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|  **Review Sheet** |
| Last Reviewed Last Amended Next Planned Review in 12 months, or13 Feb '20 13 Feb '20 sooner as required. |
| Business impact | Changes are important, but urgent implementation is not required, incorporate into your existing workflow.**MEDIUM IMPACT** |
| Reason for this review | Scheduled review |
| Were changes made? | Yes |
| Summary: | This policy details how the service will support Service Users who are at risk of or present with pressure ulcers. It defines the roles and responsibilities of staff as well as details the clinical governance framework for reducing risk and reflection.The policy has been reviewed with changes made to the procedures to reflect the NHS improvement standards relating to definitions (specifically procedure 5.3 and 5.7). A definition has been amended to reflect the current recommended definition, and a further definition added. Two further reading resources added with an additional reference. The term grade has been removed and replaced with Category across the procedure section. |
| Relevant legislation: | * The Care Act 2014
* The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
* Medicines Act 1968
* Mental Capacity Act 2005
* Mental Capacity Act Code of Practice
 |
| Underpinning knowledge - What have we used to ensure that the policy is current: | * Author: Dougherty L, Lister S, (2015), *Royal Marsden Manual of Clinical Nursing Procedures*. [Online] Available from: [Accessed: ]
* Author: National Institute for Health and Care Excellence, (2015), *Pressure ulcers - Quality standard [QS89]*. [Online] Available from: <https://www.nice.org.uk/guidance/qs89>[Accessed: 13/2/2020]
* Author: National Institute for Health and Social Care Excellence, (2014), *Pressure ulcers: prevention and management Clinical guideline [CG179]*. [Online] Available from: <https://www.nice.org.uk/Guidance/CG179>[Accessed: 13/2/2020]
* Author: European Pressure Ulcer Advisory Panel, (2014), *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*. [Online] Available from: [http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap- epuap-pppia-jan2016.pdf](http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf) [Accessed: 13/2/2020]
* Author: NICE, (2018), *Decision-making and mental capacity - Guidelines NG108*. [Online] Available from: <https://www.nice.org.uk/guidance/ng108>[Accessed: 13/2/2020]
* Author: NHS Improvement, (2017), *Pressure ulcers: Revised definitions and measurement framework*. [Online] Available from: [https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and- measurement-framework/](https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/) [Accessed: 13/2/2020]
 |
| Suggested action: | * Encourage sharing the policy through the use of the QCS App
 |
| Equality impact Assessment: | QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law. |

**1. Purpose**

* 1. To ensure that all Service Users who are at risk of pressure ulcer development (or who have pressure ulcers) are appropriately assessed, have an individualised plan of care implemented and that appropriate, timely reviews are undertaken.
	2. To support Holbeach Hospital & Nursing Home in meeting the following Key Lines of Enquiry:

## Key Question Key Lines of Enquiry

|  |  |
| --- | --- |
| EFFECTIVE | E1: Are people’s needs and choices assessed and care, treatment and support delivered in line with current legislation, standards and evidence- based guidance to achieve effective outcomes? |
| RESPONSIVE | R1: How do people receive personalised care that is responsive to their needs? |
| WELL-LED | W4: How does the service continuously learn, improve, innovate and ensure sustainability? |

* 1. To meet the legal requirements of the regulated activities that Holbeach Hospital & Nursing Home is registered to provide:
		+ The Care Act 2014
		+ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
		+ Medicines Act 1968
		+ Mental Capacity Act 2005
		+ Mental Capacity Act Code of Practice

**2. Scope**

* 1. The following roles may be affected by this policy:
		+ Registered Manager
		+ Nurse
		+ Care staff
	2. The following Service Users may be affected by this policy:
		+ Service Users
	3. The following stakeholders may be affected by this policy:
		+ External health professionals
		+ NHS

**3. Objectives**

* 1. To reduce the incidence and severity of pressure ulcers within Holbeach Hospital & Nursing Home.
	2. To provide an evidence-based approach to managing pressure ulcers in conjunction with healthcare professionals, local wound care guidelines and formularies.

**4. Policy**

* 1. Service Users who are identified as being at risk of developing pressure ulcers must have a detailed plan of care established. This must directly reflect NICE guidance for pressure ulcer prevention and management (2014).
	2. Service Users identified as at risk should be informed and advised regarding prevention measures and strategies. This verbal advice and support should be enhanced, where appropriate, with the use of Service User education leaflets based on NICE guidance, to be used with the Care Worker's support. In the absence of a Service User's capacity to be involved, the Care Worker will make decisions in the Service User's best interest in accordance with the Mental Capacity Act (2005).
	3. Care staff will be trained and competent within the realm and scope of their role to support Service Users with reducing the risk of and management of pressure damage.

**5. Procedure**

## Contributory Factors

Pressure and shearing are significant causes of pressure ulcers but there are factors that directly contribute to a Service User’s overall risk of developing a pressure ulcer. Care Workers supporting Service Users will be aware of these factors and how to implement strategies to try to minimise the risk. These factors include:

* + - Decreased/impaired level of mobility
		- Sensory impairment
		- Incontinence
		- Level of consciousness
		- Acute, chronic and terminal illness comorbidity
		- Posture
		- Cognition, psychological status
		- Previous pressure damage
		- Extremes of age
		- Nutrition and hydration status
		- Moisture to the skin
		- Creased bed sheets
		- Tight clothing
		- Incorrectly used or inappropriate type of pressure relieving device

## Pressure Ulcer Risk Assessment

* + - All Service Users will be assessed for the risk of developing a pressure ulcer by a suitably trained Nurse, using the recognised risk assessment tool at Holbeach Hospital & Nursing Home within 6 hours of admission and then as a minimum, monthly, or if the Service User's condition changes
		- Formal assessment, along with clinical judgement and decision-making, will guide Nurses to identify those at highest risk of developing pressure damage. The Nurse must be aware that it is the individual factors that raise the risk (not the overall score) and therefore should introduce personalised strategies focusing on the identified risk factors and clinical judgement
		- Outcomes of risk assessments and agreed strategies will be formulated into the Service User's Care Plan and communicated to other Nurses through daily handovers and updates. This ensures that care is provided in accordance with assessed need
		- The Service User's skin condition will be assessed during every care intervention (e.g. personal hygiene, repositioning) and concerns identified will be immediately communicated to the senior Nurse. The Nurse must be able to identify, report and record the following skin conditions:
			* Persistent erythema (redness)
			* Non-blanching erythema
			* Blisters
			* Localised heat
			* Localised oedema (fluid)
			* Localised indurations (hardening of the area)
			* Purplish/bluish localised areas
			* Localised coolness if tissue death occurs

## Pressure Ulcer Prevention

* + - Pressure ulcer prevention Care Plans will be in place for Service Users. These will detail specific risk management strategies including repositioning regimes and the use of therapeutic equipment. Where able, Service Users will be involved in the production of the Care Plan and will receive advice and guidance on the benefits and frequency of repositioning
		- Service Users who are incontinent will have their skin assessed regularly with a timely response to meeting need. Soap and water will be avoided when cleaning Service Users who are incontinent as this can promote the development of pressure ulcers. Mild pH-balanced cleansers should be used as an alternative. Prescribed skin cleansers, barriers or emollients must be administered as directed by the prescriber and recorded as such on the topical medication record
		- Service Users who can remain active or change their position should be encouraged to do so. Support and assistance must be provided to those who cannot easily change their position
		- For Service Users who require the use of clinical devices such as nasogastric tubes, catheters, PEGs etc, care must be taken to ensure that the skin is monitored to prevent medical device-related pressure ulcers
		- Care Workers must use the correct positioning, moving and handling techniques and equipment to minimise the risk of shearing
		- Service Users will be offered an activity programme that encourages regular repositioning and offloading of pressure over bony prominences

## Categorisation

* + - Pressure ulcers will be Categorised according to the European Pressure Ulcer Advisory Panel (EPUAP 2014) Pressure Ulcer Category Tool
		- If a Nurse is in any doubt about the correct categorisation of a wound, a second opinion should be sought from another trained Nurse
		- With regard to record keeping, pressure ulcers should not be reverse-Categorised. A Category 4 pressure ulcer does not become a Category 3 as it heals. As the ulcer heals it should be described as a healing Category 4 pressure ulcer. The use of photographs and accurate measurement and assessment can evidence improvements of the wound
		- Body maps and photographs (with the Service User's consent) of any pressure damage must be documented and a specific wound care plan implemented
		- The Nurse responsible for wound management will refer to the Royal Marsden Manual of Clinical Nursing Procedures for current recommended practice

## Therapeutic Equipment

Pressure reducing surfaces or devices are used to reduce and redistribute the overall pressure to the vulnerable bony prominences, such as the sacrum (bottom of the spine), hips, buttocks and heels (NICE 2014).

* + - Service Users at high risk of developing pressure ulcers will be provided with a pressure redistribution mattress. The type of device that a Service User needs will depend on their circumstances, mainly:
			* Mobility
			* Skin assessment outcome
			* Level of risk
			* Site that is at risk
			* Service User's weight
			* General health
		- Pressure redistribution devices will be introduced as soon as possible when required, and the Nurse must be aware of how to source equipment in a timely manner
		- The setting and correct functioning of the pressure mattress must be checked and recorded on a daily basis
		- Pressure relieving mattresses must be properly cleaned and maintained in line with the cleaning schedules at Holbeach Hospital & Nursing Home and the manufacturer's guidance
		- Air mattresses should be annually PAT (Portable Appliance Testing) tested and the Care Workers should have access to the manufacturer’s guidance regarding settings and alarm support
		- Cushions – appropriate pressure relieving cushions will be available for Service Users at high risk of, or with existing pressure ulcers, who are able to sit out of bed
		- This policy **does not** support the use of the following as pressure reducing aids or devices:
			* Synthetic or genuine sheepskins
			* Water-filled gloves
			* Donut ring type seat cushions
		- Portable pressure relieving devices such as heel lift boots and silicone gel pads are single-use only and should only be used for those Service Users intended. Portable devices will also be subject to proper cleaning and maintenance as per the cleaning schedules at Holbeach Hospital & Nursing Home

## Record Keeping

In addition to maintaining a Care Plan and pressure prevention risk assessment, the following apply:

* + - Ensure that relevant documentation is updated and reflective of any changes to a Service User's condition
		- For Service Users nursed in bed, repositioning charts should be used
		- Charts must clearly state the frequency of repositioning to be undertaken and clearly document when this was undertaken
		- Fluid and nutrition charts, when used, must be completed accurately so that the level of risk can be accurately judged. If the Service User refuses food or drink when offered, this should also be recorded

## Reporting

* + - Cases of single Category 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further damage.
		- Where there is a combination of moisture associated skin damage and pressure ulcers, this will be reported in accordance with the category of the pressure ulcer
		- Pressure damage at Category 3 and 4 (to include unstageable and suspected deep tissue injury), will be reported to South Holland District Council and the CQC
		- For Service Users who present with a Category 3 or 4 ulcer, or a deteriorating pressure ulcer, an urgent referral to a specialist support professional (e.g. tissue viability nurse) will be made for advice and guidance unless already involved.
		- All incidents of pressure ulcers and moisture associated skin damage will be recorded internally, monitored, investigated and reflected on to improve care practice. Staff will be made aware of the findings in line with Holbeach Hospital & Nursing Home audit procedures
		- Where a Service User transfers from another care setting (e.g. hospital or respite) or from another care provider and develops any Category 3 or 4 pressure ulcer on admission, it must be escalated and reported to the previous care provider as a clinical incident and Holbeach Hospital & Nursing Home must follow its own regulatory reporting procedures

**6. Definitions**

## Pressure Ulcers

* + - 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 be present as intact skin or an open ulcer and may be painful

## Pressure

* This is continuous physical force exerted on or against an object by something in contact with it

## Shearing

* + - Is the force which frequently accompanies both friction and direct pressure. Shear forces develop in the tissues that are distorted and pulled so that the blood supply is disrupted

## Comorbidity

* This is the presence of two or more diseases or conditions in an individual at the same time

## Oedema

* A condition characterised by an excess of watery fluid collecting in the cavities or tissues of the body

## Erythema

* + - Superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries

## Medical Device-Related Pressure Ulcer

* + - Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes - (NPUAP 2015)

**Key Facts - Professionals**

Professionals providing this service should be aware of the following:

* + - Pressure prevention involves a holistic approach to care and individually tailored Care Planning involving Service Users
		- Encouraging good skin care, movement and regular repositioning will help reduce and eliminate pressure damage
		- Nurses are responsible for keeping up to date with national recommendations around practice in pressure prevention

**Key Facts - People affected by the service**

People affected by this service should be aware of the following:

* + - You should feel supported to maintain your independence with looking after your skin. This will include regular repositioning, physical activity and skin care monitoring and management
		- You can expect to be supported by staff who are knowledgeable, competent and skilled with skin care management
		- Where necessary, you will be provided (with your consent) with equipment to help reduce the risk of developing pressure ulcers and you will have access to specialist healthcare professionals for further advice and support

**Further Reading**

As well as the information in the 'underpinning knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

**NHS - Pressure Ulcer Category Chart:** <http://nhs.stopthepressure.co.uk/docs/PU-Grading-Chart.pdf> **SSKIN (approach to managing and preventing skin damage):**

<https://improvement.nhs.uk/resources/Using-SSKIN-to-manage-and-prevent-pressure-damage/>

## Stop the Pressure:

<https://nhs.stopthepressure.co.uk/>

**Outstanding Practice**

To be ‘ outstanding ’ in this policy area you could provide evidence that:

* + - Holbeach Hospital & Nursing Home has identified a link role to join relevant associations, attend training and support Care Workers with best practice
		- The wide understanding of the policy is enabled by proactive use of the QCS App
		- The reporting of incidences and the prevalence of pressure ulcers as well as focused audits take place within Holbeach Hospital & Nursing Home in order to identify themes and benchmark practice
		- Holbeach Hospital & Nursing Home has become involved in national and local initiatives such as 'Stop the pressure' campaigns in order raise awareness and knowledge of pressure damage and how to manage it

**Forms**

The following forms are included as part of this policy:

|  |  |  |
| --- | --- | --- |
| **Title of form** | **When would the form be used?** | **Created by** |
| Reposition Chart - CCN30 | To record position changes for a Service User. | QCS |
| Reposition Chart Guidance Notes and Example - CCN30 | As guidance when filling in a Reposition Chart. | QCS |
| Waterlow Risk Assessment - CCN30 | To assess the risk of developing a pressure sore. | QCS |
| Management of Pressure Ulcer Risk - CCN30 | To provide prompts to consider when reflecting the Waterlow risk within the Skin Care Plan. | QCS |

|  |  |
| --- | --- |
| **Service User Name:** |  |
| **Agreed reposition schedule (indicate as****appropriate)** | **HOURLY 2 HOURLY 4 HOURLY 6 HOURLY Other:** |
| **Date:** | **Where applicable, add the required setting of the pump:** |
|  | **Position** | **Observations** | **Signature** |
| **01:** |  |  |  |
| **02:** |  |  |  |
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| **00:** |  |  |  |

Staff must document if repositioning has been offered but declined by the Service User. Where repositioning is frequently declined, the Care Plan must be updated to reflect this, with strategies for the management of this included. Where Service Users require the use of an air mattress, staff are responsible for ensuring that the pump is set in accordance with the Service User's current weight. As weight changes, the pump setting should be reviewed to ensure that it remains accurate. Staff should check the setting of the air mattress at every reposition opportunity and record it (as per the example below). Some air mattresses have automatic settings, in which case staff should state 'automatic' in the top section of this form.

|  |  |
| --- | --- |
| **Service User Name:** | *Joe Bloggs* |
| **Agreed reposition schedule: (Indicate****as appropriate)** | **HOURLY** | **2 HOURLY** | **4 HOURLY** | **6 HOURLY** | **Other:** |  |
| **Date:** *10/12/2019* | **Where applicable, add the required setting of the pump:** *Setting 4* |
| **Time** | **Position** | **Observations** | **Signature** |
| **01:** |  |  |  |
| **02:***45* | *Left side* | *Setting 4 - skin inspection, skin intact* | *LC* |
| **03:** |  |  |  |
| **04:** |  |  |  |
| **05:** |  |  |  |
| **06:***50* | *Back* | *Setting 4 - skin inspection, skin intact* | *RC* |
| **07:** |  |  |  |
| **08:** |  |  |  |
| **09:** |  |  |  |
| **10:** |  |  |  |
| **11:***02* | *Right side – declined (so 30 degree tilt offered and accepted to right side)* | *Setting 4 - skin inspection, skin intact* | *PR* |
| **12:** |  |  |  |
| **13:** |  |  |  |
| **14:** |  |  |  |
| **15:***00* | *Left side* | *Setting 4 - skin inspection, slight redness to right heel – elevated off the base of mattress* | *PR* |
| **16:** |  |  |  |
| **17:** |  |  |  |
| **18:***53* | *Right side* | *Setting 4 - skin inspection, redness remains to right heel, cream applied and elevated from bed* | *PC* |
| **19:** |  |  |  |
| **20:** |  |  |  |
| **21:** |  |  |  |
| **22:** |  |  |  |
| **23:***00* | *Left side* | *Setting 4 - skin inspection, no red area to right heel, skin intact* | *LC* |
| **00:** |  |  |  |

Consider the table below and record the relevant score for each section in the score table below. Several scores per category can be used. This risk assessment should be used alongside clinical judgement and individual risk factors and preferences.

|  |  |
| --- | --- |
| **Service User’s Name:** | **Room Number:** |
| **Build/Weight for Height** | **\*** | **Risk areas/visual skin type** | **\*** | **Sex/Age** | **\*** | **Special Risks** | **\*** |
| Average BMI 20-24.9 | 0 | Healthy | 0 | Male | 1 | Tissue/Malnutrition e.g.Terminal cachexia | 8 |
| Above average BMI 25 – 29.9 | 1 | Tissue paper | 1 | Female | 2 | Cardiac failure | 5 |
| Obese BMI >30 | 2 | Dry | 1 | 14-49 | 1 | Peripheral vascular disease | 2 |
| Below average BMI<20 | 3 | Oedematous | 1 | 50-64 | 2 | Anaemia | 2 |
|  |  | Clammy | 1 | 65-74 | 3 | Smoking | 1 |
|  |  | Discoloured | 2 | 75-80 | 4 |  |  |
|  |  | Broken/spot | 3 | 81+ | 5 |  |  |
| **Continence** | \* | **Mobility** | \* | **Appetite** | \* | **Neurological deficit** | \* |
| Complete/catheterised | 0 | Fully | 0 |  | 0 | Diabetes/CVA | 4-6 |
| Occasional continence | 1 | Restless/fidgety | 1 | Poor | 1 | Motor/Sensory | 4-6 |
| Incontinent of faeces | 2 | Apathetic | 2 | NG tube | 2 | Paraplegia | 4-6 |
| Urinary and Faecal incontinence | 3 | Restricted | 3 | Fluids only | 2 | Medication/Steroids, Cytotoxic/Anti- inflammatory | 4 |
|  |  | Nursed in bed | 4 | Nil by mouth/Anorexic | 3 |  |  |
|  |  | Chair bound | 5 |  |  |  |  |

**(Waterlow Risk Assessment Continued)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **SCORE** | **SCORE** | **SCORE** | **SCORE** | **SCORE** | **SCORE** | **SCORE** | **SCORE** | **SCORE** |
| **DATE** |  |  |  |  |  |  |  |  |  |
| BMI |  |  |  |  |  |  |  |  |  |
| Skin Risk |  |  |  |  |  |  |  |  |  |
| Sex/Age |  |  |  |  |  |  |  |  |  |
| Special Risks |  |  |  |  |  |  |  |  |  |
| Continence |  |  |  |  |  |  |  |  |  |
| Mobility |  |  |  |  |  |  |  |  |  |
| Appetite |  |  |  |  |  |  |  |  |  |
| Neurological |  |  |  |  |  |  |  |  |  |
| **Total Score** |  |  |  |  |  |  |  |  |  |
| **Level of risk** |  |  |  |  |  |  |  |  |  |
| **Completed by** |  |  |  |  |  |  |  |  |  |

**Score: 10+ (At risk) 15+ (High Risk) 20+ (Very High Risk)**

**Refer to the Waterlow guidelines for support with how to manage the level of risk**

Management of Pressure Sore Risk

The SSKIN approach should be taken to managing pressure sore risk, care plans should refer to:

* Surface: Make sure service users have the right support.
* Skin Inspection: Early inspection means early detection.

Show service users and their carers what to look for.

* Keep your service users moving.
* Incontinence/Moisture: Your service user’s need to be clean and dry.
* Nutrition/Hydration: Help service users have the right diet and plenty of fluids.

# The following guidelines can be used to provide prompts to consider when reflecting the Waterlow risk within the Skin Care Plan. The Waterlow however, is only one part of a skin assessment and all other aspects should be planned on an individual basis and in discussion with the service user.

Regardless of level of risk, all service users should be offered a nutritious and varied diet and Moving and Handling Care Plans followed.

Remember, the Waterlow must be reviewed at least monthly or as conditions change.

Score of < 10 NO RISK

Check skin daily.

Note any red areas, bruising, etc. and report to senior member of staff immediately.

Keep skin clean and dry.

Score 10 to 14 AT RISK Encourage mobility and provide activity.

Record how often the service user should be repositioned as agreed. Offer afternoon rests to relieve pressure.

Consider the use of specialist mattresses/cushions in accordance with EPUAP and NICE guidelines.

Keep skin clean and dry and check daily.

Note any red areas, bruising, etc. and report to senior member of staff immediately.

Score 15 to 19 HIGH RISK

If the service user is mobile, record this in the care plan as this will reduce the risk of pressure damage.

Offer and agree a reposition regime with the service user and record how often this will take place.

Consider the use of specialist mattresses/cushions in accordance with EPUAP and NICE guidelines.

Encourage an afternoon rest to relieve pressure.

Promote the skin care by keeping clean and dry as per the personal hygiene care plan.

Skin should be checked at least twice a day, individuals guided to do this independently where possible.

Note any red areas, bruising, etc. and report to senior member of staff immediately.

Score > 20 VERY HIGH RISK

If the service user is mobile, record this in the care plan as this will reduce the risk of pressure damage.

Offer and agree a reposition regime with the service user and record how often this will take place.

Consider the use of specialist mattresses/cushions in accordance with EPUAP and NICE guidelines.

Advise the service user not to spend any longer than 2 hours in the same position.

Encourage an afternoon rest to relieve pressure.

Promote the skin care by keeping clean and dry as per the personal hygiene care plan

Skin should be checked at least twice a day (at every care intervention), individuals guided to do this independently where possible.

Note any red areas, bruising, etc. and report to senior member of staff immediately.