NHS Grampian

Pressure Ulcer Prevention and Management Policy

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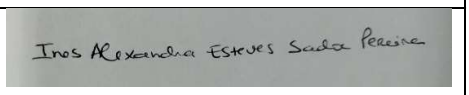
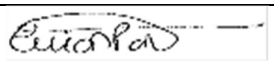
Reviewer:	Ines Pereira Tissue Viability Nurse Consultant	
Approver:	Leigh Porter Aberdeen City HSCP Lead Podiatrist/NHSG Diabetes Podiatry Co-ordinator	

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Executive Sign-Off

This document has been endorsed by the Executive Nurse Director

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Version History

Revision Date	Previous Revision Date	Summary of Changes (Descriptive summary of the changes made)	Changes Marked* (Identify page numbers and section heading)
November 2020	N/A	• Amendments of associated documentation links and wording to incorporate podiatry.	• Hyperlinks updated throughout document. • References updated.
May 2022	November 2020	• Replacement and updating of hyperlinks. • Initial PU Risk and skin assessment for new inpatients changed from 8 to 4 hrs to reflect updated risk assessments	• Hyperlinks updated throughout document. • Pages 7 & 9
January 2024	November 2020	• Full review and updating	• Hyperlinks updated throughout document. • Obsolete information removed. • References updated.

Subject (as per document registration categories): Policy

Key word(s): Pressure ulcer prevention, Tissue Viability, Datix, Podiatry

Document application: NHS Grampian

Purpose/description: Pressure Ulcer Prevention and Management

Policy statement: It is the responsibility of all staff to ensure that they are working to the most up to date and relevant policies, protocols, procedures and pathways.

Responsibilities for implementation:
Organisational: Operational Management Team and Chief Executive
Sector General Managers, Medical Leads and Nursing Leads
Departmental: Clinical Leads
Area: Line Manager

Responsibilities for review of this document: Nurse Consultant/Department of Tissue Viability

Contents

Pressure Ulcer Prevention and Management Policy

1. Introduction

The purpose of this policy is to ensure that all patients within NHS Grampian are systematically assessed, and effective preventative strategies are in place to reduce the risk to skin integrity and facilitate healing of damaged tissue.

Pressure ulcers, also known as bedsores, decubitus ulcers, and pressure injuries, are areas of injury to the skin, the tissue that lies underneath, or both. Pressure ulcers can be painful, may become infected, and affect people's quality of life. People at risk of developing pressure ulcers include those with spinal cord injuries and those who are immobile or who have limited mobility [(1)]. There are observable changes in the skin at the end of life. For pressure ulcers, it is important to determine if the ulcer may be (i) healable within an individual's life expectancy, (ii) managed conservatively, or (iii) non-healable or palliative [(2)]. Pressure ulceration may negatively affect quality of life and impose a significant financial burden on healthcare systems [(3)].

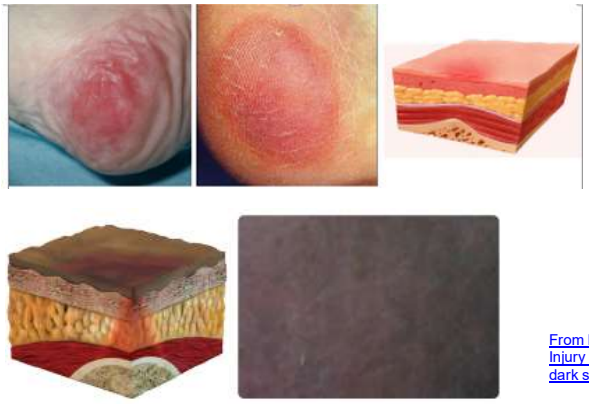
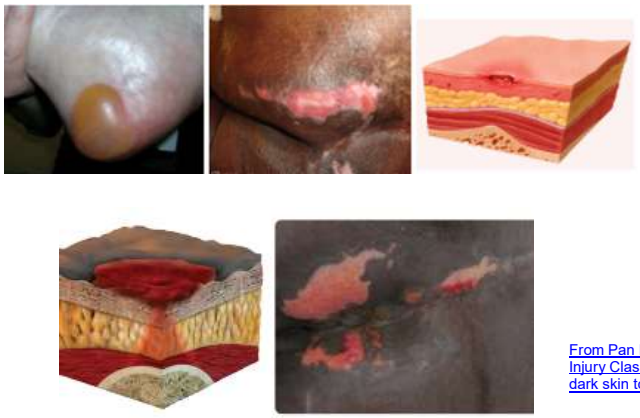
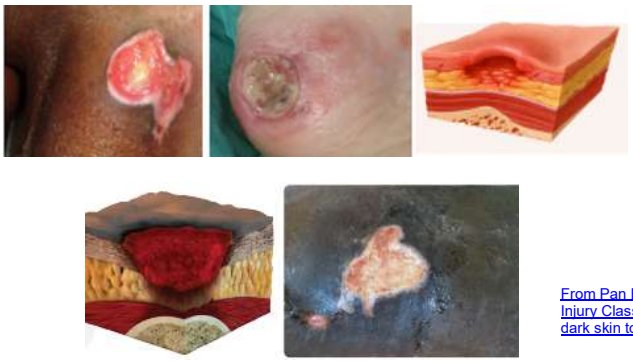
The organisational Duty of Candour (DoC) came into effect 1st April 2018[(4)]. The purpose of the DoC procedure is to support the implementation of consistent responses across health and social care providers, when there has been an incident that resulted in unintended or unexpected harm, and which is not related to the course of the condition for which the person is receiving care. The DoC applies to all organisations providing health and social care services in Scotland.

All patients who develop a new pressure ulcer, whilst under the care of NHS Grampian, must be investigated by the Healthcare professional (HCP) responsible for providing care in the clinical location where the pressure ulcer has occurred (even if patient is due for transfer or discharge). This involves completion of a RED Day Review, which will determine if the pressure ulcer was **unavoidable** (optimal care given with other factors contributing to the pressure ulcer) or **avoidable** (possible omissions in care) [(5)]. All avoidable pressure ulcers have the potential to activate DoC, refer to flowchart for process.

Unavoidable pressure ulcer - The person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and risk factors associated with the pressure ulcer. This includes planning and implementing interventions that are consistent with the persons' needs and goals, within recognised standards of practice. The impact of the interventions must be evaluated and revised, as appropriate. Also, if the individual person declined to adhere to prevention strategies, despite education on the consequences of non-concordance.

Avoidable pressure ulcer - The person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and risk factors associated with the pressure ulcer; plan and implement interventions that are consistent with the persons needs and goals and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

The Scottish Adapted European pressure ulcer Advisory Panel (EPUAP) Grading Tool is used in the assessment and grading of pressure ulcers. Damage is identified from Grade 1 to 4, depending on the severity of damage [6].

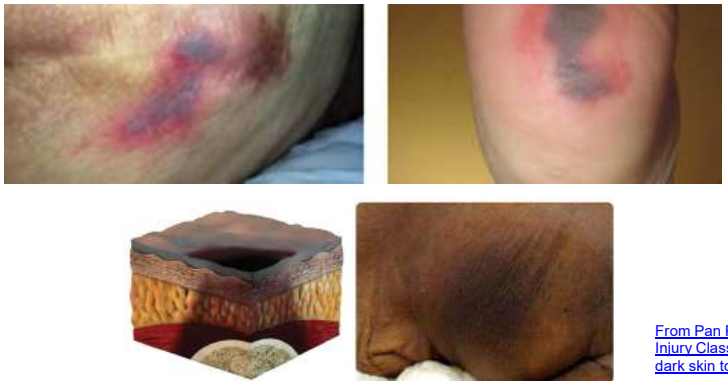
The Definition of Grades	
Grade 1	Non-blanchable erythema (redness) of intact skin. Discoloration of the skin, warmth, oedema, indurations or hardness may also be used as indicators, particularly on individuals with darker skin.  From Pan Pacific Pressure Injury Classification system for dark skin tones, Talley Group
Grade 2	Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.  From Pan Pacific Pressure Injury Classification system for dark skin tones, Talley Group
Grade 3	Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.  From Pan Pacific Pressure Injury Classification system for dark skin tones, Talley Group

Grade 4	Extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures with or without full thickness skin loss.  From Pan Pacific Pressure Injury Classification system for dark skin tones, Talley Group

A pressure ulcer may not fall into the above 4 grades, but may be one of the following:

Suspected Deep Tissue Injury

Intact epidermis, but the affected area can appear purple or maroon or be a blood-filled blister over a dark wound bed. Overtime the skin may degrade and develop into deeper tissue loss. **Once a grade has been established this must be clearly documented in the patient records.**



From Pan Pacific Pressure Injury Classification system for dark skin tones, Talley Group

Ungradable

Full thickness skin / tissue loss where the depth of the ulcer is completely obscured by slough and / or necrotic tissue. Until this tissue is removed to expose the base of the wound the true depth cannot be determined. **Once a grade has been established this must be clearly documented in the patient records.**

From Pan Pacific Pressure Injury Classification system for dark skin tones, Talley Group

Combination Lesions
These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage as above, but awareness of other causes and treatments are needed. See Moisture Associated Skin Damage (MASD) pathway.
Mucosal Pressure Ulcer
These develop on mucosal membranes such as the tongue, mouth, nasal passages, genitals and rectum. Mucosal tissue does not have the same layers of skin as rest of the body so it cannot be graded and should be documented as a mucosal pressure ulcer.

From Scottish adapted EPUAP grading tool

1.1 Definitions

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have neurological conditions, impaired mobility or impaired nutrition. As pressure ulcers can arise in several ways, interventions for prevention and treatment need to be applicable across all patient care settings inclusive of primary and secondary care. This may require organisational and individual change and a commitment to quality improvement [(7)].

1.2 Objectives and Scope of document

To support the provision of safe, effective, evidenced based person-centred care in the prevention and management of pressure ulcers within NHS Grampian this policy will support the implementation and embedding of Healthcare Improvement Scotland (HIS), Prevention and Management of Pressure Ulcers Care Standards [(8)].

1.3 Clinical situations

This policy applies to all staff involved in the delivery of healthcare regardless of the care setting and is applicable to patients of all ages. It will support and guide decision making in relation to care interventions with a focus on prevention of pressure damage and management of existing pressure ulceration. Each clinical area will be responsible for monitoring their incidence of pressure ulcers, and reporting of adverse events on Datix.

1.4 Patient groups to which this document applies to

This policy will cover all patients who receive care within NHS Grampian.

1.5 Patient groups to which this document does not apply to

This policy does not cover patients who receive care out with NHS Grampian.

2 Evidence Base

The department of Tissue Viability will use the following indicators to monitor and demonstrate progress towards the outcomes as stated above:

- Implementing and embedding of Prevention and Management of Pressure Ulcers Care Standards - Healthcare Improvement Scotland [8].
- Evidence of accurate pressure ulcer risk assessment documented in records within 4 hour time frame (for inpatients).
- Implementation of SSKIN Care Bundle for inpatients **or** SSKIN Care Plan for domiciliary patients assessed 'at risk'.
- Completion of an adverse event on Datix of all newly developed pressure ulcers, in line with adverse event – Pressure Ulcers (PU) – Duty of Candour (DoC) flowchart.
- Mandatory completion of RED Day Review and uploading into Datix for all new pressure ulcers, with learning outcomes shared with relevant teams.
- Sector Leads, Portfolio Executive Leads and clinical teams will hold accountability for taking forward implementation and embedding of best practice, demonstrating a continuous quality improvement approach.
- Service Leads will provide a leadership role regarding pressure ulcer prevention and management, and ensure a co-ordinated approach for their area, with regular quality meetings and feedback.

3 Main components and recommendations

3.1 Health and Social care staff

All health and social care staff caring for patients have responsibilities for the prevention and management of pressure ulceration. Expected contributions will be dependent on role.

Shared responsibilities may include:

- Health and social care staff must ensure that they have current and relevant knowledge and skills in the prevention and management of pressure ulceration at a level which reflects their role and responsibilities. This is essential for all health and social care staff delivering / responsible for pressure ulcer care [8].
- Contributing to the ongoing risk assessment of patients using risk assessment and their professional and clinical judgment.
- Contributing to, reviewing, evaluating and updating a multi-disciplinary, individualised person-centred documented care plan based on the patient's ongoing risk assessment.
- Providing the patient and carer, as appropriate, with information in a suitable format.
- Assessing the requirement of equipment for patients, i.e., pressure re-distributing support surfaces or moving and handling equipment.

- Obtaining and effectively using this equipment and ensuring it is functional and fit for purpose.
- Reporting an adverse event on Datix for all new pressure ulceration acquired within clinical area/caseload, with supporting clinical images.
- Knowledge of referral route for support with existing pressure ulcers (and wounds).

3.2 Senior Charge Nurse / Community Team Lead responsibilities

- Ensuring initial and on-going risk assessment is carried out and documented by appropriate staff.
- Reporting an adverse event on Datix for all new pressure ulcers within clinical area/ caseload, with supporting clinical images.
- Investigation of all new pressure damage developed within their care setting, using RED Day Review to establish if the pressure damage was avoidable or unavoidable.
- Updating and uploading recording of outcome in Datix.
- Action any issues identified from investigations and disseminating this information to all staff to achieve and maintain learning and quality improvement.
- Seek Tissue Viability and/or Podiatry assistance for educational support, when required.
- Displaying and sharing of data pertaining to pressure ulcer incidence and management with team to promote care improvement and showcase quality of care in their areas.
- Ensuring registered HCP initiates prevention and treatment plan for all grades of pressure ulcer and implements SSKIN Care Bundle (inpatients). Utilising Applied Wound Management Chart and First Choice Wound Dressing Guide to guide individualised treatment.
- Compliance to NHSG Dressings Formulary or rationale for alternative non formulary product.
- Provision of and ensuring maintenance of pressure redistribution/offloading equipment.
- Procurement, security and ensuring staff accessibility to camera, when required, and knowledge of MS Teams camera app and how to take and upload images safely.

3.3 Heads of Nurs*i*ng and Midwifery / Senior Nurses / Professional Leads / Midwives / Line Managers / Senior Charge Nurses / Community Team Leaders are responsible for ensuring that:

- Compliance and monitoring of this policy at local level.
- Local improvement and assurance activities are shared across the team to create and nurture a learning environment.
- Essential requirement that all staff maintains and updates their knowledge, skills and competence in line with their roles and responsibilities, to care for patients who are at risk of a pressure ulcer[8] .
- Ensuring that all staff can access online training via Turas, and TV Teams sessions.
- NHSG Dressings Formulary compliance at local level.

All tools and resources are available via:

- Grampian Guidance - Nursing Documentation - Section 8c/d
- Tissue Viability intranet website
- Printed colour documents via Central Stores/PECOS:
    - Applied Wound Management Assessment and Continuation chart - Stock No ZKB902
    - Preventing Pressure Ulcers: Information for patients and carers - PECOS ZRA001

3.4 Department of Tissue Viability responsibilities are:

- Act as an expert advisor to the Executive Director of Nursing, Midwifery and AHPs and associated teams.
- Provide clinical leadership, support managers and clinical staff in implementing this policy.
- Updating local policies, guidelines and procedures in accordance with national and international guidance.
- Remain updated with the latest clinical evidence and National and International guidelines on the prevention and treatment of pressure ulcers.
- Provision of specialist tissue viability clinical advice, joint assessments and treatment plans when required to support staff and patients.
- Ensuring all referrals via the Tissue Viability service e-clinic are actioned within agreed timeframes.
- Reviewing adverse events submitted regarding pressure ulcers, above malleolus (ankle).
- Support managers/teams with investigations into the development of pressure ulcers and assist with improvement plans.
- Provide input into the evaluation and purchase of pressure relieving equipment and associated contracts.
- Provision of education and training for health and social care staff on pressure ulcer prevention and management in a variety of formats, across NHSG as well as third sector care providers.
- Education events are available to all trained and untrained staff, dates and events are available on the Tissue Viability intranet webpage. Support from your local Practice Education Facilitator (PEF) and Associate PEF and they will liaise with Tissue Viability team as required.
- Self-directed e-learning education is available to **all** staff, via Turas. Prevention and Management of Pressure Ulcers and Fundamental skin care and wound management– via Turas.
- Overseeing NHS Grampians bed management contract to ensure the equipment and service is fit for purpose and meets the patient and organisation's needs;

- Maintaining and updating of Tissue Viability documentation within:
    - Grampian Guidance nursing section 8c & 8d
    - TV intranet pages
    - TV HiNet pages
- Working to improve pathways and patient experience alongside appropriate teams;
- Maintain and support an active tissue viability Wound Advocate network.

Where Tissue Viability has been involved with a patient, the ongoing responsibility and monitoring of the patient remains with the clinical team caring for the patient.

3.5 Department of Podiatry responsibilities are:

- Reviewing adverse events submitted regarding pressure ulcers below malleolus (ankle) and foot.
- Provision of specialist clinical review of pressure ulceration pertaining to malleolus (ankle) and foot, when required.

In line with NHS Grampian lower limb referral pathway, all foot and ankle ulceration must be referred onwards to Podiatry services based within each Health and Social Care Partnership and Acute sectors[9]. See below referral information.

- Podiatry in-patient referral process
- Podiatry self-referral form
- Podiatry out-patient referral process

3.6. Clinical Images

Consent must be obtained for all images taken.

Following the implementation of Microsoft Teams (May 2020), there is now the option to take clinical images on your phone (personal or NHS) [10].

Images can be shared; photos are not stored on your device/accessible to your photo-stream **if (and only if) they are taken via the MS Teams app camera**. Step by step guide is available here.

Procurement, maintenance and staff access of camera (if not using MS Teams camera app) is the responsibility of each clinical area. Once images have been uploaded, images from camera memory card must be deleted [10].

3.7 Identifying patients 'at risk'

- All new inpatients will have their pressure ulcer risk assessed within 4 hours of admission; this includes time spent in the Emergency Department.
- Acute inpatients are reassessed daily.
- Long term inpatients / residential care clients can be reassessed weekly if low risk. If condition changes and risk increases, reassess daily until considered low risk again.
- There will be clearly documented evidence in the healthcare record that a risk assessment has been completed and repeated for those at risk.
- Domiciliary visit risk assessment should be completed on first clinical visit / patient contact. Exclusion criteria would be "one off patient visits". Reassess if patient condition changes.

Digital Wards have/will move to a combined risk assessment ASSSKINGME. It is designed to identify the individual's risks in relation to pressure ulcer, falls, nutrition and cognition on admission and subsequently as required.

- ASSSKINGME Toolbox Talk
- ASSSKINGME Risk Assessment
- ASSSKINGME Best Practice Statement

Until moving to digital records which incorporates ASSSKINGME, all other areas will use SSKIN Pressure Ulcer Risk Assessment, **please note Waterlow was fully removed from NHSG August 2022, and is no longer used.**

3.8 Risk Factors

An individual's potential to develop a pressure ulcer will be influenced by both extrinsic (outside the patient) and intrinsic (from within the patient) factors. These factors must be considered when performing a risk assessment and developing a care plan. They must be removed or diminished where possible to prevent tissue damage. Once the risk of developing a pressure ulcer is established, prevention strategies should be adopted as per SSKIN Care Bundle (inpatients).

- **S**kin inspection
- **S**upport surfaces - Mattress / Cushion / Heel Protector requirements
- **K**eep patients moving
- **I**ncontinence and moisture management
- **N**utrition and Hydration assessment

A SKIN care bundle considers all fundamental preventative components into a single unit of care that must be implemented (for inpatients at risk), on every occasion that the patient is reviewed [12].

NB: If a patient declines preventative care interventions, including equipment, the risks should be fully explained to the patient and/or carer and this should be documented in their nursing records.

3.9 Adults with Incapacity

Capacity to consent must always be assessed and incapacity should never be presumed because a person has a particular health condition or disability, for example mental health problem, learning disability or dementia [13].

Without proper authorisation the person's right to make decisions about their care can be violated and could be seen as assault in the eyes of the law e.g. giving covert medication to someone with capacity to consent to treatment. The Adults with Incapacity (Scotland) Act 2000 (AWI) places an obligation on all staff to understand legislation and apply it appropriately [14].

Hence, staff should be familiar with the above legislation and ensure that all factors that may influence capacity, such as personal, physical, psychosocial and situational, available resources and support exist and take these into consideration when assessing a patient.

Individuals should be encouraged to participate in decision making about all aspects of their care and treatment as a basic right.
Staff should be aware that mental illness does not necessarily make a patient incapable of giving or refusing consent, so Incapacity/Capacity is not an absolute in relation to either all care or for an indefinite period, and it must be reassessed in the context of a patient's clinical condition, and potential treatment options, which may be simple or complex [14].

3.10 Skin inspection and discussion

On admission to an inpatient setting, patients should have a skin inspection / discussion carried out and documented within 4 hours, including time spent in Emergency Department.

On Domiciliary visit, skin inspection / discussion should take place on first clinical visit / patient contact. Exclusion criteria would be "one off patient visits" or if the case holder does not think this would be appropriate in their clinical judgement, clearly documenting the reason why skin inspection was not performed.

- **Acute care -** skin inspection / discussion must occur minimum daily (patients at risk or who have existing pressure ulcers will be reassessed more frequently) according to their SSKIN Care Bundle.
- **Long term inpatients / residential care clients –** skin inspection / discussion should occur at least daily for patients assessed as being at risk.
- **Domiciliary at risk and vulnerable adults -** skin inspection / discussion should occur at each visit.

Skin inspection / discussion is a vital part of the ongoing risk assessment process, and a fundamental component of the SSKIN Care Bundle. Particular attention should be made to skin over bony prominences and areas which are in contact with equipment e.g. tubing.

Recognition of the early signs of tissue damage (Grade 1) may prevent pressure ulcer deterioration and reduce the level of damage incurred.

- Skin inspection can take place during routine care, considering patient consent, preferences, privacy, dignity and cultural wishes.
- Skin inspection must be recorded and identified issues addressed.
- Refusal to allow skin inspection should be documented and the risks fully explained to the patient and / or carer.
- A repositioning regime must be established and documented, for patients at risk and above. The frequency will be detailed on the SSKIN Care Bundle (inpatients) and altered accordingly following skin inspection where required.
- When repositioning a patient may result in serious consequences due to the severity of a patient's clinical condition this must be documented in their clinical notes and a repositioning regime commenced as soon as their condition allows.
- If a patient is at risk of pressure damage, information will be given to the patient in an appropriate format.

3.11 Pressure ulcer assessment

On admission, first domiciliary or clinic visit, all patients with existing pressure ulcer must have a holistic assessment carried out, with completion of appropriate wound assessment chart. This will allow staff to plan, develop and implement an individualised person-centred care plan.

Discuss pressure ulcer management with the patient and their carer (as appropriate) to establish history of the pressure ulcer and their understanding of the condition.

Wound assessment (including wound sizes) and treatment plan documentation must be completed for all pressure ulcer grades. Reassessment should be carried out once weekly, minimum. This will be recorded within Applied Wound Management Assessment and Continuation Chart.

Refer to an appropriate multidisciplinary team member to address any underlying factors that may inhibit wound progression or manage symptoms in a way which is acceptable to the patient e.g. Vascular, Dermatology, Dietician, Pharmacist, AHPs, Surgical team, Bladder and Bowel Service, Psychologist Moving and Handling.

Dressing product selection must be based on the wound management objectives and specific patient's needs, and compliant with the NHSG Wound Formulary.

If using non - formulary products clinicians must document their rationale for dressing choice.

3.12 Podiatry - foot and ankle – reporting an adverse event

- Ensure “is pressure ulcer on foot (ankle to toes)” is selected within an adverse event on Datix.
- Podiatry services will endeavour to assess all foot and ankle ulceration within 2 working days of referral.
- An adverse event for new pressure ulcers to ankle and below will be reviewed and actioned by Podiatry, providing advice and support on the most appropriate management plan for the patient.
- Check-Protect-Refer for 'at risk' feet is a Scottish government directive, through the Scottish Diabetes Foot Action Group, aiming to reduce pressure ulcer damage in patients 'at risk' of developing a foot ulcer while in hospital [15].
  Check-Protect-Refer is a safe and simple process to follow:
  - **Check** - for signs of pressure damage.
  - **Protect** - from potential pressure damage.
  - **Refer** - onwards for further advice and support if required

CPR for Feet PIL
CPR Pathway for At Risk Feet
CPR For Feet

3.13 Tissue Viability – reporting an adverse event

- **All** new pressure ulcers must be reported on Datix by current clinical area, refer to guidance.
- Prevention and treatment will be initiated by Registered Nurse immediately upon discovery.
- For Grade 1 and 2 pressure ulcers, specialist Tissue Viability advice will only be given following Datix review, if required, e.g. if treatment plan commenced inappropriate.
- **All** Grade 3, 4, ungradable, suspected deep tissue injury and mucosal pressure ulcer will be reviewed via Datix report and recommendations provided by specialist Tissue Viability nurse.
- All pressure damage which has arisen from or occurs because of issues relating to equipment, supplies or treatment, must have an adverse event reported on Datix.
- Tissue Viability will advise staff if any follow up is required for individual patients.
- gram.tissueviabilityacute@nhs.scot should be used for all acute follow up referrals, referrals will be replied to within 2 working days.
- gram.tissueviability@nhs.scot should be used for all primary care follow up referrals, referrals will be replied to within 10 working days.
- The Tissue Viability e-clinic is not an emergency referral route, please escalate to medical colleagues in first instance, and refer to e-clinic thereafter, if required.

- If the referral is sent from a personal NHS email account, please ensure you have your signature with details that will allow prompt communication from the tissue viability team.
- Treatment recommendations from Tissue Viability will be viewable in Trakcare in the EPR (or communicated via email, if no letter response required).
- Further details can be found here, how to make a referral to.

NB – If a pressure ulcer deteriorates it must be reassessed. If it is re-graded at a higher grade this can be updated into existing Datix along with supporting clinical images.

3.14 Pressure re-distributing equipment

The use of any pressure re-distributing equipment does not replace the need for repositioning and skin inspection of the patient. Please refer to:

Pressure Redistributing Equipment Selection Guide
CPR for Feet - Pressure Relief
Prolevo and Heelsafe Order Codes
Prolevo NDC Codes - with boot sizes

Any equipment provided to the patient must follow a holistic assessment of the patients' needs and must be appropriate. Continual reassessment must be performed to ensure equipment remains suitable and meets patients' needs. Equipment is an adjuvant to care and not a replacement, therefore repositioning measures must form an integral part of the care plan, for both prevention and treatment.

3.15 Transfer of care

- All patients who have been identified as being at risk must have their skin inspected for any damage prior to transfer. Skin condition must be documented in the patients' records, as part of the transfer process.
- Where possible ensure transfer area is aware of pressure re-distributing equipment required prior to transfer to allow time to source.
- Provide receiving area with documented information of patient's skin condition, pressure ulcer grade and current treatment, prior to transfer.
- The receiving team must ensure that they are aware of a patient's pressure ulcer risk status at the time of transfer to their care and inspect skin upon arrival.
- Any other relevant information regarding the patient and their wound history should be communicated to the receiving HCP.

4. References

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5. Distribution List

The Pressure Ulcer Prevention and Management Policy is available on NHS Grampian Intranet and applies to all NHS staff who care for patients at risk or with pressure ulceration.