University Hospitals of Leicester NHS
NHS Trust

Prevention and Management of Pressure Ulcers in Adults and Children Policy and Guidance

Approved By:	Policy and Guideline Committee
Date of Original Approval:	**21st November 2015**
Trust Reference:	**B23/2014**
Version:	V5
Supersedes:	V4 – October 2020
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Date of Latest Approval	15 December 2023 – Policy and Guideline Committee
Next Review Date:	July 2027

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

This document is a re-write to reflect changes in local practice since the development of the previous policy.

November 2023 – Review and update of most sections within the policy to bring in line with best practice. Specifically : Section 1 information updated and condenced. Section 3 Definiations updadated and condenced . Sections 4 Roles and responsibilities updated. Section 5 updated to aSSKINg from SSKIN. Contents reorganised and condensed to reflect flow of aSSKINg care bundle. Section 7 monitoring and compliance updated. Section 9 references updated. Appendecies updated and condenced.

KEY WORDS

Pressure ulcers, skin damage, moisture lesion, mattress, category, deep tissue injury, unstageable

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for;

- The identification of patients potentially at risk of developing pressure ulcers when admitted to hospital
- Preventing the development of new skin damage
- Reporting process for all pressure ulcers
- Treating patients with existing pressure damage

1.2 The **aim** of this policy is to standardise practice in the prevention and management of pressure ulcers aiming to eradicate any hospital acquired pressure ulcers (HAPU) including the deterioration of skin damage present on admission to UHL.

1.3 Pressure ulcers are caused when an area of skin and/or the tissues below are damaged as a result of being placed under sustained pressure or distortion to impair its blood supply.

1.4 All people are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impairment to posture or positioning, compromised skin, are malnourished or have had a prolonged length of stay and may have become deconditioned.

1.5 Pressure ulcers remain a concerning and mainly preventable harm associated with healthcare delivery and can cause significant pain and distress for patients. Pressure ulcers are a key indicator of the quality and experience of patient care. Pressure ulcers remain a significant healthcare problem, with up to 200,000 people developing a new pressure ulcer in 2017/18 (Guest et al 2017). Treating pressure ulcers costs the NHS more than £1.4 million every day (Guest et al 2017). Pressure ulcers cause considerable harm to patients, hindering recovery, frequently causing pain and can cause serious infections such as sepsis. Pressure ulcers increase length of hospital stay and may negatively impact the persons mental health and quality of life.

1.6 Finding ways to improve the prevention of pressure damage is therefore a priority for patients, policy-makers, managers and practitioners alike.

1.7 This policy provides procedures, advice and guidance on the prevention and management of pressure ulcers at UHL including reporting, monitoring and Root Cause Analysis (RCA) Investigation and when to alert the Safeguarding Team.

1.8 This policy supports the national Stop the Pressure Campaign and the implementation of aSSKINg promoted by NHSi England (2018) to support a consistent approach to defining, measuring and reporting pressure ulcers.

1.9 The policy is also based on:

a) National Institute for Health and Care Excellence (2014) Pressure Ulcers: Prevention and Management (CG179)

b) European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Treatment Guidelines (2019)

c) NHSi (2018) Pressure Ulcers: Revisited definition and measurement

2 POLICY SCOPE

2.1 This policy applies to all Health Care professionals working within UHL including those on bank, agency or honorary contracts who care for adults and children admitted to UHL as inpatients.

2.2 This Policy also applies to all adult and child patients seen in UHL Outpatient areas including the Emergency Department (ED), Day Case areas and Alliance units.

2.3 This policy does not include the prevention or treatment of other wound types. To support their clinical decision about dressing's choices, staff must use the UHL Wound Care Formulary and the First Line Decisions Guide for Dressings. Staff are accountable for their knowledge and skills to be sufficient for their roles and updated regulareily.

3 DEFINITIONS AND ABBREVIATIONS (EPUAP 2019)

3.1 **Pressure Ulcer (PU)** – is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers (e.g. microclimate i.e moisture, friction, sheer etc.)

3.2 **Medical Device Related Pressure Ulcer (MDRPU)** – is a pressure ulcer that had developed due to sustained pressure from a medical device such as plaster casts, splints, oxygen therapy masks, tracheostomy tubing or urinary catheters etc.

3.3 **Moisture Associated Skin Damage (MASD)** – is a reactive response of the skin to chronic exposure to excessive moisture from sweat, urine, faecal matter or wound exudate, which could be observed as an inflammation and erythema with or without erosion. Typically, there is a loss of the epidermis and the skin appears macerated, red, broken and painful.

3.4 **Category** – This is the term used for the classification of a pressure ulcer – category 1, 2, 3 or 4, unstageable, Deep Tissue Injury (DTI) and mucosal. (Appendix 1). Staff must **not** use the pressure ulcer classification system to describe tissue loss in wounds other than pressure ulcers.

3.6 **Pressure Ulcer Present on Admission (POA)** – Are confirmed if observed during skin assessment undertaken within 6 hours of arrival to UHL.

4 ROLES AND RESPONSIBILITIES

4.1 Executive Lead

a) The Chief Nurse is the Executive Lead for policy.

b) Deputy Chief Nurse has responsibility to ensure that adequate arrangements are in place to ensure the Trust is compliant with the Regional and National agenda; support implementation of policy.

4.2 Assistant Chief Nurse for Harm Free Care and Tissue Viability Lead Nurse

a) Overseeing the UHL Hospital Acquired Pressure Ulcers Reporting Process Standard Operating Procedure UHL Guideline plus reviewing all category 3, 4 and unstageable pressure ulcers, both POA and HAPUs, to ensure that safeguarding measures are appropriately administered.

b) Provide quarterly data reports to Nursing, Midwifery and Allied Health Professionals Committee The report will include themes, trends and analysis or exception reports..

c) Provide reports in combination with the Tissue Viability Lead Nurse to the Pressure Ulcer Steering Group.

4.3 CMG Head of Nursing and Clinical Director

a) Implement the initiatives set out in this policy to ensure there is a zero tolerance to all Hospital Acquired Pressure Ulcers.

b) Maintain overall responsibility of all pressure ulcer related incidents and organise/undertake monthly RCA Care Review and Learning meetings of reported category 2, 3 and 4 pressure ulcers including Deep Tissue Injuries (DTI), unstageable and mucosal.

c) Monitor the implementation of the CMG action plans produced from Care Review and Learning meetings and serious incident report investigations.

d) Review and sign off the RCA reports and Serious Incident reports on an on-going basis and within the set timescales.

4.4 Matrons / Ward Sisters / Department Managers

a) Ensure all staff are up to date with their knowledge and competent regarding prevention, categorisation of pressure ulcers, validation and management of pressure ulcers, addressing any education and training needs identified.

b) Ensure all staff practising within their clinical area are aware of the requirement to report all pressure ulcer related incidents category 1, 2, 3, 4, DTI's, unstageable and mucosal.

c) Ensure all staff are using the current UHL Pressure Ulcer Prevention Nursing Documentation and undertake regular audits including Nursing Metrics, aSSKINg Care bundle & related care plan.

d) Ensure all staff follow the policy statements and procedures set out in this document.

e) Must investigate all confirmed hospital acquired pressure ulcer related incidents (excluding category 1). Disseminate the learning from the investigation and ensure that the appropriate changes are made and embedded in clinical practice. Ensure the RCA is completed for all Hospital Acquired Pressure Ulcers categories 2, 3, 4 and DTIs, unstageable and mucosal, within the seven day timeframe and present the fully completed RCA at the monthly CMG Care Review and Learning meetings.

f) Where patients are admitted with a category 3, 4, multiple category 2 pressure ulcers or an unstageable pressure ulcer, and there are safeguarding concerns, make a safeguarding adult referral to adult social care.

4.5 Registered Nurses, Midwives and Nursing Associates (under the supervision of the Registered Nurse).

a) Follow the policy statements and procedures set out in Section 5 and the appendices.

b) Assess all patients as to their risk of pressure damage and plan, implement and review care plans to reduce the risk within agreed timescales.

c) Report identified category 2,3,4 including Deep Tissue Injuries,Unstageable and mucosal pressure ulcers on DATIX.

d) Where patients are admitted with pressure ulcers and there are safeguarding concerns, make a safeguarding adult referral to adult social care.

e) Ensure they are up to date with their knowledge regarding prevention and management of pressure ulcers, discussing any education and training needs identified with their line manager.

4.6 Doctors and Allied Health Professionals

a) Support the patient to maintain their skin integrity.

b) Document any repositioning they may do during all patient interaction on the daily pressure ulcer prevention care plan/repositioning chart.

c) Document any skin damage identified during any physical examination of the patient.

d) Inform the nurse looking after the patient of any concerns they may have regarding the patient's skin condition and ability to maintain their pressure areas.

e) Ensure they are up to date with their knowledge regarding prevention and management of pressure ulcers, discussing any education and training needs identified with their line manager.

f) Follow the policy statements and procedures set out in Section 5 and the appendices.

4.7 All Support Staff (HCA's, Porters, Housekeepers,)

a) Support the patient to maintain their skin integrity.

b) Document any repositioning they undertake during all patient interaction on the daily pressure ulcer prevention plan.

c) Inform the Registered Nurse looking after the patient of any concerns they may have, e.g. observation of any skin changes based on BESTSHOT documentation, a change in the patient's ability to comply with repositioning, problem with the equipment e.g. mattress not switched on/alarming, anything that might affect the pressure areas care plan.

d) Ensure they are up to date with their knowledge regarding prevention and management of pressure ulcers, discussing any education and training needs identified with their line managers.

4.8 Tissue Viability Team

4.8.1 Tissue Viability Specialist Nurse

a) To support and empower nursing, medical and Allied Health Care professionals to provide competent, evidence based practice in the

prevention and management of pressure ulcers through direct clinical support, professional advice, and education and training.

b) Provide professional advice and support to the therapy bed and mattress providers for the prevention and management of pressure ulcers to ensure that the correct specification of mattress is being used.

c) Support the monthly Pressure Ulcer Standard operating procedure including:

- Monitoring incidents reported through Datix and Tissue Viability referrals, where possible undertake a visual inspection of all reported category 3, 4, Deep Tissue Injuries and Unstageable pressure ulcers within 3 working days either in persons or using clinical photography on Nerve Centre.
- Providing specialist advice and input into the investigations relating to pressure damage and Tissue Viability opinion for the RCA or SI reports as requested.
- Ensure Tissue Viability representation at the monthly CMG Care Review and Learning meetings.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 The aSSKINg Care Bundle (pictured below) was introduced in 2018 adding 2 further steps to the 5-step SSKIN care bundle: 'a' for assessing risk and 'g; for giving information. (Pressure Ulcer Core Curriculum NHSi (2018)

a	S	S	K	I	N	g
Assess Risk	Skin Assessment & Skin Care	Surface Selection & Use	Keep Patients Moving	Incontinence Assessment & Care	Nutrition & Hydration Assessment/Support	Giving Information
Assess pressure ulcer risk using a validated took to support clinical judgement • Risk assessments identify the patient's individual risk of pressure ulcers • Enables appropriate care and interventions to be implemented, ensuring resources are used appropriately	Early inspection = early detection • Perform regular skin inspections, checking the temperature and texture, ask about pain or altered sensation • Show patients and carers what to look for	Ensure the provision of appropriate pressure-reducing or pressure-relieving devices • Ensure the patient is repositioned at regular intervals, to meet their individual healthcare needs • Consider the impact of the bed frame and chair as well as the mattress and cushion	Encourage mobility and regular movement to relieve pressure over bony prominences • Assist patients who are unable to move independently	Keep skin clean, dry and protected from moisture • This may include the use of barrier creams, incontinence products and/or ointments • Elevate dependent body parts to prevent oedema • Classify MDRPU's using the NPUAP, EPUAP, PPPIA system	Assess nutritional status • Keep patients well hydrated • Remember the practical aspects of nutrition i.e. can the patient reach the food/drink, oral hygiene, SALT review/assessment • Implement prescribed diet and nutritional supplements	Communicate effectively and provide information to patients, carers and the multidisciplinary team (MDT) regarding pressure ulcer prevention (i.e. repositioning, equipment, nutrition/hydration) • Ensure the documentation is accurate, relevant and concurrent

5.2 aSSKINg – Assess Risk

All patients admitted to the Trust (emergency or planned) must have their Pressure Ulcer risk assessed using the **Waterlow score** (adults) or **Braden Score** (Children), within 6 hours of presentation to hospital. Reassessemnts must be completed on transfer to another ward/department within 6 hours, or if the patients condition changes. Risk assessment must be undertaken twice weekly thereafter.

5.3 aSSKINg – Skin Inspection

All patients (emergency or planned) must have their skin inspected within 6 hours of initial presentation to UHL or on transfer to another clinical area, and the findings documented on the BESTSHOT assessment on Nervecentre.

BESTSHOT skin inpections must be repeated a minimum twice a day and omissions are to be recorded. Concerns must be escalate to ward Sister/Matron and Datix when required. See Hospital Acquired Pressure Ulcers Reporting Process Standard Operating Procedure UHL Guideline

Patients who have been assessed as being at high risk of developing pressure damage are to have a skin assessment undertaken by a 'trained' healthcare professional. The assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for compromised skin, colour changes/ discoloration, variations in heat, firmness and moisture (for example, because of incontinence, oedema, dry or inflamed skin).

Use finger palpation to determine whether erythema or discolouration (identified by skin assessment) is blanchable. Non-blanching erythema is a category 1 pressure ulcer so will require escalation and a Datix report. Review and increase the preventative care plan actions in place.

5.3.1 Preventing Heel Damage

The heel is one of the most common sites for pressure ulcers after the sacrum. This is due to the thin layer of subcutaneous tissue between the skin and bone and patient specific risk factors such as the wearing of anti-embolic stockings, diabetes, vascular disease etc.

Heels must be inspected in line with BESTSHOT documentation and the twice daily aSSKINg Care Bundle

If there are any signs of pressure damage, utilise foot protectors (Repose foot protectors or wedges) or elevate the heels from the surface of the bed. A pillow may be placed lengthways under the calves for this purpose if foot protectors pose a falls risk. Placing the pillow lengthways distributes the weight over a greater surface area.

Heel protection devices should completely elevate the heel (off-loading) in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. The knee should be in slight flexion in order to avoid obstruction of the popliteal vein which could predispose to Venous Thrombo-Embolism (VTE)

Carefully assess the patient prior to the use of anti-embolic stockings (AES) and only apply if this is indicated by local VTE prophylaxis protocols. If AES are used, twice daily skin inspections must continue in line with BESTSHOT and AES careplan.

Particular care must be taken for patients with potential or known circulatory disorders (i.e. diabetes, cardio-vascular or peripheral vascular disease) as they will be at increased risk of foot / heel damage, AES may be contraindicated for these patients

Ensure heels are well moisturised and protected from friction.

5.3.2 Clinical photography

Clinical photography allows staff to take photographs of skin to monitor affects of care plans and treatment regiemes. Clinical photography can be used to support BESTSHOT assessments an initial presentation to UHL and transfer to subsequebnt clinical areras. Please see guides below for specific details when utilising clinical photography.

User Guide - Clinical photography

A guide to taking the best photographs.pdf

5.4 aSSKINg – Surface

The Use of Pressure Relieving Devices Including Seating

a) Decisions about the use of pressure relieving devices must be based on holistic assessment of the patient in conjunction with the mattress selection tool (Appendix 4).

b) All patients will be nursed on a high specification foam/hybrid/dynamic mattress support surface as a minimum. The choice of which type of mattress used, i.e. foam, hybrid or dynamic, will be based on the nurse's assessment with specialist advice being available from relevant teams/advisors.

c) It is necessary that before every use, the mattress is checked to ensure that it is in good condition and there is no evidence of contamination or "bottoming out" specifically in foam mattresses.

d) Patients with category 3, 4, DTI or Unstageable pressure damage who cannot independently reposition should be considered for a pressure redistributing (dynamic) mattress and cushion if able to sit out. If the appropriate equipment is not available, complete an incident form and inform the Ward Sister or Matron. Adjust the care plan accordingly, i.e. increase repositioning regime/utilise other products.

e) Patients being nursed on Hybrid with ASU mattresses will still require repositioning every 2-4 hours depending on the patient's condition and nursing assessment by the Registered Practitioner.

f) Patients nursed on a Hybrid with ASU or dynamic mattress will be re-assessed daily or as clinical need determines to ensure this mattress is still required. They will be stepped down to a foam/dynamic mattress as soon as their clinical condition allows or stepped up if their clinical needs change.

g) Appropriate pressure-relieving aids must be used, i.e. foot protectors, pillows between boney prominences, cushions or other equipment specifically designed for pressure relief.

h) Aids such as pillows, dermal pads, fluidised positioners, wedges may be used to prevent bone prominences from direct contact with one another, i.e. knees and ankles. These aids should not affect the action of a dynamic pressure-relieving surface being used as long as they are positioned correctly.

i) Specialist advice on aids, equipment, needs of bariatric patients and suitable positioning is available from the Manual Handling Team or the Tissue Viability Team if required.

j) If a patient develops a pressure ulcer or an existing pressure ulcer deteriorates, staff must check that any pressure relieving equipment is in good working order. It is essential that following every episode when a patient has attended a procedure or appointment off the ward, the mattress is plugged back in for charging and switched on.

k) Once a pressure ulcer has healed or the patient's risk of pressure ulcer has reduced they must be reassessed and appropriate interventions undertaken e.g. stepping down of mattress etc.

5.4.1 Seating

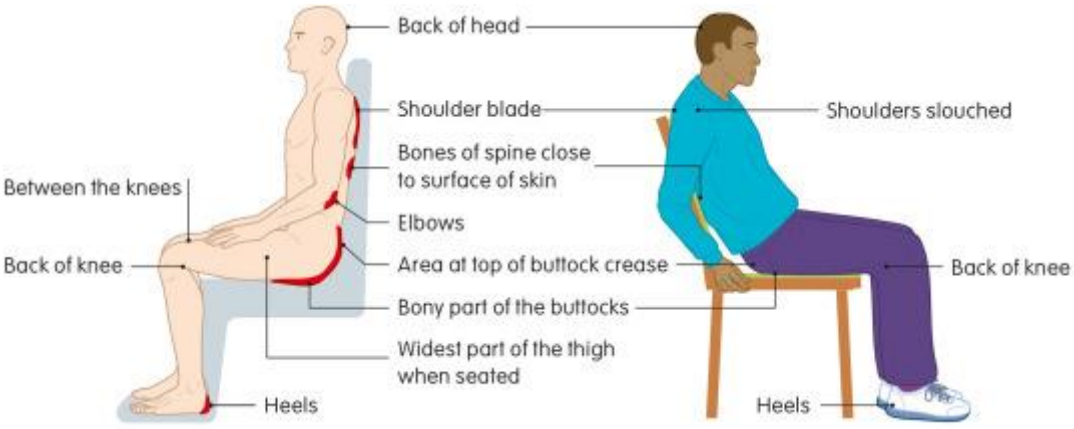
Pressure ulcers are often associated with people who lie in bed; however research indicates that people who sit for extended periods of time without effective position change are more at risk of pressure ulcers developing than those in bed.

Remaining seated for extended periods of time increases the risk of pressure ulcer development over the buttocks (ischial tuberosities) as the soft tissue in this area is compressed between two surfaces: the seat and the bones of the pelvis. The process is dependent on other factors such as health status, disability, communication, ability to change position and maintaining an upright-seated position without slumping or sliding.

For those requiring help, repositioning assistance can be given as advised by a healthcare professional. Advice from NICE/EPUAP guidelines suggests a person who is at risk of pressure ulcers should not remain seated for longer than **two** hours or a person who already has an established pressure ulcer should not sit out.

Patients with a spinal, sacral/coccyx or ischial tuberosity (buttock) pressure ulcer must not be sat out in a chair if the pressure ulcer is not showing signs of improvement.

Patients with an improving spinal, sacral/coccyx or ischial (buttock) pressure ulcer and require sitting out as part of their rehabilitation will have a clear plan documented. Sitting periods should be limited to 3 times a day in periods of 60 minutes or less and monitored (EPUAP 2019).



Areas at risk of pressure damage when seated and areas at risk of pressure ulcer damage when seated slouched in the chair.

Regardless of whether a person has a short or long-term mobility issue, there are essential factors that should be considered i.e equipment provision, patient ability /tolerance; length of time.

Patients who remain seated for longer periods of time need to have regular follow-up of their pressure-redistribution needs, which may lead to a change or replacement of equipment if necessary.

5.42 Cushion and static bed side chair selection

There are many different types of pressure redistributing seating equipment available to help prevent and manage pressure ulcers such as:

- A single cushion to use on a wheelchair or chair
- An integrated cushion into a seating system
- A bespoke custom-made cushion.

There is little research to demonstrate that one cushion is better than another and decisions about specific cushions are often based on individual opinions. It is important to consider several factors in cushion prescription such as what the cushion is made of and how it performs

Static cushions/chairs such as those made using foam, gel, air are made to decrease the risk of tissue damage by redistributing pressure at the bony points in the pelvic area of the seated individual but do not replace the need for repositioning.

5.43 Tilt, recline, and elevating leg rests in wheelchairs and static seating

For those who are at risk of pressure ulcers developing or have existing pressure damage, tilt-in-space, recline and elevating leg rests in wheelchairs and chairs are sometimes useful in providing pressure relief. In other wheelchairs and chairs, the seat and backrest angles remain fixed as they are tilted backwards with the occupant remaining in the same posture as the seat and back tilt and should be considered as part of the overall risk assessment and care planning.

5.5 aSSKINg – Keep Moving

Encourage patients ‘to keep moving’ throughout their hospital stay if this is possible. Those who have been assessed as being ‘at risk’ of developing a pressure ulcer and need to change their position frequently at least every 4 hours. If ‘high risk’, this should be more frequent. If they are unable to reposition themselves, offer help to do so using the appropriate manual handling equipment if needed. Document the frequency of repositioning prescribed by the registered nurse. All patients with a pressure ulcer or ‘at risk’ of pressure ulcer development will have a documented repositioning schedule using the aSSKINg Care Bundle . If the patient’s condition changes, a revised repositioning regime is to be documented.

The prescribed repositioning plan will be based on:

a) The results of skin inspections.

b) The patient’s clinical condition/comfort (e.g. breathlessness, end of life).

c) All surfaces used by the patient (i.e. bed, chair, boots etc).

Repositioning will:

a) Contribute to patient comfort, dignity and functional ability

b) Reduce skin hyproxia/ pressure on bony prominences is minimised

c) Alternate 30/60/90 degree tilting positions, prone, supine, standing, sitting (Appendix 3)

d) Utilise the profiling bed frame to alter patient's position and increase the patient's ability to alter their own position

e) Be undertaken every 2 hours for patients at risk, who are sitting in an approved patient bedside chair or wheel chair, with a cushion in situ.

Repositioning should not:

a) Position patients on to an area of skin causing concern on an existing pressure ulcer

b) Cause a slouched position or an upright position in bed (these positions may lead to pressure and shear on the sacrum and coccyx)

5.5.1 The Use of Aids for Moving and Handling

Manual handling equipment, e.g. slide sheets, hoist slings, will be used correctly to prevent friction and shear damage and should never be left in contact or underneath the patient after a manoeuvre. Please refer to the Safer Handling Policy for further advice.

5.6 aSSKINg – Incontinence/Increased Moisure

Consider use of barrier products to prevent skin damage to all patients who are at 'high risk' of developing moisture damage or incontinence – associated dermatitis as identified by skin assessment i.e. Incontinence, oedema, sweating, pyrexia, wound leakage.

5.7 aSSKINg – Nutrition

a) A nutritional assessment completed for all patients using the Malnutrition Universal Screening Tool (MUST) or the equivalent for Children. Protein or calorie deficiency may increase a patient's risk of pressure ulcer development due to a reduction in the body's ability to heal or repairs itself. Patients identified as being at high risk of pressure ulcer development will have their dietary intake monitored i.e. food charts.

b) Nursing staff must maintain patient hydration in order to promote adequate circulatory volume and good skin and tissue perfusion What should I eat to help my pressure ulcer or wound heal? (leicestershospitals.nhs.uk)

c) All patients with a category 3, 4 or Unstageable pressure ulcers must be referred to a Dietician, *irrespective* of their MUST score.

5.8 aSSKINg – Giving information

Patient and Carer Education

a) The results of the skin/risk assessment and care-planning will be discussed with the patient, multi-disciplinary team and family members / carers. The nurse will ensure that both verbal and written information on pressure ulcer prevention is given and this is documented.

b) Patients will be given information regarding pressure damage, including risk factors and prevention strategies. The UHL Patient Information Leaflet can be found here: Preventing and Treating Pressure Ulcers

c) All 'at risk' patients able to alter their position should be encouraged to do so and document their movements. Patients with reduced mobility will be taught / encouraged to re-distribute their weight, within their limits, using appropriate equipment i.e. bedframe side rails. Encourage patients to relieve their pressure areas every 30-60 minutes if they are able.

d) Assess the patient's mental capacity to agree to their care and record the patients agreement with their pressure ulcer prevention care plan in the patient's notes

e) Staff must also document if patients with capacity decline to concord with pressure ulcer prevention advice and ensure escalation to Nurse in Charge

f) Patients without capacity must have care planned in their best interests and lack of ability to comply with prevention measures documented in the case notes.

5.9 Discharge / Transfer

a) The Nurse in Charge will inform other departments of continued preventative care needs when a patient with a pressure ulcer, or who is assessed as 'at risk', is transferred to another area, e.g. patients requiring x-ray, discharge lounge, physiotherapy etc.

b) Patients with HAPUs should have an assessment completed on the day of discharge (whenever practically possible) with clinical photography utilised to support an accurate record of a patients skin on discharge.

c) Clinical photography can also be utilised on transfer to another clinical area to support BESTSHOT assessemnts, if completed within 6 hours of arrival. See section 5.31 for further details.

d) The patients aSSKINg care bundle should be updated prior to discharge or transfer to ensure any specific issues are highlighted and ongoing preventative care is documented by the receiving department/institute.

e) On discharge or transfer from hospital patients should have a reassessment of their skin integrity prior to discharge. This should be documented accurately and should include information concerning risk assessment, existing pressure ulcers and current treatment. This will be provided to all appropriate personnel, including the receiving ward / unit, carers, community staff, patient and relatives

f) A minimum of 3 days supply of dressings (if required for discharge) should be supplied and any equipment needed to support discharge should be ordered prior to the patient being medically optimised for discharge date.

5.10 Caring for patients at end of life or palliative care

a) It is important to implement preventive and treatment interventions in accordance with the individual's wishes, and with consideration to overall health status. The goals of palliative wound care are comfort for the individual and limiting the impact of the wound on quality of life, without the overt intent of healing (EPUAP 2019)

b) For patients approaching the end of their life, an individualised plan of care should be discussed and agreed with patients and their families which take into consideration their preferences wishes, comfort and tolerance.

c) If a patient lacks capacity around this decision then a 'best interests' decision needs to be made. The final decision must be made by the appropriate decision maker, this may be the nurse (Please refer to Mental Capacty Act Code of Practice and Mental Capacity Act UHL Policy)

d) A discussion, which shapes the goals and plan of care about pressure areas, should be clearly recorded and include:-

- Potential for Skin Changes at Life's End
- Acknowledge effect of skin changes at life's end due to skin failure and may occur with the application of appropriate interventions that meet or exceed the standard of care.
- Patients approaching end of life should have their holistic needs regularly reassessed (minimum 4 hourly) in accordance with the Individualised End of Life Plan. Clear and concise documentation about decisions made, including rationale and patient and family preferences, is essential. The decisions must also be clearly communicated with all teams involved in the patient's care including their families and carers.

e) For further advice or information regarding this information, please contact the UHL Tissue Viability or Palliative Care Teams

5.11 Medical Device Related Pressure Ulcers (MDRPUs)

a) Medical devices are often made out of rigid materials such as plastic, rubber or hard silicon, which can cause rubbing or create pressure on the skin / soft tissue

b) The most susceptible areas are the device insertion site or some boney anatomical locations with no / little fatty tissue, e.g. bridge of the nose

c) Many MDRPU's occur because of poor device positioning or fixation, poor selection of the equipment, poor padding (e.g. Plaster of Paris related PU) or failure to check that the patient is not lying or sitting on a medical device, e.g. catheter tubing.

d) Most frequently affected anatomical sites are ears, nose, neck, heels/Achilles area, toes, back of thighs and buttocks

e) To prevent MDRPU's follow the following three steps and document interventions on the daily BESTSHOT and repositioning chart

- **Position** – ensure correct position of the device so it is not pressure over patient's skin and patient not lying / sitting on the device / tubing
- **Protection** – use a protective dressing (or gel pad) to prevent friction and sheer
- **Prevention** – incorporate regular checks 2-4 hourly (dependent on patient's condition) into the daily aSSKINg care bundle interventions

Please see Appendix 2 for a Medical Device Related Pressure Ulcers Poster with the above information (STOP)

5.12 Reporting & Monitoring

a) A Data incident form (DATIX) must be completed for all patients with a category 1, 2, 3, 4, unstageable, deep tissue injury (DTI) , mucosal pressure ulcer and Moisture Associated Skin Damage (present on admission or UHL acquired) as soon as it is identified and at least within 24 hours. Where it is suspected that the damage is as a result of harm or neglect then a safeguarding referral must also be made

b) Category 2, mucosal and Deep Tissue Injuries should initially be reported as minor incidents on Datix. Following review and validation, Deep Tissue Injuries should be reviewed on a case by case basis and the level of harm confirmed and escalated accordingly. Unstageable harms as moderate and category 4 as major incidents / 'never events' (Serious Incidents). The Duty of Candour Section must be completed by the Ward Manager/Matron/Senior Nurse.

c) A referral to the Tissue Viability Team must also be completed via the online system for all all patients with multiple category 2, category 3, 4, mucosal, unstageable, and DTIs. (Appendix 5)

d) Clinical photography to be used wherever possible to record all pressure ulcers (category 2 and above) in order to support the evaluation and communication process. However, this may not always be appropriate e.g. End of Life care.

e) The Tissue Viability Team will review and monitor all Pressure Ulcer related Datix incidents. All Hospital Acquired Pressure Ulcers (HAPU) are investigated as per the UHL Standard Operating Procedure: Reporting Process for Hospital Acquired Pressure Ulcers, Moisture Associated Skin Damage, Pressure Ulcers and Moisture Associated Skin Damage Present on Admission

5.13 Root Cause Analysis (RCA) Checklist & Investigations

a) All Hospital Acquired category 2, 3, 4, unstageable, DTI and mucosal Pressure Ulcers undergo an RCA Checklist.

b) Once a Datix report for HAPU category 2, 3, 4, unstageable, DTI or mucosal is validated, the ward/department manager is informed and must complete an RCA report within 7 days of the incident date.

c) This RCA is presented at the monthly Care Review and Learning meeting where themes, actions and learning will be shared at ward / department level, throughout the CMG and via the Nursing, Midwifery and Allied Health Professionals Committee.

d) All pressure ulcers which meet the criteria of a serious incident will be reported on STEIS by the Quality and Safety Team within 72 hours of notification by the Tissue Viability Team.

e) All category 4 validated HAPU's must be treated as serious incidents until investigated as per the local Incident and Accident Reporting UHL Policy. This investigation is led by the Quality and Safety Team.

5.14 Safeguarding and Pressure Ulcers

There is a recognised potential link between pressure ulcer and safeguarding concerns. Pressure ulcers may be as a result of neglect, which is regarded as behaviour by care staff that results in the persistent or severe failure to meet the physical and/or psychological needs of an individual in their care. Neglect may consist of either deliberate acts or acts of omission.

Staff who have a concern about neglect must make a safeguarding referral to the relevant agency / person in line with the UHL Safeguarding Adults Policy

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All nurses, midwives and HCA's will receive training on the risks, classification, prevention and management of pressure damage as part of their induction.

6.3 Annual update sessions on Pressure Ulcer Prevention for Nurses, Midwives and HCA's are available to book via HELM.

6.4 The Tissue Viability Team will provide education and training to Allied Health professionals and Medical Staff as required.

6.5 All staff engaged in direct patient care will receive Moving and Handling training on Trust induction and update as per the Core Training (Statatory and Mandatory) UHL Policy

6.6 A comprehensive range of pressure ulcer resources are provided by the Tissue Viability Team and these are available on INsite for all staff to access. Raising awareness of these resources will be through INsite and the usual Trust communication channels.

6.7 Clinical advisors from contractors (i.e. bed and equipment) can support education programme as identified.

6.8 Engagement with other specialist teams i.e. continence, vascular, diabetes, dermatology, plastics & burns, podiatry, spinal/fracture clinic to address combined education, information and resources.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
1. Category 1, 2, 3, 4, unstageable, DTI & mucosal Pressure Ulcers are reported on DATIX within 24 hours of identification	CMG Leads for Harm Free Care	DATIX Form	Review weekly	Discuss at weekly HAPU validation meetings to monitor compliance
2. All DATIX reporting skin damage will will be reviewed and validated by CMG, within 2 working day of receipt	CMG Leads for Harm Free Care	TV Database	Review weekly	Discuss at weekly HAPU validation meetings to monitor compliance
3. RCA's will be completed within 7 days & sent to CMG Leads for Harm Free Care to review	Ward Sister / Charge Nurse / Matron	RCA document	Monthly review prior to HAPU CRaL meeting	Following CMG monthly HAPU CRaL meeting, signed off checklist to be uploaded to Datix
4. Number of Hospital Acquired Pressure Ulcers identified	CMG Head of Nursing	RCA Checklist	Weekly & Monthly	Weeklly running total confirmed following weekly validation meetings. Finalised figures available for board at the end of the firat full working week of the month.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Judgment of the responsible clinician it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

- National Institute for Health and Care Excellence (2014) Pressure Ulcers: Prevention and Management (CG179)
- 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.
- NHSi (2018) Pressure Ulcers: Revisited definition and measurement
- Journal Tissue Viability Seating Guideline (2018)
- NICE Quality Standard (QS89) (June 2015)
- Public Health England – Pressure Ulcers: Applying All Our Health (2015)
- NHSi (2018) Pressure Ulcer Core Cirricuilum

- Guest JF, Ayoub N, McIlwraith T, Uchegbu I, Gerrish A, Weidlich D, Vowden K, Vowden P. Health economic burden that different wound types impose on the UK's National Health Service. Int Wound J. 2017 Apr;14(2):322-330. doi: 10.1111/iwj.12603. Epub 2016 May 26. PMID: 27229943; PMCID: PMC7950097.
- Hospital Acquired Pressure Ulcers Reporting Process Standard Operating Procedure UHL Guideline

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

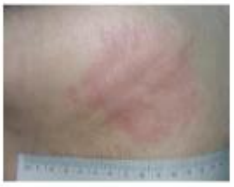
10.2 This Policy will have its first review 2 years after approval, and from then onwards it will be every three years or sooner in response to changes in practice or identified clinical risk.

NHS
Midlands and East

Pressure Ulcer Categorisation

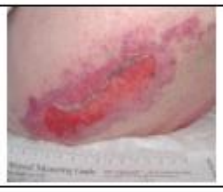
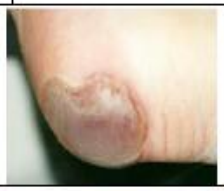
Adapted from EPUAP / NPUAP 2019 and NHS Improvement

SUPERFICIAL



EUPAP – Category 1

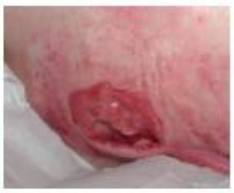
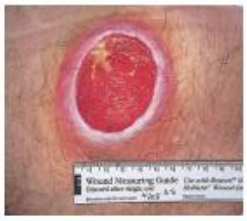
- Non blanchable erythema of intact skin, unusual over a bony prominence: persistent redness in light pigmented skin.
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin the lesion may be blue or purple.
- Warmth, oedema, softness, hardness, different texture of the skin / tissues as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).

EUPAP – Category 2

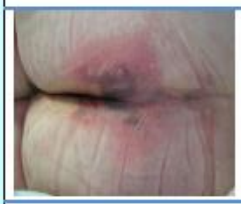
- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising.*
- Check for moisture lesion.
- Ensure the skin damage is not related to moisture.**

DEEP

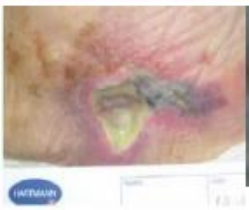
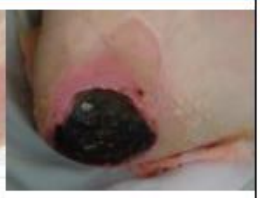
EUPAP – Category 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunnelling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and category 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep category 3 pressure ulcers.
- Bone / tendon is not visible or directly palpable.



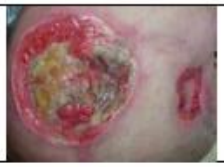

EUPAP – Deep Tissue Injury

- Bruising appearance
- Purple lesions
- Bloody filled blister may represent a deep tissue injury DTI (pending 7-14 day validation review)

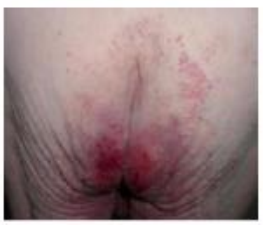
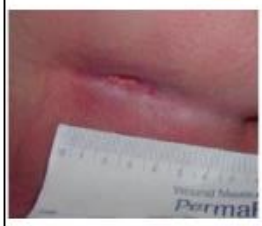
EUPAP - Unstageable PU

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth can not be determined; but it will be either category 3 or 4.
- Stable eschar (dry necrotic tissue, adherent, intact without erythema or fluctuance) on the heels serves as 'the body's natural (biological) cover' and should not be removed.
- Should be documented as Unstageable until debridement exposes true depth.



EUPAP – Category 4

- Full thickness tissue loss extending into the muscle and/or supporting structures (e.g. fascia, tendon or joint capsule, bone).
- Often include undermining and tunnelling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue) and category 4 ulcers can be shallow.

**** Moisture Lesions / Not a Pressure Ulcer**

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces, sweat or wound leakage.
- These lesions are not usually associated with a bony prominence and or necrotic tissue / irregular appearance.
- They can however be seen alongside a pressure ulcer of any category.
- Can present as a linear lesion in the natal cleft or symmetrically shaped / copy lesion to buttocks, no necrosis.

M:\STEIS spreadsheet and related documents\New\SHA Categorisation Poster – Nov 2020

University Hospitals of Leicester NHS Trust – Tissue Viability Service

Skin Inspectors

STOP Medical Device Related Pressure Ulcers!

Remember the **3 Ps bundle**:

S
- stockings (AES)
- straps
- splints

T
- tubes /catheters/lines
- NG / PEG tubes
- tube drains
- ET tubes
- CAPD/urinary/ s.p. catheters
- i.v., CVP/TPN lines
- tapes and ties (tracheostomy tapes)

O
- oxygen related devices: masks, nasal cannulas, CPAP, NIPPY, trachies

P
- probes (t°, SATs, etc.)
- plaster casts
- DVT prevention devices
- Pans (bed pans)

Position
(ensure correct position i.e device not pressing on patient's skin)

Protection
(use protective dressing or gel pad)

Prevention
(incorporate regular checks 4 - 6hrs in the daily HAPU prevention regime / SSKIN bundle)

Warning signs?

- Blanching / Non-blanching redness under the device
- Painful, sore area under the device
- Hardened area or blister under the device
- Discolouration – dark red, purple, black with the shape of the device
- Broken skin/ ulcer where the device has been resting

NB! Ensure the interventions as per the 3 Ps bundle are documented on the repositioning chart

30 Degree tilt

Removes pressure from the hip, elbow and ankle on the opposite side to the tilt

60 Degree tilt

The patient is moved slightly further into the tilt and pressure is removed from the ischial tuberosities (sit bones) and sacrum

90 Degree tilt

The patient is moved Further again into the tilt and pressure is removed from the ischial tuberosities (sit bones), sacrum and spine

30/60/90 Degree Tilts for Repositioning

- Each tilt counts as one reposition, so once in the 30 degree tilt it is easy to reposition the person slightly more onto that side to the 60 and 90 degree tilts. For slimmer/smaller patients you may be able to reposition from the 30 to the 60 and 90 with only 1 member of staff
- No special equipment is required for these tilts, only extra pillows. A slide sheet must be used to reposition on to opposite side.
- Throughout the day/night this technique gives staff 7 options: Left 30/60/90, back, right 30/60/90

Credit: Tissue Viability Service – NHS Lothian Initial Document 23/03/22

medstrom+
Improved Patient Outcomes

NHS University Hospitals of Leicester NHS Trust
Caring at its best

This protocol is designed as a guide and should always be used in conjunction with clinical judgment

Mattress Selection Guide LRI & LGH			
Positioning	**Skin / PU**	**BMI <25**	**BMI >25**
Can move independently with major position changes (Able to reposition self in bed regularly)	Normal		
	Vulnerable / Cat 1 / Cat 2 / Previous PU / Scar		
	Cat 3 / Cat 4 / Unstageable/ DTI		
Needs to be repositioned, and can go into 2-3 positions (Consider patients pain level)	Normal		
	Vulnerable / Cat 1 / Cat 2 / Previous PU / Scar		
	Cat 3 / Cat 4 / Unstageable / DTI		
Needs to be repositioned, and can go into one position only (Consider patients pain level)	Normal		
	Vulnerable / Cat 1 / Cat 2 / Previous PU / Scar		
	Cat 3 / Cat 4 / Unstageable / DTI		
Patients with unstable spinal fractures/conditions to be placed on a foam mattress until reviewed by medical team and/or spinal condition stabilises.			

Semi-dynamic (non-powered)	Dynamic Therapy (powered)	Fluid Immersion Simulation (FIS) Therapy
Aria Flex Mattress	Aria Flex Mattress with Air Supply Unit (ASU)	Dolphin Mattress
Standard Foam Mattress (NP150 / Protecta)		

Aria Flex:

- Max patient weight 227kg
- No minimum patient weight without ASU
- 20kg minimum weight limit with ASU.

Dolphin:
Max patient weight 248kg
No minimum patient weight

IMPORTANT: The hose should always be removed from the mattress when:

- The ASU is not powered on / no longer required by the patient
- Patient is being transported
- Resuscitation is required


Mattress Selection Tool Glenfield Only

University Hospitals of Leicester NHS
NHS Trust

Appendix 4

medstrom+
Improved Patient Outcomes

NHS University Hospitals of Leicester NHS Trust
Caring at its best

This protocol is designed as a guide and should always be used in conjunction with clinical judgement

Mattress Selection Guide - Glenfield Hospital			
Positioning	**Skin / PU**	**BMI <25**	**BMI >25**
Can move independently with major position changes (Able to reposition self in bed regularly)	Normal		
	Vulnerable / Cat 1 / Cat 2 / Previous PU / Scar		
	Cat 3 / Cat 4 / Unstageable/ DTI		
Needs to be repositioned, and can go into 2-3 positions (Consider patients pain level)	Normal		
	Vulnerable / Cat 1 / Cat 2 / Previous PU / Scar		
	Cat 3 / Cat 4 / Unstageable / DTI		
Needs to be repositioned, and can go into one position only (Consider patients pain level)	Normal		
	Vulnerable / Cat 1 / Cat 2 / Previous PU / Scar		
	Cat 3 / Cat 4 / Unstageable / DTI		
Patients with unstable spinal fractures/conditions to be placed on a foam mattress until reviewed by medical team and/or spinal condition stabilises			

Static	Air Immersion (Powered Dynamic Therapy)	Fluid Immersion Simulation (FIS) Therapy
NP150 Foam Mattress Protecta Foam Mattress	Aria PRO Mattress	Dolphin Mattress

Foam:

- NP150: Max patient weight 150kg / Minimum patient weight 30kg
- Protecta: Max patient weight 190kg / No minimum patient weight

Aria PRO:

- Max patient weight 227kg
- Minimum patient weight 30kg

Dolphin:
Max patient weight 248kg
No minimum patient weight

Important:
Whilst transporting the patient on the mattress, turn off the Air Supply Unit using the Intellibutton

Tissue Viability Referral Process

University Hospitals of Leicester NHS
NHS Trust

Appendix 5

Tissue Viability In-Patient Service
Monday-Friday (09:00-17:00)

For out –patient queries, refer to link nurse / champion or refer to Community team via SPA Tel: 03003001000

WHAT	WHO	HOW - All referrals to be made via ICE
• Patients with: ✓ Category 3 or 4 pressure ulcers; ✓ Unstageable / Deep Tissue Damage (DTI); ✓ significant dehisced wounds; ✓ severe wound infection; severe skin excoriation • Patients not responding to initial treatment (see Wound management Formulary on Insite) • Very high-risk patients with complex needs • Assessment for VAC Therapy / larvae therapy. Patients admitted with VAC therapy in situ • Lower limb patients Patients receiving compression bandaging (see Leg Ulcer Pathway) • Patients with Leg Ulcers where no aetiology has been established. To facilitate complex discharge planning • Guidance, education and support for staff • Advice on equipment provision • To facilitate complex discharge planning	• Registered practitioners • Doctors • Therapists • Specialist Nursing Teams • Allied Health Professionals • Link Nurse / Champion Liaise with your Link Nurse / Champion for initial review and confirm need to refer on to Tissue Viability Service or other specialist team Plastics & Burns / Vascular / Dermatology / Stoma care patients Consider direct referral to appropriate team Diabetic foot Follow Inpatient referral pathway - all to be referred to Diabetic team within 24 hours of admission	• Referrals **MUST** be supported by a completed Wound Assessment Chart. • Please give as much information as possible relating to reason for referral. • Referrals will be actioned within **5** working days. • TV service will endeavour to contact referring ward / department (via telephone) within 24 hours of receipt of referral. • First line advice will be provided via telephone. ○ All verbal advice given prior to formal assessment should be documented by both parties. • TV service will negotiate agreed time to review patient ○ Urgent – within 24 hours – where possible ○ Non-urgent – within 72 hours – where possible • For more urgent support, please contact Tissue Viability Service via switchboard - ask for site based Tissue Viability or Pressure Ulcer Nurse (see referral process flowchart) • Patients with severe skin excoriation (if continence related – refer to Adult Continence Service , via the electronic referral system • **N.B. For wounds with uncontrollable bleeding, ischaemia or severe infection - refer directly to appropriate surgical / medical team** • Further reviews will be confirmed and agreed between clinicians and patients