Document Control

Title **Prevention and Management of Pressure Ulcers Policy**			
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3.3	Feb 2013	Final	Published on BOB. Harmonised policy.
4.0	August 2018	Revision and Update	Includes recommendations from NHS Improvement issued in June 2018
4.1	March 2019	Minor revision	Frequency of pressure ulcer risk assessment included. New appendix to include the DH Safeguarding adults decision tool in a usable format. New appendix to include a 'How to' guide for completing concise investigations for healthcare acquired pressure ulcers.
5.0	January 2020	Final	Amendments to wording in responsibilities. Additional responsibility for registered nurses/midwives/NA's Addition of pre-registration nurses/midwives and AHPS's Amendments to wording and details in Documentation section. Addition of patient and carer information videos and QR reader. Amendments to wording and detail in Prevention of pressure ulcers section. Additional clarification in Incident reporting.
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CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for the prevention of pressure ulcers for those patients previously without skin damage, and the management of pre-existing pressure ulcers in patients admitted to the Trust's care. It provides a robust framework to ensure a consistent approach across the whole organisation.

1.2. The policy applies to all Trust staff.

1.3. Implementation of this policy will ensure that:

- All patients admitted to our care will have a pressure ulcer risk assessment carried out using an appropriate risk assessment tool.
- All patients admitted to our care will have a care plan devised based on their risk assessment to minimise their risk of developing a pressure ulcer or to minimise the risk of deterioration of any existing pressure ulcer.
- Care plans will be implemented and regularly evaluated to ensure their effectiveness. Care plans will be updated and amended in response to changes in patients risk or physical condition.
- Pressure relieving equipment resources are utilised appropriately.

- There is robust method for incident reporting pressure ulcers acquired in our care and those admitted to our care.

2. Definitions

Pressure Ulcer

2.1. A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical device 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. (NHS Improvement, 2018). See Appendix 9.1 for guidance on the categorisation of pressure ulcers.

Medical Device Related pressure ulcer

2.2. A pressure ulcer that has developed due to the presence of a medical device. These are medical devices designed and applied for diagnostic or therapeutic purposes.

Healthcare/Hospital acquired pressure ulcer

2.3. A pressure ulcer that develops whilst the patient is receiving nursing care, either in a hospital or community hospital or from the community nursing services provided by Northern Devon Healthcare Trust. The pressure ulcer is first observed within the current episode of care.

Pressure Ulcer Present On Admission

2.4. A pressure ulcer that is observed during the skin assessment undertaken on admission to that service.

Moisture Lesion

2.5. Moisture lesions are damage to the skin resulting from the effects of moisture. Skin damage caused solely by exposure to moisture are known as a moisture lesion. Pressure and moisture may combine to cause skin damage and where this occurs the resulting lesions will be classified as a pressure ulcer. See Appendix 10.1for guidance on differentiation of moisture lesion and pressure ulcer.

3. Responsibilities

3.1. The Chief Nurse is responsible for:

- Tissue Viability as Lead Executive Director.
- Ensuring implementation of Tissue Viability processes/procedures within all Trust services.
- Ensuring resources are provided to fulfil service requirements.

3.2. The Tissue Viability Service is responsible for:

- Producing and updating a Pressure Ulcer Prevention and Management Policy
- Supporting the Trust to meet national and local performance targets/service objectives for pressure ulcer prevention and reduction
- Ensuring there is a system of pressure ulcer incidence monitoring that records the number of pressure ulcers and provides validated information and assurance to relevant staff/ teams and trust board
- Ensuring that education and training on the prevention and management of pressure ulceration is available throughout the organisation
- Reviewing the care of patients with complex pressure ulceration with the primary caring nursing team
- Support managers/teams with investigations into the development of healthcare acquired Category 3 and 4 pressure ulcers.
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3.3. Divisional Nurses/Clinical Matrons are responsible for:

- The reduction of pressure ulcers in the area under their charge
- Utilising data provided from the Trust's information systems to monitor the effectiveness of pressure ulcer reduction strategies.
- Ensuring staff are able to access appropriate training in relation to pressure ulcer prevention and management.
- Raising problems regarding pressure ulcer prevention and management at relevant forums
- Sharing successful strategies for pressure ulcer prevention at suitable forums and engaging in benchmarking activities.
- Ensuring that investigation action plans are implemented.

3.4. Ward Managers/Community Nurse Team managers are responsible for:

- Acting as a clinical lead for pressure ulcer prevention and care within their Ward or Department
- Ensuring that all their Ward/ Department staff are adequately trained to care for patients both at risk of and with pressure ulceration.
- Ensuring that patients are risk assessed and cared for in accordance with this policy through the supervision of his/ her staff

- Ensuring that incidence/ prevalence data provided to them is used to inform pressure ulcer reduction planning.
- Ensuring that his /her ward/department implements actions as identified by investigation action plans.

3.5. Registered Nurses/ Midwives/ Nursing Associates are responsible for:

- Risk assessment of the patients under their care
- Making and maintaining an effective written care plan for pressure ulcer prevention and or treatment
- Provision of care to prevent and or treat pressure ulcers either directly or by support workers under their supervision.
- Evaluating the effectiveness of the care plan and ensuring the care plan is revised and updated accordingly as patients conditions change.

3.6. Allied Health Professionals, Assistant Practitioners and Medical Staff are responsible for:

- Ensuring pressure ulcer prevention strategies continue when the patient is predominantly under their care rather than under nursing or midwifery supervision.

3.7. Health Care Assistants/Support workers/ Trainee Nursing Assistants or Assistant Practitioners and pre-registration students (nursing, midwives and AHP's) are responsible for:

- Performing delegated tasks from registered colleagues.
- Escalating/reporting any pressure ulcers identified to a registered nurse/midwife.
- Delivering care to patients as per the care plan.
- Documenting the patients skin condition following any intervention that enables skin checks to be performed.

4. Prevention and Management of Pressure Ulcers

4.1. Assessment

- All adult in-patients (acute hospital/community hospital) will be assessed for their risk of pressure ulcers using the Pressure Ulcer Risk Assessment Tool (PURAT) within 6 hours of admission.

- Patients admitted into the Emergency Department (ED) who are considered to be at increased risk and who are going to be admitted to an in-patient bed will have their pressure ulcer risk assessed using the pressure ulcer risk assessment sticker which will be placed on the Casualty Card document.
- Maternity patients who are staying longer than 6 hours or those staying <6 hours but are having spinal /epidural anaesthesia will have a pressure ulcer risk assessment completed.
- Paediatric patients (>1 - <18 years) who are immobile either by temporary medical intervention (>2 hours) or medical necessity (e.g. desaturation on movement) or due to permanent disability will have their risk assessed using the Glamorgan Risk Assessment Scale. Neonates and infants are normally excluded due to their frequency of movement (by themselves and carers).
- Patients admitted to community nursing caseloads will have their risk assessment completed at the first face to face visit which should be within 48 hours of referral.
- In-patients will have the PURAT completed daily or when their condition changes.
- Community patients will have the PURAT re-assessed weekly (if seen weekly or more often) or at every community nurse visit if seen less than weekly.
- Every risk assessment will include a check of the skin for damage in all patients. In particular the sacrum, buttocks, heels and any notable bony prominences will be viewed. Heels should be checked in all patients, especially those who are mobile, if they have diabetes, rheumatoid conditions, peripheral vascular disease or other condition that can cause peripheral neuropathy.

4.2. Documentation

- Adult pressure ulcer risk assessment will be documented on the Pressure Ulcer Risk Assessment Tool (PURAT). See Appendix 10.2
- Paediatric pressure ulcer risk assessment will be documented on the Glamorgan pressure ulcer risk assessment chart. See Appendix 10.3
- All areas of pressure ulceration which involve broken skin must be recorded on a wound management form and have an appropriate care plan relating to management of the pressure ulcer.
- All patients at risk of or who have pressure ulceration will have a pressure ulcer prevention care plan devised, implemented and evaluated.
- A repositioning schedule, agreed with the individual where possible, will be a central part of the care plan. This should detail how often this will occur over a 24hour period.
- For in-patients, the frequency of re-positioning and skin checks will be documented on the comfort round chart. The frequency of skin checks does not need to be the same as the frequency of repositioning, but should be at least once per shift (twice daily) for those at medium or high risk of developing pressure ulcers.

- Patients and carers should be given written patient information leaflets (see Appendix 9.4) and it should be documented in the care plan that these have been given.
- There are additional patient and carer information videos accessible via the Trust public website or by scanning this code which will download the videos on to a mobile device or tablet: (See Appendix 9.4)

4.3. Prevention of pressure ulcers

- Patients able to move independently must be encouraged to do so and advised how often they need to do this.
- Patients with some degree of movement dependency will be taught how best to move themselves within the confines of their ability.
- Patients unable to move themselves must be moved using methods and aids that minimise skin damage. These methods and aids will be consistent with the Trust's Manual Handling and Risk Assessment Policy and will be documented on the patients moving and handling assessment.
- Patients on the community nursing caseload will have a pressure ulcer prevention and management care plan completed irrespective of their assessed level of risk that details the advice- written and verbal- given to them to help them minimise their risks. This will be reviewed as a minimum every 3 months or when patients risk status/condition changes.
- Nutritional risk assessment will be performed and regularly updated, using the Malnutrition Universal Screening Tool (M.U.S.T).in line with Trust policy on admission to hospital or community nursing caseload.
- Any patient identified as having urinary or faecal incontinence of any severity or frequency will have a suitable barrier product applied to minimise the risk of moisture lesions developing.
- Any patient with persistent and frequent liquid stool (with or without faecal incontinence) such as that resulting from Clostridium difficile infection should be assessed for the use of a faecal management system (normally FlexiSeal®), to prevent the development of moisture lesions, improve dignity and minimise the risk of spread of infection.
- The use of barrier products is not required unless the patients' skin is exposed to moisture (incontinence/sweat etc). Barrier products do not reduce pressure.
- Appropriate pressure relieving equipment will be utilised following risk assessment. Within in-patient areas all bed frames have high specification foam pressure relieving mattresses. Dynamic (air) mattresses are also available. Within community settings appropriate pressure relieving equipment can be accessed via the community equipment services. See Appendix 10.5.
- Anyone identifying equipment shortages should raise this via the incident reporting system.

4.4. Treatment of Pressure Ulcers

- Treatment of pressure ulceration will be undertaken by provision of appropriate pressure relieving strategies and regular change of position. Appropriate pressure relieving equipment may also be implemented. These will be designated by the Registered Nurse/Midwife in charge of the patient's care and documented clearly in the care plan. In addition, any wound will have a wound assessment documented on a wound assessment form and an appropriate wound care plan in place also designated by the Registered Nurse/Midwife.

4.5. Incident Reporting

- All pressure ulcers and moisture lesions should be reported via the Trusts incident reporting system, Datix.
- Pressure ulcers and moisture lesions will be reported:
  - If they develop whilst an inpatient or on community nursing caseload.
  - If they deteriorate during an in-patient stay or whilst on community nursing caseload.
  - If they are present on admission to hospital or caseload.
- With patient consent, for in-patients a photo should be taken and attached to the Datix form. For community nursing patients the photo should be uploaded to the electronic health record and does not need to be attached to Datix.
- All pressure ulcer incidents will be reviewed by the Tissue Viability team who will confirm the incident severity.
- Incident reports that identify gaps in care provision and/or service delivery will be escalated for a concise investigation report to identify any learning as per the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures

4.6. Safeguarding

- Pressure ulcers may occur as a result of neglect. Neglect may involve the deliberate withholding or unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support. Where concerns are raised regarding skin damage as a result of pressure there is a need to raise it as a safeguarding concern within the organisation. In a minority of cases it may warrant raising a safeguarding concern with the local authority.(DOH 2018) See Appendix 10.6 for guidance.

5. Referrals to Tissue Viability

- Referrals will be made via the on line referral form in accordance with the Tissue Viability Operational Policy available on the Tissue Viability site on BOB.
- All category 3 and category 4 and unstageable pressure ulcers should be referred to Tissue Viability.
- Patients with foot ulceration should be considered for referral to Podiatry as per their referral criteria. The Acute Diabetic Foot Pathway should be followed for patients who have diabetes and acute foot ulceration problems.

6. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

6.1. Key performance indicators comprise:

- Monitoring of pressure ulcer prevalence and incidence.
- Clinical Effectiveness Tool audit of documentation.

Process for Implementation and Monitoring Compliance and Effectiveness

6.2. Heads of Department are responsible for ensuring this policy is implemented in their areas.

6.3. Clinical support will be provided by the Tissue Viability Team.

6.4. Implementation of this policy will be monitored by:

- Monitoring of pressure ulcer incidence via the incident reporting system by the Tissue Viability team.
- Documentation audits and the clinical effectiveness tool by clinical teams.
- Concerns over non-compliance with the policy will be raised at and monitored by the Patient Safety Operational Group.
- If this policy is not followed, appropriate action may be taken in line with the Trusts capability and conduct processes.

7. Equality Impact Assessment

7.1. The author must include the Equality Impact Assessment Table and identify whether the policy has a positive or negative impact on any of the groups listed. The Author must make comment on how the policy makes this impact.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			x	
Disability			x	
Gender			x	
Gender Reassignment			x	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			x	
Pregnancy			x	
Maternity and Breastfeeding			x	
Race (ethnic origin)			x	
Religion (or belief)			x	
Sexual Orientation			x	

References

Department of Health and Social Care (2018) Safeguarding Adults Protocol. Pressure Ulcers and the interface with a Safeguarding Enquiry. Department of Health and Social Care: London Available at: https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol

NHS Improvement (2018). Pressure ulcers: revised definition and measurement. Summary and recommendations. NHS Improvement: London.

National Institute for Health and Care Excellence (2014) *Pressure ulcers: prevention and management of pressure ulcers.* NICE Clinical guideline 179. Available at: https://www.nice.org.uk/guidance/cg179

National Institute for Health and Clinical Excellence (2015) Pressure Ulcers. Quality Standard. Available at https://www.nice.org.uk/guidance/qs89

National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel/Pan Pacific Pressure Injury Supply Alliance (2014) *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide* 2nd edition. Cambridge Media: Perth, Australia/

8. Associated Documentation

- Incident reporting policy
- Moving & Handling Policy

- Safeguarding Adults policy
- Safeguarding children policy
- Tissue Viability Operational Policy
- Care of Open Wounds policy
- Incident Reporting, Analysing, Investigating and Learning Policy and Procedures

9. Appendices

9.1. Pressure Ulcer Categorisation and Excoriation and Moisture Related Skin Damage Tool

PU Categories v0.1 FINAL DRAFT 210818

9.2. Pressure Ulcer Risk Assessment Tool (PURAT) for Adults.

PURAT Update 120918.pdf

9.3. Glamorgan Paediatric Pressure Ulcer Risk Assessment Tool.

Paediatric Glamorgan Pressure Ulcer Risk A

9.4. Patient Information

- In-Patients

pressure_ulcer_how_to_reduce_the_risk.

- Home Environment

Pressure ulcer - how to reduce the risk in h

- Finger-tip test – for carers to recognise non-blanching redness

Finger-Tip-Test-leaflet.pdf

Information videos accessible via the Trust website:

https://www.northdevonhealth.nhs.uk/services/tissue-viability/pressure-ulcer-videos/

9.5. Independent Living Centre and Community Equipment Services Information.

http://ndht.ndevon.swest.nhs.uk/community-equipment-service-independent-living-centre/

9.6. Safeguarding Guidance

CSW_ulcer_protocol_guidance (1).pdf

9.7. Five Moments for Pressure Ulcer Prevention Poster

Pressure ulcer prevention poster 20

9.8. Adult Safeguarding Decision Tool (printable tool from appendix 9.6)

Adult Safeguarding Decision Guide for ind

9.9. How to Complete a Concise Investigation for healthcare acquired pressure ulcers guide.

Pressure Ulcer Investigation How to