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Royal Cornwall Hospitals NHS Trust

Prevention of Pressure Ulcers Policy

V9.0

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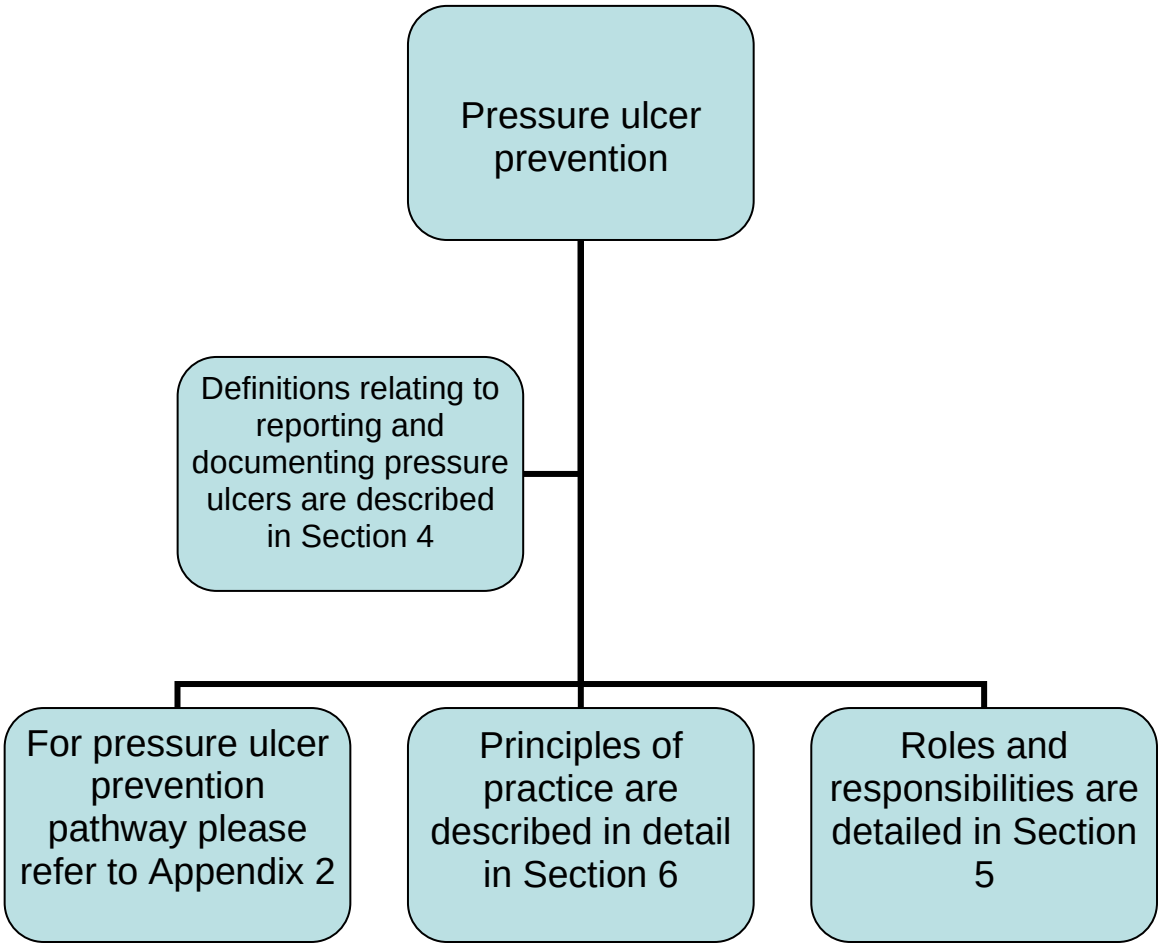
Summary


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
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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 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 cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

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 This version supersedes any previous versions of this document.

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

2. Purpose of this Policy/Procedure

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.

- 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

3.1. 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.

3.2. It will seek to provide a consistent quality approach to defining, measuring, prevention and management for those patients at risk or with existing pressure ulcers admitted to our care.

4. Definitions / Glossary

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) e.g., category 2 (d).

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

4.4. SDTI 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.

4.8. Mucosal pressure ulcers – pressure ulcers found on mucous membranes with a history of medical devices in use at the location of the ulcer.

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) and as part of the National Patient Safety agenda, (NHS England 2018).

- 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 ulcers within 4 hours of presenting to an admission area. This will be prompted on the ED checklist and the Pressure Ulcer Risk and SSKIN bundle on Nervecentre 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 to an inpatient setting using the Pressure Ulcer Risk and SSKIN bundle on Nervecentre. Depending on their level of risk their skin will be re-assessed once, twice or three times daily throughout their stay.

6.1.2.1. If not at risk the assessment is required, every 7 days or if their condition changes.

6.1.2.2. The Pressure Ulcer Risk and 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 risk level will be highlighted in Nervecentre with prompts triggered when assessments due.

6.1.3. Re- assessment of risk is noted at each SSKIN bundle episode and will also be completed when the patient's condition changes, on transfer and prior to discharge. Skin should be checked and documented on the day of discharge to ensure any skin damage is noted and communicated if required to the ongoing care team.

6.1.4. The Nursing Holistic Assessment will be completed on Nervecentre within 12 hours of admission and every 7 days after this. This may also identify other factors that may put a patient at risk and guide the practitioner to implement appropriate preventative care.

6.1.5. Any pressure ulcers that are present on admission must be documented on the Pressure Ulcer Risk and SSKIN bundle assessment tool and reported on Datix as **pressure ulcer on admission**. A wound care plan (CHA 3903) must be put in place to reflect the ongoing wound management.

6.1.6. 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 (acquired within this episode of care).** If the pressure ulcer deteriorates during their stay the Datix must be updated. If a Category 3, 4 or unstageable pressure ulcer develops a Patient Safety Review 1 (PSR 1) and Duty of Candour to the patient and or NOK must be completed. This will then be reviewed by the Executive team and at the Incident Review Learning Group (IRLG) for consideration of a PSR 2 investigation. See Appendix 7.

6.1.7. Where skin is broken as a result of pressure damage a wound care plan (CHA 3903) must be completed stating the category of damage, the site of damage, the size of the damaged area and the condition of the wound bed.

6.1.8. Where a patient is at risk of pressure damage *or has an existing* pressure ulcer a pressure ulcer prevention care plan which is in the Core Nursing Care Plan booklet (CHA 3897), must be written in agreement with the patient where possible.

6.1.9. Patients, carers, and relatives must be made aware of the reason for the assessment and intervention and provided with the **Making your stay with us safe** - available for patients and carers. CHA 3668 V1. 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.

6.1.10. 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.

6.1.11. 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 ulcer.

6.1.12. Were necessary, action will be taken to improve patients' nutritional status.

6.1.13. Where moisture impacts upon skin integrity and contributes 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. A Datix must be completed for MASD.

6.1.14. Patients at risk of pressure damage must be advised to keep moving or be repositioned as determined by individual assessment and skin condition. The patient's position must be documented on the CARE round form.

6.1.15. All patients at risk of pressure damage must be nursed on high density foam, pressure reducing mattresses as a minimum. If on a trolley, consider the use of an inflatable trolley topper if patients are unable to reposition.

6.1.16. Patients at high to very high risk must be provided with an alternating pressure replacement mattress unless contraindicated or the patient refuses. In this case there must be clear reasons documented as to why it is not in use. Where a patient can reposition a standard hospital foam mattress will be sufficient however regular skin assessments must be completed and any signs of early skin damage must trigger increased interventions such as heel protection or an alternating pressure mattress. Any patient with a category 2 or above pressure ulcer must be provided with an alternating pressure mattress or trolley topper.

6.1.17. Patients at high or very high risk of pressure ulceration should be assessed and monitored closely for risk of prolonged sitting. It is advisable to avoid sitting in a chair for more than two hours at a time and an appropriate pressure reducing cushion must be used. These can be

obtained from the RCHT Equipment library.

6.1.18. If patients have pressure damage sitting out on a cushion should be restricted to 15 mins at a time initial increasing by 15 mins a day up to 6 hours by day 18 providing, the skin condition does not deteriorate.

6.1.19. All care provided to prevent pressure damage must be recorded in the patients care plan and evaluated to determine the need for further intervention.

6.1.20. All health care professionals are requested to attend or access online education about pressure ulcer prevention and use of pressure relieving equipment. In the event of a Patient Safety Incident and where there is a consistent increase in the incidence of pressure ulcers, updates will be mandatory as part of action plans.

6.2. Assessment of Risk

6.1.1. For all 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 Pressure Ulcer Risk and SSKIN bundle tool. This should be undertaken as follows:

- Within four hours of presenting to an admission area.
- Depending on their level of risk, reassessment will be documented once, twice or three times daily throughout their stay.
- On transfer of a patient to another clinical area/environment of care within 4 hours.
- If a patient's condition changes.
- Prior to discharge from hospital a pressure ulcer risk and skin assessment is required especially if being transferred for continuing care.

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

- Activity, Mobility and ability to reposition.
- Nutrition.
- Skin Condition.
- Perfusion and oxygenation of the tissues.
- Age.
- Build/weight for height.
- Continence.

- Tissue Malnutrition.
- Surgery.
- Neurological Deficit.
- Sensory perception.
- Cognitive impairment.

6.1.3. **Activity and mobility**

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

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).

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.

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.

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

6.1.4. **Nutrition**

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).

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 are 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.

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

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

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 (CHA 3897) and refer to the dietician if necessary to ensure optimal nutritional support for patients (NPUAP/EPUAP/PPPIA 2014).

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.

6.1.5. Skin Condition

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.

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.

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

Dry skin is at risk of cracking when under pressure.

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.

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

6.1.6. 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).

6.1.7. 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).

6.1.8. Build/weight for height

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.

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

6.1.9. **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 create 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).

6.1.10. **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.

6.1.11. **Surgery**

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.

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.

6.1.12. **Neurological Deficit**

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

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.

6.1.13. **Sensory perception**

Patients with changes in sensory perception are more at risk of developing pressure ulcers as they may have an abnormal response to stimuli which in turn affects their response to pressure related discomfort.

6.1.14. **Maternity and Paediatric patients**

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

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

Preventative care planning must be in place based on individual assessment to reduce the risk of pressure ulcers.

6.2. Skin Assessment

The key principles of skin assessment are as follows:

6.3.1. All patients to have a top to toe skin assessment immediately or within four hours of presenting to an admitting area. Following a lower limb fracture, assessment must be undertaken within one hour of admission on Nervecentre. This is prompted on the ED checklist and Pressure Ulcer Risk and SSKIN bundle assessment tool.

6.3.1. 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 Pressure Ulcer Risk and SSKIN bundle assessment tool on Nervecentre.

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

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

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

6.3.5. For those patients not at risk on admission to hospital a reassessment is required every 7 days or sooner if their condition deteriorates.

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

6.3.6. If a patient develops 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.

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

- Keep the skin clean and dry, but do not let it dry out.
- 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.
- Cleanse the skin with a soap substitute.
- Use emollients on a regular basis to prevent skin dehydration.
- Avoid using talcum powder and excessive rubbing of the skin.
- Use skin barrier products topically to protect the skin from excessive moisture and potential irritants.
- 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.

6.4.2. 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 SSKIN bundle as soon as identified to include site, category, size, and appearance of any skin changes.
- Health care professionals and carers should be aware of signs that may influence skin changes at the end of the patient's life such as:
  - Diminished appetite.
  - Reduced mobility.
  - Reduced skin perfusion.
  - Exposure of skin to body fluids.

- Loss of skin integrity.
- Impaired immune function.

6.4.3. All skin breakdown that is deemed to be because 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. Can have tissue necrosis but depth of ulcer is identified.
- **Unstageable:** Depth Unknown – Full thickness skin loss in which the wound is covered with slough and / or thick 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 result in a category 3 or 4 once the necrosis or slough is removed.
- **Suspected Deep Tissue Injury (SDTI)** – 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 can 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.

http://doclibrary-rcht-intranet.cornwall.nhs.uk/RoyalCornwallHospitalsTrust/Intranet/DocumentsLibrary/Search/DocumentLibrarySearch.aspx?searchterm=Wound+care+guidelines#

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 repositioning 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 the electronic profiling bed features 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. See section 6.1.17 above.

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 (CHA 3061) 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 lower limb pathway and care plan to be followed to prevent pressure ulceration in this specific patient group. See Appendix 6

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. The use of an inflatable Trolley Topper should be considered and evidence of this recorded in the patient records.

6.9.3. Patients with existing pressure damage must be placed on a bed with the correct mattress as soon as possible after admission. If a bed is not available immediately consider the use of an inflatable Trolley Topper where risk assessment allows.

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.

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 mattress as standard.

6.12.3. 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.

6.12.4. 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.

6.12.5. 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 is available from the Equipment library if there are none available on the ward.

6.12.6. 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.

6.12.7. 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. For clinical advice on pressure relieving equipment please contact the Tissue Viability Service on 07909930765.

6.13.4. 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.

6.13.5. Static 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. Occupational therapists assess patients and identify what equipment is required for discharge. Individual needs may reflect the type of equipment provided.

Category	Detailed Information
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 with foam combination
Category 3 / 4 pressure damage	Dynamic replacement mattress

- Consider the need to provide cushions for high risk seated patients and heel protection where appropriate

- Consider the needs of palliative care patients as they may require a higher specification of support surface

6.14.2. Discuss requirements with ward based Occupational therapists who will order the equipment via the Cornwall Community Equipment Loan (CCELS). There is a mandatory online toolkit to support equipment selection for all orders.

6.14.3. 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.

6.14.4. 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.

6.14.5. Occupational Therapists at RCH have their own store and can provide Repose mattresses, Cushions and heel protection for home use if required. Community nursing teams can also access peripheral stores for immediate use items.

6.14.6. For patients being discharged to nursing homes:

6.14.6.1. 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.

6.14.6.2. 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.

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

6.14.6.4. Ensure that discharge planning is started early to allow for timely provision of equipment. At least 24 hr notice is required 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 and 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 settings are adjusted in accordance with patient need.
- The CPR is not activated.

6.15.4. Cleaning and 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

Mattress	Normal Working Hours	Out of 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 and Investigating Pressure Damage

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

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

6.16.2. All pressure ulcers must be reported on the Datix system by a Registered Nurse. This should include those acquired prior to admission and those acquired following admission.

For those incidents that are not RCHT acquired (present on admission) the Datix report is closed without investigation.

The Tissue Viability team report all non RCHT pressure ulcers greater than Category 2 to the CFT Tissue Viability team.

For those pressure ulcers acquired following admission to RCHT the following investigation process must be followed:

6.16.3. Category 1 and 2 – Category 2 pressure ulcers will be validated by a member of the Tissue Viability team. The validation outcome will be attached to the Datix for the handler to complete the investigation to ensure learning from the incident is identified and shared.

6.16.4. Category 3, 4 and Unstageable – deemed a Moderate harm incident. The category of damage will be validated by a member of the Tissue Viability team following review of the Datix. If confirmed as a moderate harm incident the Patient Safety Incident Review Framework (PSIRF) process will be triggered. A Patient Safety Review (PSR) 1 report is to be completed for all hospital acquired Category 3, 4 and Unstageable pressure ulcers. The PSR 1 once signed off by the relevant Care group will be sent to the Executive team for consideration of further investigation. If further investigation is required a PSR 2 will be commenced. See Appendix 7 for the Standing Operating Procedure.

6.16.5. Suspected Deep Tissue Injury (SDTI) – any DTI will be validated by the Tissue Viability team to determine the accuracy of pressure ulcer category. A weekly review of the SDTI will be undertaken by the Tissue Viability team where possible whilst in RCHT care. SDTI's can improve with preventative care or can develop into a moderate harm incident over time.

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

- Safeguarding is considered for PSR 2 level moderate harm incident using the Clinical decision tool. If the score is 15 or above a safeguarding referral is made by completing the MARU adult safeguarding referral form.

6.17. Audit activity

The following audit activity will be undertaken. This is detailed in the Standard Operating Procedure (SOP) in Appendix 7.

Audit / Outcomes	Frequency	Method / Reporting	Persons Responsible
Pressure Ulcer Incidence	Monthly	Data obtained from DATIX. IPR Quarterly via QAC	Tissue Viability Team

Audit / Outcomes	Frequency	Method / Reporting	Persons Responsible
SSKIN bundle, risk assessment and care planning compliance	Monthly	Quality Metrix data 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

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Incidence reporting via Monthly Datix report
Lead	Heather Newton
Tool	Datix reports and Radar data
Frequency	Monthly
Reporting arrangements	Heads of Nursing will receive Datix report monthly Care groups will report via the Clinical Governance and Nursing Quality meeting against the Trust wide action plan Harms lead meetings will note exception reports

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Heads of Nursing / Care Group Governance leads 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. Heads of Nursing will discuss findings as required through the Clinical Governance and Nursing Quality meetings

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, Inclusion and 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

Information Category	Detailed Information
Document Title:	Prevention of Pressure Ulcers Policy V9.0
This document replaces (exact title of previous version):	Prevention of Pressure Ulcers Policy V8.1
Date Issued/Approved:	07 September 2022
Date Valid From:	December 2022
Date Valid To:	December 2025
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: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Kim O'Keeffe Chief Nurse
Approval route for consultation and ratification:	Clinical Cabinet
General Manager confirming approval processes:	Louise Dickinson Deputy Chief Nurse
Name of Governance Lead confirming approval by specialty and care group management meetings:	Louise Dickinson Deputy Chief Nurse
Links to key external standards:	CQC Outcome 4

Information Category	Detailed Information
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?	Ongoing training as part of the TV education provision
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Corporate Clinical

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Not known	V4.0	Previous changes not known.	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.	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	Heather Newton, Tissue Viability Nurse Consultant

Date	Version Number	Summary of Changes	Changes Made by
		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	
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
11/07/22	V8.1	Guidelines updated as document out of date. Changes made to incident review processes and SSKIN bundle completion. Sections checked with subject experts – End of Life, IPAC, OT's, Equipment library and community services. SOP for data collection and monitoring added as an appendix Equipment for discharge section 6.14	Tissue Viability Consultant Nurse

Date	Version Number	Summary of Changes	Changes Made by
		updated Review of NICE guidance	
November 2022	V9.0	No further changes since July 2022. Policy has since been approved. Policy rechecked to ensure NICE guidance is integral to policy	Heather Newton, Tissue Viability Nurse Consultant

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Prevention of Pressure Ulcers Policy V9.0
Directorate and service area:	Tissue Viability
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Heather Newton, Tissue Viability Nurse Consultant
Contact details:	01872 252673

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To promote best practice in the prevention and management of pressure ulcers
2. Policy Objectives	To support the reduction of prevalence and incidence of hospital acquired pressure damage through assessment, implementation, and evaluation of patient care.
3. Policy Intended Outcomes	-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
4. How will you measure each outcome?	-Monthly Incidence audit -Annual audit of alternating and static mattresses -Audit of pressure ulcer assessment and care planning through Quality care indicators

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	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
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Tissue Viability Link practitioners and Senior Nurses
6c. What was the outcome of the consultation?	All staff that have been consulted are happy with the policy updates and the policy has been approved at the RCHT Senior Nurse Cabinet
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	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 or female)	No	

Protected Characteristic	(Yes or No)	Rationale
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Increased staff awareness of risk to patients with reduced mobility
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Heather Newton, Tissue Viability Nurse Consultant

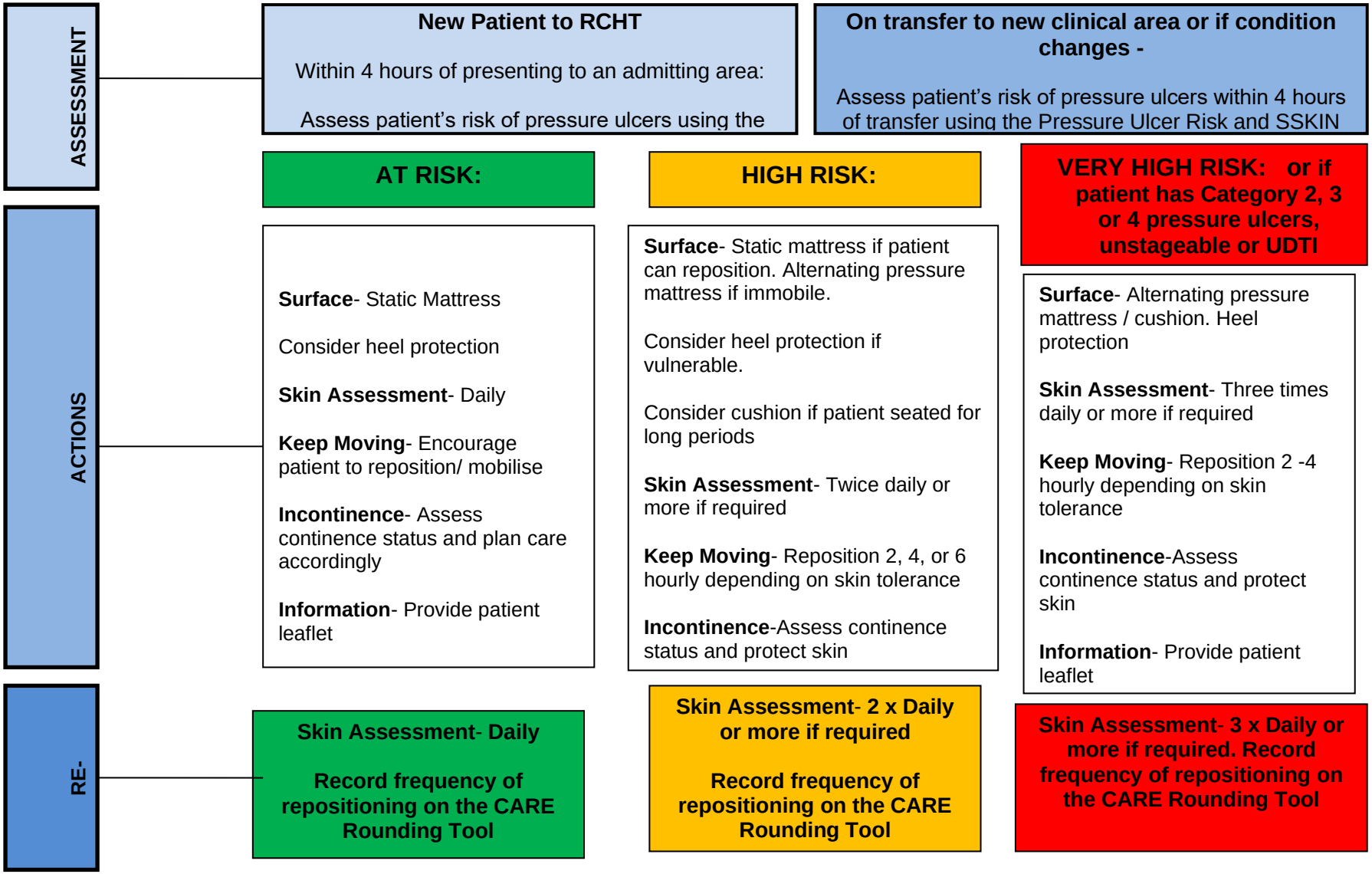
If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

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

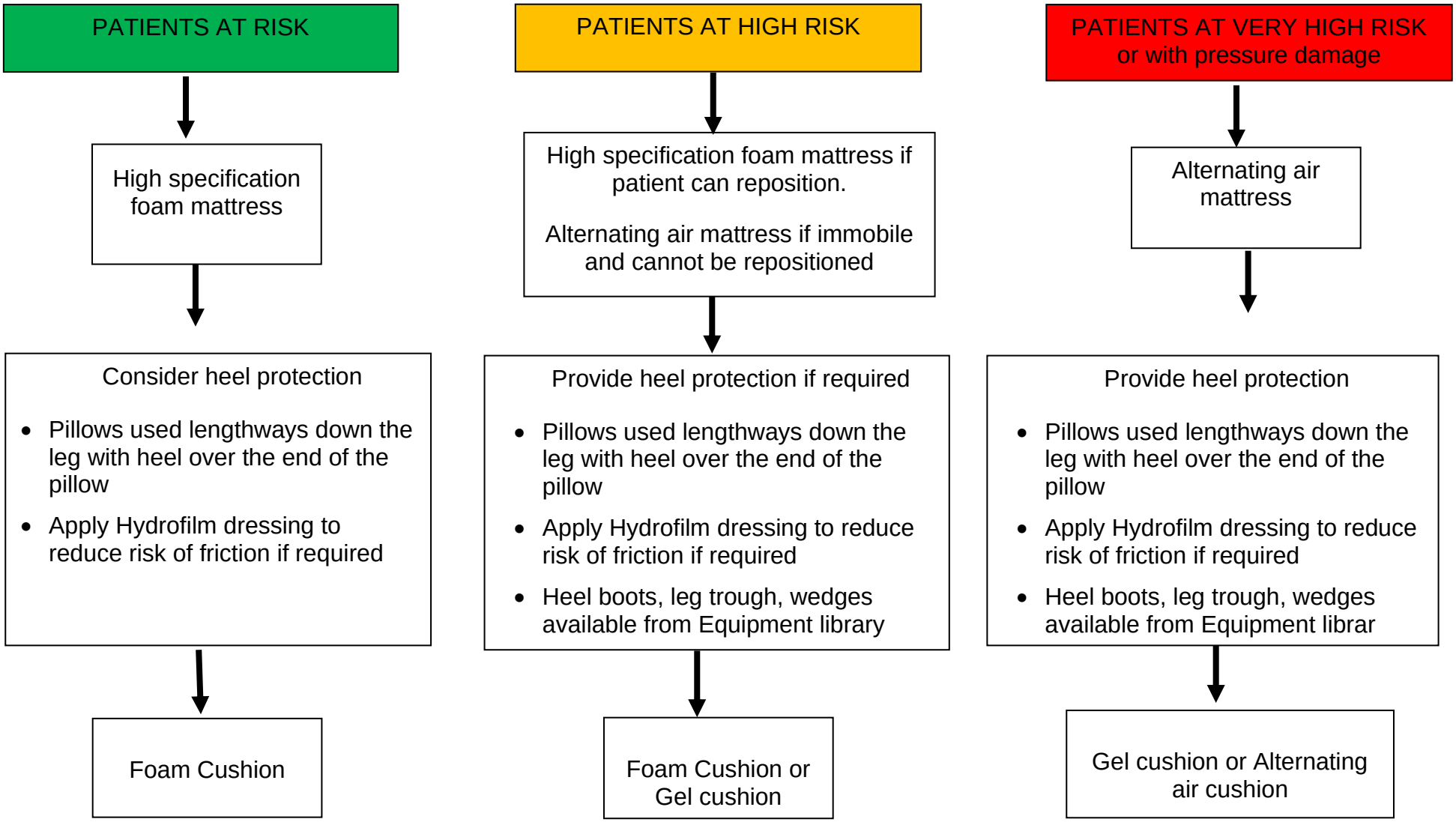
Appendix 4. Pressure Ulcer Prevention Clinical Pathway

Appendix 4. Pressure Ulcer Prevention Clinical Pathway

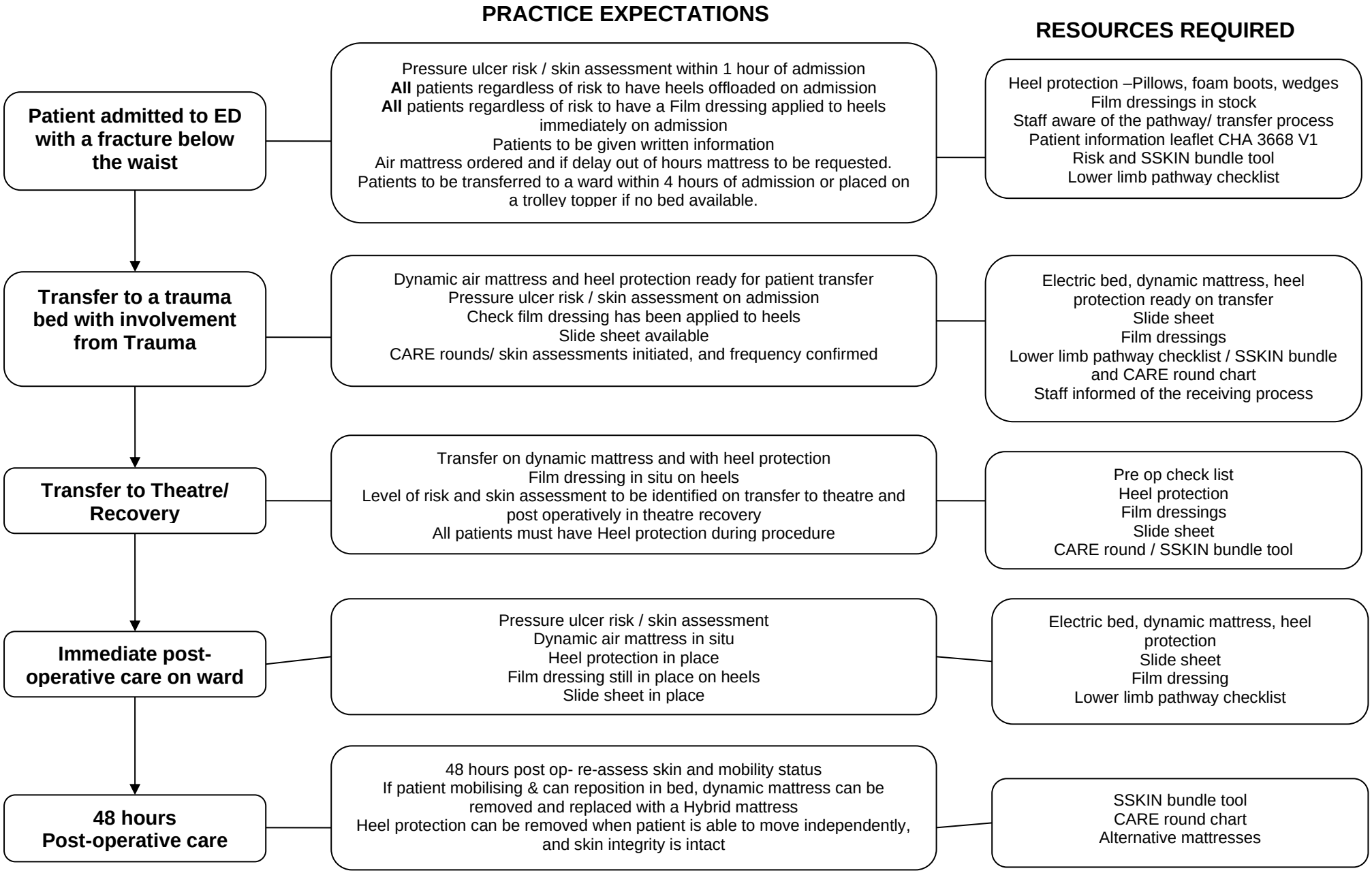


Appendix 5. Pressure Relieving Equipment Selection Guidelines

- 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.



Appendix 6. Lower Limb pathway



Appendix 7. Pressure Ulcer Reporting Standard Operating Procedure

One + all | we care

Royal Cornwall Hospitals NHS Trust

Pressure Ulcer Reporting Standard Operating Procedure

V1.0

December 2022

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 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 cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. Pressure ulcers remain a mainly avoidable harm associated with the delivery of healthcare with organisations continuing to monitor and report the incidence of pressure ulcers and implement preventative strategies to reduce patient harm.

1.2. Quantifying pressure ulcers can be complex as the type of data collected and methods used remain variable across organisations. This makes data validity challenging and as such continues to be a key component of quality improvement measures in healthcare. It is important to ensure local data collection and reporting reflects National NHSI recommendations.

https://www.england.nhs.uk/wp-content/uploads/2021/09/Guidance-for-reporting-pressure-ulcers.pdf

2. Purpose of this Standard Operating Procedure (SOP)

2.1. This SOP aims to provide an overview of what data is collected, how the data is collected, how the data is reported and how the data is shared across the RCHT.

2.2. The rationale is to provide assurance as to the consistency of data collection and reporting. Outcomes will be monitored by the RCHT Tissue Viability team and reported as per this SOP.

2.3. This document will be referenced from the NHS Improvement recommendations detailed in:

Pressure ulcers: revised definition and measurement. June 2018. NHS Improvement. London.

https://www.england.nhs.uk/pressure-ulcers-revised-definition-and-measurement-framework/

3. Ownership and Responsibilities

3.1. The development, management and implementation of this SOP is the responsibility of the RCHT Tissue Viability (TV) team who sit within the Corporate Care Group.

3.2. The TV team report into the RCHT Patient Safety Group and reports are generated for the Corporate IPR.

3.3. Role of the Managers

Line managers are responsible for:

- Ensuring that staff are reporting all pressure ulcer incidents.
- Ensuring that Datix reports are completed accurately and that the incident is investigated, finalised, and discussed with ward teams as part of the Datix report.

- Completing the Patient Safety Review (PSR) section one and/or two in a timely way when required once requested from the Patient Safety team. Responding to individual complaints relating to pressure ulcers.

- Support further Patient Safety Incident Investigations (PSII) as required

- Sharing Incident outcomes through local governance meetings and safety briefs with ward / department staff

3.4. Role of Individual Staff

All staff members are responsible for:

- Recognising and accurately categorising pressure ulcers to ensure effective reporting of all pressure ulcer incidents on Datix.

- Discussing pressure ulcer incidents with staff and patients when identified in the clinical areas using the Pressure ulcer debrief tool.

- Completing the Datix reports if identified as an incident handler and identifying shared learning as a result.

- Support Pressure ulcer investigations and complaint handling.

- Maintaining their knowledge of preventative pressure area care.

4. Standards and Practice

4.1. Required data

4.1.1. All pressure ulcers Category 1 and above will be reported via the Datix Incident reporting system. This also includes Unstageable and Suspected Deep Tissue Injuries (SDTI's).

4.1.2. Device related pressure ulcers will be reported and annotated with a (d).

4.1.3. Moisture associated skin damage (MASD) will be reported on the Datix Incident reporting system.

4.1.4. Mucosal damage will also be reported on the Datix Incident reporting system.

4.2. Data collection and analysis

4.2.1. Following admission to hospital patients will have a skin assessment completed within 4 hours and recorded on the ED checklist if admitted via ED and on the SSKIN bundle found on Nerve centre if admitted via an alternative route. If identified as at risk of pressure ulcers on admission the SSKIN bundle will be completed according to the patient's level of risk as follows:

- At risk – daily

- High risk – twice daily
- Very high risk – three times daily

4.2.2. The SSKIN bundle charts, now part of Nerve centre patient electronic record, will be used to record the patient's level of pressure ulcer risk and their skin integrity on admission and during their hospital stay. It will also reflect when and where the pressure ulcer developed.

4.2.3. All pressure ulcers **identified on admission to RCHT** will be reported via the Datix Incident reporting system as *a pressure ulcer on admission*. These incidents are closed by the respective Care Group Governance team without further investigation as not RCHT acquired.

4.2.4. If the patient **develops a pressure ulcer during their RCHT stay** this will be reported as *a new pressure ulcer* (acquired within this episode of care) incident on the Datix Incident reporting system. The incident handler will review the incident to confirm the level of harm, review care delivery, complete the incident report noting relevant learning as a result and escalate concerns as required.

4.2.5. The TV team will validate all RCHT acquired pressure ulcers where possible, either face to face or through discussion with ward teams and or notes review. The completed validation tool will be attached to the Datix report to support the incident handler with report completion.

4.2.6. If a patient develops a pressure ulcer which is higher than a category 2 or unstageable whilst in RCHT, this will be deemed as moderate harm. Once validated the TV team will notify the Patient Safety team that a Patient Safety Review section 1 (PSR1) is required from the Care group where the incident occurred. Alternatively, the Care group can trigger a PSR1 with the Patient Safety team.

- The TV team will support the completion of PSR section one if required as subject experts. They also require sight of the PSR1 prior to Executive approval to ensure the accuracy and validity of the report.

4.2.7. The completed PSR 1 will be returned to the central team who will forward to the Executive team to decide if the incident requires further review (PSR 2) or if the criteria for a Patient Safety Incident Investigation (PSII) has been met. The subject experts will continue to support completion of the PSR2 and / or PSII.

4.2.8. As part of the PSR process, consideration will be given as to whether the incident should be reported as a safeguarding incident using the Clinical Decision tool which details questions regarding patient's vulnerability and risk. A risk score will be noted as part of the PSR report. Any scores above 15 will be declared as a

safeguarding alert and will require a further decision regarding the level of investigation. The subject experts can support completion of this tool at the PSR1 stage.

4.2.9. If a patient develops an RCHT acquired SDTI weekly monitoring will commence by the TV team until discharge. Should this develop post discharge into a category 3 or 4 this will be reported via CFT incident reporting system to RCHT for further investigation as identified above.

4.3. Data reporting

4.3.1. All RCHT pressure ulcer data will be validated where possible by the TV team monthly using the Pressure ulcer validation tool. All validated forms will be uploaded to the individual Datix for reference.

4.3.2. A monthly pressure ulcer Datix report will be written identifying the number of patients in RCHT with hospital acquired pressure ulcers – Category 2-4 and Unstageable, the number related to a medical device, the number of SDTI's and the number of MASD as well as the incidence rate per 1000 bed days. A yearly comparison will be reported as will the SPC chart identifying achievements against target.

The report will also detail the wards where incidents have occurred, lessons learnt, challenges and next steps.

4.3.3. The monthly pressure ulcer Datix report will be shared across all Care Groups via Wards Sisters, Charge Nurses and Clinical Matrons as well as key RCHT Senior Quality leaders.

4.3.4. Pressure ulcer data will be included in the Monthly IPR report to the Trust board and exception reporting at the Patient Safety Group which reports to the QAC and IRLG

4.3.5. All non RCHT acquired Category 3 and 4 data will be shared with the Community TV lead and CFT Governance monthly.

5. Dissemination and Implementation

5.1. This document will be shared with the Central Governance team and all Directorate Governance leads for information and will be available on the Trust Intranet site as a new document. It will also be made available to the Patient Safety group for reference and Community Tissue Viability partners.

5.2. No training will be required as this process is already in place and this SOP is written to formalise and provide written confirmation of the pressure ulcer incident reporting process.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Pressure ulcer validation is part of the Tissue Viability monitoring process with a target of > 90% of RCHT incidents are to be validated each month. Datix reports are completed monthly as part of the Board IPR
Lead	Tissue Viability Consultant Nurse
Tool	Pressure ulcer validation tool
Frequency	Pressure ulcer validation compliance – monthly via Corporate IPR Pressure ulcer data report and IPR– monthly
Reporting arrangements	Datix report sent to all Clinical, Quality and Governance leads monthly. Each Care group reviews their data and reports when required via Care group Governance Trust board IPR reporting monthly – number of pressure ulcers and monitoring against targets included as well as areas for improvement. Patient safety group meeting – exemption reporting monthly PSR and PSII reports – fed back at IRLG meeting when required. Further actions may be required following this meeting.
Acting on recommendations and Lead(s)	The Tissue Viability team will take responsibility for reporting pressure ulcer data outcomes and support clinical areas where required with education and training. QI projects will be implemented when and where required based on specific clinic need. Actions identified in investigations should be implemented by ward/department leaders with support from the Tissue Viability team and oversight by the individual SI action plan owner.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	Any specific changes to practice will be identified and actioned as part of QI projects or Incident action plans as identified in each individual report. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

7. Updating and Review

This SOP will be reviewed in 3 years unless changes are required to data collection and reporting in advance of this date.

8. Equality and Diversity

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

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Pressure Ulcer Reporting Standard Operating Procedure V1.0
This document replaces (exact title of previous version):	New document
Date Issued/Approved:	November 2022
Date Valid From:	December 2022
Date Valid To:	December 2025
Directorate / Department responsible (author/owner):	Heather Newton Consultant Nurse Tissue Viability
Contact details:	01872 252673
Brief summary of contents:	This SOP aims to provide an overview of the methods of the type of pressure ulcer data collected, how the data is collected, how the data is reported and how the data is shared across the RCHT.
Suggested Keywords:	Pressure ulcer incident reporting Pressure ulcer data collection
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Joint Executive Director and Chief Nurse
General Manager confirming approval processes:	Central Governance Team leads Community Tissue Viability Consultant Nurse Care group Governance leads Patient Safety Group / Harm leads
Name of Governance Lead confirming approval by specialty and care group management meetings:	Louise Dickinson
Links to key external standards:	Louise Dickinson

Information Category	Detailed Information
Related Documents:	https://www.england.nhs.uk/wp-content/uploads/2021/09/Guidance-for-reporting-pressure-ulcers.pdf
Training Need Identified?	https://www.england.nhs.uk/pressure-ulcers-revised-definition-and-measurement-framework/
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Corporate Clinical

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
November 2022	V1.0	New document following consultation review and PSR process clarification.	Heather Newton Consultant Nurse Tissue Viability

All or part of this document can be released under the Freedom of Information Act 2000

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Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Pressure Ulcer Reporting Standard Operating Procedure V1.0
Directorate and service area:	Corporate Clinical
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Heather Newton, Consultant Nurse Tissue Viability
Contact details:	01872 252673

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This SOP aims to provide an overview of the methods of the type of pressure ulcer data collected, how the data is collected, how the data is reported and how the data is shared across the RCHT.
2. Policy Objectives	Consistent data collection and reporting
3. Policy Intended Outcomes	Accurate and complete data reporting
4. How will you measure each outcome?	Pressure ulcer validation is part of the Tissue Viability monitoring process with a target of > 90% of RCHT incidents are to be validated each month. Datix reports are completed monthly as part of the Board IPR
5. Who is intended to benefit from the policy?	Clinical and non-clinical leaders involved in pressure ulcer reporting, data analysis and shred learning.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Central Governance Team leads Community Tissue Viability Consultant Nurse Care group Governance leads Patient Safety Group / Harm leads
6c. What was the outcome of the consultation?	Positive approval of the content of the SOP. Monir changes following clarification of the PSR process and tine frames for completion of risk assessments.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Heather Newton, Consultant Nurse Tissue Viability

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis