### POLICY FOR: PREVENTION, MANAGEMENT AND REPORTING OF PRESSURE ULCERS

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**Type:** Policy

**Policy applies to (staff groups):** All Clinical Staff involved with the delivery of adult patient care working or contracted to Suffolk Community Healthcare.

**Required compliance:** This Policy must be complied with fully at all times by the appropriate staff. Where it is found that this Policy cannot be complied with fully, this must be notified immediately to the owner through the waiver process.

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<th>Policy/Guideline owner:</th>
<th>Director of Nursing, Therapies &amp; Governance</th>
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<td>Clinical Governance Team</td>
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<td>Other contact:</td>
<td>Modern Matrons, Falls Prevention Co-ordinators</td>
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### AGREED POLICY/GUIDELINE REVIEW / RATIFICATION / ADOPTION PATH:

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<tr>
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<td>Agreed by: Clinical Quality &amp; Safety Assurance Group</td>
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PRESSURE ULCER POLICY

STATEMENT OF OVERARCHING PRINCIPLES

All Policies, Procedures and Guidelines of SCH Serco are formulated to comply with the overarching requirements of legislation, policies or other standards relating to quality and diversity.

1. Introduction
1.1. Acute illness, immobility and poor nutrition are key factors but there are many other causes. Pressure damage can have a major impact on patients and their carers and are recognised as a major cost to the NHS. Pressure damage prevention and treatment is a fundamental aspect of care (Department of Health, 1999), is part of the Essence of Care (DoH, 2001) benchmarking tool and is the subject of three national guidelines (RCN, 2000, NICE 2003 and 2005) http://guidance.nice.org.uk/CG29 and Your Skin Matters as within the High Impact Actions for Nursing and Midwifery (2009)

1.2. The aims of this policy are:
   a) To clarify clinical responsibilities for the prevention and management of pressure ulcers
   b) To identify the process for risk assessing pressure ulcers
   c) To identify the route for reporting ALL pressure ulcers to be reported to enable monitoring and compliance with DoH guidelines
   d) To protect patients through the provision of a process that supports professional practice at all levels in the prevention and management of pressure ulcers

1.3. Regional and national initiatives are focussing on prevention/ elimination of pressure ulcers. Elimination of all avoidable grade 2, 3 and 4 pressure ulcers is one of NHS Midlands and East SHA five “ambitions” (http://www.midlandsandeast.nhs.uk/OurAmbitions.aspx) designed to improve patient safety and quality of care. Avoidable pressure ulcers are seen as a key indicator of the quality of nursing care. To make it easier for front line staff to prevent and treat pressure ulcers, a unique new accessibility tool has been developed; called the Pressure Ulcer Path, this online and printed tool helps staff to prevent and treat, step by step, including through the use of the SSKIN model/ care bundle. Staff should read the NHS Midlands and East document “The Prevention and Management of Pressure Ulcers” which is the foundation of the new initiative which can be found at: http://nww.suffolkch.nhs.uk/Home/QualityGovernance/Risk/PressureUlcerPathway.aspx

1.4. Pressure ulcer prevention is also part of ‘Safety Express' - the Department of Health QIPP Safe Care work stream, plus the Operating Framework for 2012/13 includes a new national CQUIN goal that incentivises use of the NHS Safety Thermometer. This is an improvement tool that allows NHS organisations to measure harm in four key areas including pressure ulcers.

2. Purpose And Scope Of Policy
2.1. To assist in the delivery and reporting of high quality care
2.2. Reporting and the investigation of pressure ulcer incidents when they occur
2.3. To provide information to ensure that staff can identify, prevent and manage pressure ulcers
2.4. To highlight the need for preventative measures against the adverse effects of pressure, friction and shear
2.5. To support the Essence of Care Benchmarks for Pressure Ulcers, National Institute of Health and Clinical Excellence (NICE) guidance and addressing the expectation of High Impact Actions within SCH
2.6. To support the NHS Midlands and East Strategic Health Authority pressure elimination initiative and implement the Pressure Ulcer care pathway (see 1.3 above)

3. **Policy Agreement Path**

This policy was agreed by the Clinical Policy Group and approved by the Clinical Quality and Safety Assurance Group on behalf of the Directorate Management Team.

4. **Definitions**

A pressure ulcer, otherwise known as pressure sore, bed sore, or decubitus ulcer is: ‘an area of localised damage to the skin and underlying tissue caused by pressure, shearing and friction and/or a combination of these’ *(NICE, 2005)*

5. **Cross Reference To Other Related Policies & Guidance**

- East of England Pressure Ulcer Web-path (see [http://www.stopthepressure.com/path](http://www.stopthepressure.com/path))
- Infection Control Manual
- Safeguarding Adults policy
- CES criteria for ordering equipment
- Incident reporting policy
- Consent policy
- Guidance Notes on the use of visual recordings
- Tissue Integrity and Appliance Formulary

6. **Roles & Responsibilities**

This policy applies to every employee of Suffolk Community Healthcare (SCH) involved in the care of patients who are ‘at risk’ of developing, or actually have an identified pressure ulcer

6.1. Chief Nurse/Head of Quality and Patient Safety on behalf of the Chief Operating Officer will ensure that a comprehensive policy for pressure ulcer prevention and management within the SCH is developed, agreed and reviewed

6.2. Local Area Managers:

a) Will ensure that the policy is implemented within their area of responsibility

b) Will ensure the provision of pressure reducing/relieving equipment within their areas taking clinical effectiveness, educational requirements of staff and financial factors into account

6.3. Team Leads:

a) Will ensure all staff within their areas are aware of and understand the policy

b) Will ensure compliance with the audit requirements of the policy

c) Will investigate failure to comply with the policy

d) Will take managerial action to prevent recurrence of reported incidents

6.4. Modern Matrons and Team Leaders:

a) Will ensure that all staff are aware of the policy and adhere to it

b) Will identify training needs and ensure staff are appropriately trained in pressure ulcer prevention and management, and will record all training

c) Will incorporate pressure ulcer prevention and management into staff performance review and knowledge and skills framework
d) Will use the available resources to ensure patients are provided with the correct pressure reducing/relieving equipment

e) Will ensure the Locality Lead is aware of all incidents/failures to comply with the policy

6.5. All Staff:

a) Will adhere to the SCH policy

b) Will use the information provided at clinical level to ensure correct choice of pressure reducing/relieving equipment and use this in a safe manner assessing risk as part of patient care

c) Will identify their training need and make their manager aware of training deficit

d) Will maintain personal records of all training

e) Will report all clinical incidents around pressure ulcer prevention and management

6.6. Clinical Governance Team:

a) The team will be responsible for co-ordinating the audit of pressure ulcer prevalence and the collation of data on behalf of the organisation

b) Will ensure clinical practice is developed in line with evidence and best practice guidance

c) Will support the reporting required to the National Patient Safety Agency and Commissioners

7. Pressure Ulcer Definition And Causes

7.1. Pressure damage can be described as a new or established area of skin/tissue discolouration or damage, which persists after the removal of pressure, which is likely to be due to the effects of pressure on the tissues. Pressure sores range from being little more than areas of discoloured skin, to superficial ulcers, to deep purulent cavities extending to muscle and bone (Department of Health, 1993).

7.2. An individual's potential to develop pressure ulcers may be influenced by the following intrinsic risk factors:

a) reduced mobility or immobility

b) sensory impairment

c) acute illness

d) level of consciousness

e) extremes of age

f) previous history of pressure damage

g) vascular disease

h) severe chronic or terminal illness

i) malnutrition.

7.3. Extrinsic factors include pressure, shearing, friction, and moisture to the skin.

7.4. The following definitions have the following meanings:

Pressure: Prolonged pressure compresses blood vessels, which can lead to tissue damage. The time it takes to cause damage varies considerably between individuals. In vulnerable patients pressure ulcers may develop within 15 minutes. It is generally considered that it is the duration of pressure that is the key factor in the development of pressure ulcers as opposed to the intensity of pressure.
Shearing damage may occur when a patient slips down the bed/ chair or is moved up the bed, chair. The skin remains in a fixed position and the underlying tissues and skeletal system move. This can lead to the destruction of the microcirculation and thus the tissue dies of anoxia (lack of oxygen). When moving a patient, the weight of the patient is likely to move the tissues attached to bone, but other structures such as skin and subcutaneous tissue may stay fixed to the support surface, thereby causing a shear force and possible skin damage.

Friction occurs when shear exceeds the pressure on an area and the skin begins to move against its environment. Film dressings can be used to protect the patient's skin but they do not reduce pressure.

Moisture on the patient's skin can exacerbate damage caused by pressure, shear and friction. It can lead to the tissues adhering to the support surfaces. Furthermore, the cause of the moisture can excoriate the skin e.g. faeces, urine, sweat and wound drainage.

8. Screening
8.1. The Midlands and East Pressure Ulcer Pathway lists care settings in which you must screen patients to ascertain whether or not a detailed risk assessment is required. These include:
   i) MIU and A&E: for patients who have been in the unit for 4 hours or more
   ii) Complex outpatient appointment: where a patient is scheduled to be in a unit for 4 or more hours
   iii) Other areas not applicable to SCH

9. Risk Assessment
9.1. Risk assessment is a fundamental part of preventing pressure ulcers and prescribing care. The use of a Pressure ulcer risk assessment tool is only one part of the process. Of vital importance is recognising those risk factors that come from the patient (intrinsic factors) and those that are outside the patient's control (external factors).

9.2. Holistic assessment is the responsibility of the whole multi-disciplinary team. The initial assessment will identify the interventions the patient requires to prevent pressure ulcers and the factors that place them at risk of developing them.

9.3. All new patients should have a risk assessment documented in their records at the first visit or ideally within 24 hours if in-patient admission.

9.4. Risk assessment is an ongoing process and should be continually monitored, and fully reassessed when there are changes to the patient's condition or environment.

9.5. Risk assessment tools should only be used as an aide memoire and should not replace clinical judgement. The Waterlow Risk Score (2005) (see Appendix 1) which is the tool used within SCH, is an aid to help health professionals' clinical judgement, but is only part of the documented evidence that a formal assessment of risk has taken place. Discussions or decisions regarding patient care should be recorded formally in the patient's notes.

9.6. Any specific areas of risk not included in the Waterlow score should be recorded as these additional areas could impact upon the overall risk level for the patient.

9.7. The final level of risk should be a combination of Waterlow score and clinical judgement and should be expressed as a risk level: low, medium or high. This score should be recorded in the patient notes as it is a vital part of the care planning process.

9.8. The patient should receive a holistic assessment which should include:
a) Assessment of mobility including all aspects of independent movement including walking, ability to reposition – for example in bed or a chair – or transfer – for example from bed to chair

b) A skin assessment; skin assessment must include the inspection of bony prominences (heels, sacrum, hips) and the general condition of the skin (dryness, redness)

c) Presence of any sensory impairment in an individual with a pressure ulcer should be recorded.

d) Level and duration of impaired consciousness

e) Presence of acute, chronic or terminal illness and its potential impact on ulcer healing

9.9. Previous pressure damage (site/location, stage or grade of previous ulcer and previous interventions).

9.10. Pain assessment should include: whether the individual is experiencing pain; the causes of pain; level of pain (using an appropriate tool); location and management interventions.

9.11. In the presence of systemic and clinical signs of infection in the patient with a pressure ulcer, systemic anti-microbial therapy should be considered.

9.12. Psychological assessment should include concordance and abilities of the individual to self-care (mood, motivation and aptitude).

9.13. Continence assessment should include whether the individual is continent of urine, faeces and continence interventions, which may affect ulcer healing and impair the function of pressure-relieving support surfaces – for example pads or bedding.

10. Pressure Ulcer Classification

10.1. Recording of pressure ulcer classification should follow the European Pressure Ulcer Advisory Panel Classification System (see appendix 2 and website at http://www.epuap.org/). Any area of persistent redness should be recorded including site and size. Appendix 2 offers further details as to the recognised definitions of grades.

10.2. Use of a classification system does not replace a full and accurate description of the pressure damaged area and surrounding skin.

10.3. A grade 4 pressure damaged area does not become a grade 3 as it heals, it should be described as healing grade 4 pressure damage.

10.4. A brief description of pressure ulcer grading would be:-

   a) Grade 1: non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

   b) Grade 2: partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

   c) Grade 3: full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.

   d) Grade 4: extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss

11. Monitoring Pressure Damaged Skin

11.1. The presence or absence of pressure damage is often seen as an indicator of quality care and the development of a pressure ulcer recognised as a potential indicator of neglect within a safeguarding context. Please refer to the Safeguarding Policy and also refer to Appendix 4 with view to specific identification as to where pressure ulcers may have resulted as consequence of possible poor care or neglect.
11.2. The Care Quality Commission (CQC) requires that all pressure ulcers are reported and details forwarded to the National Patient Safety Agency. All information will be shared and evaluated in a non-judgemental way. Information will be used to improve patient care.

11.3. All pressure ulcers should be documented as a clinical incident and reported to the Risk Team on the Pressure Ulcer Incident form regardless of their grade or where the patient first got the ulcer. This must be forwarded to the Risk Management Team as per the Incident Reporting Policy. See Appendices 9 and 13 respectively for Pressure Ulcer Reporting Guidance and Pressure Ulcer Reporting Form (PU1).

11.4. Those patients received into SCH care with a pre-existing pressure ulcer require the completion and submission of a Pressure Ulcer Incident Form (Appendix 6) to the Risk Management team giving details of reason for referral to their case load and where they were received from.

11.5. Pressure ulcers of Grade 2 or higher acquired whilst the patient is within SCH care should trigger a Root Cause Analysis (RCA). RCAs for those of Grade 2 severity may be undertaken by staff from within that clinical team environment.

11.6. Pressure ulcers of Grades 3 or 4 must be reported as a Serious Incident (SI) by the risk department. RCAs being undertaken for pressure ulcers of Grade 3 or 4 must be carried out by an appropriately experienced and trained clinician from outside of the direct clinical team involved.

11.7. Overall prevalence and incidence rates will be monitored and published monthly on the public website, in monthly quality reports and in regular performance reports to NHS Suffolk.

11.8. The incident form and RCA must include the following information:
   a) The incident Form:
      • Location of patient i.e. name of residential home, patients own home, inpatient unit, clinic
      • Date ulcer identified
      • Clinical speciality providing the care i.e. LCT/Inpatient unit/ D+T
      • General condition of patient
      • Location of Pressure ulcer
      • Grade of pressure ulcer
      • What action has been taken to relieve the immediate pressure?
      • What treatment has commenced for the pressure ulcer
      • What advise/education has been given to family/carers to promote healing
      • What could have been done to prevent the ulcer?
      • What learning actions have been taken to prevent an event like this recurring?
   b) The RCA form:
      Confirm all of the above and include any missing information plus:
      • Confirm the patient was with our care when the ulcer was identified What action has been taken to increase learning and prevention of a similar event within the team providing the care
      • What action has been taken to increase learning and prevention of a similar event within the team providing the care and also opportunities for sharing of learning with others
      • Is there any learning which could be identified and distributed to enhance care across the organisation
N.B.

- The Pressure Ulcer Incident Reporting Form (PU1) and RCA must be submitted to the Risk Management Team within 5 working days
- If a pressure ulcer deteriorates from one grade to another then a further incident form must be completed and submitted. The form must also state that the ulcer has been reported previously.

12. Definition of Unavoidable Pressure Ulcer

12.1. Unavoidable means that the individual developed a pressure ulcer even though the individual's condition and pressure ulcer risk had been evaluated; goals and recognised standards of practice that are consistent with individual needs has been implemented; the impact of these interventions had been monitored, evaluated and recorded; and the approaches had revised as appropriate.

12.2. Critical illness with haemo-dynamic or spinal instability may preclude turning or repositioning and lead to unavoidable pressure ulcers.

12.3. Patients who refuse to be repositioned or to maintain a position change may also develop unavoidable pressure ulcers.

12.4. Patients following the Liverpool Care Pathway or who meet the criteria are deemed to be terminally ill and may not be able to tolerate repositioning at the optimum frequency for pressure ulcer prevention. In these cases, pressure damage may be an unavoidable consequence of their terminal status as the condition of skin failure does exist.

12.5. Unavoidable damage is also possible where the patient has:
   a) • Not previously been seen by a health care professional.
   b) • Has mental capacity and has refused assessment and / or has not complied with the agreed plan of care.
   c) Unavoidable damage would also be possible where the patient is known to a health care professional but an acute / critical event occurs affecting mobility or the ability to reposition. This may include the patient being undiscovered following
   d) • A fall
   e) • Loss of consciousness due to, for example unexpected collapse; drug misuse; alcohol misuse

(BHTVNF Draft 2 based on NPUAP 2009)

12.6. The agreement that a grade 3 or 4 pressure ulcer was unavoidable will be determined through the SI / RCA process, and signed off by the organisation's Director of Nursing or equivalent. This will then be ratified by the cluster Director of Nursing prior to submission to the SHA.

13. Pressure Relieving Equipment

13.1. Pressure relieving equipment aims to reduce the magnitude and/or duration of pressure between an individual and the support surface, which is referred to as the “interface pressure”.

13.2. Decisions about which pressure-relieving device to use should be based on cost considerations and an overall assessment of the individual. Guidance on the choice of equipment can be found at Appendix 5. Holistic assessment should include all of the following points, and should not be based solely on scores from risk assessment scales:
   a) ulcer assessment (severity)
b) level of risk: from holistic assessment
c) location and cause of the pressure ulcer
d) general skin assessment
e) general health status
f) lifestyle of the patient
g) ability of the patient to reposition themselves
h) availability of carer/health professional to reposition the patient
i) acceptability and comfort of the proposed pressure-relieving equipment to the patient and/or carer
j) cost

13.3. There are two main approaches to preventing pressure ulcers using pressure-relieving devices:
a) Continuous low pressure surfaces aim to mould around the shape of the individual to redistribute pressure over a greater surface area. – low-tech devices
b) Alternating pressure surfaces mechanically vary the pressure beneath the individual, so reducing the duration of the applied pressure. – high-tech devices

13.4. The provision of pressure-relieving devices needs a 24-hour approach. It should include consideration of all surfaces used by the patient.

13.5. There is no conclusive research evidence that any one pressure-relieving support technology is superior to another. However professional consensus recommends that:

13.6. All individuals assessed as being vulnerable or having a grade 1-2 pressure ulcer should, as a minimum provision, be placed on a high-specification foam mattress or cushion with pressure-reducing properties combined with very close observation of skin changes, and a documented positioning and repositioning regime.

13.7. If there is any perceived or actual deterioration of affected areas or further pressure ulcer development, alternating pressure equipment i.e. replacement or overlay or sophisticated continuous low pressure system – for example low air loss, air fluidised, air flotation should be used.

13.8. Depending on the location of ulcer, individuals assessed as having grade 3-4 pressure ulcers – including intact eschar where depth, and therefore grade, cannot be assessed – should, as a minimum provision, be placed on an alternating pressure mattress (replacement or overlay) or sophisticated continuous low pressure system

13.9. If alternating pressure equipment is required, the first choice should be an overlay system, unless other circumstances such as patient weight or patient safety indicate the need for a replacement system. N.B. To ensure maximum effect the inflated cells of the overlay must support the body weight of the patient in all bed positions (during use of backrest, knee break) and all patient positions (sitting up, side lying).

14. **Safe Use Of Pressure Relieving Mattresses**

14.1. When selecting pressure-relieving devices consider the following factors:
a) Ensure that the mattress does not elevate the individual to an unsafe height in relation to bed rails if used.
b) For individuals requiring bed rails, AP overlay mattresses should be placed on a reduced-depth foam mattress.
c) Ensure that the individual is within the recommended weight range for the mattress.
14.2. Children and alternating pressure:
   a) Cell size of mattress – small children can sink into gaps created by deflated cells causing discomfort and reducing efficacy.
   b) Position of pressure sensors within the mattress in relation to the child – small children positioned at the top of the mattress may not register as the weight sensor is positioned in the middle of the mattress, thus producing inappropriate cell calibration.
   c) Many alternating pressure mattresses have a permanently inflated head end which may place the occiput at risk in young children.

15. Ordering Equipment
15.1. Pressure relieving equipment is supplied by the Suffolk Community Equipment Store (CES). The store does not provide information regarding pressure relieving equipment issued by CES and requires all staff ordering equipment to have a level of knowledge to be able to make an informed decision about what equipment to supply to meet the patient’s individual needs. Guidance regarding the choice of equipment can be found at Appendix 5.
15.2. The on-line catalogue for CES contains the following pressure relieving equipment
   • R019 Anti Pressure Replacement Mattress (£89.00)
   • R235 Foam Overlay – Single (£49.00)
   • R237 Foam Overlay – Double (£110.00)
   • R255 Foam Cushion- (£11.50)
   • R405 Repose Cushion (£43.00)
   • R410 Repose Mattress (£73.71)
   • R415 Repose Foot Protectors (£56.16)
   • R450 Transair 2002 Dynamic Mattress Replacement System (£2135.25)
   • R475 Transair 1001 Dynamic Mattress Overlay System (£612.50)
   • R490 Transair 250 Dynamic Cushion System (£214.50)
   • R420 Transwave R240 Supreme Mattress (£173.90)

16. Wound Assessment And Care
16.1. Patients with pressure ulcers should receive an initial and ongoing pressure ulcer assessment. Where a cause is identified strategies should be implemented to remove/reduce these. Ulcer assessment should include:
   • cause of ulcer
   • site/location
   • dimensions of ulcer
   • stage or grade
   • exudate amount and type
   • local signs of infection
   • pain
   • wound appearance
   • surrounding skin
16.2. Where possible photography should be used. Patient consent will be required and procedures followed for the storage of photographic material
16.3. The dimensions of the pressure ulcer should be measured recording the longest length/longest width as an estimate of surface area (use of tracings); the deepest part of the wound should also be measured using a sterile probe.

16.4. Reassessment of the ulcer should be performed at least weekly but may be required more frequently, depending on the condition of the wound and the result of holistic assessment of the patient.

16.5. Wound care should create the optimum wound healing environment by using current dressings – for example hydrocolloids, hydrogels, hydrofibres, foams, films, alginates, soft silicones – in preference to basic dressing types – for example gauze, paraffin gauze and simple dressing pads.

16.6. The functions of an ideal dressing:
   a) Allows excess exudate to be removed from the wound surface.
   b) Provides a moist micro-environment.
   c) Is sterile/contaminant free.
   d) Does not shed dressing material in the wound.
   e) Reduces wound pain.
   f) Is easy to remove and apply.
   g) Does not cause allergic reactions.
   h) Causes no trauma when removed.
   i) Is impermeable to micro-organisms.
   j) Provides thermal insulation.

17. Mobility and positioning

17.1. Mobilising, positioning and repositioning interventions should be considered for all individuals with pressure ulcers (including those in beds, chairs and wheelchairs).

17.2. All patients with pressure ulcers should actively mobilise, change their position or be re-positioned frequently.

17.3. Avoid positioning individuals directly on pressure ulcers or bony prominences (commonly the sites of pressure ulcer development).

17.4. Mobilising, positioning and re-positioning interventions should be determined by:
   a) general health status
   b) location of ulcer
   c) general skin assessment
   d) acceptability (including comfort) to the patient, and
   e) the needs of the carer.
   f) Frequency of re-positioning should be determined by the patient’s individual needs and recorded – e.g. a turning chart.

17.5. Passive movements should be considered for patients with pressure ulcers who have compromised mobility.

18. Nutritional support

18.1. Nutritional support/supplementation for the treatment of patients with pressure ulcers should be based on:
   a) nutritional assessment (using a recognised tool, e.g. "MUST" Tool)
b) general health status  
c) patient preference, and  
d) expert input supporting decision-making (dietician or specialists).

18.2. Nutritional support should be given to patients with an identified nutritional deficiency.

19. Patient Education And Information

Patients should be educated in the prevention of pressure ulcers. A patient advise leaflet is available at:
  
  http://www.suffolkextranet.nhs.uk/LinkClick.aspx?fileticket=Vj5m1UuY71s%3d&tabid=1109&mid=2418

20. References

- NHS Midlands and East Our Ambitions  
- NHS Midlands and East Pressure Ulcer Web-path http://www.stopthepressure.com/path
- NHS Institute for Innovation and Improvement (2009) High Impact Actions for Nursing and Midwifery – Your skin matters
Appendix 1: Anderson Screening Tool

Andersen Pressure Ulcer Risk Assessment

Name: ____________________________
Address: ____________________________
Date of Birth: ____________________________
NHS Number: ____________________________

Tick relevant factors
Score of 2 more = at risk

Absolute Score (Score 2 for each)

Not conscious
Orthopaedic trauma / surgery (major)
Rehydration necessary
Tetraplegic / paralysis
Having difficulty to or won’t move

Relative score (score 1 for each)

Limb mobility restricted
Incontinent
Nutritionally deficient / emaciated / obese
Discoloured over boney prominences
Seventy years old or more

Total risk score

Date: ____________________________
Signature: ____________________________
Signed by: ____________________________

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Appendix 2: Waterlow Assessment Tool (2005)

**WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY**

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

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<thead>
<tr>
<th>BUILD/WEIGHT FOR HEIGHT</th>
<th>SKIN TYPE VISUAL RISK AREAS</th>
<th>SEX AGE</th>
<th>MALNUTRITION SCREENING TOOL (MST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE BMI = 20-24.9</td>
<td>HEALTHY</td>
<td>MALE</td>
<td>A - HAS PATIENT LOST WEIGHT RECENTLY</td>
</tr>
<tr>
<td>ABOVE AVERAGE BMI = 25-29.9</td>
<td>TISSUE PAPER</td>
<td>1</td>
<td>0.5 - 5kg</td>
</tr>
<tr>
<td>OBESE BMI &gt; 30</td>
<td>DRY</td>
<td>FEMALE</td>
<td>5 - 10kg</td>
</tr>
<tr>
<td>BELOW AVERAGE BMI &lt; 20</td>
<td>OEDEMATOUS</td>
<td>2</td>
<td>10 - 15kg</td>
</tr>
<tr>
<td>BMI = Wt(Kg)/Ht (m)²</td>
<td>CLAMMY, PYREXIA</td>
<td>1</td>
<td>&gt; 15kg</td>
</tr>
<tr>
<td></td>
<td>DISCOLOURED</td>
<td>1</td>
<td>unsure</td>
</tr>
<tr>
<td></td>
<td>GRADE 1</td>
<td>2</td>
<td>C - PATIENT EATING POORLY OR LACK OF APPETITE</td>
</tr>
<tr>
<td></td>
<td>BROKEN/SPOTS</td>
<td>3</td>
<td>‘NO’ = 0; ‘YES’ SCORE = 1</td>
</tr>
<tr>
<td></td>
<td>GRADE 2-4</td>
<td>3</td>
<td>NUTRITION SCORE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>if &gt; 2 refer for nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>assessment / intervention</td>
</tr>
<tr>
<td>CONTINENCE</td>
<td>MOBILITY</td>
<td>SPECIAL RISKS</td>
<td>TISSUE MALNUTRITION</td>
</tr>
<tr>
<td>COMPLETE/</td>
<td>FULLY</td>
<td>TERMINAL CACHEXIA</td>
<td></td>
</tr>
<tr>
<td>CATHETER SED</td>
<td>RESTLESS/FIDGETY APATHETIC</td>
<td>8</td>
<td>DIABETES, MS, CVA</td>
</tr>
<tr>
<td>URINE INCONT,</td>
<td>RESTRICTED</td>
<td>MULTIPLE ORGAN FAILURE</td>
<td></td>
</tr>
<tr>
<td>FECAL INCONT.</td>
<td>BEDBOUND</td>
<td>8</td>
<td>MOTOR/SENSORY</td>
</tr>
<tr>
<td>URINARY + FECAL</td>
<td>e.g. TRACTION</td>
<td>SINGLE ORGAN FAILURE (RESP. RENAL, CARDIAC)</td>
<td></td>
</tr>
<tr>
<td>INCONTINENCE</td>
<td>CHAIRBOUND</td>
<td>5</td>
<td>PARAPLEGIA (MAX OF 6)</td>
</tr>
<tr>
<td>0</td>
<td>e.g. WHEELCHAIR</td>
<td>4</td>
<td>MAJOR SURGERY or TRAUMA</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>3</td>
<td>ORTHOPAEDIC/SPINAL</td>
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<td>ON TABLE &gt; 2 HR#</td>
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<tr>
<td>3</td>
<td></td>
<td>1</td>
<td>ON TABLE &gt; 8 HR#</td>
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<tr>
<td>5</td>
<td></td>
<td>5</td>
<td>MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4</td>
</tr>
</tbody>
</table>

© J Waterlow 1985 Revised 2005

Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX

* The 2005 revision incorporates the research undertaken by Queensland Health.

N.B. Weight loss score = unintentional; Medication score = 4 if any factors apply
Waterlow Score Sheet - add scores using score card above and put totals on table below

<table>
<thead>
<tr>
<th>Date</th>
<th>Build/ Weight for height</th>
<th>Continence</th>
<th>Skin Type/ Visual Risk Areas</th>
<th>Mobility</th>
<th>Sex / Age</th>
<th>Malnutrition Screening Tool</th>
<th>Special Risks Tissue malnutrition</th>
<th>Neurological Deficit</th>
<th>Major Surgery/ Trauma</th>
<th>Medication</th>
<th>TOTAL</th>
<th>Action/ Equipment ordered (type)</th>
<th>Equipment supplied (date)</th>
<th>Signature/ Designation</th>
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</table>
Pressure Ulcer Grading

**EPUAP - Category/Grade 1**
- Non-blanchable erythema of intact skin: 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 ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).

**EPUAP System - Category/Grade 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.

*Bruising appearance and blood filled blister would indicate deep tissue injury.*

**EPUAP - Category/Grade 3**
- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.
- **Plus: Unclassified PU – now Grade 3**
  - 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 cannot be determined; but it will be either grade 3 or 4.
  - Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as ‘the body natural (biological) cover’ and should not be removed.
  - Should be documented as grade 3 until proven otherwise.

**EPUAP – Category/Grade 4**
- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow.
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).

**Moisture Lesions**
- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.
Appendix 4: Prevention Guidelines

Guidelines for the Prevention of Pressure Ulcers
(Adapted from EPUAP & NPUAP 2009)

1. Introduction

Most pressure ulcers are avoidable.

Avoidable means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- Evaluate the person’s clinical condition and pressure ulcer risk factors
- Plan and implement interventions which are consistent with the person’s needs and goals, and recognised standards of practice.
- Monitor and evaluate the impact of the interventions
- Or revise the interventions as appropriate (DH England)

A pressure ulcer is defined as an area of localised damage to the skin and the underlying tissue caused by pressure, shear, friction and / or a combination of these factors. In adults damage usually occurs over bony prominences.

Whilst the evidence for preventing pressure ulcers has some limits it is generally agreed the key components of prevention are:

- Surface
- Skin care
- Keep patient moving
- Incontinence / continence
- Nutrition and hydration

It is these components which form the basis of the prevention bundle. (Appendix 1)

This guideline should be read in conjunction with local protocols

2. Risk Assessment Policy

a. Each health care organisation must have a policy in place which includes

- A structured approach to risk assessment which is relevant to the healthcare setting and clinical areas,
- The timing of risk assessments and reassessment,
- Documentation of risk assessment and
- Clear communication processes to inform the wider health care team.

b. An education process, which ensures the achievement of an accurate and reliable risk assessment.

c. Documentation which acts as a communication method within the team provides evidence that care planning is appropriate and serves as a benchmark for monitoring the individual’s progress.

3. Risk Assessment

a. Organisations will need to use appropriate screening and risk assessment tools for the different patient groups they care for.

b. All patients should be assessed for their risk of developing a pressure ulcer.

c. The recommended screening assessment tool to be used is Andersen
Appendix 5: Prevention Flowchart

Prevention flowchart

Screen
Use Andersen

Risk assess
Use Braden (B) or Waterlow (W)
or use your equivalent risk assessment tool

high risk (B) V high risk (W)
medium risk (B) high risk (W)
low risk (B) at risk (W)

Prevent
Commence prevention bundle
Follow care plan

Review as per plan or if patient’s condition changes

Patient discharged from care
Pressure ulcer occurs
No pressure ulcers. Continue prevention bundle and care plan.

Note: Complete a transfer sheet
## Appendix 6: SSKIN Prevention Bundle

**SSKIN pressure ulcer care bundle**

Use in conjunction with Pressure Ulcer care plan

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Postcode:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of birth:</th>
<th>NHS Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trust/hospital:**

**Teammwd:**

**Care delivered? ✓ or X (If X, record reasons why not overleaf)**

<table>
<thead>
<tr>
<th>Data (DD/MM/YY)</th>
<th>Time — use 24 hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Surface**
- Mattress appropriate (please state)
- Cushion appropriate (please state)
- Functionality/integrity check of equipment performed

**Skin inspection**
- Skin management

**Keep Moving**
- Use of repositioning chart

**Incontinence/Moisture**
- Urine
- Bowels
- Sweat

**Nutrition/Hydration**
- Diet (please state)
- Fluids (please state)

**Is referral required?**
- If yes, has it been made?
- Do care plans need updating?
- If yes, has this been done?

**Initials**

---

S:\Provider\Quality Governance\Clinical Policies\2. CURRENT APPROVED POLICIES\Updated Serco Policies for Intranet\Pressure Ulcer Policy+EOE Serco.doc 7
Appendix 7: Treatment Guidelines

Guidelines for the Treatment of Pressure Ulcers

(Adapted from EPUAP & NPUAP 2009)

This guidance should be read in conjunction with your local dressing formulation and anti-biotic prescribing guidelines.

1. Definitions and Grading

A pressure ulcer is defined as an area of localised damage to the skin and the underlying tissue caused by pressure, shear, friction and / or a combination of these factors. In adults damage usually occurs over bony prominences.

Pressure ulcers can be described as a category or grade ranging from 1 to 4. The grading definitions can be found at appendix 1.

2. Distinguishing between moisture lesions and pressure ulcers

a. If damage not associated with pressure, friction or shear is noted, other possible causes need to be identified, such as epidermal stripping due to traumatic removal of tapes or dressings, eczematous skin, sweat or incontinence.

b. The difference between pressure damage and moisture damage may be distinguished by location, shape and depth.

<table>
<thead>
<tr>
<th>Causes</th>
<th>Likely to indicate a pressure ulcer</th>
<th>Likely to indicate a moisture lesion</th>
</tr>
</thead>
<tbody>
<tr>
<td>If pressure / shear and moisture are simultaneously present, the ulcer could be a combination lesion.</td>
<td>Pressure and / or shear present.</td>
<td>Moisture present.</td>
</tr>
<tr>
<td>Urine, faeces, sweat and / or exudate.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Likely to indicate a pressure ulcer</th>
<th>Likely to indicate a moisture lesion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A combination of friction moisture can result in moisture lesions in skin folds.</td>
<td>Tends to be located over a bony prominence.</td>
<td>Limited to the anal cleft and has a linear shape.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not located over a bony prominence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peri-anal erythema and skin faecal matter.</td>
</tr>
<tr>
<td>Likely to indicate a pressure ulcer</td>
<td>Likely to indicate a moisture lesion</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Shape</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to one spot.</td>
<td>Diffuse – different superficial spots.</td>
<td></td>
</tr>
<tr>
<td>Circular or regular shape, with the exception of friction damage.</td>
<td>In a kissing ulcer shape.</td>
<td></td>
</tr>
<tr>
<td><strong>Depth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial-thickness skin losstop layer (grades 1 &amp; 2).</td>
<td>Superficial partial-thickness skin loss – which can deepen if infected.</td>
<td></td>
</tr>
<tr>
<td>Full thickness skin loss (grades 3 &amp; 4).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Necrosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occurs with pressure ulcers.</td>
<td>No necrosis in moisture lesions.</td>
<td></td>
</tr>
<tr>
<td><strong>Edges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edges tend to be distinct.</td>
<td>Often irregular lesions – diffused or irregular edges.</td>
<td></td>
</tr>
<tr>
<td>Friction is exerted on a moisture lesion, it will result in superficial skin loss.</td>
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<td></td>
</tr>
<tr>
<td><strong>Colour</strong></td>
<td></td>
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</tr>
<tr>
<td>Red skin non-blanching (grade 1).</td>
<td>Erythema.</td>
<td></td>
</tr>
</tbody>
</table>

3. **Pressure ulcer assessment**

   a. Complete an initial assessment of the patient with a pressure ulcer to include:

      - The patient’s goals of care. If the patient is unable to advise, consult with the family or significant others.
      - A complete health / medical and social history.
      - A focused physical examination which includes:
        - Skin assessment.
        - Factors which may affect healing (e.g. impaired perfusion,
impaired sensation, systemic infection).
- Vascular assessment in the case of extremity ulcers (e.g. history of claudication, and ankle brachial index or toe pressure).
- Laboratory tests and x-rays as required.

Nutrition assessment.

Pain related to pressure ulcers.

Risk for developing additional pressure ulcers.

Psychological health, behaviour and cognition.

Functional capacity, particularly in regard to positioning, posture and the need for assistive equipment and personnel.

The employment and adherence to pressure relieving manoeuvres.

Integrity of seating and bed surfaces.

Patient and carers knowledge re pressure ulcers.

b. With each dressing change. Observe the pressure ulcer for developments which may indicate the need to change the treatment e.g. wound improvement or deterioration, more or less exudate, signs of infection.

c. Assess and accurately document physical characteristics such as location, grade, size, tissue type/s wound bed and peri-wound condition, wound edges, sinus tracts, undermining, tunnelling, exudate necrotic tissue, odour, presence / absence of granulation tissue and epithelisation.

d. Measuring the pressure ulcer

Position the patient in a consistent neutral position for wound measurement.

Select a uniform consistent method for measuring the wound to facilitate meaningful comparisons of wound measurements over time (Refer to local guidelines).

e. Use the findings to plan interventions that will best meet the patient’s goals. Treatment needs will alter overtime as the pressure ulcer heals or deteriorates. Treatment strategies should be continuously re-evaluated based on the current status of the pressure ulcer.

4. Methods for monitoring healing

Assess progress towards healing. Consider using one or more of the following methods.

a. Local wound assessment tools or international validated tools e.g. PUSH tool (see Appendix 2).

b. Use clinical judgement to assess signs of healing e.g. decreasing amount of exudate, change in size and improvement in tissue type.
5. Role of nutrition and hydration in pressure ulcer healing

5.1 Screening and assessment for nutrition

a. Screen and assess the nutritional status of the patient with a pressure ulcer at admission and if their condition changes.

b. An example of nutritional assessment is at Appendix 4 – the MUST tool.

5.2 Screening and assessment for hydration.

a. Screen and assess the hydration status of the patient with a pressure ulcer on admission and if their condition changes.

6. Pain assessment and management

6.1 Assess for pain

a. Pressure ulcers are painful. Use local guidance to assess pain.

b. Assess all patients for pain related to a pressure ulcer or its treatment using a validated scale. Examples can be found at appendix 7.

c. An assessment of pain should include an assessment of body language and nonverbal clues e.g. change in activity, loss of appetite, guarding, grimacing and moaning.

6.2 Prevent pain

a. Use a lift or transfer sheet i.e. sliding sheet, to minimise friction and / or shear when repositioning a
patient, keeping bed linen smooth and unwrinkled.

b. Position the patient off of the pressure ulcer whenever possible.

c. Avoid postures which increase pressure, such as fowler’s position greater than 30 degree or 90 degree side-lying position or the semi-recumbent position.

1. Supine  □  or Semi-Fowler’s position  □
   Please indicate degree angle of profile i.e. 45%

2. Left side 30 degree tilt □
3. Right side 30 degree tilt □

4. Chair sitting □
   *Avoid longer than 2 hours at any one time

(Repositioning example from Bedford Hospital NHS Trust)

d. Minimise pressure ulcer pain by handling all wounds gently; flushing and not rubbing unnecessarily during cleansing; and protecting the periwound skin.

6.3 Management of general pain

a. Organise care delivery to ensure that it is coordinated with pain medication administration and that minimal interruptions follow. Set priorities for treatment.

b. Encourage patients to request a “time out” during any procedure that causes pain.

c. Reduce pressure ulcer pain by keeping the wound bed covered and moist, and using a non-adherent dressing. (note: stable dry eschar is usually not moistened.

d. Use dressings less likely to cause pain and/or those likely to require less frequent dressing changes e.g. hydrocolloids, hydrogels, alginates, polymeric membrane foams, foam soft silicone dressings and ibuprofen-impregnated dressings.

e. For a patient in pain from a pressure ulcer music, meditation, distraction, conversations and guided imagery are sometimes beneficial.

f. Administer pain medication regularly, in the appropriate dose, to control chronic pain following the world health organisation dosing ladder.

g. Encourage repositioning as a means to reducing pain.

h. Manage persistent pressure ulcer pain (Neuropathic) with a local anaesthetic or an adjuvant
(antidepressant or antiepileptic) as well as with transcutaneous nerve stimulation, warm applications or tricyclic antidepressants.

i. Refer the individual with pain to the appropriate professional.

7. Support surfaces for treatment of pressure ulcers

a. Selection of support surfaces is complex and cannot be determined solely on the basis of grade of the ulcer. Please refer to local guidelines.

7.1 Support surfaces

a. Provide a support surface that is properly matched to the patient’s needs for pressure redistribution, shear and friction.

b. Evaluate the appropriateness and functionality of the support surface on every patient contact.

c. Choose positioning devices and incontinence equipment which is compatible with the support surface.

7.2 Positioning

a. Document each repositioning activity after it has taken place.

b. Do not position a patient directly on a pressure ulcer.

c. Continue to turn and reposition the patient regardless of the support surface in use. Establish turning frequency based on the patients response and document repositioning.

d. Consider pressure impact of equipment on skin e.g. masks, cannula’s, tubing, at each repositioning event.

e. Inspect the skin each time the patient is turned / repositioned. Do not turn the patient onto a body surface which is already damaged or still reddened from a previous episode, especially if the area of redness does not blanche.

f. Limit head of bed elevation to 30 degrees for an individual on bed rest, unless contraindicated by medical condition. Encourage individuals to sleep in a 30-40 degree side-lying position or flat in bed if not contraindicated.

g. Use transfer aids i.e. sliding sheet to reduce friction and shear, Lift – don’t drag – the individual while repositioning. Do not leave moving and handling equipment under the patient after use.

h. Increase activity as rapidly as is tolerated.

i. Do not leave the patient on a bed pan longer than necessary.

j. Do not use ring or donut-shaped devices.

k. Do not apply heating devices (e.g. hot water bottles, heating pads, built in bed warmers) directly onto pressure ulcers. Heat increases the metabolic rate, induces sweating and decreases the tolerance of the
tissue for pressure. When the body heat cannot dissipate, it will increase the risk of skin maceration and may impede healing.

10. Dressings

Refer to local formulary. An example of a chronic wound toolkit can be found in appendix 8.

General recommendations

a. Assess pressure ulcers at every dressing change and confirm the appropriateness of the current dressing regime. Document findings and any changes to care plan.

b. Follow manufacturers recommendations, especially related to frequency of dressing change.

c. The plan of care should guide usual dressing wear times and patient preference, and contain plans for dressing changes as needed (for the family, patient, clinicians) due to spoilage, loosening etc.

9. Debridement

a. Debridement should be carried out by trained personnel only.

b. Do not debride stable hard dry eschar in ischaemic limbs or diabetic digits. Assess the wound daily for signs of erythema, tenderness, oedema, purulence, fluctuance, crepitation and/or malodour (i.e. signs of infection).

c. Dry eschar may be left in situ for patients who are following the Liverpool care pathway (LCP) or where removal conflicts with other care objectives.

11. Specialist patient groups

Additional guidelines can be found in appendix 9 for treating pressure ulcers for specialist patient groups, identifying those who:

a. are critically ill
b. have spinal cord injuries
c. are bariatric patients
d. require palliative care.

An example of a Integrated Liverpool Care Pathway can be found in appendix 10.
Appendix 8: Treatment Flowchart

Treatment flowchart

Grade pressure ulcer

Grade 1
Grade 2
Grade 3 or 4

Moisture lesions

Complete incident form (local)
Complete Serious Incident (SI) form

Follow local procedure

Treat

Commence treatment bundle

Follow care plan

Review as per plan or if patient's condition changes

Patient discharged from care
Pressure ulcer healed

Complete a transfer sheet

Revert to prevention bundle and care plan
Pressure ulcer healing

Not improving, review care plan
### Appendix 9: SSKIN Treatment Bundle

**SSKIN pressure ulcer care bundle**

**Treatment**

*Use in conjunction with Pressure Ulcer care plan*

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Postcode:</th>
<th>Date of birth:</th>
<th>NHS Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Trust/hospital:</th>
<th>Team/ward:</th>
</tr>
</thead>
</table>

Core delivered? ✓ or ✗ (If ✗, record reasons why not overleaf)

<table>
<thead>
<tr>
<th>Date (DD/MM/YYYY)</th>
<th>Time – use 24 hour clock</th>
<th>Surface</th>
<th>Skin Inspection</th>
<th>Nutrition/Hydration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mattress appropriate (please state)</td>
<td>Skin management</td>
<td>Diet (please state)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cushion appropriate (please state)</td>
<td>PU wound management</td>
<td>Fluids (please state)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Functionality/integrity check of equipment performed</td>
<td>Use of repositioning chart</td>
<td>Referral made (in accordance with local guidelines)</td>
</tr>
</tbody>
</table>

**Keep Moving**

Use of repositioning chart

**Incontinence/Moisture**

Urine

Bowel

Sweat

**Initials**

Do care plans need updating?

If yes, has this been done?
## Appendix 10: Screening/ Risk Assessment Audit Tool

### Initial Assessment of Risk Compliance & Audit Tool

**Ward/Care home/Patient home:**

<table>
<thead>
<tr>
<th>Ward/Care home/Patient home:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

![Audit Tool Image](image-url)

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Non-compliance</th>
<th>X</th>
</tr>
</thead>
</table>

### Risk Assessment

<table>
<thead>
<tr>
<th></th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there evidence the patient has been screened?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Had a risk assessment undertaken within the agreed timescale?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Was a Prevention plan put into place?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Compliance (Y/N)**

### If patient has a pressure ulcer

<table>
<thead>
<tr>
<th></th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Was grading tool used?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Was reporting/S1 process followed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Compliance (Y/N)**

### If the patient is assessed and deemed to be at risk undertake Audit tool 2 for prevention or Audit tool 3 for a patient with an existing pressure ulcer.

<table>
<thead>
<tr>
<th>Audit tool 2 required (Y/N)</th>
<th>Audit tool 3 required (Y/N)</th>
</tr>
</thead>
</table>

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## Appendix 11: SSKIN Prevention Bundle Audit Tool

### Prevention SSKIN Care Bundle Compliance & Audit Tool

**Audit tool 2**

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✗</td>
</tr>
</tbody>
</table>

If there is non-compliance with this statement but there is evidence in the treatment bundle evidence why this occurred this should still be recorded as compliance.

<table>
<thead>
<tr>
<th>Surface Compliance (Y/N)</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the rationale for the choice of support surface documented?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is the prescribed equipment being utilised?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is there evidence all the equipment is checked to ensure it is functioning properly at agreed time intervals?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is there documented evidence that choice of all the equipment has been discussed with the patient (where they have capacity or if not with the care team)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin Inspection Compliance (Y/N)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there evidence of a skin inspection being completed within 6 hours of decision to admit or first visit within community?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. If patient is deemed to be at risk is there:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) A care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Evidence skin review undertaken in line with care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Keep Moving Compliance (Y/N)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a requirement for repositioning identified in care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12: SSKIN Treatment Bundle Audit Tool

Treatment SSKIN care bundle Compliance & Audit Tool

Audit tool 3

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Non-compliance</th>
</tr>
</thead>
</table>

- **Ward/Care home/Patient home**
- **Date:**
- **Time:**

---

**Surface**

1. Is the rationale for the choice of support surface documented?
2. Is the prescribed equipment being utilised?
3. Is there evidence all the equipment is checked to ensure it is functioning properly at agreed time intervals?
4. Is there evidence the surfaces have been reviewed for effectiveness?
5. Is there documented evidence that choice of all the equipment has been discussed with the patient (where they have capacity or if not with the carer)?

**Surface Compliance (Y/N)**

---

**Skin/Wound Management**

1. Is there evidence of a skin inspection being completed at the time of initial assessment?
2. Is there evidence of recording the size of the wound at prescribed intervals in line with the care plan?
3. Is the wound dimension being plotted?

---

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---

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
<th>Total %</th>
</tr>
</thead>
</table>

---

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Appendix 13: Pressure Ulcer Reporting Guidance

All pressure ulcers are to be reported to the Risk Management Team on a PU1 Incident Form regardless of their grade or where the patient first developed their ulcer. Within 5 working days

Safeguarding referral required?

Yes

Complete Safeguarding referral

No

Pressure ulcer developed in SCH care (definition of “in our care” is “all patients who receive an intervention or support by a member of our staff within 72 hours of admission or first contact with the patient”?

Yes

No further action required

No

All Grade 2 pressure ulcers developed in SCH care to have an RCA completed by the team providing the care

All Grade 3 and above pressure ulcers: Quality & Governance Team will co-ordinate a member of staff from an outside team to complete an RCA

Pressure Ulcer Incident Form received by Risk Management Team

On completion of SIRI/RCA Chief Nurse will review Root Causes and Action Plan with Team Lead

Action Plan will be signed off by Lead Nurse following a meeting with the team lead and other team members once there is evidence that the actions have been completed
The Incident Form and RCA are used to monitor and report pressure ulcers to the NPSA and NHS Suffolk.

Therefore, they MUST contain the following information:

**The Incident Form:**
- Location of patient i.e. name of residential home, patient’s own home, inpatient unit, clinic
- Date ulcer identified
- Clinical speciality providing the care i.e. LCT/Inpatient unit/D&T
- General condition of patient
- Location of pressure ulcer
- Grade of pressure ulcer
- What action has been taken to relieve the pressure ulcer
- What treatment has commenced for the pressure ulcer
- What advice/education has been given to family/carers to promote healing
- What could have been done to prevent the ulcer
- What actions have been taken to prevent an event like this recurring

**The RCA:**
Confirm all of the above and include any missing information plus:
- Confirm the patient was within our care when the ulcer was identified
- What action has been taken to increase learning and prevent a similar event within the team providing the care and also opportunities for sharing learning with others
- Is there any learning which could also be identified and distributed to enhance care across the organisation?

**The Safeguarding Referral:**
Guidance relating to the identification of vulnerable adults and identification and reporting of abuse can be found in the Adult Safeguarding Policy on the SCH Intranet (*Home/Policies/Clinical Policies/Adults Children Safeguarding Policies*)
Appendix 14: Guidance regarding safeguarding issues

Aspects to consider as to whether the Safeguarding Adults Policy and Procedures need to be instigated where the development of pressure ulcers may have resulted from neglect of care.

The person has a grade 3 or 4 pressure ulcer

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Question 2</th>
<th>Question 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there concerns that all reasonable steps have NOT been taken to prevent the pressure ulcer?</td>
<td>If the person is a Vulnerable Adult? i.e. is aged over 18 and is or may be in need of community care or support services by reason of mental or other disabilities, age or illness and who is unable to take care of him/herself or unable to protect him/herself against significant harm or exploitation.</td>
<td>Is there evidence of neglect? Not all pressure ulcers in a vulnerable adult are the result of neglect. Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care such as: • Lack of appropriate equipment • Nutritional assessments • Staff awareness of wound development and care • Manual handling • Consideration of person's capacity and concordance to planned treatment</td>
</tr>
<tr>
<td>Care given should be assessed against available local and national guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A second opinion should be sought if necessary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer to all 3 question is ‘YES’ then the Safeguarding Adults Policy and Procedures must be instigated and a strategy discussion / meeting convened
## Appendix 15: Guide to choosing pressure relieving equipment

<table>
<thead>
<tr>
<th>Waterlow</th>
<th>Skin Condition</th>
<th>Mobility</th>
<th>Time spent out of bed</th>
<th>Repositioning</th>
<th>Cushion</th>
<th>Mattress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal risk</strong> (Waterlow &lt;10)</td>
<td>Skin intact</td>
<td>Good</td>
<td>Unrestricted</td>
<td>Provide patient information leaflet</td>
<td>N/A</td>
<td>Standard</td>
</tr>
</tbody>
</table>

| At Risk (Waterlow 10+) | Skin intact | Good | Restricted to a max. of 2 hours at any one time | **If patient able to turn from side to side:**
Provide patient information leaflet & Advise patient to:
- Move from side to side in bed
- Stand every 15-20 minutes when sitting out to relieve pressure | Static cushion if required | Pressure reducing static mattress |

| High Risk (Waterlow 15+) | Skin intact | Good | | **If patient able to turn from side to side unaided:**
Provide patient information leaflet & Advise patient to:
- Move from side to side in bed
- Stand every 15-20 minutes when sitting out to relieve Pressure | Static cushion if required | Pressure reducing static mattress (if patient deteriorates upgrade to mattress replacement) |

| Very High Risk (Waterlow 20+) | Skin intact | Good | | **If patient able to turn from side to side unaided:**
Provide patient information leaflet & Advise patient to:
- Move from side to side in bed
- Stand every 15-20 minutes when sitting out to relieve Pressure | Static cushion if required | Pressure reducing static mattress (if patient deteriorates upgrade to mattress replacement) |

**NB.** In occasional cases, it maybe that the only suitable option would be an alternating overlay mattress. In this case, please ensure that the mattress does not elevate the patient to an unsafe height and ensure that all appropriate Trust risk assessments are completed.
INFORMATION SHEET FOR PATIENT, FAMILY, CARERS REGARDING CARE OF:

ALTERNATING AIR MATTRESS \ CUSHION

Please make the following checks daily. If you have any questions do not hesitate to ask the health professional who provided this equipment. They will guide you to your own personal needs:

- Ensure you read the instructions given with the power unit and any information on the label attached to it
- Power supply – ensure connected at all times
- Weight or hardness is set to your needs
- Clean by wiping down with soap and water
- Keep pets off your equipment as they can cause punctures
- In addition to this equipment you must protect your skin by moving regularly or redistributing your weight. Your visiting health professional will guide you on how you can do this and how often you should do this

If you have any problems please call

……………………………………………………………………………………………

If you are no longer using your equipment please call CES to collect it on:

……………………………………………………………………………………………
INFORMATION SHEET FOR PATIENT, FAMILY, CARERS
REGARDING CARE OF:

PROPAD CUSHION AND MATTRESS

Please make the following checks daily. If you have any questions do not hesitate to ask the health professional who provided this equipment. They will guide you to your own personal needs:

- Wiped down with detergent as needed
- Ensure the surface you sit or lie on is the surface with cubes on
- Avoid added layers between the cushion and you as this affects the usefulness of the cushion
- In addition to this equipment you must protect your skin by moving regularly or redistributing your weight. Your visiting health professional will guide you on how you can do this and how often you should do this

If you have any problems please call

-----------------------------------------------

If you are no longer using your equipment please call CES to collect it on:

-----------------------------------------------
INFORMATION SHEET FOR PATIENT, FAMILY, CARERS REGARDING CARE OF:

REPOSE CUSHIONS \ BOOTIES \ MATTRESS OVERLAY

Please make the following checks daily. If you have any questions do not hesitate to ask the health professional who provided this equipment. They will guide you to your own personal needs:

- Equipment is inflated as per instruction on the pump / tube. Re-inflate as necessary
- Secured using the straps to your bed or chair
- Wipe down with detergent as needed
- Keep pets off your equipment as they cause punctures
- Avoid added layers between your cushion and you as this affects the usefulness of the cushion
- In addition to this equipment you must protect your skin by moving regularly or redistributing your weight. Your visiting health professional will guide you on how you can do this and how often you should do this

If you have any problems please call

...........................................................................................................................................

If you are no longer using your equipment please call CES to collect it on:

...........................................................................................................................................

S:\Provider\Quality Governance\Clinical Policies\2. CURRENT APPROVED POLICIES\Updated Serco Policies for Intranet\Pressure Ulcer Policy+EOE Serco.doc
Appendix 17: Pressure Ulcer Reporting Form (PU1)

SUFFOLK COMMUNITY HEALTHCARE
PRESSURE ULCER INCIDENT REPORT
AND ROOT CAUSE ANALYSIS FORM

Team reporting pressure ulcer:

Date pressure ulcer discovered

Time pressure ulcer discovered (24 hrs)

Did pressure ulcer develop/deteriorate 72hrs after admission/transfer onto SCH caseload? (If Yes)

RCA on Page 2 are required for Grade 2 and above

Yes □ No □

Is an RCA required?

Yes □ No □

Is this an avoidable pressure ulcer?

Yes □ No □

<table>
<thead>
<tr>
<th>Site (e.g. Sacrum)</th>
<th>Wound size</th>
<th>Ulcer Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1.</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

Please mark the pressure ulcer sites with their numbers (from the above table) on the diagram.

Details of the person with the pressure ulcer:

- Forename
- Surname
- D.O.B.
- Ethnicity
- NHS No.

- Patients GP
- Address:
- Address is:
  - □ Patients own Home
  - □ Residential Home
  - □ Nursing Home
  - □ Other

Incident details:

- Is this a recurring ulcer?
- Is this a previously reported pressure ulcer that has deteriorated?
- Has a safeguarding referral been made?

Where was the patient when the pressure ulcer developed?

- □ Patients own Home
- □ Community Hospital
- □ Residential Home
- □ Nursing Home
- □ Acute Care
- □ Other

Details of the incident including diagnosis details, patients general condition, medication and outcome:

Actions taken and treatment given:

Equipment supplied:

Advice provided to patient, family or carers:

Name of person completing form:

Signature and date:

Name of Line Manager:

Signature and date:

Last updated 18/07/2012
PU1 RCA

PRESSURE ULCER ROOT CAUSE ANALYSIS (RCA)

Only to be completed for ulcers Grade 2 or above which have developed/deteriorated in SCH care

Patient name: ___________________________ NHS No.: ___________________________

Does the patient have formal carers? □ Yes □ No  Informal carers e.g. family? □ Yes □ No

What actions could have been taken to prevent this ulcer occurring?

What lessons have been learnt as a result of this ulcer occurring?

What were the causes of this pressure ulcer occurring e.g. discharge planning, staff training, equipment, end of life?

How often was the Waterlow score carried out before the incident was reported and by whom?:

Daily □ Alternate days □ Every 72 hours □ Weekly □ Monthly □ Other (give details):

Name and occupation of person completing Waterlow:

How often is Waterlow score carried out now and by whom?:

Daily □ Alternate days □ Every 72 hours □ Weekly □ Monthly □ Other (give details):

Name and occupation of person completing Waterlow:

Is a skin inspection now carried out at each visit? □ Yes □ No □ Frequency:

Patients elimination? □ Continent □ Catheter □ Incontinent of:

Moisture damage? □ Yes □ No □ Describe continence aids:

Nutrition and Hydration

MUST assessment completed and documented? □ Yes □ No □ Describe:

MUST score:

Advice given:

Peg feeding? □ Yes □ No □ Dietician referral? □ Yes □ No □ Date:

Pressure-relieving equipment in place? □ Yes □ No □ Type:

Pressure-relieving equipment required? □ Yes □ No □ Type:

Has there been a delay in obtaining equipment? □ Yes □ No □ Reason:

Patient compliant with using equipment? □ Yes □ No □

Has the appropriate care plan been completed? □ Yes □ No □ Review date:

Level of Mobility

Independent □ Assistance of: □ 1 □ 2 □ Bedbound □ Chairbound □

Approximate daily length of time in bed: ___________________________

Approximate daily length of time in chair: ___________________________

Advice given e.g. turning regime:

Patient compliant with advice? □ Yes □ No □

Patient information leaflet given? □ Yes □ No □

Name of person completing RCA: ___________________________

Signature and date: ___________________________

Name of Line Manager: ___________________________

Signature and date: ___________________________

Last updated 18/07/2012
**EQUALITY IMPACT ASSESSMENT (EQIA)**

1. **Component Summary**
   EQIA Completion Details

   **Component Title:** POLICY FOR: PREVENTION, MANAGEMENT AND REPORTING OF PRESSURE ULCERS
   **Component Status:** Proposed
   Associated Components (incl. ref no. and version no.):
   1. 
   2. 

   Names and Post Titles of staff involved in completing EQIA:
   - Fiona Whitfield, Lead Nurse
   - 
   Date: 26/7/11

2. **Component Details**

   Who is likely to be affected by the component:
   - Staff
   - Patients
   - Public

3. **Component Impacts**

<table>
<thead>
<tr>
<th>Probable impact on group?</th>
<th>High, medium, or low</th>
<th>Further details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race, ethnicity, nationality</td>
<td>Yes □ No √</td>
<td></td>
</tr>
<tr>
<td>Religion, belief, faith</td>
<td>Yes □ No √</td>
<td></td>
</tr>
<tr>
<td>Gender (inc. transgender), marital status</td>
<td>Yes □ No √</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>Yes □ No √</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Yes □ No √</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Yes □ No √</td>
<td></td>
</tr>
<tr>
<td>Other grounds: homelessness, gypsy / travellers, refugees / asylum seekers /migrant workers</td>
<td>Yes □ No √</td>
<td></td>
</tr>
</tbody>
</table>

4. **Differential Treatments Identified**

   Considering the type of differential treatment identified, is this discriminatory according to legislation? Yes □ (Complete all Section 4) No √ (Go to Section 5)

   Which legislative Act applies?
   1. Human Rights Act □
   2. Sex Discrimination Act □
   3. Race Relations Act □
   4. Disability Discrimination Act □
   6. Equal Pay Act □

   Is the discrimination identified direct or indirect? Direct □ Indirect □

   Is there a genuine occupational qualification ie is the discrimination justifiable? Yes □ No □
7. Sexual Orientation Regulations □  
8. Religion or Belief Regulations □  
9. Health and Safety Regulations  
10. Part-Time Employees Regulations  

<table>
<thead>
<tr>
<th>5. Type of Discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the type of discriminatory action identified is not unlawful, does it still have an adverse effect?</td>
</tr>
<tr>
<td>Yes □ go to section 6</td>
</tr>
<tr>
<td>No □ go to section 8</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>6. Specific Issues Identified</th>
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<tbody>
<tr>
<td>Please list the specific issues that have been identified as being discriminatory / promoting adverse differential treatment.</td>
</tr>
<tr>
<td>Page / paragraph / section of component that issue relates to</td>
</tr>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<th>7. Proposals</th>
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<tbody>
<tr>
<td>How could the identified adverse effects be minimised or eradicated?</td>
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</table>

If such changes were made, would this have repercussions / negative effects on other groups as detailed in Section 3? Yes □ No □ (if No go to section 8)

Please give details:

Would such changes ensure that the component complies with all relevant legislation, therefore making it legal and good practice? Yes □ No □

OR:

If component already complies with relevant legislation: Would such changes minimise negative differential treatment? Yes □ No □

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<tr>
<th>8. Component Implementation</th>
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<tbody>
<tr>
<td>Upon consideration of the information gathered within the EQIA, the Director agrees that the component should be adopted by the PCT.</td>
</tr>
</tbody>
</table>

Directors Signature:

Dawn Godbold  
Date: 26 July 2011  
Acting Chief Operating Officer

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<tr>
<th>9. Proposed Date for Component Review</th>
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<tbody>
<tr>
<td>Please detail the date for component review: July 2013</td>
</tr>
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</table>