# Tissue Viability – Practice Guidance Notes

**Pressure Ulcer Care - V03**

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1. **Introduction**

1.1 All patients receiving care within Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (The Trust/CNTW) will have their risk of pressure ulcer development assessed at the point of admission and on-going throughout their stay with the Trust as indicated by their individual risk profile. Following assessment they will be given appropriate preventative care and/or treatment.

1.2 This practice guidance note (PGN) aims to standardise patient care, be equitable and accessible to all healthcare professionals and carers by:

- Identify potentially vulnerable patients early by implementing a robust system of assessment and review of risk
- Providing appropriate and timely interventions to reduce or eliminate the ongoing risk of pressure ulcers
- Implement individualised treatment plans to manage potential/existing risk effectively
- Provide a robust system of access to appropriate pressure relieving equipment, which is timely, suitable to patient need and safe
- Supporting families, carers and healthcare professionals with a framework for the prevention and management of pressure ulcers

2 **Roles and Responsibilities**

2.1 **Director of Infection Prevention and Control (DIPC)**

- The DIPC, on behalf of the Chief Executive, will ensure that a comprehensive PGN for pressure ulcer prevention and management within the Trust is developed, agreed and reviewed by the nominated Tissue Viability Modern Matron (TVMM)
- Will ensure that the TVMM identifies and where appropriate manages the provision of pressure reducing/relieving equipment. Ensuring it is accessible, clinically effective and takes account of financial factors as well as the educational needs of staff

2.2 **Associate Directors**

- Will ensure that the practice guidance note is implemented, monitored and evaluated within their area of responsibility
2.3 **Clinical Nurse Managers**

- Will ensure all staff in their areas are aware of and understand the guidance
- Will ensure compliance with the audit requirements of the guidance
- Will highlight omissions in the provision of appropriate assessment/equipment and work with the TVMM to review, investigate and reflect on lessons learnt
- Will take managerial action to prevent recurrence of reported incidents

2.4 **Ward Managers / Clinical leads**

- Will ensure that all staff are aware of the guidance and ensure adherence to it, reporting any exceptions to ensure effective and timely follow-up and investigation
- Will identify training needs and ensure staff are appropriately trained in both pressure ulcer prevention and management and will ensure all training is documented
- Will use the available resources to ensure patients are provided with the correct pressure reducing/relieving equipment in a timely manner

2.5 **All Staff**

- Will adhere to the Trust guidance
- Will use the information provided at clinical level to ensure correct choice of pressure reducing/relieving equipment and use this in a safe manner assessing ongoing risk as part of patient care
- Will identify their training need and make their managers aware of training deficit
- Will maintain personal records of all training
- Will report all clinical incidents about pressure ulcer prevention and management via the appropriate Trust policy CNTW(O)05 – Incidents, web based electronic reporting system (including management of serious incidents) and where indicated Safeguarding
2.6 **Tissue Viability Modern Matron**

- Will provide expert guidance and advice on the prevention of pressure ulcers
- Will provide expert guidance and advice on the management of pressure ulcers
- Will facilitate access to and management of appropriate pressure relieving equipment
- The TVMM will be responsible for leading the yearly audit of pressure ulcer prevalence and liaising with other members of the Trust to ensure clinical practice is developed in line with evidence and best practice guidance
- The TVMM will form part of an integrated approach to the management of incidents, taking a lead role in the assessment of pressure ulcers, identifying issues and ensuring remedial/corrective action is implemented
- The TVMM will ensure that where necessary and appropriate incidents are escalated and reported through safeguarding, this will include alerting relevant external agencies and departments
- Will support the process of investigation and where necessary take a lead

3 **Practice Guidance Note Objectives**

3.1 The prevention and treatment of pressure ulcers is very complex and clinical judgement must be exercised in deciding the most appropriate care for at risk patients. The qualified nurse, in collaboration with other healthcare professionals will undertake and document a comprehensive risk assessment which will include:

- The use of the Braden risk assessment tool on RiO (*Appendix 1*)
- A local skin assessment of at risk areas using the EPUAP Classification System (*Appendix 2*)
- The patients’ level of mobility
- The patients’ nutritional state – using the Trust recognised Malnutrition Universal Screening Tool (M.U.S.T)

3.2 Develop a plan of care, taking into account the equipment required and any wound care needs with reference to:

- Selection of appropriate pressure redistributing equipment. (Specialist advice should be sought from the Tissue Viability Team)
• CNTW(C)18 – Tissue Viability Policy, PGN - TV-PGN-04 - Wound Assessment; CNTW(C)20 – Health and Safety Policy PGN - HS-PGN-02 – Moving and Handling

• Nutritional needs (Referral for specialist assessment may also be indicated – specialist advise is available from dietetics team )

3.3 Prioritise the timing of the risk assessment and intervention within the patients’ immediate clinical needs. However, the majority of cases this is expected to occur within a maximum of 6 hours of admission into care.

3.4 Work collaboratively with other professionals in the Multi-Disciplinary Team (MDT) to address the needs of the at-risk patient.

3.5 Evaluate and document the effectiveness of preventative care and/or treatment within the patients integrated care records (i.e. RiO).

3.6 Report as clinical incidents all patients with a Category II, III, IV, Unstageable, suspected Deep Tissue Injury [DTI] and those lesions where it is unclear if they are potentially a mixed Moisture-Associated Skin Damage or pressure related injury. Patients considered at risk of harm or negligence must be referred to Local authority’s inline with local reporting frameworks – advice regarding this can be sought from the Trust Safeguarding Team. (Refer to separate section 11.4 Incident reporting)

3.7 Provide continuity of care between hospital and community on discharge by timely planning of discharge, this should include handover of treatment / care plans and identification of any required pressure relieving equipment.

3.8 Regularly audit pressure reducing/relieving equipment.

3.9 Information and training will be provided to ensure correct use of equipment and maintenance.

3.10 Participate in prevalence audits that will be used to improve future practice.

4 Referral to Tissue Viability (TV) - (Refer to TV-PGN-01 – Access to TV advice)

4.1 Referrals to the Tissue Viability Team can be made by the nurses caring for the patient, medical staff, professionals allied to medicine or patients themselves. The following patients should be referred:

• Patients identified ‘at risk’, who are potentially or confirmed at risk of pressure damage – this will allow early intervention and review of skin integrity

• Patients identified as requiring pressure relieving equipment – this will allow timely access to and monitoring of equipment

• Patients who have a category II, III, IV, Unstaged or suspected Deep Tissue Injury.
Patients with a deteriorating pressure ulcer - this may be any category of pressure ulcer

- Patients with a pressure ulcer that is difficult to manage

5 Education

5.1 Education of healthcare professionals is a central theme in the strategy for pressure ulcer prevention. To this end education will be provided to support this document by the Tissue Viability Team and will be implemented through a separate training strategy.

5.2 Patient and carer education also has an important role to play in pressure ulcer prevention and management and a range of information leaflets will be utilised to support this. Further specific patient/carer information can be accessed from:

https://www.CNTW.nhs.uk/resource-library/pressure-ulcers-patient-information-leaflet/

6 Guidance Review

6.1 This is a working document that will be reviewed in light of experience or new knowledge. If you have any comments about this policy or experience difficulty in its implementation please contact: Kevin Chapman, TVMM (Kevin.chapman@CNTW.nhs.uk)

7 Background Information – Pressure Ulceration: A Definition

7.1 A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction or a combination of these (European Pressure Ulcer Advisory Panel (EPUAP 2014).

7.2 Pressure ulcers range from being little more than areas of discoloured skin, through superficial ulcers, to deep purulent cavities extending to and possibly involving muscle and bone (Department of Health, 1993). This is reflected in the EPUAP grading classification (Appendix 2).

7.3 Aetiology of Pressure Ulcers

Definition:

“A pressure ulcer is 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” (EPUAP, 2014)
7.3.1 Pressure ulcers form as a result of extrinsic and/or intrinsic factors that impact on the viability of skin and underlying tissues. The impact of these forces will vary according to an individual’s susceptibility. Pressure ulcers result from prolonged and/or repeated insults producing local ischemia without adequate time for total tissue recovery (Bader, 1990). They can develop very quickly and can occur within an hour (National Institute for Health and Care Excellence 2014 (NICE, 2014) although the damage may not become apparent until some time after the tissue insult. There is a potential for all individuals to develop pressure ulcers, the relative risk is dependent upon the presence of one or more of the following risk factors:

- **Extrinsic risk factors** - The forces of pressure, shearing and friction act upon the tissues

- **Pressure** This is the most important factor in pressure ulcer development. Tissue damage is caused by skin distortion, resulting in occlusion of the blood vessels that leads to tissue necrosis and breakdown. Damage often occurs from the inside/out and therefore the true extent may not be obvious at first assessment. Most pressure ulcers occur where the skin and tissues are directly compressed between bone and another hard surface e.g. floor, bed, chair. Pressure damage can also occur when equipment is incorrectly applied e.g. splints/bandages/plaster of Paris or when pressure between two body surfaces is unrelieved for a prolonged period e.g. pressure between both knees. The most common sites for pressure damage in adults are, sacrum, heels, hip bone, and buttocks, but they may occur elsewhere e.g. spine, ears or elbows. Pressure ulceration in infants and children is more likely to occur to the occipital area or ears. There is no scientific agreement about the time a given amount of pressure needs to be exerted before injury begins. Prolonged low pressure can be as harmful as short-term high pressure (Swain and Bader, 2004, Nixon, 2004)

- **Shear** forces are initiated when the deeper tissues near the bone “slide” while the skin remains at its point of contact with the supporting surface (Waterlow, 2005). This most commonly occurs when any part of the supported body is on a gradient. As a result of shear forces blood vessels are stretched and angulated – causing a reduction of blood supply and tissue damage. Subcutaneous fat lacks tensile strength and with its reduced vascularity is particularly susceptible to damage by shearing forces (Vohra and McCollum, 1994). Reference should be made to the Trust’s CNTW(O)20 – Health and Safety Policy, practice guidance note, HS-PGN-02 – Moving and Handling. Specialist seating and positioning recommendations, should be sought from the Trust lead for Manual Handling or specialist Allied Health Professionals

- **Friction** This is defined as the force generated by two surfaces moving across one another (Krouskop, 1983). Frictional forces e.g. those generated by pulling a patient across a bed sheet, can cause intra-epidermal blisters by the abrasive action of sliding across a surface.
Friction and shear often occur in the same clinical situations. Reference should be made to the manual handling policy

- **Moisture** Excessive moisture is considered to be a risk factor in pressure ulcer development (Nixon, 2004). Moisture can cause maceration that makes skin more susceptible to pressure, shear, friction and infection (Dealey, 2005). Moisture can also lead to the tissues adhering to support surface. Some causes of the moisture e.g. urine, faeces, wound exudates, sweat etc., can damage the skin and reduce its protective function

7.4 **Intrinsic risk factors**

7.4.1 This refers to patient characteristics, such as age. Individuals at the extremes of age are at increased risk (NICE, 2014), which increases their susceptibility to pressure ulcer formation.

- **Mobility/activity** - The patient’s ability to reposition himself or herself affects risk. Mobility may be restricted by a patient’s conscious level, medication such as sedatives, hypnotics and analgesics, medical disease, acute illness, severe chronic or terminal illness, weight, pain, extremes of age etc

- **Skin/tissue condition** - This is adversely affected by age, dehydration, malnutrition, medication such as systemic or topical steroids, hypoxia and skin moisture and/or tissue oedema. Previous skin trauma such as surgical scars or previous pressure ulceration increases the risk of future pressure damage (NICE, 2014)

- **Sensory functioning** - The loss of protective response is a major factor in pressure damage. The inability to feel discomfort or pain e.g. after spinal anaesthesia, spinal injury, CVA, MS or neuropathy related to conditions such as Diabetes Mellitus, may decrease the usual response of changing position

- **Vascularity** - Pressure damage is an ischemic injury. This may be affected by conditions such as hypotension, diabetes and peripheral vascular disease

7.5 **Patient quality of life**

7.5.1 The physical, psychological and social impact of living with a pressure ulcer can be severe. For the individual, a pressure ulcer can cause pain, systemic illness, an increased length of hospital stay, extended absence from work and normal activities, loss of earnings, low self-esteem, amputation and altered body image (Franks et al., 2002, Fleurence, 2005). All of these factors could be compounded by a person’s mental health or learning disability and this should be taken into account when assessing risk.
7.6 **Patient choice**

7.6.1 Patients can only make a choice when provided with appropriate information. This should be provided in a way that is suitable for an individual’s level of understanding and reflect their needs, language and culture. Verbal and written information should be provided to patients and carers by healthcare professionals. Specialist support and information can be provided on an individual basis by the Tissue Viability Team.

7.6.2 Patients should, when possible, be actively involved in the care process and the selection of the most suitable equipment for their needs. The rationale for using specific equipment should be explained. Patients have a right to decline treatment and have their opinion respected if they are competent to do so. Some patients may refuse to use the equipment, particularly if the use of that equipment affects their independence or impacts on other family members or cultural requirement. The patient’s reason for refusal should be explored, alternatives considered and the outcome documented. However, we would be negligent in our duty of care if we did not act to safeguard patients if they were incompetent to decide what was in their best interest. Patients cannot request equipment over and above their defined clinical need as assessed by the healthcare team.

8 **Assessment**

8.1 **Identifying individuals vulnerable to, or at, elevated risk of pressure ulceration**

8.1.1 Assessment is the first step in the development of a patient-centred multidisciplinary management strategy and the key to individualised, cost-effective care. Responsibility for coordinating and documenting care lies with the admitting nurse unless a pressure ulcer is the reason for hospital admission in which case responsibility lies with the consultant.

8.1.2 All staff members are accountable for their actions and in actions in delivering care to patients and should ensure that documentation accurately reflects care given and the rationale for decisions taken. The assessment, which should be undertaken within six (6) hours of admission or at initial assessment, should be carried out by an appropriately trained healthcare professional. The assessor should have a clear understanding of the extrinsic and intrinsic factors that may relate to each individual patient and the knowledge to understand and act upon the findings of the assessment. Using this information the assessor will generate an immediate care plan which should be discussed with and agreed by the patient and/or their carers.

8.1.3 When identifying risk factors consideration must be given to the period leading up to assessment when the patient may have already experienced pressure e.g. as a result of being unable to move after a fall. Risk assessment should include both informal and formal assessment approaches, the results of which are clearly documented. Pressure ulcer risk assessment is an ongoing process. Formal re-assessment should be undertaken if:
• There is a change in an individual’s clinical condition (deterioration or improvement)

• There is a change in the patient’s clinical need following surgery or a procedure

• The patient moves wards or is transferred back into the Trust following a period of care in another provider organisation

• Frequency will be dictated by clinical need and not time

8.1.4 When a pressure ulcer is present a wound assessment should be completed and appropriate wound care provided – refer to CNTW(C)18 – Tissue Viability Policy, PGN – TV-PGN-04 - Wound Assessment.

9  RISK CALCULATORS

9.1 Risk assessment tools should only be used as an aide memoire and should not replace clinical judgement (NICE, 2014). Few risk calculators have been subjected to validity and reliability testing (Bridel, 1993, Edwards, 1995), these tools should therefore be used as indicators of care rather than prescribers of care. The potential uses of risk assessment scales are to:

• Identify the risk status of individual patients

• Structure patient assessments and act as an aide memoire of risk factors

• Facilitate clinical audit of patient management and outcomes

• Provide evidence of assessment

• Assist with targeting resources appropriately

• Algorithm risk for risk assessment, prevention and management in Adults (NICE, 2014) is available for reference

https://www.nice.org.uk/guidance/cg179/resources

9.2 The Braden Scale assessment tool is used within the Trust (Appendix 1). Staff working in specialist areas i.e. Children and Young people’s services should ensure the Braden Scale is used in the first instance and results balanced against the range of risk factors, age and clinical presentation of the young person being assessed. Specialist advice is available from the Tissue Viability Team.

10  Skin Assessment

10.1 All patients’ skin should be assessed and the initial status documented using The European Pressure Ulcer Advisory Panel classification system (Appendix 2). Any change in the skin status should be fully recorded. Skin assessment
should occur regularly. The frequency should be determined by the previous skin condition and any changes in the individual’s condition. Patients, carers or health professionals can perform skin inspection. Individuals, who are able, should be taught and/or encouraged to inspect their own skin (National Institute Health and Care, 2014).

10.2 Skin inspection should be based on an assessment of the most vulnerable areas of risk for each patient. These are typically bony prominences that include sacrum, heels, hips, ankles, elbows and back of the head. Risk areas for children include the head and ears. The use of equipment such as plaster casts and splints can increase interface pressure as can anti-embolic hosiery. Skin in these areas requires more frequent assessment. The condition of the skin should be documented, including if the skin is intact. The site and extent of discoulouration, dryness, cracking, erythema (redness), maceration, localised oedema, fragility, blisters, localised heat, localised pain and induration (hardness) should be recorded.

11 Categorising of Pressure Ulcers

11.1 The use of a standard system of categorising pressure ulcers is essential by providing objective and accurate descriptions of pressure ulcers. It also gives a more accurate picture of the amount of tissue damage. The staging system however should also be used on conjunction with other descriptive tools such as measuring and describing the ulcers appearance. The Trust has adopted the European Pressure Ulcer Advisory Panel Classification System of Pressure Ulcer Categories (EPUAP 2014).

11.2 Blanching erythema. The body’s ‘normal’ physiological response to pressure is a blanching erythema – a reddening of the skin that blanches when light finger pressure is applied, indicating that the microcirculation is still intact. The early signs of tissue damage include persistent erythema or non-blanching hyperaemia.

11.3 The categories are - (Refer to Appendix 2 for pictorial reference)

- **Category I – Non-blanching erythema / hyperaemia** - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. Where Non blanching erythema is identified staff should consider reassessment of the area every 2 hours as clinically indicated or resolved.

- **Darker pigmented skin** - In people with darkly pigmented skin the initial signs of tissue damage such as non-blanching hyperaemia may be difficult to detect. It can be identified by a purplish/bluish localised area of skin. One method of identifying it is the heat detection method described by Lowthian (1994). This involves running one’s middle finger slowly over the suspect area to feel the heat. Alternatively,
palpating the skin will show if it is turgid or if a lump is present – this is indicative of subcutaneous trauma

- **Category II** – Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. *This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.  *Bruising indicates suspected deep tissue injury.

- **Category III** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a category III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category III pressure ulcers. Bone/tendon is not visible or directly palpable.

- **Category IV** – Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Category IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

- **Unstageable: Depth Unknown**
  Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ‘the body’s natural (biological) cover’ and should not be removed.

- **Suspected Deep Tissue Injury [DTI]: Depth Unknown**
  Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

As identification of a suspected Deep Tissue Injury is complex and requires specialist skills, staff unsure if present or developing should alert the TVN’s for early review and management. Incident reports should initially identify
pressure ulcer category as ‘Unstageable’, this will be updated and amended by TVN’s once assessment has taken place.

- Moisture-Associated Skin Damage [MASD] covers the range of skin problems that occur due to prolonged exposure to moisture, either by urine, faeces, perspiration, or wound exudate. Other terms used included: Moisture lesions, Moisture ulcers, Incontinence associated dermatitis (IAD), ‘Nappy rash’.

- Pressure ulcers believed to directly result from the use of medical devices designed and applied for diagnostic or therapeutic purposes MUST be alerted immediately to the TVN team for investigation and follow-up.

- Wherever possible the pressure ulcer should be documented and mapped to establish a baseline. Where patient consent can be obtained, all pressure ulcers are to be photographed, measured and recorded on admission, on discharge and if a patient develops a pressure ulcer while in hospital. Staff should refer to the relevant policy for consent forms within the Trust’s CNTW(O)45 – Visual Imaging and Audio policy. In circumstances where informed consent cannot be obtained, then following review and agreement with the MDT, photographs may be taken for clinical reference purposes but the decisions for this must be logged in the patient’s notes.

11.4 Incident Reporting

- PLEASE NOTE: All hospital acquired pressure ulcers Category II and above should be documented as a clinical incident and reported in line with local policies as well as being **urgently** referred to the Tissue Viability team.

- CNTW(C)04 – Safeguarding Children Policy and associated PGN’s

- CNTW(C)24 – Safeguarding Adults at Risk policy and associated PGN’s

- CNTW(O)05 – Incident policy and associated PGN’s

- Where ‘Unstageable or Deep Tissue Injury’ is suspected and where staff are unable to categorize an ulcer because of clinical presentation or lack of knowledge, alert the Tissue Viability Team as soon as possible to facilitate assessment. Whilst this is pending normal incident policy/procedure should be followed as the Tissue Viability Team can amend category retrospectively after review and investigation.

- Where the clinical diagnosis of a queried moisture or pressure related injury has been identified or occurred then the clinician must report this using the Trust’s Incident reporting system and alert the TVN’s to support timely assessment, prevention and treatment.
12 Pressure Ulcer Prevention

12.1 The involvement of the patient or carer in preventing pressure ulcers is vital; explanation should be given about risk factors, their implications and strategies for prevention. Their experience in successfully preventing pressure ulcers should be taken into account when planning care. Patient information should be verbal, supported by written information as appropriate. The patient/carer should be involved in long term care planning which may involve other members of the community healthcare team.

12.2 There are three principles of action to prevent pressure ulcers:

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

12.3 Should a situation occur where specific interventions are indicated (Equipment, repositioning etc) and offered but refused by the patient, staff should ensure urgent MDT evaluation of the case to fully risk assess management and treatment options. The Trust Tissue Viability Team can support this process. It is essential full and comprehensive documentation is kept.

12.4 Reducing/Relieving Pressure

12.4.1 Pressure relief is the main strategy used in the prevention of pressure ulcers (Dealey, 2005). This includes:

- Patient positioning and repositioning
- The use of specialist equipment

12.5 Positioning and repositioning

12.5.1 Periodically repositioning the patient is one way of relieving pressure and transferring it to another area in order to prevent tissue damage. How often this is carried out will depend on the individual patient’s skin redness, mobility, risk factors and the support system in use. i.e. Mattress or type of chair. Individuals who are able to do so safely should be taught and encouraged to actively mobilise and reposition themselves whether in bed or chair. The frequency of timing and positioning must be included in the patient’s written care plan of repositioning chart. (Appendix 3). NICE, 2014 indicates that patients identified ‘at risk’ should be encouraged to re-position 6 hourly or as clinically indicated, this should be reduced to a minimum of 4 hourly if at ‘high risk’. Repositioning should respond to individual client need and be reviewed regularly in line with client identified risk factors.

12.5.2 Staff should ensure that clients receive advice on the benefits and frequency of repositioning.
12.5.3 In situations where the client is unable to reposition themselves staff should risk assess and provide positional changes to minimise risk to clients – the frequency of such changes will need to reflect the individual requirements of the client.

12.5.4 The effects of **shear and friction** can be minimized by:

- Correct positioning of the patient e.g. use of profiling bed
- Using appropriate manual handling techniques and equipment
- Careful removal, when appropriate, of handling equipment
  - e.g. slings after moving the patient
  - The use of the 30-degree tilt to position patients in such a way to minimize the impact on bony prominences can also reduce the risk of pressure damage. The risk of tissue damage due to shear and/or friction can be reduced by providing effective means of assisting movement in accordance with the individual’s positioning and care plan. See the Trust’s CNTW(O)20 – Health and Safety policy, practice guidance note, HS-PGN-02 – Moving and Handling. Patients “at risk” from pressure damage, who cannot relieve their own pressure independently, should restrict chair sitting to a maximum of 2 hours at any one time (NICE, 2014)

- Repositioning should take into consideration other relevant matters, including the patient’s medical condition, their vulnerable areas, their daily routine, their comfort, the overall plan of care and the support surface. Ensure bony prominences such as knees are kept from being in direct contact with one another

12.6 **Equipment**

12.6.1 Pressure redistributing support surfaces work by reducing the magnitude and/or duration of pressure between the individual and the support surface. They are an important adjunct to effective nursing care rather than a replacement for it (University of York, 1995). The provision of pressure relieving devices needs a 24-hour approach and should include consideration of all surfaces used by the patient e.g. wheelchair. The medical devices lead and TVMM will support and advice regarding decisions about choice of equipment available to the Trust. When considering equipment provision for individuals the holistic assessment should include all of the following:

- Risk assessment and level of risk
- Skin assessment and the presence and severity of any pressure ulcers
- Location, cause and grade of pressure ulcer
- Comfort
- Acceptability of the proposed equipment to the patient or carer
- Critical care needs
- General health status
- Patient weight
- Lifestyle and potential affect that the equipment will have on their abilities
- Treatment objectives
- Any contraindication advised by the equipment manufacturer
- Suitability for area of usage
- Safety of patient (e.g. ligature risk)

12.6.2 The initial choice and subsequent changes of equipment, including the rationale, should be documented. Patients with identified category I or II pressure damage are at significant risk of developing more severe ulcers and should, as a minimum provision, be placed on a high specification foam mattress/cushion with pressure reducing properties (NICE, 2014). Patients with deteriorating category I or II pressure damage and all category III / IV pressure ulcers should, as a minimum provision, be placed on an alternating cell pressure air mattress/cushion that provides periodic pressure relief (NICE, 2014). Water filled gloves, synthetic or genuine sheepskins or doughnut-type devices should not be used as pressure relieving or redistributing aids.

12.7 Seating

12.7.1 Trained healthcare professionals who have developed specific knowledge and skills in this area or who have undergone locally approved training should carry out seating assessments for aids and equipment. Positioning of individuals who spend substantial periods of time in a chair or wheelchair must take into account distribution of weight, postural alignment and balance and support of the lower limb/feet. The benefits of a pressure redistributing mattress/cushion should not be undermined by prolonged chair sitting. When planning to sit the patient out of bed consider the following points:

- The severity and location of any ulcer
- The patients’ ability to sit comfortably in an armchair and reposition themselves
- Ergonomics of the chair (e.g. height, depth, width, armrest)
- Ease of transfer from the bed to chair and the use of appropriate moving equipment
- Posture, mobility, comfort and support
- Functions required when sitting e.g. eating/washing
- Patient choice and psychological considerations
13 Preventing Damage to the Skin

13.1 Caring for the skin is a nurse’s fundamental role. In order to keep it in good condition the skin needs to be protected from maceration, irritation, the removal of natural oils and accidental damage. Treatment of the skin therefore depends on the state in which it is found, rather than any routine procedure. Boore et al (1987) identify the following principles in caring for the skin:

- Keep it clean
- Do not let it remain wet
- Do not let it dry out
- Prevent accidental damage

13.2 To achieve the above:

- A mild cleansing agent (e.g. aqueous cream) should be used to minimise irritation and dryness of the skin. Avoid rubbing the skin and pat the area dry. Emollients (e.g. Hydromol\textsuperscript{TM}) can be applied to help prevent skin dehydration

- Avoid talcum powder as this can ‘cake’ and cause irritation and friction

- Reduce the effect of moisture on the skin. Barrier products such as Sorbaderm\textsuperscript{TM}, which is compatible with many continence aids, may be applied. Zinc oxide cream (Sudocrem\textsuperscript{TM}) and zinc and caster oil should be avoided particularly if continence products are used

- Film or thin hydrocolloid dressings may be used to protect the skin from friction. Care must be taken in their application to prevent “ruffling up” which could cause further damage. Specialist dressing advice is available from the TVN team.

13.3 Incontinence

- Effective promotion of continence or management of incontinence is needed to maintain skin integrity. Skin should be kept free of contamination by urine and faeces by gentle cleansing. Incontinence management and pressure relief must be coordinated. For patients with incontinence dermatitis, seek advice from specialist clinicians and/or the Tissue Viability Team

14 Treatment of Pressure Ulcers

14.1 The principles of intervention are:

- Removing the cause i.e. pressure, shear and friction
- Create a healing environment at the wound surface – remove dead tissue/slough and infection
• Improve the patient’s general condition - Refer to TV-PGN-04 – Wound Care PGN

15 Nutrition and Tissue Viability

15.1 Poor nutritional status and dietary intake have been associated with the presence of pressure ulcers (European Pressure Ulcer Advisory Panel, 2003). However, the relationship between nutritional status and pressure ulcers is complex and poor nutritional status may be a contributory factor, rather than a major aetiological factor in the development of pressure ulcers. Early assessment of nutritional status should be undertaken as part of a holistic approach to prevent pressure ulcer development.

15.2 All patients should be screened using a validated tool for nutritional status, see the Trust’s CNTW(O)27 – Nutrition Policy. This should not replace clinical judgement. Excess of body weight may mask nutritional deficiencies. Nutritional status should be re-assessed regularly following an individualised assessment plan that includes an evaluation date. The frequency of re-assessment should be based upon the condition of the individual (EPUAP 2014). Where an assessment (M.U.S.T) or screening of nutritional status indicates that malnutrition may be present, nutritional intervention should be considered and discussed with the medical team and/or dietician. Where patients have established pressure ulcers, a similar strategy of nutritional intervention should normally be considered although nutritional needs may be increased due to the presence of tissue damage.

16 Information

16.1 People at high risk of developing pressure ulcers and their carers should have access to a range of information regarding prevention, identification treatment and management of pressure ulcers this may include leaflets or online resources. If requested access to the Tissue Viability Team should be facilitated by the clinical team caring for the client.

17 References


