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.

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Which Relevant CQC Fundamental Standards?	Person centred care, dignity and respect, safety, good governance, staffing	

Contents

REFERENCES AND ASSOCIATED MANDATORY DOCUMENTATION (Appendix1-5 are Mandatory)

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 number	Date	Comments (description change and amendments)
Version 10	March 2017	Review: reporting and investigation (13.0) updated in line with new processes. **Appendix 13** 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	February 2022 – September 2023	The policy has been extensively updated in sections 7. aSSKINg, 11. Reporting and investigating pressure ulcers and **Appendix 7** pressure ulcer scrutiny template. Remote consultation flow chart **Appendix 18**.
Version 13	January 2024	Update to information and background, review of relevant appendix. Update to Pressure ulcer prevention monitoring and compliance section (**Appendix 6)** Language standardised throughout document.
Version 14 Version 14.1	May 2024	Updates to training need analysis (section 15.0 and Appendix 1). Addition of flow chart for process of reporting and managing incidents for Allied health professional and community nursing (Appendix 16). Updated Ekamove criteria (Appendix 15). Minor update and amendments

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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 procedures 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.

Please refer to due regard assessment (**Appendix 4**) of this policy.
For further advice go to the LPT Due Regard Toolkit on e-source.

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	Localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful (NHSI 2018). 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 patients 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 8** 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	Depending on skin tone this may present as redness, darkening, lightening or grey/blue/purple tones (Wounds UK 2021). Skin is intact and non-blanching in a localised area, usually over a bony prominence. The area may feel tight, spongy or appear shiny with pain or numbness. Skin may feel warmer or cooler in comparison to adjacent tissue. (Wounds UK 2021) **Category 1 pressure ulcers <u>do not</u> require reporting.**
Category 2 Pressure Ulcer	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 9).** 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	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 9**). **Category 3 pressure ulcers require incident reporting.**
Category 4 Pressure Ulcer	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 9).** **Category 4 pressure ulcers require incident reporting and will require the completion of a Pressure Ulcer investigation template which will be signed off as per the Category 4 pressure ulcer investigation process.** If the category 4 pressure ulcer occurs to an inpatient, then the same investigation template is completed however this is STEIS reportable.
Suspected Deep Tissue Injury (SDTI)	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 9**). **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	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)	Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes (EPUAP et al 2019). Pressure ulcers caused by medical devices will require incident reporting. Device-related pressure ulcers should be reported and identified by the notation of (d) after the report – e.g., Category 2 PU (d) – to allow their accurate measurement (NHSI 2018).
Pressure Ulcer on Admission (POA)	A pressure ulcer that is observed during the skin assessment undertaken on admission to that service (LPT caseload/ward) (NHSI 2018).
Pressure ulcer which developed in LPT Care	A new pressure ulcer that it is first observed within the current episode of care (NHSI 2018).
Trained	For purpose of this policy, 'trained' refers to a member of staff who has completed the LPT pressure ulcer prevention training and passed the assessment. However, there will be occasions where this policy is for use/consultation for supporting clinical practice and are 'temporary workforce' (agency) who are required to have undertaken pressure ulcer prevention training previously in another healthcare /learning environment before they are assigned to work at LPT.

1.0. Purpose of the Policy

1.1 The aim of this policy is to:

1.1.1 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.

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

2.0. Summary and scope of the Policy

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 & Background

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 Pressure ulcers remain a concerning. and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients1 were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. Finding ways to improve the prevention of pressure damage is therefore a priority for policymakers, managers, and practitioners alike. https://www.england.nhs.uk/wp-content/uploads/2021/09/NSTPP-summary-recommendations.pdf

3.4 Pressure ulcer development in NHS funded care is also recognised as an increasing risk for financial claim (ligation) according to NHS Resolution in addition to the distress caused to patients.

3.5 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.

3.6 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 carers of their on-going pressure ulcer prevention needs. Healthcare professionals need to be guided by the provisions of the Mental Capacity Act (2005).

3.7 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 Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

5.2 The Trust Policy Committee is mandated on behalf of the Trust Board to adopt policies.

5.3 Directorate 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 and must ensure 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 healthcare 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 Responsibility of Clinical Staff

6.1 Consent

- 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 patient consenting must have the capacity to make the decision.

- In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a 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 aSSKINg

7.1 Many factors are involved with a patient'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.

7.2 ASSKING is an acronym which covers the key elements of pressure ulcer prevention: 'Assess risk, Skin Assessment and Skin Care, Surface, Keep Moving, Incontinence, Nutrition and Giving Information'. It has been adopted as a best practice model for reducing pressure ulcers (NHSI 2018).

7.3 Assess Risk

7.3.1 Risk assessments will be documented at the first contact visit in the community if the patient is housebound.

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

7.3.3 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 and recorded as such.

7.3.4 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). Consider the potential impact of mental health status on pressure injury risk (EPUAP et al 2019).

7.3.5 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).

7.3.6 Risk assessment will be completed using a structured approach that includes a comprehensive skin assessment, consideration of additional risk factors and interpretation of outcomes using clinical judgment (EPUAP et al 2019).

All rationales for decisions should be documented at each risk assessment (Waterlow 2005).

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

7.3.8 The Waterlow and Braden Q Risk Assessment tools 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.

7.3.9 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.*

7.3.10 Patient assessed as **'not at risk'** should be reassessed if there is a change in the patients mental and/or physical health condition.

7.3.11 Patients assessed as **'at risk'** 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, signs of pressure ulcer development and provided with resources on pressure ulcer prevention. 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.
- Where visits are less frequent, information should be given to patients, parents and carers to ensure they are aware to inform the service if there is a change in their condition.
- Weekly within physical 'in-patient' healthcare settings.
- Monthly within inpatient DMH/LD/FYPC settings.
- **or MUST be reassessed when the patients' mental or physical condition alters.**

7.3.12 Patients assessed as at **'high risk'** or **'very high risk'** of pressure ulcer development must have an individualised care plan for the prevention of pressure ulcers and will be reassessed.

- Patients in their own home requiring frequent visits i.e., those receiving insulin and those at the end of their life will require a Minimum of '**monthly**' reassessment.
- Patients requiring less frequent contact should be reassessed at each visit. i.e., patient receiving wound or catheter care or B12 injections.
- Where visits are less frequent, information should be given to patients, parents and carers to ensure they are aware to inform the service if there is a change in their condition.
- **Weekly** within physical 'in-patient' healthcare settings.
- Minimum of '**monthly**' for those within inpatient DMH/LD/FYPC settings.
- **Or MUST be reassessed when the patients' mental or physical condition alters.**

7.3.13 Reassessment will be documented each time it is completed.

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

7.3.14 Patients who attend Clinic Appointments – all health care professionals facilitating a clinic have a responsibility to improve patient's awareness of pressure ulcer risk by displaying, and drawing attention to, the 'Are you at risk of developing a pressure ulcer?' poster (see **Appendix 7**). A QR code is on the poster for them to scan and download the pressure ulcer prevention leaflet 'Stop, Plan, Prevent': this is also available via the Tissue Viability team administrator by emailing llr.tissueviability@nhs.net.

7.2 Skin Assessment

7.2.1 Assessment of skin should encompass a thorough inspection of the skin and identify what the patients' baseline skin tone is: it is important to note this can vary according to anatomical location and comparing a similar area may be useful i.e., both heels (Wounds UK 2021).

7.2.2 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 and consent.

7.2.3 Where a skin assessment is declined the health care professional will discuss rationales and risk with the patient to ensure their decision is fully informed: this will be recorded in the patient record.

7.2.4 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.

7.2.5 Where a dark skin tone is present it can be helpful to ask the patient if they have any areas that feel sore or if they have noticed any changes in their skin (Wounds UK 2021).

7.2.6 Dark skin tones are more susceptible to trans-epidermal water loss and water content (Wounds UK 2021) this will increase the risk of skin damage and must be considered when assessing skin and developing a plan of care.

7.2.7 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
- hips
- knees
- ankles
- spine
- ischial tuberosity's
- parts of the body affected by compression hosiery/anti-embolic stockings
- femoral trochanters
- parts of the body where pressure, shear, and friction are exerted in the course of a patient's daily living activities.
- parts of the body where there are external forces exerted by equipment and clothing
- elbows
- whole head, inclusive of face and ears
- shoulders, back of head
- toes

- contractures where moisture will be a co-efficient
- Colour changes or discolouration.
- Variations in heat, firmness, and moisture.
  (NICE 2014)

7.2.8 In addition to these areas the risk of a pressure ulcer must be highlighted to patients/parents/carers where a plaster cast or splint is in place following fracture. Ulcers can develop as oedema reduces beneath the cast/splint and friction becomes a co-efficient, signs include soreness not associated with the fracture and pink discolouration to the plaster cast from haemoserous exudate.

7.2.9 Patients who wear thromboembolic stockings (TED) are also at risk from pressure injury so reviews of skin should be included during personal hygiene delivery by removing, inspection and replaced. Patients should be advised to do this in the community setting as part of discharge planning.

7.2.10 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. At enhanced risk are those wheelchair users with uncontrolled head movements across the head rest: this continued friction combined with pressure can lead to ulcers across the occiput.

7.2.11 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.

7.2.12 Patients/parents/carers should always be educated on blanch testing and escalation to nursing services as part of aSSKINg (see **section 7.7** Giving Information).

7.2.13 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 DMH/LD areas.

7.2.14 Assess the skin under and around any medical devices as part of routine skin assessment, ensuring the device is fitted correctly and is the correct size/shape for the patient (NHSI 2018).

7.1.15 Where a bony prominence has been protected from the pressure/friction of a medical device i.e., hydrocolloid on the nose bridge/silicone heel protector, the health care professional must inspect this as part of their skin assessment to ensure the skin is not broken beneath.

7.2.16 If clinically safe to do so, alternate oxygen delivery between a correctly fitting mask and nasal prongs to reduce the risk of pressure damage from the medical device in adults and children (NHSI 2018).

7.2.17 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.

7.2.18 Patients who receive a remote consultation from a service in CHS should be asked about their skin integrity. If there are any concerns about their skin, they should be advised to send a photograph to that service for a virtual review. If a patient has broken skin a referral to community nursing services should be made. The remote consultations process can be found in **Appendix 18**.

7.3 Surface

7.3.1 Equipment availability and type varies across service provision. Community services access equipment from a catalogue of options via the community equipment supplier ordering portal. Inpatient services will have air/static mattresses and static cushions provided via Medical Devices: the provision of heel off-loading devices are the responsibility of individual areas.

7.3.2 When prescribing a support surface for pressure ulcer prevention it is important to understand their mechanism of action and match them to patient need (**Appendix 13**). Equipment availability varies across settings but may include mattresses, cushions, profiling beds, turning systems, overlays, heel off-loading devices and friction reducing devices (NHSI 2018).

7.3.3 Health care professionals need to be aware of the range of equipment available to them and the impact different surfaces can have on patient independence (NHSI 2018).

7.3.4 Pressure relieving equipment will be selected based on the patient's circumstances, including assessed level of risk, number/severity/location of existing pressure ulcers, level of mobility/inactivity, patient comfort, patient choice, size/weight of the individual, place, and circumstances of care provision (EPUAP / et al 2019).

7.3.5 If a need for an alternating air mattress has been identified, health care professionals must ensure that their smoking status has been discussed and refer to the 'Dynamic Mattress Flowchart for patients who smoke' to inform decision making **(Appendix 19).**

7.3.6 Seating support surfaces need to be chosen in consideration of the patient's body size and shape, effects of posture and deformity on pressure distribution, mobility and lifestyle needs (EPUAP et al 2019).

7.3.7 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 or moulded wheelchair 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.

*No additional cushions or padding should be added into moulded wheelchairs and any concerns relating to pressure relief within this should be referred back to the local wheelchair centre.

7.3.7 Patient's with existing pressure damage to the ischium/sacrum may need assessing for a very high specification cushion in the following circumstances:

*cannot be positioned off the existing ulcer
*existing pressure ulcer does not heal or deteriorates despite all appropriate care/repositioning
*has pressure damage on 2 or more turning surfaces that limits repositioning options
(NPUAP et al 2019)
*Should any of the above be a concern discuss with TVN.

7.3.8 Ensure all seating is suitable for the patient's weight (EPUAP et al 2019).

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

7.3.10 A specialist seating assessment can be provided by the therapy team if a patient has specific postural needs, where a standard chair is not sufficient to support their posture. When providing or recommending patients with a specialist chair, the chair will be appropriate for the patient ensuring that the patient is able to:

- Sit with their feet square on the floor or footplate with their bottom at the back of the seat. Their back will be fully supported within the chair in either an upright or reclined position depending on assessment.
- Have their thighs fully supported to approximately 1" behind the knee.
- Have approximately a 90-degree angle at the hips, knees and ankles or chair positioned to accommodate restricted angles of hip, knee or ankle.
- 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 Therapy seating 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 or accommodating them in their existing chair if deemed safe and supportive of their positioning needs.

7.3.11 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.

7.3.12 Silicone heel supports are available on the LLR formulary which provide pressure relief and can be used on **intact** skin. Internal pathways are available to support application and care (see **Appendix 14**).

7.3.13 Heel off-loading devices for the management and prevention of pressure ulcers are available in community services to offload pressure to the heels. These are not suitable for ulcers to the plantar, medial or lateral aspects of the foot or ankle ulcers.

7.3.14 Heel off-loading devices are available in some inpatient areas: ensure instructions for use are followed.

7.3.15 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.

7.3.16 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.

7.3.17 Where patient choice is to remain in their own bed a static overlay must be offered (EPUAP et al 2019).

7.3.18 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 (**See section 9.1**).

7.3.19 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 (**see section 9.2**).

*Please refer to **section 9.0** 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 a safeguarding alert to the local authority.

7.3.20 A referral can be discussed with the therapy service to review suitability for a sleeping system to support postural realignment (NHSI 2018). Sleep Systems do not offer pressure relief (see **Appendix 17**).

7.3.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 (NHSI 2018) (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.

7.4 Keep Moving

7.4.1 To maximise the benefits of repositioning all strategies need to be collaborative, promote early enablement and self-management, where possible (NHSI 2018). All patients unable to independently mobilise will require a moving and handling assessment (NHSI 2018): this can be found on SystmOne.

7.4.2 All patients with or at risk of developing a pressure ulcer should have an individualised repositioning schedule agreed with them unless contraindicated (EPUAP et al 2019). This will be recorded within the patients' plan of care.

7.4.3 Repositioning frequency will be dependent on the patient's level of activity, mobility and ability to independently reposition in conjunction with their medical condition, pain/comfort, treatment objectives, results of the risk assessment and skin tolerance assessment (EPUAP et al 2019, NHSI 2018). Skin tolerance assessment is required when a new medical device is fitted/orthotics issued or when a patient is starting to have periods sitting out after a period of being nursed in bed due to illness/recovery from acute event. This will be recorded within the patients' plan of care.

*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 (NHSI 2018). Refer to Positioning Guidance and Therapy Referral Tool (**Appendix 17**).

7.4.4 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 considering the patient's environment and individual needs and *patient choice. Repositioning frequency may range from 30 minutes – 2 hours depending on skin tolerance to pressure. 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 make 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.

7.4.5 It is acknowledged that LPT patients in their own homes may not be repositioned as often due to frequency of care calls and what can reasonably be provided by carers, parents, or relatives. In these circumstances, clinicians should use clinical judgement when providing advice, assess the patients tissue tolerance to pressure and offer education about their level of risk, how to check their skin and how often they should be repositioned.

Adult 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 agencies 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. Where the health care professional advice is to increase the care package and the patient has been assessed as lacking capacity to make the decision, a best interest's decision will need to be made in consultation with family. Should there be a conflict of opinion the health care professional will need to refer to safeguarding due to the risk of patient harm occurring (NHSI 2018).

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

Parents or those with parental responsibility of children and young people have a responsibility to provide care for their children and arrange further care support if this is required. Should parents be advised to seek further support where the welfare of the child is of concern and there is a failure to do so, a referral should be made to safeguarding and the local authority.

7.4.6 Where patients need assistance to reposition, use manual handling techniques and equipment that reduce friction and shear (EPUAP et al 2019, NHSI 2018). 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.

7.4.7 The 30-degree tilt should be used in preference to a 90-degree side lying position (EPUAP et al 2019):

*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.

7.4.8 Where the patient's medical and physical condition allow, avoid extended periods in the prone position (EPUAP et al 2019).

7.4.9 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 patient's care plan and repositioning schedule.

7.4.10 When sitting out, and reclining is not an option, ensure the patient's feet are well supported either on the floor or on wheelchair foot plates (EPUAP et al 2019).

7.4.11 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 and that weight is distributed along the calf to avoid placing pressure on the achilles tendon and popliteal vein (EPUAP et al 2019). This will be recorded within the patients' plan of care.

7.4.12 Patients who are recovering from a period in bed should have an early mobilisation plan, in conjunction with therapy support where appropriate, to increase their levels of activity as rapidly as tolerated (EPUAP et al 2019).

7.4.13 Patients with an ischial or sacral ulcer may benefit from periods of bed rest, this will need evaluating with them and consider the risk of further pressure injury or deterioration of existing ulcer versus quality of life, potential for reduced mobility/loss of muscle tone and emotional wellbeing (EPUAP et al 2019, NHSI 2018). This will be recorded in their plan of care.

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

7.4.15 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.

7.4.16 Patients' and, where appropriate, carers will have the electric profiling bed functions, including knee break, demonstrated and their function in pressure redistribution/reducing friction and shear explained. All clinical health care professionals will receive training in the moving and handling of patients inclusive of profiling bed functions.

7.4.17 Cognitive impairment/challenging behaviour can impact on repositioning frequency and impact (NHSI 2018). A Mental Capacity Act (MCA) assessment will be required.

7.4.18 There are circumstances where a patient will need assistance to move that needs to be provided by an electronic turning system (Ekamove). For example, pain levels on manual repositioning or to treat existing deep pressure damage to the sacrum/hip. See **Appendix 15** for full provision criteria for an electronic turning system.

7.4.19 Medical devices, where clinically safe to do so, must be repositioned to minimise the risk of ulceration from pressure.

7.4.20 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.

7.5 Incontinence

7.5.1 It is essential that any skin breakdown to the sacrum/buttocks is correctly assessed to identify moisture damage from urine/faeces/sweat as opposed to pressure. The treatment pathway for each is different: relieving pressure will not prevent moisture damage deteriorating and vice versa.

7.5.2 All patients assessed as incontinent will be referred for a continence assessment by the continence team (NHSI 2018), excepting those who are 'end of life' and have pads provided by community nursing. 'End of life' can mean up to one year before anticipated death.

7.5.3 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.

7.5.4 Patients will be encouraged, or when appropriate assisted to, maintain dry, clean skin, particularly in identified vulnerable areas and to cleanse the skin promptly after episodes of incontinence with a PH balanced soap/cleanser. Ensure vigorous rubbing of skin is avoided due to the risk of shearing damage (EPUAP et al 2019). If the skin is broken plain water should be used.

7.5.5 Patients will be assessed for and provided with, if necessary, skin protectants and moisturising treatments (EPUAP et al 2019, NHSI 2018).

7.5.6 All patients who are incontinent will have an individualised plan of care that includes their skin hygiene regime, skin cleansers and, if used, barrier creams (NHSI 2018). Where they have formal/informal carers this will be communicated to them (see **Appendix 10**).

7.5.7 All episodes of moisture within skin folds must be assessed for fungal infections.

7.6 Nutrition

7.6.1 Patients at risk or high risk of pressure ulcers will have their nutritional needs assessed as part of an initial holistic assessment and in line with risk thereafter: to include ability to access food/fluids and ability to feed self (EPUAP et al 2019, NHSI 2018).

7.6.2 Patients at risk of nutritional compromise or those already nutritionally compromised will have a plan of appropriate support that meets individual needs and is consistent with the overall patient management plan. This will include advice on high calorie, high-protein, fortified foods and/or nutritional supplementation (EPUAP et al 2019). This may include referrals to a dietician or Speech and Language Therapy (SaLT) for a modified texture diet to support intake.

7.6.3 Refer to a dietician to discuss the benefits and harms of enteral or parenteral feeding to support pressure injury treatment in light of preferences and goals of care for patients with pressure injuries who cannot meet their nutritional requirements through oral intake despite nutritional interventions (EPUAP et al 2019).

7.6.4 Provide/encourage water/fluid intake for hydration in those at risk of or with an existing pressure ulcer (EPUAP et al 2019). Ensure this is within any fluid reduction or fluid consistency advice advised by a health care professional.

7.6.5 Children at risk of or with existing pressure ulceration who have an inadequate oral intake should be considered for age-appropriate nutritional supplementation, enteral or parenteral support (EPUAP et al 2019). Consider a paediatric dietetic referral for assessment with consent/best interests.

7.6.6 All patients prescribed supplements should have their concordance with these monitored and any concerns discussed with the GP if they cannot be resolved with the patient/carer. Different supplementation options/flavours are available and should be discussed with the patient/carer to help maximise concordance.

7.7 Giving information

7.7.1 An essential element of pressure ulcer prevention is the provision of information that enables effective decision making this includes patients, carers, and the MDT (NHSI 2018).

7.7.2 Information will need to be communicated at a level suitable to the recipient to maximise concordance and engagement (NHSI 2018). Strategies include personalising the Trust pressure ulcer prevention leaflet to them, use of pictures, health information websites, use of pressure ulcer photos (with their consent), escalation indicators/contacts and visual/audible reminders. This will be recorded in the patient record. Recommended websites for patient resources are:

Pressure ulcer prevention resources

www.nhs.uk/live-well/eat-well/eight-tips-for-healthy-eating
React To Red: Pressure Ulcer Prevention Awareness for Carers | React To
www.lnds.nhs.uk Leicestershire Nutrition and Dietetic Service
LPT Tissue Viability Service: Repositioning for pressure ulcers (youtube.com)
Pressure Ulcer | National Wound Care Strategy Programme

Patient stories

https://www.youtube.com/watch?v=1tzwzwQ5J1I
https://www.youtube.com/watch?v=naFqXcjevVQ
https://www.youtube.com/watch?v=OJzxOLauiv0
https://www.youtube.com/watch?v=YuG18uKth9w

Blanch testing

https://www.youtube.com/watch?v=THjmjtDDDoc

7.7.3 When advising a patient who has capacity, about self-care and prevention of pressure ulcers, it is important to establish that the patient has understood the advice, can put the advice into practice, has any necessary equipment, knows how to use it, and understands the implications of not following the advice (DoH 2018).

7.7.4 A core element of pressure ulcer prevention is ensuring patients/carers understand how to blanch test skin, what the result means and when/who to escalate to. Blanch testing is less effective in dark skin tones therefore when providing information greater emphasis should be given to using other senses i.e., touch and feel to increase diagnostic value (Wounds UK 2021).

7.7.5 Where the patient lacks capacity to understand their risk an MCA assessment will need completing and best interests' decision taken ensuring representation from relevant health care professionals and family (see **section 6.1 (second bullet)**, 7.4.15, 7.4.16).

7.7.6 Where the patient is a minor, pressure ulcer prevention strategies will be discussed with their parent/legally appointed guardian, ensuring full rationales and safe use of interventions are recorded (NHSI 2018).

7.7.7 Non-concordance with pressure ulcer prevention strategies can be minimised through effective communication of personal risk, potential ulceration, and quality of life impact. Patients who are considered non-concordant should, in the first instance, be discussed with a senior nurse within the team to facilitate a problem-solving approach, or senor colleague if not open to nursing, that reviews their management plan with them. Information should be provided to the patient and the barriers explored. Informed consent to the intervention should be gained and recorded. If at any point, there is doubt regarding the patient's ability to provide valid consent to treatment then an MCA assessment should be completed. For advice at any stage please contact LPT Safeguarding Team. Clear records of discussion and non-concordance must be made in the electronic patient record.

7.7.8 Where it appears the patient is neglecting themselves or the environment, staff should seek further advice (DoH 2018) with LPT Safeguarding Team and line manager.

7.7.9 Giving information allows for health promotion and the negotiation of individual goals that the patient is motivated to achieve. This is essential to maximise positive outcomes and effectively allocate resources (NHSI 2018).

8.0 Overall

8.1 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 and actions taken.

9.0 Pressure Relieving Equipment

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

9.1.1 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 aSSKINg and pressure ulcer prevention plan reviewed every 3 months unless 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.

9.1.2 Patients' meeting the criteria in 9.1 will have a dynamic mattress 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.

9.1.3 The Tissue Viability Nurses (TVN) 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.

9.1.4 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 an aSSKINg/Waterlow for a further 1 year.

9.1.5 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, and the patient is in a residential home it is the Residential Home's responsibility to provide one.**

9.2 Static mattresses

9.2.1 All patients provided with static pressure relieving equipment will be reassessed in line with their risk if they continue to be in receipt of professional healthcare 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 3 monthly 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.

9.2.2 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.

10.0 Categorising Pressure Ulcers

10.1 All pressure ulcers will be assessed using the NHSI 2018 classification system: **refer to definitions (pages 6-9** and **Appendix 19**).

10.2 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.

10.3 Moisture lesions are not attributable to pressure and should not be categorised as such (see **Appendix 8**). Where pressure does become a factor and a combination ulcer develops this will need categorising and reporting as a pressure ulcer.

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

10.5 Mucosal pressure ulcers cannot be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These pressure ulcers are therefore uncategorisable (NOT unstageable). They are usually caused by devices and therefore should be reported on the incident form as PU (d) denoted "Mucosal" as the cause group (NHSI 2018).

10.6 Where an ulcer develops on the foot of a patient with diabetes, consideration must 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.

11.0 Reporting and Investigation of Pressure Ulcers

11.1 Category 2, 3, 4, unstageable pressure ulcers and suspected deep tissue injuries (SDTI) must be recorded as a clinical incident on the Trust reporting system (eIRF). All pressure ulcers will be identified as 'developed in LPT care' or 'pressure ulcer on admission' (POA).

- Developed in LPT 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 etc.

- 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.

11.2 Suspected deep tissue injuries or unstageable pressure ulcers that evolve into category 3, 4 pressure ulcers should be re reported using the 'evolved into' cause group. i.e., SDTI evolved into a Category 4 Pressure Ulcer.

*If the suspected deep tissue injury 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.

11.3 If an unstageable pressure ulcer or suspected deep tissue injury develops into a Category 3, 4 pressure ulcer, it is the health care professional's responsibility to report a new incident.

*If a suspected deep tissue injury 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

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

11.5 It is the Tissue Viability Services responsibility to verify and confirm the level of damage that has been reported for all category 4 pressure ulcers and Category 3, Unstageable and Deep Tissue Injuries (DTI) that have developed in LPT care. 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.**

11.6 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.

11.7 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.

11.8 Senior nursing staff within each area will be responsible for verifying all Category 2 pressure ulcers, and deep tissue injuries, unstageable and category 3 pressure ulcers which have been reported as present on admission. If the level of damage has been reported incorrectly, they will be responsible for changing the incident and documenting on the patient record.

If a pressure ulcer is found by an Allied Health Professional, an electronic incident reporting form should still be completed, however following an initial managers review, the incident should be transferred to the relevant nursing team to take over management of the incident. The process for this can be found in **Appendix 16.**

11.9 All pressure ulcers will be reported in accordance with the categorisation system as stated on **page 7/8/9** and **Appendix 9**.

11.10 All staff should use the 'Stop Plan Prevent' tool when notified of a category 2, 3, suspected deep tissue injury and unstageable pressure ulcer to support them in ensuring that all elements of the aSSKINg model have been implemented into the patient's care. If any gaps are identified an appropriate plan should be instigated to ensure they are implemented at the earliest opportunity to stop the pressure ulcer from deteriorating. This includes those that have been caused by a medical device (see **section 14.10** for category 4 process).

11.11 Senior nursing staff are responsible for overseeing all category 2, 3, deep tissue injuries and unstageable pressure ulcer incidents and ensuring that all elements of aSSKINg have been implemented, using the Stop Plan Prevent tool for support **(Appendix 16).** If any gaps are identified an appropriate plan should be instigated to ensure they are implemented at the earliest opportunity to stop the pressure ulcer from deteriorating. This plan should also be highlighted within the managers form on Ulysses prior to closing the incident.

This includes those that have been caused by a medical device (see **section 14.10** for category 4 process).

11.12 As part of the learning into action process, if any gaps are identified when using the Stop Plan Prevent tool should be communicated to the team or individual staff if relevant to improve learning.

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

11.13 Service leads can request further support from the Tissue Viability Team in the form of a telephone conversation or one to one discussion.

11.14 As part of the learning into action 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 patient's environment, care and wellbeing, as well as establishing the level of harm that has been caused due to the development of the pressure ulcer.

11.15 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 reviewed and could be changed following the scrutiny of the pressure ulcer if required, this is the responsibility of the senior nursing staff members.

- Category 2 Pressure Ulcers – Minor Harm (Low).
- Category 3/Suspected Deep Tissue Injury/Unstageable Pressure ulcers – Minor Harm (Low).
- Category 4 Pressure Ulcers – Moderate Harm.
- Pressure Ulcer on Admission –use the same principles as above, as it is harm to the patient.

11.16 The Safeguarding Adults Protocol (Nov 2018) should be used as guidance for making the decision on whether a Safeguarding Concern should be raised: (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf

11.17 Category 3 & 4 pressure ulcers should have a Safeguarding threshold completed by the Senior Nurse Complex Care (SNCC) / Matron (for Category 3) or TVN (for category 4). Further support can be accessed by contacting the safeguarding team for advice as to referral to Local Authority should threshold be met.

11.18 The Safeguarding Adults Protocol (Nov 2018) should be used as guidance for making the decision on whether a Safeguarding Concern should be raised for all patients 16 years and over.

11.19 Children / young people who develop pressure ulcers (category 3 & 4) should be assessed from a safeguarding perspective and consideration given to the contributing factors. The child / Young person has suffered significant harm and consideration should be given to making a Children's social care referral by completing a Multi-agency Referral Form (MARF) which is in Letters and communications, safeguarding templates on SystmOne. Advice should be requested from the Safeguarding team.

11.20 **All** Category 4 pressure ulcers that develop in LPT Care will require an Investigation in line with patient safety incident response framework and local patient safety investigation priorities.

11.21 For the majority of category 4 pressure ulcers that develop in the community, an MDT review of care will be led by the Matron and/or Senior Nurse for Complex Care for the relevant community area. Other clinicians will be invited to the meeting such as tissue viability nurses, podiatry, therapists, etc. Gaps in care, lessons learnt and actions to address will be agreed at the meeting.

11.22 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 Investigation will not be required.

11.23 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.

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

11.25 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 be re-reported as per the category that it has evolved to. However consideration must be taken as to if the original damage was present on admission or developed in LPT care.

***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 a new incident should be reported as 'unstageable, evolved to a Category 4, pressure ulcer on admission (POA). The pressure ulcer would remain as present on admission, as the pressure damage was already present when it was an unstageable.*

12.0 Duty of Candour (DOC) (for further details refer to the Trust's Culture of Candour Policy)

12.1 All clinical staff have a responsibility to 'be open and transparent' with patients and their families 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,

apology, appropriate remedy offered, regardless of whether a complaint has been made (Care Quality Commission, 2015).

12.2 When a category 4 pressure ulcer has been verified the patient/family should be informed and provided with support in relation to the incident. This level of harm is considered to moderate and above and will trigger the initial statutory duty of candour. The patient should be provided with a brief outline on what may have contributed to the pressure ulcer development but be informed that an investigation will take place in order to determine the cause. They should also be asked if they would like to contribute to the investigation and whether they feel anything could have been done differently to prevent their pressure ulcer from occurring, this information should be recorded in the DOC template.

*The managers of the service are responsible for contacting the patient when they receive a notification of a category 4 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.

12.3 Once a review of care has been undertaken, patient and or their family should be offered to have the report shared with them and always a final duty of candour letter undertaken describing the findings and learning and a further apology.

13.0 Photography

13.1 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 a weekly thereafter, or on deterioration of ulcer. (Parameters for photography are in the Trust Consent to Examination or Treatment policy).

13.2 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, i.e., end of life, then this also needs to be documented. In these instances, description and measurement of the wound must be recorded.

13.3 If a patient lacks mental capacity to make an informed decision and give consent, a best interest's decision should be considered to allow team communication and comparison for pressure ulcer improvement/deterioration.

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

13.5 Nurses should consider involving patients in this aspect of their care to assist with education and to support position and equipment compliance by showing them the photographs of their pressure damage. This should be undertaken, compassionately and with the focus on engagement in their care and recorded as part of the patient record.

14.0 Wound Management

14.1 Wound assessment templates/charts will be used to record the condition and monitor the progression of pressure ulcers. A full wound assessment should be completed at the time the pressure ulcer is identified and every 4 weeks thereafter or if there are any signs of deterioration.

14.2 Where a patient has multiple ulcers a full wound assessment is completed for the largest of these and abridged wound assessments for any others within close proximity. Multiple ulcers not in proximity i.e., heel and sacrum, will have individual full assessments.

14.3 The Tissue Viability team receives notification of all category 4 pressure ulcers, and deep tissue injuries, category 3 and unstageable pressure ulcers that have developed in LPT care 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 suspected deep tissue injuries if clear rationale is provided on how the service can offer support.

14.4 Pressure ulcer notifications and referrals are clinically triaged by a Tissue Viability Nurse then added to either a routine or urgent waiting list depending on severity of pressure ulcer and individual patient factors.

14.5 The timescale for Tissue Viability response is as follows:

- 5 working days for urgent.
- 20 working days for routine.

14.6 Patients whose pressure ulcers do not heal as expected, experience delayed healing or have extensive necrosis should be referred to a TVN, Podiatrist (foot ulcers) or surgical specialist; whichever is the most relevant to the situation.

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

14.8 Pressure ulcers that develop on the lower limb, such as heels or feet, 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.

14.9 Patients with diabetes who have developed a pressure ulcer below their ankle should be referred to Podiatry and will be offered an appointment within 5 working days. Podiatry can also arrange referral to the diabetic foot multidisciplinary team at Leicester General Hospital as per NICE guidance.

14.10 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 sharp debridement is required refer to the Tissue Viability service (Podiatrist if it is a foot wound).

15.0 Training needs (see Appendix 1).

15.1 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 recommended to be role essential for staff within CHS and specific services within DMH & FYPCLD. This is currently being taken though LPT process for sign off and anticipated in late 2024.

15.2 Specified clinical staff must attend the half day pressure ulcer prevention training programme (Level 3) which outlines their role and responsibilities. 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.

15.3 An Intermediate (Level 2) pressure ulcer prevention e-learning session (currently in development) will also be available for groups of staff who have been identified as role essential but require a more condensed version of training. The training will include key points and actions relevant to their required level of knowledge.

15.4 Level 1 training (currently in development) will focus on a basic awareness of pressure ulcer prevention, including risk factors and sign posting, and will be available for all staff wanting to develop their knowledge in this area, who are not required to complete the role essential training.

15.5 Role essential Pressure ulcer Prevention training should be repeated bi-annually.

15.6 Training will be provided in accordance with EPUAP 2019 guidance and NHSI 2018 recommendations 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.

15.7 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

16.0 Monitoring Compliance and Effectiveness

16.1 Compliance with this policy will be demonstrated by the reporting of all category 2, 3, 4, suspected deep tissue injuries and unstageable pressure ulcers inclusive of medical device related ulcers and completing a Pressure Ulcer Scrutiny Template for all 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.

16.2 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 review of patient 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.
- Identifying quality and safety improvement initiatives.

17.0. Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Respect and dignity	Personalised care plans, timely interventions, appropriate wound management.
Safety and good governance	• Aspire to ‘Zero’ Category 4 Pressure Ulcers developed in LPT care. • All Category 4 Pressure Ulcers developed in LPT will be reviewed through a patient safety review process both inpatient and community. • Monitoring of themes and trends to pressure ulcer development. • Embedding lessons learnt from patient pressure ulcer reviews in practice by sharing learning, themes, and trends. • Pressure Ulcer review and improvement will be led through the Quality Improvement (QI) approach.

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
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 Ambition group and a quarterly report will be communicated to commissioners.
Pressure ulcer free days	CHS inpatient areas will continue to record an up-to-date pressure ulcer free days on a public facing notice board.

18.0. References and Bibliography

The policy was drafted with reference to the following:

1. Care Quality Commission (2015, updated 2022) Regulation 20: Duty of Candour, Department of Health, London.

Retrieved from https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour

2. 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
3. Department of Health (2018) Safeguarding Adults Protocol, Department of Health, London Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf

4. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
5. National Institute for Health and Clinical Excellance (2014) The prevention and treatment of pressure ulcers, www.nice.org/CG179
6. National Patient Safety Agency (2010) NHS to adopt zero tolerance approach to pressure ulcers. Retrieved from http://npsa.nhs.uk/corporate/new/nhs-to-adopt-zero-tolerance-approach-to-pressue-ulcers/?locale=en./
7. NHS Improvement (2018) Pressure Ulcers: revised definition and measurement, NHS Improvement, London
8. NHS Improvement Pressure ulcer categorisation group (2019) *Pressure Ulcer Categorisation. Available from http://nhs.stopthepressure.co.uk/*
9. NHS Improvement (2018) Pressure Ulcers: core curriculum, NHS Improvement, London
10. 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
11. Tissue Viability Society (2012) Achieving Consensus in Pressure Ulcer

Reporting, Journal of Tissue Viability
12. Waterlow, J. (2005) Pressure ulcer prevention manual: Waterlow pressure ulcer prevention / treatment policy, Waterlow, Taunton
13. Wounds UK (2021) *Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones.* Wounds UK, London. Available to download from: www.wounds-uk.com

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	Pressure ulcer prevention and management
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☑ Role specific - For CHS and specific staff roles from DMH / FYPCLD Currently awaiting sign off though LPT process. ☑ Personal development –
Division(s) to which the training is applicable:	☑ Adult Mental Health & Learning Disability Services ☑ Community Health Services ☐ Enabling Services ☑ Families Young People Children ☐ Hosted Services
Staff groups who require the training:	All clinical staff inclusive of Nurses, allied health professionals, and health care support workers.
Regularity of Update requirement:	Bi-annually
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?	☑ ULearn ☐ Other (please specify)
How is this training going to be monitored?	Evaluation forms post sessions

Appendix 2

The NHS Constitution

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 3

Stakeholders and Consultation

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.

Key individuals involved in developing the document

Name	Designation
Anita Kilroy Findley	Clinical Lead Tissue Viability
Laura Browne	Operational Lead Tissue Viability
Emma Wallis	Deputy Director of Nursing & Quality
Hannah Blackwell	Clinical Lead Tissue Viability

This version Circulated to the following individuals for comment

Name	Designation
Tracy Yole	Deputy Head of Nursing & Quality Community Services (County)
Strategic Pressure Ulcer Group Members including: Viveen Ashman	CHS Deputy Head of Nursing & Quality Community Services (City)
Hannah Blackwell	CHS Clinical Lead for Tissue Viability
Laura Browne	CHS Operational Lead for Tissue Viability
Emma Camp	CHS Community Services Matron
Bernadette Cawley-Nash	FYPC/LD&A Deputy Head of Nursing
Helen Cooper	CHS Therapy Manager for Care Homes
Ghizlane Dunn	CHS Continence Lead
Kim Fox	CHS Operational Service Manager for Community Therapy
Simon Guild	MHSOP Deputy Head of Nursing
Neil King	LPT Head of Safeguarding
Victoria McMenamin	
Claire Moran	LPT Senior Safeguarding Practitioner
Louise Moran	CHS Deputy Head of Nursing for Community Hospitals
Sarah Morley	Head of CHS
Stephanie O'Connell	CHS AHP Lead and Clinical Director
Debbie Parmar	CHS Clinical Lead for CINSS
Name	**Designation**

Jodhun Persand	MHSOP Modern Matron
Niya Peryagh	CHS Clinical Quality Governance Lead
Pauline Rawle	CHS Community Services Matron for Care Homes
Deanne Rennie	LPT Associate Director AHP and Quality
Emma Wallis	LPT Deputy Director of Nursing & Quality
Tracy Ward	LPT Head of Patient Safety
Lesley Weaving	CHS Podiatry Lead
Helen Cooper	Clinical Lead Occupational Therapist
Katie Willetts	Senior Nurse, Diana Children's Services
Sue Arnold	Lead Nurse Corporate Patient Safety Team
Trust Policy Expert Group	

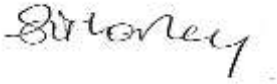
Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	Pressure Ulcer Prevention and Management Policy
Date Screening commenced	July 2023
Directorate / Service carrying out the assessment	LPT
Name and role of person undertaking this Due Regard (Equality Analysis)	Hannah Blackwell, Clinical 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. This policy relates to all ages of patients. This is referenced in section 7.3 where risk assessment for people of all ages is stated.
Disability	People with a disability that impacts specifically on their mobility may be at a greater risk of pressure ulcer development. This is referenced in section 7.
Gender reassignment	No impact.
Marriage & Civil Partnership	No impact.
Pregnancy & Maternity	No impact.
Race	It is recognised within the policy (section 7.2) that people with dark skin tones are at increased risk of skin. People with dark skin tone may require alterative skin inspections to visual and this is addressed within the policy.
Religion and Belief	No impact.
Sex	Females may be considered to be at greater risk of pressure ulcer development; individual risk 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 tick 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	Hannah Blackwell	**Date**	28/07/23
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	23/06/24

Appendix 5

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Pressure Ulcer Prevention and Management Policy**		
Completed by:	**Hannah Blackwell**		
Job title	**Clinical Lead Tissue Viability**	**Date**	**07/05/2024**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		n	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		n	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		n	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		**n**	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		n	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		n	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		n	
8. Will the process require you to contact individuals in ways which they may find intrusive?		**n**	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:	**Sarah Ratcliffe**		
Date of approval	**03/07/2024**		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 6

PUP Monitoring compliance section

Page/ Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
	Number of Pressure Ulcers developed or deteriorated in LPT care – Categories 2-4, DTI, Unstageable, Moisture associated and skin care/trauma	Incident reporting	Individual/Team Pressure Ulcer Prevention Group Quality Forum Trust Board	Bi-monthly monitoring
	Completion/compliance of pressure ulcer prevention training	Completion reports for desirable training. Compliance for role essential training.	Ward/Team/Unit Pressure Ulcer Prevention Group Training Education and Delivery Group	Bi-monthly
	People admitted to hospital have their risk reviewed within 6 hours	AMAT audit	Community Hospitals service line DMT Quality & Safety meeting Pressure Ulcer Prevention Group	Quarterly
	People with a risk factor referred to community nursing have a risk assessment completed at first face to face assessment	AMAT audit	CHS Community Nursing and Therapy DMT Quality & Safety meeting Pressure Ulcer Prevention Group	Quarterly

Appendix 7


REACT TO RED
NHS
Leicestershire Partnership
NHS Trust
Are you at risk of developing a pressure ulcer?
Anyone can develop a pressure ulcer but there are certain factors which can increase the risk.
If you've got a pressure ulcer or have had one
Incontinence
Surgery/infection
Poor mobility
Incorrect/ ill-fitting footwear
Risks
Dementia, stroke, Parkinsons disease, multiple sclerosis, motor neurone disease, learning disability
Not having a balanced diet/drinking enough
Smoking
Underweight or overweight
Taking steroidal drugs can cause thinning of the skin and some drugs to support mental wellbeing can cause drowsiness
High temperature, feeling ill
Heart failure
COPD
Diabetes
Kidney failure
Long-term condition or circulatory problem
If you answer yes to any of these questions or have any concerns relating to your pressure ulcer risk, then please speak to a health care professional for further advice.
You can ask your health care professional for a pressure ulcer prevention booklet to support you in preventing pressure ulcers or scan here on your mobile phone/ device for a full guide on pressure ulcer prevention.

Appendix 8

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 9

Pressure Ulcer Classification

Please select the category 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

Appendix 10

Information for formal/informal carers

NHS
Leicestershire Partnership
NHS Trust

A care plan for implementing a structured skin care regime

This form is designed to support care staff to carry out a skin care regime advised by a health care professional and aid continuity of care between different carer's involved in the patients care.

The following form should be completed and a copy provided to care staff to place in their patient's care notes and a copy scanned onto the patient's electronic record.

If the advice changes a new care plan should be created.

Name of patient:

Patient NHS Number: Date:

Name of agency/care home/ formal/informal carer:

Name of health care professional creating the care plan:

Name of health care professional creating the care plan:

Skin care regime advised

*We do not advocate the use of baby wipes, Sudocrem or perfumed products. All the products we advise are on LLR Wound Care Formulary and have been trialled and deemed the most effective treatment for the prevention and management of moisture associated skin damage.

Skin cleanser: Frequency:

Skin protection: Frequency:

Skin hydration (if required): Frequency:

Additional comments:

Appendix 11


Making Every Contact Count
MECC
NHS
Leicestershire Partnership
NHS Trust
aSSKING PUP STOP PLAN PREVENT TOOL
STOP: opportunity to prevent deterioration
a Assess risk
Are your patient's assessments reviewed and up to date?
Holistic, Waterlow, SSKIN, pain, wound assessment - review needed if deterioration noted/new damage identified
Ensure photographs of the pressure ulcer(s) are taken weekly or on change of condition
Community nursing: ABPI/Lower Limb Assessment – if lower limb and appropriate (if PAD reading use handheld doppler to record foot pulses)
Alternative services (Community Hospitals, Directorate of Mental Health, Families Young People & Childrens Services, Learning Disability and Autism Services: Perform a manual foot pulse check and/or review for arterial symptoms such as claudication/rest pain/cold feet/hairless
Has a Mental Capacity Act assessment been completed if required?
S Surface
Make sure your patients have the right support
Is the correct pressure ulcer equipment in place? – Consider mattress, cushion, heel protection, turning systems
Is the patient utilising the equipment correctly?
Patient/carer education on equipment use – mattress and turning system settings, heel boot application, cushion use
Slide sheets/parafricta products/offloading/Kerrapro/high specification cushion (air or gel)
Community specific products: Treat-Eezi Overlay/Ultracline/Turning System/MaxXcare Heel Boots/Equazone Cushion/Dynamic Air Mattress/Visco Foam Mattress
Community Hospitals: Promat plus with or without pump/repose boots or offloading with pillows/Tolero chair as standard with integrated C-gel cushion/Alternative mattress or pressure relieving cushion on request
S Skin inspection
Early inspection means early detection
Early detection is key!! Category 1 pressure ulcers are reversable if offloaded
Pressure damage reported correctly? Cause identified?
*STOP PREVENT: Is tissue viability/podiatry advice needed?
Duty of candour? Showing patients their pressure ulcer? Risk awareness!
Individualised care plans and SMART goal recorded?
Making each contact count! Checking the skin at every opportunity and provide education on checking the skin (blanching testing). Acknowledge dark skin will not blanch and to observe for changes to vulnerable areas (warmer/cooler/firm/tight/boggy)
Community patients: Are we checking the patient's pressure areas at least weekly?
CHS Inpatient Settings: Skin check twice daily.
Ensure close monitoring of changes to dark skin tones.
K Keep moving
Keep your patients moving
Has the specific repositioning regime been documented and reviewed? – including advice on positioning/30 degree tilt/offloading/consider overnight repositioning needs/leg exercises in patient leaflet
Complex positional needs/early signs of limbs beginning to contract
Review current positional aids and care plans – are they being followed/ still appropriate - *STOP PREVENT: Is therapy advice needed?
Implement/review of repositioning charts - patient/carer education – offloading/repositioning
Provide patient/carer education
I Incontinence/ moisture
Your patients need to be clean and dry
Are the patients continence needs met?
*STOP PREVENT: Is continence specialist advice needed?
Unknown cause of loose stools – liaise with GP
Structured skin care regime including barrier products
Continence assessment and annual reviews
N Nutrition/ hydration
Help patients have the right diet and plenty of fluids
Nutritional assessment completed? Consider reversible causes of poor appetite, nausea/ vomiting, toothache (poor fitting dentures)
*STOP PREVENT: Is dietician advice needed?
Nutritional advice provided to promote wound healing - fortified diet/high protein advice – provide nutritional wound healing leaflet
Refer back to GP/ANP if not taking prescribed supplements, why?
g Giving information
Patient education
Develop an agreed plan of care with the patient
Personalise care plans with agreed PUP planned strategies
Discuss patients quality of life/risk of deterioration
Record of patient's view?
Communication – next of kin/carers (with patient consent) to ensure risk/actions being taken are understood
Has the patient been provided with a Stop Plan Prevent Leaflet? Adults, Children's and Easy Read options available.
Nutrition leaflets available on LDNS webpage
Pressure Ulcer Prevention video resources
Is the 'Are you at Risk?' poster in view on wards/clinic settings?
*Is your patient declining help? Why? Can we do anything? Consider mental capacity
Edition 4 July 2024

Appendix 12

Due to the variation of equipment within community hospitals we are unable to provide a specific equipment flow chart, however, **please refer to Appendix 14** where it will state ‘or inpatient equivalent’ to help guide.

Appendix 13

Ordering and monitoring requirements for dynamic systems

- Dynamic air systems for community patients are ordered and monitored in accordance with need.

- A trained (role essential) 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 if unable to order themselves.

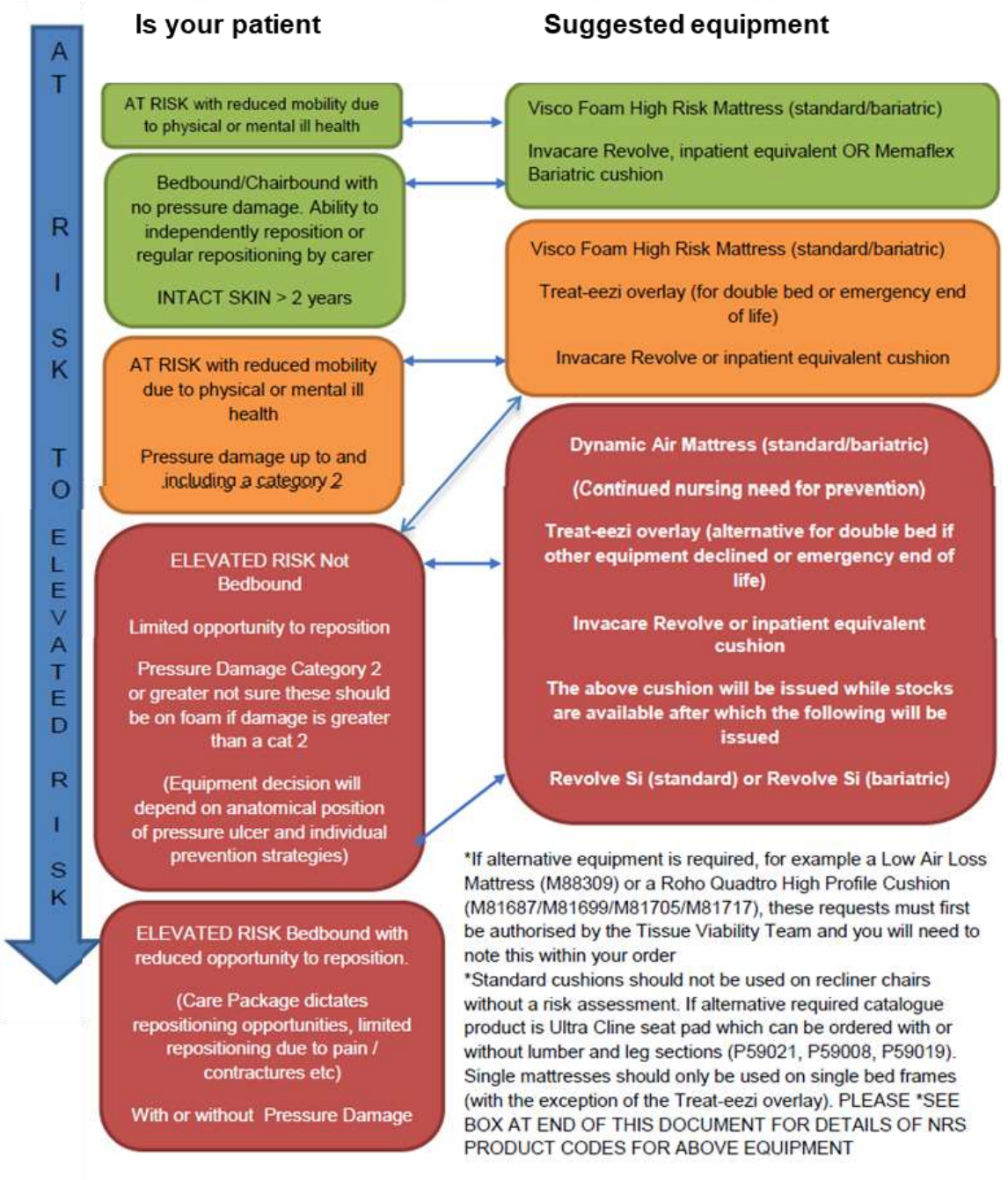
- Where a trained (role essential) Allied Health Professional or Community Learning Disability/Mental Health Nurse are the only health professional involved they will monitor pressure prevention needs utilising Waterlow/SSKIN. On discharge from caseload any patient on a dynamic system will be referred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

- A trained (role essential) health care professional will be identified to monitor children and young people on dynamic services in FYPCLDA where no other health professional is involved.

Appendix 14

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.



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 - Revolve Si 18x18 – P71379
- Cushions: Bariatric – Si – P71367/P71380/P71392
- Dynamic mattress: Standard – Talley – M75146/Bariatric – M27474
- Treat-eezi overlay: P58489

Appendix 15

A turn system may be considered for a **bedbound** person who, due to their condition, has no ability to change their own position sufficiently to offload pressure whilst in bed e.g., spinal injuries/neurological condition/dementia and are alone overnight. The person must remain on the prescribing team case load and be subject to regular review and risk assessments whilst the Ekamove is in use.

All orders require authorisation from the ICELS Triage, and the prescriber will need to evidence that the following criteria has been met and this information should be included within the clinical reasoning form.

A turn system should only be requested when **all other** interventions for pressure ulcer prevention have been considered and are either unsuitable or have failed.

CRITERIA:

- To prevent further deterioration of existing pressure ulcers or to treat existing deep pressure ulcers (category 3 and 4) to sacrum/buttocks/hips/spine where lack of repositioning has been deemed to be the causative factor
- To prevent recurrence of the above where no alternative aid to repositioning can be achieved for the bedbound person

Hospital discharge would need to satisfy the above criteria and the request should be made by their tissue viability team and a prior conversation with ICELS triage or lead nurse so as not to delay discharge.

PROCESS:

If a person meets the above criteria then the prescriber will be required to follow the process below:

- Send an e-referral to the Tissue Viability Team which will be triaged within 1 working day.
- Evidence of other options trialled and failed and that no other interventions have/will meet the needs of the person must be provided.
- Confirmation of Team/hub who will be responsible for regular review of the Ekamove and when no longer in use it is returned to the equipment provider (Medequip) **MUST** be documented on SystmOne.
- Tissue Viability following review will document their decision on SystmOne and advise prescriber to continue with the order
- The prescriber will then place the order using the Medequip TCES System
- The patient turn system trigger form must be completed in full and the TV decision documented within the form – if there is no evidence of the TV confirming approval for this item then the order will not be processed and will be rejected

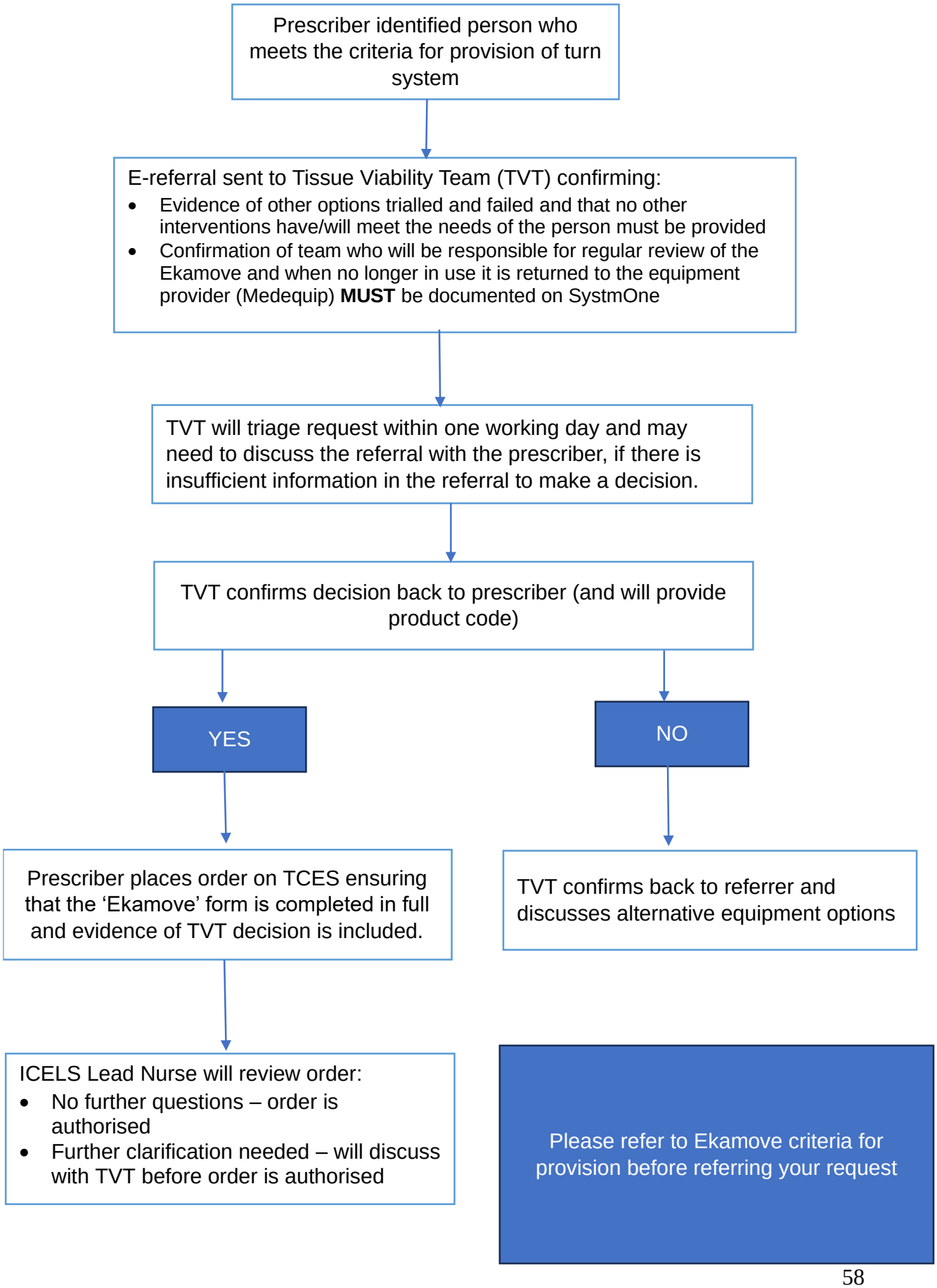
Provision of equipment into Nursing or Residential Homes:

Turn systems will **not** be permitted into nursing or residential homes or other setting where 24-hour care is available.

Points to consider.

- The person must be able to have bed rails fitted to the bed. This means that a bed rail risk assessment must be completed, and it is established that the bed rails are suitable for the person, and these must be regularly reviewed by the prescribing team
- Alternating air mattresses **do not** work effectively when used with turn systems and can lead to breakdown of equipment, it is therefore advisable to use a static high-risk foam with or without a Treat-eezi overlay
- Low air loss mattresses will **not** be issued with a turn system due to the height of the mattress and increased risk associated with entrapment
- The person's continence management must be addressed as repositioning will not replace the need for regular skin care

EKAMOVE (TURN SYSTEM) DECISION PROCESS FLOW CHART



Appendix 16

Allied Health Professionals – Process for reporting and the managing of pressure ulcer incidents by community nursing teams

AHP identifies a pressure ulcer. A photograph should be taken with patient consent or in best interests. Pressure ulcer incident to be reported as per category. AHP to use categorisation poster / categorisation wheel to support their knowledge.

AHP should take initial actions to make the immediate situation safe and make a referral to community nursing for wound care via SPA or direct electronic referral (adults) or direct electronic referral to the Diana nursing service (children's).

The referral should state the electronic Incident Report Form (eIRF) number to avoid duplication. If the eIRF number is not available at the time of the referral, the expectation is that this is provided to the relevant service via task as soon as it is available.

The AHP manager / person responsible for closing the incident should check that the appropriate actions have taken place and write this in the manager's section of the incident form. Click 'save for later'. Do not submit or close the incident.

The AHP manager / person responsible for closing the incident should email the LPT incidents team to request the incident is transferred to the relevant nursing team. This information can be sought by checking the patient record and see which team is now responsible for the patients wound care.

The patient should be reviewed by the relevant nursing team. **A new incident report is not required**. If the category reported by the AHP is incorrect, this should be amended on the eIRF by the manager / person responsible for closing the incident.

If the pressure ulcer has deteriorated since it was referred by the AHP, then a new incident will need to be completed.

Wound photography can be used to support this decision making.

The managers form will then need to be completed and closed by the person responsible for closing the incident from the relevant nursing team. This should include:

- Verification of the category or changing category if this is incorrect.
- A review of care to ensure everything has been done.
- The Stop, Plan, Prevent tool can be used to guide this.

Appendix 17

Positioning guidance and therapy referral tool

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Is your patient?

At risk with reduced mobility due to physical or mental ill health

Bedbound/chairbound with no pressure damage. Ability to independently reposition or regular repositioning by carer

Intact skin > 2 years

At risk with reduced mobility due to physical or mental ill health

Pressure damage up to and including a category 2

Elevated risk: not bedbound

Limited opportunity to reposition

Pressure Damage Category 2 or greater

(Equipment decision will depend on anatomical position of pressure ulcer and individual prevention strategies)

Elevated risk: bedbound with reduced opportunity to reposition.

(Care Package dictates repositioning opportunities, limited repositioning due to pain / contractures etc)

Suggested equipment

Visco Foam High Risk Mattress (standard/bariatric)

Invacare Revolve or inpatient equivalent cushion

The above cushion(s) will be issued while stocks are available after which the following will be issued: Revolve Si (standard) or Revolve Si (bariatric)

Visco Foam High Risk Mattress (standard/bariatric)

Treat-eezi overlay (for double bed or emergency end of life)

Invacare Revolve or inpatient equivalent cushion

The above cushion(s) will be issued while stocks are available after which the following will be issued Revolve Si (standard) or Revolve Si (bariatric)

Dynamic Air Mattress (standard/bariatric)

(continued nursing need to prevent further deterioration)

Treat-eezi overlay (alternative for double bed if other equipment declined or emergency end of life) Invacare Revolve or inpatient equivalent cushion

The above cushion will be issued while stocks are available after which the following will be issued: Revolve Si (standard) or Revolve Si (bariatric)

*If alternative equipment is required, e.g a Low Air Loss Mattress (M88309) or a Roho Quadtro High Profile Cushion, 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 can be ordered. Single mattresses should only be used on single bed frames (with the exception of the Treat-eezi overlay)

Please use pressure prevention policy for product codes and details for above equipment

Therapeutic interventions and therapy referral:

Consider therapy referral to review mobility to optimise repositioning and independence
If the patients mobility baseline has recently changed

Within your input:

- Provide the patient/carer with appropriate repositioning advice Provide
- the pressure ulcer prevention leaflet
- Encourage patients to do any exercises they may have been set and/or the exercises in the leaflet

Consider contracture prevention within your input – the need for patients not to be static for 8 – 10 hours in one position:

Advice as above and:

- Advise patients/carers on a daily position routine – going to bed in the afternoon and returning to sit out for their dinner or vice versa depending on fatigue and activity levels
- On pressure area checks notice any restrictions at patients' joints:
  - Bending or lack of movement to end range at hips/knees/ankles, shoulders, elbows, wrists, fingers
- Encourage patient/carers to maintain range of movement with exercises and extended limbs when changing position
- Encourage body shape and alignment to be supported on surfaces in bed or chair – with use of pillows/cushions/wedges.
- Encourage use of any positional aids/splints that are already in place (check/advise that the positional aid care plans are being followed correctly)
- Consider ringing therapy for advice if you have concerns but specialist input may not be

Early positioning and movement intervention is paramount to prevent contracture/ misalignment occurring - Consider of all of the above steps and advice within your intervention.

In addition these patients will be at increased risk of body shape distortion by any of the following:

- Is their alignment and positioning limited by pain? Does
- their head appear mainly to turn to one side?
- Does their body flex forward? Or extend backwards? Or to one side? Does that patient appear windswept, kyphotic or in a foetal appearance?
- Do they have spasticity or tonal problems causing or putting them at risk of body distortion? Is the patient/carers struggling with personal care/hygiene due to joint movement?

If the patient has any one of the above risk factors and they do not have a positional program in place already or the positional aids are no longer fitting as per the care plan then a **therapy referral may be required**.

Appendix 18

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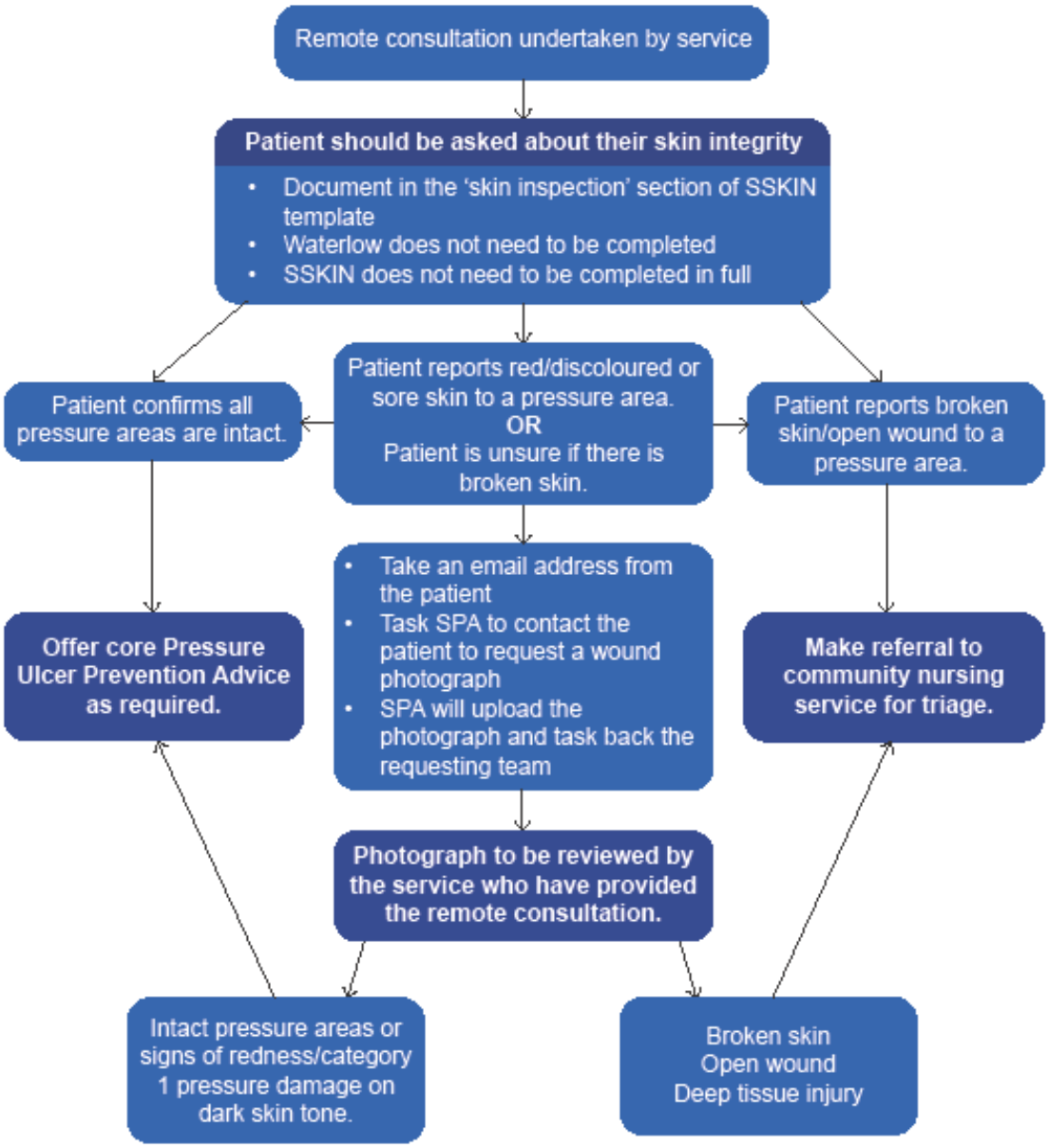
Remote Consultations: Pressure Ulcer Prevention Process



January 2024

Appendix 19

Flowchart: Providing Dynamic Mattresses for patients that smoke

Guidance Page for All Health Care Professionals

All Discussions should be clearly documented in the patients record.

If you have identified that the patient requires a dynamic mattress, it is important to ensure that their smoking status is discussed and recorded on the holistic assessment template.

Patient should always be provided with health education to encourage them to stop smoking, as part of Making Every Contact Count (MECC).

ALL PATIENTS/HOUSEHOLD MEMBERS THAT SMOKE/USE E-CIGARETTES: Must be provided with an Air Safety Mattress Leaflet and you must discuss the risks involved with smoking/using e-cigarettes when using a dynamic mattress, oxygen therapy and/or emollients, including a discussion around the odour damage smoking causes to the equipment.

With the patients consent, complete a free Home Safety Check referral form for the Fire and Rescue Service using the link or QR code in the leaflet.

****Household Members:** Must be advised not to smoke on/near the dynamic equipment, oxygen or applied emollients.

****Patients Using E-Cigarettes**: You must document that you have advised the patient not to leave the device on the equipment whilst charging.

****Ex-smokers:** Advise the patient that if they start smoking again to promptly inform a health care professional and educate them on the fire risks associated with smoking near dynamic mattresses and follow the flowchart below.

If you find the patient/household members smoking near oxygen therapy, you need to complete an Erif via Ulysses AND report this to the services below who will remove any portable oxygen cylinders from the property and perform an MDT meeting to assess whether all oxygen therapy should be removed, this is due to the significant risk of harm to the patient/household and surrounding residents.

Home Oxygen Service: 0116 250 2880 AND

British Oxygen Company: 0800 151 0138.

If you find the patient/household members smoking near applied emollients, you discuss must discuss the associated risks and consider discontinuing the product and supplying a suitable alternative.

Following provision of air mattress safety education:

If you identify that the patient will smoke/charge e-cigarettes on/near the dynamic mattress, or you are unsure of their mental capacity you must follow the below flowchart to support your decision to supply the equipment and mitigate the risk of fire within the patient's home.

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