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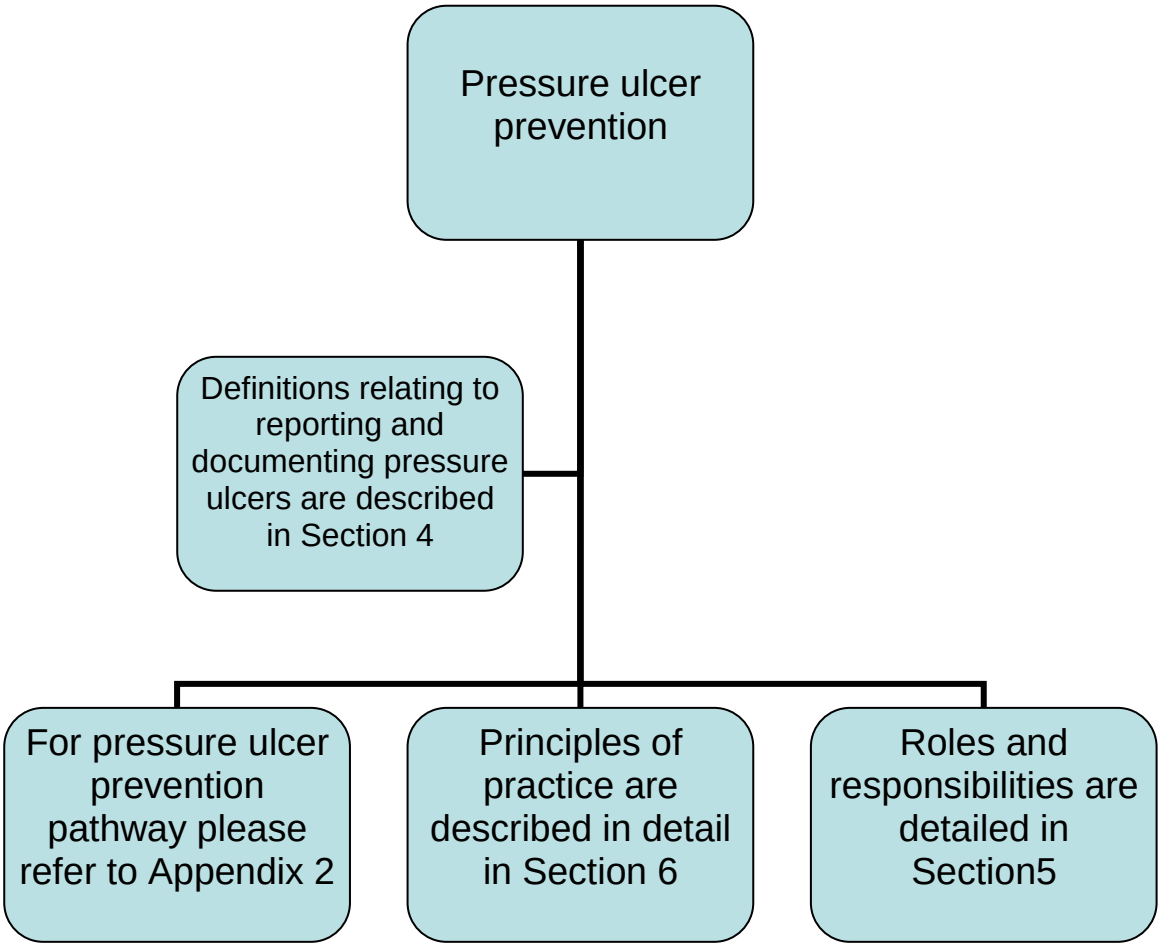
Royal Cornwall Hospitals NHS Trust

Prevention of Pressure Ulcers Policy

V8.1

July 2019

Summary.


Pressure ulcer prevention
Definitions relating to reporting and documenting pressure ulcers are described in Section 4
For pressure ulcer prevention pathway please refer to Appendix 2
Principles of practice are described in detail in Section 6
Roles and responsibilities are detailed in Section5

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1. Introduction

1.1. This policy sets out the framework to guide evidence-based care in the prevention and management of pressure ulcers and reflects nationally agreed consensus and NICE guidance.

1.2. This version supersedes any previous versions of this policy.

1.3. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. Purpose of this Policy/Procedure

2.1. The purpose of this policy is to ensure that the Trust meets best practice standards for the prevention and management of pressure ulcers in line with national, regional and local guidelines.

2.2. Implementation of this policy will help to ensure that:

- There is clear guidance to prevent and manage pressure ulcers in a standardised way across the Trust.
- All staff act in accordance with this policy to prevent the development of pressure ulcers or to prevent the deterioration of existing pressure damage.

3. Scope

This document is applicable to all staff regardless of category or profession, working within a clinical setting, caring for patients with, or at risk of, pressure ulcers.

4. Definitions

4.1. Pressure Ulcer – A pressure ulcer is defined as: ' A localised damage to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, (or related to a medical or other device) resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful. (NHS Improvement 2018)

4.2. Medical Device related pressure ulcer – pressure ulcers that develop from the use of devices designed and applied for diagnostic or therapeutic purposes. When reporting this type of pressure ulcer the report should be annotated with a (d) eg category 2 (d)

4.3. Pressure ulcer categories – Pressure ulcers will be defined by category rather than grade which includes categories 1-4, deep tissue injury (DTI) and unstageable.

4.4. Suspected DTI and unstageable pressure ulcers – where a pressure ulcer cannot be categorised at the time of assessment the skin damage must be reviewed by a clinician with appropriate skills on a weekly basis to help identify a definitive PU category.

4.5. Pressure ulcer on admission – this definition should be used when a pressure ulcer is observed during the skin assessment undertaken on admission to that service.

4.6. New pressure ulcer- the definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care.

4.7. Moisture associated skin damage (MASD) - skin damage caused by moisture rather than pressure. If pressure also present this must be reported based on the category of pressure damage.

5. Ownership and Responsibilities

5.1. Role of all staff

- To be responsible for acting to reduce the number of patients developing pressure ulcers and achieving “no avoidable pressure ulcers in NHS care” (Department of Health, 2009).
- All staff must act to achieve the Principles of Practice outlined in Section 6.
- All staff will be responsible for reporting pressure ulceration in accordance with this policy.

5.2. Role of the Tissue Viability service

- To advise and support staff in achieving the principles of practice through visible role modelling and clinical support in practice and through education and training in the form of study days, self-directed learning resources, toolboxes and practical workshops.

5.3. Role of the Equipment Library

- To supply equipment to protect patients’ skin integrity whilst in hospital. Nursing staff will be responsible for requesting and documenting the use of equipment.

6. Standards and Practice

6.1. Pressure Ulcer Prevention Principles of Practice

All staff must adhere to the following principles of practice to ensure care is delivered in accordance with the best available evidence and every possible step is taken to reduce the risk of pressure ulcers occurring.

6.1.1. All patients will be assessed for their risk of pressure ulcer development, using the registered nurse's clinical judgement within 4 hours of admission to hospital, when their condition changes, and on transfer or discharge. This will be documented in the admission nursing care record (CHA 3831) and communicated as part of the nursing handover.

6.1.2. All patients will have a skin assessment carried out within four hours of admission, and throughout their stay according to the RCHT clinical pathway (Appendix 2). The SSKIN bundle tool details specific indicators which may increase a patient's risk of pressure ulcers. Staff are then guided depending on the risk category, Red, Amber or Green to implement the appropriate level of skin assessments. The frequency of re assessment will be documented on the SSKIN bundle assessment tool together with the skin assessment. (CHA 3501 V2)

6.1.3. Any pressure ulcers that are present on admission must be documented on the admission nursing care record and SSKIN bundle assessment tool and reported on Datix as **pressure ulcer on admission**. A wound care plan must be put in place to reflect the wound management.

6.1.4. Where a patient develops pressure ulceration during their hospital stay this must be reported as a clinical incident on the Datix system as a **New pressure ulcer.** If the pressure ulcer deteriorates during their stay the Datix must be updated. If a Category 3 or 4 pressure ulcer develops a 48 hour report must be completed for consideration as a Serious Incident. See Appendix 5

6.1.5. Pressure damage must be described on the wound assessment tool by stating the category of damage, the site of damage, the size of the damaged area and the condition of the wound bed.

6.1.6. Where a patient is at risk of pressure damage or has an existing pressure ulcer a pressure ulcer prevention care plan must be written in agreement with the patient where possible.

6.1.7. Patients, carers and relatives must be made aware of the reason for the assessment and intervention and provided with the Trust information leaflet. CHA 3668 V1

6.1.8. Patients, carers and relatives must be involved in decision making regarding pressure area care and the use of devices to prevent and/or treat pressure ulceration.

6.1.9. Communication with all members of the multi-disciplinary team involved in caring for the patient at risk of pressure damage is vital to ensure

prompt recovery and optimum management of pressure areas across care settings.

6.1.10. All patients at risk of pressure damage must have regular CARE rounds and immediate action must be taken if the skin shows signs of deterioration. Patient repositioning should be recorded at each CARE round. See Appendix 2 for clinical pathway for prevention of pressure ulcers.

6.1.11. Where necessary action will be taken to improve patients' nutritional status.

6.1.12. Where moisture may impact upon skin integrity and contribute to pressure damage (i.e. incontinent patients) action must be taken to protect the skin. Skin breakdown from moisture on pressure vulnerable sites must be categorised as moisture associated skin damage (MASD) unless pressure, shear and / or friction damage is also present. The skin damage is then categorised according to the category of skin damage and not the moisture damage.

6.1.13. Patients at risk of pressure damage must be advised to keep moving or be repositioned as determined by individual assessment and skin condition. This is incorporated within the principles of the SSKIN bundle and will be documented on the CARE round form. S – surface. S – skin inspection K – keep moving, I – incontinence, N – nutrition.

6.1.14. All patients at risk of pressure damage must be nursed on high density foam, pressure reducing mattresses as a minimum.

6.1.15. Patients with a high to very high risk must be provided with a hybrid static air mattress or an alternating pressure replacement mattress. Where a patient can be repositioned or can reposition themselves a hybrid mattress is suitable to meet their needs providing the skin is inspected at regular intervals according to the SSKIN bundle assessment. Any patient with a category 2 or above pressure ulcer must be provided with a dynamic mattress.

6.1.16. Patients at high or very high risk of pressure ulceration should not sit out in a chair for more than two hours at a time and an appropriate pressure reducing cushion must be used.

6.1.17. All care provided to prevent pressure damage must be recorded in the patient's records and evaluated to determine the need for further intervention.

6.1.18. All health care professionals are required to attend education about pressure ulcer prevention and use of pressure relieving equipment. In the event of Serious Incidents and where there is a consistent increase in the incidence of pressure ulcers, updates will be mandatory.

6.2. Assessment of Risk

6.2.1. For adults, excluding women in labour the risk of pressure ulcers must be determined using clinical judgement supported by specific risk criteria which is detailed on the SSKIN bundle. This should be undertaken as follows:

- Within four hours of admission
- On transfer of a patient to another clinical area/environment of care
- If a patient's condition changes
- Prior to discharge from hospital

6.2.2. When using clinical judgement to determine risk, the following factors must be considered (NPUAP/EPUAP/PPPIA 2014)

- Activity and Mobility
- Nutrition
- Skin Condition
- Perfusion and oxygenation of the tissues
- Age
- Build/weight for height
- Continence
- Tissue Malnutrition
- Surgery
- Neurological Deficit

6.2.3. <u>Activity and mobility</u>

6.2.3.1. Consider all individuals who are bedfast and/or chairfast to be at risk of developing pressure ulcers (NPUAP/EPUAP/PPPIA 2014)

6.2.3.2. Chair bound patients have almost 50% of their weight on only 8% of their body, therefore the sacrum and buttocks are at increased risk of damage (Collins 1999).

6.2.3.3. Restlessness and fidgeting may cause blistering and abrasions to the skin's surface. The use of a film dressing and or preventative aids should be considered.

6.2.3.4. Traction or splints reduce one's ability to reposition. In addition, they may rub and cause damage to the surface of the skin and underlying tissues.

6.2.3.5. When patients are sedated, unconscious or unable to move staff must take responsibility for protection from pressure damage.

6.2.4. <u>Nutrition</u>

6.2.4.1. Reduced weight, impaired nutritional intake, dehydration and low serum albumin levels may increase the risk of pressure ulcer

development. However, under nutrition is a reversible risk factor. (NPUAP/EPUAP/PPPIA 2014)

6.2.4.2. Nutritional indicators include anaemia, haemoglobin and serum albumin levels, measurement of nutritional intake (e.g. food charts) and weight. Weight loss may result in loss of fatty tissue and muscle wastage, which can increase pressure on bony prominences. Good nutrition and hydration is vital for maintenance of skin function and prevention of pressure damage. Protein is required for cell metabolism and the production of collagen, which gives the skin its strength.

6.2.4.3. Carbohydrates and fats allow the body to use protein efficiently, generating new cells and reducing the risk of breakdown.

6.2.4.4. Iron, zinc, vitamin A, C, B1, B2 and B6 are also required for collagen synthesis.

6.2.4.5. Nutritional assessment using the MUST (Malnutrition Universal Screening Tool) tool must be carried out on all patients on admission and weekly thereafter. For patients who score as medium or high risk of malnutrition commence a nutritional care plan and refer to the dietician if necessary to ensure optimal nutritional support for patients (NPUAP/EPUAP/PPPIA 2014)

6.2.4.6. Be aware that the MUST tool may not give a high score for obese patients who may be at increased risk of developing pressure ulcers.

6.2.5. Skin Condition

6.2.5.1. All individuals with alterations to intact skin are at risk of developing pressure damage. This includes dry skin, erythema, excessive moisture and non-blanching erythema.

6.2.5.2. Incontinent patients may have permanently moist skin. This reduces their tolerance of pressure shear and friction. Moist skin is 5 times more likely to break down than healthy skin.

6.2.5.3. Patients with thin friable skin are at increased risk of blistering or abrasions.

6.2.5.4. Dry skin is at risk of cracking when under pressure.

6.2.5.5. Oedematous skin may have a reduced blood or lymphatic supply, resulting in toxins building up in the tissues. Oedema can leak onto the skin causing maceration and increasing the risk of breakdown.

6.2.5.6. Discolouration may indicate poor blood supply or early pressure damage and pressure relief, or a change of position is required.

6.2.6. Perfusion and Oxygenation of the Tissues

Factors affecting perfusion and oxygenation of skin tissue include diabetes, cardiovascular instability, norepinephrine use, low blood pressure, reduced ankle brachial pressure index and use of oxygen (NPUAP/EPUAP/PPPIA 2014)

6.2.7. Age

As the skin ages the amount of collagen and elastin in the dermis reduces. This results in thinning of skin, loss of tensile strength and increased risk of breakdown (Wounds UK 2008).

6.2.8. Build/weight for height

6.2.8.1. Distribution of weight requires consideration and bariatric patients may be at risk of pressure damage. Where excess weigh occurs on specific areas of the body there may be an increased risk of deep pressure damage secondary to friction.

6.2.8.2. If weight is below average the amount of tissue covering bony prominences is reduced, resulting in a concentration of pressure onto a smaller area.

6.2.9. Continence

Moisture on the surface of the skin can result in maceration and the skin is less able to resist damage (Cutting and White 2002). Urine and faecal fluid creates changes in the skin's pH and reduces its tensile strength, this can then make it more susceptible to pressure ulceration (see skin condition above).

6.2.10. Tissue Malnutrition

Some conditions can reduce blood flow through the arteries and capillaries. This can result in poor perfusion of the tissue. The addition of pressure when circulation is already poor can increase the risk of damage.

6.2.11. Surgery

6.2.11.1. Immobility during and after surgery, will increase the risk of pressure damage. Some patients may need to be cared for in certain positions post operatively, (e.g upright) limiting the extent to which they can be repositioned. This must be considered within the care plan. Patients undergoing surgery will have an increased risk for 48 hours post operatively however this may be for longer if their post-operative recovery is slow.

6.2.11.2. Anaesthetics and analgesia can prevent patients from experiencing pain associated with pressure damage. It is important to inform them that they may be at risk and closely monitor skin condition.

6.2.12. Neurological Deficit

6.2.12.1. Damage to the nerves can prevent patients being aware that they are experiencing pressure damage.

6.2.12.2. Other factors requiring consideration are:

- Acute, chronic or terminal illness
- Co-morbidity, (e.g. pain, infection, medication)
- Body temperature
- Posture
- Psychosocial issues
- Exposure to pressure, shear or friction prior to admission

6.2.12.3. For maternity patients, the Maternity Risk Calculator must be used according to the guidance provided as part of the Pregnancy and Birth Hand held record. (CHA2624)

6.2.12.4. For paediatric patients, the Braden Risk Assessment Scale must be used.

6.3. Skin Assessment

6.3.1. The key principles of skin assessment are as follows:

6.3.1.1. All patients to have a top to toe skin assessment immediately or within four hours of admission to hospital. Following a lower limb fracture, assessment must be undertaken within one hour of admission. This is to be recorded on the admission nursing care record and the SSKIN bundle assessment tool.

6.3.1.2. All patients to have a reassessment of their skin following transfer to a new clinical area or to theatre, if their condition changes and prior to discharge. This is to be recorded on the skin bundle assessment tool.

6.3.1.3. Following admission, all patients at risk of pressure damage, require a daily skin assessment.

6.3.1.4. For all patients at high risk of pressure damage, a twice daily skin assessment is required.

6.3.1.5. For all patients at very high risk of pressure damage, a three times daily skin assessment is required.

6.3.1.6. **A daily skin assessment should be viewed as a minimum standard for those at risk patients.**

6.3.1.7. If a patient has Category 1 skin damage (non-blanching erythema) an increase in the frequency of the skin assessment and frequency of repositioning should be undertaken until resolved.

6.3.2. Maintaining healthy skin: The following principles should be considered in maintaining healthy skin:

6.3.2.1. Keep the skin clean and dry, but do not let it dry out.

6.3.2.2. Avoid excessive moisture from urine, faeces, wound exudates, saliva and perspiration, as this can increase the risk of friction and shearing, reduce skin integrity and lead to maceration.

6.3.2.3. Cleanse the skin with a soap substitute.

6.3.2.4. Use emollients on a regular basis to prevent skin dehydration.

6.3.2.5. Avoid using talcum powder and excessive rubbing of the skin.

6.3.2.6. Use skin barrier products topically to protect the skin from excessive moisture and potential irritants.

6.3.2.7. Ensure that the patient has adequate nutritional and fluid intake.

6.4 Pressure ulcers at life's end.

6.4.1. At life's end a reduction in the delivery of oxygen to the skin and the body's inability to absorb and metabolise vital nutrients can result in compromised skin integrity (NPUAP/EPUAP/PPPIA 2014). When a patient is reaching the end of their life changes in the colour and integrity of the skin can occur and can be of sudden onset. Skin changes may develop despite optimal care.

6.4.1.1. Patients at the end of their life should be considered at very high risk of pressure damage and as such should:

- Have immediate access to equipment required to protect the skin from pressure damage (alternating pressure mattress, heel protection and cushion)

- Have a skin assessment schedule and repositioning plan that reflects the patient's wishes and allows for protection of the skin

- Any changes in the skin must be documented on the SKIN bundle as soon as identified to include, site, category, size and appearance of any skin changes

6.4.1.2. Health care professionals and carers should be aware of signs that may influence skin changes at the end of the patients life such as:

- Diminished appetite
- Reduced mobility

- Reduced skin perfusion
- Exposure of skin to body fluids
- Loss of skin integrity
- Impaired immune function

6.4.1.3. All skin breakdown that is deemed to be as a result of pressure must be reported as a pressure ulcer in accordance with Trust policy.

6.5 Categorising Pressure Damage

6.5.1. Pressure damage is categorised according to severity and depth as follows:

Category One Intact skin with non-blanching redness of a localised area. The area may be painful, firm, soft, warmer or cooler.

Category Two Partial thickness skin loss involving the epidermis and possibly the dermis. Presents as a shallow ulcer with red / pink wound bed.

Category Three Full thickness skin loss (visible fat)
Full thickness skin loss involving the epidermis, dermis and sub-cutaneous layer, but not extending into the fascia

Category Four Deep ulcer
Extensive destruction of fascia, muscle and bone, with or without skin loss
Tissue necrosis

Unstageable: Depth Unknown – Full thickness skin loss in which the base of the wound is covered with slough and / or eschar. Until enough of this devitalised material is removed the true depth and therefore the categorisation cannot be determined accurately. An Unstageable pressure ulcer can often be a category 3 or 4 once the necrosis or slough is removed.

Suspected deep tissue injury – Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying tissues form pressure and / or shear. Tissue may be boggy, mushy, warmer, cooler compared to adjacent tissue.

If the category remains difficult to determine the tissue viability team must be contacted for advice and a period of watchful waiting will be required before determining the accurate category of skin damage.
Surgical debridement may be considered to remove the area of necrosis and support accuracy of categorisation.

6.6 Management of Pressure Ulcers

6.6.1. The most important factor in management of pressure damage is pressure relief. Repositioning and use of pressure reducing/relieving equipment is key.

6.6.2. When pressure damage does occur the position, category and appearance of the ulcer needs to be assessed and documented, and care planned to reduce the risk of any deterioration in skin condition. A holistic assessment is required with specific consideration given to repositioning, nutrition, continence, mobility, psychosocial issues and pain (NPUAP/EPUAP/PPPIA 2014)

6.6.3. Any breaks in the skin should be treated as wounds and dressed to protected them from infection and promote healing. Debridement should only be carried if the tissue is well perfused, otherwise necrotic tissue should be left dry. The Dressing Selection Guideline in the Wound Care Guidelines can be used to support clinical decision making.

6.7 Patient Information

6.7.1. It is essential to ensure patients, relatives and carers are aware of the risk of pressure damage. Patient information should include:

- What is a pressure ulcer
- Who is at risk
- What to do to prevent damage
- What to look for
- When and how to report changes in skin condition
- Repositioning
- Where to go for further information

6.7.2. All clinical areas should keep copies of the Trust information leaflet – **Making your stay with us safe** - available for patients and carers. CHA 3668 V1

6.7.3. Additional resources available to patients and carers and staff include NICE, NHS Direct and the 'Your Turn' website – www.your-turn.org.uk

6.7.4. Where possible patients should be involved in decision making regarding their care, these include repositioning times, and use of pressure relieving equipment. (NICE 2014).

6.8 Patient Repositioning

6.8.1. All patients at risk of pressure damage should be repositioned if it is safe to do so. Medical condition, comfort and over all care (e.g. physiotherapy) need to be considered and incorporated into a turning plan.

6.8.2. Timing of repositioning is determined by individual assessment of the patient's risk and the skin's response to pressure.

6.8.3. Repositioning should be undertaken in a way that does not put pressure on bony prominences. Tilting the patient 30º and placing a pillow in the small of the back to relieve pressure on the sacrum and ischial tuberosities can be

effective. Pillows can also be used **lengthways** along the calf to raise the heels, protecting them from the surface below.

6.8.4. The use of an electronic profiling bed can assist in repositioning without turning. Reduce shear factors by maintaining the head position at the lowest position possible. The use of the knee break will also help to break heel pressure.

6.8.5. It is an important part of recovery to allow patients to sit out in a chair, however where the patient is at risk of damage, or has a pressure ulcer, a pressure reducing cushion should be used and sitting out limited to two hours at a time. The patient's seating position may influence the development of a pressure ulcer; therefore the correct size chair should be used and the patient observed to ensure he/she is comfortable and not at risk of sliding.

6.8.6. The patient's position must be recorded on the Care Rounding form (CHA3061 V6) at every rounding episode or when he/she is repositioned.

6.8.7. Patients with a lower limb fracture such as fractured neck of femur and pelvis are at very high risk and as such there is a specific pathway and care plan to be followed to prevent pressure ulceration in this specific patient group. See Appendix 4

6.9 Care of Patients Nursed on Trolleys

6.9.1. If a patient is lying on a trolley for more than 1 hour the trolley must have a pressure reducing high density foam surface.

6.9.2. If patients are assessed as being at high or very high risk of pressure ulcers they must not be on trolleys for more than 4 hours.

6.9.3. Patients with existing pressure damage must be placed on a bed with the correct mattress as soon as possible after admission.

6.9.4. NICE (2014) recommend that all patients with category 2 or above pressure damage should be nursed on alternating pressure mattresses, therefore trolleys are not recommended for these patients. Hybrid mattresses may be suitable if the patient can reposition with help or unaided.

6.10 Patient Nutrition

All patients should be assessed on admission and reassessed throughout their stay, for the nutritional risk using the MUST tool. All nutritional care requirements should be implemented according to the patient's level of risk and a care plan must be in place.

6.11 Patient Continence

All patients should be assessed on admission and throughout their stay for their continence status. Care must be planned according to the risk of skin damage and their level of incontinence.

6.12 Equipment Selection

6.12.1. Guidelines for equipment selection based on individual patient assessment can be found in Appendix 3.

6.12.2. All patients will be provided with a pressure reducing high density foam or visco-elastic foam mattress as standard.

6.12.3. A Hybrid mattress can be used when the patient is deemed at high to very high risk / existing category 2 yet is able to reposition and / or be repositioned. Assessment of skin tolerance is important when using Hybrid mattresses to determine if a change in support surface to a dynamic system is required.

6.12.4. An alternating pressure mattress is required when:

- The patient is assessed as being very high risk and has existing pressure ulceration of Category 3 or above
- The patient is unable to reposition independently or with assistance

6.12.5. The following factors also need to be considered:

- Patient comfort
- The patient's ability to reposition on the mattress
- Patient choice
- Site of pressure damage

6.12.6. When patients with or at high / very high risk of pressure damage sit out in the chair a pressure reducing cushion is needed. A selection of cushions are available from the Equipment library if there are none available on the ward.

6.12.7. Heel protection- Placing a pillow from the ankle to below the knee allows the heel to be free from pressure and is an acceptable method of relieving the pressure. Heel troughs, heel pads or Heel boots can also be used to protect the heels and can be obtained from the equipment library.

6.12.8. Training on specific pressure relieving equipment is available and the equipment library staff inform the wards of training dates.

6.13 Obtaining Equipment

6.13.1. Pressure reducing and alternating pressure mattresses are available from the equipment library and can be obtained by contacting extension 3049 or bleep 3988, between 08:00 and 16:00.

6.13.2. Outside these hours when a mattress is required, reassess all patients in your clinical area to determine whether anyone can be stepped down to a high-density foam mattress. If not, contact the porters on extension 2468 as they have a list of available equipment. If there is none available, please contact the other wards to check for availability.

6.13.3. An overlay mattress is available for **out of hours use** via the Porters. These are to be considered for short term use (maximum 72hours) and a full replacement air mattress should be obtained as soon as possible. Please ensure a message is left for the library staff on Ext 3049 for the replacement mattress to be delivered. Staff must record that the air mattress has been requested in the patient records.

6.13.4. For clinical advice on pressure relieving equipment please contact the tissue viability service on 07909930765

6.13.5. To ensure alternating pressure mattresses are utilised effectively, patients should be reassessed and stepped down onto a pressure reducing surface as soon as possible. Mattresses should then be cleaned, labelled and returned to the equipment library.

6.13.6. Static or hybrid mattresses not in use should be cleaned, labelled and returned to the equipment library for storage.

6.14. Discharge of Patients Requiring Specialist Equipment

6.14.1. For discharge to patients own home or residential home

6.14.2. Ward staff to identify the type of pressure relieving equipment required

Category 2 pressure damage but can **move independently**	High density or Visco foam mattress or Repose overlay
Category 2 pressure damage or very high risk patients that are **unable to move independently**	Dynamic overlay mattress
Category 3 / 4 pressure damage	Dynamic replacement mattress

Consider the need to provide cushions for **high risk seated patients** and also **heel protection** where appropriate
Consider the needs of **palliative care** patients as they may require a higher specification of support surface.

6.14.3. Discuss requirements with ward based Occupational therapists who will order the equipment via the Community Loan Store system (CELS). There is a mandatory online toolkit to support equipment selection for all orders.

6.14.4. The earlier the equipment is requested the better and there is a move to provide an express delivery service in the light of the need to provide faster discharges and emergency orders.

6.14.5. Equipment will usually be delivered to the patient's home within 24 – 48 hours however where clinically authorised by the Clinical Equipment lead in CFT same day delivery can be achieved to facilitate discharge.

6.14.6. Community nursing teams can access peripheral stores for immediate use items.

6.14.7. For patients being discharged to nursing homes:

6.14.7.1. Equipment is provided for the treatment of pressure ulcers. It is the nursing homes responsibility to provide equipment for prevention unless there are special circumstances such as end of life care.

6.14.7.2. Discuss requirements with the Discharge Nurses who will liaise with the **Community Tissue Viability team** regarding funding. Complete the relevant continuing health care needs form.

6.14.7.3. The Community TV team will then organise the equipment where appropriate: equipment should not be ordered via the CELS system for these patients.

6.14.7.4. Ensure that discharge planning is started early to allow for timely provision of equipment. At least 24 hr notice is required in order to put equipment in place for patient discharge to home. The Occupational Therapist or Discharge Liaison Nurse will confirm when the equipment is in place, to then enable the discharge to proceed.

6.15. Cleaning & Decontamination of Equipment and Reporting Faults

6.15.1. Reporting Faults- **All mattresses must be checked between patients** for cover, foam, and operational faults. Any equipment not fit for use must be dealt with as detailed in the table below.

6.15.2. Static foam mattresses that are no longer fit for use must be condemned when:

- The cover is damaged and fluids permeate through to the foam
- The foam has “bottomed out” and the base of the bed can be felt through the mattress.

6.15.3. Alternating pressure mattresses should be set up in accordance with the manufacturer’s instructions for use. When a mattress fails to work correctly ensure:

- It is correctly attached to the mains and switched on
- It is not in static mode
- The setting are adjusted in accordance with patient need
- The CPR is not activated

6.15.4. Cleaning & Decontamination- All pressure relieving equipment should be cleaned prior to returning to the equipment library following the Trust Decontamination Policy and the guidelines below.

6.15.5. Decontamination of pressure reducing/relieving equipment is carried out through cleaning or disinfection depending on the extent to which the equipment is exposed to bacteria which are likely to cause infection.

6.15.6. Clean all mattresses between patients with mild detergent and warm water, paying particular attention to the mattress folds and loose flaps. Rinse and dry thoroughly.

6.15.7. If soiled with body fluids, a chlorine releasing agent such as sodium hypochlorite and di-isochlorocyanurate (NaDcc) e.g. Actichlor, can be used to clean the mattress in line with RCHT Decontamination Policy.
http://intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/InfectionPreventionAndControl/DecontaminationPolicy.pdf

6.15.8. Please follow the guidance in the table below for specific cleaning and disposal of mattresses.

Mattress	**Normal Working Hours**	**Out of Hours**
STATIC- Clean, not condemned, no longer required	Clean mattress as per policy. Attach 'clean' label and send mattress to Equipment Library via the Porters	As per normal working hours
ALTERNATING- Clean, not faulty, no longer required	Clean mattress as per policy. Place in clear plastic bag. Label as 'clean' and return to the Equipment Library via the Porters	As per normal working hours
ALTERNATING- Faulty	Clean as above. Contact the Equipment Library to report the fault (x 3049) and return to the library with a 'fault' label attached	As per normal working hours
STATIC- Dirty/ condemned	Place mattress in a large yellow bag (available to order via top up). Label as condemned and call the waste dept as soon as possible to arrange removal of the mattress. Replacement mattresses can be requested via the Equipment Library	As per normal working hours. A condemned mattress should not be left on a ward for more than 72 hours once reported.
ALTERNATING- Contaminated	Clean mattress as per policy. Place in large clear bag. Label as contaminated and contact the Equipment Library staff (x3049). Return to the Equipment Library via the Porters	As per normal working hours

6.16. Reporting of Pressure Damage

6.16.1. When a pressure ulcer occurs or deteriorates re-assessment of the patient and the category, position and appearance of pressure damage must be documented by a Registered Nurse. A new care plan should reflect interventions to heal existing ulceration and prevent further damage.

6.16.2. All pressure ulcers must be reported on the Datix system by a Registered Nurse as follows:

6.16.3. Category 1 & 2 – report on Datix. Incident to be investigated as soon as possible or within 5 days to ensure the records are available.

6.16.4. Category 3 and 4 – on Datix. A 48 hour report is to be completed for all hospital acquired Category 3 and 4 pressure ulcers. A Serious Incident investigation will be commenced on review of the 48 hour report if the specific SI criteria is met. See Appendix 5 for SI process.

6.16.5. When reporting pressure ulcers on the DATIX system the report must include:

- Patient details
- Category of pressure damage
- Site of pressure damage
- Hospital (New) or non-hospital acquired damage
- Equipment in use
- Action taken to manage the increased risk

6.16.6. Reporting pressure ulcer incidents under safeguarding. (See Appendix 9 for process flow chart)

If a patient develops a Category 3, 4 or Unstageable pressure ulcer whilst under RCHT care:

- Pressure ulcer is Datixed as a clinical incident by registered ward staff member
- Category of pressure ulcer is validated by RCHT TV team on receipt of the Datix
- If confirmed Category 3, 4 or Unstageable pressure ulcer the RCHT SI investigation process is commenced
- **A Safeguarding referral is considered using the Clinical decision tool and if the score is 15 or above a safeguarding referral is made by completing the safeguarding referral form.**

If a patient is admitted to RCHT with an existing Category 3, 4 or Unstageable pressure ulcer:

- Pressure ulcer is Datixed as a clinical incident by registered ward staff member
- Category of pressure ulcer is validated by the RCHT TV team
- The Community TV team or CFT Incident administrator is contacted via email to determine if the patient is known to a CFT care team and if a safeguarding referral and SI investigation has already been considered. They will action the SI investigation and consider safeguarding alert if required.
- No further action by RCHT staff

6.16.8. New pressure ulcers:

6.16.9. When reporting Category 3, 4, Ungradeable, DTI or multiple site Category 2 pressure ulcers that have developed **following admission** consideration must be given to the possible cause being neglect. The RCHT TV team will make a decision as to whether an adult safeguarding alert needs to be made using the following process:

6.16.9.1. The Adult Safeguarding Decision Guide for Individuals with Severe Pressure Ulcers will be completed by the RCHT Tissue Viability team If the score is above 15 a MARU Adult safeguarding adult referral form will be completed and sent to Cornwall council for further review. The form will also be sent to the RCHT Adult safeguarding team and the Community Tissue Viability team.

6.16.9.2. A 48 hour report will be requested from the ward where the incident occurred and consideration of a Serious Incident made on review of the report.

6.16.9.3. An SI investigation will be completed if required

6.17. Audit activity

The following audit activity will be undertaken. The results will be reported through the RCHT Quality Action group. This is detailed in the Standard Operating Procedure (SOP) in Appendix 6.

Audit / Outcomes	Frequency	Method	Persons Responsible
Pressure Ulcer Incidence	Monthly	Data obtained from DATIX.	Tissue Viability Team
SKIN bundle and risk assessment and care planning compliance	Monthly	QUANTA Ward accreditation	Ward Sisters / Charge Nurses / Clinical Matrons
Alternating and Static mattress audits	Annually	All available mattresses checked within the Trust	Equipment Library

6.18. Complaints and Legal

6.18.1. All complaints relating to pressure ulcers will be investigated by the individual Care groups with support from the Tissue Viability team.

6.18.2. The Tissue Viability team will support the legal team with any legal claims against the Trust in relation to pressure ulcers.

7. Dissemination and Implementation

7.1. This policy, once ratified, will be stored electronically on the Trust's Document Library.

7.2. The Senior Nursing teams across the Divisions will be made aware of the updated policy and will be responsible for the dissemination of the information within.

8. Monitoring compliance and effectiveness

Element to be monitored	Incidence reporting
Lead	Heather Newton
Tool	Datix reports
Frequency	Monthly
Reporting arrangements	Divisional Nurses will receive Datix report monthly Divisional teams will report via the Clinical Governance and Nursing Collaborative meeting against the Trust wide action plan
Acting on recommendations and Lead(s)	Divisional Nurses will be responsible for leading the actions/changes required to improve compliance
Change in practice and lessons to be shared	Changes will be monitored and reported monthly as part of the report. Divisional Nurses will discuss findings as required through the Clinical Governance and Nursing Collaborative meeting

9. Updating and Review

This is managed via the document library. Review will be undertaken every two years unless best practice dictates otherwise.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 8.

Appendix 1: Governance Information

Document Title	Prevention of Pressure Ulcers Policy V8.1					
Date Issued/Approved:	October 2018					
Date Valid From:	July 2019					
Date Valid To:	December 2021					
Directorate / Department responsible (author/owner):	Heather Newton, Tissue Viability Nurse Consultant					
Contact details:	01872 252673					
Brief summary of contents	This policy sets out the framework to guide evidence based care in the prevention and management of pressure ulcers.					
Suggested Keywords:	Ulcer, Pressure, Tissue viability,					
Target Audience	RCHT	KCCG	CFT			
	✓					
Executive Director responsible for Policy:	Kim O'Keeffe Chief Nurse					
Date revised:	October 2018					
This document replaces (exact title of previous version):	Pressure ulcer prevention policy V8					
Approval route (names of committees)/consultation:	Senior Nurses Clinical Cabinet					
Divisional Manager confirming approval processes	Claire Martin Deputy Chief Nurse					
Name and Post Title of additional signatories	Not Required					
Signature of Executive Director giving approval	{Original Copy Signed}					
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only			
Document Library Folder/Sub Folder	Clinical					
Links to key external standards	CQC Outcome 4					
Related Documents:	• Tissue Viability Referral Pathway • NICE Guidance Prevention and Treatment of Pressure Ulcers CG179 • NHSI Pressure ulcers: revised definition and measurement 2018					

	NHS Improvement (2018) Pressure Ulcers: revised definition and measurement. NHS England. London NPUAP/ EPUAP/PPPIA (2014) Prevention and Treatment of Pressure ulcers. Australia. NICE (2014) CG179 Pressure ulcer prevention and management. NICE. London
Training Need Identified?	Yes on updated guidance

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
	V4.0	Previous changes not known.	
20 Feb 13	V5.0	Addition of preventative flow chart and update of SOP to reflect data collection processes. Changes to time frame for risk assessment from 6 hours to 4 hours. Update of cleaning and disposal of mattresses	Heather Newton, Tissue Viability Nurse Consultant
26 Aug 14	V5.1	Mobile summary linked at appendix 1. No other changes.	Heather Newton, Tissue Viability Nurse Consultant
08 July 16	V6	Updated category of pressure ulcers to include deep tissue injury and unstageable Addition of skin changes at life's end Updated Cat 3 and 4 SI investigation process References updated to 2014 guidance Paediatric risk score updated to Braden score Cat 2 RCA process added Equipment selection chart updated Link added for safeguarding referral Updated RCA process Lower limb pathway addition	Heather Newton, Tissue Viability Nurse Consultant
15 March 17	V7	Updated 6.80 Reporting of pressure ulcers to reflect the need for a Registered nurse to complete the Datix report. App 7 Data collection SOP and App 10 Pressure Ulcer RCA methodology also updated to reflect the changes mentioned above.	Heather Newton, Tissue Viability Nurse Consultant

22.10.18	V8	Policy updated to reflect new NHSI guidance on definitions and measurement. Sections updated include: Section 4, 6.1, 6.2, 6.3, 6.4, 6.12, 6.14, 6.16. Appendix 2,3,4,5,6	Heather Newton, Tissue Viability Nurse Consultant
16.07.19	V8.1	Updated the deep tissue section on page 15 because of new wording and process and also the safeguarding section on pages 22 and 23 as the new process has just been agreed. Add another Appendix to demonstrate the flow chart.	Heather Newton, Tissue Viability Nurse Consultant

Appendix 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Name of Name of the strategy / policy /proposal / service function to be assessed
Prevention of Pressure Ulcers Policy V8.1</td></tr>
<tr><td colspan="3">Directorate and service area:
Tissue Viability</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Heather Newton</td><td colspan="3">Telephone:
01872 252673</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To promote best practice in the prevention and management of pressure ulcers</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">To support the reduction of prevalence and incidence of hospital acquired pressure damage through assessment, implementation and evaluation of patient care.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">-Prevalence of pressure ulcers will reduce
-Incidence of pressure ulcers will reduce
-Staff will provide pressure area care in accordance with the best available evidence
-Equipment to reduce or relieve pressure will be available
-To meet policy standards</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">-Monthly Incidence audit
-Annual audit of alternating and static mattresses
-Audit of pressure ulcer assessment and care planning through Quality care indicators</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">All patients admitted to RCHT who are at risk of pressure damage or are admitted with a pressure ulcer
All staff caring for patient with, or at risk of pressure damage
Informed workforce
Patients risks of developing pressure ulcers are reduced
Patients are managed according to best practice</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups

Tissue Viability Link practitioners and Senior Nurses</td></tr>
<tr><td>c) What was the outcome of the consultation?</td><td colspan="5">All staff that have been consulted are happy with the policy updates and the policy has been approved at the RCHT Senior Nurse Cabinet</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		Older person's skin is at greater risk of pressure damage and so will be assessed and protected according to the best available evidence. This treatment is highlighted within the policy.
Sex (male, female, trans-gender / gender reassignment)		**x**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		Increased staff awareness of risk to patients with reduced mobility
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

Full statement of commitment to policy of equal opportunities is included in the policy.

Date of completion and submission	July 2018	Members approving screening assessment	Policy Review Group (PRG) **APPROVED**

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

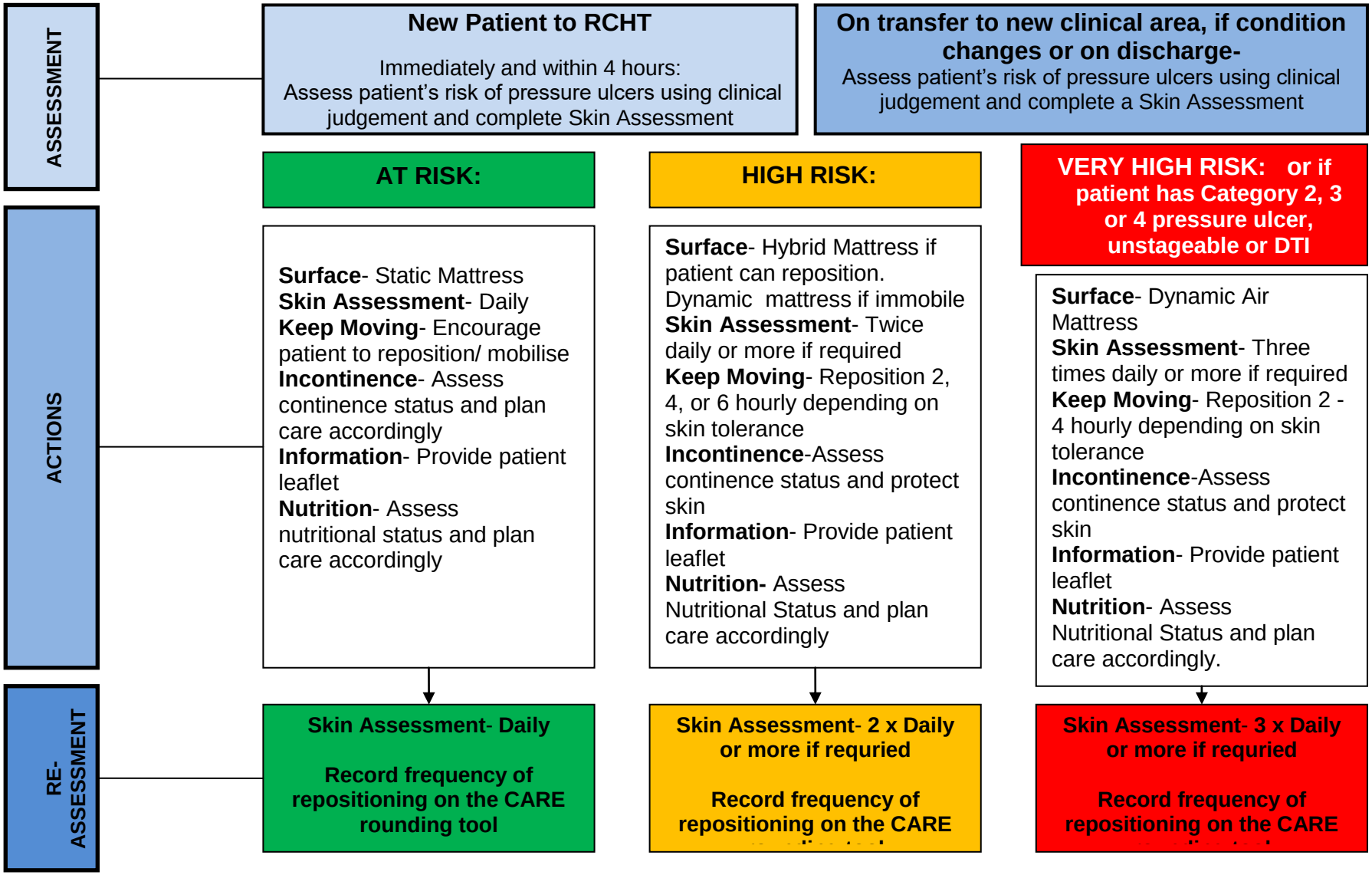
A summary of the results will be published on the Trust's web site.

Appendix 3. Policy Mobile Summary

Summary guidance published separately – available via Document Library (search for 'pressure ulcer prevention' or click here)

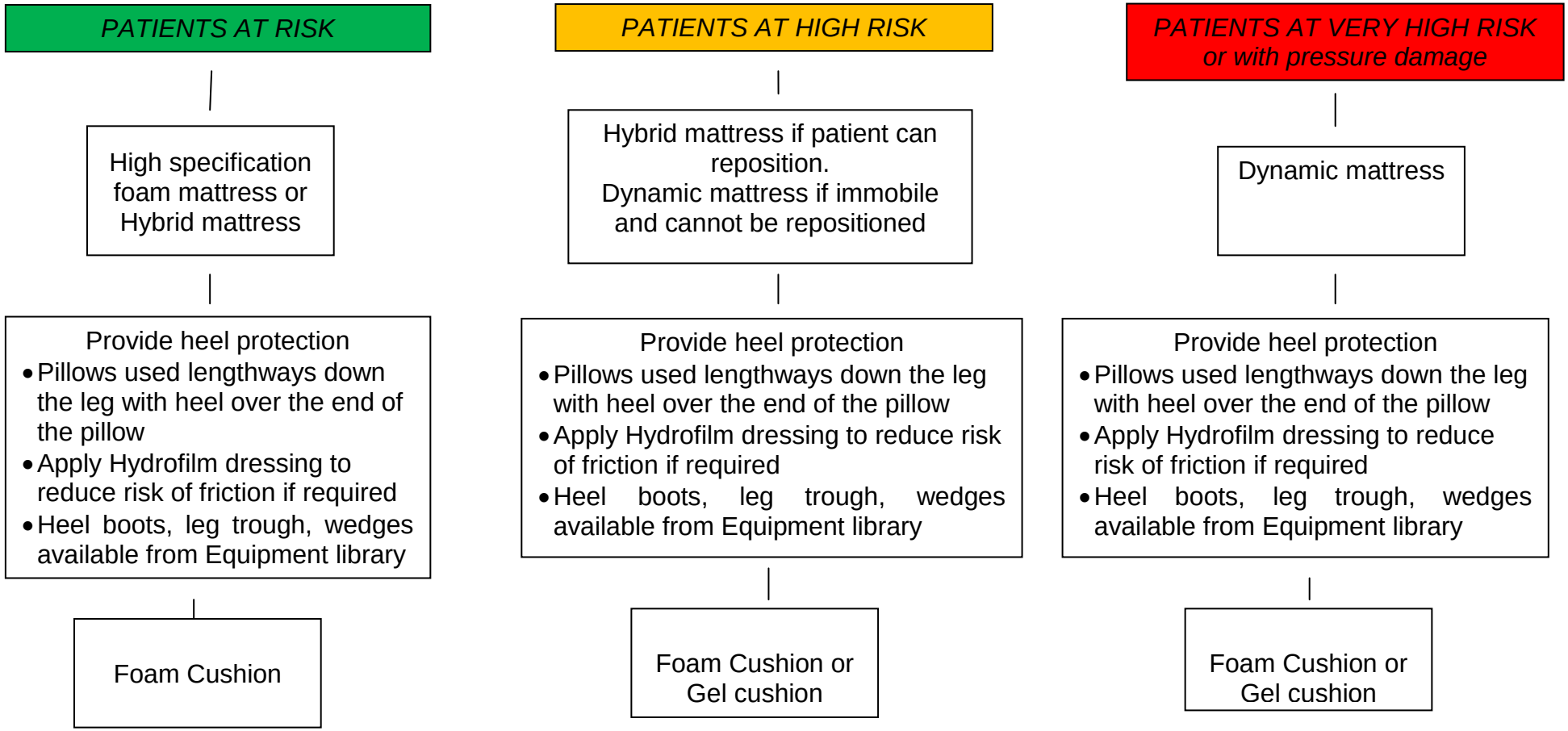
The summary guidance is the Pressure ulcer prevention pathway detailed in Appendix 4

Appendix 4. Pressure Ulcer Prevention Clinical Pathway

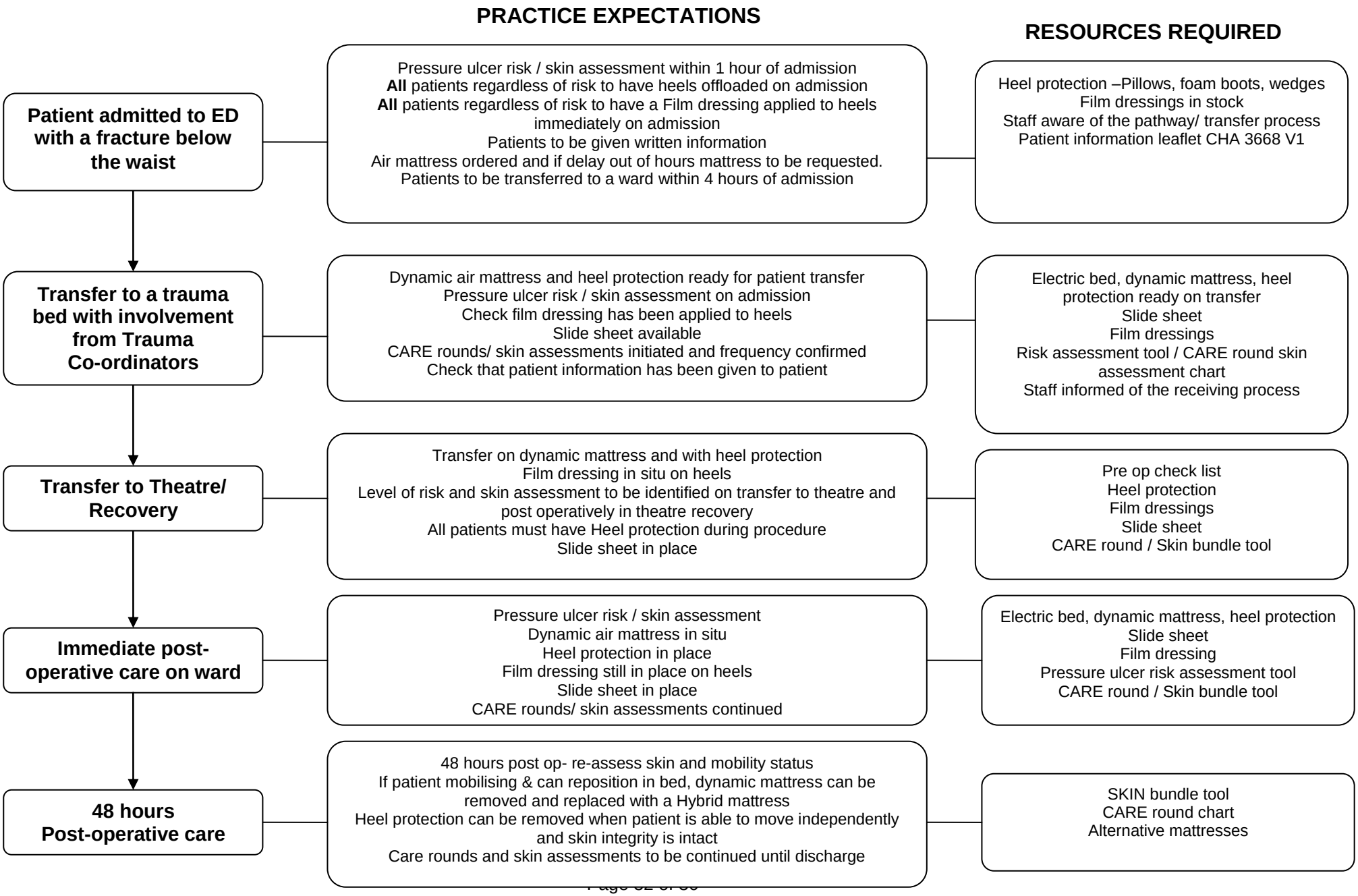


Appendix 5. Pressure Relieving Equipment Selection Guidelines

- If patients are at risk or have pressure ulcers the following guidelines should be used to select appropriate equipment.
- If patients have heel pressure ulcers, heel protection should be considered with or without dynamic mattresses, depending on clinical need.
- Hybrid static air mattresses are being phased in across the Trust and can be used for patient up to very high risk alongside a robust skin assessment and repositioning regime. **PLEASE ENSURE THAT THE PATIENTS ABILITY TO REPOSITION OR BE REPOSITIONED IS CONSIDERED WHEN USING HYBRID MATTRESSES.**



Appendix 6. Lower Limb pathway



Appendix 7. Serious Incident (SI) Reporting Process

1. If a patient develops a RCHT hospital acquired Category 3 or 4, Multiple category 2's Unstageable or Deep Tissue Injury (DTI) a Datix must be completed as soon as possible by the clinical area.

2. Once the incident has been Datixed the Tissue Viability team will review the patient and confirm the Category of pressure ulcer. If a confirmed RCHT acquired Category 3 or 4 the patient will be given an apology and informed that an investigation will be commenced. This will be recorded in the patient record as per duty of candour. The central Governance team will be informed of the category of skin damage by the TV team and a 48 hour report form will be sent to the relevant divisional governance team.

4. The completed 48 hour form will be returned to the central governance and TV teams where a judgement will be made as to which of the criteria listed below deems this incident to be an SI.

The criteria for deciding if the incident should be declared as a Serious Incident is based on the *Tissue Viability Society. Achieving Consensus in Pressure Ulcer Reporting. Journal of Tissue Viability 2012:*

- Loss of limb
- Loss of life
- Requiring surgery for their pressure ulcer
- Transfer for care of pressure ulcer e.g. transfer to Plastics for treatment
- Cluster of pressure ulcers in a clinical area
- Safeguarding concerns
- Where there has been a significant failure to follow the recommended care pathway which directly led to the pressure ulcer harm.

5. The TV team will inform the Executive team of the decision to declare the incident as an SI with the supporting evidence. This will be declared to STEISS.

6. Once the SI has been formally declared the central governance team will forward the SI pack to the TV team for investigation. All Pressure ulcer related SI's will be completed by the RCTH TV team.

7. Outcomes of the SI will be shared with the relevant clinical teams and where there is organisational learning this will be incorporated into Trust wide education and training for pressure ulcer prevention.

Appendix 8. Standard Operating Procedure (SOP)- RCHT Pressure Ulcer Prevention Data Collection

1 Purpose

1.1 This RCHT Pressure Ulcer Prevention SOP will guide the process of collecting Prevalence data from the Safety Thermometer and Incidence data from Datix reporting. Compliance with this data set is required as part of the NHS Safety Thermometer

1.2 This SOP reflects the commitment by the RCHT to monitoring pressure ulcer incidence and prevalence with the overall aim to eliminate avoidable pressure ulcers and take a zero-tolerance approach.

1.3 The objective is to achieve a level of understanding at ward level of why the data is required, how it is to be collected and when it is to be collected. This will provide assurance that the data collected is valid, robust and meaningful; to reduce all avoidable pressures ulcers in our care.

2 Who Should Use This SOP?

2.1 This SOP will be used by the Clinical teams who will be collecting the data. Clinical Matrons and Divisional Nurses will also understand the implications and the relevance of the data to improving quality, patient's safety, and harm free care.

2.2 The Tissue Viability team will use the data collected to analyse and report findings and required actions to the Senior Nursing and Executive teams.

3 When This SOP Should Be Used

3.1 This SOP may be subject to change and it is therefore the responsibility of all users to ensure that the most up to date version is being used.

3.2 Pressure Ulcer Incidence data will be collected using information from the Incident reporting system (Datix)

3.3 Pressure ulcer Prevalence data will be collected on one day a month as per the safety thermometer process

3.4 <u>Pressure Ulcer Incidence (Quantitative data)</u>

When a patient develops a hospital acquired pressure ulcer this is to be reported as a clinical incident on the Incident reporting system by a Registered Nurse (Datix)

Where possible the pressure ulcer category will be validated by the TV team.

The ward sisters and charge nurses together with the Clinical matrons are responsible for ensuring that this information is correct on the system and that investigations are completed as soon as possible after the incident. In order for the

monthly report to be completed accurately all incident handlers are required to complete all of the previous months Datix's by the 4th of the next month.

Incidence data is collected and analysed by the Tissue Viability CNS or Consultant Nurse at the end of each month.

Outcomes will be reported to the Divisional and Executive Teams as follows:

- Total number of patients with pressure ulcers both hospital and non-hospital acquired
- Total number of pressure ulcers reported
- The incidence (rate) of patients with hospital acquired pressure ulcers based on patient activity per 1000 bed days
- Pressure ulcers by category and site

Any hospital acquired Category 2 pressure ulcers will be investigated using a Root cause analysis methodology which is embedded as part of the Datix investigation process.

Any hospital acquired Category 3 and 4 pressure ulcers will be reported as Serious Incidents and investigated accord to Trust policy. See Appendix 5

Any potential Deep Tissue Injury or unstageable will be observed on a weekly basis and only declared if the skin deteriorates to a category 3 or 4.

Pressure Ulcer Risk Assessment, Care Planning and Skin Bundle compliance (Qualitative data)

This data is to be collected by the ward teams on a monthly basis using QUANTA. This will include pressure ulcer risk assessment, care planning, skin assessment and compliance with the SKIN bundle. The ward accreditation process has specific questions relating to documentation of risk of pressure ulcers and actions taken.

Safety Thermometer – pressure ulcers

This data will be collected from all in patient areas on one day each month by the ward / dept teams. The worse new and the worse old pressure ulcers will be reported by Category. Old are defined as being present on admission. New are defined as developing following admission.
Electronic data will be uploaded on the day to a National database.

Appendix 9. Reporting Pressure Ulcers as a Safeguarding Alert process