Mandatory Training Workbook 2021

Pressure Ulcer Prevention

Clinical Staff

Checklist

- **Read through this section of the workbook.**
- **Complete the on-line assessment on My PACT**
- **If further information is required please contact the Tissue Viability Specialist Nurse on extension 1324**

Background

How big is the problem?

- 412,00 people in the UK likely to develop a pressure ulcer each year (Bennett, 2004)
- 4-10% of patients in hospital (RCN, 2005).
- Hospital acquired pressure ulcers can increase length of stay by 5 – 8 days (Bennett, Dealey and Posnett, 2012)
- Prevalence in community – more difficult to monitor
- 30% community patients and 20% nursing home patients (Your Skin Matters, 2010)

What is a pressure ulcer?

'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 present as intact skin or an open ulcer and may be painful.''

NHS Improvement ***Pressure Ulcers: revised definition and measurement*** (June 2018))

How pressure ulcers occur

Pressure ulcers develop mainly as a result of disruption to the vascular system (blood supply) – network of arteries, arterioles and capillaries; and often over a bony prominence.

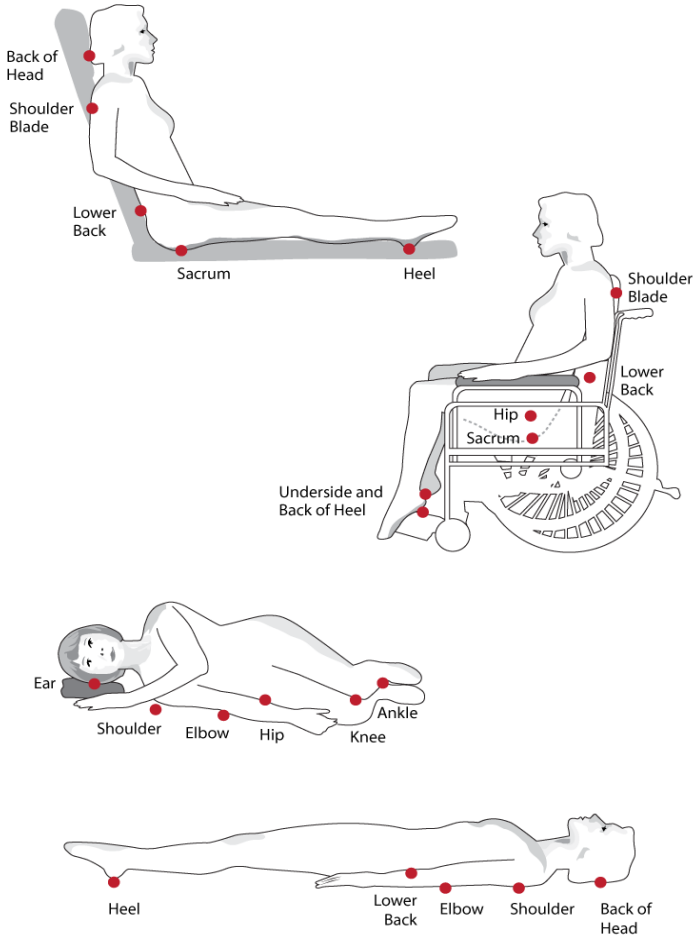
Prolonged pressure may cause ischaemic changes (this is death of the tissues) at and around the point of occlusion, where the blood supply has been blocked.

The release of pressure produces a large and sudden increase in blood flow – this is a normal response called “reactive or **blanching erythema**.”
If you see this, it suggests that the micro –circulation is generally intact.

However, when erythema (or redness) stays the same colour when a light finger pressure is applied, this is **non – blanching erythema**.
This indicates a degree of micro-circulation disruption.
This is assessed as a category 1 pressure ulcer.

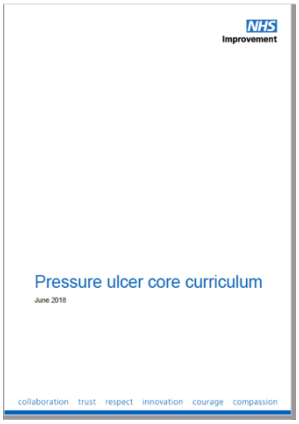
Where do they develop?

- High points of pressure
- Bony prominences
- Medical devices



NHS Improvement (2018) introduced a framework called **''aSSKINg''**

1) **Assess risk**
2) **Skin Inspection**
3) **Surface**
4) **Keep moving/repositioning**
5) **Incontinence**
6) **Nutrition**
7) **Giving information**



(1) Assess the patient's risk

Pressure ulcer risk assessment is fundamental in preventing pressure ulcers and prescribing care.

All patients must have a risk assessment including skin inspection carried out by a trained healthcare professional within 6 hours of admission or first community contact, using a recognised risk assessment tool. Ideally the assessment should be done within one hour of admission, especially if the patient is acutely ill, has existing or previous pressure ulcers or has been on a hard surface (i.e. floor) prior to admission.

Re-assessment of risk must be carried out in the following circumstances

- upon any change in the patient's condition
- following surgery
- on planned transfer to another ward or department
- prior to discharge
- at next planned review date (frequency determined at local level)

Results of risk assessment must be recorded within Trust/Provider Documentation.

Patients assessed as "at risk" will have a care plan appropriate to their individual needs. The patient and their relatives or carers should be involved in the assessment and planning process wherever possible.

Pressure ulcer risk assessment – adapted from the Waterlow tool

This assists in predicting a patient's level of risk.
However, any risk assessment tool can under or overestimate a patient's level of risk.
This should be completed regularly and *used in conjunction with nurses' clinical judgment*.

Pressure Ulcer Risk Factors
There are many factors which increase the risk of pressure ulcer development.

Intrinsic risk factors (those individual to the patient) may include:

- Reduced mobility or immobility
- Sensory impairment or sensory neglect
- Cognitive impairment
- Acute illness
- Level of consciousness
- Extremes of age
- Vascular disease
- Severe chronic or terminal illness
- Systemic infection
- Previous history of pressure damage
- Malnutrition
- Dehydration
- Pain
- Posture
- Medication (e.g. steroids, anti-inflammatory drugs, cytotoxic drugs)
- End of life

Extrinsic risk factors include:

Pressure: When a person is lying/sitting, the tissues are compressed between the bones and the bed/chair surface. This squeezes the capillaries and impedes the blood supply to that area of skin. Tissues that are dependent on these capillaries are deprived of their blood supply. Eventually, the ischaemic tissues will die leading to tissue damage.

Shear: Damage occurs when the skin remains stationary and the underlying tissue shifts e.g. when a patient slides down the bed/chair. The microcirculation can be destroyed and the tissue dies. In more serious cases, lymphatic vessels and muscle fibres may also become torn, resulting in a deep tissue damage.

Friction: The epidermis is stripped when rubbed against another surface causing superficial ulceration (or blistering).e.g. from manual handling techniques.

Moisture: e.g. from incontinence, perspiration, wound exudate.

Guide to completing Pressure Ulcer Risk Assessment should be read – this is available on the Intranet, Tissue Viability section (in Support Services)

(2) Skin Inspection

- Skin inspection must be carried out within six hours of admission (NICE, 2014). Ideally it should be completed within one hour of admission, especially if the patient is acutely ill or has had a prolonged period on a hard surface.

- Identify and record any medical conditions that increases the risk of pressure damage i.e. diabetes peripheral arterial disease, chronic skin conditions such as eczema and psoriasis.

- Special attention must be paid to **the skin over bony prominences** i.e. heels, sacrum, buttocks, elbows, shoulders, hips, occiput (back of head), knees, ankles, and toes.

- Attention must also be paid to parts of the body affected by external forces exerted by equipment/devices e.g. anti-emboli stockings, hoist sling, invasive lines, NG tubes, catheters, oxygen masks, nasal cannula, ET tubes/tape.

- A baseline skin inspection to be completed alongside a risk assessment on the first contact and recorded as evidence in Trust/Provider documentation.

- Identify and record existing or previous pressure damage to the skin.

- Inspect all at-risk areas, looking for red areas, hardness of the skin, pain, darker skin pigment. Dark pigmented skin which mask visible indicators of damage to the skin or head hair not allowing visualisation of skin under cervical collar.

- Inspect areas of **high risk from medical devices** i.e. catheter tubing, CPAP, glasses, halo frame and aspen collars, orthopaedic metal framework.

- After obtaining patient consent (as per organisation's policy), photograph any areas of pressure damage present on assessment.

- If safeguarding concerns are suspected, discuss with safeguarding team or lead and follow local authority protocols and guidelines.

The following signs may indicate pressure damage:

- **Blanching erythema:** apply light finger pressure to the area for 5 seconds then release the pressure. If the area turns white and then returns to the original erythema, this is an indication that the micro-circulation is intact and further damage can be prevented. Consider this as an early warning sign.

- **Non-blanching erythema:** where skin appears reddened and does not blanch (go white) when light finger pressure applied. This suggests that the local micro-circulation is now damaged. This is a category 1 pressure ulcer (EPUAP, 2014). Pressure should be removed from the affected site and the

skin should be inspected every 2 hours. Results of skin inspections should be recorded in the patient's record.

- Blisters
- Discolouration
- Localised heat
- Localised oedema
- Localised induration or hardening of the skin

- The following signs may indicate pressure damage in patients with darkly pigmented skin:
    - Purple/blue localised areas
    - Localised heat
    - Induration/hardness

Assess all patients for pain over common pressure ulcer sites (or pain related to a pressure ulcer or its treatment). Relieve pressure from this site, as far as possible. Provide medication or other methods of pain relief as needed and appropriate.

The Skin Inspection Record in EPR should be completed for ALL in-patients, on both the early and the late shift and early, late and night shift on critical care.

It lists a number of common sites for pressure ulcer development and then requires staff to select the description of the site:

Staff should not record ''not clinically indicated.'' **All patients** require close skin inspection as **all patients** in hospital are at risk of developing pressure ulcers.

If *''declined examination''* is selected, staff should record what additional actions they have taken to ensure that the patients understand the rationale for performing skin inspection and risks associated of the skin not being inspected.

If *''not examined''* is selected, staff should record the reason for this and also note when they next plan to attempt skin inspection.

(3) Surface

No pressure-redistributing device/mattress or cushion should be relied upon as a substitute for regular change of a patient's position

Decisions about which pressure redistribution device to use is based on an overall assessment of the individual and not solely on the basis of scores from the risk assessment tool.

Pressure ulcer prevention and treatment strategies usually comprise a combination of pressure redistribution (in the form of mattresses and other support surfaces), positioning and repositioning, and wound management strategies (NICE 2005).

All patients assessed as being at risk of developing pressure ulcers will have a high-specification foam mattress as standard (NICE 2014).

High-specification foam cushions can be used suitable for high risk patients as part of their overall pressure ulcer prevention plan. These are also suitable for patients who use a wheelchair.

The use of higher specification mattresses (alternating pressure mattresses, continuous low-pressure mattresses) can be considered:

- As a first line preventative strategy for people at elevated risk as identified by holistic assessment
- When individual's history of pressure ulcer prevention and/or clinical condition indicates that he/she is best cared for on a high-tech device;
- When a low-tech device has failed.
- For patients at higher risk of pressure ulcer development where frequent manual repositioning is not possible.
- Individuals assessed as having category 3-4 pressure ulcers including intact eschar (where depth and therefore category, cannot be assessed).

Heel Protection

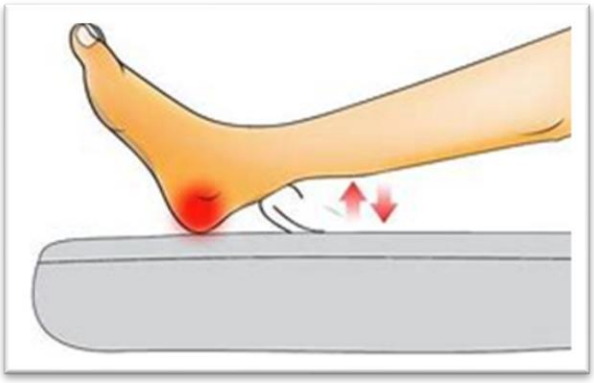
The incidence of pressure damage to the heels remains high nationally and can lead to prolonged treatment, reduced mobility, infection and possible amputation. The risk of heel pressure ulcer development is greatly increased in patients with sensory impairment (i.e. neuropathy) and vascular insufficiency.

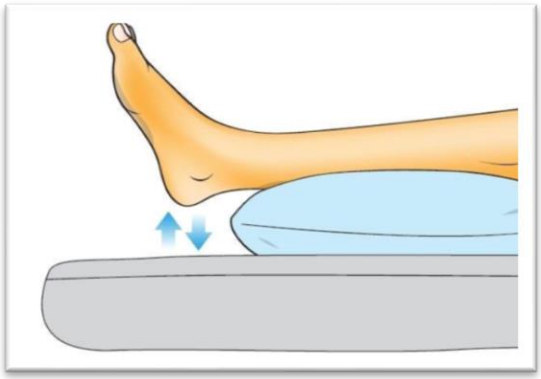
The shape of the heel and minimal subcutaneous fat makes it more difficult to reduce pressure over this bony prominence, therefore total offloading or 'floating' is recommended to lift the heel off the bed/footstool.

- ***Inspect the skin of the heels regularly.***
- Use knee break prior to back elevation on a profiling bed to reduce drag effect on heels.
- Reduce friction and shear during repositioning by ensuring the slide sheet is positioned under the heels.
- For patients at high risk of developing heel pressure ulcers, heels should be offloaded by using a pillow full length under the calves (*****knees slightly

bent) so that heels are elevated (i.e. “floating”) or using heel protection aids. Pillows are advised to be used as a short-term intervention.

Heels should be offloaded 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 also be in slight flexion as hyperextension of the knee may cause obstruction of the popliteal vein, and this could predispose an individual to deep vein thrombosis.





- Consider using a slide sheet under heels as a temporary intervention (review at each planned repositioning or skin inspection) or use of specialist products designed at reducing shear and friction, for patients who are restless or agitated in bed or who have involuntary movements of the feet, to reduce shear and friction forces.

- Regular inspection of skin to the feet/heels is still needed when wearing anti-embolism stockings.

Medical Device Related (MDR) Pressure Ulcers

''Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes'' (EPUAP, 2014).

Any individual with a medical device should be considered to be at risk of developing a pressure ulcer from the device. Individuals with impaired sensory perception, inability to communicate discomfort, compromised vascularity, compromised skin integrity and presence of oedema are at higher risk of device related pressure ulcers.

Tips for prevention

- Observe the skin for pressure damage caused by medical devices. Many different types of medical devices have been reported as having caused pressure damage e.g. catheters, oxygen tubing and masks, ventilator tubing.
- Conduct more frequent (greater than twice daily) skin assessments at the skin-device interface in individuals vulnerable to fluid shifts and/or showing signs of oedema. Oedema can cause a medical device that initially fits properly to exert external pressure to the skin that then leads to pressure ulcer formation (EPUAP, 2014).
- Remove medical devices that are potential sources of pressure as soon as medically feasible.
- Move devices to inspect the skin
- Keep skin clean and dry under medical devices.
- Rotate or reposition medical devices when possible
- Ensure that medical devices are correctly sized and fit appropriately to avoid excessive pressure.
- Apply all medical devices following manufacturer's specifications.
- Ensure that medical devices are sufficiently secured to prevent dislodgement without creating additional pressure.
- Inspect the skin under and around medical devices at least twice daily for the signs of pressure related injury on the surrounding tissue; or more frequent skin assessments in patients vulnerable to fluid shifts and/or exhibiting signs of localised or generalised oedema.
- Consider using a prophylactic dressing for preventing medical device related pressure ulcers.

It is not always obvious that a medical device may cause a pressure ulcer – be aware of:

- catheter tubing, oxygen tubing, intravenous tubing, ET tube, Tracheostomy / ET ties, NG tube, O2 probe, CPAP mask, bedpan, splints, nasogastric bridle, hearing aids, spectacles, bandages, plaster of Paris, wrinkled sheets, pads, foot/head boards, hoist slings, compression hosiery, cot sides/bed rails.

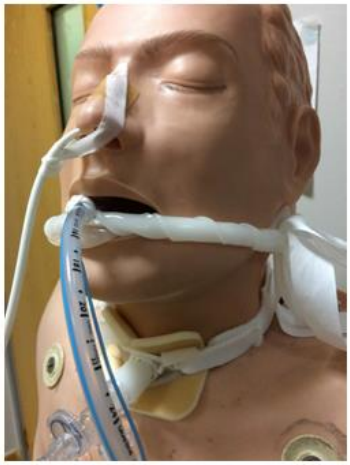
This list is not exhaustive but highlights the need for vigilance with all equipment used.

Reducing pressure from medical devices – posters available

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

REDUCING PRESSURE FROM MEDICAL DEVICES

Use of Dermisplus PREVENT strips under ET tube and tracheostomy tube



***Change to Anchorfast after 24 hours**

Tissue Viability Service (bleep 2138 or Extension 1324)

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

REDUCING PRESSURE FROM MEDICAL DEVICES

Use of Dermisplus PREVENT under CPAP/BiPAP

(1) Apply strip of Duoderm to the bridge of the nose first, this will help reduce moisture and friction

(2) Then apply a **long strip of Dermisplus PREVENT,** as above (stored in Omnicell/ITU).
This will help reduce pressure.
Take care to position the mask as above, if the mask slips, it should be re-positioned
Close skin inspection
LOOSEN THE STRAPS

Tissue Viability Service (bleep 2138 or Extension 1324)

Liverpool Heart and Chest Hospital NHS
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PREVENTING PRESSURE ULCERS AT Naso Gastric (NG) Tube sites

NG tubes can cause pressure against the sides or tip of the nostril and tape can obscure the site of the pressure

Secure the tube using the 'Authbert hammock' technique below
The tube is secured with single strip of Durapore which will be stored next to the NG tubes in the Omnicell (ITU)
This is looped around the tube twice and secured to the nose in a 'hammock'

Where there is a clinical need to bridle the NG
Medihoney Barrier Cream should be applied
Regular and close skin inspection is required
Ensure that the ribbons are not 'tight' & causing damage to the skin

Skin inspection should be performed and record completed

Tissue Viability Service (bleep 2138 or Extension 1324)

Seating

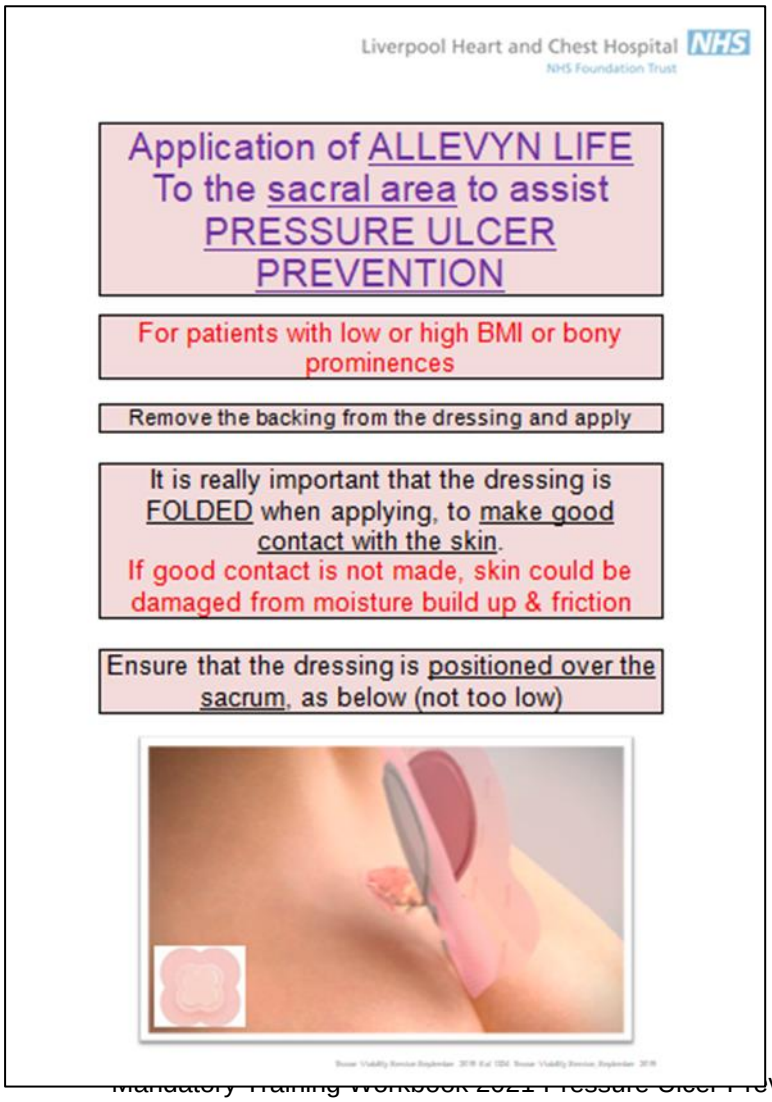
Lengthy sitting in chairs has been shown to be a high-risk activity for patients who are susceptible to pressure ulcers as exceptionally large compressive forces are generated on the ischial and sacral regions (NICE 2003).

A change in position means a full change in position – standing or marching on the spot does not provide sufficient time for tissues to re-perfuse.

Remember that pressure ulcer prevention is a 24 hour consideration so staff should consider if a **pressure redistributing cushion** is required as part of the patient's prevention plan if required.

Prophylactic dressings

The use of prophylactic 5 layered silicone bordered foam dressings (e.g. Allevyn Life) is advised as part of a pressure ulcer prevention plan – apply to high risk sites, bony prominences. These must be peeled back (then can be repositioned) to observe the skin at skin inspection times.

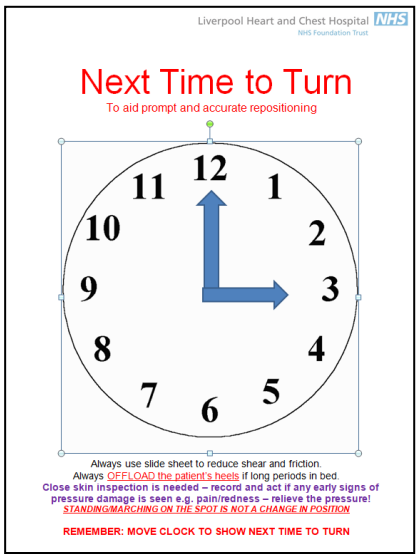


(4) Keep moving/repositioning

- Patients who are at risk of pressure ulcer development should be repositioned and the frequency of repositioning determined by **the results of skin inspection** and individual needs. Look for redness or discoloration – taken the pressure off any affected areas and recheck in 2 hours.

- A **repositioning regime and chart is needed** where:
  - ✓ Patients assessed as being at high risk of developing pressure ulcers (assessment based on risk assessment score and clinical judgement)
  - ✓ Patients in bed 24 hours a day/cannot independently change their own position,
  - ✓ Patients who require any assistance to mobilise e.g. walking aid, support of staff
  - ✓ Patients with pressure damage/existing pressure ulcers

- Use **'Next Time to Turn' clock** when a patient has a 'Repositioning Chart in Use'



- The repositioning plan should take into account patient's medical condition, comfort, overall plan of care, support surface.

- Positioning of patients should ensure that prolonged pressure on bony prominences is minimised, that bony prominences are kept from direct contact with one another and friction & shear are minimised.

- Some pressure ulcer prevention strategies advocate the use of the 30 degree tilt. Patients are tilted to 30 degrees and supported in that position by pillows rather than being turned on their side.

- A repositioning schedule, agreed with the patient, should be recorded and established for each patient ''at risk''.

- Patients who are willing and able should be taught how to redistribute weight.

- Manual handling devices should be used correctly to minimise shear & friction, aids not left under the patient.

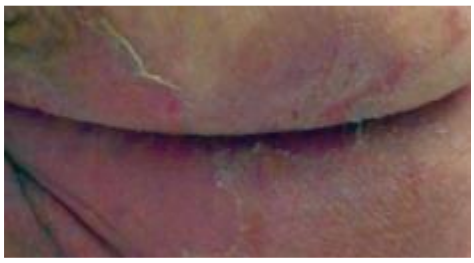
(5) Incontinence

What is meant by incontinence?
Urinary incontinence is the unintentional passing of urine. It's a common problem thought to affect millions of people.
Bowel incontinence, or faecal incontinence, is when you have problems controlling your bowels (NHS, 2019).

Types of Moisture Associated Skin Damage

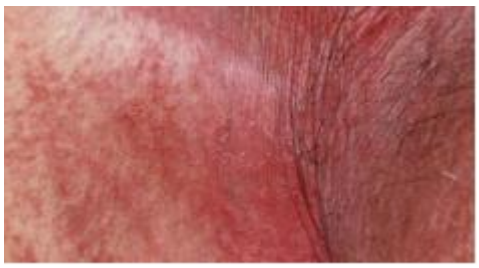
(1) Incontinence Associated Damage (IAD)

Damage caused when urine and faeces make prolonged contact with the skin.



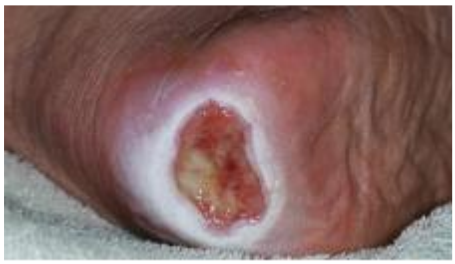
(2) Intertriginous dermatitis (intertrigo)

When 2 surfaces of skin are in contact with one another, friction and moisture e.g. under arms, groins, under breasts.
Mild, mirror image erythema on each side of the skin fold. May have erosion and skin loss as result of exposure to chronic perspiration



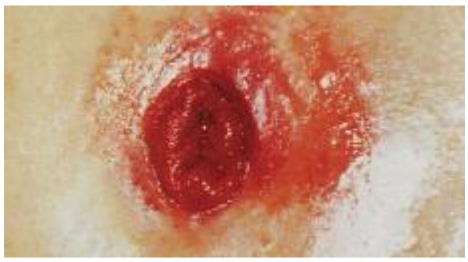
(3) Peri-wound moisture associated dermatitis

From high volumes of exudate, skin becomes macerated and can breakdown.



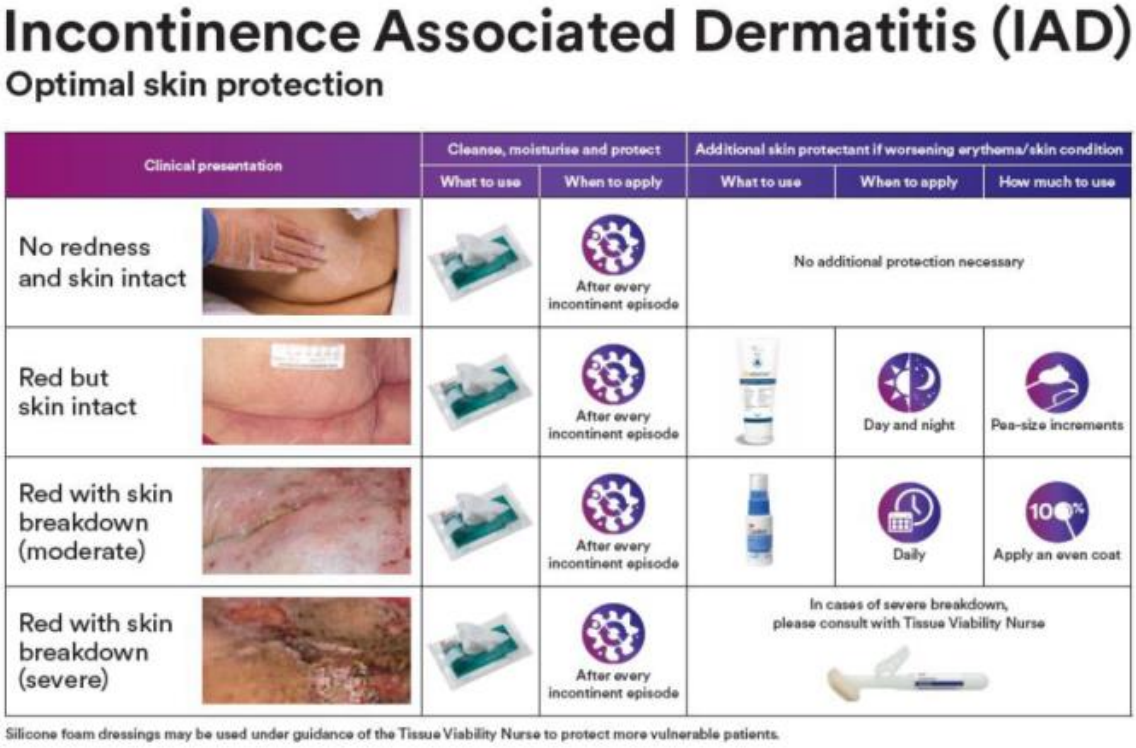
(4) Peri-stomal dermatitis

Inflammation and erosion of skin related to moisture from bodily fluids such as urine, faeces and gastric fluids.



Identifying Incontinence Associated Damage (IAD)

IAD presents initially just as redness; in dark skin however it may present as paler or darker skin, purple/dark red or yellow. The size of the affected area can vary.
It will have irregular edges, may be patchy or continuous over a larger area
It may extend beyond the perineum, affecting folds of the skin, between thighs, gluteal fold (crease between the buttocks) and buttocks.



Potential physical and emotional impact of IAD

The epidermis (outer layer of skin) may be intact or it may be eroded (worn away) exposing moist, weeping skin.
Patients may experience pain or discomfort, burning, itching or tingling to affected areas; it can have a detrimental impact of a patient's emotional and physical wellbeing and can disrupt their rehabilitation or their usual activities or sleep.

Pathophysiological mechanisms resulting in MASD

- The skin is a physical barrier against external environment.
- The pH level of the skin, or the power of hydrogen, is the balance of acid and alkaline, with a range of 1 to 14.
- A measurement lower than 7 is considered acidic, while readings higher than 7 indicate alkaline.
- The body functions optimally at a neutral level, however, normal skin is slightly more acidic at 4 to 6.5, this is called the 'acid mantle'.
- Changes in skin moisture level can lead to a reduction in the barrier function. Over hydration of the skin can cause inflammation, irritants can enter the skin, causes dermatitis.
- Chemical irritation – ammonia in urine, enzymes in faeces, chemicals and toxins in fluid can damage the epidermis.
- Urine and faeces (which are alkaline) change the normal *slightly acidic PH* of the skin, more prone to bacterial/fungal infections.

Increased moisture increases the risk of skin damage caused by shear and friction

- This is a mechanical injury.
- Older people have a thinner epidermis, less collagen, less elastin, so it is less resistant to the effects of shear and friction.
- Damp, soggy skin is more susceptible to shear and friction.
- Patients with IAD are susceptible to secondary skin infections, such as fungal infections. This typically presents as a bright red rash spreading from a central area.

Patients with faecal incontinence and/or urinary incontinence are at ***highest risk*** of developing IAD than those with urinary incontinence alone.

Poor or inappropriate management of incontinence can contribute to the development or worsening of IAD.

Differentiating between pressure ulcers and moisture damage

It is vital to differentiate between incontinence associated dermatitis and the presence of pressure damage as incorrect assessment could lead to inappropriate care and treatment, with potential detrimental effects for the patient.

IAD and pressure damage can co-exist; it may not be possible to accurately assess aetiology to begin with.

A pressure ulcer:

- Must have pressure and/or shear present
- Occurs over bony prominence
- Often limited to one spot
- Circular wounds or wounds with a regular shape
- Superficial or deep
- Edges are distinct

Moisture Associated Skin Damage:

- Moisture must be present
- May occur over a bony prominence
- However, pressure and shear should be excluded as causes, and moisture should be present
- Moisture/friction in skin folds
- Can be limited to the natal cleft/linear shape
- Peri-anal redness/skin irritation/skin loss
- Diffuse, different superficial spots
- No necrosis in a moisture lesion
- Moisture lesions often have diffuse or irregular edges
- Redness is not uniformly distributed

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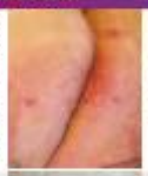
Moisture lesions vs pressure ulcers

Location

Moisture lesions



Combination of moisture and friction may cause moisture lesions in skin folds. Most commonly present in the anal cleft.

Pressure ulcers

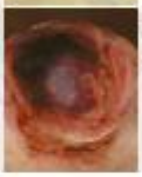
A pressure ulcer is most likely to occur over a bony prominence.

Necrosis

Moisture lesions

There is no necrosis in a moisture lesion.

Pressure ulcers



A black necrotic scab on a bony prominence is a pressure ulcer.

Shape

Moisture lesions

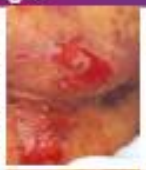
Diffuse, different superficial spots are likely to be moisture lesions. In a kissing ulcer (copy lesion) at least one wound is most likely caused by moisture.

Pressure ulcers

Circular wounds or regular shaped wounds are most likely pressure ulcers. The possibility of friction injury has to be excluded.

Edges

Moisture lesions



Moisture lesions often have diffuse or irregular edges.

Pressure ulcers

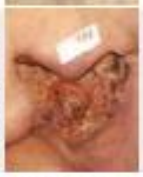
If the edges are distinct, the lesion is most likely to be a pressure ulcer.

Depth

Moisture lesions

Moisture lesions are superficial (partial thickness skin loss). In cases where the moisture lesion gets infected, the depth and extent of the lesion can be enlarged.

Pressure ulcers



Pressure ulcers vary in depth depending on classification.

Colour

Moisture lesions

If redness is not uniformly distributed, the lesion is likely to be a moisture lesion.

Pressure ulcers

If redness is non-blanchable, this is most likely a pressure ulcer. In dark pigmented skin, persistent redness may manifest as blue/purple.

If the aetiology of redness (erythema) is not definite, then pressure ulcer prevention and management of moisture damage must both be implemented and reviewed.

Appropriate prevention and management strategies

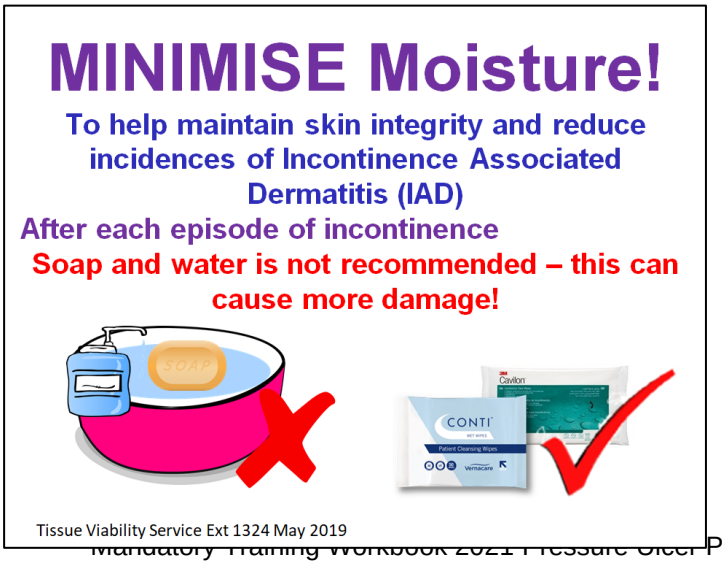
The presence of urinary and/or faecal incontinence should trigger the implementation of an appropriate IAD prevention protocol to minimise/prevent exposure to urine and faeces and to protect the skin.

Continence assessment and management is needed to minimise the risk of skin coming into contact with urine and/or faeces.

Use of a structured skin-care regime is advised – **cleanse, protect and restore**

Skin cleansing has traditionally used standard soap and water; however this has been shown to change the normal PH of the skin, affecting the skin barrier function. This may be further impaired by the rubbing texture associated with wash cloths and towels which can cause friction.
MINIMISE Moisture - what does **M.I.N.I.M.I.S.E.** stand for?

Management of incontinence – making the right choice at the earliest opportunity: pads, urinary catheter, faecal management system
Inspect the skin – checking areas that can be affected by urine, faeces, sweat and wound fluid
Nutrition and hydration – optimise
Implement prevention/management strategies for at risk patients
More moves **–** changing the patient's position regularly aids evaporation of moisture & cooling
Identify moisture damage correctly (4 types and understanding the differences between pressure and moisture damage)
Skin care – skin care protocol, cleansing and topical products
Educate – staff who you work with and patients – about actions they can take to reduce the risk of MASD



No rinse cleansers have shown to save staff time and efficiency (such as Cavilon Continence Wipes). Additional barrier film/cream may be needed to protect the skin from moisture.

KEY POINTS:

- Identify who is at risk – patients who are INCONTINENT, immobile, high BMI, skin folds
- Plan prevention - skin care is important – avoid soap and water for at risk sites, use Cavilon wipes, allow to 'air' dry
- Early use of Cavilon Advance for patients with liquid stools/or Flexi-Seal –apply when skin is perfect – PREVENTION is always better than CURE!

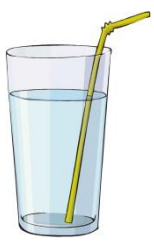
MINIMISE Moisture™ campaign
Promotional video
You tube Video **MINIMISE Moisture™**
https://www.youtube.com/watch?v=76bWWcT9ML0

(6) Nutrition

- Nutrition and hydration play a key role in keeping the skin healthy. Deficiencies in diet are a risk for developing pressure ulcers and it is recommended that a nutritional screening tool is used to assess risk of malnutrition (NICE 2014) e.g. MUST.
- It is important to screen and assess the nutritional status of every patient at risk of pressure ulcers as under nutrition is a reversible risk factor for pressure ulcer development.
- All patients admitted to hospital are to be screened for malnutrition using a recognised screening tool within 24 hours of admission, and weekly thereafter or if change in clinical condition; and at the first face to face contact in the community, then as indicated by the Risk Assessment.
- It is important to assess weight status to determine their weight history and note any significant weight loss from their usual body weight; also assess their ability to eat independently and if their total nutrient intake is adequate (EPUAP 2014).
- Patients with nutritional risk identified should be referred to the dietician for a more comprehensive nutritional assessment (EPUAP 2014).
- Patients with category 3 or 4 pressure ulcers of moderate or severe harm should be referred to the dietician. Offer high calorie, high protein nutritional supplements, vitamins and minerals in addition to the usual diet to adults with nutritional risk and pressure ulcer risk, if nutritional requirements cannot be achieved by dietary intake alone.

Adults: Hydration (within any fluid restriction)

- Monitor individuals for signs and symptoms of dehydration.
- Provide and encourage adequate daily fluid intake for hydration for an individual assessed to be at risk of or with a pressure ulcer. This must be consistent with the individual's co-morbid conditions and goals.



(7) Giving information

Ensure your patient has been provided with the Trust *Patient Information Leaflet Pressure Ulcers* and that this is recorded on the pressure ulcer care plan on EPR

NICE (2014) advise that staff should offer timely, tailored information to people who have been assessed as being at high risk of developing a pressure ulcer, and their family or carers. The information should be delivered by a trained or experienced healthcare professional and include:

- the causes of a pressure ulcer
- the early signs of a pressure ulcer
- ways to prevent a pressure ulcer
- the implications of having a pressure ulcer (for example, for general health, treatment options and the risk of developing pressure ulcers in the future).

Staff should also:

- select and implement the most appropriate approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies
- communicate effective and safe use of interventions effectively for the patient, family and within the multidisciplinary team
- understand and recognise when clinical concerns need to be escalated
- be able to promote effective pressure ulcer prevention approaches, techniques and equipment
- understand effective resource allocation, be able to escalate concerns when resources are unavailable
- be aware of safeguarding issues
- be able to facilitate health promotion with patients and families
- understand strategies for individuals who are non-concordant (see non-concordance)

Pressure Ulcer Core Curriculum (NHSI, 2018b)

Healthcare professional training and education

Training should be undertaken by healthcare professionals on pressure ulcer prevention, and should include:

- who is most likely to be at risk of developing a pressure ulcer
- how to identify pressure damage
- what steps to take to prevent new or further pressure damage
- who to contact for further information and for further action
- how to carry out a risk and skin assessment
- how to reposition
- information on pressure redistribution devices
- discussion of pressure ulcer prevention with patients and their carers
- details of sources of advice and support (NICE, 2014)

Safeguarding consideration

As a minimum, multiple category 2 pressure ulcers and all category 3 or 4 pressure ulcers should be referred to a Safeguarding Team.

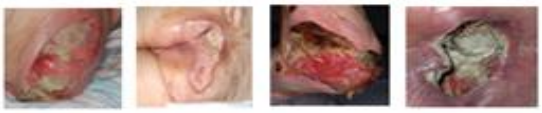
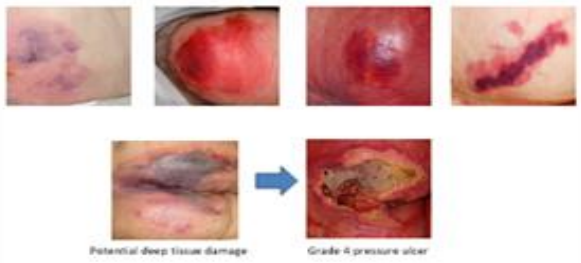
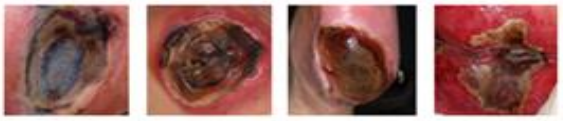
It is **CRITICAL** that the concern is raised immediately where:

- there are concerns that the pressure ulcer developed as a result of carer wilfully ignoring or preventing access to care or services.
- there are any concerns regarding abuse or neglect of the person receiving care.

Pressure Ulcer Categorisation

Designed and created by The North West Tissue Viability Nurses Group

NHS Improvement

CATEGORY (GRADE) 1 Intact skin Non blanching redness Usually occurs over bony prominence Individuals with dark skin, observe for additional signs e.g. warmth, oedema, pain, hardness	
CATEGORY (GRADE) 2 Superficial skin loss Pink/Red wound bed May be minimal slough with healthy tissue evident May present as a clear filled blister with no discoloration underneath	
CATEGORY (GRADE) 3 Full thickness tissue loss Subcutaneous fat may be visible but bone/tendon/muscle are not exposed Depth may vary depending on anatomical location	
CATEGORY (GRADE) 4 Full thickness loss Can extend to expose bone/tendon or muscle or they may be directly palpable Depth can vary by anatomical location	
POTENTIAL DEEP TISSUE DAMAGE A localised area of purple discoloration over intact skin, or blood blister, due to damage of underlying soft tissue. It may be painful, firm, mushy, boggy, warmer or cooler compared to the adjacent skin. May develop into a category 3 or 4 but cannot be confirmed until extent of damage is evident Damage may be recoverable with effective 'off-loading' of affected area	
UNSTAGEABLE **GRADE TO BE DETERMINED AT A LATER DATE** Minimal category 3 but potential 4 The wound bed is not visible due to presence of slough or necrotic tissue Classification may not be possible until the ulcer is debrided.	

collaboration trust respect innovation courage compassion

The Trust 'Pressure Ulcer Prevention and Management Guideline' includes NICE and EPUAP recommendations.
Intranet, in Policies and Procedures/Clinical Policies

Remember!
Pressure ulcers are largely preventable

If there is a dispute about the cause or treatment of a patient with a pressure ulcer, then the **patient's records** will be important in determining whether there was a risk assessment of the patient's condition, and whether it was followed by a treatment plan which the records must show was properly implemented.

References used in the workbook can be provided on request.
There are many useful resources available on the Intranet, in the Tissue Viability section

- **Please complete the on-line assessment**
- **100% is required in order to be assessed as competent in basic pressure ulcer prevention awareness**
- **If further information is required please contact the Tissue Viability Service on extension 1324**