Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

STANDARD OPERATING PROCEDURE	**Pressure Ulcer Prevention and Management Procedure**
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VERSION NUMBER	**3.1**
APPROVING COMMITTEE	**Nursing Midwifery, Allied Health Professionals (NMAHP) Safeguarding Executive Committee**
DATE THIS VERSION APPROVED	**February 2022**
RATIFYING COMMITTEE	**PARG (Policy Approval and Ratification Group)**
DATE THIS VERSION RATIFIED	**April 2022**
AUTHOR(S) (JOB TITLE)	**Tissue Viability Service Safeguarding**
DIVISION/DIRECTORATE	**Corporate**
ASSOCIATED TO WHICH POLICY?	**TW21-101 Pressure Ulcer Prevention and Management Policy** **With links to: Safeguarding Adults at Risk Policy, Safeguarding Children and Young People's Policy, Clinical Photographic and Videographic Policy**
CONSULTED WITH	**Nursing, Midwifery and Allied Health Leadership Teams (NMAHLT)**

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DATE OF NEXT REVIEW	**April 2025**
MANAGER RESPONSIBLE FOR REVIEW (Job Title)	**Deputy Chief Nurse**

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Version Control

Version	Date	Amendment
3	February 2022	
3	April 2024	Pressure Ulcer category update in line with National Wound Care Strategy Programme Change in terminology for mattresses due to acute implementation of Total Bed Management.

Contents

1 INTRODUCTION

1.1 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 (NHSI 2018).

1.2 Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and create significant difficulties for patients, their carers and families. The impact of pressure ulcers is psychologically, physically and clinically challenging for both patients and NHS staff. The total cost in the UK is estimated to be £3.8 million per day, with 24,674 patients developing new pressure ulcers between April 2015 and March 2016 (NHSI 2018).

1.3 Acute illness, immobility and poor nutrition are some of the factors that can contribute to the development of pressure ulcers and affect the healing process. The prevention and treatment of pressure ulcers can have a major impact on patients and carers, and they are recognised as a major cost to the National Health Service. Wrightington Wigan and Leigh NHS Teaching Hospitals NHS Foundation Trust (hereafter referred to as the Trust) is committed to implementing and monitoring practice that is in line with guideline from the National Institute for Health and Care Excellence (NICE 2014).

1.4 New pressure ulcers affect an unknown proportion of people in the community, as reliable data is not available, but it is estimated that up to 30% of patients may suffer and 20% of patients in nursing and residential homes may be affected. The prevalence and incidence of pressure ulcers are recognised as key indicators of the quality of care delivered (Clay 2000). The Health of the Nation report set an annual reduction target of between 5-10% in the incidence of pressure ulcers (Stephen-Haynes 2006).

1.5 Reported prevalence rates range from 4.7% to 32.1% for hospital populations and up to 22% in nursing-home populations. It was further shown that the sacrum and heels were the most affected sites/ locations (Vanderwee et al. 2007).

1.6 This SOP aims to provide Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust (hereafter referred to as the Trust) staff with guidance to ensure a consistent and unified approach for the prevention and management of pressure ulcers.

1.7 This SOP supersedes previous Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust and Bridgewater NHS Foundation Trust SOP's.

1.8 This SOP is applicable to all clinical staff employed within the Trust who undertake patient assessments in relation to pressure ulcer prevention and management.

2 CATEGORISING PRESSURE ULCERS

2.1 The use of a standard system for categorising pressure ulcers is essential by providing objective and accurate descriptions of pressure ulcers. The categorisation system however should be used in conjunction with other descriptive tools to measure and describe the ulcers appearance (NICE 2014, EPUAP et al, 2014 and NHSI 2018).

2.2 The pressure ulcer category tool defined by the National Wound Care Strategy Programme, Pressure Ulcer Recommendations and Clinical Pathway Oct 2023 must be used when assessing and documenting skin damage (section 2.5.1-2.5.10).

2.3 Pressure ulcers must not be reverse categorised i.e., a healing category 4 ulcer must not

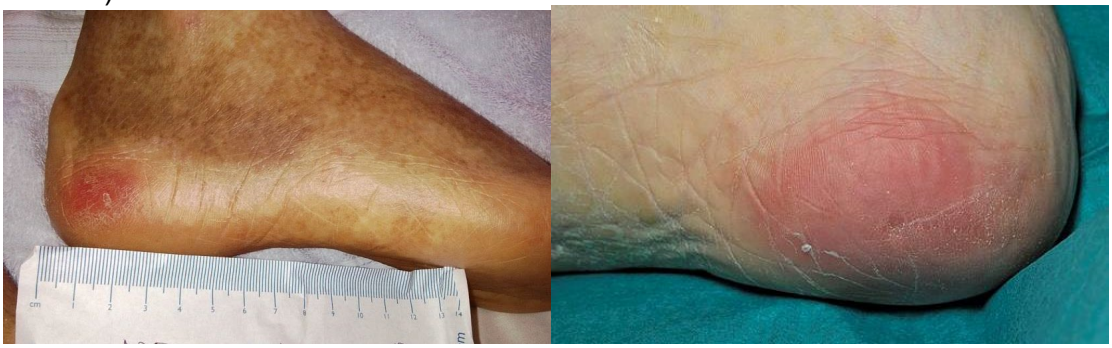
be reclassified as a category 3 ulcer when it begins to heal. It must always be classified as a category 4 pressure ulcer e.g., a healing category 4 pressure ulcer.

2.4 If a pressure ulcer to the foot is present, consideration must be given to the patient's vascular state and a Doppler ultrasound must be performed and onward referral if necessary.

2.5 Categories:

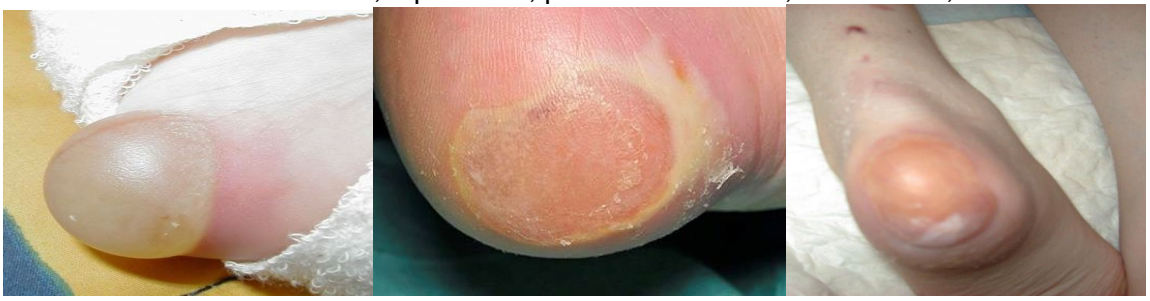
2.5.1 Category 1: non-blanchable erythema

Intact skin - In lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).



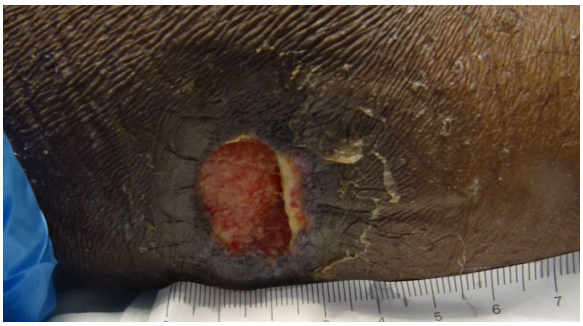
2.5.2 Category 2: Partial Thickness Skin Loss

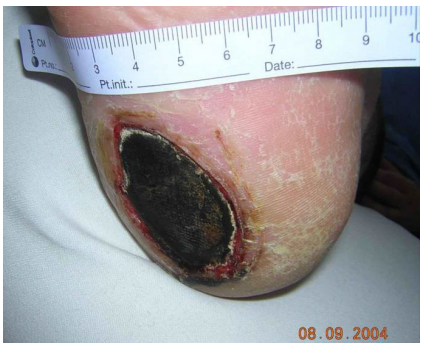
Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister or as a shiny or dry shallow ulcer without slough or bruising*. This Category should not be used to describe skin tears, tape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



2.5.3 Category 3: Full Thickness Skin Loss

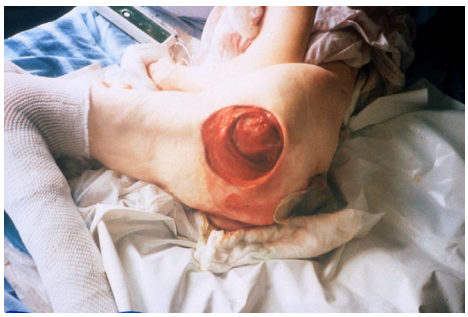
Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough or necrosis may be present. May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus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





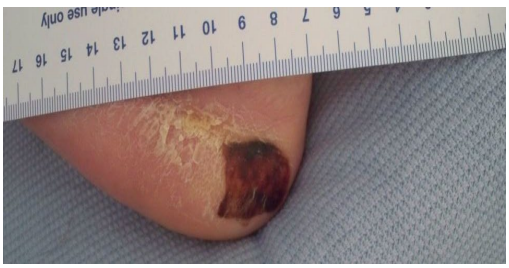
2.5.4 Category 4: Full Thickness Tissue Loss

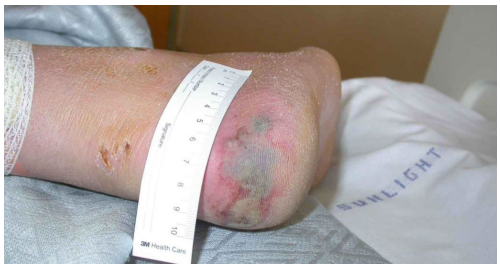
Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 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.



2.5.5 Deep Tissue Injury: Intact skin with persistent non-blanching

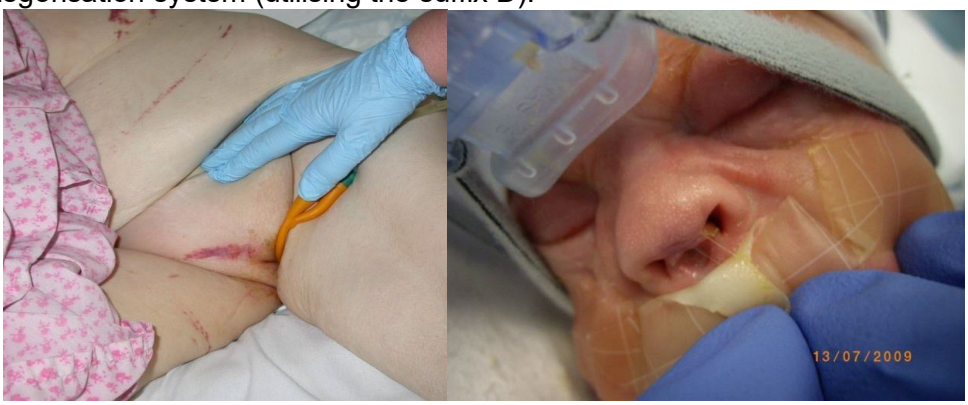
Persistent non-blanchable deep red, maroon or purple discoloration with an intact epidermis or be a blood filled blister over a dark wound bed. Over time this skin will degrade and develop into deeper tissue loss. The depth of the damage is unknown. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Darkly pigmented skin may make it difficult to detect a deep tissue injury. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.





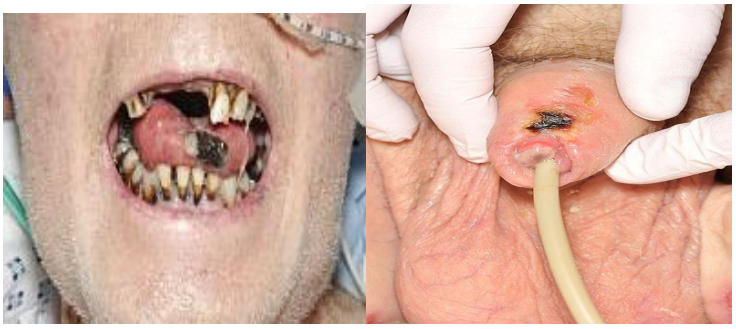
2.5.6 Medical Device Related Pressure Injury:

Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The pressure injury generally conforms to the pattern or shape of the device. The injury should be categorised using the categorisation system (utilising the suffix D).



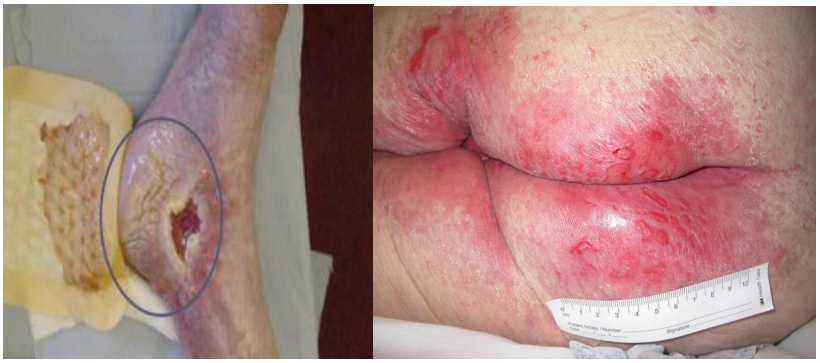
2.5.7 Mucosal Membrane Pressure Injury:

Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.



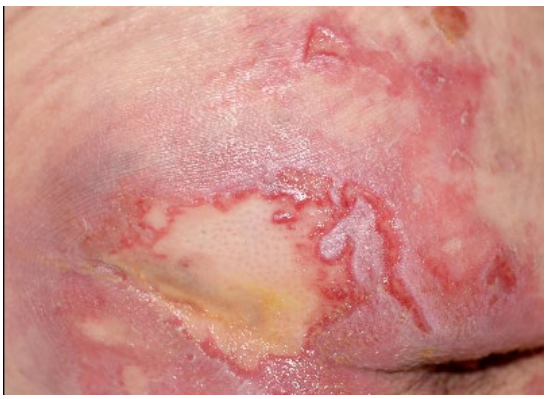
2.5.8 Moisture lesions (Moisture Associated Skin Damage)

Moisture associated skin damage (MASD) is a broad term for inflammation and skin damage as a result of prolonged or continuous exposure to moisture on the skin.The moisture can be from urine, faeces, perspiration or fluid from a wound or stoma. If this excess moisture is not controlled can also increase the risk of development of pressure ulcers. Moisture lesions cause superficial loss of epidermis and/or dermis, which may be preceded by areas of erythema on intact skin. They will usually cause pain. The skin will either be excoriated which presents as superficial broken skin which is red and dry, or macerated presenting as red and white, wet, soggy and shiny.



2.5.9 Combination Lesions:

These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. Categorisation of the pressure damage is required but awareness of other causes and treatments is needed and should be discussed with the patients and carer givers.



2.5.10 Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration.

2.6 Further guidance on wound care, can be found on the Procedural Document Library under 'Community: Wound Care TW21-093 SOP'.

3 ASSESSMENT

3.1 Clinical Management of Pressure Ulcers

All patients at risk of, or suffering from, pressure/ moisture damage should have a full holistic assessment in line with the individual service/ team assessment.

3.2 aSSKINg assessment must be completed as per the appropriate individual areas SOP flowchart and appropriate action is taken if the vulnerability of the patient's skin is increasing.

3.3 Risk Assessment

3.3.1 All patients, on initial contact, must have a pressure ulcer risk assessment completed to determine if they are at risk of pressure ulcer development (see specific SOP for specialised area of work).

3.3.2 An assessment of the patient must be undertaken to include the Waterlow assessment tool incorporating a full skin assessment and MUST. For staff working with babies and children a paediatric screening tool must be used.

3.3.3 The risk assessment must be used in conjunction with clinical judgement. The aim of risk assessment is to identify the presence of pre disposing and precipitating factors which may influence the development of pressure ulcers.

3.3.4 Patients who are identified to be at risk of development of pressure ulcers must have a plan of care detailing preventative interventions required.

3.3.5 Patients identified at risk or those with pe existing pressure ulcers should be Informed of their individual level of risk and advised on preventative measures to minimise the risk of pressure ulcer development or further deterioration. A pressure

ulcer prevention information leaflet and Moisture Associated Skin Damage information leaflet must be provided to the patient and appropriate care givers to support any verbal information.

3.3.6 Reassessment of the patient's risk must be undertaken at intervals agreed in the individualised care plan or where changes in the patients' medical condition occur (refer to SOP flowchart for specific area of work).

3.4 Medical Device Related Pressure Injury

3.4.1 Medical devices can increase the risk of pressure damage and need to be risk assessed. The medical devices should be of correct size and fit and correctly secured / positioned to avoid causing damage.

3.4.2 The skin under the medical device must be checked regularly (if possible) as per SOP flowchart for specific area of work.

3.4.3 All possible risks must be assessed, recorded and precautions should be taken in the prevention of medical device-related pressure ulcers.

3.4.4 Medical device related pressure ulcers should be reported on Datix as a medical device related ulcer.

3.5 Incident Reporting

3.5.1 All pressure ulcers (apart from category 1) and all moisture lesions must be reported on the Datix incident reporting system (in accordance with the Incident Reporting Policy) as soon as the skin damage is identified.

3.5.2 If an existing and previously reported pressure ulcer deteriorates, then this should result in an additional separate incident report with reference to the previous Datix number.

3.5.3 An RCA (root cause analysis) will be carried out on all category 2, 3, 4, and DTI pressure ulcers which have developed under the care of the Trust. The level of investigation will be determined by the NPSA according to the severity of harm; this report should be attached electronically to the incident report. It will be reviewed by the Trust pressure ulcer review panel to determine if any lapses in care have occurred. It will then be forwarded to the commissioners for review.

3.5.4 Any identified gaps in care relating to the incident will require recommendations by the Trust for service changes to mitigate the risk in the future. This information can then be made available to the Harm Free Care Group for Pressure Ulcers for dissemination.

3.6 Duty of Candour

3.6.1 The duty of candour processes as per the Duty of Candour (Being Open) policy must be followed and evidenced in both the patient's records and datix. The letter should be sent as per local policy to all patients who develop a category 3 or category 4 pressure ulcer under the care of the Trust.

3.6.2 For patients who have developed a deep tissue injury pressure ulcer under the care of the Trust the duty of candour letter must be sent only when the datix report has been updated and the true extent of the tissue damage has been assessed.

3.7 Safeguarding

3.7.1 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.

3.7.2 Neglect and acts of omission include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating. In some instances, this is highly likely to result in significant preventable skin damage.

3.7.3 The 2015 incident reporting framework NHS England states that category 3 and 4 pressure sores should have an RCA investigation report.

3.7.4 The Department of Health and Social Care issued guidance in 2018 with an Adult Safeguarding Decision Tool to support the assessment for service users with pressure ulcers. This should be completed for all category 2 (including multiple 2's), 3, 4 and DTI's.

3.7.5 The tool should be completed by a qualified member of staff who is a practising Registered Nurse. The Adult Safeguarding Decision Tool should be completed immediately or within 48 hours of identifying the pressure ulcer of concern.

3.7.6 The threshold for raising a safeguarding concern is where the assessment generates a score of 15 or above. A safeguarding referral must be raised to the local authority for patients within the community and hospital setting. For all patients within the acute setting the Safeguarding Team must also be informed.

3.7.7 For patients under the age of 18 years a referral to children's social care must be completed.

3.8 Mental capacity

3.8.1 The clinician may feel that a patient is making an unwise decision about their care, potentially increasing their risk of pressure damage, if they refuse to engage or accept the proposed plan following discussions. If the patient does decline the recommended treatment plan every effort should be made to understand the reasons for this and to develop a mutually agreeable plan to minimise the risks of pressure damage that is acceptable to their needs/wishes.

3.8.2 Clinicians need to consider whether the patient has the capacity and can adequately weigh up the risks and consequences of their choice. If an individual makes what might be deemed an unwise decision, it cannot be assumed that they lack the capacity to make that decision. The patient must be given all practicable help to make their own informed decision or to maximise their participation in the decision-making process. If capacity is in doubt a full capacity assessment needs to be completed.

3.8.3 Capacity assessments are time and decision specific and determine what a person is able to understand, retain and feedback relating to the risks and benefits of their choices. If the patient is assessed as having capacity staff should continue to work with them and support in making safer choices about their care ensuring that they fully understand all the risks associated with this.

3.8.4 If it is identified that a patient does not have the capacity to make an informed choice then a best interest approach must be used. A relative or carer cannot make a decision about the treatment of the patient unless they have lasting power of attorney for health. They must however be involved with any best interest decision made about the patient. Any decision made on behalf of a person who lacks capacity must be done, or made, in that individual's best interests.

3.8.5 A best interest decision must be made by all who have contact with the patient. The decision must be discussed fully, and they must follow the formal best interest decision process contained within the Mental Capacity and Best Interests Decision Making Policy. Decisions must be clearly recorded in the patient records.

4 SURFACE

4.1 Equipment Provision

Patients under the care of the Trust who are at high risk of developing pressure ulcers will be provided with pressure redistribution devices where appropriate in accordance with NICE Quality (2015).

4.1.1 An assessment of the patient's needs with regards to pressure relieving equipment should be in conjunction with clinical judgement, the Waterlow score and local equipment guidelines.

4.1.2 A risk assessment is NOT a substitute for sound clinical judgment. Other factors should be taken into consideration when selecting a piece of equipment, such as mobility, length of time spent out of bed and evidence of pressure damage.

4.1.3 When assessing for the appropriate equipment to meet the patient's needs the patient and their carers should be involved in the decision-making process. Consideration must be given to patient choice and the impact of the equipment or advice on the patient's quality of life.

4.1.4 Reassessment of the patients need for pressure reducing equipment must be undertaken in accordance with SOP flowchart for specific area of work or if the patient's condition alters.

4.1.5 Pressure-redistributing devices must not be used as a substitute for re-positioning (NICE, 2014). This is particularly important for permanent wheelchair users. Consider if sitting time should be restricted to less than two hours per session.

4.2 Selecting a Pressure-Relieving Device

4.2.1 The prescribing of any pressure-relieving device requires a 24-hour approach. It should include consideration of all surfaces used by the patient. The type of pressure relief support must be changed to suit any alteration in level of risk i.e. Patients' must be provided with a more suitable product when their risk level increases or decreases. This is commonly referred to as 'stepping- up' or 'stepping down'.

4.2.2 The health care professional will make a professional and clinical judgement in relation to the prescribing of pressure relieving equipment. Education regarding increasing mobility, changing position, using the 30 degree tilt may be adequate for the individual concerned.

4.2.3 The clinical assessment and treatment plan including equipment provision must be fully discussed with the patient and/ or carers to ensure that they understand the rationale and risks associated with treatment choices. This will ensure that the patient is able to make an informed choice about their care.

4.2.4 When prescribing pressure relieving equipment consideration of the patient's weight should be taken into account. Equipment is available for patients with low weight and bariatric patient' as required.

4.2.5 Where equipment is deemed necessary the Waterlow score is used as a guide to provision: The prescriber's clinical judgement is paramount to each individual's holistic needs when prescribing equipment. N.B. The following information is only a guide not a recommendation: -

4.2.5.1 Waterlow score of 10-14 (at risk): consider a pressure reducing foam overlay cushion (local equipment guidance) or pressure relieving mattress (high specification foam mattress or semi-dynamic mattress without pump)

4.2.5.2 Waterlow score of 15+ (high risk) and those patients with a category 1-2 pressure ulcer, consider the use of, as a minimum a pressure reducing foam overlay cushion (local equipment guidance), a high specification mattress (foam or semi-dynamic with or without pump) and the ulcer monitored for deterioration

4.2.5.3 Waterlow score of 20+ (very high risk) consider the use of a high specification mattress (foam or semi-dynamic with or without pump or dynamic)

4.2.6 Patients with a category 3 or 4 pressure ulcers:
consider the use of a high specification mattress (foam or semi-dynamic with or without pump or dynamic)

4.2.7 For patients with pressure ulcers to the heels consider the use of specific pressure reducing devices for the foot and/ or offloading the heels alongside or instead of a pressure relieving mattress.

4.3 Contra Indications for the use of dynamic pressure relieving mattress (mattress dependant, see manufacturers user manual)

4.3.1 Patients with unstable fractures including spinal injuries
4.3.2 Patients exceeding the maximum weight limit - Bariatric equipment is available as required.
4.3.3 Patients with gross oedema.
4.3.4 Burns
4.3.5 Patients with low weight (under 4.5 stones / 28.6kg)

4.4 Patients own pressure redistribution mattress and cushions

4.4.1 Check the make and model of the mattress. If it has pressure redistribution properties, then it may be suitable for the patient to continue to use their own mattress. Seek specialist advice from the Tissue Viability team if required.

4.4.2 If the patient wishes to continue to use their own mattress ensure it is suitable and discuss the risks in detail with the patient and carers. All risks must be discussed

recorded, and the plan agreed with the patient and carers. This must be reassessed at any change in condition or as per SOP flowchart for specific area of work.

4.4.3 Manufacturer's guidance must always be followed when using any pressure-relieving device.

4.5 Seating

4.5.1 Seating assessments must be carried out where appropriate and equipment may be provided following an assessment of each individual's needs e.g., wheelchair seating, static seating. Individuals are at a higher risk of pressure ulcer development when sitting out of bed due to increased weight through the ischial tuberosities.

4.5.2 Individuals who are wheelchair users will receive training in methods of pressure relief to allow them to become as independent as possible.

4.5.3 Wheelchair users must not be encouraged to use their wheelchair as an alternative to more substantial seating. All staff should encourage wheelchair users to take regular breaks from their wheelchair. Consider referral for a specialist seating assessment or posture support by a physiotherapist or occupational therapist.

4.5.4 If a pressure reducing or relieving cushion is in use the cushion should provide the optimum postural support and maximum contouring with the patient's body shape in order to distribute pressure as evenly as possible. Any contouring provided by the cushion will allow the ischial tuberosities to sit lower than the thighs, this increases stability and risk of sliding forward which can cause shearing.

4.6 Pressure relieving/ reducing mattress management

Community setting:

4.6.1 All patients' who are provided with equipment must have an equipment care plan instigated.

4.6.2 All dynamic pressure relieving equipment will have an annual service provided by ICES stores.

4.6.3 All foam pressure reducing equipment will be checked 3 monthly by the prescribing team/ department.

4.6.4 Refer to manufacturer's guidelines for correct mattress settings for the patient's weight and ensure that the mattress setting is checked at each visit.

4.6.5 Staff prescribing pressure-relieving devices must provide patients and their carers with: -

- 4.6.5.1 Safety instructions for the use of the device, which includes actual or potential risks (e.g., fire hazard for dynamic mattress)
- 4.6.5.2 Cleaning instructions for the device
- 4.6.5.3 Contact information should the device fail
- 4.6.5.4 This information should be reinforced with a patient information leaflet

Acute setting:

4.6.5 All patients' who are provided with equipment must have an equipment care plan instigated.

4.6.6 Mattresses will be checked weekly and documentary evidence secured on the ward/department.

4.6.7 The Tissue Viability Service/Infection Control and Prevention team will perform yearly mattress audits at all acute sites.

4.6.8 Refer to manufacturer's guidelines for correct mattress settings for the patients weight and ensure that the mattress setting is checked daily.

5 SKIN

5.1 A full skin inspection must be completed on all patients on admission and any areas of pressure damage noted on the body map and a plan of care implemented. Refer to specific SOP flowchart to your area of work for timescales.

5.2 All patients assessed as 'at risk' of pressure damage, regardless of if they have pressure damage or not, must have a preventative care plan implemented which includes full skin inspections as per specific SOP flowchart to your area of work.

5.3 All patients and care givers, who are able to do so, should be provided with verbal advice to ensure they have the knowledge and skills to check their skin for early signs of pressure damage. This should be 'backed up' with written advice in the form of leaflets: Patient and carers pressure ulcer prevention and advice leaflet and Moisture Associated Skin Damage leaflet.

5.4 A good skin care regime is essential in reducing moisture and pressure damage. A simple skin cleanser with neutral pH should be used. Avoid soaps with perfume or additives as they can strip the skin's natural oils and alter the local pH balance.

5.5 For patients with no or occasional incontinence an unperfumed simple moisturiser to protect the skin may be enough. Refer to MASD (moisture associated skin damage) pathway.

5.6 For patients with moisture damage a skin barrier in the form of a cream or film will be required. Refer to MASD pathway.

6 KEEP MOVING

6.1 Positioning (please note this is not an exhaustive list):

6.1.1 Consider mobilising, positioning and repositioning interventions for all patients (including those in beds, chairs and wheelchair users). Acceptability to the patient and the needs of the carer must be considered.

6.1.2 An individualised plan of care should be implemented for all patients at risk of developing a pressure ulcer, or with a pressure ulcer. Encourage active mobilisation and change of position; assist with repositioning as per patients needs and utilise the 30 degree tilt (appendix 12) as required. Patients and carers should be encouraged to document change of position when possible, by use of a repositioning chart (appendix 13) or turning clock.

6.1.3 All patients assessed as 'at risk' of pressure damage, regardless of if they have pressure damage or not, must have clear instructions documented in the

care plan as to the minimum expected position changes within a 24 hour period. Refer to specific SOP flowchart to your area of work.

6.1.4 A pressure ulcer prevention information leaflet must be provided to the patient and appropriate care givers to support any verbal information.

6.1.5 Pressure-redistributing devices must not be used as a substitute for re-positioning (NICE, 2014). This is particularly important for permanent wheelchair users. Consider restricting sitting time and ensure an appropriate plan is instigated following full discussion with the patient and/ or care givers.

6.1.6 Moving and handling equipment e.g., slide sheets, banana boards and slings, must be used appropriately to minimise the risk of shearing forces. Slings and other handling equipment must not be left underneath individuals unless they have been designed for that purpose by the manufacturer.

6.1.7 Minimise pressure on bony prominences and avoid positioning on an existing pressure ulcer.

6.1.8 Seek specialist advice where and when appropriate in relation to available aids and equipment and positioning of the patient

6.2 Moving and handling

6.2.1 Skin damage can be minimised by the correct positioning, transferring and reposition techniques, and with the correct use of aids. An individualised patient handling risk assessment must be completed within 2 hours or on the first assessment within the community. Individuals should be encouraged to move independently were possible. Slide sheets help to eliminate friction and should be used to manoeuvre individuals safely.

6.2.2 Moving and handling equipment e.g., slide sheets, banana boards and slings, must be used appropriately to minimise the risk of shear and friction damage. Slings and other handling equipment must not be left underneath individuals unless the manufacturer has designed them for that purpose. Hoist slings must be the correct size and properly fitted. The use of electric profiling beds can contribute to reducing pressure and shearing forces if the bed is used to its full potential. Use the auto contour mechanism (raises the foot end, when head end is raised), use the knee-break facility, use appropriate manual handling techniques such as the 30 degree tilt and equipment. Ensure the feet are not resting on the end of the bed frame, bed extenders are available if necessary.

7 INCONTINENCE

7.1 Excessive moisture on the skin caused by urinary and/or faecal incontinence greatly increases the risk of pressure ulcers (NHSI Improvement, 2018). The presence of urine and faeces (particularly liquid faces) on the skin makes the local pH more alkaline as skin bacteria converts urea in urine and faeces to ammonia, this increases the risk of localised infection.

7.3 Patients must have a continence assessment completed to establish the cause of the problem and a treatment plan instigated to assist in relieving or reducing the effects of incontinence.

7.4 Consider liaising with the specialist continence service or onward referral as required.

7.5 Effective skin care is essential in preventing/ resolving incontinence associated dermatitis (IAD). Refer to section 5 for effective skin care regime.

8 NUTRITION

8.1 Anyone at risk of pressure ulcers must have a nutritional screening assessment documented within their records and any appropriate actions recorded in the care plan. The MUST (malnutrition universal screening tool) is the recommended assessment tool.

8.2 Nutritional supplements should only be prescribed for patients following consultation with a Dietician or doctor.

8.3 Patients with a category 3 or 4 pressure ulcer or clinically indicated should be referred to a Dietician.

8.4 Healthcare professionals should discuss the appropriate dietary intake with the patient and provide a How to make your meals nutritious leaflet.

8.5 Fluid and food intake charts can be utilised for both patient and care givers to aid the monitoring of dietary and fluid intake where it is deemed appropriate/ necessary.

8.6 Consider the patients oral hygiene needs. A healthy mouth, teeth and gums will assist the patient's ability to eat and drink. Consider such things as ill-fitting dentures, oral thrush, dry mouth etc.

9 GIVING INFORMATION

9.1 Self-Care/Shared Decision Making

9.1.1 There is an expectation that whenever possible that patients and carers are involved in a shared decision-making process with the relevant health care professionals to ensure care is individualised and appropriate to their needs. Health care professional should also respect and incorporate the knowledge of patients who have a long-term need for pressure area care (NICE 2014).

9.1.2 Those who are able are encouraged, following education, to inspect their own skin. For example, use a mirror to inspect the areas that they cannot see easily, or ask others to inspect them.

9.1.3 Individuals identified 'at risk' must be given a copy of the 'Pressure Ulcer Prevention' Leaflet as recommend in NICE (2015) and the 30 degree tilt method of pressure relief leaflet if required.

9.1.4 Individuals and carers (who are willing and able) should be taught how to redistribute pressure. Passive movements can also be considered for patients with compromised mobility.

9.1.5 It is essential that patients are involved in their care and treatment plan from the beginning of their episode of care. Patients should be given information about treatment choices and the associated risks to support them to make an informed choice about their care.

9.1.6 Proposed care and treatment plan decisions should take into consideration patient choice and impact on daily activities/quality of life. Involving the patient and ensuring they are fully informed and agree with the proposed plan is more likely to lead to the patient agreeing to the plan and engaging

with clinicians to mitigate risks.

9.1.7 A patient may refuse to engage or accept the proposed plan following discussions. If the patient does decline the recommended treatment plan every effort should be made to understand the reasons for this and to develop a mutually agreeable plan to minimise the risks of pressure damage that is acceptable to the needs/wishes of the patient (refer to section 3.8).

9.2 Transfer Arrangements

9.2.1 Healthcare staff that are responsible for patients moving between care settings should provide the following information, as a minimum, to the subsequent care giver: -

9.2.1.1 Establish and record the cause/ timing of any skin damage related to pressure/shear within the body of the nursing notes and ensure that this is included in any handover/ referral to other departments/ care settings.
9.2.1.2 Risk status
9.2.1.3 Type of pressure redistributing/ relieving mattress/cushion required (advance notice should be given whenever possible)
9.2.1.4 Existing pressure or moisture damage (including size, category and location)
9.2.1.5 Any previously healed pressure ulcers
9.2.1.6 Wound management regime
9.2.1.7 Any on-going nutritional support
9.2.1.8 Any prescribed medication
9.2.1.9 Pain management.

10 TREATMENT OF PRESSURE ULCERS

10.1 Refer to wound care guidelines and Trust wound care formulary

10.2 Any patients presenting with pressure damage (excluding category 1 and 2) below the ankle should be considered for an ABPI (ankle brachial pressure index) performed, or pedal pulses auscultated via a handheld doppler ultrasound to determine any arterial disease involvement. Onward referral to Tissue Viability Service or the vascular team as deemed necessary.

11 PHOTOGRAPHY

11.1 A photograph should be taken of all pressure and moisture damage.

11.2 If a patient is unable to consent the Mental Capacity Act Policy should be referred to.

Community setting:

11.3 A photograph should be taken on initial identification of the pressure/ moisture damage and at intervals thereafter as per specific SOP flowchart for your area of work.

Acute setting:

11.4 A referral should be made to the Medical Illustration Team via HIS system as soon as the pressure/moisture damage is identified and at intervals thereafter as per specific SOP for your area of work.

11.5 If the pressure ulcer is identified out of hours or weekend the tissue viability camera should be used which is located in the reception area between Astley and Standish Wards.

12 SPECIALIST REFERRAL TO TISSUE VIABILITY SERVICE

Refer to Tissue Viability referral criteria

13 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

14 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd. For more details, please contact the HR Department on 01942 773766 or email equalityanddiversity@wwl.nhs.uk

Appendix 1

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