Prevention and Management of Pressure Ulcers Policy

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Contents

1.0 Introduction

Pressure damage is common in many healthcare settings affecting all age groups and is costly in terms of both human suffering and use of resources. The policy is intended to provide comprehensive guidance regarding the prevention and management of pressure ulcers. It aims to minimise the risk of pressure ulcers from developing and effectively manage pressure ulcers, improve clinical practice and reduce variations in standards of care; and to disseminate best practice across the organisation and the Cheshire and Merseyside region.

Pressure ulceration is often preventable and the overarching guidance for pressure ulcer prevention and management is provided nationally within National Institute for Clinical Excellence (NICE 2014) Clinical Guideline and Quality Standard (2015).

The term 'patient' will be used to encompass all individuals who are under the care of a healthcare professional, including 'service users' and 'clients.'

The National Wound Care Strategy Programme (NWCSP, 2023) provided recommendations which outline a pathway of care that promotes early risk identification and preventative care, enabling fast access to evidence-informed therapeutic interventions, with escalation of treatment or service provision for people requiring more complex care.

2.0 Roles and responsibilities

- **The Chief Executive and the organisation's senior staff** are responsible for the implementation of this policy.
- **The Tissue Viability Service (if one is available) or the policy committee** is responsible for developing and updating this policy.
- **Senior Staff/Team Leaders/Managers** are responsible for ensuring that all staff under their management complies with the content of this policy.
- **All Staff** who are involved in the management of patients at risk of developing, or those with existing pressure ulcers are responsible for ensuring their compliance with the policy.

This policy applies to all staff that have direct or indirect involvement with patients at risk of pressure ulceration. It includes the prevention, assessment and management of pressure ulcers in all settings, including hospitals, inpatient mental

health settings and care homes with and without nursing and people's own homes. It covers people of all ages including neonates, infants, children, young people and adults, including older people (NICE, 2015).

Any deviation from the policy must be recorded in the patient's record with a clear rationale for doing so. Clinical judgement plays a crucial part in making decisions about patient care relating to pressure ulcer prevention and management.

This document has been developed collaboratively by the following organisations:

- Alder Hey Children's Hospital NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- Cheshire & Merseyside Clinical Commissioning Groups
- East Cheshire NHS Trust
- Liverpool Heart and Chester NHS Foundation Trust
- Liverpool Women's Hospital NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- NHS England and NHS Improvement (Northwest)
- **Mersey West Lancashire Teaching Hospitals Trust** (previously St Helens and Knowsley and Southport and Ormskirk Hospitals)
- The Clatterbridge Cancer Centre NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- Wirral Community NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- **Cheshire and Merseyside Integrated Care Board (C&M ICB)**

It should also be noted that various C&M ICB place representatives and staff from the independent sector have been engaged in the writing of this document.

3.0 Definitions

3.1 Pressure Ulcer (PU)

''A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can

present as intact skin or an open ulcer and may be painful'' (NHS Improvement, 2018a).

3.2 Device Related Pressure Ulcer (DRPU)

A device related pressure ulcer may be caused by a medical device or a device, object or product without a medical purpose.

'A DRPU involves interaction with a device or object that is in direct or indirect contact with the skin or implanted under the skin' (Gefen et al, 2021)

Device related pressure ulcers should be reported and identified as "device related" within the Patient Safety Reporting system. They should be reported and identified by the notation of (d) after the report e.g. category 2 PU (d) (NHSI, 2018a).

Examples include but are **not limited to**:

- naso-gastric tube
- endotracheal tubes
- tracheostomy tubes
- oxygen/ventilation mask
- urinary/supra-pubic catheter
- percutaneous gastric tubes
- cannula/administration set
- compression bandaging or hosiery or anti-embolic stocking
- plaster of Paris
- neck collars
- halo brace
- anti-embolic stockings
- wheelchair/footplate
- splints

3.3 Category 1 Pressure Ulcer

Intact skin - In lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).

3.4 Category 2 Pressure Ulcer

Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. *

This Category ***should not*** be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.

3.5 Category 3 Pressure Ulcer

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity (fatty tissue) can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

3.6 Category 4 Pressure Ulcer

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

(NWCSP, 2023)

See Appendix 1 for categorisation poster (NWCSP, 2024).

3.7 Pressure ulcers where the skin is broken

Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration (NWCSP, 2023).

3.8 Deep tissue injuries (DTIs)

Deep tissue injuries (DTIs) should not be reported as pressure ulcers unless they result in broken skin or they fail to resolve and it is evident on palpation that there is deep tissue damage present, at which point, they should immediately be categorised and reported. However, the skin change must be recorded within the clinical record (for example by ticking the vulnerable skin option in the PURPOSE T tool) and appropriate preventative care delivered as soon as the damage is noted (NWCSP, 2023).

3.9 Pressure Ulcer on Admission to a Service (POA)

A pressure ulcer that is observed during the skin assessment undertaken on first assessment and admission to the service. N.B. The 72-hour rule should no longer be

used to determine whether a pressure ulcer has occurred prior to admission to care (NHSI, 2018a).

3.10 New Pressure Ulcer (NEW)

A pressure ulcer that is observed within the current episode of care. The 72-hour rule should no longer be used to define whether the pressure ulcer developed prior to admission to care (NHSI, 2018a).

3.11 Moisture Associated Skin Damage (MASD)

Where skin damage is caused only by moisture it will be reported as moisture associated skin damage to current episode of care. Where skin damage is caused by a ***combination*** of MASD and pressure it will be reported based on the category of pressure damage (NICE, 2014).

3.12 Diabetic Foot Ulcer (DFU)

A foot ulcer can be defined as a localised injury to the skin and/or underlying tissue, below the ankle, in a person with diabetes. The risk of foot problems in people with diabetes is increased, largely because of either diabetic neuropathy (nerve damage or degeneration) or peripheral arterial disease (poor blood supply due to diseased large- and medium-sized blood vessels in the legs), or both (NICE, 2016).

3.13 Heel / Foot Pressure Ulcer (PU)

Localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to medical or other device), resulting from sustained pressure, including pressure associated with shear (NHS Improvement, 2018). Any ulcer on the foot, heel or ankle, where **inactivity** is a major contributing factor can be classified as a **pressure ulcer**.

3.14 Pressure

A perpendicular (or vertical) load exerted on an area of the body e.g. the sacrum. The intensity and duration of pressure, particularly over bony prominences, is a major risk factor for pressure ulceration.

3.15 Shear

When underlying body structures try to move but the surface of the skin remains attached to the support surface e.g. heels pushing up in bed. This is frequently associated with poor positioning techniques, manual handling and postural problems.

3.16 A pressure ulcer that has developed at end of life due to 'skin failure'

A pressure ulcer that has developed at end of life due to 'skin failure' should not be referred to as a 'Kennedy ulcer' (NHSI, 2018a). The same pressure ulcer categorisation tool should be used, and ongoing prevention should be continued to be planned, implemented and evaluated for patients at end of life.

4.0 Guidance for Pressure Ulcer Prevention & Management

SSKIN (Skin Assessment, **S**upport Surface, **K**eep moving**, I**ncontinence and **N**utrition & hydration) is a mnemonic to guide appropriate practice and care for patients at risk of pressure ulceration. This was updated in NHS Improvement (2018) guidance using "**aSSKINg**".

- **A**ssess Risk
- **S**kin Assessment
- **S**upport Surface
- **K**eep moving
- **I**ncontinence
- **N**utrition and Hydration
- **G**ive information

Summary of key points:

Assess Risk

- All patients must have a risk assessment including skin inspection carried out by a healthcare professional trained in pressure ulcer assessment within 6 hours of admission or first community contact, using a recognised risk assessment tool.
- Patients assessed as "at risk" will have a care plan appropriate to their individual needs. The patient and their relatives or carers should be involved in the assessment and planning process wherever possible.

Skin Assessment

- Skin inspection must be performed on initial patient contact in the community, admission to clinical areas and on transfer from other organisations or prior to discharge.
- Skin inspection must be carried out within six hours of admission (NICE, 2014). Ideally it should be completed within one hour of admission, especially if the patient is acutely ill or has had a prolonged period on a hard surface. It should be documented accordingly.
- Assess all patients for pain over common pressure ulcer sites (or pain related to a pressure ulcer or its treatment) and document accordingly.
- Inspect areas of high risk from medical devices i.e., catheter tubing, CPAP, Glasses, halo frame and aspen collars, orthopaedic metal framework, and document accordingly.
- Changes in skin condition must be recorded as soon as they are observed.

Support Surface

- No pressure-redistributing device/mattress or cushion should be relied upon as a substitute for regular change of a patient's position.
- All patients assessed as being at risk of developing pressure ulcers will have a high-specification foam mattress as standard
- Aids NOT recommended for use include, water-filled gloves, doughnut type devices and artificial sheepskins
- The use of higher high-specification mattresses (alternating pressure mattresses, continuous low-pressure mattresses) is advised for individuals assessed as having category 3-4 pressure ulcers including intact eschar (where depth and therefore category, cannot be assessed).

Keep moving

- Frequency of repositioning should be determined by skin inspection and individual needs *not by a ritualistic schedule*.
- If an acutely ill individual is established to be at risk of pressure ulcer development, they should sit **for no longer than 2 hours at a time.**

Incontinence

- Patients at risk of developing Moisture Associated Skin Damage (MASD) should be identified and strategies planned and implemented to help prevent MASD.

Nutrition and Hydration

- It is important to screen and assess the nutritional status of every patient at risk of pressure ulcers as under nutrition is a reversible risk factor for pressure ulcer development.
- All patients admitted to hospital are to be screened for malnutrition using a recognised screening tool within 24 hours of admission, and weekly thereafter or if changes noted in clinical condition; and at the first face to face contact in the community, then as indicated by the Risk Assessment.

Give information

- Staff should offer timely, tailored information to people who have been assessed as being at high risk of developing a pressure ulcer, and their family or carers.
- The information should be delivered by a trained or experienced healthcare professional

Section 4 of this guidance covers the topics listed above in more detail to guide evidence based best clinical practice.

Care to prevent pressure ulcers

Use the aSSKINg Framework to plan and deliver individualised care that addresses the individual's presenting risk factors for anyone identified at risk of pressure ulceration.

Deliver care according to the identified pathway.

No pressure ulcer and not currently at risk

- Document outcome of risk in the clinical record.
- Review risk at regular intervals which should be based on:
- a change in that individual's condition
- a change in the place of care delivery
- a change in the individual's circumstances, or
- at the pre-planned interval, which should be as a minimum once a week in acute settings and once a month in community or care settings.

No pressure ulcer but at risk

As above plus:

- Implement an individualised plan of preventative care that addresses their presenting risk factors and follows the aSSKINg bundle.
- Ensure there is regular monitoring of skin condition and escalate preventative care if any deterioration in skin condition is noted.
- Document outcome of risk in the clinical record.
- Provide information to the patient and / or their carer about the level of risk and what they can do to help reduce the risk.

Category 1 pressure ulcer or above or scarring from previous pressure ulcer

As above plus:

- If deterioration in skin or wound is noted, escalate interventions including review of equipment (beds, mattresses, cushions, and off-loading devices) and repositioning schedules.
- Complete a full wound assessment and document in the care record.
- Agree a patient-centred objective of care.
- Implement evidence-informed wound care based on the objective of care.

Document the plan of care in the patient's care record.

(NWCSP, 2023)

4.1 Assess risk

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

Identification of someone at risk of pressure ulcers and immediate care

Consider whether a patient or client has pressure ulcer risk factors at every contact with a health and social care professional.

Respond to a request from an individual, their family or informal carer who has identified risk factors for pressure ulceration.

'Red flag' risk factors are:

- Skin over a bony prominence that is hot, discoloured and swollen or the patient complains of new onset or change / increase in pain or numbness, and this does not resolve when the patient is repositioned.
- An existing pressure ulcer or scar from a pressure ulcer or other wound in an at-risk area.
- The individual has had a long lie (fall and being on the floor) of more than 1 hour.
- Rapid deterioration in the clinical condition of the patient.
- There is a medical device in prolonged contact with the skin.

Immediate care:

- Reposition the patient off the affected area and record the position in which the patient was found.
- If the skin is broken, clean and dress the wound using a sterile dressing as per local policy. Ensure any existing equipment is functioning and in use. • Take a digital image of any broken skin.
- Seek assistance / escalate care / refer to specialist as necessary.
- Give patient, family, and carers information about what they can do to help manage the skin damage, including what they should avoid doing.
- Document any interventions, conversations or care plans and ensure these are handed over to other caregivers to ensure continuity.
- Check if medical devices in use are still required. If it is still, necessary fit and position correctly.

Initial screening

If the person identifying someone at risk of a pressure ulcer, (or responding to a request for a risk assessment) does not have the appropriate knowledge / skills to carry out screening, they should provide immediate preventative care that reduces any identified risk and refer to a suitably trained professional.

Everyone receiving care from a health or care professional should be screened for pressure ulcer risk using the PURPOSE T tool, or other validated risk assessment tool that, as a minimum, contains the same risk factors.

Screening should follow a structured and replicable approach and consider, as a minimum, mobility and activity limitations, skin status and other risk factors that are highly predictive in specific populations.

Screening and skin assessment should be based on a combination of skin temperature, skin texture, patient reports of pain and discomfort as well as visual skin assessment. This is particularly important when considering skin of dark colour and tone.

Risk Assessment
Those identified as being potentially at-risk following screening (e.g., step 1 of the PURPOSE T tool) should receive a full pressure ulcer risk assessment using the PURPOSE T tool, or other risk assessment tool that, as a minimum, contains the same risk factors.

Risk assessment for those admitted to hospital or a care home with nursing should be done within 6 hours of admission or in a community health care service the first face-to-face visit. This includes virtual contact via telephone or video and may be based on questioning the patient about their skin. Clearly document the risk assessment and whether it was conducted face-to-face or virtually.

Document the outcome of the risk assessment in the clinical or care record along with a prestipulated date for review of risk and planned care.

Reassess if there is a change in that person's condition, circumstances, or environment.

For those whose condition is stable, review at regular intervals to monitor for more subtle changes in level of risk.
If the person identifying someone in need of a full pressure risk assessment does not have the appropriate knowledge / skills to carry out that risk assessment, they should provide immediate preventative care that reduces any identified risk and refer to a suitably trained professional.

(NWCSP, 2023)

Primary diagnosis of pressure damage
Document pressure ulceration accurately, avoiding confusion with similar but different aetiologies (e.g., incontinence associated dermatitis (IAD). Differential diagnosis of pressure ulceration should consider:

Is there evidence of pressure or shear?
Is the wound or skin damage over a bony prominence or under a device?
Are the edges distinct?

Categorisation of pressure damage
Categorise pressure ulcers using Pressure Ulcer Categories 1 – 4.

Outcome of risk assessment
Combine the outcome of risk assessment and diagnosis together to identify which of the following pathways should be followed.

No pressure ulcer, not currently at risk, or
No pressure ulcer but at risk, or
PU Category 1 or above or scarring from previous pressure ulcers.

(NWCSP, 2023)

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

Risk assessment tools should not replace clinical judgement.

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

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

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

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

Pressure Ulcer Risk Factors

There are many factors which increase the risk of pressure ulcer development.

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

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

Extrinsic risk factors include:

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

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

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

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

For paediatric patients also consider the possibility of:

- Significantly reduced mobility
- Significant loss of sensation
- Previous or current pressure ulcer
- Nutritional deficiency
- The inability to reposition themselves
- Significant cognitive impairment

4.2 Skin assessment

- Skin inspection must be performed on initial patient contact in the community, admission to clinical areas and on transfer from other organisations or prior to discharge.

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

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

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

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

- Assessment must include full skin inspection, from head to toe.

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

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

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

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

- Changes in skin condition must be recorded as soon as they are observed.

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

- Massage of high-risk areas is contraindicated.

- Review emollient use if the skin is dry and provide education for staff on how to apply the products.

- Any pressure damage must be recorded and documented via the organisation's patient safety reporting system.

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

The following signs may indicate pressure damage

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

- **Non-blanching erythema –** where skin appears reddened and does not blanch (go white) when light finger pressure applied. This suggests that the local micro-circulation is now damaged. This is a category 1 pressure ulcer (EUPAP, 2019). Pressure should be removed from the affected site and the skin should be inspected every 2 hours. Results of skin inspections should be recorded in the patient's record.

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

The following signs may indicate pressure damage in patients with **darkly pigmented skin:**

- Purple/blue localised areas
- Localised heat
- Induration/hardness

The colour of intact dark pigmented skin may remain unchanged (does not blanch) when pressure is applied over a bony prominence.

Localised skin colour changes can still occur where pressure is applied. These changes may differ from the individual's usual skin colour.

Local areas of intact skin that are subject to pressure may feel either warm or cool when touched. This assessment should be performed without gloves to make it easier to distinguish differences in temperature. It is important to clean the skin of any body fluids before making this direct contact.

If patients have had a previous pressure ulcer, the healed area may be lighter in colour.

Areas of dark skin subjected to pressure may be purplish/bluish/violet in colour. This can be compared with the erythema seen in people with lighter skin tones.

Oedema may occur with an induration (area of skin hardness), the skin may be taut and shiny.

Patients may complain of, or indicate, current or recent pain or discomfort at body sites where pressure has been applied (Bennett, 1995).

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

Skin Care

- It is important to maintain skin integrity and optimise skin condition. This can be achieved through good hygiene, use of emollients if necessary, adequate hydration and nutrition, avoidance of excessive heat or cold, prevention of prolonged exposure to moisture (i.e. urinary incontinence, sweat, and wound exudate).
- Avoid the use of harsh soap as this can alter the pH of the skin and will remove natural oils. Soap can also contain preservatives and perfumes that may irritate the skin.
- Do not use talcum powder on patients at risk of developing pressure ulcers as this may dry the skin and increase the risk of friction.
- Barrier products should be used to protect skin from moisture if needed (e.g. if the patient is incontinent).
- If a patient's skin is excoriated from incontinence or wound exudate, barrier creams or barrier films can be used. For severe excoriation or moisture lesions refer to the Tissue viability team (if one is available) for advice.
- When drying the patient's skin, pat the skin dry with a towel, particularly over vulnerable areas. Ensure skin is completely dry. Do not rub (wet or dry) skin as this may cause or exacerbate skin damage.
- Observe for blanching erythema - this is an early indication of pressure and with timely intervention further damage can be prevented.

Local Trust/Provider Practice:

Additional information for assessing patients with darker skin tones

Skin inspection with an awareness of skin tone should be carried out as part of a full holistic assessment that includes the patient's skin, their overall health and medical history, and their wound, ensuring that care is tailored to the individual and their needs. It is important to note that patients with all skin tones should receive an equitable level of assessment. Assessing skin for colour so that early identification can be made of any changes or issues should be a routine part of care for every patient.

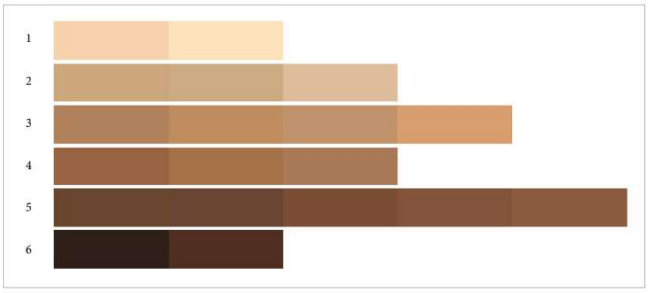
The skin tone tool (adapted from Ho & Robinson, 2015) is a validated classification tool that shows a range of skin tones so that the tone can be selected that most closely matches **the patient's inside upper arm** (colour of skin that has not been altered by sun or other types of ultraviolet (UV) exposure). Skin tone may differ across different areas of the body.

Skin tone is separate to ethnicity and staff should have confidence to talk about this in a professional way, treating the patient as an individual.

Hospital acquired pressure ulcer data should include the patient's skin tone. This can be used to monitor numbers and categories of pressure ulcers and the patients' skin tones. It can be used to highlight any necessary actions to raise awareness of skin inspection and how staff can assess for early signs of pressure damage, to ensure all patients receive optimum assessment and care.

Staff should record the patient's skin tone in the Skin Inspection Record.
All staff will be provided with a lanyard with the skin tone tool below.

Skin tone tool:



(Ho BK, Robinson JK, 2015)

As skin tone may vary across different anatomical locations on the body, it is important to inspect a similar area of skin for comparison – for example, if you are examining the heel for a potential PU, make sure to look at the other heel as well (in patients where this is possible), noting that in patients with dark skin the soles of the feet are generally much lighter.

People with dark skin tones are more likely to develop higher category pressure ulcers. This may be due to current skin assessment protocols being less effective for people who have dark skin tones, resulting in early damage arising from pressure not being recognised. For example, it has been found that dark skin rarely shows the blanching response that clinicians are trained to look out for, and erythema may also be hard to detect.
The senses – especially touch – should be considered as part of skin inspection and assessment.

Clinicians must be aware of all signs and symptoms of pressure ulcer development and how these may present across skin tones.

In patients with dark skin tones, extra care should be taken to ensure that eschar or necrosis are not incorrectly diagnosed.

Extra care should be taken to prevent scarring in patients with dark skin tones, as dark skin tone constitutes a risk factor for keloid scarring.

Infection must be identified early by investigating signs and symptoms that do not rely on 'redness.'

Possible presentation of pressure damage in dark skin

- Change in skin colour: this may present as redness, darkening, lightening or grey/blue/ purple tones.
- The skin may feel tight, spongy or appear shiny.
- Change in temperature – check if the skin feels cold or hot.
- Pain or numbness over the affected area.

Possible presentation of Moisture-associated skin damage (MASD) in dark skin

- Change in skin colour: this may present as redness, darkening, lightening or blue/purple tones.
- The skin should be checked for changes so that diagnosis can be made before maceration occurs if possible.

(Wounds UK, 2021)

4.3 Support Surface (this includes other pressure redistributing equipment and aids)

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

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

They should be based on clinical judgement i.e. individuals can have high risk validated score however remain mobile and self-caring. The rationale for decisions not to obtain pressure redistribution devices should be clearly documented.
Initial choice and then subsequent decisions following re-assessments, related to the provision of pressure-redistribution support surfaces for patients with pressure ulcers should be based on:

- pressure ulcer assessment (severity)
- level of risk - from holistic assessment
- location and cause of the pressure ulcer
- general skin assessment
- general health status
- mobility
- patient's weight (NICE 2015)

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

Pressure ulcer prevention and treatment strategies usually comprise a combination of pressure redistribution (in the form of mattresses and other support surfaces), positioning and repositioning, and wound management strategies (NICE 2005). Holistic assessment should include level of risk, comfort and general health state, lifestyle and abilities, critical care needs, and acceptability of the proposed pressure relieving equipment to the patient and/or carer (NICE 2003).

Aids NOT recommended for use include water-filled gloves, doughnut type devices and artificial sheepskins. Their use has been proven to be detrimental to tissue integrity and can contribute towards pressure ulcer formation (NICE 2003, EPUAP 2019).

High-specification foam cushions can be used suitable for high risk patients as part of their overall pressure ulcer prevention plan. These are also suitable for patients who use a wheelchair. Active cushions may be used/required for very high-risk patients and/or those with existing damage.

Ensure that the individual is within the recommended weight range for the mattress/bed, for safe use of mattresses.

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

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

With support from the Tissue Viability Service (if one is available) or Equipment Specialist Team (if one is available in the community), consider replacing the mattress with a support surface that provides more effective pressure redistribution, shear reduction, and microclimate control for the individual if they:

- cannot be positioned off the existing pressure ulcer;
- has pressure ulcers on two or more turning surfaces (e.g. the sacrum and trochanter/hips) that limit turning options;
- fails to heal or demonstrates ulcer deterioration despite appropriate comprehensive care;
- is at high risk for additional pressure ulcers; and/or
- 'bottom out' on the existing support surface.

Changing the mattress/support surface is only one of several strategies to consider. More frequent repositioning, preventive interventions and local wound care should also be intensified as needed (EPUAP 2019).

Heel Protection

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

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

- Inspect the skin of the heels regularly.
- Use knee break prior to back elevation on a profiling bed to reduce drag effect on heels.
- Reduce friction and shear during repositioning by ensuring the slide sheet is positioned under the heels.
- For patients at high risk of developing heel pressure ulcers, heels should be offloaded by using a pillow full length under the calves (*knees slightly bent) so that heels are elevated (i.e., "floating") or using heel protection aids. Pillows are advised to be used as a short-term intervention.
- Consider using a slide sheet under heels as a temporary intervention (review at each planned repositioning or skin inspection) or use of specialist products designed at reducing shear and friction, for patients who are restless or agitated in bed or who have involuntary movements of the feet, to reduce shear and friction forces.
- Regular inspection of skin to the feet/heels of patients wearing anti-embolism stockings.

For individuals with diabetes and heel pressure ulcers (category 3 or 4 or DTI) consider referral to the Podiatry Service and/or Diabetic Foot Clinic (if available) for assessment.

Where possible, a vascular assessment should be completed for extremity pressure ulcers. This may include physical examination, palpation of foot pulses, listening of pulses, history of claudication, rest pain and Ankle Brachial Pressure Index (ABPI) if no contraindications, to establish vascular supply and determine healing potential. Prior to considering debridement of heel pressure ulcers it is important to exclude arterial insufficiency. Stable dry eschar should not be debrided on ischaemic limbs.

*Important note:
Heel-protection devices should elevate the heel completely (offload them) in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. The knee should also be in slight flexion as hyperextension of the knee may cause obstruction of the popliteal vein, and this could predispose an individual to deep vein thrombosis.

Other aids used in the prevention and treatment of pressure ulcers include:

Pillows: Useful for supporting individuals in bed when using a 30-degree tilt regime to alter weight-bearing areas, can keep bony prominences from direct contact with one another.

Foam Wedges: to keep bony prominences free from excess pressure.

Electric Profiling Bed Frame: aids repositioning and contributes to redistribution of pressure (EUPAP, 2019).

Turning mattresses: dynamic mattresses which can be 'set' to turn the patient automatically, reducing the need for frequent manual handling to change position.

Silicone based pads/strips: reduces pressure under medical devices.

Heel protection devices: aimed at reducing shear and friction or providing pressure relief at the heel.

Medical Device Related (MDR) Pressure Ulcers

''Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes'' (EUPAP, 2019).

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

Tips for prevention

- Observe the skin for pressure damage caused by medical devices. Many different types of medical devices have been reported as having caused pressure damage e.g. catheters, oxygen tubing and masks, ventilator tubing.
- Conduct more frequent (greater than twice daily) skin assessments at the skin-device interface in individuals vulnerable to fluid shifts and/or showing signs of oedema. Oedema can cause a medical device that initially fits properly to exert external pressure to the skin that then leads to pressure ulcer formation (EUPAP, 2019).
- Remove medical devices that are potential sources of pressure as soon as medically feasible.
- Move devices to inspect the skin
- Keep skin clean and dry under medical devices.
- Rotate or reposition medical devices when possible
- Ensure that medical devices are correctly sized and fit appropriately to avoid excessive pressure.
- Apply all medical devices following manufacturer's specifications.
- Ensure that medical devices are sufficiently secured to prevent dislodgement without creating additional pressure.
- Inspect the skin under and around medical devices at least twice daily for the signs of pressure related injury on the surrounding tissue; or more frequent skin assessments in patients vulnerable to fluid shifts and/or exhibiting signs of localised or generalised oedema.
- Consider using a prophylactic dressing for preventing medical device related pressure ulcers.

Pressure ulcers related to medical device use are not a new category of pressure ulcer and should be classified according to level of tissue loss using the EPUAP (2014) grading tool. However, this classification system for pressure ulcers of the skin cannot be used to category mucosal pressure ulcers (EUPAP 2019).

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

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

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

Seating

Basic advice regarding seating assessment for aids and equipment and seating positions can be sought from Physiotherapists and Occupational Therapists, or Equipment Specialist Team (if one is available in the community). Lengthy sitting in chairs has been shown to be a high-risk activity for patients who are susceptible to pressure ulcers as exceptionally large compressive forces are generated on the ischial and sacral regions (NICE 2003).

Correct seating – other principles to consider:

- the body should be symmetrical, taking weight on both ischial tuberosities, encouraging postural stability.
- the seat should support the maximum possible surface area of the body, lowering interface pressure.
- the feet should be well supported to aid stability.
- the qualities of the seat should enable maximum functional ability.
- the seat surface should be comfortable to the patient.
- the patient's bottom should be as far back in the chair as possible.
- the thighs should be supported along their full length.
- the hips, knees and ankles should be at approximately 90 degrees.
- the lumbar spine should be supported.
- where a leg rest is used, the total height of the leg rest, including a pillow, should be level with the chair.
- the heel should be clear of the leg rest.
- where a patient has difficulty in maintaining a position, pillows may be used to provide extra support.

The provision of pressure redistribution cushions should not be based solely upon the outcomes of a risk assessment but consider the patients' individual needs as

well as the properties of the cushion.
While restriction of chair use may be the apparent solution to promote healing of severe pressure ulcers (category 3 and 4) this may restrict an individual's lifestyle and ability to work. The risks of continued chair use should be explained, and an informed decision reached and documented.

Key outcomes for ***the long-term seated individual*** should include whether the equipment has:

- Maintained their occupational performance
- Provided satisfaction
- Maintained their health-related quality of life.

Assessment for the ***acutely ill*** individual's vulnerability to pressure ulcer development should be based on consideration of risk factors. If an acutely ill individual is established to be at risk of pressure ulcer development, they should sit **for no longer than 2 hours at a time** then be returned to bed, with assisted repositioning if required or where appropriate the individual should be encouraged to walk and then lie down and rest, and to avoid sitting down again within an hour (TVS, 2009).

Limit the time at risk individual spends seated in a chair without pressure relief.
When an individual is seated in a chair, the weight of the body causes the greatest exposure to pressure to occur over the ischial tuberosities. As the loaded area in such cases is relatively small, the pressure will be high; therefore, without pressure relief, a pressure ulcer will occur very quickly.

(Collins, 2004; Tissue Viability Society, 2009 and 2012; EPUAP 2019; Nutting, 1992)

Local Trust/Provider Practice:

Special Population: Patients in the Operating Theatre

The risk assessment of individuals undergoing surgery should also include other factors that are likely to occur that will increase risk of pressure ulcer development, including:

a) Length of the operation
b) Increased hypotensive episodes intraoperatively
c) Low core temperature during surgery
d) Reduced mobility on day one postoperatively

Theatre staff should ensure that a pressure-redistributing mattress is on the operating table for all individuals identified as being at risk of pressure ulcer development.

Where possible, position the patient in such a way as to reduce the risk of pressure ulcer development during surgery; record position.

Where possible, elevate the heels completely (offload them) as described above.

Pay attention to pressure redistribution *prior to* and *after* surgery:

- Place the individual on a pressure-redistributing mattress both prior to and after surgery;
- Where possible, position the individual in a different posture preoperatively and postoperatively than the posture adopted during surgery (EPUAP 2009).

Local Trust/Provider Practice:

4.4 Keep moving (repositioning)

- All individuals with pressure ulcers should actively mobilise to change their position or be repositioned frequently.

- High pressures over bony prominences, for a short period of time, and low pressures over bony prominences, for a long period of time, are equally damaging. In order to lessen the individual's risk of pressure ulcer development, it is important to reduce the time and the amount of pressure she/he is exposed to.

- Individuals who are 'at risk' of pressure ulcer development should be repositioned if it is medically safe to do so, and that when repositioning patients to do so in such a way as to minimise the impact on bony prominences and individual vulnerable areas and ensure that bony prominences are kept from direct contact with one another.

- Individuals or carers, who are willing and able, should be taught how to re-distribute the patient's weight.

- Regularly assess the patient's skin condition and general comfort. Reconsider the frequency and method of repositioning if the patient is not responding as expected to the repositioning regime. Frequent assessment of the individual's skin condition will help to identify the early signs of pressure damage and, as such, their tolerance of the planned repositioning schedule. If changes in skin condition should occur, the repositioning care plan needs to be re-evaluated (EPUAP 2019). Turn assist mattresses may be used.

- Frequency of repositioning should be determined by skin inspection and individual needs *not by a ritualistic schedule*. If there are signs of persistent erythema, then the interval for repositioning should be reduced. If the patient is marking after 2 hours or category 1 pressure damage occurs, then the pressure relieving surface may require upgrading. Please contact the Tissue Viability Service (if one is available) or Community Equipment Service (if community based) for advice on alternative surfaces.

- Repositioning should also take into consideration the patient's medical condition, their comfort, the plan of care and the support surface.

- Regular positioning is not possible for some individuals because of their medical condition, and an alternative prevention strategy such as providing a high-specification mattress or bed may need to be considered (EPUAP 2019).

- Individuals identified as ‘at risk’ should be sat on an appropriate pressure relieving cushion. In choosing a cushion consideration should be given to postural alignment, balance and stability. Those considered to be acutely at risk of pressure ulcer development should restrict chair sitting to less than 2 hours until their general condition improves.

- If sitting in a chair is necessary for individuals with pressure ulcers on the sacrum/coccyx or ischia, limit sitting to three times a day in periods of 60 minutes or less.

- Use the 30° tilted side-lying position (alternately, right side, back, left side) if the patient can tolerate this and her/his medical condition allows (EUPAP 2019). Use of the 30-degree tilt can be used to avoid positioning patients directly onto bony hip prominences.

- Avoid postures that increase pressure, such as the 90-degree side-lying position, or the semi-recumbent position. Limit head-of-bed elevation to 30° for an individual on bed rest unless contraindicated by medical condition or feeding and digestive considerations (EPUAP 2019) and for patients in critical care who may require greater head-of-bed elevation.

- Do not position an individual directly onto a non-blanching area and or existing pressure ulcer. Redness indicates that the body has not recovered from the previous loading and requires further respite from repeated loading (EPUAP 2019). Avoid positioning individuals directly onto an area of existing pressure damage.

- Pillows / foam wedges can be used to avoid direct contact of bony prominences with each other along with the use of bed cradles to reduce weight of bed clothes and reduce pressure from heels.

- Earlier guidance has recommended that individuals who are **acutely at risk** of developing pressure ulcers should restrict chair sitting to **less than 2 hours** until their general condition improves. This category of patient has the potential to acquire a pressure ulcer on their sacrum or buttocks very rapidly (NICE 2003).

- Ensure appropriate use of knee break on profiling beds is utilised to reduce shearing forces ensuring involvement with the individual / carer and demonstration provided.

- A repositioning schedule and chart should be planned where possible, agreed with the patient and implemented, recording the frequency of repositioning (24-hour frequency of repositioning must be recorded) for each person

identified as being at risk, as part of a pressure ulcer prevention plan. The frequency of repositioning should be determined by the patient's individual needs.

As a minimum, a repositioning chart should be implemented for:

- Patients assessed as being at high risk of developing pressure ulcers (assessment based on risk assessment score and clinical judgement), or
- Patients in bed 24 hours a day/cannot independently change their own position,
- Patients who require any assistance to mobilise (including walking aids)
- Patients with pressure damage/existing pressure ulcers

The chart should be planned where possible with the patient and implemented, recording the frequency of repositioning required and ensuring it is accurately completed (NICE 2014).

NICE (2014) recommends that patients who have been assessed as being at risk of developing a pressure ulcer should be encouraged to change their position frequently, **at least every 6 hours**; and patients (including young people) assessed as being at high risk of developing a pressure ulcer to change their position frequently, **at least every 4 hours**. If individuals are unable to reposition themselves, health and social care professionals should offer help to do so, using appropriate equipment if needed.

Manual handling considerations

- Manual handling issues relating to the repositioning or transfer of patient's needs to be assessed involving informal and formal carers. Manual handling risk assessment must be completed if required and the details and technique recorded on the care plan. Manual handling techniques need to be adapted to reduce the risk of shearing – 'don't drag'. Specific equipment to aid repositioning should be considered e.g. slide sheets, hoists.

- **Remember that this includes heels. Position the slide sheet to include under the heels during repositioning.**

- Prior to repositioning, maximally inflate (auto-firm) an active mattress to ensure a smooth surface to assist in reducing shear and friction during repositioning.

- Do not leave moving and handling equipment such as hoist slings under the individual after use, unless the equipment is specifically designed for this purpose (EUPAP 2019). Exception noted above in section 4.3 Heel protection, use of slide sheet under heels as temporary intervention for patients who are agitated – reassess at each planned repositioning.

Repositioning Seated Patients

Sitting is obviously important to reducing the hazards of immobility, facilitating eating and breathing, and promoting rehabilitation. But every effort should be made to avoid or minimise pressure on the ulcer. Modify sitting time schedules (using repositioning chart) and re-evaluate the seating surface and the individual's posture if the ulcer worsens or fails to improve (EUPAP 2019).

Things to consider:

- Use a pressure redistributing seat cushion for individuals sitting in a chair whose mobility is reduced.
- Position the individual to maintain stability and his or her full range of activities.
- Select a seated posture that is acceptable for the individual and minimises the pressures and shear exerted on the skin and soft tissues.
- Provide adequate seat tilt to prevent sliding forward in the wheelchair or chair and adjust footrests and armrests to maintain proper posture and pressure redistribution.
- Ensure that the feet are properly supported either directly on the floor, on a footstool, or on footrests when sitting (upright) in a bedside chair or wheelchair.

- To avoid shear and friction select a seat with an appropriate seat-to-floor height for the individual.
- If the individual's feet cannot be positioned directly on the ground, footrest height should be adjusted so as to slightly tilt the pelvis forward by positioning the thighs slightly lower than horizontally.
- Limit the time an individual spends seated in a chair without pressure relief.

(EUPAP 2019)

If sitting in a chair is necessary for individuals <u>with pressure ulcers</u> on the sacrum/coccyx or ischia, limit sitting to three times a day in periods of 60 minutes or less (EUPAP, 2019).

For those individuals who are actively dying, prevention and treatment of a Pressure Ulcer may be superseded by the need to promote comfort by minimising turning and repositioning (NPUAP 2010). Recognising that a person is entering the imminently dying or terminal phase of their illness is critical to appropriate care planning, with a shift to comfort care and the patient's overall condition may even be exacerbated by the continuation of standard care (Bailey and Harman, 2018). Discussions with the individual, family and Palliative Care Team should take place.

Local Trust/Provider Practice:

Critical Care patients

Robust systems should be put in place to manage the risk. A number of considerations should be made in attempts to prevent pressure damage occurring and in their on-going management made.

- For those patients with poor local and systemic oxygenation and perfusion consider the need to change support surfaces to assist in the redistribution of pressure, reduce shear forces and utilise additional interventions such as turn assistance.
- Patients with spinal instability, haemodynamic instability and/or nursed in the prone position, may not be able to be moved or turned as would be normal practice. Consideration should therefore be given to the need to change to appropriate support surfaces as soon as possible and resume routine repositioning as soon as conditions allow.
- In order to minimise the physiological effects on patients due to movement, alterations to their position should be undertaken in a controlled unrushed manner, allowing enough time for stabilisation of haemodynamic and oxygenation status. Consider subtle frequent shifts in position, to allow tissue re-perfusion in individuals who cannot tolerate frequent major shifts in body position.

(North West Critical Care Networks Pressure Ulcer Management Group, 2018)

Prone position

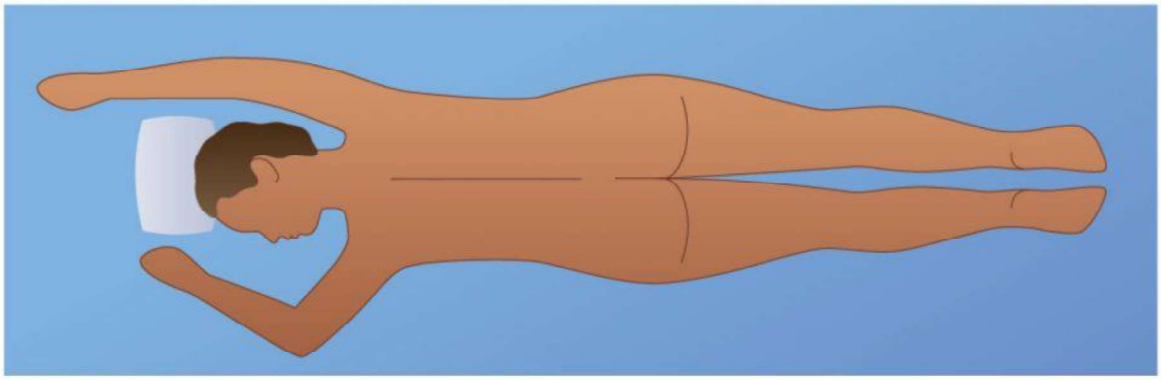
For patients who tolerate it, the prone position can be used; however, this can only be done for short periods as it exposes new areas of the body to pressure and increases the risk of medical devices becoming trapped. Nurses should check for uneven distribution of pressure and the location of medical devices once the patient is positioned. Areas requiring specific attention include:

- Breast region
- Knees
- Toes
- Penis
- Clavicles
- Iliac crest
- Symphysis pubis

Use of additional pressure redistributing devices – for example, using prophylactic dressings over bony prominences such as the iliac crest, ribs and patella – should be considered.

The prone position is most commonly used in intensive and critical care areas; the prone 'swim' position – in which the patient is positioned with their head on one side, one arm lying straight alongside the back of the head and the other (near the face) slightly bent (Fig 4) – allows for smaller changes in position by changing the arm that is positioned alongside the head and turning the head.

Fig 4. **The prone 'swim' position**



(Fletcher, J. 2020)

Neonates, infants, children and young people

- Neonate and infants who have been assessed and identified as high risk should have a high-specification foam cot mattress or overlay put in place and identified in their personalised care plan.

- Children and young people identified at high risk of pressure ulcers should be nursed on a high specification foam mattress at a minimum.

- Children and young people who are long term wheelchair users should have regular wheelchair assessments and should be assisted and encouraged to relieve pressure frequently (frequency should be individual to patient and skin assessment).

- Children and young people whom cannot physiologically tolerate repositioning, this should be documented and discussed with parent / carer.

- A repositioning schedule for neonates, infants, children and young people who are at risk of developing a pressure ulcer must be established.

- Neonates, infants, children and young people identified ‘at risk’ of developing a pressure ulcer should be repositioned or encouraged to change position every 4 hours.

- Consider more frequent repositioning if the neonate, infant, child or young person has been identified at ‘high risk’ of developing a pressure ulcer.

- Ensure that repositioning equipment / aids are available at all times if needed.

- Relieve pressure on the scalp and head when repositioning neonates, infants, children or young person at risk of developing a pressure ulcer.

Local Trust/Provider Practice:

4.5 Incontinence & Moisture Associated Skin Damage (MASD)

Care of the skin is essential when caring for any patient. When skin is compromised in any way it can have a detrimental effect on their wellbeing. The aim of this section is to provide advice and guidance on skin care in relation to preventing and/or managing Moisture Associated Skin Damage (MASD).

Types of Moisture Associated Skin Damage

- **Incontinence Associated Dermatitis (IAD):** damage caused when urine and faeces make prolonged contact with the skin. These have commonly been referred to as moisture lesions.
- **Intertriginous dermatitis (Intertrigo):** when 2 surfaces of skin are in contact with one another, friction and moisture e.g. under arms, groins, under breasts.
- **Peri-wound moisture associated dermatitis:** from high volumes of exudate, skin becomes macerated and can breakdown.
- **Peri-stomal dermatitis:** sore and excoriated skin around stoma.

To prevent moisture damage, the most important factor is keeping the skin clean and dry and protected with a barrier film or cream.

Moisture lesions may present as a linear wound in the natal cleft or between skin folds, or as superficial wounds on the buttocks, often both buttocks (copy or kissing lesions).

Avoid the use of harsh soap as this can alter the pH of the skin and will remove natural oils. Soap can also contain preservatives and perfumes that may irritate the skin.

Patients at risk of developing MASD should be identified and strategies planned and implemented to help prevent MASD.

A continence assessment should be completed and the use of a barrier preparation to prevent skin damage.

Wound related characteristics (causes, location, shape, depth, edges, and colour) and patient related characteristics are helpful to make a differentiation between a pressure ulcer and a moisture lesion.

MASD will not heal with pressure relief/reduction alone.

A combination lesion is one which has both pressure and moisture as causes, for example this may develop in a patient who is immobile and has continence problems or who has pressure damage and a heavily exuding wound.

It is important to be aware of all the causes of skin damage, assess the patient's risk and plan management accordingly. If the moisture lesion does not improve despite the use of skin barrier products and incontinence/moisture management, and pressure and/or shear is present, consider the possibility that the ulcer is a pressure ulcer and categorise accordingly (Fletcher 2008).

Wounds to the sacrum or buttocks are sometimes incorrectly classed as pressure ulcers but often moisture may be the cause of the lesion. Moisture may be from wound exudate, perspiration or more significantly unresolved or unmanaged incontinence. It is important to identify the cause of the lesions as the treatment and management of pressure ulcers and moisture lesions differ.

Appendix 2 shows the difference between pressure ulcers and Moisture Associated Skin Damage.

MASD should be counted and reported in addition to pressure ulcer incidence (NHSI, 2018a).

Local Trust/Provider Practice:

4.6 Nutrition and Hydration

Adults: nutrition

- Nutrition and hydration play a key role in keeping the skin healthy. Deficiencies in diet are a risk for developing pressure ulcers and it is recommended that a nutritional screening tool is used to assess risk of malnutrition (NICE 2014).
- It is important to screen and assess the nutritional status of every patient at risk of pressure ulcers as under nutrition is a reversible risk factor for pressure ulcer development.
- All patients admitted to hospital are to be screened for malnutrition using a recognised screening tool within 24 hours of admission, and weekly thereafter or if change in clinical condition; and at the first face to face contact in the community, then as indicated by the Risk Assessment.
- It is important to assess weight status to determine their weight history and note any significant weight loss from their usual body weight; also assess their ability to eat independently and if their total nutrient intake is adequate (EUPAP 2019).
- Patients with nutritional risk identified should be referred to the dietician for a more comprehensive nutritional assessment (EUPAP 2019).
- Patients with category 3 or 4 pressure ulcers of moderate or severe harm should be referred to the dietician.
- Relevant and evidence-based guidelines on nutrition and hydration for individuals who exhibit nutritional risk, and who are at risk of pressure ulcers or have an existing pressure ulcer should be used and an individual nutritional plan be made (EUPAP 2019).
- Offer high calorie, high protein nutritional supplements, vitamins and minerals in addition to the usual diet to adults with nutritional risk and pressure ulcer risk, if nutritional requirements cannot be achieved by dietary intake alone.
- Do not offer nutritional supplements specifically to prevent a pressure ulcer in adults whose nutritional intake is adequate.
- Provide information and advice to adults with a pressure ulcer and, where appropriate, their family or carers, on how to follow a balanced diet to maintain an adequate nutritional status, considering micro-nutrient requirements (NICE 2014)

Adults: Hydration (within any fluid restriction)

- Monitor individuals for signs and symptoms of dehydration.

- Provide and encourage adequate daily fluid intake for hydration for an individual assessed to be at risk of or with a pressure ulcer. This must be consistent with the individual's co-morbid conditions and goals.
- Provide additional fluid for individuals with dehydration, elevated temperature, vomiting, profuse sweating, diarrhoea, or heavily exuding wounds.
- Do not offer subcutaneous or intravenous fluids to treat a pressure ulcer in adults whose hydration status is adequate. (NICE 2014)

Nutrition: Neonates, infants, children, and young people

- Offer an age-related nutritional assessment to neonates, infants, children and young people with a pressure ulcer. This should be performed by a paediatric dietician or other healthcare professional with the necessary skills and competencies.
- Discuss with a paediatric dietician (or other healthcare professional with the necessary skills and competencies) whether to offer nutritional supplements specifically to treat a pressure ulcer in neonates, infants, children and young people whose nutritional intake is adequate.
- Offer advice on a diet that provides adequate nutrition for growth and healing in neonates, infants, children and young people with a pressure ulcer.
- Discuss with a paediatric dietician whether to offer nutritional supplements to correct nutritional deficiency in neonates, infants, children and young people with a pressure ulcer (NICE 2014).

Hydration: Neonates, infants, children, and young people (within any fluid restriction)

- Assess fluid balance in neonates, infants, children and young people with a pressure ulcer.
- Ensure there is adequate hydration for age, growth and healing in neonates, infants, children and young people. If there is any doubt, seek further medical advice (NICE 2014).

Local Trust/Provider Practice:

4.7 Giving Information

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

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

Staff should also:

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

Pressure Ulcer Core Curriculum (NHSI, 2018b)

Individual needs should be considered when supplying information to people with degenerative conditions, impaired mobility, neurological impairment, cognitive impairment, impaired tissue perfusion (NICE, 2014).
To support the provision of written information, a Cheshire and Merseyside Regional Pressure Ulcer Patient Information leaflet is available.

Healthcare professional training and education
Training should be undertaken by healthcare professionals on pressure ulcer prevention, and should include:

- who is most likely to be at risk of developing a pressure ulcer?
- how to identify pressure damage
- what steps to take to prevent new or further pressure damage
- who to contact for further information and for further action?

- how to carry out a risk and skin assessment
- how to reposition
- information on pressure redistribution devices
- discussion of pressure ulcer prevention with patients and their carers
- details of sources of advice and support

(NICE, 2014)

Local Trust/Provider Practice:

4.8 Assessment and Management of pressure ulcers

It is important to differentiate pressure ulcers from other types of wounds. Wounds from various aetiologies (e.g. venous ulcers, neuropathic ulcers, incontinence associated dermatitis, moisture lesions and skin tears) may appear like a pressure ulcer.

On assessment of a pressure ulcer, a wound assessment should be completed including measurements of the surface area (or length and width).
Assess and document physical characteristics including:

- Location
- Size
- Tissue type(s) and colour
- Peri-wound condition
- Wound edges
- Sinus/tracking
- Undermining
- Exudate
- Odour

(EPUAP, 2019)

After obtaining patient consent (as per organisation's policy), pressure ulcers should be photographed or mapped and when possible, an estimate of the depth of all pressure ulcers and the presence of undermining should be documented (NICE 2014).

Undertake and document a comprehensive wound assessment in line with the wound minimum data set that includes:
Full history, including any previous history of pressure ulceration.
Review of medication.
Pain and analgesia needs.
Psychosocial needs.
Possible infection.
Nutrition.
Record image(s) of ulcer(s) using digital imaging

(NWCSP, 2023)

Assess the pressure ulcer initially and re-assess it at least weekly, ideally using a wound assessment tool which includes the minimum data set. Weekly assessments provide an opportunity for the health care professional to detect early complications and the need for changes in the treatment plan (EUPAP 2019).
Be mindful that inflammatory redness from cellulitis and deeper tissue damage may be difficult to detect in individuals with darkly pigmented skin.

Look for:

- skin heat
- skin tenderness
- change in tissue consistency
- pain

Use the findings of a pressure ulcer assessment to plan and document interventions that will best promote healing (EUPAP 2019).

Plan and deliver individualised care that addresses the presenting risk factors using the aSSKINg Framework for anyone with an existing pressure ulcer plus:

- If appropriate, treat infection in line with local guidelines.
- Offer analgesia to alleviate pain.
- As far as possible, use ANTT to cleanse the wound bed, skin around the ulcer and consider debridement if required.
- Apply an appropriate dressing with sufficient absorbency.

At each dressing change:

- Review care and identify, discuss, and incorporate opportunities for supported self-management into treatment plan in line with the individual's and their carers' capacity, capability and wishes.
- Review effectiveness of treatment plan and if there is deterioration, escalate in line with local pathway.

All those with category 3 and 4 pressure ulcers should be considered for possible surgical revision in line with local guidance based on the following criteria:

- Have all reasonable conservative / non-surgical methods been tried to close the pressure ulcer?
- Would the individual consider surgical revision?
- Is the individual able and motivated to adhere to post-operative regimens to prevent pressure ulcer recurrence or breakdown of surgical repair.
- Does the individual have available skin / muscle for surgical revision (to be assessed by a member of the surgical team).
- Is the individual fit for surgery or able to become fit for surgery (e.g., through treatment for infection, by improved nutrition)?

(NWCSP, 2023)

Review of healing:

- At 4 weekly intervals (or more frequently if concerned) monitor for healing by:
- Completing wound assessment in line with the wound minimum data set.
- Taking digital wound image(s) and comparing with previous images.
- Review the effectiveness of treatment plan and escalate any concerns to the relevant clinical specialist at weekly intervals. Wounds that are deteriorating should be escalated to the relevant clinical specialist unless this is anticipated (e.g., in final days of life) and preventative intervention, including surface provision and repositioning regimens, escalated.

- Undertake a comprehensive holistic re-assessment at 12 weeks, for patients with wounds that remain unhealed.

Care following healing:

- Determine an agreed process of evaluation of care and review of risk level for all individuals at continued risk.

- Discuss with all individuals and/or their carers their specific risk factors and what they or their carer's role in preventative care could be.

- Provide all individuals at risk of pressure ulcers with information about their risk factors and treatment plan. This may be in written form (in a relevant format e.g., braille, different languages), using digital media or verbally, but the form of delivery and content must be clearly documented.

- Identify, discuss, and incorporate opportunities for supported self-care into treatment plans in line with each individual's capacity, capability and wishes.

(NWCSP, 2023)

Pain

- Assess all individuals for pain related to a pressure ulcer or its treatment
- Assess for deterioration of the ulcer or possible infection when the individual reports increasing intensity of pain over time
- Assess the impact of pressure ulcer pain on the individual's quality of life.
- Position the individual off the pressure ulcer whenever possible.
- Avoid postures that increase pressure
- Organise care delivery to ensure that it is coordinated with the administration of pain relief medication.
- Reduce pressure ulcer pain by keeping the wound bed covered and moist and using a non-adherent dressing (EUPAP, 2019).
- Consider seeking advice from the Acute Pain Nurse/Medical Staff.

Dressings

- For appropriate dressing selection, create the optimum wound healing environment; to aid continuity of care the dressing should be documented in the plan of care on the wound chart with rationale for its use.

- Discuss with patients with a pressure ulcer and, if appropriate, their family or carers, what type of dressing will be used, considering:
    - pain and tolerance
    - position of the ulcer
    - amount of exudate
    - the frequency of dressing change
- Dressings should be used which promote a warm, moist wound healing environment; *do not use gauze dressings*.

Nutritional supplements and hydration for patients with pressure ulcers

- Patients with a pressure ulcer should have a nutritional assessment by a dietician or other healthcare professional with the necessary skills and competencies.
- Nutritional supplements should be provided to patients with a pressure ulcer who have a nutritional deficiency
- Provide information and advice to adults with a pressure ulcer and, where appropriate, their family or carers, on how to follow a balanced diet to maintain an adequate nutritional status, taking into account energy, protein and micronutrient requirements.
- Patients should not be offered nutritional supplements to treat a pressure ulcer if their nutritional intake is adequate; or subcutaneous or intravenous fluids to treat a pressure ulcer if hydration status is adequate.

Topical Negative Pressure (TNP)

- Consider TNP as an early adjuvant for the treatment of deep, category 3 and 4 pressure ulcers (EUPAP 2019). However, it should not be routinely used to treat a pressure ulcer, unless it is necessary to reduce the number of dressing changes, for example, in a wound with a large amount of exudate (NICE 2014).

Debridement

- Assess the need to debride a pressure ulcer in adults, taking into consideration the amount of necrotic tissue, the category, size and extent of the pressure ulcer, patient tolerance and any comorbidities.
- Pressure ulcers will be debrided using autolytic debridement (appropriate dressings), or sharp debridement if autolytic debridement is likely to take longer and prolong healing time. Larval therapy will be considered if debridement is needed and sharp debridement is contraindicated or if there is vascular insufficiency (NICE 2014).
- Obtain a surgical consultation for possible surgical sharp debridement for individuals with undermining, tunnelling/sinus tracts, and/or extensive necrotic tissue that cannot be easily removed by other debridement methods (EUPAP 2019).
- Caution: Debridement should only be performed when there is adequate perfusion to the wound.
- Do not debride stable, hard, dry eschar in ischemic limbs.
- Debride the wound bed when the presence of biofilm is suspected or confirmed (EUPAP 2019).
- Select the debridement method(s) most appropriate to the individual, the wound bed, and the clinical setting.
- Consider the use of medical-grade honey in heavily contaminated or infected pressure ulcers until definitive debridement is accomplished.

Antibiotics

- Systemic antibiotics will be needed if there is clinical evidence of systemic sepsis or spreading cellulitis or underlying osteomyelitis, this may be discussed with the Microbiologist. Systemic antibiotics should not be used specifically to heal a pressure ulcer in adults; or based only on positive wound cultures without clinical evidence of infection.
- Topical antiseptics or antimicrobials should not be routinely used to treat a pressure ulcer in adults (NICE 2014).

5. Reporting Requirements for Pressure Ulcers

Incidence is defined as the actual number of new pressure ulcers within a certain period. This can be useful for local monitoring and reporting.

Pressure ulcer incidence should also be measured *per thousand occupied bed days*, to support benchmarking and comparatives and a standardised approach to measuring and reporting pressure ulcer incidence.

Prevalence is defined as a cross sectional count of the number of pressure ulcers at a particular point in time. Prevalence data can be used to plan for resources, assist in monitoring compliance with prevention and treatment guidelines, documentation of risk status and care planning.

There are some physical and social factors which may lead to the development of pressure ulcers, even when all care has been appropriately planned:

- Haemodynamic or spinal instability precluded turning or repositioning
- The patient has mental capacity but has refused assessment and/or will not comply with agreed plan of care including repositioning or maintaining position
- Patient following an end-of-life pathway and not able to tolerate repositioning as planned
- An acute/critical event occurs (e.g. cardiac arrest) which affects mobility or the ability to reposition
- Patient lacks capacity to understand and therefore support treatment/advice and where care meets criteria above

In these instances, it is advised that a record of a conversation with patient and/or next of kin/family members (where applicable) is be made (include the date, name of the person the conversation was with and significant details). This does not change our overall responsibility and commitment to preventing pressure ulcers and planning and implementing appropriate interventions.

Medical Device Related Pressure Ulcers

Device related pressure ulcers should be reported and identified by the notation (d) after the report e.g. category 2 PU (d) – to allow their accurate measurement (NHSI, 2018a).

Where patients decline pressure ulcer prevention strategies (e.g. refuse appropriate mattress/repositioning)
In the event of patients declining pressure ulcer prevention, staff are advised to check that they have mental capacity to make an informed decision regarding pressure ulcer prevention and that they understand the potential consequences of their choice. If they do, staff are advised to explore strategies to promote engagement and ensure the patients understand the associated risks. These actions should be recorded in the patient record.

Do not reverse category
A healing category 4 pressure ulcer, for example, should be described as such and not re-categorised as a category 3 pressure ulcer. Pressure ulcers should not be reverse categorised as categorising is only appropriate for defining the maximum depth of tissue involvement.

Record category 2 pressure ulcers and above as a patient safety incident
All pressure ulcers of category 2 and above (i.e. category 2, 3 and 4) should be recorded as a patient safety incident.

For category 3 and 4 pressure ulcers, organisations will follow their own pressure ulcer review processes in line with Patient Safety Incident Reporting Framework (Appendix 3).

The Department of Health and Social Care's definition of "avoidable/unavoidable" should not be used (NHSI, 2018a).

[1] StEIS is the Strategic Executive Information System, NHS England's web-based serious incident management system

Local Trust/Provider

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6. Safeguarding consideration

Where concerns are raised regarding skin damage because of pressure there is a need to raise it as a safeguarding concern within the organisation. In a minority of cases, it may warrant raising a safeguarding concern with the local authority.

A history of the development of the skin damage should first be obtained by a clinician, usually a nurse. If the person's care has recently been transferred, this may require contact being made with former care providers for information, to seek clarification about the cause and timing of the skin damage. This is the responsibility of the organisation raising the concern.

If a concern is raised that a person has severe damage, you should:

- complete the adult safeguarding decision guide (see below)
- raise an incident immediately as per organisation policy

Note: severe damage is multiple pressure ulcers of category (or grade) 2, or a single case of category 3 or 4.

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

Where category 2 pressure ulcers have developed and any healthcare professional suspects that there is a safeguarding concern, a referral should still be made.

The flowsheets in Appendix 4 are based on the Department of Health and Social Care guidance *'Safeguarding Adults Protocol: pressure ulcers and the interface with a safeguarding enquiry'* (2018), updated in 2024 in the *Safeguarding Adults protocol: pressure ulcers and raising a safeguarding concern*.

''Pressure ulcers may occur as a result of neglect and may involve the deliberate withholding OR unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support… In some instances, this is highly likely to result in, significant preventable skin damage'' (Department of Health and Social Care, 2018).

Where pressure ulcers do occur, this guidance offers a clear process for the management of removal and reduction of harm to the individual, whilst considering whether an adult safeguarding response under s42 of Care Act 2014 is necessary.

There are three separate flowcharts providing guidance, dependent on which care setting the pressure ulcer was acquired:
Flowchart 1 – NHS Provider Acquired Pressure Ulcer (*Appendix 4a*)

Flowchart 2 – Nursing Home Acquired Pressure Ulcer (*Appendix 4b*)
Flowchart 3 – Residential / Domiciliary Care/ Community Acquired Pressure Ulcer (*Appendix 4c*)

The adult safeguarding decision guide decision guide (appendix 4d) should be completed by a qualified member of staff who is a practising registered nurse with experience in wound management and not directly involved in the provision of care to the service user. This does not have to be a tissue viability nurse.

The adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded.

The outcome of the assessment should be documented on the adult safeguarding decision guide. If further advice or support is needed with regards to making the decision to raise a concern to the local authority, the safeguarding adults lead or the next most senior manager within the organisation should be contacted.

Where the individual has been transferred into the care of the organisation it may not be possible to complete the decision guide. Contact should be made with the transferring organisation to ascertain if the decision guide has been completed or any other action taken. Following this, a decision should be made whether to raise a safeguarding adults concern with the local authority, in line with agreed local arrangements.

The decision as to whether there should be a section 42 enquiry will be taken by the local authority, informed by a clinical view. A summary of the decision should be recorded and shared with all agencies involved.

Where an internal investigation is required, this should be completed by the organisation that is taking care of the individual, such as the district nurse team lead, ward manager or nursing home manager, in line with the local policies, such as pressure ulcer or risk management policies.

The local authority needs to decide or agree after completion of the internal investigation if a full multi-agency meeting or virtual (telephone) meeting needs to be convened to agree findings, decide on safeguarding outcome and any actions.

The safeguarding decision guide assessment considers 6 important questions that together indicate a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

The threshold for raising a concern is 15 or above. However, this should not replace professional judgement.

The completed Decision Guide considers 6 key questions to determine if a concern needs to be raised with the Local Authority.

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

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

Local Trust/Provider Practice

7.0 Education and Training

It is recommended that training includes:

- how to carry out a risk assessment
- how to carry out a skin inspection/assessment
- looking for early warning signs and preventative action
- how to reposition a patient
- information on pressure redistributing devices and aids
- discussion of pressure ulcer prevention with patients and their carers
- details of further sources of advice and support

(NICE 2014)

Local Trust/Provider Practice

8.0 Expert advice

Where one is available, expert advice will be provided by the Tissue Viability Nurse or a member of staff deemed to be experienced in tissue viability.
Guidance is also available through local clinical policy/guidelines available via the Trust/Provider Intranet.

Local Trust/Provider Practice

9.0 Equality and Diversity

An Equality Impact Assessment has been completed. It is considered that this policy does not negatively impact on any patient group. It may have a positive impact in relation to older patients and those with disabilities which may increase their risk of developing pressure ulcers.

''Good communication between healthcare professionals, social care practitioners and people with pressure ulcers is essential. This also applies to children and young adults with pressure ulcers, and their families or carers. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with pressure ulcers and their families or carers should have access to an interpreter or advocate if needed.'' (NICE, 2015)

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Linked Areas/Useful Websites

National Institute for Clinical Excellence (NICE)
www.nice.org.uk

European Pressure Ulcer Advisory Panel (EPUAP)
www.epuap.org.uk

Worldwide Wounds
www.worldwidewounds.com

National Electronic Library for Health
www.nelh.nhs.uk

APPENDIX 1
Categorising Pressure Ulcers poster (NWCSP 2024)

To be added when published

APPENDIX 2
Local Pressure Ulcer Review process

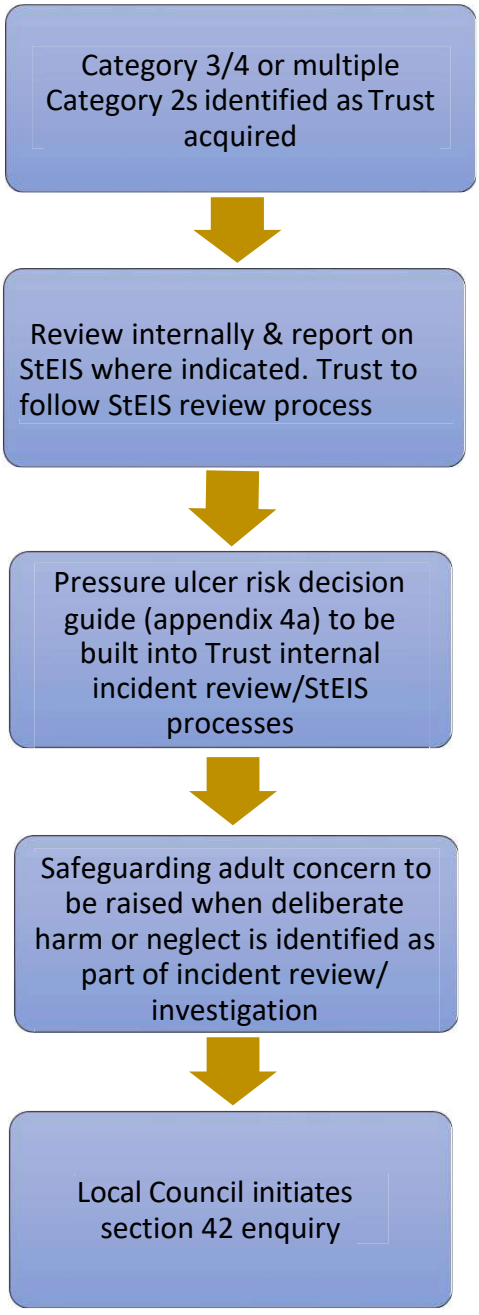
Add local process

Appendix 3
Difference between pressure ulcers and Moisture Associated Skin Damage

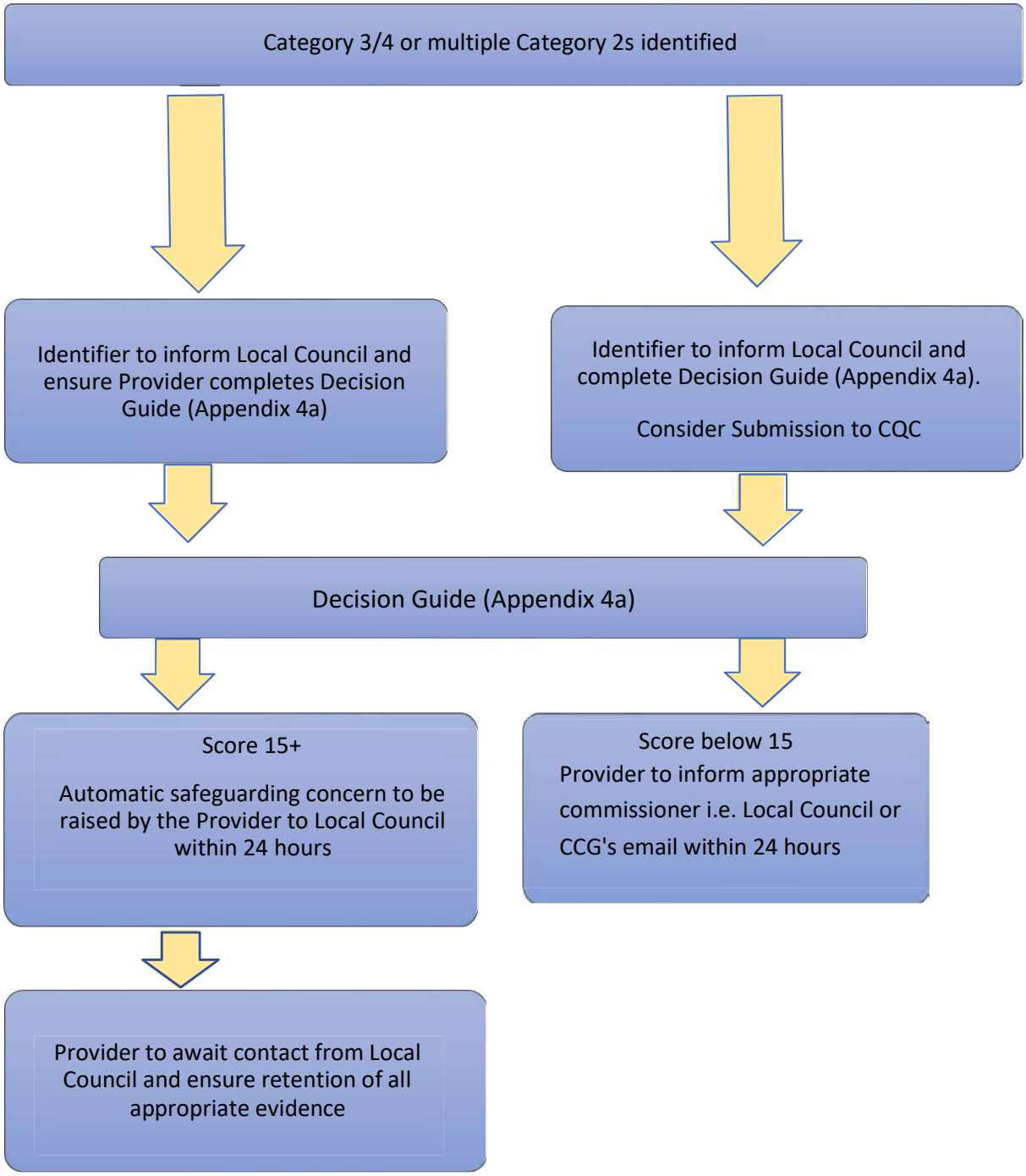
Add local document or tool

Appendix 4a

Flowchart 1 – NHS Provider Acquired Pressure Ulcer

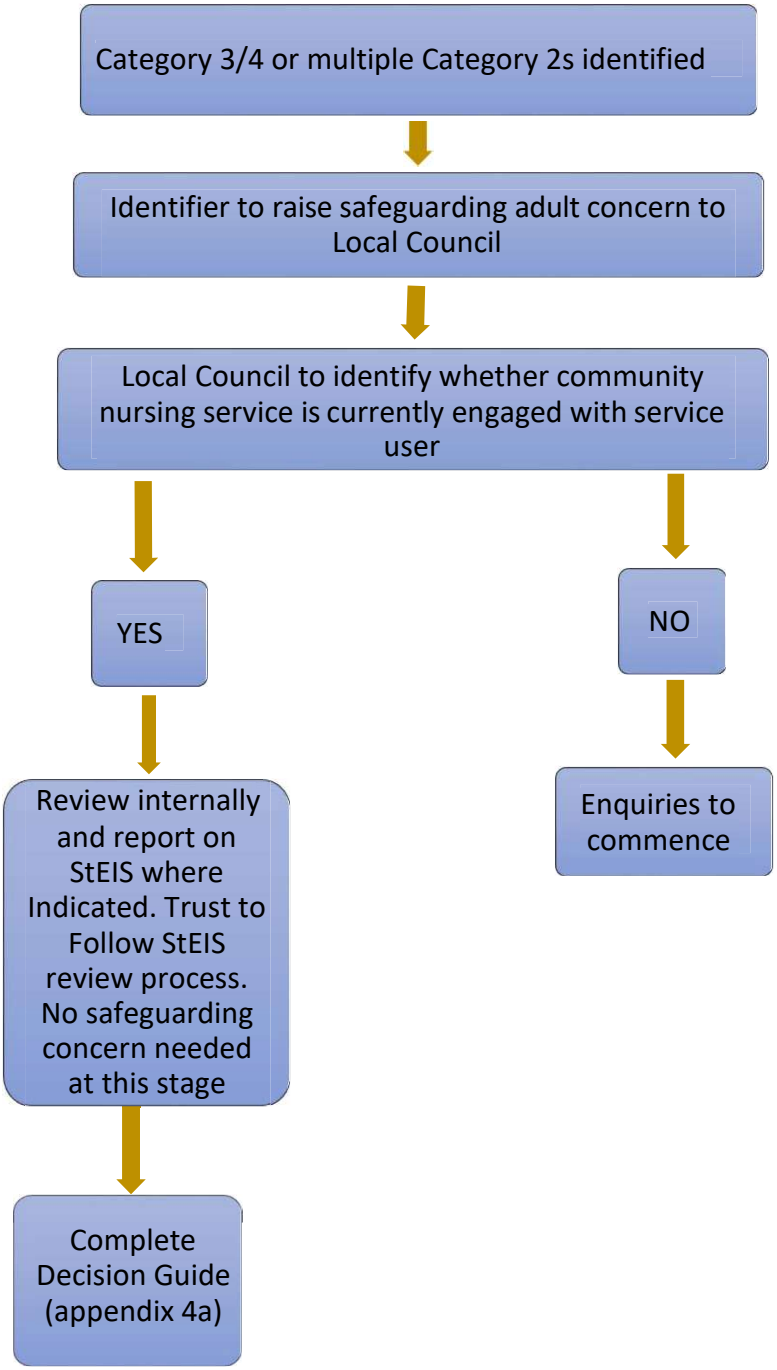


Appendix 4b
Flowchart 2 – Nursing Home Acquired Pressure Ulcer



Appendix 4c

Flowchart 3 – Residential/ Domiciliary Care/ Community / Own Home Acquired Pressure Ulcer



(Flowsheets used with permission, included in '*The Management of Pressure Ulcers under Safeguarding Across the Borough of Sefton*' , 2019)

Appendix 4d

Department of Health and Social Care (2018, 2024) Adult Safeguarding Decision Guide

	Patient Name: Patient DOB:	NHS number:	Patient Address:	
Q	**Risk Category**	**Level of Concern**	**Score**	**Evidence**
1	Has the patient's skin deteriorated to either category 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	**Yes** e.g., record of blanching/non-blanching erythema or category 2 progressing to multiple category 2s or category 3 or 4, or unstageable	5	e.g., evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		No e.g., no previous skin integrity issues or no previous contact health or social care services	0	
2	Has there been a recent change? i.e. within days or hours, in their clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care, critical illness	**Change in condition** contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	

3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? (In line with each organisations policy and guidance)	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score/Risk level
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place?
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not?
4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services	**No/Not applicable**	0	
		Yes	15	
5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk– Category 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0	

		Skin damage more severe than patient's risk assessment suggests is proportional	10	
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan.			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Patient has not followed care plan and local non concordance policies have been followed	0	
		Patient followed some aspects of care plan but not all	3	
		Patient followed care plan or not given information to enable them to make an informed choice	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	0	

		No documentation of care being undertaken in patient's best interests	10	
	Total Score			

If the score is 15 or over, or where professional judgement determines safeguarding concerns, a copy of the completed decision guide, and a completed adult safeguarding proforma regarding the pressure ulcer should be sent to the adult safeguarding team within the local authority. Copies of both should be held in the service user's electronic or paper record.

When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised, the tool should be stored in the patient's notes.

Note: Where there is ***suspected abuse or neglect*** the health care practitioner MUST immediately submit a safeguarding concern, irrespective of Category of Pressure Damage.

(Appendices 4a-4d: South Sefton Clinical Commissioning Group, 2019, "Safeguarding and Pressure Ulcers across Sefton" v1)

Record of Changes to Document – Issue number: V2			
Changes approved in this document:			
Section Number	**Amendment (*Shown in bold italics)***	**Deletion**	**Addition**
3.6	Change to Appendix 1	Appendix 1 NWTVN categorisation poster	See Appendix 1 for categorisation poster (NWCSP, 2024).
4.0		The guidance has been updated following changes … new pressure ulcer prevention curriculum issued by NHS Improvement (2018b).	
4.0			Care to prevent pressure ulcer (NWCSP)
4.1			Identification of someone at ris pressure ulcers and immediate (NWCSP) Initial screening Risk Assessment Primary diagnosis of pressure damage Categorisation of pressure dar Outcome of risk assessment

4.8			Plan and deliver individualised that addresses the presenting factors using the aSSKINg Framework for anyone with an existing pressure ulcer … Care following healing
6.0	Minor amendments to this section		
References	NWCSP, 2023 DoH, 2024 NHS England, 2023 NWCSP, 2024	 DoH, 2018 NHS England, 2015	