Pressure Ulcers: Detection, Prevention and Treatment Policy

Part 1

(Part 2 – Separate Appendices)
<table>
<thead>
<tr>
<th>Section</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>2 PURPOSE</td>
<td>4</td>
</tr>
<tr>
<td>3 SCOPE</td>
<td>4</td>
</tr>
<tr>
<td>4 RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>5</td>
</tr>
<tr>
<td>4.1 The Trust</td>
<td>5</td>
</tr>
<tr>
<td>4.2 Chief Executive</td>
<td>5</td>
</tr>
<tr>
<td>4.3 Director and Senior Managers</td>
<td>5</td>
</tr>
<tr>
<td>4.4 Tissue Viability Nurse Specialist</td>
<td>5</td>
</tr>
<tr>
<td>4.5 Matrons and Clinical Team Leaders</td>
<td>5</td>
</tr>
<tr>
<td>4.6 Registered Healthcare Professional</td>
<td>6</td>
</tr>
<tr>
<td>4.7 Healthcare Assistants</td>
<td>6</td>
</tr>
<tr>
<td>4.8 All Staff Members</td>
<td>6</td>
</tr>
<tr>
<td>5 PROCEDURE/IMPLEMENTATION</td>
<td>7</td>
</tr>
<tr>
<td>5.1 Risk Assessment</td>
<td>7</td>
</tr>
<tr>
<td>5.2 Skin inspection</td>
<td>8</td>
</tr>
<tr>
<td>5.3 Risk assessment and skin inspection</td>
<td>8</td>
</tr>
<tr>
<td>5.4 Guidelines for Specialist patient groups</td>
<td>11</td>
</tr>
<tr>
<td>5.5 Categorisation of Pressure Ulcers</td>
<td>14</td>
</tr>
<tr>
<td>5.6 Pressure Relieving Devices</td>
<td>18</td>
</tr>
<tr>
<td>5.7 Equipment selection</td>
<td>19</td>
</tr>
<tr>
<td>5.8 Treatment of Pressure Ulcer</td>
<td>22</td>
</tr>
<tr>
<td>5.9 Liaison between care setting</td>
<td>25</td>
</tr>
<tr>
<td>6 TRAINING IMPLICATIONS</td>
<td>25</td>
</tr>
<tr>
<td>7 MONITORING ARRANGEMENTS</td>
<td>26</td>
</tr>
<tr>
<td>8 EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>26</td>
</tr>
<tr>
<td>8.1 Privacy, Dignity and Respect</td>
<td>26</td>
</tr>
<tr>
<td>8.2 Mental Capacity Act</td>
<td>26</td>
</tr>
<tr>
<td>9 LINKS TO OTHER PROCEDURAL DOCUMENTS</td>
<td>27</td>
</tr>
<tr>
<td>10 REFERENCES</td>
<td>27</td>
</tr>
<tr>
<td>11 APPENDICES (Part 2 – available on Policy web page)</td>
<td>29</td>
</tr>
<tr>
<td>Appendix 1 South Yorkshire &amp; Bassetlaw Pressure Ulcer Good Practice Protocol for Safeguarding</td>
<td></td>
</tr>
<tr>
<td>Appendix 2 PURPOSE T - Pressure Ulcer Risk Assessment –</td>
<td></td>
</tr>
<tr>
<td>Appendix 3 React to RED – Advice for Carers</td>
<td></td>
</tr>
<tr>
<td>Appendix 4 Mattress Flow Chart – Selection Criteria for Management and prevention of Pressure Ulcers in line with NICE Guidance</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Contents</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Re-Positioning Schedule</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Continence and Tissue Viability</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Leaving Slings In-situ Guidelines</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Simple, Safe, Effective – The 30° Tilt</td>
</tr>
<tr>
<td>Appendix 9</td>
<td>Pressure Ulcer Grades</td>
</tr>
<tr>
<td>Appendix 10</td>
<td>Wound Management Guideline with TIME</td>
</tr>
<tr>
<td>Appendix 11</td>
<td>Strategic Executive Information System (STEIS) form</td>
</tr>
<tr>
<td>Appendix 12</td>
<td>Root Cause Analysis, Pressure Ulcer (RCA) Form</td>
</tr>
<tr>
<td>Appendix 13</td>
<td>Informed Refusal Form</td>
</tr>
<tr>
<td>Appendix 14</td>
<td>Safe Use of Bed Rails</td>
</tr>
<tr>
<td>Appendix 15</td>
<td>A Guide to Basic Seating, The Importance of Correct Seating Posture</td>
</tr>
<tr>
<td>Appendix 16</td>
<td>NERDS and Stones</td>
</tr>
<tr>
<td>Appendix 17</td>
<td>Tissue Viability and Lymphoedema Service (TVALS) Referral Form.</td>
</tr>
<tr>
<td>Appendix 18</td>
<td>Discharge/Transfer Form for Patients with Wounds</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

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 (NPUAP-EPUAP Pressure Ulcer Definition 2009).

Pressure damage is common in many health settings, affecting all age groups, and is costly in both terms of human suffering and resources. Most pressure damage could be prevented and it is important to have prevention and educational strategies in place based upon the best available evidence.

2. PURPOSE

- Raise staff awareness of the risks of pressure ulcer formation and staff acknowledgement that no action or omission on her/his part leads to either unnecessary pressure ulcer development or deterioration of an existing pressure ulcer (NMC 2015).
- Assist staff in the detection, prevention and management of pressure ulcers and reflects a multidisciplinary approach
- Underpin the implementation of the NICE Clinical Guideline 29 for the Prevention and Treatment of Pressure Ulcers (NICE 2005 and NICE Quality Standards 2015.) and to provide a standardised approach to pressure ulcer detection, prevention and management within the Trust. Document can be viewed on www.nice.org.uk/CG029.
- All patients/service users within the Trust will have their risk of pressure ulcer development assessed on admission to in-patient areas and/or on first community visit.
- All patients/service users within the Trust assessed to be at risk of developing a pressure ulcer will have the correct evidence based preventative measures employed, according to the degree of risk and taking into account the wishes of the patients/carers, including their option to decline intervention and medical conditions.
- Patients/service users who have a pressure ulcer will also have the correct treatment regime in line with national/ regional and local guidance

3. SCOPE

This policy applies to all staff employed by the Trust including agency and bank staff, those with an honorary contract or work experience whilst undertaking duties on behalf of the Trust or working on Trust premises and forms part of their arrangements with the Trust. As part of good employment practice, agency workers are also required to abide by the Trust policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work for the Trust.

This policy is intended for use predominantly in the community, Tickhill Road
Hospital site in-patient services and in-patient services for older people. However, it may also be relevant for all other In-patient services and the need for a pressure ulcer risk assessment will be determined by the physical assessment on admission, in line with the Policy for the Physical Assessment, Examination and Ongoing Care of In-patient Service Users.

In the North Lincolnshire and Rotherham localities tissue viability and wound care services is provided by North Lincolnshire and Goole NHS Foundation Trust and Rotherham NHS Foundation Trust. The tissue viability and wound care services provided are a combined hospital and community service.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 The Trust

The Trust has responsibility for the effective implementation of NICE Guidance to promote best practice. This policy relates to the Guidance for the Prevention and Treatment of Pressure Ulcers. CG29

4.2 Chief Executive

The Chief Executive responsible for there being a structured approach to procedural document development and management in place. Although responsibility for procedural document development may be delegated to other officers, accountability remains with the Chief Executive.

4.3 Directors and Senior Managers

Will make arrangements for the effective implementation and monitoring of the policy.

4.4 Tissue Viability Nurse Specialists and Tissue Viability and Lymphoedema Services (TVALS) (employed within RDASH)

- To provide expert professional advice and education on the prevention and control of infection to other professionals, multi-disciplinary groups, patients and carers.
- To lead in the investigation of identified breaches of Tissue Viability
- To advise on treatments and interventions, delegating responsibility to Trust staff as appropriate.
- To give advice on complex issues relating to Tissue Viability and report findings to the relevant Business Divisions.
- To report any breaches in policy compliance through IR1 system and to Health and Safety forum.

4.5 Matrons and Clinical Team Leaders

- Raising awareness of the policy and for its implementation and monitoring
adherence to it.

- Will identify training needs and ensure staff are appropriately trained in pressure ulcer detection, prevention and management and will record all training.
- Will ensure compliance with the Audit requirements of the policy.

4.6 Registered Healthcare Professional

- Initial and on-going assessment for prevention and management of pressure ulcers is the responsibility of a registered healthcare professional
- A standardised approach will be taken to the patient/service user’s individual health needs and pressure ulcer prevention and treatment strategy, to maintain continuity of care.
- The record of the assessment of risk must be recorded in the individual’s plan of care, noting all the relevant factors.
- If a pressure ulcer is evident this should be reported in inpatient area to the medical staff / nurse in charge, for community to senior nurse on duty
- Any pressure ulcers of Category 2 and above must be reported, using the Trust’s Safeguard Electronic Incident Reporting System. Record as inherited if present on transfer/admission to inpatient area/community caseload or acquired if developed and noted whilst an inpatient or active community caseload.
- Any Trust acquired pressure ulcer Category 3 or Category 4 must be reported using the Strategic Executive Information System (STEIS) process for Route Cause Analysis (RCA) investigation and if appropriate onward investigation through the Trust’s Serious Incident and the Trust’s Duty of Candour process.
- Any patient presenting with 4 or more pressure ulcers of any severity at any one episode of time or Category 4 pressure ulcer must be reported through the Trust’s Safeguarding Adults process as an Alert

Appendix 1 South Yorkshire & Bassetlaw Pressure Ulcer Good Practice for Safeguarding

- Any patient presenting with an ungraded pressure ulcer must be referred to senior team member and if issues with classification of grade then a referral to TVALS for the classification of category is required.

4.7 Healthcare Assistants

Healthcare Assistants may contribute to pressure ulcer care regimes by recognising the importance of and act upon the outcome of any risk assessment.

4.8 All staff members

- All staff have a responsibility to work on in line with Trust procedural
documents and should:

- Be aware of how to access them
- Be aware of those which are relevant to their work
- Act in accordance with them
- Attend any training which is offered in relation to them
- Report to their manager any issues affecting compliance with them in other that these may be taken in to account.

5. PROCEDURE/IMPLEMENTATION

Prevention of pressure ulcers

5.1 Risk Assessment

The qualified nurse will perform an initial risk assessment in first episode of care, on admission to inpatient areas within 6 hours for planned admissions and at first visit for community patients. (This may be extended up to 12 hours if the service user’s mental health state will not allow it to be undertaken within 6 hours). If the clinical presentation of the patient is “high risk” for example immobile, unconscious or critically ill then prevention strategies must be implemented immediately.

Risk assessment is a fundamental part of preventing pressure ulcers and prescribing care. Many pressure ulcer risk assessment scales have been developed but these represent only one part of the process. Individual’s risk of developing a pressure ulcer can change over a short or long period of time. It is linked with the general health and wellbeing of the individual in the majority of cases; however small changes in care or routine can dramatically increase risk. Once recognised these factors should be removed if possible or reduced as much as possible.

The Trust supports the use of Pressure Ulcer Programme of Research Tool (PURPOSE T) adapted from university of Leeds and Leeds Teaching Hospitals NHS fountain Trust as the pressure ulcer risk assessment tool.

Review risk assessment in line with care plan notification e.g. in line with Complexity Score in the community, with changes in clinical condition for example patient becomes unwell, develops incontinence or reduction in mobility or nutrition.

All patients/ service users will have a multi-disciplinary approach to their pressure ulcer prevention or treatment management. Service users with identified risk factors may require referring to other members of the health care team. Referrals to a dietician, physiotherapist or continence advisor should be made where appropriate.

Risk status can increase or decrease; both may require changes in care.
Appendix 2 PURPOSE T Risk Assessment Tool

5.2 Skin Inspection

A patient’s skin must be inspected in conjunction with use of PURPOSE T risk assessment tool. On initial contact with the health care services all individuals should have a skin inspection assessment based upon their clinical presentation and consideration of risk factors.

A patient’s skin should be inspected following every episode of repositioning, at position change and for treatment or care intervention. The appearance of skin overlying bony prominences should be clearly documented following each assessment and outcome communicated to other staff members and in the community carers.

Any existing pressure damage should be documented using the EPUAP classification tool.

Individuals who are willing and able should be encouraged, following education, to inspect their own skin / pressure areas. Where practicable the patient/service user and their family/carers should be involved in the inspection process. Any education and training should be recorded and supported with written information. The importance of reporting to the healthcare professional any areas of concern should be stressed.

Appendix 3 React to RED leaflets for patient / carers

Individual care plans will be developed from the nursing assessment, taking into account the patient /service user’s needs, preferences and legal requirements. This personalised prevention plan may include a pressure-relieving device. References made to Trust Protocol and in the community in partnership with the providers of Community Loan Equipment for the selection of pressure relief equipment for the prevention and management of pressure ulcers.

Appendix 4 Selection Criteria for Management and Prevention of Pressure Ulcers in line with NICE Guidelines

All patients/ service users will have a multi-disciplinary team approach to their pressure ulcer prevention or treatment management. Patients/Service users with identified risk factors may require referring to other members of the health care team. Referrals to a dietician, physiotherapist or continence advisor should be made where appropriate.

5.3 Risk Assessment and Skin Inspection

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
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<tr>
<td>Verbally check the identity of the patient by asking for name and date of birth. If not possible – check details with family or carers – community. Check patients ID bracelet – in-</td>
<td>To confirm that the patient/service user is correct recipient for procedure.</td>
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Treatment of the skin therefore depends on the state in which it is found, rather than routine procedure. The following principles in caring for the skin:

- Keep it clean
- Do not let it remain wet
- Do not let it dry out
- Prevent accidental damage
- Skin inspection can take place during routine care taking into account patient consent, preferences, privacy and dignity.
- Refusal to allow skin inspection should be documented and the risks fully explained to patient/service user and carer(s)

Skin assessment for individual identified at risk should be carried out after each position change; this will allow the practitioner to guide decisions on the length of time between each position change. Completion of repositioning chart will assist in care planning for assessment of pressure areas identified as high risk.

When working in partnership with other agencies, the compliance and documenting of turns and repositions and the effectiveness of the regime, to be reviewed and recorded at each visit.

**Appendix 5  Re-positioning Chart**

Patient/service user’s should have a turning/re-positioning regime and pain assessment related to the pressure ulcer or its treatment. Manage pain by eliminating or controlling the source and offer pain relief as appropriate. Seek specialist advice if necessary. Document all findings.

Where a red area is noted, apply light finger pressure for 10 seconds if the area blanches, goes pale, on removal of finger there is no damage to microcirculation. If the area remains red, non blanching erythema of intact skin, a Category 1 pressure ulcer is indicated and further action is required.

Patients/service users wearing prescribed anti-embolic stockings for up to 23.5 hours a day, they require removal, for a maximum of 30 minutes in a 24 hour period to allow the legs and feet to be washed and skin condition and integrity observed. Document all findings.
Staff should be aware of the following signs on the skin which may indicate incipient pressure ulcer development

- persistent erythema
- non-blanching hyperaemia previously identified as non-blanching erythema
- blisters
- discolouration
- localised heat
- localised oedema
- localised induration

In patients / service users with darkly pigmented skin:

- purplish/bluish localised areas of skin
- localised heat localised oedema
- localised induration
- Full assessment of skin areas can often involve removal of clothing, surgical appliances and mobility aids.
- Assessment should not only be visual as pressure ulcers can often be ‘felt’ as hot hard areas of skin (induration)
- Persistent redness (erythema) does not always lead to ulceration but must be closely observed.
- Other causes of skin damage and redness may be from incontinence rather than pressure – any area of abnormal skin should be examined by a registered nurse and documented.

Where nutritional status has been identified as a risk factor a nutritional assessment should be completed using MUST assessment tool. All patients/service users who are nutritionally compromised should have a plan of appropriate nutritional support or supplementation that meets the individual needs and is consistent with overall goals of therapy. Referral to the dietetic service should be made as appropriate.

Where incontinence and/or moisture to the skin is identified as a risk factor advice can be sought from the Continence specialist services

**Appendix 6 Continence and Tissue Viability**

Correct positioning and support is important to minimise friction and shear whether in bed, chair and wheelchair. This includes the use of pillows to keep bony prominences apart (for example knees, heels or ankles). However care should be taken to ensure that these do not interfere with the action of any other pressure relieving equipment in use. Patients/service users at risk of developing pressure ulcers because of the time spent sitting in a chair should be encouraged to sit in a chair, which is of the correct height in addition to the use of a pressure
relieving device.

Any patient/service user who is acutely ill and is at risk of developing a pressure ulcer should avoid sitting out of bed for periods longer than 2 hours (NICE 2005). The period of time should be defined in the individualised care plan but generally will not be more than two hours at any session. Individuals, where appropriate should be encouraged to reposition themselves if this is possible.

Devices to assist manual handling should be used during the transfer and positioning of patients/service users who require help with movement. These should be used in accordance with trust policy and will help to minimise skin damage from both friction and shear forces.

Appendix 7 Guidelines Leaving Slings Insitu

The use of the 30 degree tilt has been found to be beneficial to the patient. It involves the patient being positioned at a 30 degree angle using pillows, rather than at a 90 degree angle which would place them directly onto their hip and therefore at increased risk.

Appendix 8 Simple, Safe Effective the 30º Tilt

5.4 Guidelines for Specialist Patient groups

5.4.1 Critically ill patients

Consider the need to change support surfaces for patients who cannot be turned for medical reasons such as spinal instability e.g. spinal cord compression and haemodynamic instability.

Consider more frequent small shifts in position to allow some reperfusion in patients who cannot tolerate frequent major shifts in body positions e.g. utilise 30 degree tilt techniques

Prevent shear injury with the use of slide sheets for any repositioning move

If patient presents with a pressure ulcer / wound document the number of dressings and their position if filling undermining areas to ensure they are correctly removed at next dressing change. Do not pack tightly as this will cause additional pressure.

5.4.2 Bariatric obese patients

Ensure adequate assistance to fully inspect all skin folds. Pressure ulcers may occur in unique locations, such as beneath folds of skin and in locations where tubes and other devices have been compressed between skin folds.

Pressure ulcer develops over bony prominences, but may also result from tissue pressure across buttocks and other areas of high adipose tissue concentration.
Consider the use of pillows or other positions devices to off load panniculus or other large skin folds and prevent skin on skin pressure e.g. Aderma pads™. Ensure the correct fit of the bed that supports the weight of the individual and ensures sufficient width to allow turning and patient does not rest up against side rails of the bed when turned from side to side.

5.4.3 **Patients receiving palliative care**

Complete a comprehensive assessment of patient’s health status and combine this with patient’s preferences in turning, including whether they have a “position of comfort” after explaining the rationale for turning.

Establish a flexible repositioning schedule based on the patient’s preference and tolerance and the pressure redistributing characteristics of the support system. Individualise the turning and repositioning schedule, ensuring it is consistent with the patient’s goals, wishes, administration of prescribed analgesia, current clinical status and combined co-morbidity conditions as medically feasible. Document turning and repositioning as well as the factors influencing these decisions e.g. patient wishes, medical need.

Comfort is of primary importance and may supersede prevention and wound care for patients who have been diagnosed as being the final stages of dying or who have conditions causing them to have a single position of comfort. If appropriate offer stat dose of medication to the patient 20-30 minutes prior to a scheduled position change for patients who experience significant pain on movement.

Consider the following factors in repositioning:

- Protect the sacrum, elbows, and greater trochanters, which are particularly vulnerable to pressure
- Use positioning devices such as pillows as necessary to prevent direct contact on bony prominences and to avoid having the patient lie directly on a pressure ulcer (unless this is the position of least discomfort and the patients preference)
- Use heel protectors and/or suspend the length of the leg over a pillow(s) to float the heel away from the bed surface
- Use a chair cushion that redistributes pressure on the bony prominences and increases comfort for patients who are seated
- Ensure the family and carers understand the goal(s) for the patient’s plan of care

For pressure ulcer care, pain management, odour control and exudate management are the main aspects closely related to supporting the patient’s comfort. Select extended wear dressings to reduce pain associated with frequent dressing changes. If consistent with the treatment plan provide opioids and/or non-steroidal anti-inflammatory medications 30 minutes prior to dressing changes or procedures and afterwards as prescribed.
5.4.4 Spinal Cord Injured Patients

Specialist wheelchair assessment services should individualise the prescription of a wheelchair and seating support surface and associated equipment for posture, pressure re-distribution and consideration for transfers for lifestyle needs.

Use of a wheelchair is imperative for spinal-cord injured individuals but sitting will need to be restricted when pressure ulcers are present on sitting surfaces. Ideally ischial pressure ulcers heal in an environment where the ulcers are free of pressure and mechanical stress.

Total bed rest may be prescribed to create a pressure free wound environment. However this approach comes with potential physical complications e.g. muscle wasting, deconditioning, respiratory complications, psychological harm, social isolation and financial challenges if a period off employment is required.

Deconditioning is a complex process of physiological changes following a period of inactivity, bed rest or sedentary lifestyle. It results in functional losses in such areas as mental status, degree of continence and ability to accomplish activities of daily living. It is frequently associated with hospitalisation in the elderly. The most predictable effects of deconditioning are seen in the musculoskeletal system and include diminished muscle mass, decreases of muscle strength by two to five per cent per day, muscle shortening, changes in periarticular and cartilaginous joint structure and marked loss of leg strength that seriously limit mobility.

This creates a challenging dilemma for the patient and clinician to provide a balance between the physical, social and psychological need against the need for total pressure off loading. Consider referring to the surgeon for an opinion regarding surgical intervention.

5.4.5 Patients in plaster casts

A complication of wearing a plaster cast is the development of a pressure ulcer as a result of sustained pressure on the skin or caused by a plaster cast being poorly fitted or too tight.

Symptoms of a pressure ulcer under a plaster cast include:

- Feeling a rubbing or blister like pain or discomfort within the cast
- A odour from the cast
- Staining has developed on the outside for the cast
- Complaint of pain or local heat from an area under the cast

Immediate referral is required for removal/alteration to the plaster cast.

If the patient is in a leg plaster cast and turning onto their side place a pillow between the knees to prevent the cast rubbing on the other leg.
A pillow(s) positioned the length of the leg will support the heel off the bed surface and off load pressure from the heel.

5.4.6 Patients with dementia

Older people in general are at higher risk of pressure ulcers, particularly if they have difficulty moving. Dementia increases this risk further, especially as it progresses. Pressure ulcers are linked to dementia because of various associated problems:

- Mobility as people with dementia may have difficulty changing position without help. This can include problems with walking, transferring between bed and chair, or repositioning themselves. Their movement may also be restricted by others for fear of falls.
- Frailty as a result of loss of protective fat and muscle loss and thinning skin
- Poor diet and dehydration which reduce the strength and healing capacity of the skin
- Incontinent because of the damage to the skin that can be caused by moisture
- Poor blood supply with conditions such as diabetes
- Agitation or restlessness with the behavioural rubbing often over heels and elbows
- Medications that may cause sedation or drying of skin
- Communication as the person may be less able to tell someone they are in pain

When assisting a person with dementia to wash or dress take the opportunity to assess the skin at pressure points

Further information [https://www.alzheimers.org.uk/](https://www.alzheimers.org.uk/)

5.5 Categorisation of Pressure Ulcers

Assessing the Ulcer

All patients/service users who present with a pressure ulcer should receive an initial and on-going pressure ulcer assessment.

Pressure ulcers should be graded using the classification system in the European Pressure Ulcer Advisory Panel classification system of pressure ulcer categories.

Establish the origin of the pressure ulcer: if noted on transfer onto community caseload, or reason for first community visit or on admission to the in-patient area defined as inherited pressure ulcer; if developed whilst on active community caseload or an in-patient on the ward defined as Trust Acquired.
European Pressure Ulcer Advisory Panel classification system of pressure ulcer categories

Category 1: non-blanchable erythema of intact skin. Discolouration of the skin warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

Category 2: partial thickness skin loss involving epidermis or dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Category 3: full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.

Category 4: full thickness tissue loss with exposed bone tendon or muscle extensive destruction. Often includes undermining and tunnelling. The depth varies by anatomical location

Pressure Ulcer Advisory Panel Tool (EPUAP) 2009

Appendix 9 Pressure Ulcer Grades

The category of a pressure ulcer is recorded as ungraded pressure ulcer when patient/service user presents with localised area of discoloured intact skin or blister over a dark wound bed. The category is recorded as ungraded until obscuring slough and/or eschar is removed to expose the true depth of the wound. Record the incident as inherited or acquired ungraded pressure ulcer and document category when wound bed visible

When sacral ulcer(s) do not show signs of healing when appropriate wound dressing and appropriate pressure relief is achieved give consideration to other causative factors:

- Medication e.g. Nicorandal
- Incontinence dermatitis – defined as an irritant dermatitis
- Underlying medical condition e.g. renal failure
- Consequence of medical condition e.g. cancer
- Skin changes at end of life e.g. Kennedy Terminal Ulcer – located predominantly on coccyx or sacrum usually shaped like a pear, butterfly or horseshoe. They are a variety of colours including red, yellow, or black, are sudden in onset, typically deteriorate rapidly and usually indicate the death is imminent.
- Moisture lesions presents as intact skin with a history of incontinence or perspiration. Area blanches on finger pressure test
### Pressure Ulcer and Moisture Lesion Differentiation

<table>
<thead>
<tr>
<th><strong>Causes:</strong> If pressure/shear and moisture are simultaneously present, the ulcer could be a combined lesion</th>
<th>Likely to indicate pressure ulcer</th>
<th>Likely to indicate moisture lesion</th>
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<tbody>
<tr>
<td>Pressure and/or shear present</td>
<td>Moisture present. Urine, faeces, sweat and/or exudate</td>
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<tr>
<th><strong>Location:</strong> A combination of friction and moisture can result in moisture lesions in skin folds</th>
<th>Likely to be located over a bony prominence</th>
<th>Limited to the anal cleft and gas a linear shape. Not located on a bony prominence. Per-anal erythema and skin irritation caused by faecal matter.</th>
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<tbody>
<tr>
<td>Tends to be located over a bony prominence</td>
<td>Limited to the anal cleft and gas a linear shape. Not located on a bony prominence. Per-anal erythema and skin irritation caused by faecal matter.</td>
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<tr>
<th><strong>Shape</strong></th>
<th>Limited to one area. Circular or regular shape, with exception of friction damage</th>
<th>Diffuse – different superficial areas In a “kissing” ulcer shape,(copy lesion/butterfly/reflection)</th>
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<td>Limited to one area. Circular or regular shape, with exception of friction damage</td>
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<tr>
<th><strong>Depth</strong></th>
<th>Partial skin loss of top layer of skin – category 2 Full thickness skin loss Category 3/4</th>
<th>Superficial partial thickness loss – which can deepen if infected</th>
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<tr>
<td>Partial skin loss of top layer of skin – category 2 Full thickness skin loss Category 3/4</td>
<td>Superficial partial thickness loss – which can deepen if infected</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Necrosis</strong></th>
<th>Occurs with pressure ulcers</th>
<th>No necrosis in moisture lesions</th>
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<tbody>
<tr>
<td>Occurs with pressure ulcers</td>
<td>No necrosis in moisture lesions</td>
<td></td>
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<tr>
<th><strong>Edges:</strong> If friction is exerted on a moisture lesion, it will result in superficial skin loss</th>
<th>Edges tend to be distinct</th>
<th>Often irregular lesions – diffused or irregular edges</th>
</tr>
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<tbody>
<tr>
<td>Edges tend to be distinct</td>
<td>Often irregular lesions – diffused or irregular edges</td>
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<thead>
<tr>
<th><strong>Colour</strong></th>
<th>Red skin: non blanching category 1</th>
<th>Erythema</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red skin: non blanching category 1</td>
<td>Erythema</td>
<td></td>
</tr>
</tbody>
</table>

For pressure ulcer presenting on heels a Doppler or Vascular Assist is required to establish blood supply before considering use of debriding wound care products as directed for treatment aims for limb necrosis in “Wound Management Guideline with TIME (TIME is a wound assessment guide T – tissue, I – inflammation or infection, M-management of exudate, E- edge of wound )

**Appendix 10 Wound Management Guideline with TIME**

For pictorial examples of pressure ulcer grading visit

[www.epuap.org/puclas/index.html](http://www.epuap.org/puclas/index.html)
**Documentation of Pressure Ulcer**

Document the origin, length, width, depth, wound bed presentation and category (using the above classification system) in the patient/service user’s care plan.

At first recording complete the Wound Care Integrated Pathway of Care (IPoC) and record variances as they present.

Healing pressure ulcers should not be reverse graded. A category 4 pressure ulcer does not become a category 3 as it heals it should be described as a healing category 4 pressure ulcer.

Reasons for deterioration in a pressure ulcer should be noted and if not expected a through reassessment should be under taken.

All pressure ulcers within the Trust Category 2 or above must be reported using the Trust’s Safeguard Electronic Incident Reporting system (IR1) recognising the occurrence of pressure ulcers as adverse events. In the community the details of the incident registration number to be recorded as a reminder in the patient’s electronic records on Patient Home page.

Trust acquired Category 3 and Category 4 to be reported as serious incident logged on the Trust’s Strategic Executive Information System (STEIS) within 24 hours of the incident happening and Route Cause Analysis (RCA) investigation commenced. The completed RCA is presented at the trust’s Pressure Ulcer Serious Incident Panel where it is determined if the pressure ulcer is avoidable or unavoidable and if a Safeguarding concern has been identified and further investigation is required.

**Appendix 11 Strategic Executive Information System (STEIS) form**

**Appendix 12 Route Cause Analysis for Pressure Ulcers (RCA) form**

The majority of pressure ulcers are entirely preventable through risk assessment and the implementation of pressure relieving measures. However the NPUAP (2010) issued a statement on unavoidable pressure ulcers, agreeing that patients who choose not to participate in their own pressure ulcer prevention regime could develop unavoidable pressure ulcers. The panel issued the revised definition of an unavoidable pressure ulcer as: “Unavoidable – means that the individual developed a pressure ulcer even though the provider had evaluated the individual’s clinical condition and pressure ulcer risks: defined and implemented interventions that are consistent with the individuals need goals and recognised standards of practice; monitored and evaluated the impact of the intervention: and revises the approached as appropriate”

The simple fact that a person at risk has a pressure ulcer, even a Category 3 or Category 4, or multiple pressure ulcers, more than 3 or 4 at a lower category or mixed categories, is not in itself a reason to suspect abuse or neglect. There are a number of factors to help decide whether it potentially indicates neglect or whether it indicates a need for care providers to improve practice.
These factors include:

- The person’s physical health and existing medical conditions
- Any skin conditions the person may have
- Any other signs of neglect, such as poor personal hygiene
- The appropriateness of their care plan and whether it has been properly carried out
- The person’s own view, and the views of their family and friends, on the treatment and care.

Consider these factors against The Care Act: Three Point Check (for Section 42 enquiry)

The safeguard duty applies to any adult who:

1. Has need for care and support (whether or not the authority is meeting any of those needs) AND
2. Is experiencing, or is at risk of, abuse or neglect AND
3. As a result of that need is unable to protect themselves from either the risk of or the experience of abuse or neglect

Staff will record in the appropriate document/care plan the patients/service users and carers understanding and comprehension of pressure ulcer prevention or management plans. This to include information on the patient’s capacity to understand the information to ensure informed choose. The patients capacity to be recorded on completion of Mental Capacity Form (MCA form)

Staff will record in the appropriate document/care plan the distribution of patient/carer information

Staff will record in the appropriate document/care plan efforts to re-enforce the principles and activities needed for an effective management plan

When a patient/service user or principle carers decline to take on board the recommendations relating to pressure ulcer prevention / management e.g. use of pressure relief equipment, limit the time spent sitting in a chair. After explanation of the advice provided, the potential benefits and the probable risks of not following the recommendations they should be given the opportunity to record their preferences by completing the Informed Refusal Form

The issues covered by the Informed Refusal form need to be revisited at least monthly, to ensure the accurate records of patients’ preferences and choices.

Appendix 13 Informed Refusal Form

5.6 Pressure Relieving Devices

Support surfaces for beds and chairs must reflect the patient’s pressure ulcer risk and ability to change position. If a patient cannot reposition independently then consider the use of dynamic mattress systems where two hourly repositioning is
not feasible

Devices (mattresses and cushions) come in two main types; those that reduce pressure by spreading the weight and increasing the surface area, and those that relieve pressure by removing the pressure at frequent intervals. Decisions about which pressure redistributing device to use should be based on an overall assessment of the individual and not solely on the basis of scores from risk assessment scales.

Pressure relieving equipment does not replace the need for repositioning and should be used as an adjunct with a repositioning and skin inspection regime that suits the patient and circumstances.

Pressure relief equipment is supplied in the community by Community Loan Equipment Loans Service. Details of equipment provided and ordering procedures are included in the online Nottingham Rehabilitation Society (NRS) IRIS electronic catalogue.

Within the Doncaster Community Integrated Services (DCIS) in-patient area pressure relieving equipment is available on the ward and equipment library.

Only authorised staff with an individual personal identification number (PIN) can order equipment via NRS. Staff must attend training before they are issued with a requisition number and will be expected to attend periodic refresher training to retain their Requisitioner status.

5.7 Equipment selection

Equipment and mattresses available in the in-patient areas should be cleaned in line with latest guidance from

Before equipment is chosen existing support surfaces (bed, chair) should be examined for suitability. Lack of support and ‘bottoming out’ from an old mattress or cushion could be causing the pressure damage.

All vulnerable patients/service users, including those with a category 1-2 pressure ulcer should receive, as a minimum provision, a high specification foam mattress and the ulcer should be closely observed for deterioration.

The level of equipment support should be increased (stepped up) when:

- The patient/service user is showing signs of pressure damage
- As a first line preventative strategy for persons identified at elevated risk
- The patient’s condition deteriorates

The level of support should be decreased (stepping down) when:

- The patients/service user condition improves
- Mobility improves
• Post operatively (24hrs)
• Facilitate rehabilitation

Adverse incident reports using the Safeguard system (IR1s) should be raised to report:

• Equipment failures
• Non-compliance with manufacturer’s instructions
• Misappropriate use of equipment e.g. allocated equipment is not with the named patient.
• Prescribed pressure relief equipment is not available in a timely manner.

There are three principles of action when selecting a pressure relief device for pressure ulcer prevention and/or management

• Reducing / relieving pressure
• Preventing damage to the skin
• Improving tissue resistance

Decisions about support surfaces should be made following a holistic assessment of a person’s risk, comfort and general health state.

Patient/service user movement in and out of bed should be considered as air mattresses can restrict movement.

Assessment should be on-going throughout an individual’s episode of care and the type of pressure relief support changed to suit any alteration in risk. Patient/service user may choose not to use any therapy products because of their personal circumstances in particular those that wish to continue sleeping with their partner. Decisions must be documented

If bed rails are appropriately allocated after assessment and were appropriate they should be replaced with these should be replaced with additional height bed rails

**Appendix 14 Safe use of bed rails.**

Electric Profiling Beds

• Electric profiling beds reduce skin damage by:
• Making movement easier for the patient/service user, carers and staff to perform, reducing friction and shear.
• Use of the knee break prevents sliding down the bed reducing friction and shear.
• Allowing patients/service users to change their own position.
• It is vital that an environmental check be carried out to ensure space is
available as these beds a larger than a standard divan and require room to ‘move’.

- For patients with Category 4 pressure injury the profiling bed base is supplied with a pressure relief mattress replacement system

Equipment and mattresses available in the in-patient areas should be cleaned in line with latest guidance from infection prevention and control

Equipment allocated from Community Loan Equipment Services should be returned at the end of allocation for cleaning and decontamination.

Healthcare professionals are responsible to ensure that equipment remains with the patient it was prescribed for and not transferred to another patient.

Healthcare professionals have a duty of care to their patients when using pressure reducing /relieving equipment to ensure it is used safely and appropriately. Information leaflets provided should be read and adhered to and all healthcare professionals should be able to trouble shoot routine and minor equipment failures.

Most pressure reducing/relieving systems are fitted with visual and/or audible alarms and informal and formal carers should be informed of who to contact should the alarms be activated.

Prescribed equipment should be monitored for safe and effective working order at each community visit and reassessment of appropriate allocation in-line with “at risk” status / pressure ulcer management plan as a minimum in line with patients Community Complexity Score review.

Foam mattresses should be checked for collapse of foam (bottoming out use both fists to lean weight on mattress and test to feel base of bed frame) and integrity of cover on at least a monthly basis

Mattress with a ripped /torn cover through to the foam need to be condemned and replaced this is due to the risk of contamination to the foam.

Pressure relief system covers that are ripped/torn also require replacement because of risk of contamination.

Electrical equipment requires an adequate electrical supply and should be plugged directly into the electrical socket. Consider the safe positioning of trailing wires either around and under the bed. All wires should be secured and neatly placed.

All manual handling tasks should consider the whole picture and assessed using the ergonomic framework of; task, load, individual, environment and equipment provision. Giving consideration to the environmental factors e.g. space around the bed and mattress.

The following should not be used as pressure relieving aids: water filled gloves;
synthetic sheepskins; genuine sheepskins and doughnut-type devices.

- Doughnut type devices impair lymphatic drainage and therefore are likely to cause rather than prevent pressure ulcers.
- Water filled gloves are ineffective because their small surface area does not redistribute the pressure.
- Sheepskins and fibre filled overlays can be used to provide comfort at the patient’s request but neither will provide relief from pressure. If used, care should be taken with regard to cross infection.

The benefits of a pressure redistributing device should not be undermined by prolonged chair sitting.

- When sat in a chair 70% of your body weight is spread over 8% of your surface area. This means that seating increases the risk of pressure damage. Poor seating increases the risk even more.
- When planning to sit a patient/service user out of bed consider the following points:
  - The severity and location of any pressure ulcers.
  - The patient/service user’s ability to sit comfortably in an armchair and reposition themselves.
  - Ergonomics of the chair e.g. height, depth, width, position of armrests
  - Ease of transfer from bed to chair and the use of appropriate moving equipment.
  - Posture, mobility, comfort and support.
  - Functions required when sitting e.g. eating/washing.
  - Patient choice and psychological consideration.
  - A patient/service user considered at high risk who is provided with an alternating pressure mattress but who ‘sits out’ should also have their seating assessed and suitable equipment provided’.
  - Patients should be advised of the risk of prolonged ‘chair sitting’ so they can make informed choices about it.
  - NICE recommend restricting the time spent seated to a maximum of 2 hours at a time for high risk patients.
  - Advice should be sought from the multidisciplinary team (Occupational therapists, Physiotherapists, Wheelchair services) if seating is a problem.

**Appendix 15  A Guide to Basic Seating**

**5.8  Treatment of Pressure Ulcer**

A patient/service user with a pressure ulcer will also require preventative care plan as well as a wound treatment plan for pressure ulcer management. Patients/service users with pressure ulcers should receive an initial and on-going holistic assessment. This section of the policy should be used in conjunction with wound management guidelines/policy and Doncaster District Formulary.
The general principles for the management of pressure ulcers are to minimise the perpetuating factors that delay healing;

- To alleviate the effects of the intrinsic factors which contribute to tissue breakdown and delayed healing;
  - Malnutrition
  - Incontinence
  - Debilitating concurrent illness

- To remove the extrinsic factors significant in the development and delayed healing of pressure ulceration
  - Unrelieved pressure
  - Shearing forces
  - Friction
  - Moisture

- To provide the optimal local environment for healing at the wound site

Wound measurement should be carried out at each dressing change

Choose dressings / topical agents or method of debridement or adjunct therapy should be based on:

- ulcer assessment
- general skin assessment
- treatment objective
- characteristic of dressing/technique
- previous positive effect of dressing / technique
- manufacturers indications for use and contraindications
- risk of adverse events
- service user/patient preference.

Debridement is defined as the removal of devitalised tissue from a wound. The rationale for removing such tissue is that:

- it removes a medium for infection
- it facilitates healing
- it aids assessment of wound depth

The removal of devitalised tissue in pressure ulcer(s) is appropriate when it is consistent with the patient’s condition and goals.

With the end of life/terminal ill patient their overall quality of life should be taken into account when deciding whether to debride the wound.

Methods of debridement include enzymatic, autolytic and larval therapy may be
used when there is no urgent clinical need for drainage or removal of devitalise tissue.

If there is an urgent need for debridement, as with advancing cellulites or sepsis referral for surgical debridement is required. For in-patient areas refer to a member of the medical team when signs of clinical are present. Community team immediately to a more senior colleague and referral to the GP.

All pressure ulcers are colonised. Therefore do not take a swab unless clinical signs of infection are present. Recognised clinical signs of infection include:

- localised redness
- localised pain
- localised heat
- cellulites
- Oedema

**Further criteria include**

- Abscess
- Discharge that may be viscous in nature, discoloured and purulent
- Delayed healing not previously anticipated
- Discolouration of tissue both within and at the wounds margins
- Friable, bleeding and granulation tissue despite gentle handling and the non-adhesive nature of dressings.
- Unexpected pain or tenderness at dressing changes or reported by the service user specifically associated with the wound even when the dressing is in place.
- Abnormal smell
- Wound breakdown associated with pocketing at the base of the wound

In-patient areas refer to a member of the medical team when signs of clinical infection are present. Community team to a more senior colleague and GP. When there are clinical signs of infection, which do not respond to treatment, referral for radiological examination to exclude osteomyelitis and joint infection may be required.

**Appendix 16 Nerds and Stones**

Consider antimicrobial therapy in the presence of systemic and/or local signs of infection

Protect pressure ulcers from sources of contamination (e.g. faeces)
Create an optimum wound healing environment using modern dressings (for example hydrocoloids, hydrogels, foams, films, alginates) with dressing selection following a comprehensive risk assessment as presented in the Trust’s Wound Management Policy.
Referral to Tissue Viability and Lymphoedema Service (TVALS) can be made when:

- Patient has a ungraded or category 4 pressure ulcer
- Patient presents with a deteriorating pressure ulcer
- Patient presents with a difficult to manage pressure ulcer
- Patient presents with concerns regarding neglect or safeguarding contributing issues to pressure ulcer development

**Appendix 17 TVALS Request for Visit Referral Forms**

5.9 Liaison between Care Setting

Pressure ulcer prevention and management is complex, frequently crosses care and professional boundaries and benefits from a multidisciplinary and collaborative approach to care.

Sharing information and documentation will ensure continuity between care settings and ensure an appropriate package is instigated.

When possible communication should take place prior to transfer and/or discharge ideally the information should include:

- patient’s level of risk
- any equipment used
- skin condition
- plan of care e.g. moving and handling plan, member of MDT involved
- relevant social and cultural information including communication needs
- wound dressing regimes
- wound dressing supplies for one change – to allow time for prescription to be arranged

**Appendix 18 Tissue Viability / Wound Care Discharge / Transfer form for patients with wounds**

6. TRAINING IMPLICATIONS

Educational programmes for the detection, prevention and management of pressure damage will be structured, organised and comprehensive and made available at all levels of health care providers, Patients/service user’s, family and care givers. Details of sessions available through the Trust’s training and development programme.

A multi-disciplinary approach will be taken. The educational programme will be updated on a regular basis based on the best evidence (EPUAP2009, NICE 2003/5)
7. MONITORING ARRANGEMENTS

<table>
<thead>
<tr>
<th>Area for monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Guard IR1 Reporting of Pressure Ulcers grade 2 and above</td>
<td>Number of IR1 reports</td>
<td>Safety Team Matrons Nursing Staff</td>
<td>Business Divisions/Care Groups</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Trust acquired category 3 or 4 pressure ulcers reported via STEIS</td>
<td>Submission to RCA panel</td>
<td>Team Leaders</td>
<td>Business Divisions/Care Groups</td>
<td>Monthly</td>
</tr>
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</table>

8. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published this policy's RDaSH Policy Library web page.

8.1 Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organize care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

Indicate how this will be met
There is no requirement for additional consideration to be given with regard to privacy, dignity or respect.
9. LINKS TO OTHER PROCEDURAL DOCUMENTS

- Infection Prevention and Control Policy
- Hand Hygiene Policy and Procedure
- Standard Precautions Policy
- Nutritional Support Policy for In-Patient Services
- Policy for the Physical Assessment, Examination and Ongoing Care of In-patient Service Users
- Nutritional Support Policy for In-Patient Services
- Policy for the Physical Assessment, Examination and Ongoing Care of In-patient Service Users
- DOH (2012) Delivering the NHS Safety Thermometer CQUINN
- DOH (2014) Care and support Statutory guidance issues with Care Act 2014
- NMC Record Keeping (2010)

10. REFERENCES

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11. APPENDICES (Part 2)

To access these appendices please see individual documents on the Pressure Ulcer Detection, Prevention and Treatment Policy webpage on the RDaSH Policy website.

Appendix 1     South Yorkshire & Bassetlaw Pressure Ulcer Good practice Protocol for Safeguarding
Appendix 2     PURPOSE T – Pressure Ulcer Risk Assessment
Appendix 3     React to RED – Advice for Carers
Appendix 4     Selection Criteria for Management and Prevention of Pressure Ulcers in line with NICE Guidance
Appendix 5     Re-Positioning Chart
Appendix 6     Continence and Tissue Viability
Appendix 7     Guidelines – Leaving Slings in-situ
Appendix 8     Simple, Safe, Effective – The 30° Tilt
Appendix 9     Pressure Ulcer Grades
Appendix 10    Wound Management Guideline with TIME
Appendix 11    Strategic Executive Information System (STEIS) Form
Appendix 12    Route Cause Analysis for Pressure Ulcers (RCA) Form
Appendix 13    Informed Refusal Form
Appendix 14    Safe Use of Bed Rails
Appendix 15    A Guide to basic Seating
Appendix 16    Nerds and Stones
Appendix 17    TVALS Request for Visit Referral Forms
Appendix 18    Tissue Viability/Wound Care Discharge/Transfer Form for Patients with Wounds