Leicestershire Partnership NHS Trust

Pressure Ulcer Prevention and Management Policy

This policy provides the overarching principles for all health care professionals with responsibility for the prevention and management of pressure ulcers throughout LPT.

Key Words:	Equipment, Sore, Tissue Viability, SSKIN, Waterlow, Reposition, Skin	
Version:	12	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	27 October 2020	
Name of Author:	Laura Browne	
Name of responsible Committee:	Patient Safety Improvement Group	
Please state if there is a reason for not publishing on website:	n/a	
Date issued for publication:	October 2020	
Review date:	June 2023	
Expiry date:	August 2024	
Target audience:	All healthcare workers	
Type of Policy	Clinical X	Non Clinical
Which Relevant CQC Fundamental Standards?	Person centred care, dignity and respect, safety, good governance, staffing	

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation
Anita Kilroy Findley	Clinical Lead Tissue Viability
Laura Browne	Operational Lead Tissue Viability
Joanne Earle-Marshall	Community Matron
Tracy Yole	Lead Nurse Community Services
Caroline Towers	Governance Manager

Circulated to the following individuals for comments

Name	Designation
Pressure Ulcer Ambition Group Members	Across all divisions
Members of the Trust Patient Safety Group	Across all divisions
Michelle Churchard	Head of Nursing AMH/LD
Claire Armitage	Lead Nurse AMH/LD
Kathy Feltham	Lead Nurse MHSOP
Jude Smith	Head of Nursing CHS
Amin Pabani	Head of Podiatry
Sue Wyburn	Professional Lead for Occupational Therapy CHS
Clare Tacey	Tissue Viability Nurse
Ann Silver	Tissue Viability Nurse
Laura Browne	Tissue Viability Nurse
Hannah Konig	Tissue Viability Nurse
Hannah Bowles	Tissue Viability Nurse
Alicia Kelly	Tissue Viability Nurse
Yvonne Aldous	Tissue Viability Nurse
Helen Shaw	Tissue Viability Nurse
Danica Charles	Tissue Viability Nurse
Chloe Skinner	Tissue Viability Nurse
Kerry Palmer	Medical Devices Asset Manager
Neil King	Lead for Safeguarding
Greg Payne	Lead Practitioner for Adult Safeguarding

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
Version 1	June 2014	Guideline reviewed and rationalised to a policy in line with new NICE guidance
Version 2	September 2014	Reviewed for AMH/LD/FYPC divisions by TVN
Version 3	October 2014	Updated following comments received from PU ambition group. Review of appendices.
Version 4	November 2014	Spelling errors and grammatical changes to definitions (9.6). Duties within the organisation: Professional names amended form nursing professionals to encompass all clinical groups. SSKIN scoring amended for at risk to read 10 to 14 waterlow score. Braden Q examples of risk added (8.1.1). Ability of carers added to the support the individual with reference to care planning (8.1.2). Specific at risk areas added to the care plan section for consideration (8.1.2). Added non-concordant expectations (10.8). Added environmental factors to four hour position change (10.2.2). Added patient informing to cleaning equipment (11.3). Changed dynamic equipment caseload to any HCP not just nursing (11.6). SDTI not reported as deterioration (13.1). SDTI investigation (13.6 and 13.7). Section 18 monitoring completed.
Version 5	December 2014	Amendment to care planning (6.4, 7.8 and 7.9, 8.1.1) to state those at high risk in line with NICE guidance. Amendments to frequency of risk assessment in line with pressure ulcer NICE guidance. Addition to patient information (8.1). Expanded on roles and responsibilities (5.2.3 and 5.2.4).
Version 6	January 2015	Reference updated to include EPUAP 2014. Additional comment to the definition of category 2; determining the definition of slough and bruising. Added gentle positioning for end of life.
Version 7	February 2015	Addition of detailed summary following CEG request.
Version 8	February 2015	Expansion of monitoring information.
Version 9	March 2015	Final amendments following presentation at the Policy Group.

Version 10	March 2017	Review; reporting and investigation (13.0) updated in line with new processes. Appendix C added to clarify roles and responsibilities re dynamic systems. Addition to introduction to include Mental Capacity Act. Clarification (3.1) that services may have their own SOP to reflect policy. Addition of 'patients and carers' to 10.1, consideration of need for specialist seating assessment added to 10.3.2. Clarification re monitoring with statics on discharge (11.7). Added use of Trust smartphone for photography (14.2). Added refer heel ulcers to podiatry (15.5). Added e-learning (16.4). 18.0 'monitoring' updated to reflect current process. Removal of CQUIN.
Version 11	March 2019-Oct 2020	The policy has been updated to meet new national guidance and changes made to the PU process as a result of this.
Version 12	January 2024	Training section updated to reflect hybrid training delivery, face to face and eLearning

For further information contact:

Tissue Viability Service
Charnwood Mill
Sileby Road
Barrow Upon Soar
LE12 8LR
01509 410225

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and services are free from discrimination;
- LPT complies with current equality legislation;
- Due regard is given to equality in decision making and subsequent processes;
- Opportunities for promoting equality are identified.

A due regard review found the activity outlined in the document to be equality neutral because there were no negative impacts on any service user group (Appendix J).

Definitions that apply to this Policy

Patient	For the purpose of this policy a patient is considered to be any person in receipt of healthcare from Leicestershire Partnership NHS Trust regardless of age or care setting.
Pressure Ulcer	An area of localised damage to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear (NPUAP -EPUAP 2014)). Pressure ulcers have previously been referred to as bed sores, decubitus ulcers, and pressure sores.
Prevalence	Prevalence is defined as a cross-sectional count of the number of cases at a specific time, or the number of persons with pressure ulcers who exist in a population at a particular moment in time (Defloor et al 2002). Both prevalence and incidence are used to measure disease frequency. While both have been used to record the number of people with pressure ulcers, they provide different perspectives on the scale of the problem (EPUAP 2014).
Incidence	Incidence is defined as the number of persons who develop a new pressure ulcer, within a particular time period in a particular population (Defloor et al 2002). Incidence can be captured within the in-patient setting per 1000 bed day, or based on percentage rate of admissions, and within the community per 10,000 populations.
Harm	Degree of harm (physical and psychological) caused by pressure ulcer incident
High Risk	Are individuals who usually have multiple risk factors (such as significant limited mobility, nutritional deficiency, inability to reposition themselves, significant cognitive impairment). Those patients' with a history of pressure ulcers or a current pressure ulcer are at high risk. (NICE 2014)

Moisture Lesion	A moisture lesion is an area of skin damage that has occurred due to incontinence or moisture. Pressure ulcers should not be mistaken for moisture lesions; refer to appendix A for key differences between pressure ulcer and moisture lesions. Ulcer that has occurred due to a combination of pressure / shear and moisture should be recorded as a pressure ulcer and categorised accordingly (Tissue Viability Society 2012). **Moisture Lesions require incident reporting**
Category 1 Pressure Ulcer **(EPUAP 2014)**	Non- blanching erythema. Intact skin with non-blanching redness of a localised area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler in comparison to adjacent tissue. Dark skin tones may not have visible blanching: colour may differ from surrounding areas (refer to appendix B). **Category 1 pressure ulcers <u>do not</u> require reporting**
Category 2 Pressure Ulcer **(EPUAP 2014)**	Partial thickness. Dermal loss presenting as a shallow open ulcer with a red pink wound bed, without the presence of thick, fixed slough. May also present as an intact or open / ruptured serum filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or with superficial slough and visible granulation across the wound bed. Superficial slough may be present as long as granulation can be clearly seen to the expanse of the wound bed (refer to appendix B). Should not be used to describe skin tears, maceration, excoriation, moisture lesions, or burns. *Bruising indicates suspected tissue injury and is not a category 2 ulcer. **Category 2 pressure ulcers require incident reporting**

Category 3 Pressure Ulcer **(EPUAP 2014)**	Full thickness skin loss. Full thickness tissue loss: Subcutaneous fat may be visible but bone, tendon or muscle is not exposed or palpated. Slough may be present but does not obscure the depth of tissue loss. Undermining and tunnelling may be present. The depth of category 3 ulcer may vary dependent upon the anatomical location (refer to appendix B). **Category 3 pressure ulcers require incident reporting**
Category 4 Pressure Ulcer **(EPUAP 2014)**	Full thickness tissue loss. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present, bone may be palpated. Often includes undermining and tunnelling. The depth of category 4 ulcer may vary dependent upon the anatomical location (refer to appendix B). **Category 4 pressure ulcers require incident reporting and will require the completion of a Serious Incident (SI) template which will be presented at the SI Meeting.**
Suspected Deep Tissue Injury (DTI) **(EPUAP 2014)**	Suspected Deep Tissue Injury (Purple Discolouration). This category will be used to capture pressure ulcer that cannot be classified according to the categories stated above as the extent of the damage is not immediately known. The pressure damage may present as a discoloured or blood filled blister; the area may be painful, firm, mushy, boggy, and have a different temperature compared to adjacent tissue (refer to appendix B). **SDTI will require incident reporting** **If the SDTI evolves into a category 3 or 4 pressure ulcer, it should be reported using the correct cause group.**
Unstageable **(EPUAP 2014)**	Pressure ulcers where depth cannot be ascertained due to the presence of fixed slough and / or necrosis. **Unstageable pressure ulcers require incident reporting.** **If the unstageable pressure ulcer evolves into a category 3 or 4, it should be reported using the correct cause group.**

Pressure Ulcer caused by a medical device (d)	A medical device related pressure ulcer. All pressure ulcers including category 2-4, SDTI and Unstageable that have been caused by a medical device. **Pressure ulcers caused by medical devices will require incident reporting**
Pressure Ulcer on Admission (POA)	A pressure ulcer that the patient developed prior to admission onto an LPT caseload/ward.
Pressure ulcer which developed in LPT Care	A pressure ulcer that developed whilst the patient was on an LPT caseload/ward.

1.0 Purpose of the Policy

1.1 The purpose of the policy is to:

Provide healthcare staff with the standards of care and processes to be followed by all staff caring for patients at risk of or with a pressure ulcer.

All care processes and local arrangements must be in line with the standards set out within this policy.

2.0. Summary and Key Points

2.1 This document establishes best practice for Pressure Ulcer Prevention. It requires mandatory compliance, staff must have clearly documented rationale for not implementing the standards or practices set out within this policy, or for measuring consistent variance in practice.

3.0 Introduction

3.1 This policy sets out the standards of care for the prevention and management of pressure ulcers. All health care professionals have a duty to ensure all patients within their care are appropriately risk assessed for pressure ulcers. Patients assessed to be at risk of developing a pressure ulcer must have the appropriate care provided in line with the policy.

3.2 This policy is for use by all healthcare professionals who have contact with patients who are at risk of developing a pressure ulcer. The responsibility for pressure ulcer prevention is not isolated to one professional group; all health care workers should be involved with the prevention of pressure ulcers. Therefore, the policy is relevant across all clinical areas.

3.3 Estimated figures suggest that pressure ulcers affect approximately 20 per cent of patients in acute care, 30 per cent of people in the community and 20 per cent of people in nursing and residential homes. The cost of treating pressure ulcers, and related conditions, to the NHS is suggested to be up to four billion pounds each year. Untreated and / or infected pressure ulcers can lead to severe pain, serious harm or death (NPSA 2014).

3.4 All patients are potentially at risk of developing a pressure ulcer. Patients with impaired mobility, impaired nutrition, seriously ill, suffer from neurological condition, have poor posture and or a deformity are at greater risk of developing pressure ulcers. Intervention for the prevention and treatment of pressure ulcers is essential across all inpatient and community settings.

3.5 If the patient does not have the mental capacity to give informed consent and understand pressure ulcer prevention and management, a best interest decision may be reached to agree a suitable plan of care and involve the patient's parents / relatives / informal and formal carer's of their on-going pressure ulcer prevention needs. Healthcare professionals need to be guided by the provisions of the Mental Capacity Act (2005).

3.6 All care processes and local arrangements must be in line with the standards set out within this policy.

4.0. Flowchart/process chart

4.1 Internal process charts are available to support with reporting and scrutinising pressure ulcers. These can be obtained from the individual services managers.

5.0. Duties within the Organisation

5.1 The policy committee is mandated to adopt policies on behalf of the Trust Board

5.2 Trust Board sub-committees have the responsibility for ratifying policies and protocols.

5.3 Divisional Directors and Heads of Service are responsible for the operational management of this policy: Ensuring that staff develop and maintain professional competence in pressure ulcer prevention and management, and adhere to the processes set out within this policy.

5.4 Managers and senior health care professionals with line manager responsibility are responsible for ensuring that the policy is adhered to by all staff within their clinical areas. This will include the responsibility for; managerial review of reported pressure ulcers (eIRF); the investigation of pressure ulcers; and be accountable for pressure relieving equipment within their clinical area.

5.5 All healthcare staff have a responsibility to adhere to this policy. All staff must ensure that they have sufficient knowledge to be deemed competent in the prevention and management of pressure ulcers in accordance with their role.

5.6 All registered staff have a duty to ensure all patients within their care are risk assessed within recommended time frames and that those patients at risk of pressure ulcers are provided with appropriate information for their pressure ulcer risk to be minimised; those who are identified as high risk will have an individualised pressure ulcer prevention plan of care.

5.7 Registered healthcare staff must ensure that the delegation of care to non-registered healthcare workers is appropriate and in line with the LPT Skills Matrix

6.0 Consent - Responsibility of Clinical Staff

6.1 Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

6.2 In the event that the patient's capacity to consent is in doubt, clinical staff

must ensure that a decision specific mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;

*Understand information about the decision
*Remember that information
*Use the information to make the decision
*Communicate the decision

Health Care Professionals responsibilities for the prevention and management of pressure ulcers

7.0 Risk Assessment

7.1 Risk assessments will be documented at the first contact visit if the patient is housebound.

Risk assessment will be documented on admission to facilities providing 24 hour care (NICE 2014).

- In Adult Mental Health/Learning Disability services it may not be appropriate to perform a pressure ulcer risk assessment on admission i.e. if they have been brought into the unit by the police or are extremely distressed/aggressive this should however be performed at the earliest opportunity.

7.2 Risk assessment will be documented at the first healthcare assessment for patients within their own homes or in receipt of care in another health care setting if they have apparent risk factors i.e. significant limited mobility, significant loss of

sensation, previous or current pressure ulcer, nutritional deficiency, inability to reposition independently or significant cognitive impairment (NICE 2014).

7.3 Risk assessment will be carried out by health care staff trained to recognise the risk factors that contribute to the development of pressure ulcers and know how to initiate and maintain correct and suitable preventative measures (NICE 2014).

7.4 Risk assessments completed by non-registered healthcare workers will be a delegated responsibility; delegation of care must be in line with Trust policy.

7.5 The Waterlow Risk Assessment Tool should always be used in conjunction with the trained health care professional's clinical judgement and all rationale for decisions should be documented at each risk assessment (Waterlow 2005).

7.6 Clinical judgement will be supported by the use of the Braden Q tool for paediatrics which will be recorded at each risk assessment.

'In Braden Q, a higher score generally indicates healthier patient condition and function. Patients are scored by physical assessment, patient/parent interview, and chart review'. (Martha, Curley, Noonan, Quigley, 2011, p4).

*The total score will be between 6 and 23 points. Clients scoring 16 or less are considered to be **'at risk'**. The lower the score, the greater the risk for skin breakdown however degree of risk is not noted with this tool.*

Clients with additional risk factors not included in the Braden Q tool, such as an existing pressure ulcer, hemodynamic instability, low diastolic pressure and fever may be at greater risk than that indicated by the total score on this tool and needs to be considered.

7.7 All Patients will be reassessed;

- When the patients' mental or physical condition alters.
- All patients within physical in-patient healthcare settings, such as community hospitals will be assessed at least weekly irrespective of any condition changes.

7.8 Patients assessed as **'at risk'** (Waterlow of 10-14, Braden Q 13-16, as a guide in line with clinical judgement) of pressure ulcer development will be informed of strategies to minimise their risk; inclusive of importance to reposition, maintain a balanced diet, maintain good standards of hygiene and skin care, and signs of pressure ulcer development and provided with resources on pressure prevention.

As a minimum, patients will be assessed **'monthly'** or when the patients' mental or physical condition alters.

7.9 Patients assessed as at **'high risk'** (Waterlow 15-19, Braden Q 10-12 as a guide in line with clinical judgement) and **'very high risk'** (Waterlow >20 Braden Q <9 as a guide in line with clinical judgement) of pressure ulcer development must have

an individualised care plan for the prevention of pressure ulcers and will be reassessed;

- minimum of **‘weekly’** for those within their own homes receiving frequent visits i.e. chronic or acute wound management, insulin patients and end of life patients
- At each visit if less frequent contact visits i.e. patient receiving catheter care or B12 injections
- **weekly** within physical ‘in-patient’ healthcare settings.
- **weekly** within inpatient AMH/LD/FYPC settings.
- **or MUST be reassessed when the patients’ mental or physical condition alters.**

7.10 Patient assessed as **‘not at risk’** (using a Waterlow <10 as a guide with clinical judgement) should be reassessed if there is a change in the patients mental and/or physical health condition.

7.11 Reassessment will be documented each time it is completed.

8.0 SSKIN and Care Planning

8.1 SSKIN is an acronym which covers the 5 key elements of pressure ulcer prevention, Skin Integrity, Surface, Keeping Moving, Incontinence and Nutrition. It has been adopted as a best practice model for reducing pressure ulcers.

8.2 Patients assessed as **‘at risk’** (Waterlow of 10-14, Braden Q 13-16s a guide in line with clinical judgement) of pressure ulcer development will be informed of strategies to minimise their risk; as highlighted above (6.8/6.9). They will also have an individualised care plan for the prevention of pressure ulcers and will be reassessed;

- minimum of **‘monthly’** for those within their own homes receiving frequent visits i.e. chronic or acute wound management, insulin patients and end of life patients
- At each visit if less frequent contact visits i.e. patients receiving catheter care or B12 injections
- weekly within physical ‘in-patient’ healthcare settings.
- Monthly within inpatient AMH/LD/FYPC settings.
- **or MUST be reassessed when the patients’ mental or physical condition alters.**

8.3 Patients identified to be at **‘high risk’** of developing a pressure ulcer as identified by individual risk assessment, or with an existing pressure ulcer, will have a care

plan developed reflecting their individual pressure ulcer prevention plan (NICE 2014).

8.4 The developed care plan will take into account:

- the patient's ability to self-manage their risk factors;
- patient preference;
- frequency and knowledge base of carers;
- ability of the carers to support the individual to manage their risks;
- the outcome of the risk assessment;
- any specific areas at greater risk of pressure ulcer development and methods to overcome the risk;
- a strategy to off load heel pressure for patients at high risk of developing a heel pressure ulcer (NICE 2014).

8.5 Patients assessed as at **'high risk or very high risk'** of pressure ulcer development will have SSKIN completed;

- minimum of **'weekly'** for those receiving multiple visits per week
- At each visit for those patients within the community seen less often.
- Daily within 'in-patient' healthcare settings
  *FYPC/AMH/LD – weekly in line with care plan
  Or MUST be completed when the patients' mental or physical condition alters.

These should not be stand-alone visits unless assessing for suspected new pressure damage

9.0 Skin Assessment

9.1 Below is a list of areas of the body that are particularly vulnerable to pressure damage. Whilst being mindful that pressure damage can occur on any part of the body, all patients should have their personal 'at risk' areas identified which must be highlighted on their care plan and a skin assessment of these areas should be offered to ensure there are no changes in the skin condition.

- heels
- sacrum
- ischial tuberosity's
- parts of the body affected by anti-embolic stockings
- femoral trochanters
- parts of the body where pressure, shear, and friction are exerted in the course of an individual's daily living activities
- parts of the body where there are external forces exerted by equipment and

clothing
- elbows
- temporal region of skull
- shoulders, back of head
- toes
- contractures where moisture will be a co-efficient
- Skin inspection must include occipital area for children and young people.
- Colour changes or discolouration.
- Variations in heat, firmness and moisture.
(NICE 2014)

Patients who are bed/chair bound and use wheelchairs with footplates and head rests are at further risk due to extended periods spent in their wheelchairs. This leads to prolonged pressure to areas at high risk of developing pressure damage.

In addition any patient requiring orthotics will need to gradually build 'tissue tolerance' and be advised of their increased pressure ulcer risk should this not be done.

Patients/parents/carers should always be educated on blanch testing and escalation to nursing services as part of SSKIN.

9.2 Skin assessments will be undertaken by competent health care professionals who understand the 'high risk' areas of the skin associated with pressure ulcers and the importance of a thorough head to toe check of the skin for any changes in skin condition. This should be performed according to individual patient need.

9.3 Skin changes will be documented, acted upon and recorded immediately. Where it is not possible to act on them, a rationale will be entered in the patient records

9.4 In-patients, will have their skin assessed a minimum of twice daily if they have been identified as 'at high risk' of developing a pressure ulcer or more frequently if there is evidence of non-blanching erythema.
*Excluding AMH/LD areas.

9.5 It may not always be feasible or possible to complete a full skin assessment. In this instance the reason why a skin assessment is not performed will be documented. Where possible the patient / carer / parent will be asked if there are any concerns; the response will inform future management planning.

10.0 Interventions to be used in the Prevention and Management of Pressure Ulcers

Many factors are involved with an individual's potential to suffer from tissue damage. Strategies to reduce or eliminate these factors must be developed to prevent and manage pressure ulcers; this must involve patients and carers and may require involvement of the multi-disciplinary team.

10.1 **Repositioning:**

10.1.1 Frequency of repositioning will be individually determined based upon the patients' medical condition, comfort, results of the risk assessment and skin assessment, overall plan of care and the support surface.

10.1.2 Repositioning schedule will be agreed with the patient and carers' where appropriate. This will be recorded within the patients' plan of care. The optimum recommended timescale for repositioning is two hourly, (if the patient is in bed, they should be supported to change their position using each side and back) or at least every 4 hours overnight; this will be decided by taking into account the patient's environment and individual needs and *patient choice. Four hourly is recommended for infants, children and young people. (NICE 2014).

*Patients should be encouraged to change their position in line with best practice by ensuring they understand the risk of prolonged pressure to one area of the body and the impact on their quality of life. If they are able to made the informed decision and choose not to follow this advice every effort should be made to negotiate an agreed repositioning schedule to support their wishes. These discussions should be clearly documented in the patients care record.

10.1.3 Patients who are on an LPT caseload and visited at home may not have a care package that supports 2-4 hourly repositioning. In these cases a discussion should be had with the patient to consider whether *additional care visits are recommended and/or the care agency should be consulted to review the feasibility of reviewing the carer visits to ensure that they are appropriately spaced throughout the day. Care agency's should be advised to have a care plan and repositioning schedule in line with advice provided by the community nursing health care professionals and this should be reviewed by the health care professional during their visit to assess whether further support and education is required.

*the maximum non-CHC funded care package available is four calls per day.

10.1.4 The following techniques should be considered;

- 30^0 degree tilt
-gentle position changes for those at end of life
- profiling the foot end of a profile bed (knee break)
-*pillows, foam wedges, or pressure relief devices to prevent direct contact of bony prominences or high risk areas and optimise pressure ulcer prevention.

*Pillows used should be soft in texture and patients and carers should be educated on how to position the pillows correctly in order to offload the pressure effectively from high risk areas of the body.

It is acknowledged that a number of patients have challenging positional needs due to contractures, hemiplegia or altered body morphology. These patients must be referred to therapy for advice and support.

10.1.5 Patients will not be repositioned onto areas of existing pressure damage unless no alternative is available. If an alternative position is not available this will be factored into the individual's care plan and repositioning schedule.

10.1.6 All clinical health care professionals will receive training in the moving and handling of patients.

10.1.7 Manual handling devices will be removed after use unless they are specifically designed to remain in place and their use is supported by a moving and handling risk assessment, as well as a pressure ulcer risk assessment.

10.1.8 Sleep systems are not designed to off load pressure and a referral should not be made for this reason.

10.2 **Seating:**

10.2.1 As a minimum all wheelchair users should be assessed and offered a pressure-reducing cushion through wheelchair services and should be encouraged to use it. Wheelchair users will be referred for a specialist seating assessment from the local wheelchair centre, to include a pressure reducing cushion if necessary.

*If the health care professional has any concerns about the provision of the wheelchair they should refer the patient back to their local wheelchair centre for a review.

*Cushions must not be ordered through community equipment services for wheelchairs.

10.2.2 Patients at risk or high risk of pressure ulcer development will be offered an appropriate pressure relieving cushion in accordance with their individual needs.

10.2.3 A specialist assessment can be provided by the therapy team, if a patient has special postural needs and a standard chair is not sufficient to support their posture. When providing patients with chairs, the chair will be appropriate for the individual ensuring that the patient is able to;

- Sit with their feet square on the floor with their back touching the back of the chair in an upright position.

- Have their thighs supported the full length.
- Have approximately a 90^0 angle at the hips, knees and ankles.
- Pressure ulcer prevention will be incorporated into the assessment for the provision of a chair.
- Some patients may have more complex needs and require specialist seating via an OT or physiotherapist.

*Following an assessment, if the patient does not meet the criteria for the provision of seating then the above advice can be provided to support them in making a private purchase.

It is important to be mindful that poor posture can have a significant impact on the interface pressure through a patient's body and put them at greater risk of pressure damage, therefore education on the optimum seating position should be discussed with the patient.

10.2.4 If the patient has their legs elevated when sat out a suitable foot stool or leg rest should be available and positioning will ensure, or the patient will be advised, that the patients' heel(s) are clear of the rest / stool. This will be recorded within the patients' plan of care.

10.2.5 Pillows should not be used behind patients when seated as this alters the centre of gravity and increases pressure on the sacrum.

10.2.6 Pillows can be used at the patients sides to provide extra support if the patient has difficulty maintaining a safe seated position. Patients with difficulty maintaining position should be referred to the appropriate therapist for advice.

10.3 **Nutrition:**

10.3.1 Patients at risk or high risk of pressure ulcers will have their nutritional needs assessed.

10.3.2 Patients at risk of nutritional compromise or those already nutritionally compromised will have a plan of appropriate support and/or supplementation that meets individual needs and is consistent with the overall patient management plan. This may include referral to a dietician.

10.4 Skin Care:

10.4.1 Patients will be encouraged, or when appropriate assisted to, maintain dry, clean skin, particularly in identified vulnerable areas.

10.4.2 Patients will be assessed for, and provided with if necessary, skin protectants and moisturising treatments.

10.4.3 Patients will be referred for a continence assessment for the treatment/management of any associated issues: please refer to the Moisture/Incontinence Associated Dermatitis Guidelines.

10.5 **<u>Overall</u>:**

10.5.1 All preventative and management interventions will be recorded to ensure that legal and professional obligations are met, this will include; care planning for the prevention and / or management; advice given to patient, carers and significant others; any episodes of non-concordance.

10.5.2 Patients who are considered to be non-concordant with their optimum prevention strategies, as detailed in their prevention of pressure ulcer care plan, and who have the mental capacity to do so, will be involved with reviewing their pressure ulcer prevention needs and developing an alternative management plan. Patients who are considered to be non-concordant with their optimum prevention strategies as detailed in their prevention of pressure ulcer care plan, and who lack the mental capacity for that decision, will have a decision specific best interest's meeting to establish a plan of care.

10.5.3 Staff must ensure that patient's decisions are informed ones. If a patient chooses to decline their optimum treatment plan, the healthcare professional must ensure all the risks have been explained to them in a way they can understand. This should include the impact a pressure ulcer would have on their quality of life. The patients understanding and rationales for declining intervention must be documented in their record and alternative management options considered with them; this may require an MDT approach.

- *With the patients consent it may be useful to show them a photo of their pressure ulcer/a category 4 ulcer to help them understand the extent of potential/actual skin damage.*

11.0 Pressure Relieving Equipment

11.1 Pressure relieving equipment will not be solely relied upon to prevent or manage pressure ulcers.

11.2 Pressure relieving equipment will be selected based on the individuals' circumstances, including; assessed level of risk; pressure ulcer; level of mobility; patient comfort; patient choice; place and circumstances of care provision (EPUAP / NPUAP 20014: NICE 2014).

11.3 All pressure relieving equipment, will be cleaned when soiled using a neutral detergent, warm water and a disposable cloth, and then thoroughly dried. Patients and their carers should be informed of how to clean pressure relieving equipment within their own homes. (Further information can be obtained from the Infection Prevention Policy). All staff will follow local guidance in relation to: equipment selection; ordering; patient transfers; cancellation; reporting faults; reassessment processes and audit requirements.

11.4 Patients assessed at risk or at high risk of pressure ulcer will be nursed on a minimum of a static pressure relieving mattress: unless patient choice or place of care provision inhibits such. Any variation must be documented.

11.5 Dynamic pressure relieving equipment will be available for patients assessed as requiring higher specification mattress beyond static pressure relieving equipment. The assessment for and provision of dynamic pressure relief equipment is the on-going responsibility of healthcare staff and will be included in the patients plan of care.

11.6 Pressure relieving equipment should be provided to residential homes for patients at 'high risk' of developing pressure ulcers or with existing pressure damage, following a holistic assessment and when active nursing treatment is commenced.

*Please refer to section 11.7 for when a patient's pressure ulcer has healed.
*Consider whether the equipment is detrimental to the patient's mobility on/off or the mattress.

*Any safeguarding concerns surrounding equipment should be reported to the safeguarding team and as a notification of concern via the CCG website.

11.7 **Dynamic Equipment Criteria: For patients in their own home with/without carers**

All patients in their own home, with or without carers who no longer require active community nursing input and meet the following criteria will have their SSKIN and pressure ulcer prevention plan reviewed every 3 months unless we are notified of a condition change.

- Patients that remain at **'very high risk'** (Waterlow >20) of developing pressure damage AND have healed category 3 or 4 pressure damage

  AND

- Are bedbound or a full time wheelchair user

11.8 Where a patient is at **'very high risk'** of developing a pressure ulcer, has a healed category 3 or 4 pressure ulcer and they are bed bound or full time wheelchair user, then the dynamic mattress should be provided for 1 year post healing, at this point

a holistic assessment should be completed and the patient referred to the Tissue Viability Service for an electronic review, to see whether the equipment is still required.

The Tissue Viability Nurses will determine whether the mattress is still required or if it can be downgraded to a **static system and the patient can be discharged from the caseload.

*If the TVN advises that the patient can be discharged, the referring team needs to ensure that a collection is arranged for the unneeded equipment.

If the TVN advises that the patient needs to continue with the dynamic equipment, then the referring team needs to continue to visit the patient every **3 months** to complete a SSKIN/Waterlow for a further 1 year.

At the end of the second year a full holistic assessment will be completed to identify if the patient is fit for discharge and suitable for the mattress to be returned.

**Please note: If the mattress is downgraded to a static system it is the Residential Home's responsibility to provide.

11.9 All patients provided with static pressure relieving equipment will be reassessed regularly if they continue to be in receipt of professional healthcare; *frequency of evaluation will be dependent upon the patients place and circumstances of care provision. Reassessment will discontinue on discharge from professional healthcare. Responsibility is devolved to the patient/relative/carer to contact The Single Point of Access service (SPA) should there be a concern about the piece of equipment or if pressure damage has developed. Patients should be educated about potential equipment faults such as 'bottoming out', rips/tears.

*If the patient is visited 3monthly for catheter care an equipment check should be performed at this visit.
*If a patient resides within a care home or at home with carer input, it would be the carer's responsibility to report any concerns with the equipment.

11.10 Reassessment of pressure relieving equipment will be recorded within the patients' notes and will include details confirming that the equipment selection meets patients' needs; that the equipment is in correct working order; and equipment is being used according to manufacturer's instructions.

11.11 Patients assessed at high risk of developing a heel pressure ulcer will have a strategy to offload heel pressure included within their individualised plan of care.

11.12 Silicone heel supports are available on the LLR formulary which product pressure relief and can be used on intact skin. Internal pathways are available to support application and care.

11.11 Heel boots for management and prevention of pressure ulcers are available in community services to offload the pressure to the **heels.** These are not suitable for ulcers to the medial or lateral aspects of the foot.

11.13 A referral can be made to the therapy service to review suitability for a sleeping system to support postural realignment.

11.14 Aids listed below should not be used

- Synthetic sheepskins (unless synthetic sheepskin, which is present in palm protectors, has been prescribed by therapists)
- Water filled gloves
- Donut type devices i.e. ring cushions

12.0 Categorising Pressure Ulcers

12.1 All pressure ulcers will be assessed using the EPUAP and NPUAP (2014) classification systems refer to definitions (p8 and appendix B).

12.2 Category of ulcer will not be reversed as the wound heals. The pressure ulcer will be referred to as a healing or healed category 2, 3 or 4.

12.3 Moisture lesions are not attributable to pressure and should not be categorised as such (appendix A). Where pressure does become a factor and a combination ulcer develops this will need categorising and reporting as a pressure ulcer.

12.4 Moisture lesions which have developed solely as a result of moisture related issues require reporting separately

13.0 Diabetic Foot Ulcers and Pressure Ulcers

13.1 Where an ulcer develops on the foot of a person with diabetes, consideration has to be given as to whether it is a pressure ulcer or diabetic foot ulcer. The key pointers are; does the patient have diabetic neuropathy and if so, did this cause the patient to be unaware of pressure on their foot. Examples of this would be:

- Callus build up on toes removed by podiatrist and revealing an ulcer beneath. The callus is a result of pressure and / or friction, if left untreated this leads to pressure on underlying tissues. The patient doesn't recognise this pressure due to the presence of sensory neuropathy, leading to ulcer formation beneath the callus. If the patient hadn't had neuropathy, they

would have felt pain / discomfort and sought help earlier preventing the ulcer from forming - therefore this would be a diabetic foot ulcer

- Neuroischaemic ulcers on toes can be caused by ill–fitting footwear /trauma. If the patient has full sensation in their feet (i.e. don't have sensory neuropathy) they would have felt their shoes were too tight and they would not have got the ulcer, therefore this would be a diabetic foot ulcer

- Heel ulcer to the plantar aspect of the foot from a stone in the shoe. The patient doesn't feel the stone due to sensory neuropathy; this would be a diabetic foot ulcer from trauma and pressure

- Heel ulcer to the back of the heel in a patient with sensory neuropathy and who is unable to independently mobilise due to functional limitations or temporary ill health. Whilst the patient may not have felt the pressure due to neuropathy the ulcer is a direct cause of no off-loading, therefore it is a pressure ulcer on a diabetic foot

14.0 Reporting and Investigation of Pressure Ulcers

14.1 Category 2, 3, 4, unstageable pressure ulcers and SDTI must be recorded as a clinical incident on the Trust reporting system (eIRF).

SDTI's, cat 3, category 4 and unstageable pressure ulcers will be verified by the Tissue Viability Team and any relevant advice provided.

SDTI's that develop into category 3, 4 or unstageable pressure ulcers are not be re reported as a deterioration, as this is most probably due to the existing deep tissue damage but should be re-reported using the 'evolved into' cause group i.e. SDTI evolved into a Category 4 Pressure Ulcer.

*If the SDTI or unstageable pressure ulcer was present on admission the category that it develops into will be classed as 'pressure ulcer on admission (POA) and vice versa. This is due to the existing damage already being present.

If an unstageable pressure ulcers or SDTI develops into a Category 3, 4 pressure ulcer, it is the health care professional's responsibility to re-report the incident via eIRF

*The Tissue Viability Nurse will receive a new notification of this incident to verify the pressure ulcer and plan a review if required.

*If a SDTI or unstageable pressure ulcer evolves into a category 3 or 4 pressure ulcer the correct cause group should be used.
- PU unstageable/SDTI in LPT/POA evolved into a XXXXXX

If a patient has multiple pressure ulcers in different locations on the body i.e. heel, bunion, sacral, these should be reported as separate incidents.

14.2 All pressure ulcers will be identified as 'developed in our care' or 'pressure ulcer on admission' (POA).

- Developed in our care pressure ulcers have occurred whilst the patient was receiving care by LPT. This may be **any** area within LPT i.e. a community team patient admitted to a community hospital, a therapy patient admitted to MHSOP.
- Pressure Ulcer on Admission (POA) the pressure ulcer was present on admission, or at first assessment, to the reporting area and the patient was not under the care of any other LPT services.

14.3 It is the Tissue Viability Services responsibility to verify and confirm the level of damage that has been reported for Category 3, 4, Unstageable and SDTI's. The Tissue Viability Nurses will record on the patient's electronic record the confirmation details and any advice in relation to the care provided.

***It is vital that a full wound assessment and clear/labelled photos are uploaded to the patient's electronic record when reporting any pressure ulcer incident.**

If the incident is inaccurate i.e. the category of pressure damage or location of where it developed is incorrect, the Tissue Viability Nurse will be responsible for changing the incident and documenting on the incident form.

The Tissue Viability Nurses will be responsible for notifying the relevant people if a Category 4 pressure ulcer has been verified and confirmed. They will also need to notify the relevant people if a category 4 has been reported but verified as a different level of damage.

14.4 Senior staff within each area will be responsible for verifying Category 2 pressure ulcers and if the level of damage has been reported incorrectly they will be responsible for changing the incident and documenting on the patient record.

14.5 All pressure ulcers will be reported in accordance with the categorisation system as stated on page 7/8 and appendix B.

14.6 All pressure ulcers developed in our care will follow a scrutiny process to determine whether any care recommendations have been highlighted to improve practice:

- All category 2, 3, unstageable and SDTI pressure ulcers will have a Pressure Ulcer Scrutiny Template completed. This includes those that have been caused by a medical device (see section 14.10 for category 4 process).

14.7 The Pressure Ulcer Scrutiny Template for category 2, 3, unstageable and DTIs pressure ulcers will be completed by the Team Leader/Ward Sister/Ward Matron/District Nurse/Senior DN/Senior Nurse Complex Care who is responsible for that team/ward.

The scrutiny process should also involve the staff and patients and their views on why the pressure ulcer developed and whether they feel anything could have been done differently to prevent it.

The scrutiny of category 3 and unstageable pressure ulcers will be overseen by the ward/team Matron and the Tissue Viability Nurses will offer support to services where required. Any care recommendations will be highlighted on the scrutiny template as part of this process and a plan devised to embed the captured learning into practice.

Any reflection performed with staff members can be used to form part of the clinical supervision process and record keeping audit.

14.8 Following the completion of the PU Scrutiny Template the service leads can request further support from the Tissue Viability Team in the form of a telephone conversation, one to one discussion.

14.9 As part of the reporting and scrutiny process consideration should be given to whether any safeguarding issues have arisen and been escalated appropriately. The safeguarding team can offer their support in making these decisions. Staff need to be mindful and consider any safeguarding concerns that relate to the patients environment, care and wellbeing, as well as establishing the level of harm that has been caused due to the development of the pressure ulcer.

When reporting a pressure ulcer the level of harm caused by the incident needs to be recorded. The following should be used as a guide, however the level of harm should be changed following the scrutiny of the pressure ulcer if required, this is the responsibility of the senior staff members.

- Pressure Ulcer on Admission – Always documented as ‘no harm’
- Category 2 Pressure Ulcers – Minor Harm
- Category 3/SDTI/Unstageable Pressure ulcers – Use clinical judgement – either Minor or Moderate
- Category 4 Pressure Ulcers – Moderate Harm

The Safeguarding Adults Protocol (Nov 2018) can be used as guidance for making the decision on whether a Safeguarding Concern should be raised. Further support can be accessed by contacting the safeguarding team for advice.

14.10 **All** Category 4 pressure ulcers that develop in LPT Care will require a Root Cause Analysis Investigation completing using an (SI) Serious Incident Template.

The SI template will be completed by the senior staff within the service and reviewed by a Tissue Viability Nurse. It will then be presented at a 'Locality Analysis Group' (LAG) to confirm and challenge care provision and identify causal factors and learning.

If a category 4 pressure ulcer heals and then breaks down within 4 weeks of being reported a new eIRF will need to be completed but a new SI template will not.

14.11 A clinical supervision/reflection session facilitated by the Tissue Viability Team can be requested for category 4 pressure ulcers where significant learning has been highlighted, this will be monitored through clinical governance line meetings.

14.12 Pressure ulcers that have a significant amount of fixed slough or necrosis inhibiting categorisation are classed as unstageable and should be recorded as such.

If the slough and/or necrosis are debrided from an unstageable pressure ulcer, so that the wound bed can be seen, and it is possible to accurately categorise, the pressure ulcer should not be re-reported but the original report that was submitted should be changed to the appropriate cause group, leaving the location of its development the same.

Example: An unstageable pressure ulcer is reported as 'pressure ulcer on admission (POA). As the slough/necrosis is debrided (if appropriate), bone becomes visible, then the original; incident should be changed to a Category 4, pressure ulcer on admission (POA).

15.0 Duty of Candour

15.1 All clinical staff have a responsibility to be open and transparent with patients in relation to their care and treatment. Any patient that is harmed by a provision of a health service should be informed of the fact, appropriate remedy offered, regardless of whether a complaint has been made (Care Quality Commission, 2015).
When a pressure ulcer has been verified the patient should be informed and provided with support in relation to the incident. The patient should be provided with a brief outline on what may have contributed to the pressure ulcer development but be informed that a full investigation will take place in order to determine the cause. They should also be asked if they would like any information highlighting in the investigation and whether they feel anything could have been done differently to prevent their pressure ulcer from occurring, this information should be recorded on the pressure ulcer scrutiny template.

*The managers of the service are responsible for contacting the patient when they receive a notification of a pressure ulcer incident and informing them that they will

be investigating the pressure ulcer and will communicate its outcome and any changes in care that have arisen as a result.

16.0 Photography

16.1 All pressure ulcers will be photographed where a patient/parent gives informed consent and has the mental capacity to do so; photographs will be completed when the pressure ulcer is first identified then regularly thereafter, ideally every 2 weeks or on deterioration of ulcer. (Parameters for photography are in the Trust Consent to Examination or Treatment policy).

16.2 If a patient has mental capacity to make an informed decision and chooses not to have the wound photographed this should be documented; if photography is not considered to be appropriate in the individual patient circumstances, such as end of life, then this also needs to be documented. In this instance description and measurement of the wound must be recorded.

16.3 If a patient lacks mental capacity to make an informed decision and give consent, a best interest's decision should be considered.

16.4 Photographs must only be taken using an LPT smart phone, an LPT camera or an LPT 'tough book' and uploaded to the patient's electronic record within 24hrs.

17.0 Wound Management

17.1 Wound assessment templates/charts will be used to record the condition and monitor the progression of pressure ulcers.

These should be completed at the time the pressure ulcer is identified and every 4 weeks thereafter or if there are any signs of deterioration.

17.2 The Tissue Viability team receives notification of all category 3, 4, unstageable and SDTI incidents in order to verify the level of damage that has been reported is correct. They will also review the care provided and offer any relevant advice/support. The team will automatically arrange a face to face visit for all category 4 and significant unstageable pressure ulcers however an additional referral can be made for category 3, unstageable and SDTI's if clear rationale is provided on how the service can offer support.

17.3 Patients whose pressure ulcers do not heal as expected, experience delayed healing or have extensive necrosis should be referred to Tissue Viability Nurse,

Podiatrist (foot ulcers) or surgical specialist; whichever is the most relevant to the situation.

17.4 Pressure ulcers will be treated with the most appropriate wound treatment products in line with the local LLR formulary or Tissue Viability recommendation.

17.5 Pressure ulcers that develop on the lower limb, such as heels, feet or ankles, will not be actively debrided until the vascular status of the limb is ascertained by performing a lower limb assessment. All foot/heel/ankle ulcers should follow the foot ulcer pathway and be referred to podiatry.

17.6 Patients with diabetes who have developed pressure ulcers on their lower limbs will be referred to the Fast Access Diabetic Foot Clinic for urgent assessment of offloading / debridement and Tissue Viability Nurse if appropriate.

Fast Access Diabetic Foot Clinic will see all diabetic patients with a new ulcer to the feet/ankles within 24hours.

Diabetic Fast Access Clinic: 0116 225 5105

17.7 If a pressure ulcer needs debridement of devitalised tissue from its wound bed then consideration needs to be given to the most appropriate method of debridement which will be dependent on individual patient factors. Types of debridement include, sharp debridement, enzymatic or autolytic. If advice and support is needed with this process you should liaise with your local Tissue Viability Link Nurse who can contact the Tissue Viability service if further advice is required.

17.8 Please refer to the Wound Management Guidelines for further advice on wound management and treatment.

18.0 Training needs

18.1 There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as ‘role specific training’ for CHS and role essential for specific services within the directorates of Mental Health and Families, Young People and Learning Disability and Autism.

18.2 All clinical staff identified as role specific must attend either the half day pressure ulcer prevention training programme, or Trust eLearning module in line with their role and responsibilities.

New healthcare support workers will complete pressure ulcer prevention training as part of their new to healthcare clinical induction.

Compliance for this should be monitored via the monthly Workforce Report by line managers within the team. Training will include:

- Performing risk assessments;
- Repositioning;
- Pressure relieving devices;
- Categorisation;
- Determining pressure ulcer prevention and management strategies.

18.3 Once either the half day pressure ulcer prevention or eLearning training has been completed an update should be completed to refresh knowledge on a two yearly basis.

18.4 Training will be provided in accordance with NICE (2014) to all healthcare professionals who have contact with patients deemed to be at 'high risk' and those who may be the sole healthcare contact for a patient. This will include all healthcare staff inclusive of allied health professionals.

18.5 Residential Care/Nursing Homes can request Pressure Ulcer Prevention Training via the Integrated Care Home Team. The website below is aimed at carers specifically and should be utilised as a first port of call for advice around pressure ulcer prevention.

www.reacttoredskin.co.uk

19.0 Monitoring Compliance and Effectiveness

19.1 Compliance with this policy will be demonstrated by the reporting of all category 2, 3, 4, SDTI's and unstageable pressure ulcers and completing a Pressure Ulcer Scrutiny Template for all of these pressure ulcers that have developed in LPT care, including those caused by a medical device. As part of this process any lessons should be captured which could lead to an improvement in patient care, it is then the role of the senior staff and service Matrons to embed this learning into practice.

19.2 The Pressure Ulcer Group will be responsible for reviewing:

- Multi-disciplinary attendance and approach at the meetings
- Themes and trends to pressure ulcer development
- Learning captured from the scrutiny of the incidents
- Mapping the prevalence of pressure ulcers
- Supporting with ideas to embed learning into practice
- Monitoring and evaluating whether improvement plans have been successful in reducing the development of pressure ulcers across the trust

19.3 The numbers of pressure ulcers reported are recorded each month and shared as per 18.

20.0 Links to Standards/Performance Indicators

20.1 This policy links to the Care Quality Commission (CQC) Outcomes safe and effective and pressure ulcer guidance issue d by NICE (2014)

TARGET/STANDARDS	**KEY PERFORMANCE INDICATOR**
Respect and dignity	Personalised care plans, timely interventions, appropriate wound management
Safety and good governance	0 Category 4 Pressure Ulcers developed in LPT care All Category 4 Pressure Ulcers developed in LPT care to be reviewed as a Serious Incident Monitoring of themes and trends to pressure ulcer development. Embedding lessons learnt from pressure ulcer scrutiny in practice
Staffing	Essential to complete role essential training completed by all identified staff. Assessments completed by all staff that are trained and competent to do them
Data compliance	Policy compliance will be monitored and reviewed by the service matrons, governance and PU group..
Pressure ulcer free days	CHS inpatient areas will continue to record pressure ulcer free days.

21.0 Stakeholders and Consultation

21.1 The involvement of relevant groups, committees and stakeholders are vital to the review and development of authorised documents. The policy author has the responsibility to ensure consultation takes place with the appropriate stakeholders. The policy author may take guidance from the policy group and Integrated Equality and Human Rights Service with regards to which stakeholders should be involved in the consultation process, for example in demonstrating due regard in context of requirements under the Equality Act 2010. The draft document should be circulated to the identified stakeholders clearly identifying the deadline for responding and the named contact for comments to be forwarded to. Following consultation all persons who responded should receive feedback relating to their specific comments.

22.0 References and Associated Documentation

This policy was drafted with reference to the following:

1) National Institute for Health and Clinical Excellance (2014) The prevention and treatment of pressure ulcers, www.nice.org/CG179

2) National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel (2014) Pressure ulcer prevention and treatment (2nd Ed). National Pressure Ulcer Advisory Panel, www.epuap.org www.npuap.org.

3) NHS Improvement (2018) Pressure Ulcers: revised definition and measurement, NHS Improvement, London

4) Noonan C, Quigley S, Martha AQ, Curley RN (2011), Using Braden Q to predict pressure ulcer risk in paediatric patients, Journal of Paediatric Nursing, (07/6) p2-10

5) Defloor, T. Bours, G. Schoonhaven, L. Clarke, M. (2002) Prevalence and incidence monitoring. Draft EPUAP statement on prevalence and incidence monitoring, EPUAP Review 4 (1) 13-15

6) National Patient Safety Agency (2010) NHS to adopt zero tolerance approach to pressure ulcers, http://npsa.nhs.uk/corporate/new/nhs-to-adopt-zero-tolerance-approach-to-pressue-ulcers/?locale=en./ (last accessed 4th January 2015)

7) Tissue Viability Society (2012) Achieving Consensus in Pressure Ulcer Reporting, Journal of Tissue Viability

8) Department of Health (2018) Safeguarding Adults Protocol, Department of Health, London

9) Waterlow, J. (2005) Pressure ulcer prevention manual: Waterlow pressure ulcer prevention / treatment policy, Waterlow, Taun

Appendix 1

Pressure Ulcer or Moisture Lesions Chart

	PRESSURE ULCER Pressure and /or shear must be present	MOISTURE LESION Moisture from urine, sweat or faeces must be present
LOCATION	Usually over a bony prominence but can occur anywhere on the body where there is sustained pressure.	Can occur over a bony prominence but pressure and shear must be excluded and moisture must be present. A linear split in the natal cleft is a moisture lesion . A 'teardrop' shape wound to the natal cleft is a pressure ulcer.
SHAPE	circular = direct pressure teardrop = pressure and shear	Diffuse and superficial in appearance, can 'mirror' where 1 buttock ulcer matches another. Often more than one in a group.
DEPTH	Variable according to categorisation (1-4)	Very superficial; size and depth may change if it becomes infected.
NECROSIS	Necrotic tissue on a pressure point is a pressure ulcer.	Moisture lesions have no necrosis.
EDGE	Usually well defined edges that may mirror the cause.	Irregular edges, may be 'jagged' where friction is also present.
TREATMENT	Use the wound management dressings Formulary to identify a dressing suitable for the stage of healing.	Identify the cause, implement good hygiene, educate carers and prescribe suitable preventative measures i.e. barrier cream or film.

Appendix 2

Pressure Ulcer Classification

Please select the stage that is best suited to the Incident

Developed in LPT Care
This means under the care of any area within LPT (not just the reporting teams area)

Pressure Ulcer on Admission (POA)
This means that the PU was present on admission to LPT ward/caseload

Suspected Deep tissue Injury

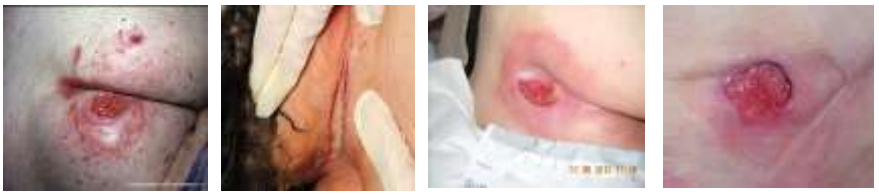
A localised area of purple discolouration over intact skin, or blood blister due to damage of underlying soft tissue. May be painful, firm, mushy, boggy, warmer or cooler compared to adjacent skin. may develop into a category 3 or 4 but cannot be confirmed until extent of damage is evident. Damage may be recoverable with effective 'off-loading' of affected area.

PU-Category-2 Developed In LPT Care

Superficial skin loss. Pink/Red wound bed. May be minimal superficial slough with healthy tissue evident. May present as a clear filled blister with no discoloration underneath.

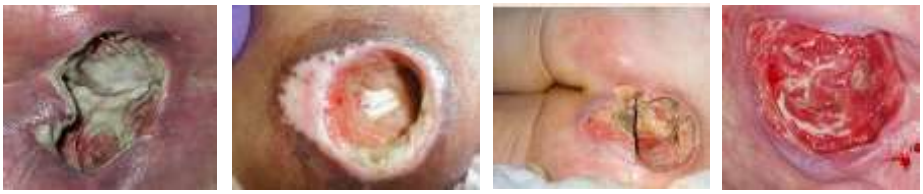
PU-Category-3 Developed In LPT Care

Full thickness loss. Subcutaneous fat may be visible but bone/tendon/muscle is not exposed and cannot be felt. Depth may vary depending on anatomical location

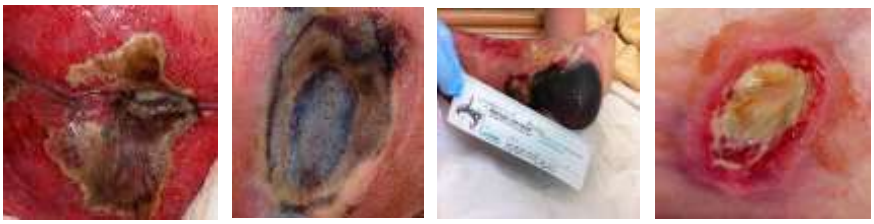


PU-Category-4 Developed In LPT Care

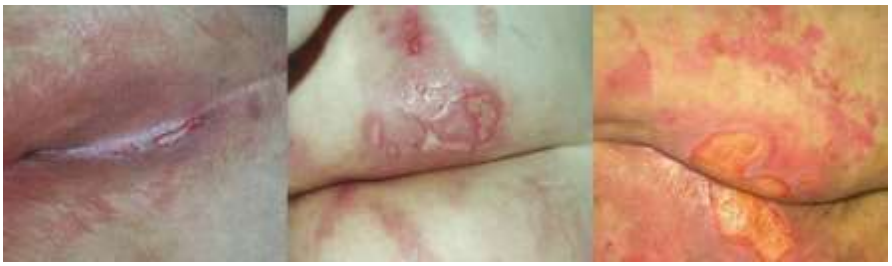
Full thickness loss. Can extend to expose bone/tendon or muscle or they may be directly palpable. Depth can vary by anatomical location. TVN involvement needed.



PU-Unstageable Developed in LPT Care
The wound bed is not visible due to presence of slough or necrotic tissue. Classification may not be possible until the ulcer is debrided. Tissue Viability Nurse involvement recommended



Moisture-associated skin damage (MASD) Developed in LPT Care
A lesion due to the constant presence of urine, faeces, perspiration or wound fluid Often have diffuse or irregular edges Very superficial size and depth There is no necrosis If redness is not uniformly distributed the lesion is likely to be a moisture lesion Pink or white surrounding skin (if it is pressure damage surrounding skin will be red non-blanching)



Medical Device Related Pressure Ulcer

A pressure ulcer (category 2-4, SDTI and Unstageable) that has developed due to the presence of a medical device, including:

- Catheters
- Oxygen Tubing
- Casts
- Incorrect use of equipment
- Orthotic devices

Appendix3

Leicestershire Partnership Trust

Pressure Ulcer Scrutiny Template Guidance

Scrutiny review by:

Location of patient (when PU developed):

Location of pressure ulcer:

1. Tell us a bit about this patient – patient centred information that is specific to the individual – why they are on caseload, how frail are they, what risks do they have for developing a pressure ulcer?

Guide – areas to consider

- ✓ Review assessments on admission including any long term conditions (physical and mental health), Waterlow, MUST / NST score / Braden Q – is this complete/accurate?
- ✓ If seen by other professionals, i.e. Dietician – what have they advised re PU in the past?
- ✓ Is there a Pressure Ulcer Prevention Care Plan – is this complete, accurate and personalised?
- ✓ Is the wound assessment completed on identification of PU?
- ✓ Body map / photograph completed?
- ✓ Has Duty of Candour been discussed?/ Mental Capacity Assessment
- ✓ Rapidly changing condition
- ✓ Patients / parents/Carers/Staff views in relation to the care provided

Planned Care

- ✓ Patient location - give name of care home if applicable (may impact if any learning required for care homes)
- ✓ Has the Incident been report to the Local Authority?
- ✓ Safeguarding concerns

Drop down calendars to record dates of:

- Waterlow / Braden Q last completed
- SSKIN last completed
- Photographs initially completed
- Resources provided
- Date PU occurred

2. Why do you think the pressure ulcer happened?

Guide – areas to consider

- ✓ Check that the SSKIN document is completed as per care plan and completed as per risk assessment on SystmOne (daily for inpatients)
- ✓ Was patient / parent or carer provided with advice/resources?
- ✓ Check equipment in place prior to PU development
- ✓ Did this PU develop due to a medical device?
- ✓ Did the patient / parent or carer choice differ from clinical recommendations? Was an alternative discussed?
- ✓ Was appropriate referral to specialist carried out timely eg: TVN/Podiatry/Therapy/Dietician?
- ✓ Are there any gaps in care, delay in provision of equipment, completion in assessments or evaluation?
- ✓ Did the patient have concerns regarding energy usage which may have impacted on care decisions? I.e. use of electricity for air mattress and profiling beds.
  *For County patients – was' First Contact Plus' support offered?
  *For City patients – contact Social Care Services for advice and support

3. What did we do well?

- ✓ Areas of good practice
- ✓ Key staff to feedback good practice too
- ✓ Integration
- ✓ Consider recommendation for Valued Star

4. If you could go back would you have done anything differently for the patient on admission, during their period of care and in the visits/immediate time before the pressure ulcer was identified?

Guide – areas to consider

- ✓ Were the assessment tools (or inpatient admission checks) clearly documented and completed timely?
- ✓ Was the risk to the patient explained clearly to them with a plan to reduce risk documented?
- ✓ Has repositioning been discussed? And a clear plan been put into place?
- ✓ Are all the SSKIN elements clearly discussed with risk modification plans in place?
- ✓ Is there documented evidence of review within MDT?

Lead Nurse/Matron to complete at Review Meeting		
Date of review	**Reviewed by**	**Outcome agreed (Lessons Learnt/Safeguarding threshold)**

5. Lessons learnt for sharing within the team and wider team across LPT

- ✓ How will learning be fed back
- ✓ Clinical supervision dates planned
- ✓ Training needs identified
- ✓ Gaps in policy procedure identified

Drop down / tick box to identify themes for lessons learnt (can choose multiple options):

- Patient education / information
- Patient voice in care
- Repositioning
- Delegation of care
- Missed visits / delay in healthcare contact
- Delay in ordering equipment provision / identifying equipment need
- Lack of assessments/reassessments
- Inaccurate assessments
- Lack of care plan/review of care plan
- Evaluation of prevention strategies
- Lack of SSKIN /elements of SSKIN/review of SSKIN

Drop down / tick box to identify Actions for Lessons Learnt:

- Clinical supervision
- Formal/ELearning training
- Learning Boards
- Policy/Guideline Review
- Shadowing
- Audit
- Delegation of care education
- Performance Management

Appendix 4

Ordering and monitoring requirements for dynamic systems

- Dynamic air systems for community patients are ordered and monitored in

accordance with need (see 10.6)

- An Allied Health Professional or Community Learning Disability/Mental Health Nurse may complete a risk assessment identifying pressure prevention needs for a community patient; they will refer to CHS community nursing for equipment.

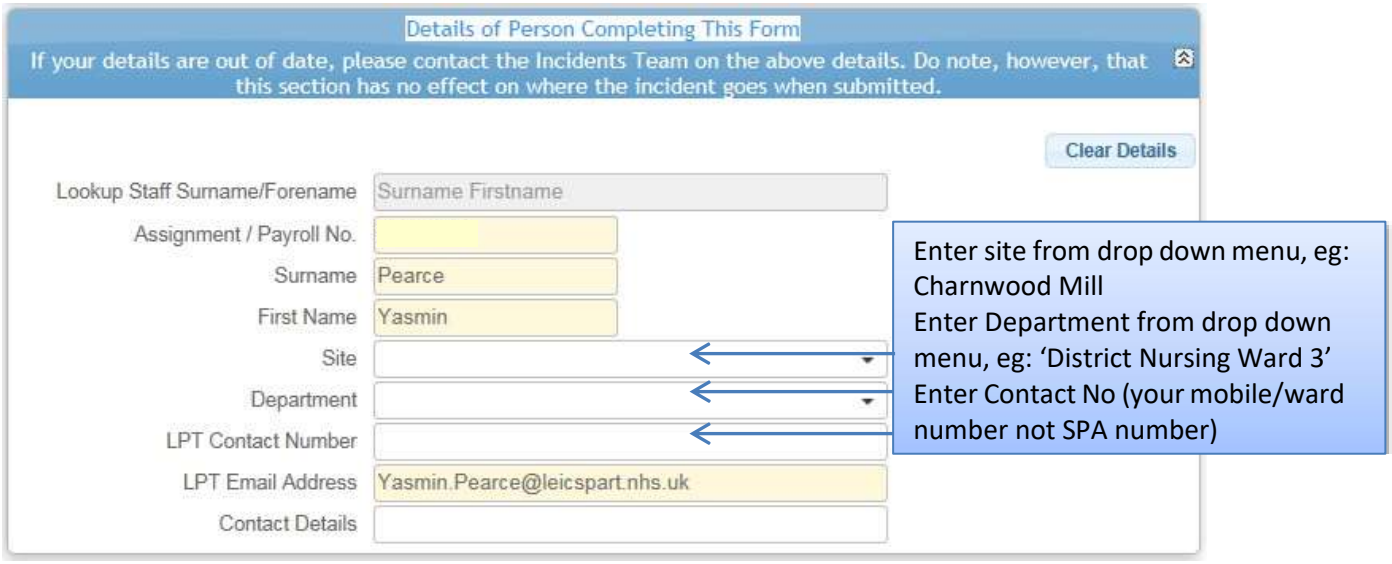
- Where an Allied Health Professional or Community Learning Disability/Mental Health Nurse are the only health professional involved they will monitor pressure prevention needs utilising Waterlow/SSKIN. On discharge from caseload any patient on a dynamic system will be referred into CHS community nursing for monitoring of pressure prevention needs.

- A health care professional will be identified to monitor children and young people on dynamic services in FYPC where no other health professional is involved.

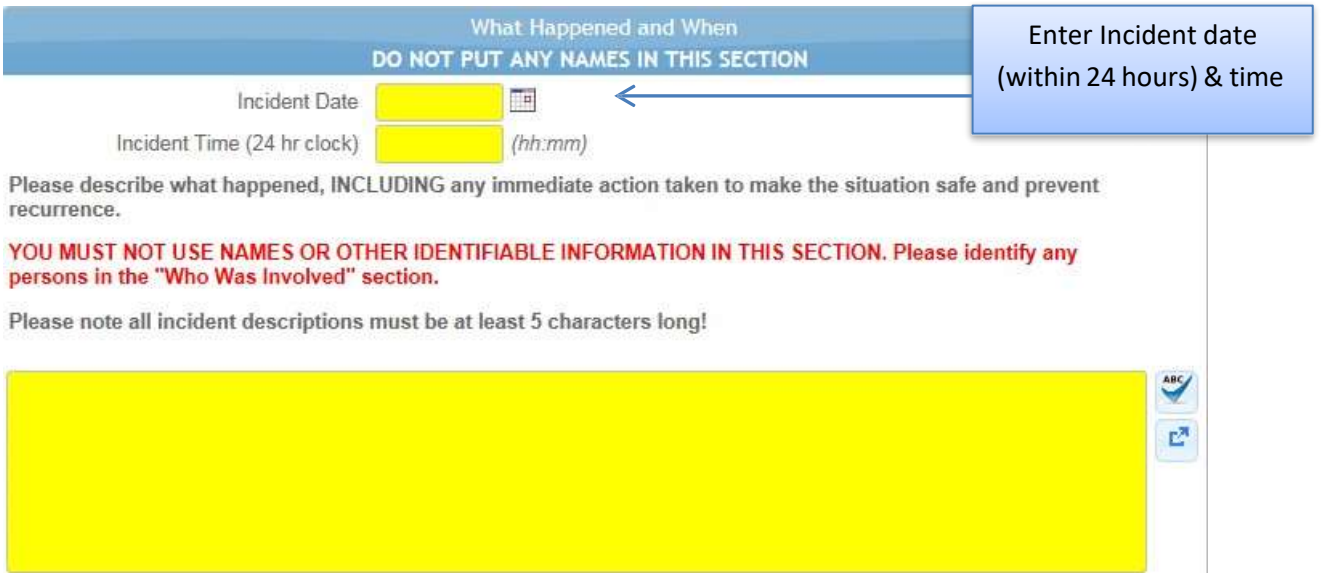
Appendix 5

Pressure Ulcer Incident Reporting Guidance

Details of Person Completing This Form



What Happened and When (DO NOT PUT ANY NAMES IN THIS SECTION)



Note: When writing your Incident description, please include the following

- Why do you think the pressure damage developed?
- The category & anatomical location of the pressure ulcer
- Completed Wound Assessment including recent photograph, SSKIN & Waterlow
- Use SSKIN as a template to describe what care was in place prior to pressure ulcer development, to identify any factors that could have contributed to development
- Any other factors you feel are relevant (e.g. patient at end of life, peripheral vascular disease)
- Did patient choice differ from the advice given? – If so please state what?
- If device related – describe what device?
- Any advice given or actions taken

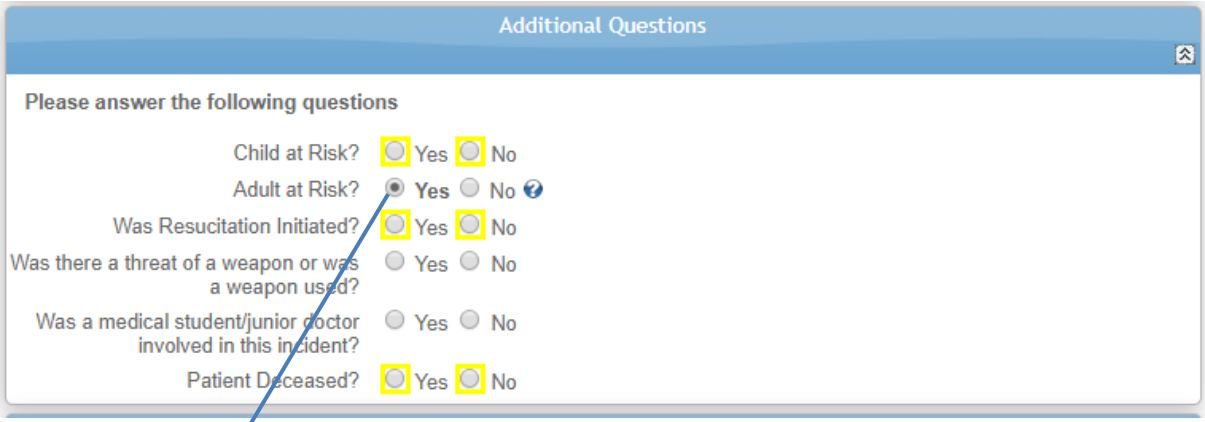
Cause Group – Select **Tissue Viability**, this will open another page with Images for identifying the classification category of the pressure ulcer. Select the appropriate image and description. If the patient has multiple pressure ulcers which are in different locations on the body, ie heel/sacrum/bunion they should be reported as separate incidents.

Cause codes in the Ulysses:

- Pressure ulcers that are not developed in LPT care are now call **'Pressure Ulcer on admission' (POA)**
- Unstageable Pressure Ulcers
- Pressure Ulcer caused by medical device
- Moisture-associated skin damage (MASD) previously known as moisture lesions

Please Note - New sub category codes in Ulysses from 1st July 2020:

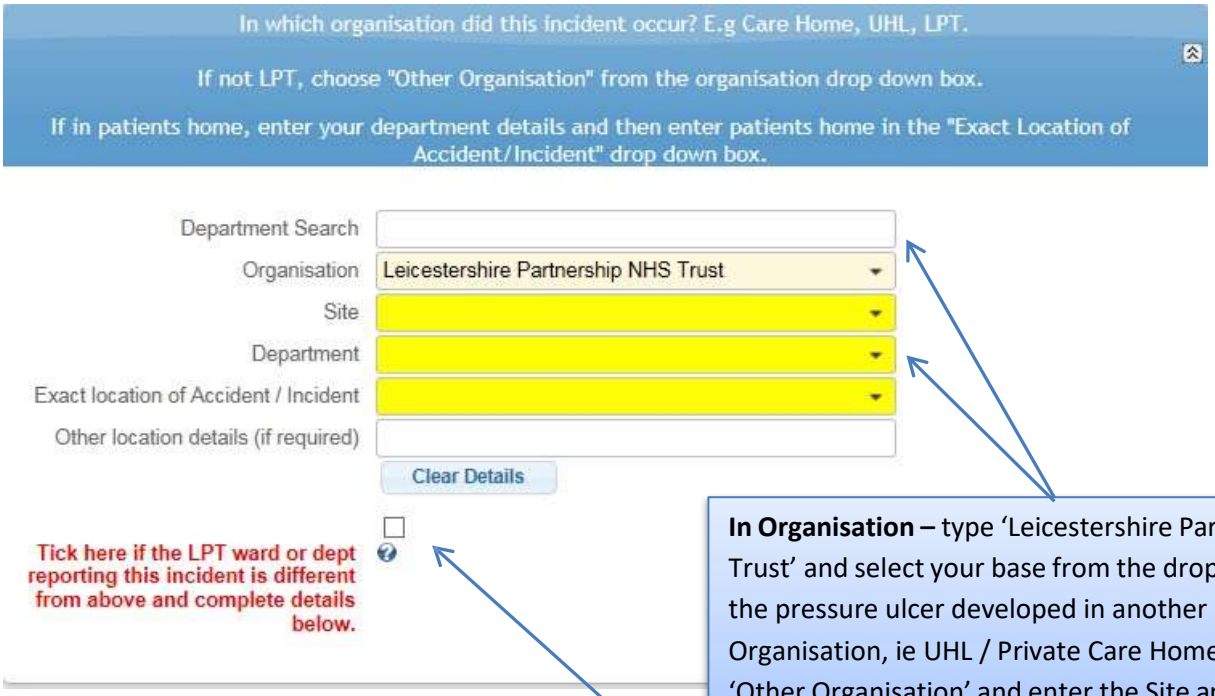
- Deep Tissue Injury (Suspected) in LPT care evolved to Category 4
- Deep Tissue Injury (Suspected) in LPT care evolved to Category 3
- PU Unstageable in LPT care evolved to Category 4
- PU Unstageable in LPT care evolved to Category 3
- Deep Tissue Injury present on admission evolved to Category 4
- Deep Tissue Injury present on admission evolved to Category 3
- PU Unstageable present on admission evolved to Category 4
- PU Unstageable present on admission evolved to Category 3



The **'Adult at Risk'** button is automatically ticked. Pressure ulcers can be caused by neglect which would be a safeguarding issue. Select **'No'** if there are no safeguarding risks linked to the incident.

Adult/Child at Risk - Definition from the Trusts Safeguarding Policy is: *('a person who has needs for care and support (whether or not those needs are being met) who is experiencing or is at risk of abuse or neglect and as a result of those needs is unable to protect himself or herself')*

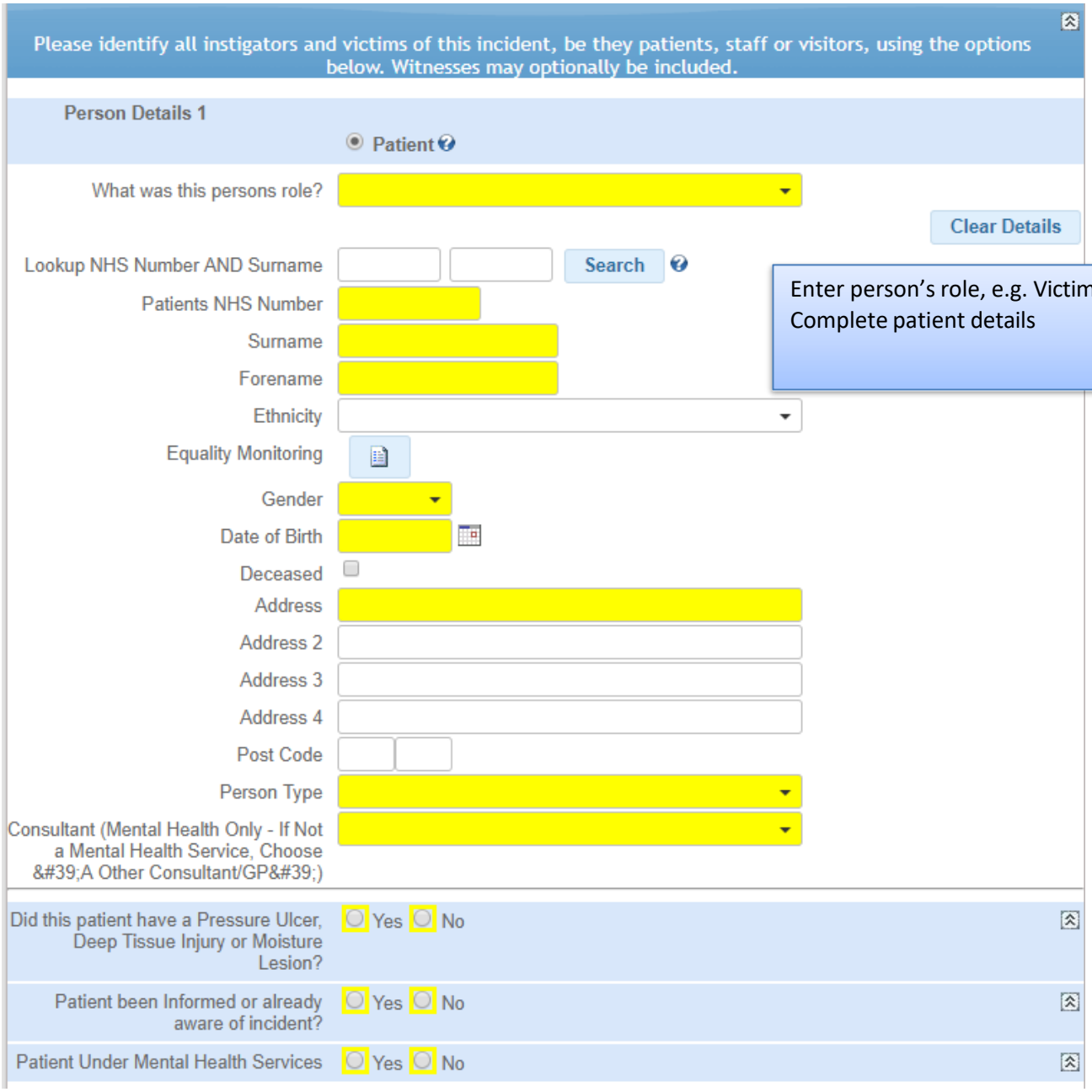
Which organisation did this incident occur? e.g. Care Home, UHL, LPT



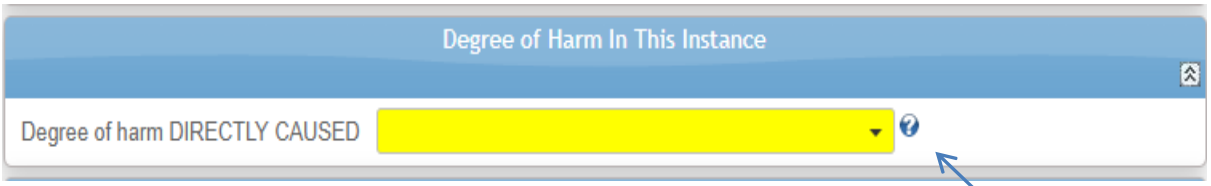
In Organisation – type 'Leicestershire Partnership Trust' and select your base from the dropdown list, if the pressure ulcer developed in another Organisation, ie UHL / Private Care Homes select 'Other Organisation' and enter the Site and Department

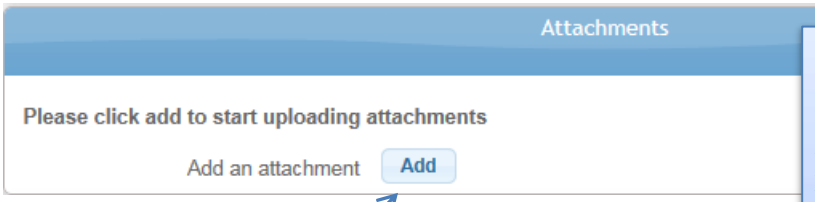
Tick this box if you have selected 'Other Organisation' in the above box and record your site and department

Who Was Involved?



Degree of Harm in This Instance

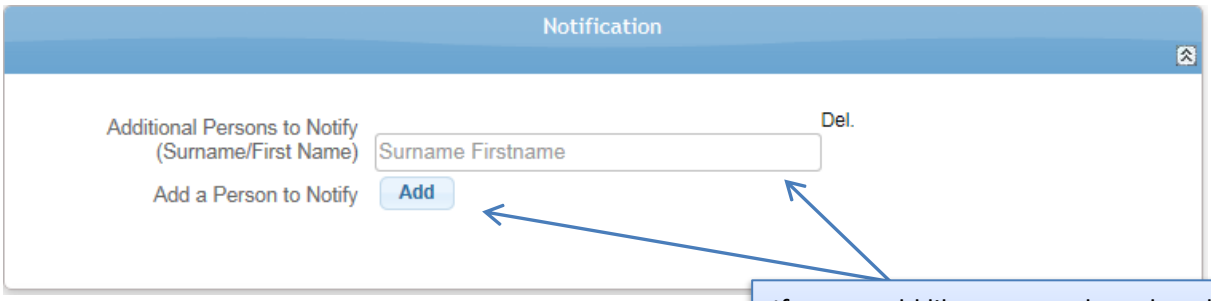




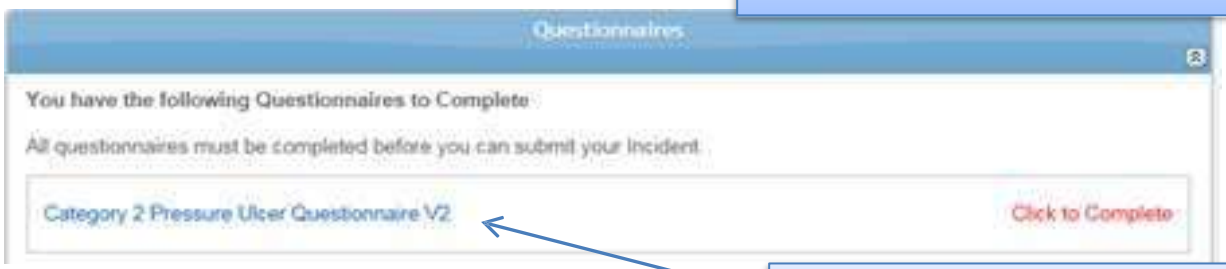
Please use the question mark icon to identify the degree of harm:

- Pressure on Admission – No Harm
- Category 2 – Minor Harm
- Category 3/DTI/Unstageable – review on case by case basis (could be minor or moderate) - amend post scrutiny
- Category 4 – Moderate Harm

Click **Add** to upload any attachments/documents



If you would like anyone else other than your team managers to be notified, enter their name in this box



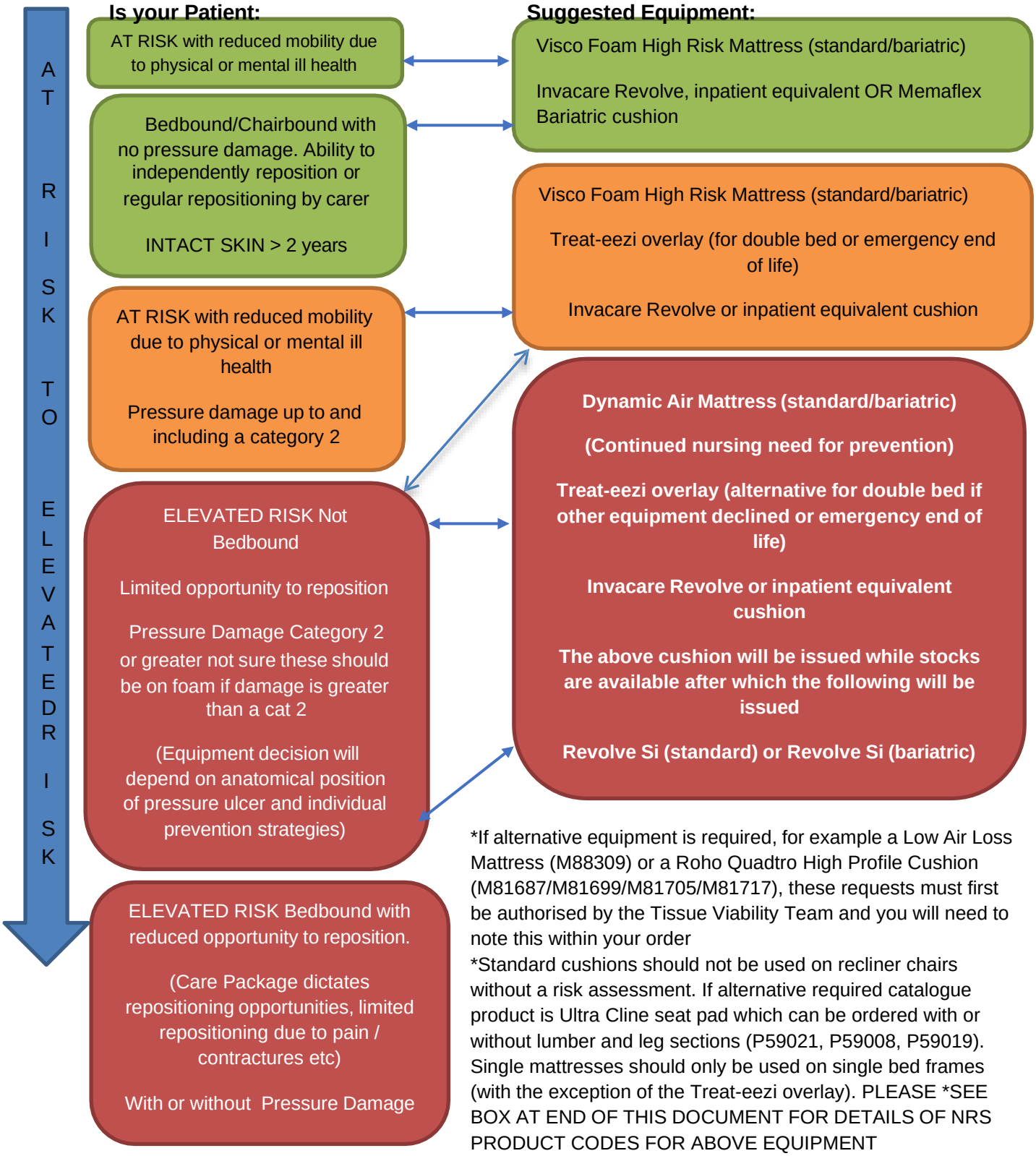
Click here to complete Pressure Ulcer Questionnaire

Appendix 6

Pressure Relieving Equipment Flow Chart

- Pressure relieving equipment should not be solely relied upon to prevent or manage pressure ulceration. This flow chart is for guidance only and should be used in conjunction with clinical judgement.

- All patients should have an individualised repositioning schedule and be fully informed of their individual pressure ulcer risk and pressure area prevention strategies.



*If alternative equipment is required, for example a Low Air Loss Mattress (M88309) or a Roho Quadtro High Profile Cushion (M81687/M81699/M81705/M81717), these requests must first be authorised by the Tissue Viability Team and you will need to note this within your order

*Standard cushions should not be used on recliner chairs without a risk assessment. If alternative required catalogue product is Ultra Cline seat pad which can be ordered with or without lumber and leg sections (P59021, P59008, P59019). Single mattresses should only be used on single bed frames (with the exception of the Treat-eezi overlay). PLEASE *SEE BOX AT END OF THIS DOCUMENT FOR DETAILS OF NRS PRODUCT CODES FOR ABOVE EQUIPMENT

Prevention of Pressure Ulcers on the Heels

Top Tips

- Advise carers / patient to apply emulsifying cream /ointment each day.
- Avoid massaging heel prominences.
- If being nursed on a profiling bed, ensure that the knee break is being used to decrease the shearing and friction forces and enhance the positioning of the heels.
- Where possible encourage the patient to rotate / exercise the ankle each hour.

Patients assessed as 'At Risk' of pressure ulceration to their heels

- Float heels: use pillows to support lower limb when in bed enabling patients to elevate the heels leaving the heels free from any pressure.
- Elevating legs when sat out; 'float heels' over the edge of a stool; use pillows to support lateral length of leg if needed.
- Use KerraPro pads to keep ankles / knees separate, to protect posterior foot and ankle as part of the repositioning schedule.
- Advise patient/carer to check correct positioning of KerraPro pad frequently throughout the day. Ensure patient/carer is aware to remove the kerrapro at night to prevent moisture building up
- Consider Parafricta Products (available on FP10) or film dressings to prevent friction injuries on the heels of agitated patients.

Kerrapro Pads are obtained via Formeo

Patients assessed as 'Elevated Risk' of pressure ulceration to their heels.

Patients with oedematous legs, diabetes, reduced blood supply to the lower limb or previous pressure ulceration to the heels will be at elevated risk particularly during periods of prolonged bed rest.

- Apply MaxxCare Pro Evolution boot (NB these boots can remain in position to allow for patient transfers but it is not advisable to mobilise).
- Ensure correct positioning of MaxxCare Pro Evolution boots frequently throughout the day.
- Consider referral to podiatrist for alternative offloading devices

MaxxCare Pro Evolution boots are ordered via the Integrated Community Equipment Loan Service (NRS)
(please note these items are only available on a 5 day service level. If you require these more urgently then you must discuss and obtain approval from the Tissue Viability Team and this must be recorded in the delivery notes when placing your order)

NRS PRODUCT CODES

- Standard memory foam mattress – P58648/Bariatric memory foam mattress – P53836
- Cushions: Standard - Talley Si – P73379
- Cushions: Bariatric – Si – P71367/P71380/P71392
- Dynamic mattress: Standard – Talley – M75146/Bariatric – M27474
- Treat-eezi overlay: P58489

Appendix 7

The purpose of this template is to provide assurance that any training implications have been considered

Training topic:	Pressure ulcer prevention and management.
Type of training:	☐ Mandatory (must be on mandatory training register) ☑ Role Specific – CHS and specific DMH & FYPCLD services ☐ Personal development
Division(s) to which the training is applicable:	☑ Adult Learning Disability Services ☑Adult Mental Health Services ☑Community Health Services ☐ ☑Families Young People Children ☐
Staff groups who require the training:	*Please specify…* *All clinical staff inclusive of Nurses, allied health professionals, and health care support workers.*
Update requirement:	Every two years
Who is responsible for delivery of this training?	Tissue Viability team
Have resources been identified?	On-going
Has a training plan been agreed?	On-going
Where will completion of this training be recorded?	☑Trust learning management system ☐ Other (please specify)
How is this training going to be monitored?	Evaluation forms post sessions

Appendix 8

Policy Monitoring Compliance and Effectiveness Section

Criteria Number & Name:

Duties outlined in this Policy will be evidenced through monitoring of the other minimum requirements

Where monitoring identifies any shortfall in compliance the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance.

Reference	Minimum Requirements	Self assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
7.0	Patients have a prevention care plan for those at high risk.	7.0	Record keeping audit	Each team / service/ area / division to complete.	Monthly to Chief Nurse
6.0 8.0	Patients are risk assessed for pressure ulcer.	6.0 8.0	Record keeping audit	Each team / service/ area / division to complete.	Monthly to Chief Nurse
7.0	All elements of SSKIN are fulfilled in relation to patients needs.	7.0	Data Compliance tool completed	TVN team	Monthly to divisional Patient Safety Experience

Appendix 9

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☑
Respond to different needs of different sectors of the population	☑☐
Work continuously to improve quality services and to minimise errors	☑☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☑☐
Help keep people healthy and work to reduce health inequalities	☑☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☑☐

Appendix 10

Due Regard Screening Template

Section 1	
Name of activity/proposal	Pressure Ulcer Prevention and Management Policy
Date Screening commenced	October 2020
Directorate / Service carrying out the assessment	LPT
Name and role of person undertaking this Due Regard (Equality Analysis)	Laura Browne Operational Lead Tissue Viability
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To ensure revised pressure ulcer prevention and management policy considers all necessary aspects for due regard	
OBJECTIVES: Ensure policy is fit for purpose.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	People at both end of the age spectrum may be considered to be at greater risk of pressure ulcer development.
Disability	People with a disability that impacts specifically on their mobility may be at a greater risk of pressure ulcer development.
Gender reassignment	No impact.
Marriage & Civil Partnership	No impact.
Pregnancy & Maternity	No impact.
Race	People with darker skins tones may need require alterative skin inspections to visual.
Religion and Belief	No impact.
Sex	Females may be considered to be at greater risk of pressure ulcer development; individual assessment is required to enable all patient factors to be considered.
Sexual Orientation	No impact.
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4

If this proposal is low risk please give evidence or justification for how you reached this decision:			
The pressure ulcer prevention and management policy is for use across all divisions; risk assessment, interventions and management of patient's requirements is expected to be performed on an individual patient by patient basis.			
Signed by reviewer/assessor	Laura Browne	**Date**	7.10.20
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	l.browne	**Date**	7.10.20