin, presenting as either skin damage associated with incontinence, sweating (intertrigo), peri-stomal leakage or wound exudate. For the purpose of this policy MASD is mostly related to that caused by incontinence or intertrigo. A pressure ulcer should not be mistaken for MASD; refer to appendix 2 for key differences between pressure ulcer and moisture lesions. Ulceration that has occurred due to a combination of pressure / shear and moisture should be recorded as a pressure ulcer and categorised accordingly (NHSI 2018)
Category 1	-Intact skin with non-blanching redness -Usually over a bony prominence. -The area may also have a change in texture, temperature or may be painful. -Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding skin (appendix 3 and 4)
Category 2	- Partial thickness skin loss of the epidermis, dermis or both. - Presents as a superficial, shallow open ulcer -Wound bed may present as clean, pink or red tissue, but should have **NO** slough. -May also present as an intact clear or ruptured blister with no bruising or discolouration. *(*appendix 3 and 4*).*
Category 3	-Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. -May include undermining and tunnelling. -Slough and necrotic tissue may be present on parts of the wound bed but should not obscure the full depth. -The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have fatty tissue so depth of damage may be shallow. In contrast areas with large amounts of fatty tissue can develop very deep category 3 wounds. (appendix 3 and 4)
Category 4	-Full thickness skin loss with exposed or palpable bone, tendon, or muscle. -Slough and necrotic tissue may be present on parts of the wound bed. -Depth will vary depending on anatomical location. -May include undermining and tunnelling. (appendix 3 and 4)
Unstageable	- A pressure ulcer that due to the amount of slough or necrosis present, the exact category cannot be determined. Unstageable pressure ulcers are divided into 2 categories - Suspected Category 2 or 3:- present as shallow with a little slough present. Staff have 5 working days to determine the correct category and update Risk team – if Risk team does not receive an update as to the category then it will automatically be verified as a category 3. -Suspected Cat 3 or 4:- Present as having thicker slough or necrosis. Staff have 3 working days to verify the cause as pressure and a category 3 or 4 – (once the slough or necrotic tissue is debrided staff will need to update and confirm with the Risk team the category). If the risk team is not notified of category then it will automatically be verified as a category 3 at least.
Deep tissue injury (DTI)	-Skin is intact but the area presents as a deep purple or maroon colour.

	-Also includes blood filled blisters and blisters that have a discoloured base under the blister tissue. -The area may be painful, firm, boggy, and warmer or cooler compared to adjacent tissue. -Deep tissue injury may be difficult to detect on darkly pigmented skin. -DTI's should be monitored weekly to observe and report changes -Over time the discoloured area may resolve, or the tissue damage may become necrotic or evolve into an open ulcer, if this happens a new incident will need to be completed for category 2, category 3, category 4 or unstageable depending on presentation and extent of tissue loss. -A photograph must be taken with consent to accurately measure the timeline of ulcer evolution
Diabetic Foot Ulcer	A full thickness wound below the ankle of a diabetic patient, irrespective of duration. Skin necrosis and gangrene are also included in the current system as ulcers." (The International Consensus on the Diabetic Foot - International Working Group on the Diabetic foot, 2007).

7. SSKIN – Pressure Ulcer Prevention Care

SSKIN is referred to as a SSKIN bundle (appendix 5). This started as an initiative by NHS England's "Change Champions" in 2012. The "Bundle" is a collection of actions that when put together provide a way of ensuring all aspects of effective pressure prevention have been addressed i.e. Checking Skin regularly; ensuring the correct support surface is being used correctly; regular repositioning regimes are agreed; incontinence issues are addressed and nutritional needs are met.

In 2018 NHS improvements updated this to include:- assessing risk and giving information creating SSKIN

8. Assess risk

Each individual receiving care within the Trust must have their risk of developing a pressure ulcer assessed.

Assessing risk is the first step in pressure ulcer prevention, once a level of risk has been identified then the correct advice, plan of care and equipment or surface to suit individual needs can be provided.

Risk assessment may be done informally by Allied Health Care Professionals using clinical judgement and asking “is my patient at risk?” Considering each individuals co-morbidities, skin condition, level of mobility, understanding/capacity, continence and nutritional needs

Formal risk assessment is completed by nursing staff including all specialist nurses using a risk assessment tool. This will be the “Waterlow Score” in adults in Mental Health inpatient settings.

A risk assessment must be completed by a registered nurse on either the first visit/appointment or within 6 hours of inpatient admission. If this is not possible then the rationale must be documented in the patient records.

If the patient is deemed to be at risk, then a pressure ulcer prevention plan of care must be implemented by that nurse or their team as soon as possible.

8.1 Skin Inspection

All patients must be offered a skin inspection regardless of care setting, a visual inspection is best practice, in some clinic/care settings where the patient/service user is fully independent and mobile, asking the patient/service user about the condition of their skin over the pressure area points may be more appropriate to maintain dignity. Skin assessment within the mental health environment may be difficult due to the patients’ mental health condition, but inability to do so must be documented and further attempts made as soon as feasibly and practically possible.

Establishing the condition of the skin via visual inspection or questioning must be recorded at the initial assessment and continue as part of ongoing risk assessment. All at risk areas should be checked for signs of skin damage, this can include change in colour or skin tone, a change of temperature or texture, presence of oedema, or if the skin has become broken.

Although bony areas such as heels, hips, elbows, ankles and coccyx are the most vulnerable sites a pressure ulcer can occur anywhere on the body, especially when related to a medical device.

8.2 Waterlow Pressure Ulcer Risk Calculator for Adults and Children

The Waterlow Pressure Ulcer Risk Calculator is an assessment tool used within the mental health environment to support clinical assessment to identify the potential risk of pressure ulcer development. The Waterlow calculator was deemed an appropriate tool to use within the mental health environment because the categories are more relevant to acute mentally unwell patients and it is easily understood by practitioners. (appendix 6)

Score the patient in each of the TEN categories, more than one score in each category may be relevant, then total the score to help determine the level of risk. It is important that the Waterlow score is not used alone and that clinical judgment is also used when planning care.

Initial assessments must be completed by a Registered Nurse on the first assessment/appointment, or within 6 hours of admission to an inpatient setting, if mental health status allows. If this is not possible document the reason why and assess the risk of damage at the earliest opportunity.

Risk assessment may be done informally by Allied Health Professionals, HCSW and Phlebotomists by asking the following questions:

- Does the patient require help of another person to stand up from their chair? Yes/No
- Does the patient report any soreness or redness to their skin, particularly over their heels, bottom, hips and other bony areas? Yes/No

If the answer is yes to either of the above questions, please inform either the nurse lead in your team, or refer to an appropriate healthcare professional such as the GP for a formal pressure ulcer risk assessment that will include a full skin check. Please ensure the discussion is documented.

8.3 Guidance on completion of the Waterlow pressure ulcer risk assessment

TERMINAL CACHEXIA/MULTIPLE ORGAN FAILURE = weight loss and deterioration in physical condition associated with a chronic long term condition, including respiratory failure, renal failure and/or cardiac failure. It is defined as an involuntary loss of 5% weight loss within a 12 month period. Patients will be at an increased risk of skin breakdown due to poor nutrition and blood circulation.

PERIPHERAL VASCULAR DISEASE = reduced blood flow reduces the amount of oxygen and nutrients available for normal tissue/cellular activity and replacement.

ANAEMIA = reduced capacity to oxygenate tissues.

SMOKING = Has a detrimental effect on peripheral circulation causing vaso-constriction. It also alters platelet function with a higher risk of blood clots affecting smaller vessels, thus increasing the risk of arterial disease.

Toxins contained in cigarette smoke have a particularly damaging effect on the wound healing process. Affecting the amount of oxygen the haemoglobin can carry.

NEUROLOGICAL DEFICITS/DIABETES = Patients with these conditions have a delayed cellular response to injury and reduced wounds strength and an Increased risk of developing arterial disease. They also have reduced white blood cell activity.

CVA/MOTOR/SENSORY/PARAPLEGIA = inability to recognise sensation of discomfort and alter position involuntarily, therefore the patient is lying in one position for extended periods resulting in compression of capillaries between internal skeleton and surface on which they are sitting/lying. This will cause tissue damage unless addressed which may progress to severe pressure ulceration**.**

MAJOR SURGERY OR TRAUMA = associated risks due to inability to alter body position as an effects of spinal anaesthetic or type of surgical intervention. The duration of surgery increases the risk because the patient is likely to be in one position during surgical intervention resulting in sustained pressure to vulnerable areas. Medications given inter-operatively to reduce blood flow result in reduced circulating nutrients and oxygen to extremities.

MEDICATION = CYTOTOXICS, LONG TERM/ HIGH DOSE STEROIDS, ANTI-INFLAMMATORIES = disrupt cell division and reduces protein synthesis. Anti inflammatories suppress inflammation which is vital for wound healing.

8.4 Action Following Completion of WATERLOW Pressure Ulcer Risk Calculator

WATERLOW Score risk level	Action
Below 10 /Not at risk	Ensure that the patient is given advice on how to self-check skin regularly and how and who to contact if they notice any changes
BETWEEN 10 - 14/ AT RISK	• In addition SSKIN bundle information and a pressure ulcer preventative care plan for self-care is to be utilised if needed. • Document time and date explanation given. • Check skin integrity on each shift as part of the SSKIN bundle. • Nurse on a high specification foam mattress. • Provide negative pressure to heels. • Ensure chair cushion has high specification foam. • Record weight weekly. • Monitor continence and manage appropriately.
Between 15-19 / HIGH RISK	• Pressure ulcer prevention care plan to be initiated, which may need to include SSKIN bundle checklist. • Commence SSKIN bundle at least 2-4 hourly. • Check skin integrity on each shift. • Nurse on an appropriate mattress. • Ensure specialist seating is considered – liaise with Occupational Therapists if needed. • Provide negative pressure to heels. • Consider referral to Physiotherapy for mobility if appropriate. • Consider dietician referral where indicated. • Record weekly weight. • Monitor continence and manage appropriately.
20 + VERY High risk	• Pressure ulcer prevention care plan to be initiated. • Commence SSKIN bundle every 1-3 hours. • Check skin integrity on each shift. • Nurse on an appropriate mattress.

	• Ensure specialist seating is considered – liaise with Occupational Therapists if needed. • Provide negative pressure to heels. • Consider referral to Physiotherapy for mobility if appropriate. • Consider dietician referral where indicated. • Ensure a medication review is completed to manage any high risk drugs. • Record weekly weight. • Monitor continence and manage appropriately.

8.5 Waterlow Pressure Ulcer Risk Calculator - Reassessment.

Each time a reassessment takes place a skin check **must** also be completed.

On-going risk assessments when in a Community Hospital or Mental Health setting: -

Weekly if the patient has a pressure ulcer or is being nursed on an alternating pressure mattress, low air loss equipment or requires SSKIN Bundle care.

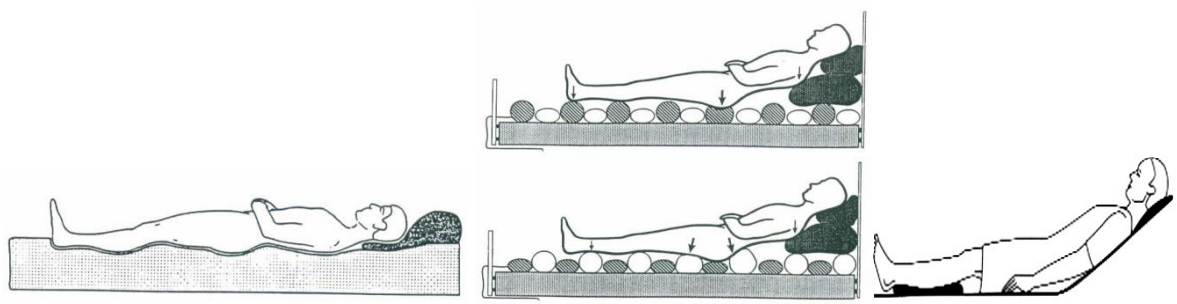
Risk assessment for all other patients: - minimum of weekly in community hospital and monthly in the mental health setting. If the patients' condition changes, however, a new assessment will be required.

On-going assessments Primary/Community care setting: - A Waterlow score should be completed monthly. Re-assessment should be done sooner if there is any significant change in the patient's condition.

Allied health professionals are not expected to use the Waterlow risk assessment calculator but to informally assess risk, as detailed in section 8.2, and to refer to a registered nurse for a full assessment should they have concerns around risk of pressure ulcer development.

9. Surface. Equipment for Pressure ulcer Prevention

Specialist mattress, cushions and heel proctors help to reduce pressure by either redistributing the pressure over a larger area, alternating the pressure between different areas or offloading the pressure, so that the area is pressure free. Please contact Tissue Viability for advice as needed.



Redistribution Alternating off-loading of heels

9.1 Choosing equipment – mattresses and cushions

All patients that are admitted to hospital need to use a high specification foam mattress as a minimum level of equipment; this will help to redistribute pressure over a larger area.

In some cases such as spinal injuries, unstable fractures and terminal care, alternating mattresses may be contra-indicated. Please seek relevant specialist advice if unsure.

The patient's need for pressure reducing equipment must be reviewed as the patient's condition changes. Alternating mattress that are being used for treatment of pressure ulcers, may need to be upgraded or downgraded depending on the progress of the pressure ulcer. All equipment must be evaluated to ensure appropriate allocation of resources.

Although risk reduction is the main objective overall, patient comfort must receive equal priority when selecting equipment.

For patients who sit for prolonged periods of time and/or are at high risk of developing pressure ulcer, a high specification foam or equivalent redistributing cushion must be in use.

Manual handling devices should be used correctly in order to minimise shear and friction damage. NB: After manoeuvring, slings, slide sheets or other parts of the handling equipment should not be left underneath individuals, unless specifically designed to do so.

9.2 Choosing equipment for heel protection

All Patients that are bedbound as a result of surgery, CVA or illness, and have diabetes, neuropathy and/or arterial problems are at greater risk of developing heel pressure ulcer and so should have equipment and procedures in place to off load or reduce pressure to the heels.

All patients with pressure ulcer to the heels must have equipment and procedures in place to off load or reduce pressure to the heels, to aid healing.

Offloading pressure; whilst in bed or when feet are elevated on stool, this can be performed by placing pillows under the calf and supporting the knee, allowing the heels to float off the mattress or stool. Other products are also available such as leg troughs and boots that will provide negative pressure to the heels.

Reducing pressure; this can be performed by using silicone gel pads and specialist foams, these products will not eliminate pressure, but will reduce the amount of pressure to the heels, and are available on prescription. (appendix 7).

If advice has been given to elevate legs, then care must be taken to ensure an appropriate stool is used that will support the legs, including the backs of the knees, whilst still allowing the heels to float off the stool and maintain negative pressure.

9.3 Equipment cleaning and checking - Inpatient

Inpatient settings must clean down all mattress and cushions with detergent, or a hypochlorite if the patient has a known infection, or if blood or body fluid is present. This must happen between each patient use, or sooner if needed due to leakage or spillage. The mattress and cushion cover also needs to be checked for rips, tears or stains, between each patient use. Appropriate audits must be undertaken to ensure integrity of mattresses and cushions.

9.4 Discharging in-patients

When planning for discharge, thought needs to be given about replicating the level of equipment that is going to be provided at home. For example, if the patient does not require an alternating mattress when at home, then prior to discharge the patient should not be nursed on one. If a patient is still requiring an alternating mattress on discharge then a similar alternating mattress will need to be ordered for the patient's home, this needs to be arranged by making a referral to the Tissue Viability Team for equipment. This will ensure that the patient will be safe on discharge with the agreed level of equipment that has been arranged.

10. Skin inspection

10.1 Skin Inspection - Adults

Patients that have been assessed as being at risk, high risk or very high risk of developing pressure ulcers should still be encouraged if possible to check their skin regularly and liaise with their nurse to discuss any concerns. If however they are unable to do this then the nurse will need to discuss skin inspection with carers. Frequency of skin inspections will be dependent on level of risk and clinical judgement and should be included as part of the plan of care. Document the skin assessment within the care records using the SSKIN pressure ulcer checklist.

If a person regularly declines the inspection, document in the care records.

Patients that have been assessed as being low risk, should be given advice on how to self-check skin regularly and how and who to contact if they notice any changes.

10.2 Skin Inspection – Children

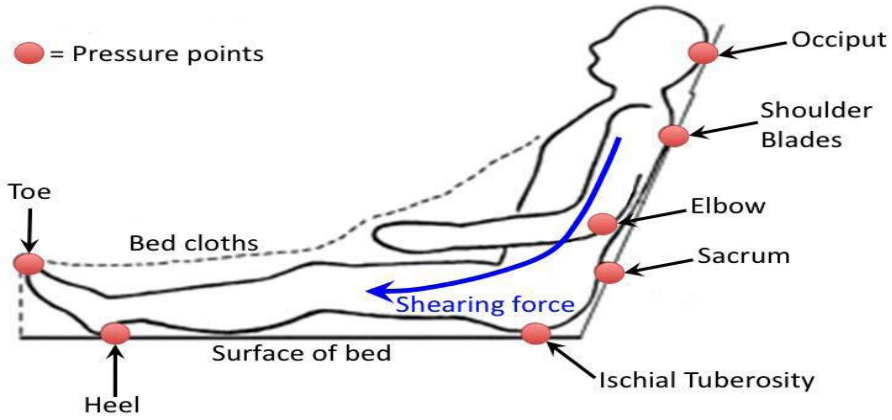
Parents or guardians may undertake the skin inspection for their child. Explain to the parent/ guardian what they should be looking for and document in the care records if the inspection was undertaken by the parent, guardian, or the nurse.

10.3 Skin Tone and Colour

Full use of the senses increases the diagnostic value for all patients, but is particularly important with dark skin as there is less visual evidence base for assessment and diagnosis. It is important that touch is used as part of the skin assessment in order to gain a more accurate overall picture of the patients skin and its condition (assessing texture and temperature).

Good communication with the patient is essential. Asking and listening to their perspective on the condition of their skin and if they have noticed any change in sensation or presentation can help obtain information that might otherwise be missed.

10.4 Common sites of pressure ulcer



10.5 React to Change

'React to Red' was a pressure ulcer prevention campaign in 2012 that helped in educating people about the dangers of pressure ulcers, and the simple steps that could be taken to avoid them. However it is recognised that the terminology of React to Red reflects a white bias. Mukwende 2020 identified that information and illustrative images overwhelmingly focused on white skin and this contributed to a lack of knowledge in the assessment and diagnosis of patients with dark skin tones.

Moving forward, we advocate **React to Change**. Patients, family and care staff can be taught how to check the skin. Following these simple steps they should be advised to notify Nursing staff of any changes noted.

- Check the most commonly affected areas for a pressure ulcer to appear, such as the buttocks, heels, lower back, ankles, shoulders and other bony parts of the body.
- If an area of skin has appeared to change colour, compare it if possible to a similar area of skin (e.g. heels, elbows, buttocks) touch the skin and feel for changes in texture or temperature.
- In patients with light skin tones it may be possible to perform a simple test, known as the blanch test, to check if there is still a healthy supply of blood to that area of the skin. Lightly press on the area with your finger. The skin in that area should go paler; remove the pressure and the area should return to original colour within a few seconds, this indicates intact blood flow.
- If the area does not go paler then blood flow has been impaired and damage has begun. This is called non blanching erythema and is a Category 1 pressure ulcer.
- Dark skin may not have visible blanching even when healthy, so it is important to look for other signs of damage like colour changes, temperature changes, swelling or hardness compared to surrounding areas.
- If skin has become non-blanchable then action needs to be taken to ensure further damage does not occur. Check all preventative care is in place and being adhered to;

increase the frequency of position change or off load pressure from that area if able to. Follow pressure ulcer treatment procedures.

R	**R**emove the source of the pressure
E	**E**nsure the skin is protected
A	**A**ssess the impact the preventative plan has had
C	**C**ommunicate to the staff/carers
T	**T**alk to the patient about how to prevent further damage.

11. Keep Moving - Repositioning Patients

Changing position frequently is the body's main way of preventing skin damage caused from pressure. Therefore a repositioning regimen needs to be devised for patients unable to independently change position for themselves. This includes those patients with a pressure ulcer and those who are identified as being high or very high risk.

If a patient is mobile but still at high or very high risk, then the patient needs to be reminded to reposition themselves at suitable intervals, a repositioning regimen may still be helpful as a reminder for the patient.

11.1 Methods of repositioning when in bed.

- The 30 Degree Tilt (appendix 8)
- Changing from lying down to sitting up in bed. If a hospital bed is in use then the patient may be able to use the controls to change position themselves.
- Changing from bed to chair
- In some instances a tilting bed frame may be deemed appropriate.

11.2 Methods of repositioning when in a chair

- Standing up
- Tilting from side to side in the chair whilst lifting the opposite bottom and leg will help to relieve pressure temporarily.
- If the patient has good upper body strength they can push down on the arms of the chair and lift bottom
- Changing from chair to bed.

11.3 Frequency of repositioning

Frequency of position change will depend on level of risk and skin condition.

As a minimum

- All at risk patients should be encouraged to change position **at least** every 6 hours.
- All high risk patients should be encouraged to change position **at least** every 4 hours.
- If a patient has pressure ulcer to the sacrum, buttocks or ischial tuberosity area, then time spent sitting must be limited

(NICE 2017)

Each time a patient's position is changed the new position and time must be documented.

When planning for discharge from a 24hrs care setting, to a community service, where care is limited to a set number of care calls per day; thought needs to be given about replicating the number of position changes that are going to be provided at home by the community service. This will ensure that the patient will be safe on discharge with the agreed level of care that has been arranged.

11.4 Avoiding friction and shear

Friction and shear are well known contributing factors in skin damage. When assisting patients to change position, correct manual handling principles should be followed, and appropriate equipment such as slide sheets must be in place. Please refer to the Manual Handling Policy.

If a hospital bed is in use then the use of the knee brake function should be utilised to avoid patients slipping down the bed.

To help avoid friction and shear, when a patient is sitting their feet should be able to reach the floor with the whole of their foot, the patient's knees should be at 90 degrees, their bottom should be at the back of the chair and the arm rests should be at the correct height for their elbows. Referral to OT may be appropriate.

12. Incontinence

When the skin is exposed to excessive amounts of moisture, the skin will soften, swell and become wrinkled, all of which make the skin more susceptible to damage. Healthy skin is slightly acidic which provides a natural barrier to bacterial growth, the chemical irritation from both urine and stools disrupt this and changes the skin pH, causing the skin to break down.

If a patient is incontinent then every effort needs to be made to find and treat the cause of the incontinence rather than just managing the symptoms of the problem. A continence assessment must be completed so that the correct continence products can be used. Referral to the Continence Team may be appropriate for advice and support.

12.1 Do's and Don't

Do's		Don't	
Complete incontinence assessment so that the correct level of absorbency pad can be used to avoid over hydration or drying the skin out.	✓	Use a large incontinence pad in the hope it will mean less changing.	✗
Frequently check to ensure incontinent patients are clean and dry. This will reduce the time skin is exposed to the damaging effects of urine and faeces	✓	Don't allow your patient to wear a heavily soiled incontinence pad for long periods of time, change pad as soon as you are made aware that it is soiled, not according to routine checks.	✗
Use a skin friendly cleanser that will maintain the skins PH.	✓	Use soap frequently as a cleansing agent, as it is detrimental to the skins barrier function	✗

Use a barrier cream or spray from the Wound Care Formulary that will not affect the absorption of the incontinence pad.		Use occlusive skin protectant products as they will block the incontinence pad causing over hydration to the skin.	
Allow the skin friendly cleanser to soften any faecal matter so that it can easily be wiped away.		Use aggressive cleansing techniques to rub the skin clean, as this will increase the frictional forces on the skin	

13. Nutrition

Malnutrition is frequently cited as a risk factor for the presence, development and non-healing state of a pressure ulcers.

The Trust's Nutrition Policy provides advice and guidance on maintaining a healthy weight and the screening and management of malnutrition. The Malnutrition Universal Screening Tool (MUST) must be completed during initial assessment of adults and the appropriate nutritional care plan implemented.

13.1 Nutrients that are particularly important for wound healing

Protein - is essential for new cell production; even a low intake over a couple of days can delay wound healing. Advise protein rich foods such as milk, eggs, meat, fish, nuts, lentils, Quorn and soya products.

Iron - is needed in the process of making new skin, having a low intake can delay wound healing. Iron rich sources will help the body repair at an optimal rate. Advise iron rich foods such as fortified cereals, red meat, green vegetables, and apricots.

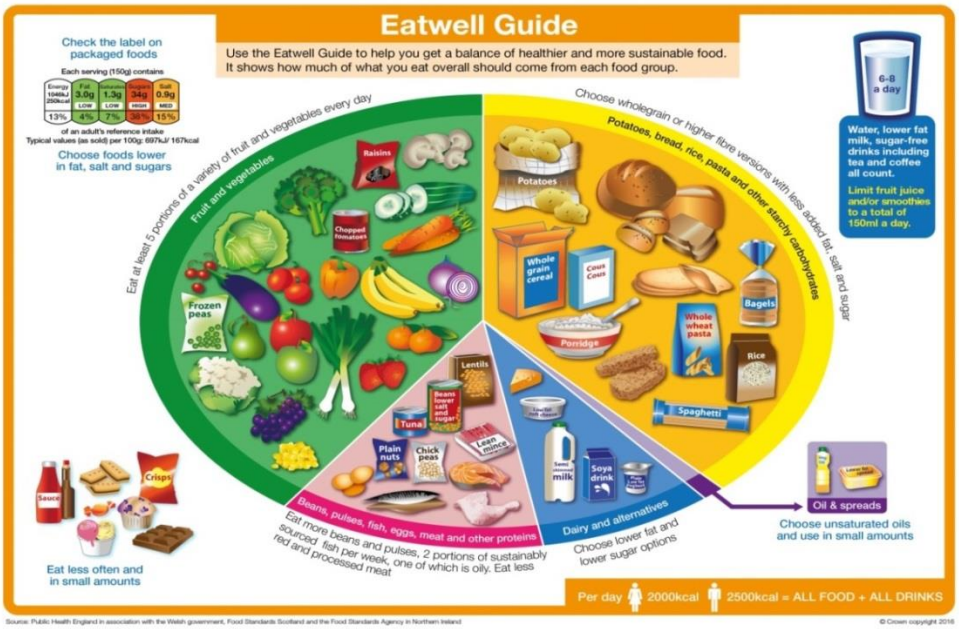
Zinc - is essential in the process of building protein to repair the skin, it is important to have enough for the body to repair itself. Advise zinc rich foods such as milk products, shellfish, breads, cereal products and meats.

Vitamin C - is important in helping the body absorb iron and important in collagen synthesis. When eating iron rich foods accompany them with a good source of vitamin C.

Patients should also be encouraged to stay hydrated.

All patients at risk of pressure ulcer can be given written information regarding a healthy diet. If patients are following a healthy diet and are not identified as being at risk of malnutrition they should be meeting their nutritional requirements for vitamin C, zinc, protein and iron.

13.2 Eat well Guide



14. Preventative care planning

The following patients will require a pressure ulcer prevention care plan.

- All patients identified as high or very high risk when using the Waterlow Pressure Ulcer Risk Assessment, regardless of care setting.
- All patients that you feel are at high risk of developing pressure ulcer using your clinical judgment.
- All patients that have pressure ulcer

The care plan for high or very high risk patients/service users should take into account the 7 areas of SSKIN, (Skin, Surface, Keep moving, Incontinence and Nutrition), and the SSKIN Bundle should also be utilised.

The care plan for patients that are low risk should include advice on how the patient can self-check their skin daily, what skin changes they are looking out for, and advice regarding not sitting for long periods of time.

Care plans will need to be reviewed every month or sooner if the patient's condition changes, this is to ensure that the patient's pressure ulcer prevention needs continue to be met.

14.1 Patient and carer information and advice

All patients and or family/carers of patients that are at high or very high risk of developing pressure ulcers **must** be given verbal advice regarding their pressure ulcer prevention care plan.

Formal and informal carers, must be informed about the pressure ulcer prevention care plan, and advised on how to escalate concerns to healthcare staff.

15. Pressure ulcer categories and treatment

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of sustained pressure, or pressure in combination with shear. A number of contributing factors are also associated with pressure ulcer; the significance of these factors is yet to be elucidated. (EPUAP 2014)

15.1 Categorising

It is important that pressure ulcers are categorised accurately and in accordance with the Trust pressure ulcer categorising tool that has been adapted from the EPUAP pressure ulcer categories. (appendix 3 and 4*)*

Only wounds that have been caused by pressure or pressure in combination with shear should be categorised (i.e. we do not categorise leg ulcers or surgical wounds etc). Care needs to be taken when other elements such as moisture and diabetes are involved in skin damage. (Refer to moisture lesion section and Appendix 2 plus diabetic foot section within this policy)

When a patient/service user is transferred into a different care setting, the category of any present pressure ulcer must be identified during the hand over period. This will help to reduce confusion and aid in accurate categorising of the pressure ulcer.

Category 2, 3, and 4 pressure ulcers cannot be re categorised as the wound improves, when the pressure ulcer improves and is no longer matching the description of the original category then the term ‘healing category 2, 3, or 4’ should be used.

An unstageable pressure ulcer where the wound bed remains unable to be seen will continue to be called unstageable (but treated as at least a category 3 pressure ulcer, because the tissue damage will be deemed to be full thickness). Once the wound bed has become clean enough that the full extent of the pressure damage can be determined, then the pressure ulcer can be re categorised as either category 3 or category 4. A new incident report will then be required via the Trust’s safe guard system to document this change.

Deep tissue injury (DTI) is when pressure has caused damage to the subcutaneous tissues under intact skin. These areas have the appearance of a deep bruise. The damage may resolve as long as pressure is quickly alleviated. However they can also evolve into an area of dry necrosis or an open wound exposing additional layers of skin tissue. When this happens, a new incident form will need to be completed to indicate what category the DTI has evolved into. The time frame for recognisable changes following a DTI varies considerably. A DTI should be monitored weekly until it either resolves or develops into a categorised or uncategorised pressure ulcer. A photograph should be taken with consent to aid verification and record keeping.

Care needs to be taken to ensure accurate categorising between 100% necrotic wounds that should be classified as unstageable and treated as a category 3 and deep purple/black bruised area of intact skin that should be categorised as DTI. (appendix 9)

15.2 Device related pressure ulcers

Wounds that have been caused by pressure from devices designed and applied for diagnostic or therapeutic purposes will need to be categorised using the pressure ulcer categorising tool and incident reported via the Trust’s Ulysses system.

To help identify device related pressure ulcers a letter 'd' should be placed after the category i.e. category 3 (d). Within the incident reporting system all device related pressure ulcers should be identified by selecting medical device as a causative factor.

Device related pressure ulcers of category 3 or 4 sustained whilst in Trust care are classed as 'acquired' and meet the criteria for a serious incident (SI) and will need to be investigated via a root cause analysis (RCA) to see if any learning needs in care are required.

15.3 Treatment of pressure ulcer

All patients who have a pressure ulcer will need to have a wound assessment and care plan completed.

Wounds should be formally re-assessed every 2 weeks, to ensure the wound is progressing as expected, and treatment remains optimum.

Patients with pressure ulcers to the feet will require an Ankle Brachial Pressure Index (ABPI) test, to ascertain the patients' blood supply and to rule out Peripheral Arterial Disease (PAD). An ABPI **must** be performed prior to commencing treatment/dressing that will create a moist environment to aid autolytic debridement. Adding moisture to a wound where the blood flow is compromised can lead to infection and other significant complications. Aim to keep the wound dry until an ABPI can be completed. Please refer to Tissue Viability for this assessment.

It is advised to monitor haemoglobin and serum albumin levels in those clients with Category 3 and above tissue damage and those with heavily exuding wounds.

It is expected that all patients with pressure ulcer of category 3 and above, will need an alternating mattress, and appropriate cushion if not bed bound. Staff are able to access hospital owned equipment and should contact Tissue Viability for advice.

16. Reporting and Notification

All categories (1, 2, 3, 4 unstageable and DTI) of pressure ulcers, plus moisture associated skin damage (MASD), will need to be reported as an incident via the Trust safeguarding system. The incident form needs to **state the category, whether it is device related and if the pressure ulcer was a pressure ulcer on admission (POA) or acquired within Trust care**. (appendix 10 and 11)

The incident form needs to be completed by the nurse that first identified the pressure ulcer, ideally on the same day, but within 24 hours. Within the incident form, the nurse will be asked if a Waterlow Pressure Ulcer Risk Assessment was completed and if a suitable pressure ulcer prevention care plan is in place. By assessing the level of risk and ensuring a pressure ulcer prevention care is in place, it will hopefully help to prevent the pressure ulcer from deteriorating.

16.1 Confirmation of a Community Acquired Pressure Ulcer.

Pressure ulcers that have developed whilst the patient has been receiving care from the Trust must be confirmed, according to the table below and the verification/confirmation of pressure ulcer pathway (appendix 10).

Category of pressure ulcer	Does it need to be confirmed	Time frame for confirmation
Category 1 (any size)	NO	Not applicable
Category 2 (any size)	NO	Not applicable
Category 3 (1cm x 1cm or smaller)	NO	Not applicable
Category 3 (over 1cm x1cm)	YES	5 working days
Category 4 (any size)	YES	5 working days
Unstageable (1cm x1cm or smaller)	NO	Not applicable
Unstageable (over 1cm x1cm)	YES	5 days or sooner,
Deep tissue injury (DTI) (any size)	NO	Not applicable
MASD	NO	Not applicable

Refer to the 'Watch and Wait' flow chart (appendix 12)

Pressure ulcers will need to be confirmed by a registered nurse that has had appropriate training, and been deemed competent (a photograph taken with consent may also be useful as evidence of category). If there are no members of the ward team that are able to confirm the pressure ulcer category, then Tissue Viability will support. (appendix 13)

Once the pressure ulcer has been verified/confirmed an RCA will need to be completed by a trained investigator and reviewed at the appropriate Incident Review Group meeting. The RCA must cover all care input that the patient receives not just the nursing aspect.

Unstageable pressure ulcers that are over 1cm x 1cm are allowed up to 5 working days for the confirmation to be completed. This will give the nursing team time to try and debride the unstageable wound so that a more accurate decision on the category can be made at the time of confirmation. If after 5 working days the level of slough and or necrosis is still obscuring the wound bed, then the pressure ulcer will be deemed to be full thickness. The pressure ulcer we remain unstageable but will be treated as a category 3 pressure ulcer. If the unstageable pressure ulcer has such a degree of necrosis or devitalised tissue, that it is obvious it is full thickness damage then confirmation can be completed as sooner.

16.2 Incident Reporting Due To Deterioration.

A new incident form will need to be completed if the pressure ulcer deteriorates and becomes a different category. A new incident form will also need to be completed if a pressure ulcer that was previously 1cm x1cm or under deteriorates and becomes larger.

If a DTI evolves into a category 3, category 4, or unstageable pressure ulcer, a new incident form will need to be completed. If the DTI was present on admission into our care, and incident reported accordingly, then the new incident report for the category 3/4 or unstageable should be reported as acquired

17. Being Open and Duty of Candour

The Trust is committed to the principle of openness and having open and honest communication with patients and people with parental responsibility.

Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the 'Duty of Candour', any 'unintended' or 'unexpected' incident which results in moderate harm, severe harm or death must have documented evidence of the 'Duty of Candour' being complied. This is also a contractual requirement from Commissioners. For the purpose of this

Policy all acquired Category 3 and unstageable which are over 1cm x1cm and category 4 pressure ulcers are covered under the Trust's Duty of Candour requirements. If a patient is non-concordant with care, appropriate advice and equipment, and pressure ulcer prevention advice has been reiterated to the patient, by the qualified nurse caring for them, but the patient declines to take this advice, then any resulting pressure ulcer development is 'expected'. However, the pressure ulcer will still need to be incident reported, confirmed, an RCA completed and a Duty of Candour letter may still need to be given. Non concordance will need to be sensitively documented in the clinical records by the nurse caring for them. Full requirements are detailed in the Trust's Being Open Policy which incorporates Duty of Candour.

18. Moisture Associated Skin Damage (MASD)

Moisture associated skin damage can relate to inflammation and damage of the skin caused by prolonged contact with a number of different types of moisture including, urine, stool, perspiration, wound exudate and saliva. There are four main types of MASD:

- Incontinence Associated Dermatitis (IAD) = skin damage caused by prolonged exposure to urine and faeces only.
- Intertriginous Dermatitis = skin damage caused from perspiration and possibly friction in skin folds such as under breasts, groins and abdominal folds.
- Periwound Dermatitis = skin damage around a wound edge caused by exudate and skin stripping.
- Peristomal Associated Dermatitis = skin damage around a stoma caused from urine, faeces or gastric fluid.

The skin has a natural pH of 5.5 (slightly acid), urine and faecal incontinence changes this, and eventually causes the skin to break down. Over hydration and maceration from the incontinence also has a damaging effect on the skin. If left untreated, the patient will be at a high risk of pressure, friction and shear causing skin breakdown.

When making clinical decisions about whether the skin damage is caused from pressure or moisture a holistic assessment has to be performed including a patient history looking into episodes of pressure and incontinence. The use of the moisture verses pressure chart may also be of help in the diagnosis. (appendix 2)

If ulceration has occurred due to a combination of pressure /shear and moisture, the damage should be recorded as a pressure ulcer and categorised accordingly.

19. Skin Changes At Life's End (SCALE)

At life's end a reduction in the delivery of oxygen to the skin and the body's inability to absorb and metabolise vital nutrients can result in compromised skin integrity (EPUAP 2009). Skin Changes At Life's End (SCALE) typically occur in the last few weeks of life. It is important that providers of care ensure that all actions have been taken to prevent skin breakdown during this time. The SCALE Consensus document 2009 recommended the following.

Discussion around end of life care with the patient, patient carers and healthcare professionals should include the potential of SCALE and pressure ulcer, goals of intervention to prevent breakdown of the skin, and education for carers on preventing and identifying SCALE.

Patients skin at life's end should be considered at very high risk of pressure ulcer, therefore

- The frequency of risk assessment (Waterlow Risk Assessment Calculator) should be increased as the patient's condition changes,
- Have immediate access to equipment required to protect the skin from pressure ulcers,
- Have a skin assessment schedule and repositioning plan that reflects the patient's wishes and allows for protection of the skin

SCALE can have a significant impact on the individual's psychological and emotional well-being. The following factors must be considered:

- Control of pain related to skin changes
- Sleep patterns
- Odour
- Socialisation
- Privacy and dignity

When SCALE occurs the skin integrity may be compromised, placing the patient at increased risk of infection. Action to prevent infection includes:

- Maintaining hydration of the skin to reduce risk of cracking
- Covering any open wounds with a suitable dressing,
- Reducing the risk of wounds becoming contaminated with urine and faecal matter by keeping the patient as clean and dry as possible.

19.1 Consider The 5 P's

When assessing and planning care considering the 5 P's can help determine the most appropriate intervention strategies

1. **P**revention - promote optimum care to prevent skin damage where possible.
2. **P**rescription - take action to heal any damage to the skin and underlying tissues.
3. **P**reservation – take action to achieve maintenance without deterioration.
4. **P**alliation - maintaining the patient's comfort and dignity is priority
5. **P**references - patient's wishes are paramount

19.2 Incident Reporting and Investigations

Skin damage that may be relating to end of life skin changes, still needs to be categorised according to the trust pressure ulcer categorising tool (appendix 3 and 4) and incident reported.

20. Pressure ulcer or Diabetic foot ulcer?

Definition Of Diabetic Foot Ulcer: "A full thickness wound below the ankle in a diabetic patient, irrespective of cause. Skin necrosis and gangrene are also included in the current system as ulcers." (The International Consensus on the Diabetic Foot - International Working Group on the Diabetic foot, 2007).

All "new" diabetic foot ulcers including DTI's should be incident reported as a **diabetic foot ulcer** via the incident reporting system. The incident should be completed by the health professional that discovered the ulcer first.

If a diabetic patient sustains a wound below the ankle, then careful thought needs to be taken to ensure correct diagnosis is given so that incident reporting and treatment are also correct. If the diabetic patient with a wound below the ankle has remained mobile during the time the wound occurred, then the cause of the ulcer is unlikely to be pressure and so therefore should be incident reported as a diabetic foot ulcer. However, if the diabetic patient with a wound below the ankle has been immobile during the time the wound occurred, then the wound is likely to be pressure and should be incident reported as a pressure ulcer.

All diabetic patients with new wounds below their ankles need to be referred to Podiatry services. Existing wounds - staff must check if the patient is already known to the Podiatry services. If the patient is not already under the care of Podiatry due to a previous diabetic foot ulcer, then the patient needs to be referred urgently for full assessment.

20.1 The Key Issue Regarding Diagnosis

If the patient has recently been, or still is, immobile and therefore spending a significant amount of time in bed or sat in a chair in a fixed position, depending on the location of the wound, pressure is likely to be the overriding cause of the damage. Care needs to be taken in these instances that pressure ulcer is not miss diagnosed as diabetic foot ulcers.

If the Podiatrist diagnosis is pressure ulcer rather than diabetic foot ulcer, then a new incident form will need to be completed detailing the pressure ulcer category.

20.2 Podiatry Referrals

Podiatry referrals can be made using the Podiatry Request for Assessment form.

Although all diabetic patients that have foot wounds must have Podiatry input, it may also be beneficial for non-diabetic patients/service users with foot wounds to also be referred to Podiatry Services.

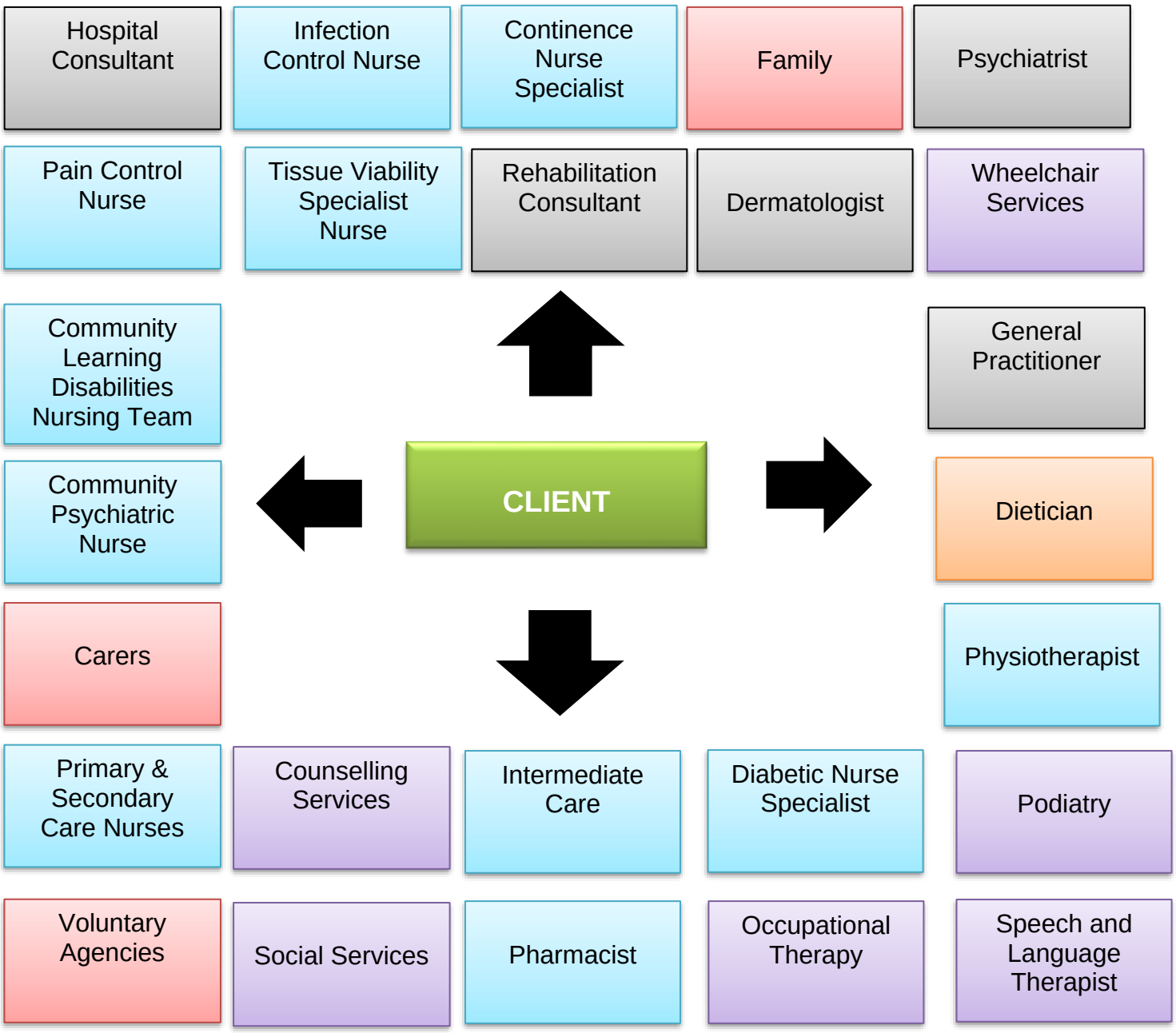
21. The Multidisciplinary Approach To Pressure ulcer Prevention and Management

A multidisciplinary approach will be needed in order for pressure ulcers to heal in a timely fashion. Appropriate referrals or advice will be required dependent upon the patient’s holistic assessment and individual identified risk factors.

21.1 The Multidisciplinary Team

The following health professionals and groups of people might need to be involved to enable a holistic approach to pressure ulcer treatment and prevention.

The Multidisciplinary Team



22. Safeguarding

Pressure ulcers can be a result of lack of care or neglect, if this is suspected then a referral to Safeguarding must be made. The referring health care professional does not need to be able to prove any claims of neglect or omitting of care, as this will be the job of safeguarding team to investigate.

A patient or service user that self-neglects can also be referred to the Safeguarding Team if the level of self-neglect is causing harm.

It's important to remember that not every patient that develops pressure ulcer will need a safeguarding referral, a referral only needs to be made if you suspect care that should have been performed has not taken place.

Further guidance can be sought from the Safeguarding Team.

23. Choice and Mental Capacity

The patient (and carers where appropriate) must be fully involved in the planning of care and every effort must be made to ensure the patient is in a position to make an informed choice.

The mental capacity of the patient to make that choice must be assumed, unless the Practitioner believes that there may be a reason why capacity is reduced, in which case they must carry out and document a formal Mental Capacity Assessment.

Nevertheless, the patient may prefer to use equipment and strategies regarded as less than optimal as judged by the Multidisciplinary Team. In this event, every effort must be made to resolve these issues with the patient, carers and family, and they **must** be made fully aware of their risk of developing pressure ulcer if the advice is not followed. Any divergence from recommended practice and the measures taken to overcome non-compliance must be documented. Practitioners must continue to work with patients, family and carers regarding the patient's decisions and the risks that that decision could impact on.

All discussions need to be documented within the patient's notes.

In the event that the patient is assessed not to have capacity, a best interest meeting should be held, involving all appropriate members of the Multidisciplinary Team, including the responsible doctor. Family members (including next of kin) cannot make a decision on behalf of an adult lacking capacity unless they have Power of Attorney for Health and Welfare. However, family and carers opinions should be sought during the best interest process. Following consultation with family members a safeguarding alert may need to be considered if family members are suspected of neglect or acts or omission.

Further guidance can be sought from the Safeguarding Team.

24. Discharge and Transfer Arrangements

If a plan of care for pressure ulcer prevention is in place, it is essential to communicate this on transfer of care or discharge.

Information on any pressure ulcer including category, ulcer size, ulcer site, appearance, level of exudate and if infection is present, plus a plan of care including equipment must be included as part of the discharge or transfer process.

Staff must communicate the origin of the pressure ulcer, and whether an RCA has been completed.

When planning for discharge from a 24hr care setting, to a community service, where care is limited to set number of care calls a day; thought needs to be given about replicating the number of position change and equipment that is going to be provided at home by the community service. This will ensure that the patient will be safe on discharge with the agreed level of care that has been arranged

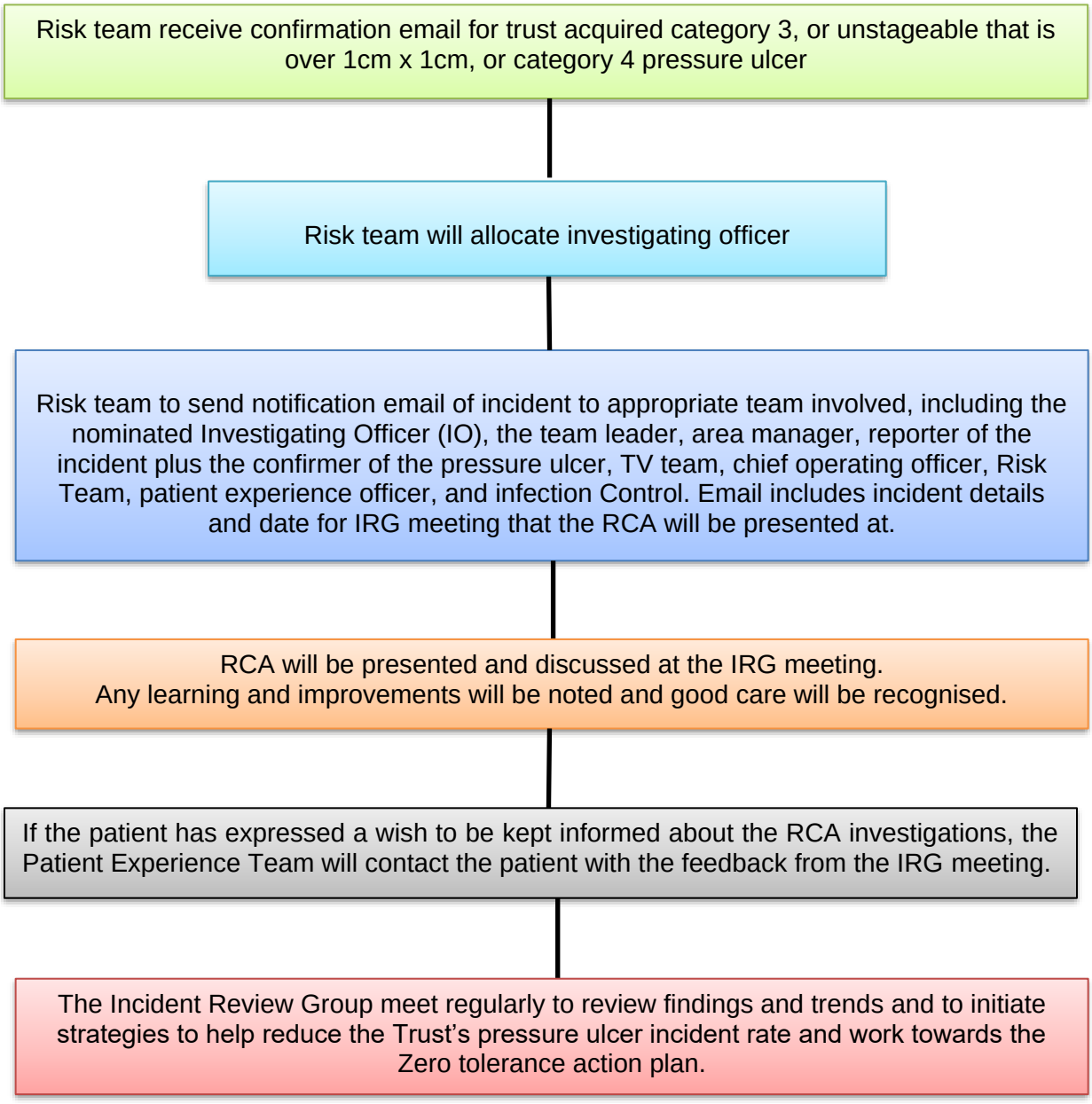
If pressure relieving equipment is required for discharge or transfer of care, this must be arranged prior to discharge.

25. Training and Resource Implications

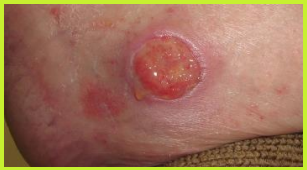
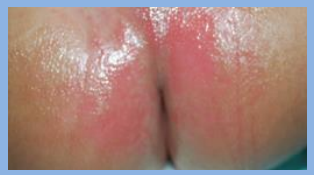
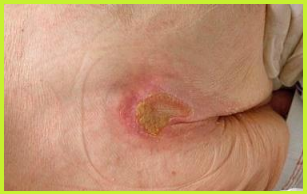
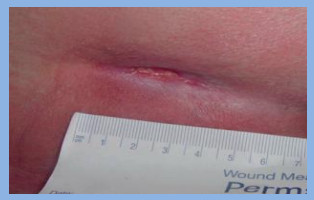
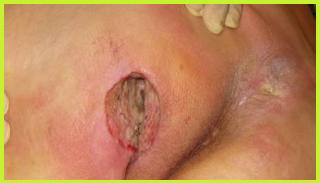
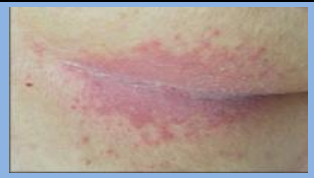
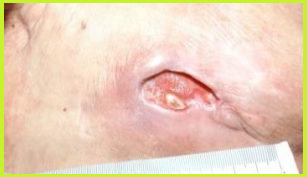
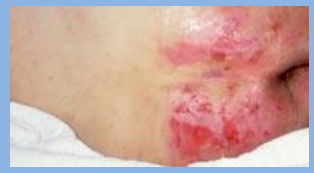
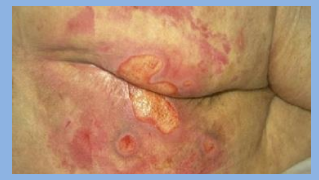
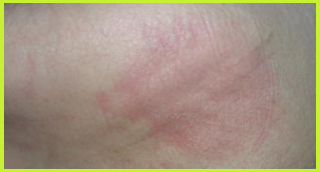
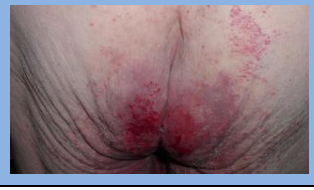
All Nursing staff will receive education on categorising, prevention, treatment, and pressure relieving equipment. This will be available via face to face sessions. The frequency of the training will be as directed in the Trust Training Needs Analysis document. Attendance data will be recorded and monitored via the training department LMS system.

Appendix 1

RCA flowchart



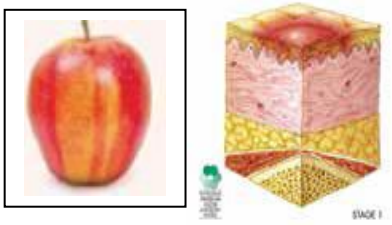
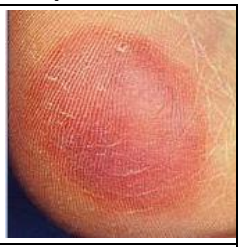
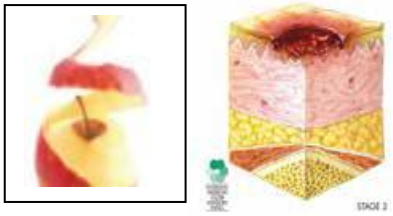
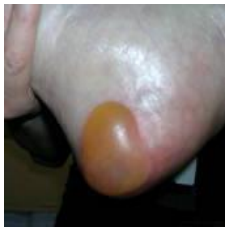
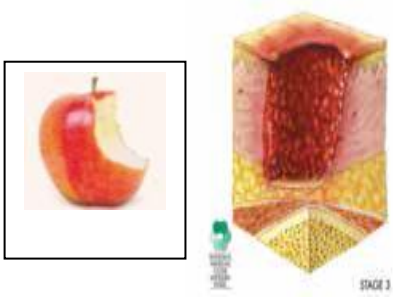
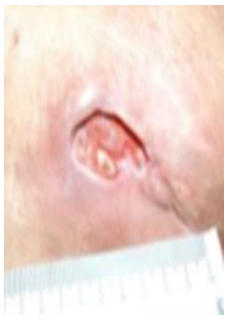
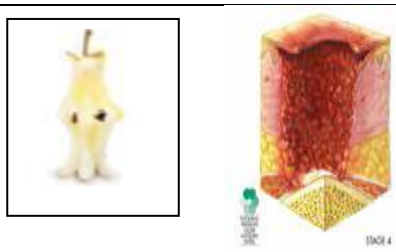
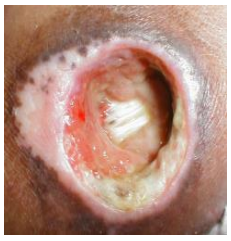
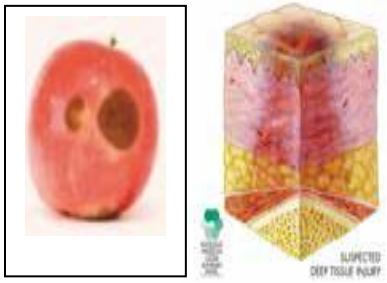
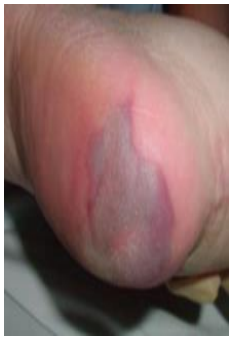
Appendix 2

Pressure ulcer		Versus	Moisture Associated Skin Damage (MASD)	
	Pressure and or shear must be present	**Causes** If both are present then wound should be classed as pressure with moisture involvement	Moisture must be present either from either urine and or faecal incontinence, or sweat, exudate, with no pressure element.	
	Usually over a bony prominence and limited to a defined spot.	**Location** It is possible to develop pressure ulcer over soft tissue if the area is being compressed by a device such as catheter/nutritional/ oxygen tube. This needs to be documented as a device related pressure ulcer.	Can be any part of the sacrum/buttocks/ groin that has come into contact urine and or faecal incontinence. Wounds in gluteal cleft and are a linear shape are likely to be moisture.	
	Circular in shape or with defined regular edges.	**Shape** Fiction can also cause circular skin damage particularly on the heels- pts history and observation will help decision making	Irregular or diffused shape that may be symmetrical across both buttocks (kissing ulcer)	
	Can be superficial, or full thickness skin loss depending on the category of pressure ulcer	**Depth** Friction in both pressure and moisture damage will cause wound edges to be jagged and torn.	Superficial skin loss only, however if the MASD gets heavily infected, extent and depth of tissue loss can extend.	
	Reduced blood supply to the skin caused by prolonged exposure to pressure will result in necrosis forming.	**Necrosis** Once necrosis is present skin damage is most likely to be a category 3 or above pressure ulcer.	Necrotic tissue will not normally be present as blood supply to the tissue has not been disrupted by pressure.	
	If redness is non-blanchable then skin damage is most likely to be category 1 pressure ulcer.	**Red skin** Light pink, yellow or white colour may indicate maceration from moisture.	Redness is very patchy not uniformly distributed over the area	

Appendix 3

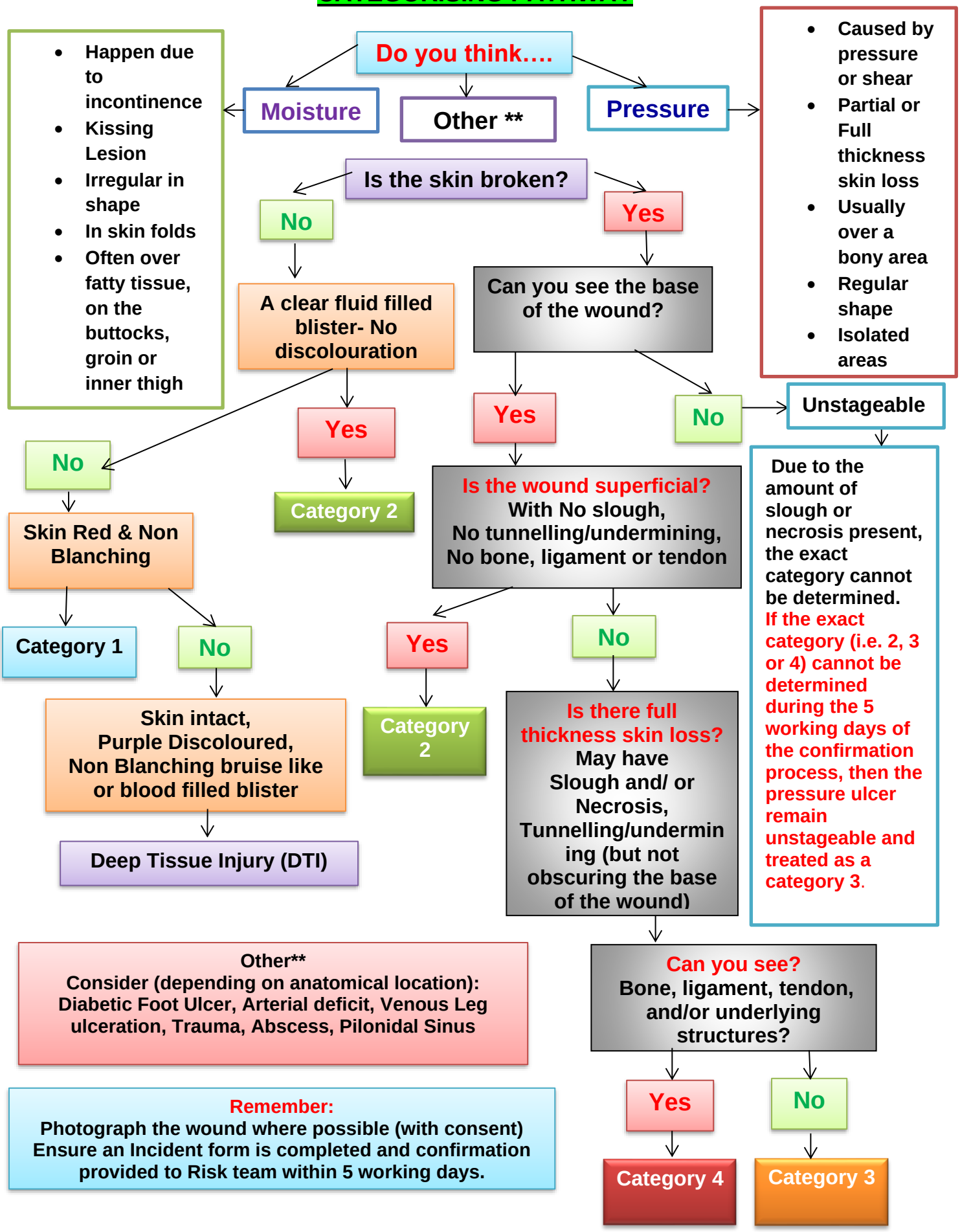
Pressure ulcer Categorising Tool

Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Classification system (version 2)

<u>Category 1</u> - Non Blanching Erythema -Intact skin with non-blanching redness -Usually over a bony prominence. -The area may also have a change in texture, temperature or may be painful. -Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding skin		
<u>Category 2</u> - Partial Thickness Skin Loss - Partial thickness skin loss of the epidermis, dermis or both. - Presents as a superficial shallow open ulcer -Wound bed can contain pink (epithelialising) or red (granulating) tissue, **but no slough**. -May also present as an intact clear blister with no bruising or discolouration.		
<u>Category 3</u> - Full Thickness Skin Loss -Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. -May include undermining and tunnelling. -Slough and necrotic tissue may be present on parts of the wound bed **but not obscure the full depth**. -The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have fatty tissue so depth of these ulcers may be shallow. In contrast areas with large amounts of fatty tissue can develop very deep category 3 ulcers.		
<u>Category 4</u> - full thickness tissue loss -Full thickness skin loss with exposed or palpable bone, tendon, or muscle. -Slough and necrotic tissue may be present on parts of the wound bed. -Depth will vary depending on anatomical location. -May include undermining and tunnelling.		
<u>Unstageable</u> – depth unknown -Pressure ulcers that due to the amount of slough or necrosis present, the exact category cannot be determined. -If the exact category (ie 2,3 or 4) cannot be determined during the 7 working days of the confirmation process, and the pressure ulcer remains unstageable it will be treated as category 3 pressure ulcer, as the extent of the damage will be full thickness. - In the future, when the full extent of the pressure ulcer can be determined, a new incident will need to be completed stating that the previous unstageable pressure ulcer is now a category 3 or category 4.		
<u>Deep tissue injury</u> - depth unknown -Skin is intact but area is a deep purple or maroon colour. -Also includes blood filled blister and blisters that have discoloured base under the blister tissue. -The area may be painful, firm, boggy, warmer or cooler compared to adjacent tissue. -Deep tissue injury may be difficult to detect on darkly pigmented skin. -Over time the discoloured area may resolve, or the tissue damage may evolve into an open ulcer, if this happens <u>a new incident will need to be completed for category 3, 4 or unstageable</u>		

Appendix 4

CATEGORISING PATHWAY



Appendix 5

Pressure Ulcer Checklist and Communication Tool For Patients & Carers- ASSKING BUNDLE

SSKIN pressure ulcer care bundle

Prevention

Use in conjunction with Pressure Ulcer care plan

Name:

Address:

Postcode:

Date of birth: NHS Number:

NHS Midlands and East

Trust/hospital:
Team/ward:

Care delivered? ✓ or ✗ (if ✗, record reasons why not overleaf)

Date (DD/MM/YY)										
Time – use 24 hour clock										
Surface										
Mattress appropriate (please state)										
Cushion appropriate (please state)										
Functionality/integrity check of equipment performed										
Skin Inspection										
Skin management										
Keep Moving										
Use of repositioning chart										
Incontinence/Moisture										
Urine										
Bowels										
Sweat										
Nutrition/Hydration										
Diet (please state)										
Fluids (please state)										
Is referral required?										
If yes, has it been made?										
Do care plans need updating?										
If yes, has this been done?										
Initials										

Code	Descriptor
RA	Patient has mental capacity but has refused assessment and /or will not comply with agreed plan of care including repositioning or maintaining position
MC	Patient does not have mental capacity to comply
CI	Critical illness with haemodynamic or spinal instability precludes turning or repositioning and may lead to unavoidable pressure ulcers
CE	Patient is known to a health care professional but an acute or critical event occurs, which affects the patients mobility or ability to reposition. This may include the patient being undiscovered following a fall or loss of consciousness or cardiac arrest
SC	Carers not implementing plan (community only)

Date & time	Record element	Reason for not delivering care	Initials

SSKIN pressure ulcer care bundle

Treatment

Use in conjunction with Pressure Ulcer care plan

Name:

Address:

Postcode:

Date of birth: NHS Number:

NHS Midlands and East

Trust/hospital:
Team/ward:

Care delivered? ✓ or ✗ (if ✗, record reasons why not overleaf)

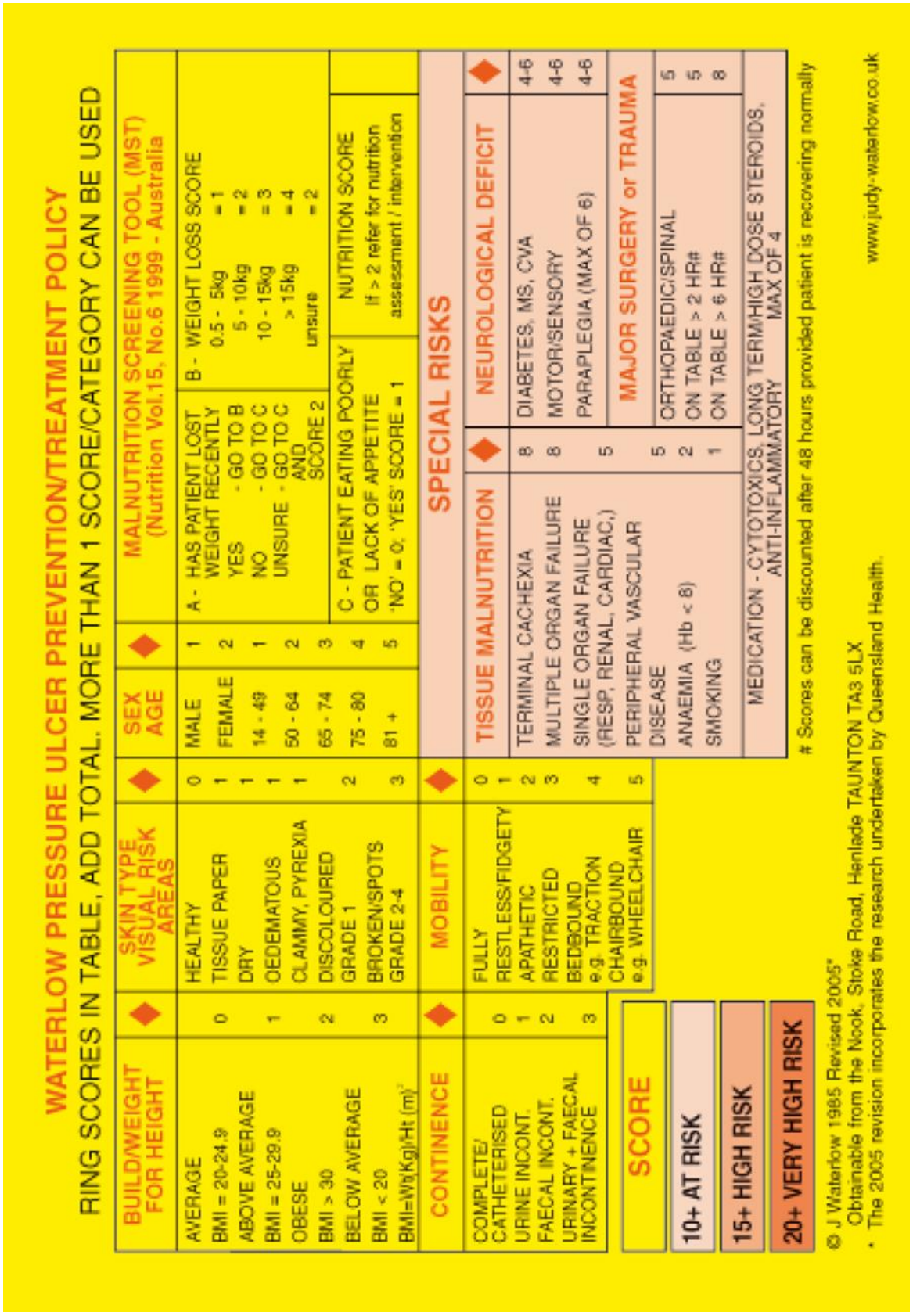
Date (DD/MM/YY)										
Time – use 24 hour clock										
Surface										
Mattress appropriate (please state)										
Cushion appropriate (please state)										
Functionality/integrity check of equipment performed										
Skin Inspection										
Skin management										
PU wound management										
Keep Moving										
Use of repositioning chart										
Incontinence/Moisture										
Urine										
Bowels										
Sweat										
Nutrition/Hydration										
Diet (please state)										
Fluids (please state)										
Referral made (in accordance with local guidelines)										
Do care plans need updating?										
If yes, has this been done?										
Initials										

Code	Descriptor
RA	Patient has mental capacity but has refused assessment and /or will not comply with agreed plan of care including repositioning or maintaining position
MC	Patient does not have mental capacity to comply
CI	Critical illness with haemodynamic or spinal instability precludes turning or repositioning and may lead to unavoidable pressure ulcers
CE	Patient is known to a health care professional but an acute or critical event occurs, which affects the patients mobility or ability to reposition. This may include the patient being undiscovered following a fall or loss of consciousness or cardiac arrest
SC	Carers not implementing plan (community only)

Date & time	Record element	Reason for not delivering care	Initials

Appendix 6

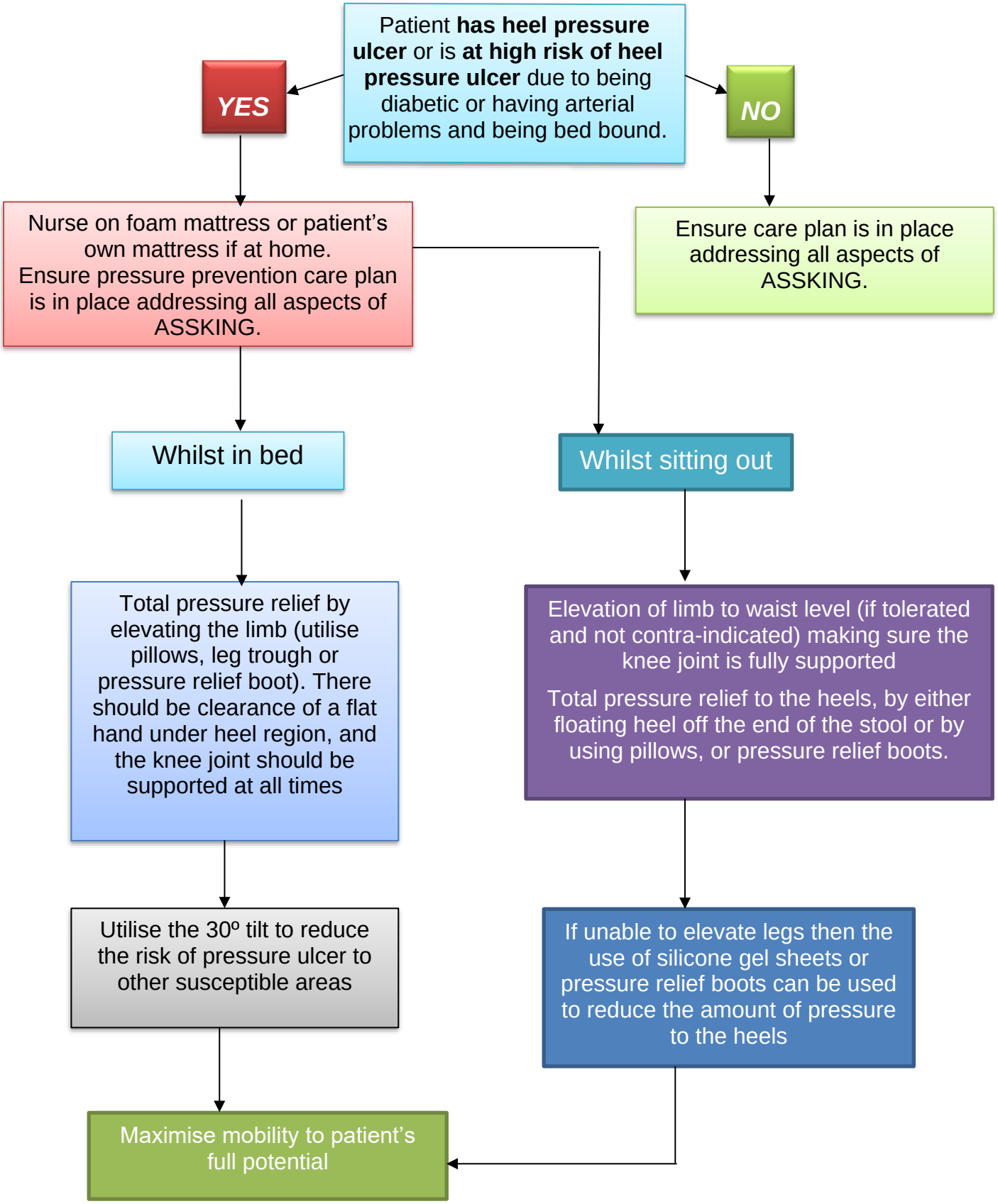
Waterlow Pressure Ulcer Risk Calculator (adapted)



Appendix 7

Management of Pressure Relief to Heels

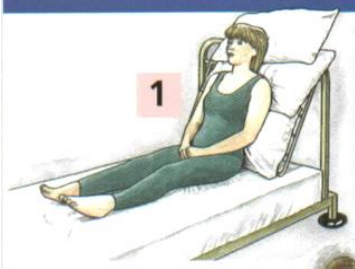
This flow chart should always be used in combination with the full Policy



Appendix 8

SIMPLE....SAFE.... EFFECTIVE.... 30° *TILT*

SEMI-RECUMBENT POSITION



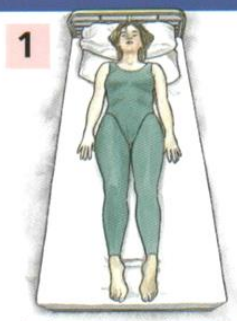
The patient's lower back should be positioned as far into the pillows as possible, to support the lumbar spine. Plump or fold the lower pillow if necessary.

The legs are supported as in diagram 3 and 4 of the recumbent position. Ensure that the heels are clear of the mattress and that the feet are correctly positioned.

An additional pillow is placed underneath the others. The corner is carefully positioned under the buttock to *'tilt'* the body and give clearance to the ischial tuberosities and sacrum.

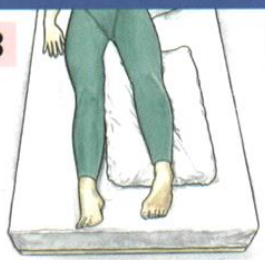
The full semi-recumbent 30° *'tilt'* position.

RECUMBENT POSITION

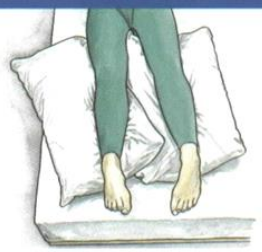


Lie the patient in the centre of the bed. Use one or two pillows to support the head and neck.

Use a further pillow to support the lumbar region and shoulder. This *'tilts'* the patient onto one buttock and lifts the sacrum clear of the mattress. Use your hand to check this clearance.



Support the full leg by placing it centrally on another pillow. Ensure that the heel overhangs the edge of the pillow.



An additional pillow gives further comfort to any unsupported areas of the other leg.

The full recumbent 30° *'tilt'* position.

POINTS TO REMEMBER

1. Illustration 6 demonstrates the necessity to use an additional pillow to prevent 'drop foot'.
2. It is important to explain the whole procedure to the patient, prior to repositioning, and to continue reassuring them.
3. Remember to ask the patient if they are comfortable and check their position at regular intervals.
4. The 30° tilt is used to promote patient comfort and reduce pressure over high risk areas. It should be used with, and not in place of, an appropriate pressure reducing support surface/mattress.

SUPPORT AND COMFORT

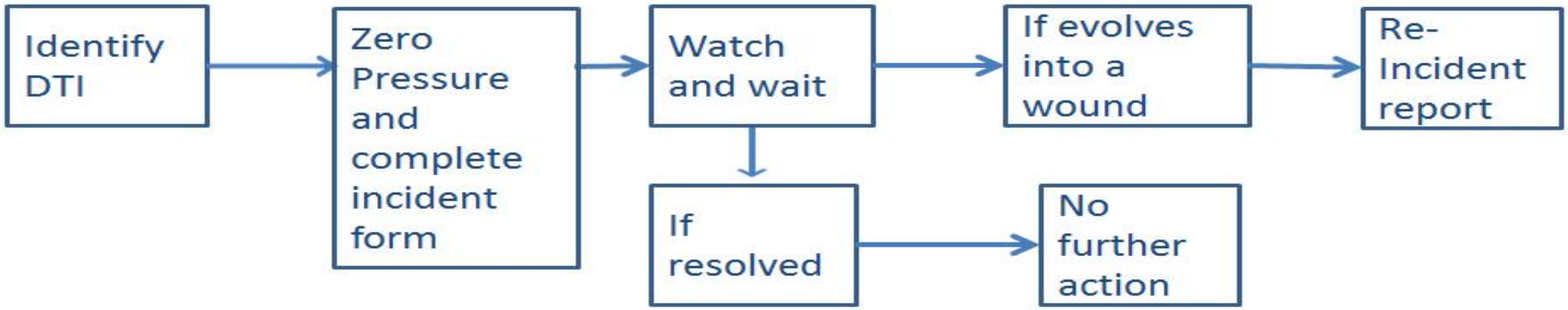
30° TILT POSITIONING TECHNIQUE - REFERENCES

Preston KW (1988) Positioning for comfort and pressure relief: the 30 degree alternative. *Care - Science and Practice* 6 (4): 116-119. **Seiler WO, Allen S, Stahelin HB (1986)** Influence of the 30 degree laterally inclined position and the 'Supersoft' 3 piece mattress on skin oxygen tension on areas of maximum pressure - implication for pressure sore prevention. *Gerontology* 32: 158-166. **Seiler WO, Stahelin HB (1979)** Skin oxygen tension as a function of imposed skin pressure - implication for decubitus ulcer formation. *J of Am Geriatric Soc* XXV11 (7): 298-301. **Colin D, Abraham P, Preault L, Bregeon C, Saumet J-L (1996)** Comparison of the 90° and 30° laterally inclined positions in the prevention of pressure ulcers using transcutaneous oxygen and carbon dioxide pressures. *Adv Wound Care* 9:3.

Appendix 9

Identification, Assessment and Management of Deep Tissue Injury

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust



If there is a breakdown of DTI it will be classed as a serious incident and will have a Root Cause Analysis (RCA) completed.
DIT's can resolve or evolve into a category 3/4/unstageable pressure ulcer

What is not a DTI? →

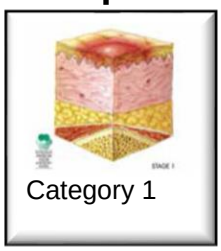
Appendix 10

Acquired Pressure ulcer Flowchart

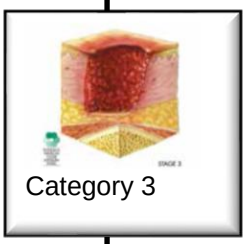
Patient develops pressure ulcer (or existing pressure ulcer deteriorates to a higher category), whilst receiving care from NSCHT.

- Complete wound assessment chart
- Ensure pressure ulcer prevention care plan is in place and up to date,
- Ensure all other appropriate assessments are completed such as Waterlow, MUST, manual handling and Continence etc.
- Photograph to be taken with consent if possible and uploaded to Lorenzo

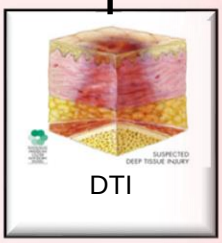
Incident form to be completed within 24 hours, stating acquired, if device related and type of tissue damage.

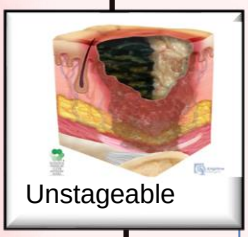

Category 1


Category 2


Category 3


Category 4


DTI


Unstageable

Complete wound assessment every 2 weeks

Is the wound 1 x 1 cm or less in size?

YES

NO

Watch and wait flowchart

Watch and wait flowchart

Is the wound 1 x 1 cm or less in size?

YES

NO

Watch and wait flowchart

Improving

>Continue to reassess wound every 2 weeks
>Downgrade equipment when appropriate
>Discharge when healed if no further healthcare input needed

Static

>Reassess wound every 2 weeks
>Follow factors affecting wound healing guide
>Refer to Tissue Viability if no improvement noted.

Deteriorating

Restart pressure ulcer flowchart

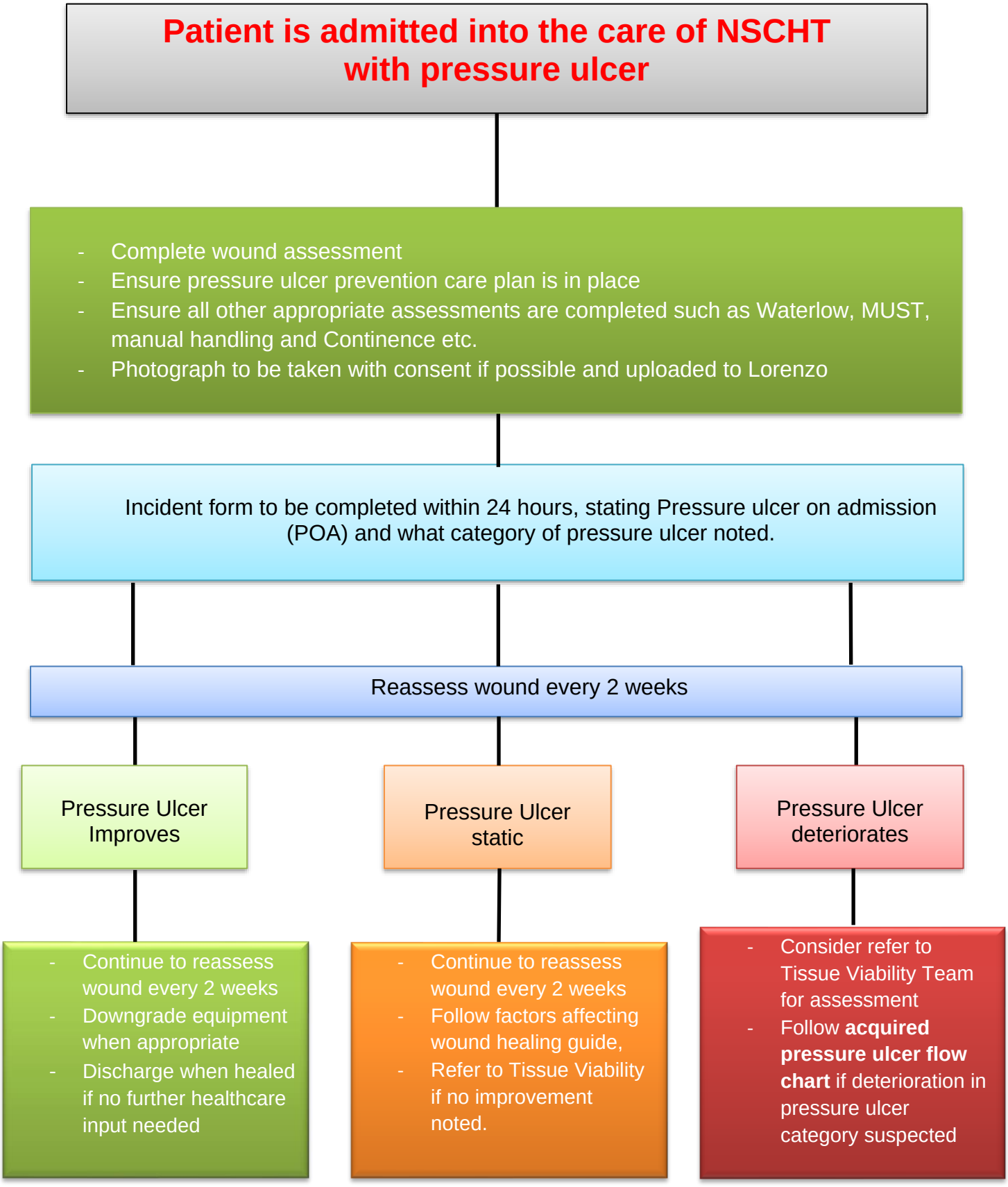
Pressure ulcer to be confirmed by a Verifier within 5 working days

Pressure ulcer to be confirmed by a Verifier within 5 working days

Note: If wound is on the foot and the patient is diabetic, incident report as a diabetic foot ulcer, not pressure ulcer and refer to podiatry services. Podiatry services will do a full assessment and if main cause is pressure, then a new incident form for pressure ulcer needs to be completed.

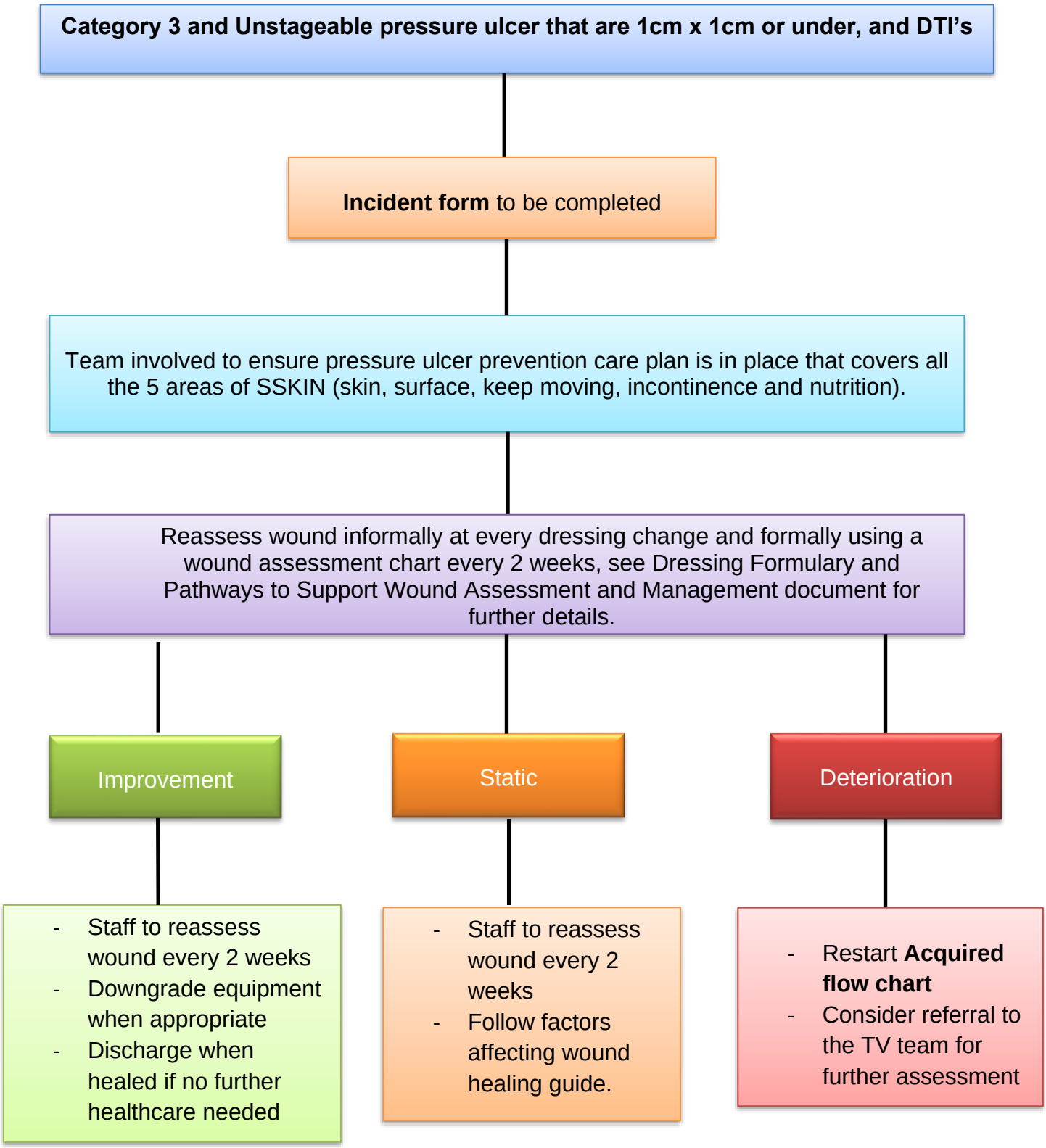
Appendix 11

Pressure ulcer on admission (POA) Flowchart



Appendix 12

Watch and Wait



Appendix 13

VERIFICATION/CONFIRMATION OF PRESSURE ULCER PATHWAY

All of the following categories of pressure ulcer will need to be confirmed:
- Acquired unstageable over 1cm x 1xm
- Acquired category 3 over 1cm x1cm
- Acquired Category 4 all sizes
- Pressure ulcer (either POA or acquired) that has deteriorated in NSCHT care and becomes one of the above categories

Once incident reported the category of the pressure ulcer must be confirmed by a nurse that has been deemed competent at categorising pressure ulcers. The findings need to be reported back to the Risk Team.
This must be done within 5 working days

A verbal apology must be given to the patient at the time of confirmation for all category 3 and unstageable pressure ulcer that are over 1cm x1cm and all category 4 pressure ulcers

An email is to be sent to **Risk Management Team** on the day the confirmation has taken place. The following information is required.

VERIFICATION DETAILS:
- Patient Name
- Incident Number
- Directorates
- Pressure ulcer Category
- Size of wound
- Date Verified
- Is the patient End of Life?
- Location of Pressure ulcer
- Name of Nurse confirming category
- Photo on Lorenzo yes/no

Once confirmed the Risk Team will contact the area and will outline when the RCA needs to be completed for, who the investigating officer will be, and when the RCA will to be presented at the

Incident Review Group

For further support or guidance please contact:

Tissue Viability Team North
0300 123 0905 Ext 6125