# PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

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<th>Purpose of Issue/Description of Change</th>
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<tr>
<td>July 2012</td>
<td>Three</td>
<td>To outline evidence based practice for the Prevention and Management of Pressure Ulcers</td>
<td>2016</td>
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**Named Responsible Officer:** Tissue Viability Specialist Nurse  
**Approved by:** Quality, Patient Experience and Risk Group  
**Date:** August 2013

**Target Audience:** Multidisciplinary

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THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION
## Title

**Procedure for Pressure Ulcer Prevention and Management**

## Purpose

To outline evidence based practice for the Prevention and Management of Pressure Ulcers

## Author

Tissue Viability Team

Quality and Governance Service (QGS)

## Impact Assessment

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<th>No</th>
<th>Actions Required</th>
<th>Yes</th>
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## Subject Experts

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## Document Librarian

QGS

## Groups consulted with:

Clinical Policies and Procedures Group

## Date formally approved by Risk and Governance Group

31st July 2013

## Infection Control Approved

26.06.2013

## Method of distribution

- Email ✓
- Intranet ✓

## Archived

- Date 18/07/2012
- Location S Drive QGS

## Access

Via QGS

### VERSION CONTROL RECORD

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<td>Version 1</td>
<td>Tissue Viability Specialist Nurse</td>
<td>R/TC</td>
<td>Responsibilities clarified when joint care package in place with a Care Home</td>
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<tr>
<td>Version 2</td>
<td>Tissue Viability Specialist Nurse</td>
<td>R/TC</td>
<td>To add in a section regarding responsibilities and delegation of care</td>
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<tr>
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<td>Tissue Viability Specialist Nurse</td>
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<td>To clarify that wound reassessment for pressure ulcers will be weekly and to add an appendix for potential of pressure ulcers for wheelchair users and loan of equipment from Community Equipment Service for patients in respite care</td>
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Status – New / Revised / Trust Change
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PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

Introduction

Pressure ulcers represent a major source of distress for patients in terms of physical, social and financial implications, as well as affecting quality of life for patients and their carers. Nurses will follow this procedure to prevent pressure ulcer development for those at risk and to reduce the occurrence of pressure ulcers for patients on the Wirral.

The principles are based on clinical guidelines recommended by the National Institute of Clinical Evidence (NICE 2005), the Royal College of Nursing (RCN 2005), and Commissioning for Quality and Innovation (DH 2008)

Aim

• To ensure that all patients receive evidenced based care for the prevention and management of pressure ulcers
• All patients with a Grade Two Pressure Ulcer and above, pressures ulcer must be reported using the Trust Incident Reporting System

Completion of Pressure Ulcer Documentation

When nurses are assessing patients and completing Initial Assessment Community Nursing Documentation, there is a section for nurses to assess patients at risk of pressure ulcer development. To guide and enable nurses to complete the relevant documentation there are flow charts at the end of this procedure in the appendix section:

• Appendix 2 Flow Chart 1 - For the Prevention of Pressure Ulcers
• Appendix 3 Flow Chart 2 - For the Assessment and Management of patients with existing or new pressure ulcers

The flowcharts highlight all current documentation currently being used within the Trust.

Target Group

Community nurses, Auxiliaries, Assistant Practitioners and Wheelchair Service employed by the Trust who are required to deliver pressure ulcer prevention and care management.

Related Trust Policies and Procedures

Please refer to related policies and procedures

Training

All staff in the Trust are required to comply with mandatory training as specified in the Trust’s Mandatory Training Matrix. Clinical Staff are also required to comply with service specific mandatory training as specified within their service training matrix.
**Definition of a Pressure Ulcer**

A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (European Pressure Ulcer Advisory Panel (EPUAP), 2009).

**DIFFERENCE BETWEEN PRESSURE ULCER AND MOISTURE LESION**

If damage is not associated with pressure, friction or shear, other possible causes need to be identified, such as epidermal stripping due to traumatic removal of tapes or dressings, eczematous skin, sweat or incontinence.

The difference between pressure damage and moisture damage may be distinguished by location, shape and depth.

**MOISTURE LESION CAUSES**

<table>
<thead>
<tr>
<th>Causes</th>
<th>Likely to indicate pressure ulcer</th>
<th>Likely to indicate moisture lesion</th>
</tr>
</thead>
<tbody>
<tr>
<td>If pressure / shear and moisture are simultaneously present, the ulcer could be a combination lesion.</td>
<td>Pressure and / or shear / friction present.</td>
<td>Moisture must be present (e.g. shining wet skin caused by urinary incontinence or diarrhoea. Urine, faeces, sweat and / or exudate</td>
</tr>
<tr>
<td>Location</td>
<td>Tends to be located over a bony prominence</td>
<td>Limited to the anal cleft and has a linear shape. Not located over a bony prominence. Peri-anal erythema/ skin irritation most likely to be a moisture lesion due to faecal matter.</td>
</tr>
<tr>
<td>A combination of friction moisture can result in moisture lesions in skin folds.</td>
<td>Limited to one spot. Circular or regular shape, with the exception of friction damage.</td>
<td>Diffuse – different superficial spots. In a kissing ulcer shape (paired or copy lesions that are capable of coming into contact).</td>
</tr>
<tr>
<td>Shape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depth</td>
<td>Skin remains intact (grade 1) Partial- thickness skin loss top layer (grade 2). Full thickness skin loss (grades 3-4).</td>
<td>Superficial partial-thickness skin loss – if a moisture lesion becomes infected, the depth and extent of the lesion can be enlarge/deepened extensively.</td>
</tr>
<tr>
<td>Necrosis</td>
<td>Occurs with pressure ulcers.</td>
<td>No necrosis with moisture lesions</td>
</tr>
<tr>
<td>Edges</td>
<td>Edges tend to be distinct.</td>
<td>Often irregular lesions – diffused or irregular edges.</td>
</tr>
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lesion, it will result in a superficial skin loss.

| Colour          | Red skin non-blanching (grade 1). | Erythema – If the redness is not uniformly distributed, the lesion is likely to be a moisture lesion. Pink or white surrounding skin – this indicates maceration due to moisture. |

**Intrinsic Factors**

There are a number of intrinsic factors, which contribute to the development of tissue damage which should be considered during the assessment.

<table>
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<th>Extrinsic Factors</th>
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<td>Increasing age</td>
<td>Reduced mobility</td>
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<tr>
<td>Chronic illness</td>
<td>Neurological deficit</td>
</tr>
<tr>
<td>Poor oxygen perfusion</td>
<td>Poor nutritional intake and dehydration</td>
</tr>
<tr>
<td>Body weight (thin/obese)</td>
<td>Incontinence</td>
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<td>Major surgery</td>
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<td>Level of consciousness</td>
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**Extrinsic Factors**

The extrinsic factors involved in the development of pressure ulcers are:

- Pressure
- Friction
- Shearing
- Moisture
- Medication

**Assessment**

All patients who are deemed to be at risk of pressure ulcer development are assessed using formal assessment methods to determine their level of risk of pressure ulcer development. When completing pressure ulcer assessment documentation the nurse will need to complete a body map chart that correlates with the assessment documentation using a numbering system e.g. 1, 2, 3. Clinical assessment needs to include routine medical history, physical and psychosocial history and patient preferences and the following documentation needs to be completed:

**Patients at risk** – Follow Flow chart 1 - Prevention of Pressure Ulcers (Appendix 1)

**Patients with existing or new pressure ulcers** – Follow Flow chart 2 - the Assessment and Management of Patients with Existing or New Pressure Ulcers (Appendix 2)

The (EPUAP) classification tool should be utilised when assessing the extent of tissue damage. This will provide a formalised specific and valid grade of tissue damage. This
will aid in determining appropriate pressure redistribution equipment and suitable sterile dressings, as well as influencing the patient’s 24 hour care needs.

Formal risk scales should be used in conjunction with clinical judgement (NICE 2005). This enables staff to formulate an individualised care plan identifying pressure-reducing measures which should take into consideration the care setting that the patient is being cared for in.

A holistic wound assessment is needed to decide the most appropriate methods of wound management and dressing selection.

**Care Homes**

Patients living in a Care Home who are funded for residential care may require nursing care from the Community Nursing Service.

Following assessment for the management of pressure ulcers, community nurses must discuss with the manager / duty manager at the Care Home the level of care required by the home care staff to prevent and/or manage pressure ulcers in between community nurses visits.

Community nurses must document the expected level of shared care for the patient on a care plan for Care Home staff to follow; this may include advice on frequency of repositioning, manual handling and the skin integrity check list. Community nurses must review and reassess care at least weekly and document any deviations from care in the patient’s health records.

Community nurses must liaise with the Care Home Manager at stated periods as defined by care plan, e.g. weekly, fortnightly etc. The minimum contact is monthly.

If the Care Home does not deliver the agreed shared care arrangements despite discussions with Care Home manager, Trust nurses will complete an incident form using the Trust’s incident reporting system and the nurse will refer to the Safeguarding Team if appropriate.

If the Care Home cannot meet the needs of the patient for the prevention and management of pressure ulcers, the community nurse will inform the manager of the Care Home that the nurse will be discussing the level of care required for the patient with their line manager, to discuss potential alternative arrangements for care.

**Wheelchair Service**

For patients who have a wheelchair provided by Trust’s wheelchair service who have or developed a pressure ulcer, each individual will have been prescribed an appropriate cushion at the time of issue of the wheelchair.

If any concerns that the cushion is not meeting the clinical need of the patient refer back to wheelchair service.
Dressing Selection

Decisions about choice of dressing or topical agent for those with a pressure ulcer should be based on:

- Ulcer assessment
- General skin assessment
- Treatment objectives
- Previous positive effect of dressing/technique
- Manufacturers indications for use and contra-indications
- Risk of adverse events
- Patients preference
- Wirral wound dressing formulary

Create an optimum wound healing environment by considering the use of modern dressings (for example, hydrocolloids, hydrogels, foams, films, alginates)

Consider anti-microbial therapy in the presence of systemic and/or local signs of infection (Trust Antibiotic Formulary)

Wound Re-Assessment

Reassessment of the ulcer should take place as a minimum weekly but may be required more frequently, depending on the condition of the wound and the result of holistic assessment of the patient.

For pressure ulcers grade 2 – 4 skin integrity must be assessed weekly using the skin integrity checklist.
For grade 1 pressure ulcers skin integrity checklist must be completed at least monthly.

For pressure ulcers grade 2 - 4 that do not show evidence of healing within 4-6 weeks, refer to Tissue Viability Specialist Nurses (TVN) for advice and support and a joint visit if required.

If required, discuss with multidisciplinary team for possible referral for surgical intervention, surgery is not usually indicated in patients who have grade 1 or 2 pressure ulcers. It is usually used as an intervention in those with grade 3 or 4 pressure ulcers.

For patients at risk of pressure ulcers or have healed pressure ulcers reassessment for pressure ulcer equipment should be at least every three months for as long as it is required. The ordering officer for the equipment has the responsibility for the monitoring of the patient and need for equipment.

Photography

Following European Pressure Ulcer Advisory Panel (EPUAP 2009) recommendations, Trust health professionals will reassess and photograph the pressure ulcer at least monthly or if clinical need dictates. All nursing teams will have access to this equipment, and any problems accessing equipment to be raised with line manager.
Health professionals must obtain consent for the use of photographs, for each episode of care, using Trust Consent for Photography Form, available on the Trust intranet.

Photographs of the pressure ulcer will be printed, one copy for the patient’s records and one copy for the base notes, identifying the image with the patient’s full name, date of birth and NHS Number. No digital images must be stored on individual computers.

**Wound Debridement** – (Refer to: Procedure for Conservative Sharp Debridement)

Debridement involves the removal of dead or necrotic tissue, or other debris, from the wound to reduce the wound’s biological burden. A number of terms are used to describe dead tissue in wounds: necrosis, slough and eschar.

Clinicians should recognise the positive potential benefit of debridement in the management of pressure ulcers. Decisions about the method of debridement should be based on:

- Ulcer assessment (condition of wound)
- General skin assessment
- Previous positive effects of debridement techniques
- Manufactures indications for use and contra-indications
- Risk of adverse events
- Patient preference (lifestyle, abilities and comfort)
- Characteristic of dressing/technique
- Treatment objectives

It is also important to assess vascular status when debriding from an extremity such as lower limb, clinicians should undertake a Doppler Ultrasound to record ABPI of the limb prior to considering debridement of the foot.

The sharp debridement of loose, devitalised tissue must only be carried out by tissue viability specialist nurses (TVN). Contact the TVN if debridement is required.

Podiatrists must follow Procedure for Conservative Sharp Debridement for Community Podiatrists.

**Nutritional Status**

All patients at risk of pressure ulcer development will be assessed by completing Pressure Ulcer and Nutrition Risk assessment Form. Staff must refer to the current Trust Protocol for Best Practice in the Identification and Treatment of Malnutrition in Adults. A generic Nutritional Care Plan must be initiated for medium or high risk patients. All documents are available on Trust staff zone.

Malnutrition is frequently cited as a risk factor for the presence, development and non-healing of pressure ulcers. Best practice entails monitoring the nutritional status of individuals as part of a holistic assessment and as an ongoing process throughout an individual’s episode of care. Patients need to be re-assessed at least monthly or earlier if the patient’s condition changes.
Certain diseases and treatments such as cancer and mal-absorption syndromes, surgery, radiotherapy and chemotherapy can either reduce absorption of food or increase nutritional requirements. Hypo-albuminaemia (An abnormally low concentration of albumin in the blood) low levels of iron, vitamin A and C and zinc status can all affect the healing rates of wounds.

If specialist advice is required refer to the Community Dietetics Team to arrange a joint visit.

**Pain Assessment**

Pressure ulcers can be a great source of pain and can affect an individual’s quality of life. Pain assessment must include: whether the individual is experiencing pain; the causes of pain; level of pain using a pain assessment chart; as well as location and management interventions. The patient’s pain *must* be assessed at each visit and documented appropriately either on the patient’s pain assessment chart or the wound chart which should be located within the patient’s health care records. If pain is not managed effectively then discussion should take place with the patient’s General Practitioner regarding adequate analgesia for pain relief. Assessment should include appropriate repositioning techniques, equipment and pressure relieving devices and any discussions or recommendation must be documented.

**Infection**

Chronic wounds often harbour a variety of bacteria to some degree and this can range from contamination through colonisation to infection. When a wound becomes infected it can display the classic characteristic signs of heat, redness, swelling, pain, heavy exudates and malodour. The patient may also develop generalised pyrexia. However, immuno-suppressed patients, diabetic patients or those on systemic steroid therapy may not present with the classic signs of infection. Instead they may experience delayed wound healing, breakdown of the wound, presence of friable granulation tissue that bleeds easily, increased production of exudates and malodour, and increased pain.

Careful wound assessment is essential to identify potential sites for infection, although routine swabbing of the area is not considered beneficial. If infection is suspected, obtain swab and await results prior to treatment if required.

Contact the TVN if further advice is required.

**Repositioning**

Patients at risk of pressure ulcer development are repositioned to minimise pressure friction and shearing. The frequency upon which this is done is determined by the patient’s condition, comfort and skin integrity. Evidence to support this action should be in the form of accurate documentation with explicit information regarding:

1. Position
2. Time and Date
3. Members of staff involved
4. Condition of the skin
5. Other nursing care performed
6. Advice to carers
7. Evaluation including repositioning recommendations should be documented.

Repositioning will be detailed in the patients care plan, outlining who will perform the task, how often and what education to the carer’s have been given to conduct this safely.

Individuals assessed at an elevated risk should consider whether sitting should be restricted to less than 2 hours per session (NICE 2005).

If a patient resides in a residential/nursing home then specific advice to formal carers should be documented in the care plan and evidence that a Helping to Prevent Pressure Sores Leaflet has been issued to the staff, available on the Trust web site.

Risk Assessment

Patients who sit out for more than 2 hours have an increased risk of developing pressure ulcers over their ischial tuberosities, natal cleft and sacral areas due to body weight focusing onto these areas.

Patients and carers need to be advised of implications of ‘long term seating’ (Tissue Viability Society 2009) and be educated around alternative positions in the chair, fully document advice in the patients’ records.

Patients assessed as being at risk of pressure ulcer development need to be nursed as a minimum on an Option One mattress (Page 14) as based on pressure ulcer assessment documentation, not solely on the Waterlow Risk Assessment, in conjunction with clinical judgement for which a clear rationale has been documented.

A number of factors need to be considered when deciding on which pressure redistributing mattress to use:-

1. Clinical efficacy
2. Ease of maintenance
3. Impact on nursing procedures
4. Patient acceptability, including manual handling and transfer, double bed, hospital beds
5. Home or care home
6. Ease of use
7. Formal or informal carer providing care

This would be on a conditional basis but thereafter every 3 months, this must include a review of the patient’s pressure redistributing equipment and the reassessment and outcome must be recorded in the patients pressure ulcer documentation.

Equipment is available from the Community Equipment Service and staff must refer for equipment as soon as possible following assessment, for any urgent requests for equipment nurses should contact the community equipment manager for advice.

Community nurses must have a system in the Team in place to monitor that equipment has been provided for the patients, as ordered and subject to ongoing evaluation.

The provision of pressure redistributing equipment should form part of an overall prevention strategy and never as a sole intervention.
Any problems in obtaining equipment need to be reported using Trust Incident Reporting System and discussed with your line manager.

**LOAN OF EQUIPMENT FOR PATIENTS IN RESPITE CARE**

If a patient is admitted to a care home for respite care who requires pressure relieving equipment, a profiling bed, a pressure relieving mattress and a pressure relieving cushion can be ordered. When the client leaves the residential setting, the community nursing team must contact the Community Equipment Service (CES) and the CES will arrange for the equipment to be collected from the residential home.

**CARE OF EQUIPMENT**

All staff must be competent to care for equipment supplied by the Community Equipment Service and the CES runs monthly equipment awareness days that include fault finding sessions for new ordering officers.

**Generic Care Plans**

- Generic care plans are available on the Trust staff zone as outlined in the documentation flowcharts

A detailed care plan must be in the patient’s health records supported by specialist advice from the Tissue Viability Team as appropriate.

**Delegation of Care**

The delegation of nursing care must be appropriate, safe and in the best interests of the patient at all times and the decision to delegate must always be based on an assessment of their individual needs (NMC 2008). Where Trust staff delegate clinical tasks to non registrants within the team, they will retain accountability and responsibility for that delegation via supervision:

- Registered nurse to reassess patient’s at least monthly dependent on grade of pressure ulcer (EPUAP). To determine whether condition is stable and predictable – or sooner if clinically indicated
- Trust staff should only delegate clinical tasks to other members of staff whom they deem clinically competent and able to fully understand the nature of the delegated task and also what is required of them.
- Health care assistants should be encouraged to understand their limitations and recognise when it would be unsafe to proceed with a clinical task which has been delegated to them. In this instance, the member of staff should contact the Community Nursing team and liaise with the most appropriate member of staff.
- The assistant practitioner/ auxiliary nurse/ bank nurse must document their findings as per Trust record keeping procedure and report any changes to the senior nurse on duty
- Providing support and supervision to the assistant nurse practitioner /auxiliary nurse / bank nurse as per Supervision Procedure
- Ensuring robust documentation of the delegated care.
**Skin Care**

All patients at risk of pressure ulcer development must have their skin assessed as part of the whole assessment process. This will include general assessment of the skin, but with particular attention to high risk areas, i.e. observation and management of the skin.

<table>
<thead>
<tr>
<th>Heels</th>
<th>Sacrum, natal cleft</th>
<th>Cranium</th>
<th>Skin over ischial tuberosities (particularly relevant for patients who are sat out for prolonged periods)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbows</td>
<td>Hips</td>
<td>Pinna</td>
<td></td>
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**Skin Integrity Check List**

Observation and management of the skin integrity will reduce the incidence of skin deterioration and breakdown. Where appropriate or clinically indicated skin inspection and findings should be recorded and documented using skin integrity check list. The frequency of reassessment of the patient’s pressure areas using the skin integrity checklist should be documented within the patient’s care plan.

For pressure ulcers grade 2 – 4 skin integrity must be assessed weekly using the skin integrity checklist.

For grade 1 pressure ulcers skin integrity checklist must be completed at least monthly

Blanching erythema is an indication of early pressure, with timely intervention further damage can be prevented

Formal or informal carers should be educated on how to inspect the patient’s skin in between episodes of care provided by community nurses. Carers should also be advised that any concerns should be reported to community nurses as soon as possible for reassessment of the patients’ skin condition, to prevent further trauma. Carers must be given a copy of ‘Helping to Prevent Pressure Sores’

**Examination of erythema should include:**

- Apply light finger pressure to the area for 5 seconds
- Release pressure. If the area is white and then return to the original erythema, this can indicate that the superficial circulation remains intact.
- If on release of the pressure the area remains the same colour as before pressure was applied, it is an indication of pressure ulcer development and further preventative strategies must be employed (non re-active hyperaemia).
- If further skin discoloration is observed by redness, purple, black or blistering with an increase in heat or swelling, this may indicate deeper tissue damage. This is particularly relevant when induration or hardening of the underlying tissue is palpated. Health care professionals need to be vigilant when caring for patients with darkly pigmented skin. (NICE 2005)
Hygiene

Over use of soaps and water may undermine skin integrity when combined with urinary and/or faecal incontinence. Urine and faeces can undermine skin integrity through changes in PH and contribute to shear and friction susceptibility. Non soap based foam cleansers are an alternative. Refer to the Clinical Protocol for Skin Care using Emollients and Ointments.

Continence Management

Community Nurses should carry out continence assessments for palliative care patients as required in the Trust Continence Procedure, if any concerns refer to continence specialist nurse for advice and fully document in the health records.

Incontinence may increase the risk of developing pressure ulcers. The key factor is moisture to the skin, which puts it at a greater risk from maceration, friction and shearing forces. Therefore, effective management of incontinence is an essential part of skin care and fundamental to maintaining a person’s dignity and comfort.

Manual Handling

Manual handling issues relating to the repositioning of patients need to be assessed, involving both informal and formal carers.

Consider the implications for care across a variety of care settings including the independent sector, day and night services as required.

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

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

Generic care plan for manual handling for informal carers is available on Trust intranet.

Nurses’ Responsibilities:

- To assess pressure ulcer risk at first contact with every patient, complete relevant documentation and the relevant pathway followed for the prevention and management of pressure ulcers
- To have a care plan for pressure ulcer prevention and management in the patients health records individualised to the needs of the patient
- When delegating care to formal/informal carers care plans will be in the health records individualised to the needs of the patient
- To complete incident forms for grade two and above pressure ulcers
- Team leaders/caseload managers must ensure adequate supplies of patient information leaflets for the prevention of pressure ulcer

Team Leaders Responsibilities:

- To comply with audits undertaken by Tissue Viability Specialist Team or other nominated audit lead
- To monitor compliance with this procedure
To keep a record of staff attendance at Tissue Viability Training

**Equipment**

All equipment must be checked regularly to ensure fit for purpose; any concerns contact Community Equipment Service.

If equipment is supplied by wheelchair service, health professionals must liaise with the wheelchair service. **Community nursing team must liaise with the Wheelchair Service, as changes in clinical need may require re assessment.**

If equipment is supplied by any other service, health professionals must liaise with the appropriate service.

If wheelchairs have been purchased privately but pose pressure ulcer risk, wheelchair service can be contacted for advice.

**Pressure Redistribution Cushion Options**

For mattress selection or cushion assessment complete a formal assessment that needs to consider distribution of weight, postural alignment and support of feet. Even with appropriate pressure relief, it may be necessary to restrict sitting time to a maximum of 2 hours until the level of risk changes. Although there has been guidance from the National Institute of Clinical Excellence (NICE 2005) with regards to the minimum mattress provision, there is no such guidance for cushions only that no one seat cushion has been proven to perform better than another.

<table>
<thead>
<tr>
<th>CUSHION PROVIDION – AT RISK TO ELEVATED RISK</th>
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</thead>
<tbody>
<tr>
<td>Cushion Gel / foam mix</td>
</tr>
<tr>
<td>Grades 1 – 4 EPUAP (European Pressure Ulcer Advisory Panel)</td>
</tr>
</tbody>
</table>

Clear guideline instructions are provided with all mattresses from Community Equipment Service. Some patients may require specialist seating assessment (Tissue Viability Society 2009), nurses need to consider referral to appropriate services for example occupational therapist or wheelchair centre.

**Pressure Redistributing Mattress options**

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

- repositioning,
- seating,
- skin inspection

All patients assessed as being vulnerable to pressure ulcers should, as a minimum provision, be placed on a high specification foam mattress with pressure-relieving properties (NICE 2005).

An alternating system or other high-tech pressure relieving system should be employed, under the following criteria

- As a first line preventative strategy for people at risk as identified by assessment.
• When the individual’s previous history of pressure ulcer prevention and/or clinical condition indicates that he or she is best cared for on a high tech device.
• When a low tech device has failed (NICE 2005)

Nurses must document in the patient’s care plan the appropriate mattress pump setting for those mattresses which are not automatically set. Formal / Informal care staff must also be instructed regarding the correct mattress pump settings.

<table>
<thead>
<tr>
<th>MINIMUM PROVISION</th>
<th>STATIC FOAMS</th>
<th>HIGH TECH EQUIPMENT &amp; VERY HIGH RISK MATTRESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW TECH FOAM MATTRESS</td>
<td>HIGH RISK MATTRESSES</td>
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<tr>
<td>RISK</td>
<td>RISK</td>
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<tr>
<td>High Risk Grade 1 - 2</td>
<td>Very High Risk Grade 3 - 4</td>
<td></td>
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</tbody>
</table>

Where to get advice from

Contact Specialist Tissue Viability Team for any advice or guidance as required.

If a patient is a wheelchair user and at risk of developing a pressure ulcer or has a pressure ulcer seek advice from the wheelchair service

**Incident Reporting**

The National Institute for Health and Clinical Guidelines (NICE 2005) recommends that all pressure ulcers graded 2 and above must be reported as a clinical incident via Trust Incident Reporting system. Pressure ulcers grade 2 and above will be reviewed and maybe subject to a root cause analysis, in order to learn from experience and improve patient care.

**Safeguarding**

In any situation where staff may consider the patient to be a vulnerable adult, they need to follow the Trust Safeguarding Adult Policy and discuss with their line manager and document outcomes.

**Referrals**

Any referrals to health professionals, therapists or other specialist services must be followed up and all professional advice or guidance documented in the patients health records.

**Equality Assessment**

During the development of this procedure the Trust has considered the clinical needs of each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation). There is no evidence of exclusion of these named groups.
If staff become aware of any clinical exclusions that impact on the delivery of care a Trust Incident form would need to be completed and an appropriate action plan put in place.

References

Clinical Protocol: Skin Care using Emollients & Ointments. Use current version of Wirral Community NHS Trust

Commissioning for Quality and Innovation (DH 2008)


https://uhra.herts.ac.uk/dspace/bitstream/2299/190/1/100614.pdf


Malnutrition Universal Screening Tool (MUST). Malnutrition Advisory Group (MAG) May 2004

National Institute of Clinical Excellence (NICE) The Management of Pressure Ulcers in Primary & Secondary Care: A Clinical Practice Guideline (September 2005) in collaboration with the Royal Collage of Nursing (RCN)

National Pressure Ulcer Advisory Panel (NPUAP) July 2007 http://www.npuap.org/print.htm

NHS Wirral Antimicrobial Guidelines for the Management of Common Infections in Primary Care (2012); 7th Edition. Wirral Drug and Therapeutics Committee


Safeguarding Adults Policy: Use current version of Wirral Community NHS Trust


Bibliography

PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

APPENDIX 1

All New Patients on the Caseload

FLOW CHART 1 – For Prevention of Pressure Ulcers

Complete the following documentation

INITIAL ASSESSMENT COMMUNITY NURSING OR ADVANCE CARE PLANNING PATIENT AND CARER ASSESSMENT (PACA)
Includes Pressure Ulcer and Nutritional Risk Assessment /Must Assessment

If Pressure Ulcer and Nutritional Risk Assessment score is around 10 and health professional considers patient not at risk of pressure ulcer development, this must be recorded on initial assessment documentation or palliative care documentation

At risk of pressure ulcer development

Yes

Complete the following:
• Supplementary Pressure Ulcer Prevention / Management Form
• Manual handling assessment (if required)
• Complete body map

IF Pressure Ulcer and Nutritional Risk Assessment is 10 or more and patient clinically assessed as being at risk of pressure ulcer development

Put the following in place and individualise to patients needs:
• Care Plan – Pressure Ulcer Prevention and management
• Care Plan - Prevention of Pressure Ulcers for Domiciliary & Residential Carers (if required)
• Care Plan – Delegation of Manual Handling Activities to Informal carers
• Consider care plan for nutritional support
• Consider pain assessment chart
• Consider frequency of completing skin integrity check list

No

Not at risk of pressure Ulcer development tick no and go to next section healthy lifestyle promotion or continue to complete Advance Care Planning Patient and Carer Assessment (ACP PACA)

IF PATIENT DEVELOPS A PRESSURE ULCER FOLLOW GUIDELINES IN FLOW CHART 2
FLOW CHART 2 – For the Assessment and Management of Patients with Existing or New Pressure Ulcers

Complete the following documentation:

- Complete Initial Assessment Community Nursing documentation or Advance Care Planning Patient and Carer Assessment (PACA)
- Joint Comprehensive Assessment – If required
- Pressure Ulcer and Nutrition Risk Assessment / MUST assessment tool
- Manual handling assessment (if required)
- Skin integrity checklist – (if required)
- Supplementary Pressure Ulcer Prevention / Management Form
- Wound Assessment Form – (if required)

Complete an Incident Form for Grade 2 or above

COMPLETE THE FOLLOWING:
  - Care Plan - Pressure Ulcer Prevention and Management (each pressure ulcer must have an individual care plan)
  - Care Plan – Prevention of Pressure Ulcers for Domiciliary and Residential Carers
  - Care plan for nutritional support (if required)

REFER TO TISSUE VIABILITY SERVICE (If required)

ALWAYS FOLLOW THE PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

Commence the following care plans to meet the patient’s clinical needs:
Procedure for the Prevention and Management of Pressure Ulcers for users in wheelchairs

The Wheelchair Service assesses and supplies wheelchairs, specialist seating and pressure distribution cushions for adults and children with long-term mobility problems. All wheelchairs are issued with an individually prescribed pressure cushion.

Following an individual assessment and considering all factors such as level of mobility, current/historic pressure concerns and a postural assessment, the appropriate level of seating and pressure relieving cushion will be individually prescribed. Wheelchair users are advised to contact the wheelchair service if there are any changes in their condition which would affect equipment provision.

Appropriate or specialist equipment can enable the patient to achieve an optimum seated posture. Poor seating or an asymmetric posture can be a key cause of skin breakdown.

Pressure Ulcer Prevention for Wheelchair Users

The risk of pressure ulcers amongst permanent wheelchair users is high. This direction provides health professionals with guidance to minimise the risk of developing pressure ulcers for patients who are permanently seated in wheelchairs.

When seated a high proportion of body weight is supported by the ischial tuberosity and buttocks, the sacrum and upper thigh. Further body weight is supported by the arms (where armrests are in use) and the feet.

Areas where pressure ulcers can develop while seated:

- Ischial tuberosities
- Sacrum
- Trochanter
- Popliteal Fossa (back of knee)
- Bony prominences of the spine
- Scapula
- Heels

Other sites that may be affected less frequently:

- Elbows
- Medial aspect of knees
- Palms of hand during manual wheelchair propulsion
- Genitals in some seated patients with severe postural difficulties
- Head/ear

Wheelchair prescription and the prevention of pressure ulcers
Consideration of the wheelchair user’s posture when seated in the wheelchair is essential to minimise the risk of developing a pressure ulcer. Variables to consider when minimising risk of pressure ulcers while seated in wheelchairs should include the configuration of the wheelchair e.g.

- Height of the seat
- Depth of the seat
- Width of the seat
- Backrest height
- The angle between the seat and the back of the chair
- Style of armrests
- Footrest/arm rest heights
- Tilt in space (if provided)
- The prescribed equipment is used/ is being used correctly

Assessing an individual's need for seating can be complex and assessment should be carried out by an appropriately trained health professional. A key part of the seating assessment is the requirement to inform the individual, the patient’s family and carer (if present), upon why seating or cushions may be provided and how to use and maintain the equipment.

It is important to explain factors that may suddenly increase the individual’s risk of developing pressure ulcers including changes of routine (long journeys, holidays), length of time spent in wheelchair and changes in their condition (including medical, nutritional or continence status and wellbeing).

The wheelchair service carries out multi-disciplinary assessments for complex pressure ulcers/postural concerns. These are carried out by the appropriate member of the team, which consists of a Consultant in Rehabilitation Medicine, Rehabilitation engineer, Therapists and support staff.

**Preventative measures must include:**

- Documented evidence that the importance of skin integrity and the potential risks of developing a pressure ulcer has been explained to the patient
- A patient information leaflet offered
- Advising patient on healthy lifestyles and appropriate referrals where appropriate i.e. smoking cessation, good nutrition
- Documented assessment of potential risks e.g. incontinence, poor diet
- Advising patients how to use a mirror to check skin integrity
- Importance of repositioning (if appropriate) / self-positioning

Positioning of individuals who spend substantial periods of time in a wheelchair should take into account: distribution of weight; postural alignment and support of feet, arms, trunk etc. Healthcare professionals need to share information to ensure joint working/ appropriate prescription of equipment.

As a general rule, wheelchair users will need to change their position at least once every 15 to 30 minutes (NHS Choices 2013). Many permanent wheelchair users cannot achieve this but need to be aware of the risks. In the community, wheelchair users spend up to 18 hours a day in a wheelchair (Stockton and Parker, 2002). Many are subject to sustained unrelieved pressures due to their lack of pressure-relieving movement.
There is little evidence that one cushion of the same risk rating is better than another (McInnes et al, 2008). It is important to consider all factors of user’s daily life when prescribing pressure cushions e.g. transfers, comfort and weight of cushion.

**Pressure Ulcer Management:**

Health professionals in the Wheelchair Service must liaise with the relevant community nursing team when appropriate to ensure safe continuity of care. Community nursing teams must liaise with the Wheelchair Service, as changes in clinical need may require reassessment. All professionals involved need to consider all aspects of daily living and position (24 postural management) e.g. static seating, bed etc.

**REFERENCES**

