Shropshire Community Health NHS
NHS Trust

Policies, Procedures, Guidelines and Protocols

Document Details	
Title	Pressure Ulcer Prevention and Management
Trust Ref No	969-
Local Ref (optional)	
Main points the document covers	Guidance on preventing and managing pressure ulceration. The guidelines will support the delivery of safe and effective care.
Who is the document aimed at?	All healthcare professionals in contact with patients
Owner	Jodie Jordan, Tissue Viability Service Lead
Approval process	
Who has been consulted in the development of this policy?	Tissue Viability Team, Patient Safety Committee
Approved by (Committee/Director)	
Approval Date	21/10/24
Initial Equality Impact Screening	Y
Full Equality Impact Assessment	N
Lead Director	Director of Nursing and Clinical Delivery
Category	Clinical
Subcategory	Policies relevant to all services
Review date	21/10/27
Distribution	
Who the policy will be distributed to	Directors, Divisional Managers, Service Leads and Team leaders for dissemination to relevant staff within their areas.
Method	Publishing to the Trust website, team meetings/briefings
Keywords	Pressure ulcer, pressure, pressure ulcer category, skin damage, moisture associated skin damage, safeguarding, PURPOSE T, aSSKINg, risk assessment, MUST, Moving and Handling, wound assessment, pain, prevention, nutrition.
Document Links	
Required by CQC	Yes
Other	

Amendments History		
No	Date	Amendment
1	V1 May 2017	New Policy
2	V2 Sept 2017	Full review with additional guidance on pressure ulcer prevention and management, revised patient leaflet and reformatting
3	V3 Oct 2024	Scheduled review of Policy with updates to pressure ulcer risk assessment and associated documents
4		
5		

Contents

1 Introduction

Pressure ulcers remain a significant healthcare problem affecting 700,000 people per year (Wood J, Brown B, Bartley A, et al, 2019); they are associated with reduced quality of life, affecting an individual's physical, social, and emotional wellbeing.

Estimates on pressure ulcer incidence and prevalence from hospital-based studies vary widely, according to the definition and category of ulcer, the patient population and care setting. Treating a pressure ulcer costs the NHS more than £3.8 million every day (NHS Improvement 2016), in the most severe cases the cost can range from £11,000 to £40,000 per person.

Pressure ulcer prevention can improve patient outcomes and reduce the cost to the NHS. When considered alongside the human suffering there is a clear need to find innovative and simple ways for all members of the multi-disciplinary team to address this fundamental aspect of nursing care in everyday clinical practice.

Shropshire Community Health NHS Trust (SCHT) aims to provide the best possible care for their patients and will make every effort to prevent patients developing pressure ulcers and associated conditions whilst in their care. In addition, the Trust has a responsibility to ensure that there are systemic measures in place to prevent the development of pressure ulcers and associated conditions and to assess and manage them if they should occur.

2 Purpose

This policy provides health professionals across SCHT with knowledge to inform and support their actions and decision making, ensuring they can provide the most effective pressure ulcer preventative and/or treatment strategy.

This policy is intended as a brief overview and should be read in conjunction with more detailed guidance from National Pressure Ulcer Advisory Panel (NPUAP) 2019, European Pressure Ulcer Advisory Panel (EUPAP), 2019.

3 Definitions

Pressure Ulcer (PU)	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.
EUPAP	European Pressure Ulcer Advisory Panel
PSIRF	Patient Safety Incident Response Framework
Medical Device related pressure ulcer (MDRPU)	Pressure ulcer that has developed due to the presence of a medical device (NHSI June 2018).
Moisture Associated Skin Damage (MASD)	Skin damage caused by excessive moisture.
Pressure ulcer present on admission (POA)	When undertaking a skin inspection on admission to the service (caseload, inpatient or clinic setting), if the patient is observed to

	have a pressure ulcer, it will be referred to as a 'pressure ulcer on admission' (POA). This must be documented in the patient's notes and reported accordingly.
Deep Tissue Injury (DTI's)	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

4 Duties

The Board of Directors are responsible for ensuring that the necessary clinical policies, procedures, and guidelines are in place to safeguard patients and reduce risk. In addition, they will require assurance that clinical policies, procedures, and guidelines are being implemented and monitored for effectiveness and compliance.

The Director of Nursing and Clinical Delivery and the Medical Director are responsible for overseeing the implementation of this document.

4.1 Clinical Service Managers and Professional Leads:

Clinical Service Managers and Professional Leads will, for their areas of responsibility, ensure that this document is implemented by ensuring that:

- This document is made available to all staff within their department, and that their staff comply.
- There is adequate provision of suitable staffing levels, working conditions and environments. Each day all team members will undertake a pressure ulcer prevention safety huddle (where appropriate).
- Each team will have a healthcare professional/clinical lead to act as a link nurse/champion for Pressure Ulcer Prevention and Tissue Viability to disseminate updates in care and be a link for their area to/from the Tissue Viability Service (TVS).
- That their staff are properly informed and trained by ensuring that staff are released for training in undertaking skin assessment and risk assessment and complete the on-line training pressure ulcer prevention module.
- All new staff joining the Trust will receive pressure ulcer prevention training as part of their induction programme.

4.1.1 Team Leaders (Adults):

Team leaders will:

- Ensure all caseload holders undertake daily handover discussion and pressure ulcer safety huddle within their teams.
- Be responsible for confirming the correct pressure ulcer category within their teams and that it is reported via Datix.
- Develop and implement action plans and risk reduction measures resulting from the investigation of incidents and provide assurance of completion.
- Monitor action plans until completed and that the Risk Management Team and the Tissue Viability Service are kept informed of progress.

4.2 Tissue Viability Team:

Tissue Viability Nurses are responsible so far as is reasonably practical for:

- Ensuring that this document reflects National and Commissioner's Guidance and is disseminated throughout the Trust.
- Specialist assessment of complex and Category 3 and 4 pressure ulcers.
- Overseeing Datix to ensure all pressure ulcers reported are confirmed with correct category of damage and harm level.
- Attend Patient Safety Incident Panel (PSIP) to review all in-service category 3 and 4 pressure ulcer incidents.
- Pressure ulcer prevention and management education and awareness for key events (Stop the Pressure Day).

4.2.1 All nursing staff have a responsibility to:

- Participate in the daily team handover and pressure ulcer safety huddle when on duty.
- Ensure that they develop and maintain their knowledge and skills in Pressure Ulcer Prevention and management.
- All staff are responsible for reporting all pressure ulcers Category 2 and above within 24hrs of discovery.
- All patients that have developed a Category 3 and/or Category 4 pressure ulcer, unstageable pressure ulcer and/or multiple Category 2 pressure ulcers should have a safeguarding score recorded and a safeguarding referral reported if indicated and recorded on Datix.
- Duty of Candour: all patients or their family who have developed a pressure ulcer whilst under the care of the Trust must receive a Duty of Candour written apology from the Trust.
- Staff issuing pressure relieving equipment must review the equipment regularly as directed in Pressure Relieving Equipment Guidance (Appendix 1).

4.2.2 All staff have a responsibility to:

- Attend pressure ulcer prevention and awareness training.
- Be aware of the Pressure Ulcer Prevention and Management policy and the process to follow when a pressure ulcer is discovered.

5 Pressure Ulcer Risk Assessment

Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE T) is an evidence-based pressure ulcer risk assessment tool which supports clinical decision making and makes a distinction between three groups of patients:

- those not at risk of developing a pressure ulcer
- those patients who have no pressure ulcer but who are at risk (requiring primary prevention)
- and those with an existing pressure ulcer/scar, or who have had a pressure ulcer in the past (requiring secondary prevention and treatment)

PURPOSE T (Appendix 2) has a three- step assessment process:

Step 1: Screening - to quickly screen out those clearly not at risk. It comprises assessment of mobility and skin status (including medical devices) as well as encouraging healthcare

professionals to use their clinical judgement to highlight any other risk factors which significantly impact the individual patient.

Step 2: Full Assessment – incorporates the following evidence-informed items:

- Analysis of independent movement
- Detailed skin assessment
- Previous pressure ulcer history
- Medical devices
- Perfusion and nutrition
- Sensory perception and response
- Moisture due to perspiration, urine, faeces, or exudate
- The presence of diabetes.

Step 3: Assessment decision based on step 2 and aided by colour-coding:

Green: No pressure ulcer – not currently at risk

Amber: No pressure ulcer – but at risk, requiring primary prevention

Red: Pressure ulcer Category 1 or above or scarring from previous pressure ulcer – requiring secondary prevention/treatment.

Following Step 3, associated guidance is available to follow based on green, amber and red pathways (Appendix 3), this should be used in collaboration with the Pressure Ulcer Clinical Pathway (Appendix 4).

The PURPOSE T risk assessment tool should be completed on RiO and should always be used in conjunction with the trained health care professional's clinical judgement and all rationale for decisions documented at each risk assessment.

Assessment should also be on-going, and frequency of re-assessment should be dependent on change in the patient's condition within the environment:

- Patients on the community caseload - PURPOSE T should be completed monthly, or sooner if a reported change has occurred in the person's condition or changes noted on skin inspection.

- On transfer to another care setting.

5.1 Skin Inspection

Skin inspection provides essential information for pressure ulcer prevention. Regular inspection of vulnerable parts of the body will enable early detection of pressure damage. (Appendix 5).

Inspection must be documented, and clinical images taken, skin assessment should also consider parts of the body where pressure, friction or shear is exerted during an individual's daily living activities e.g., on the hands of wheelchair users.

The assessment of darkly pigmented skin is different, clinical signs to consider during skin inspection are - localised heat and purplish/blue skin hue, the area may also feel cool, harder and have increased pain and localised oedema. (Appendix 7).

Patients or relatives/carers should be encouraged to participate where necessary, following appropriate information/training. Skin inspection can be undertaken during routine care,

considering patient consent, and should be documented in the patient's electronic care record and any problems acted upon.

Skin inspection should be based on an assessment of the most vulnerable at-risk areas for each patient. Usually these areas are the heels, ischial tuberosity's (sitting bones), hip and sacrum (Appendix 5).

Importance must be taken with potential or actual skin damage to the heels. All patients who have heels at risk or damaged must off-load heels and have pressure relieving heel protectors.

***A mirror can be used when inspecting the heels to aid all round visualisation of any potential or existing damage.**

In-patients (at community hospitals) will have their skin assessed a minimum of twice daily if they have been identified on the Secondary Prevention and Treatment pathway.

It may not always be feasible or possible to complete a full skin assessment. In this instance the reason why a skin assessment is not performed will be documented and completed at the next available opportunity.

5.2 Pressure Relieving Equipment

Pressure relieving equipment will be selected based on the patient's circumstances, including assessed level of risk, pressure ulcer, level of mobility, patient comfort, patient choice, place, and circumstances of care provision (NICE, 2014, EUPAP 2019).

It is important that the following factors are considered:

- Level of immobility and inactivity
- Need to influence microclimate control and shear reduction
- Size and weight of the individual
- Number, severity, and location of existing pressure injuries
- Risk for developing new pressure injuries.

Pressure relieving equipment guidance should be followed when ordering equipment (Appendix 1).

All equipment must be used in accordance with the manufacturer's instructions.

The provision of pressure relieving equipment does not replace the need for repositioning the patient as directed by their individual risk assessment.

If additional equipment i.e. pillows or gel pads are used to prevent pressure between knees and ankles, their use must not compromise the pressure redistribution/relief of the support surface the patient is being nursed on.

5.2.1 Repositioning

Frequency of repositioning will be individually determined based upon the patient's level of activity, mobility, and ability to independently reposition, consideration should also be given to the patient's:

- Skin and tissue tolerance
- General medical condition

- Overall treatment objectives
- Comfort and pain

Repositioning schedule will be agreed with the patient and carers where appropriate, this will be recorded within the patient's 24-hour pressure ulcer prevention management plan (Appendix 8).

Patients will not be repositioned onto areas of existing pressure damage; there should also be optimal offloading of all bony prominences so that maximum redistribution of pressure is achieved.

If unable to turn the patient's position due to medical reasons, then a 30-degree lateral tilt can be achieved to minimise pressure on bony prominences (Appendix 9).

Manual handling techniques and equipment should be used to reposition patients to reduce friction and shear – these should be removed after use unless they are specifically designed to remain in place and their use is supported by a moving and handling risk assessment, as well as a pressure ulcer risk assessment.

Patients who use wheelchairs should be assisted to regularly redistribute their weight. An agreed period of time should be negotiated with the patient and carer and should be recorded in the care plan, this should be no longer than two hours. Use of pressure relieving cushions should be based on risk assessment. Specialist advice and expertise should be gained from the Wheelchair Services Team.

Seating

Patients at risk or high risk of pressure ulcer development will be offered an appropriate pressure relieving cushion in accordance to their individual needs and risk assessment.

A specialist assessment can be provided by the therapy team if a patient has special postural needs, and a standard chair is not sufficient to support their posture – a referral should be made to Occupational Therapy (OT) or Physiotherapy.

As a minimum all wheelchair users should be assessed and offered a pressure relieving cushion through Wheelchair Services and should be advised to use it. There should also be an equipment review incorporating pressure mapping for wheelchair users with newly developed pressure damage to ensure equipment is sufficient for risk level and needs.

For patients with an ischial or sacral pressure ulcer, evaluate the benefit of periods of bedrest in promoting healing versus the risk of new or worsening pressure injuries and the impact on lifestyle, physical and emotional health.

Nutrition

Inadequate dietary intake and poor nutritional status have been identified as key risk factors for both the development of pressure ulcers and prolonged wound healing (Appendix 10 & 11).

Patients at risk of malnutrition:

- Elderly
- Chronic illnesses
- Neurological disorders

- Physical disabilities
- Learning difficulties
- Inflammatory bowel disease
- Mental health illness

To prevent occurrence of pressure ulcers we must:

- Provide nutritional support to patients identified of having an inadequate dietary intake and poor nutritional status.
- Complete a nutritional assessment using the MUST Tool on RiO and referral to the dietician for nutritional.

Consider referral to Speech and Language Therapy if there are any concerns/deficits in swallowing ability which may be affecting nutritional intake.

5.3 Pressure Ulcer Classification

All pressure ulcers will be assessed using the EUPAP (2014) classification system (Appendix 12).

Category of ulcer will not be reversed as the wound heals. The pressure ulcer will be referred to as a healing Category 2,3 or 4.

Moisture Associated Skin Damage (MASD) is not attributable to pressure and should not be categorised as such (Appendix 13). Where pressure does become a factor, and a combination ulcer develops this will need categorising and reporting as a pressure ulcer.

5.3.1 Process for assessing Pressure Ulcers

Pressure Ulcer Assessment should include:

- Recording of location/site
- Category of pressure ulcer
- Size and depth of the wound and measurements recorded
- Wound bed appearance using TIMES (Tissue, Infection, Moisture, Edges, Surrounding Skin)
- Pain score
- Photograph wound

All pressure ulcers should be assessed utilising the Individual Wound Assessment Chart (NA 115) and documented on the Wound Body Chart (NA 113).

A digital wound photograph should also be obtained on first assessment and then subsequently repeated weekly alongside a wound assessment (Refer to Clinical Photography Guidelines).

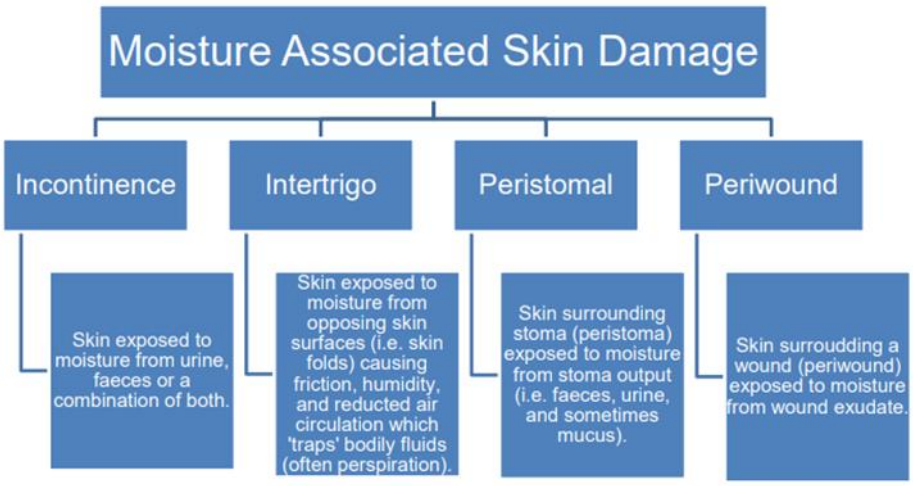
Dressing selection from the Wound Care Formulary should follow the holistic assessment and documented on the SMART Treatment Plan.

Pressure Ulcer Management

Care should be delivered according to the identified guidance based on PURPOSE T outcome (Appendix 2); this should be used in conjunction with the Pressure Ulcer Clinical Pathway (Appendix 4).

Moisture Associated Skin Damage (MASD)

MASD is an umbrella term, underneath which sits four different causes of skin damage directly associated with prolonged exposure to moisture. Correct identification is integral to the implementation of appropriate management (See MASD Pathway, Appendix 13).



Compliance/Capacity

Compliance/capacity refers to patient's ability to follow a treatment plan that has been agreed between the patient and the health care professional. The health care professional should not only assess compliance/capacity but also identify potential reasons for non-compliance (Refer to Self-Neglect Framework and ADDER).

Safeguarding

Where concerns are raised regarding skin damage as a result of pressure there is a need to consider if this is a safeguarding concern and it should be discussed as such within the organisation. In a minority of cases, it may warrant raising a safeguarding concern with the local authority.

An Adult Safeguarding Decision Guide assessment for service users with pressure ulcers should be completed by a qualified member of staff who is a practising Registered Nurse (RN), with experience in wound management and not directly involved in the provision of care to the service user.

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 (Refer to Safeguarding Adults Protocol, Department of Health, and Social Care. 2024).

For further support and guidance refer to Safeguarding Team.

5.4 Reporting and Investigation of Pressure Ulcers

All pressure ulcers Category 2 or above must be reported to the Trust through the Clinical Incident Reporting System (DATIX) and a Safeguarding Score should be done and actioned.

Deep Tissue Injuries (DTI's), Category 3, 4 and unstageable pressure ulcers will be verified by the Tissue Viability Team and any relevant advice provided.

DTI and unstageable pressure ulcer incidents will be kept under review until the pressure damage has evolved, the incident will then be updated to reflect the true category of damage i.e., DTI evolved into Category 3 pressure ulcer.

Duty of Candour

All clinical staff have a responsibility to be open and transparent with patients in relation to their care and treatment. Any patient that is harmed by a provision of a health service should be informed of the fact, appropriate remedy offered, regardless of whether a complaint has been made.

Some incidents need to be dealt with under the Duty of Candour. Requirements of the Duty of Candour are set out in the NHS Standard Contract (renewed each year), and in the Health and Social Care Regulations (2014).

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. The Incident Reporting Policy should be implemented. This would include:

- Acknowledgment and an apology, where applicable, from an appropriate member of staff as part of the Being Open process.

- Verbal notification must be followed up by written notification, this must include all of the information given in the verbal notification, any results of further enquiries to be undertaken. The NHS Standard Contract states that this must be done within 10 working days.

6 Consultation

Tissue Viability Team

Patient Safety Committee

7 Dissemination and Implementation

7.1 Dissemination

This policy will be disseminated to all relevant clinical teams by:

- Managers informed via Datix system who then confirm they have disseminated to staff as appropriate
- Team leaders at IDT meeting/Pressure Ulcer Panel
- Via Tissue Viability Link Nurses
- Published to Staff Zone on the Trust Website
- Training and education to raise awareness which will be included at Pressure Ulcer Prevention sessions delivered by CPT Team, Bitesize Microsoft Teams sessions to raise awareness of new policy

- Tissue Viability Team to discuss and promote at caseload reviews held with team leaders and caseload holders

8 Monitoring Compliance

8.1 Monitoring

Tissue Viability Service Lead and Team Leaders will monitor compliance by:

- Clinical audits
- Responding to any incidences reported on the Trust incident reporting system and ensuring appropriate lessons learnt are identified and action plans implemented and completed
- Caseload Holders to ensure pressure ulcer huddles take place
- All new staff must have completed the pressure ulcer prevention training as part of their induction programme
- The Tissue Viability Service will provide a range of training and educational opportunities for all health care professionals

9 References

Department of Health and Social Care (2024). Safeguarding Adults Protocol – Pressure Ulcers and the interface with a Safeguarding Enquiry.
https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults/safeguarding-adults-protocol-pressure-ulcers-and-raising-a-safeguarding-concern

EPUAP (2019). Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide.

Fletcher J, Beeckman D, Boyles A et al (2020) International Best Practice Recommendations: Prevention and management of moisture-associated skin damage (MASD). Wounds International.

Gray M, Black JM, Baharestani MM et al (2011) Moisture associated skin damage: overview and pathophysiology. J Wound Ostomy Continence Nurs 38(3): 233-41

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National Wound Care Strategy Programme (2024) Pressure Ulcer Recommendations and Clinical Pathway
https://www.nationalwoundcarestrategy.net/wp-content/uploads/2024/07/NWCSP-PU-Clinical-Recommendations-and-pathway-Updated-21st-May-2024.pdf

NHS Improvement (2018). Pressure ulcers: revised definition and measurement. Summary and recommendations. NHS Improvement.
https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_2.pdf

National Institute for Health and Clinical Excellence (2014) The prevention and treatment of pressure ulcers. www.nice.org/CG179

Wood J, Brown B, Bartley A, et al. (2019). Reducing pressure ulcers across multiple care settings using a collaborative approach BMJ Open Quality 2019;8: e000409. doi: 10.1136/bmjoq-2018-000409

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

10 Associated Documents

Patient Safety and Incident Reporting Framework
Incident Reporting Policy
Consent to Examination or Treatment
Safeguarding Adults Policy

11 Appendices

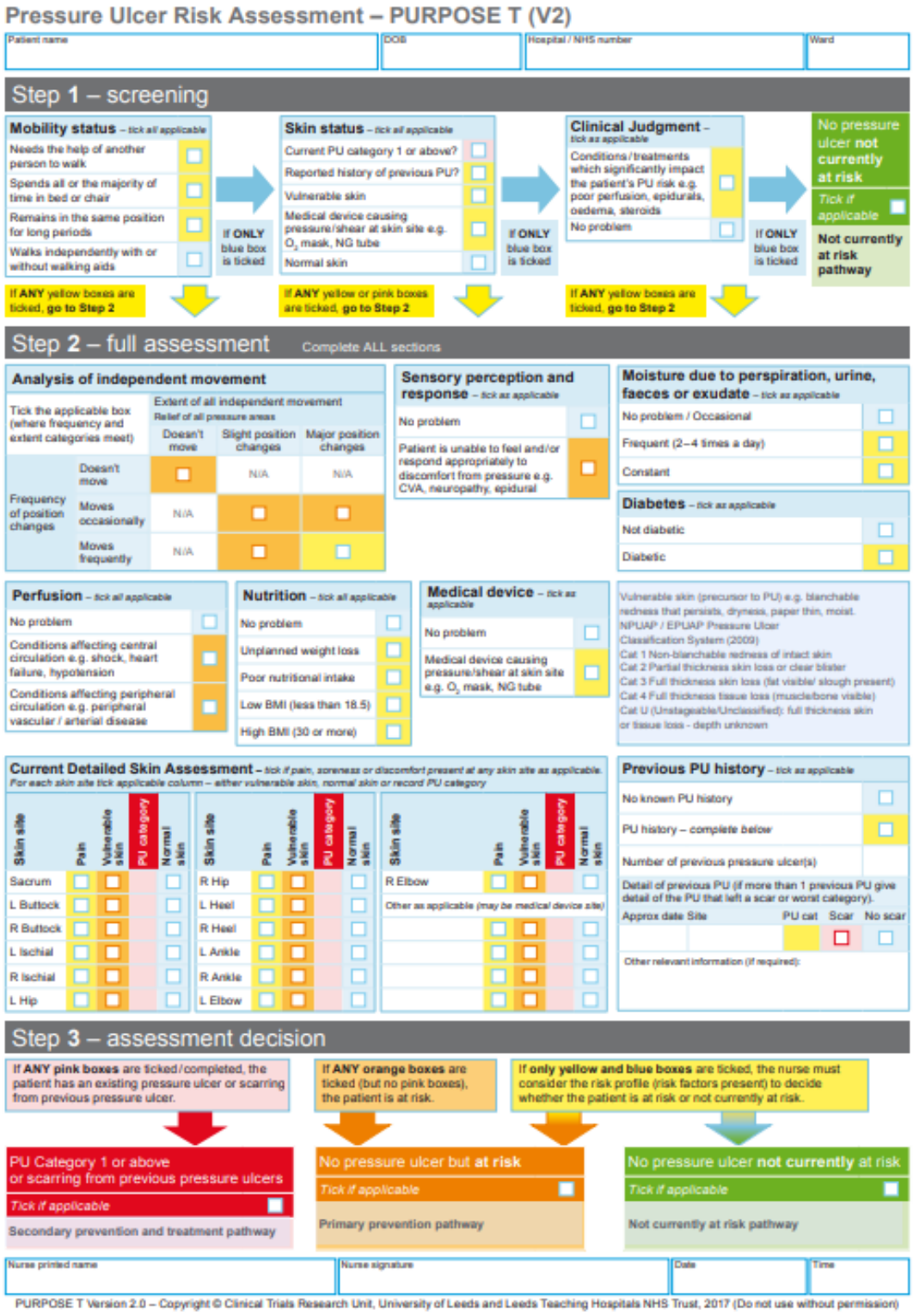
1 – Pressure Relieving Equipment Flow Charts – await from Medequip
2 – PURPOSE T risk assessment (paper format)
3 – aSSKINg green, amber, and red guidance
4 – The Pressure Ulcer Clinical Pathway
5 – Bony Prominences
6 – Prevention of Medical Device-Related Pressure Ulcers (MDRPU) Guidance
7 – Pressure Ulcer Classification in Darker Skin Tones
8 – aSSKINg 24-hour treatment plan
9 – 30-degree Tilt Guidance
10 – Think Food Guidance
11 – BDA Pressure Ulcer Leaflet
12 – Pressure Ulcer Classification EUPAP
13 – PU vs MASD
14 – MASD Pathway
15 – Pressure ulcer patient leaflet

11.1 Appendix 1

Await Equipment pathway from Medequip

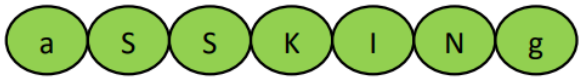
11.2 Appendix 2

Purpose T risk assessment



11.3 Appendix 3

aSSKINg Green, Amber and Red Guidance



Shropshire Community Health NHS Trust

PURPOSE T (not currently at risk) GREEN GUIDANCE

For pressure ulcer prevention 7 key principles are required, commonly referred to as 'aSSKINg'. The framework is a tool which brings together best practice with the aim of minimising variation in care, recommended by the National Wound Care Strategy Programme (2023).

	Principle	Action
a	Assess risk (Risk Assessment)	Complete a PURPOSE T risk assessment on first contact within the community setting/or within 6 hours of admission to ward.
		Update the PURPOSE T risk assessment monthly or if any changes to clinical condition.
s	Skin assessment and skin care	Undertake a skin inspection, including skin under devices where it is safe to do so, alongside the risk assessment.
		Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb.
		Consider risk factors associated with impaired skin integrity.
		Apply emollient daily to keep the skin well hydrated and promote skin integrity.
		Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
s	Surface (Equipment)	Refer to pressure relieving equipment guide for further advice on support surfaces.
		Consider the impact of medical devices and contact with the skin, use preventive techniques where required, refer to the Medical Device Pressure Ulcer Prevention Guidance.
k	Keep moving (Repositioning)	Encourage the patient to reposition throughout the day.
		Use relevant formal tools to assess mobility (falls/moving and handling).
i	Incontinence or increased moisture (Moisture associated skin damage MASD)	Keep the skin clean, dry and maintain hydration - refer to MASD Pathway if required.
n	Nutrition (Nutrition and Hydration)	Undertake a MUST assessment on first contact in community setting/or within 24 hours of admission to ward.
		Advise on food fortification and provide Think Food leaftlet.
g	Give information	Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
		Recognise when clinical concerns need to be escalated.

Based on the National Wound Care Strategy Programme Pressure Ulcer Recommendations

a s s K I N g

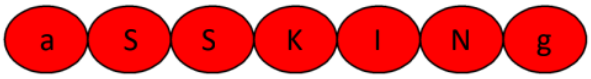
Shropshire Community Health NHS Trust

Purpose T (Primary Prevention) AMBER GUIDANCE

For pressure ulcer prevention 7 key principles are required, commonly referred to as 'aSSKINg'. The framework is a tool which brings together best practice with the aim of minimising variation in care, recommended by the National Wound Care Strategy Programme (2023).

Principle		Action
a	Assess risk (Risk Assessment)	Complete a PURPOSE T risk assessment on first contact within the community setting/or within 6 hours of admission to ward.
		Update the PURPOSE T risk assessment monthly or if any changes to clinical condition.
s	Skin assessment and skin care	Undertake a skin inspection, including skin under devices where it is safe to do so, alongside risk assessment
		Utilise Barrier Products for prevention/protection as per MASD pathway to promote skin integrity.
		Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
		Refer to Pressure Ulcer Clinical Pathway.
s	Surface (Equipment)	Refer to pressure relieving equipment guide for further advice on support surfaces.
		Consider the role of support surfaces and equipment on the patient's level of independence whilst managing the risk of pressure ulcer development.
		If pressure relieving equipment is being used, ensure in good working order at each visit and set to correct weight for patient (with air flow mattresses).
		Ensure heels are off-loaded when in bed and in the chair if at risk.
		Consider the impact of medical devices and contact with the skin and use preventive techniques where required, refer to Medical Device Related Pressure Ulcer Prevention Guide.
		Identify and undertake relevant seating and moving and handling risk assessments.
k	Keep moving (Repositioning)	Consider the patient's usual daily routine when planning repositioning schedules - for non-concordance, ensure this is documented on the repositioning schedule and ADDER is completed.
		Refer to appropriate members of the interprofessional team to support mobility and repositioning.
		Use relevant formal tools to assess mobility (falls/moving and handling).
		Safely use a range of appropriate equipment to encourage self-mobilisation and good posture.
i	Incontinence or increased moisture (Moisture associated skin damage MASD)	Identify the cause of moisture-related skin damage i.e. Incontinence, sweat, saliva, stoma, wound leakage.
		Where possible, address the cause of the moisture and refer to continence services where necessary.
		Implement appropriate prevention and management strategies - refer to MASD Pathway.
		Keep the skin clean, dry and maintain hydration.
n	Nutrition (Nutrition and Hydration)	Undertake a MUST assessment on first contact in community setting/or within 24 hours of admission to ward.
		Advise on food fortification and provide Think Food leaflet/utilise relevant tools and documentation if appropriate e.g. food and fluid charts.
		Collaborate to deliver appropriate care with relevant members of the interdisciplinary team (Dietitian, Speech and Language Therapist).
g	Give information	Provide the patient with a **Pressure Ulcer patient information leaflet** -discuss this with patient, relatives and carers (as appropriate).
		Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
		Recognise when clinical concerns need to be escalated.

Based on the National Wound Care Strategy Programme Pressure Ulcer Recommendations



Shropshire Community Health NHS Trust

PURPOSE T (Secondary Prevention and Treatment)

Red Guidance

For pressure ulcer prevention 7 key principles are required, commonly referred to as 'aSSKINg'. The framework is a tool which brings together best practice with the aim of minimising variation in care, recommended by the National Wound Care Strategy Programme (2023).

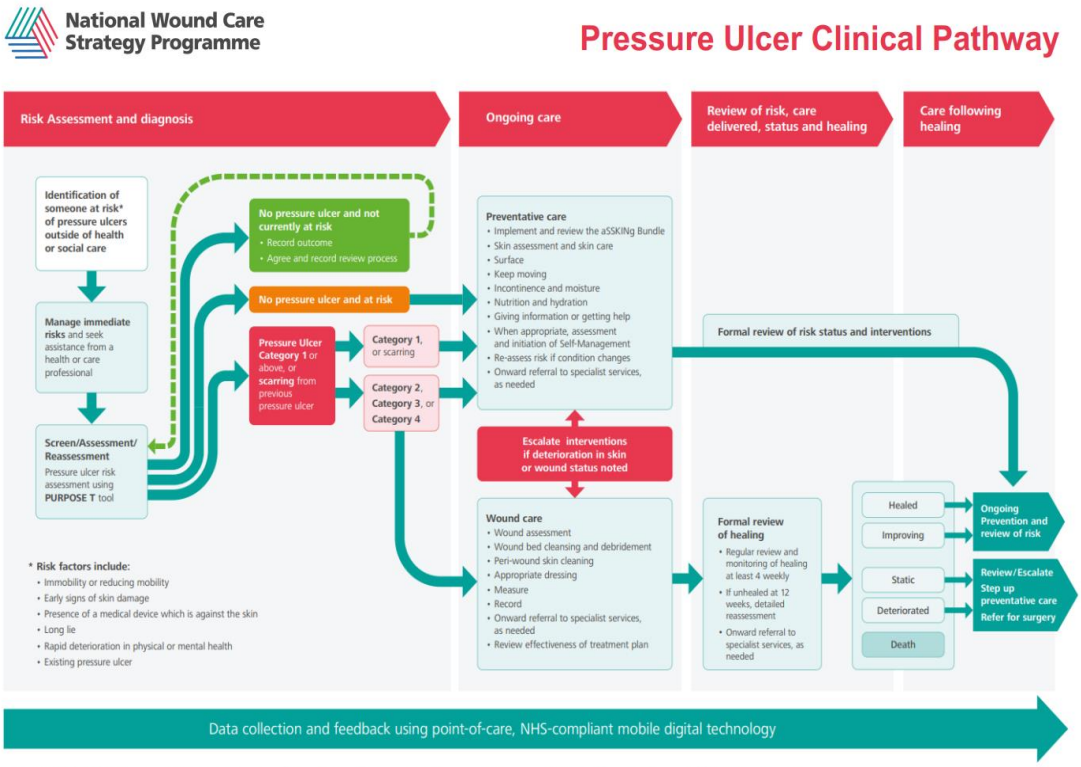
	Principle	Action
a	Assess risk (Risk Assessment)	Complete a PURPOSE T risk assessment on first contact within the community setting/or within 6 hours of admission to ward
		Refer all Category 3 and 4 pressure ulcers to Tissue Viability **(Datix all Category 2 and above pressure ulcers and also MASD).**
		Update the PURPOSE T risk assessment monthly or if any changes to clinical condition
s	Skin assessment and skin care	Undertake a skin inspection, including skin under devices where it is safe to do so, alongside the risk assessment.
		Utilise Barrier Products for protection as per MASD pathway to promote skin integrity.
		Refer to Pressure Ulcer Clinical Pathway for management.
		If the patient has a pressure ulcer or wound to the heel refer to Podiatry for further support.
		Undertake and document a wound assessment and SMART treatment plan for any pressure ulcers and MASD.
		Follow SCHT Wound Management Formulary for dressing advice.
s	Surface (Equipment)	Refer to pressure relieving equipment guide for further advice on support surfaces.
		Consider the role of support surfaces and equipment on the patient's level of independence whilst managing the risk of pressure ulcer development.
		If pressure relieving equipment is being used, ensure in good working order at each visit and set to correct weight for patient (with air flow mattresses).
		Ensure heels are off-loaded when in bed and in the chair if at risk.
		Consider the impact of off-loading devices such as boots.
		Consider the impact of medical devices and contact with the skin and use preventive techniques where required, refer to Medical Device Related Pressure Ulcer Prevention Guide.
		Ensure appropriate manual handling aids (hoists/slide sheets) are used.
		For wheelchair users ensure recent wheelchair service review has taken place, if not refer for reassessment.
k	Keep moving (Repositioning)	Consider the patient's usual daily routine when planning repositioning schedules (general rule would be 2-4 hourly repositioning in bed and 1 hour maximum at a time when sat in the chair) – for non-concordance, ensure this is documented on the repositioning schedule and ADDER completed.
		Use relevant formal tools to assess mobility (falls/moving and handling).
		Refer to appropriate members of the interprofessional team to support mobility.
		Ensure appropriate manual handling aids (hoists/slide sheets) are used when repositioning.
		Identify and understand, and where possible, address the cause of any change in mobility.
		Safely use a range of appropriate equipment to promote self-mobilisation and good posture - for example: hoists and slings, standing hoists, frames etc.
i	Incontinence or increased moisture (Moisture associated skin damage MASD)	Identify the cause of moisture-related skin damage i.e. incontinence, sweat, saliva, stoma, wound leakage.
		Where possible, address the cause of the moisture and refer to continence services where necessary.
		Implement appropriate prevention and management strategies – refer to MASD Pathway.
		Keep the skin clean, dry and maintain hydration.

n	Nutrition (Nutrition and Hydration)	Undertake a MUST assessment on first contact in community setting/or within 24 hours of admission to ward.
		Advise on food fortification and provide Think Food leaflet/utilise relevant tools and documentation if appropriate - e.g. food and fluid charts.
		Collaborate to deliver appropriate care with relevant members of the interdisciplinary team (Dietitian, Speech and Language Therapy).
		For patients with a category 3 or 4 pressure ulcer refer to the dietitian service for a review of enhanced protein and/or moderation of dietary restrictions.

g	Give information	Provide the patient with a **Pressure Ulcer patient information leaflet** – discuss this with patient, relatives, and carers (as appropriate).
		Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
		Be aware of safeguarding policies and take appropriate action when necessary.
		Recognise when clinical concerns need to be escalated.
		When capturing/using digital images, ensure appropriate consent has been obtained.

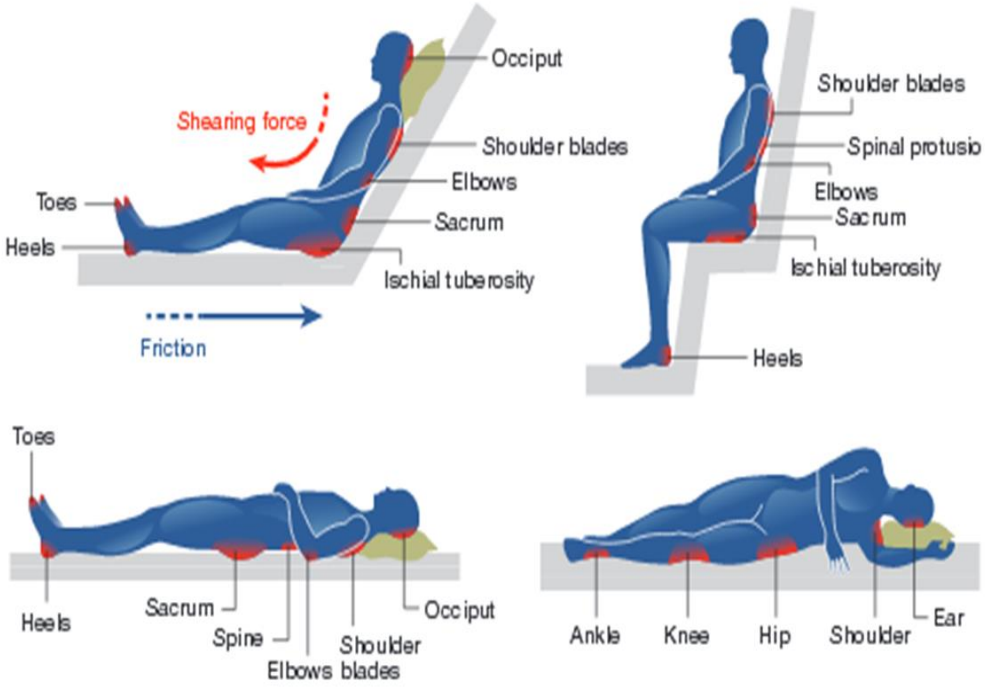
11.4 Appendix 4

The Pressure Ulcer Clinical Pathway



11.5 Appendix 5

Bony prominences



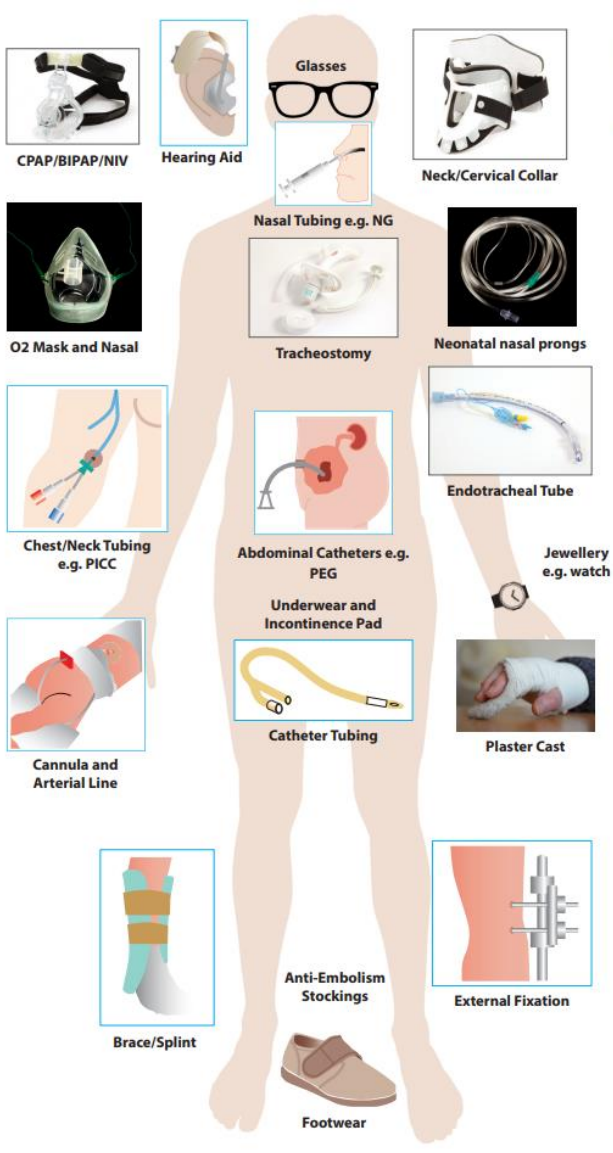
11.6 Appendix 6

Prevention of Medical Device-Related Pressure Ulcers (MDRPU) Guidance

NHS
Shropshire Community Health
NHS Trust

Prevention of Medical Device-Related Pressure Ulcers (MDRPU) guidance

Pressure ulcers that result from the use of devices designed and applied for diagnostic and therapeutic purposes are known as MDRPU.



Assessment:

SELECT a device that can induce the least degree of pressure and/or shear, ensuring that it is correctly sized and fits appropriately.

CORRECT positioning and care of the equipment.

Management:

REPOSITION and/or offload the pressure from the device every two hours as a minimum to provide pressure relief if clinically safe to do so.

Ensure the skin beneath and around the device is kept clean and dry.

INSPECT the skin beneath and around the medical device three times a day.

Consider the use of barrier protectants, thin hydrocolloids or film dressings as a preventative measure to minimise the risk of a MDRPU developing.

Refer to Tissue Viability for further support and guidance if required.

Evaluation and referral:

ESCALATE any skin changes to the nurse accountable for the patient's care.

Ensure regular review of the use of barrier protectants to ensure they are clinically appropriate.

Patient Information

If the patient and/or care giver is able to undertake self-prevention and management of a medical device provide them with recommendations following an holistic assessment for repositioning, inspection and escalation.

REPORT all MDRPU via Datix

Developed October 2024 by Tissue Viability Service

References: NHS Improvement (2018) Pressure ulcers: revised definition and measurement summary and recommendations. Jaul (2010) Ostomy Wound Management. Black et al. (2010) International J of Wound Care. European Pressure Ulcer Advisory Panel (2019) Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline.

11.7 Appendix 7
Pressure Ulcer Classification in Darker Skin Tones

Pressure Ulcers in People with Dark Skin Tones

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR DARK SKIN TONES

Category/Stage I:
Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).

Category/Stage II:
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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Category/Stage III:
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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.

Category/Stage IV:
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 Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries 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.

Unstageable:
Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover' and should not be removed.

Suspected Deep Tissue Injury:
Purple or maroon localised area of discoloured intact skin or bloodfilled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Text adapted from: International NPUAP-EPUAP Pressure Ulcer Classification System (2009,2014) published in National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, 2014. Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy Dr Karyln Carville, used with permission.

A pressure ulcer (PU) can be defined as:
"Localised damage to the skin and / or underlying tissue, as a result of pressure, or pressure in combination with shear. Pressure injuries / ulcers usually occur over a bony prominence but may also be related to a medical device or other object" [1]

Pressure ulcers are categorised by their severity and may be limited to the superficial tissues of the epidermis and dermis or extend to deeper tissue exposing and/or involving muscle, tendon and bone.

Early detection of pressure related skin damage is essential, as it allows for appropriate intervention which can prevent progression to more severe ulceration [2]. Therefore, the ability to accurately identify and confirm Category I pressure ulcers in all skin types is of significant importance for clinical staff, carers and healthcare providers.

Health care professionals and carers are typically taught to look for redness (erythema) as a first sign of pressure damage and whilst this is relatively simple to identify in Caucasian skin it can prove to be difficult to diagnose accurately when assessing individuals with darker skin tones. It is likely that Category I PUs are under-reported in individuals with dark skin tone due to failure to identify early differences in skin colour as a result of pressure related tissue injury [3].

Skin pigmentation can mask the visual indication of erythema and Category I pressure ulcers are more likely to go undetected and deteriorate to full thickness pressure ulcers (Category III and IV) in darkly pigmented skin [2, 3].

To reduce the risk of erythema (redness) and Category I pressure ulcers developing into full thickness wounds in patients with dark skin tones, it is essential for clinical staff and carers to recognise the other signs and symptoms than can be observed on the skin as early indicators of pressure related tissue injury [4, 5].

These important additional indicators of pressure related tissue injury to the skin include:

- Purple/bluish discoloration
- A purple hue where ischaemia is present
- Localised oedema / swelling due to the inflammatory response
- Temperature change – initial warmth due to the inflammatory response which will become cooler as tissue death occurs
- Pain and discomfort
- Alteration in sensation in response to either inflammation or ischaemia
- Change in tissue consistency in relation to surrounding tissue. For example, induration (hardness) due to excessive inflammation and necrosis. May also become soft and boggy.

Whilst these additional signs and symptoms are applicable to all skin tones, they can be particularly useful when caring for patients with dark skin tones when obvious pressure-related redness on the skin can be more difficult to identify.

CONSIDERATION FOR CLINICAL PRACTICE

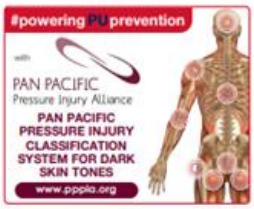
Skin should be carefully inspected for any discolouration over pressure areas. Areas of discolouration in relation to surrounding skin should be assessed more closely for temperature changes, oedema, changes in tissue consistency and pain [1].

Note: This is a guide only, signs and symptoms of pressure ulcers may present differently on different skin tones.

Education is a critical factor in ensuring that all members of the clinical team can strive to prevent and treat pressure ulcers according to the best evidence available [7].

REFERENCES

1. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Ulcer Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline 2019.
2. Springle S, Sharq L, Duckworth M. Detection of skin erythema in darkly pigmented skin using multispectral images. Adv Skin Wound Care. 2009;22(4):172-9.
3. Bennet A. Report of the task force on the implications for darkly pigmented intact skin in the prediction and prevention of pressure ulcers. Adv Wound Care. 1995;8(6):34-5.
4. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick reference Guide. Australia; 2014
5. Baker M. Detecting pressure damage in people with darkly pigmented skin. Wound Essentials. 2016;11(1):28-31.
6. Pan Pacific Pressure Injury Classification System for Dark Skin Tones. 2020. Pan Pacific Pressure Injury Alliance (PPPIA). Available online at https://pppia.org/static/pdfs/pppia-classification-system-dark-skin-tones.pdf. Accessed 21st September 2020.
7. MacGregor L, Caine, S, Day K. International Review: Pressure ulcer prevention: Pressure, Shear, Friction and microclimate in context. A consensus document. Wounds International. 2010. London.



11.8 Appendix 8
aSSKINg 24-hour Treatment Plan

Shropshire Community Health NHS Trust

First Name:
Last Name:
Date of Birth:
NHS No:

aSSKINg 24hr Pressure Ulcer Prevention Management Plan

Plan No:

Problem:
Goal/Aim:
Plan:
Assess the risk:
Surface:
Skin Inspection:
Keep Moving:
Incontinence:

SSKIN 115 - aSSKINg 24hr Pressure Ulcer Prevention Management Plan V1.2 Apr 2021.docx 1

Nutrition & Hydration:	
Giving Information:	
Concordance issues: Yes ☐ No ☐ (If yes please complete self-neglect framework)	
Healthcare Professional Details	
Print Name:	Designation:
Signature:	Date:
Evaluation Outcome of Intervention:	
Healthcare Professional Details	
Print Name:	Designation:
Signature:	Date:

11.9 Appendix 9
30 Degree Tilt Guidance

Thinkpressurecare

Simple... safe... effective... the 30° tilt

Semi-recumbent Position

1

Supports the lumbar spine. Plump or fold the lower pillow if necessary.

2

An additional pillow is positioned under the buttock to 'tilt' the body, giving the ischial tuberosities and sacrum clearance.

3

Ensure that the heels are clear of the mattress.

4

The full semi-recumbent 30° 'tilt' position.

Recumbent Position

1

Use one or two pillows to support the head and neck.

2

Added pillows 'tilt' the patient onto one buttock and lifts the sacrum clear of the mattress.

3

Support the full leg on another pillow. Ensure that the heel overhangs the edge of the pillow.

4

Additional pillows may provide comfort for the legs.

5

The full recumbent 30° 'tilt' position.

6

This demonstrates the necessity to use an additional pillow to prevent 'drop foot'.

7

Variant position. Alternative position for patients who cannot achieve or maintain normal posture.

Points to remember

1. Encourage patients to re-position themselves if possible.
2. Remember to ask the patient if they are comfortable and check their position and skin* at regular intervals.
3. The 30° 'tilt' is used to enhance patient comfort and reduce pressure over high risk areas. It should be used with, and not in place of, an appropriate pressure reducing support surface/mattress and in line with Trust pressure ulcer prevention protocols.
4. Use your hand to check clearance.

* Consult Tissue Viability for guidance on skin condition if concerned

www.thinkpressurecare.co.uk

Invacare Limited
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Bridgend CF35 6AQ - United Kingdom
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E-mail: uk@invacare.com
Sales Order E-mail:
ordersuk@invacare.com
www.invacare.co.uk

1492224 - UK - 02/2012

NHCAN
Yes, you can.

11.10 Appendix 10

Think Food Guidance

think-food-recipes-march-2017.pdf

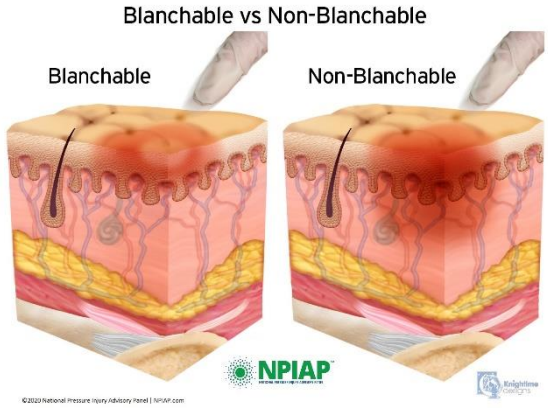
11.11 Appendix 11

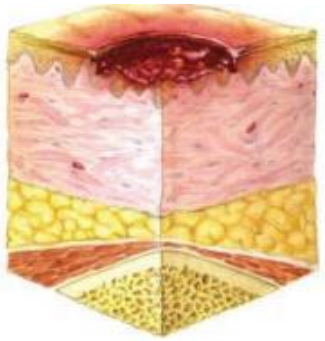
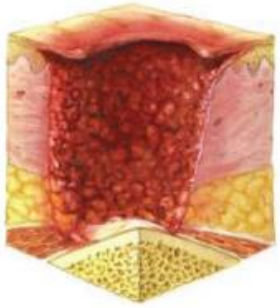
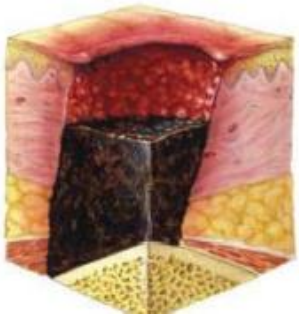
BDA Pressure Ulcer Leaflet

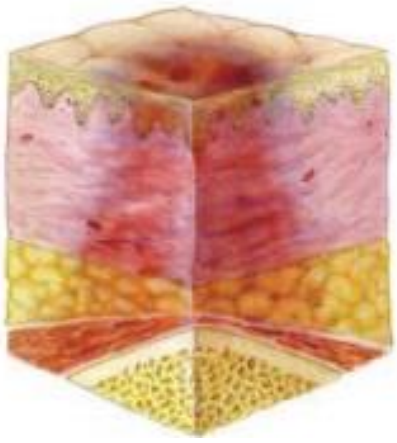
BDA Pressure Ulcer Leaflet.pdf

11.12 Appendix 12

Pressure Ulcer Classification EUPAP

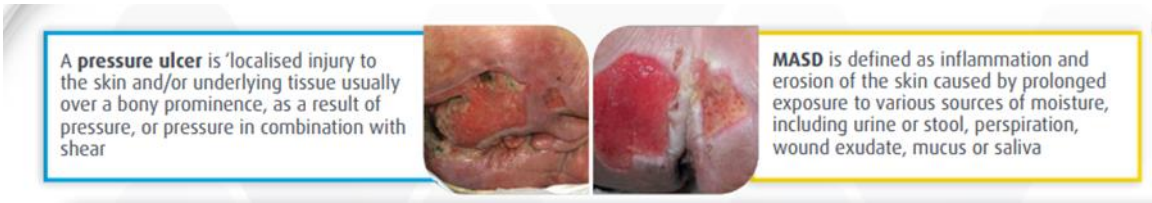
Term	Definition
Category 1 – Non-blanchable erythema 	Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. This is the first sign the individual is at high risk and preventative measure must be taken. Discoloration of the skin, warmth, oedema, induration, or hardness may also be used as indicators, particularly those individuals with darker skin.

Category 2 – Partial thickness 	Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May present as an intact or open/ruptured serum filled or serosanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates deep tissue injury). This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration, or excoriation.
Category 3 – Full thickness skin 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 ulcer varied by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have (adipose) subcutaneous tissue and so may be shallow in contrast to areas with significant adiposity which can develop deep category 3 ulcers
Category 4 - Full thickness tissue loss with exposed bone, tendon, or muscle 	Exposed bone/muscle is visible or directly palpable. Slough or eschar may be present. Often includes undermining with tunnelling. The depth of a category 4 ulcer varies with anatomical position as with category 3. Those which extend through supporting structures (e.g. fascia, tendon, joint capsule) osteomyelitis is likely to occur.
Unstageable 	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serve as 'the body's natural (biological) cover' and should not be removed
Suspected Deep Tissue Injury	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to

	adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

11.13 Appendix 13

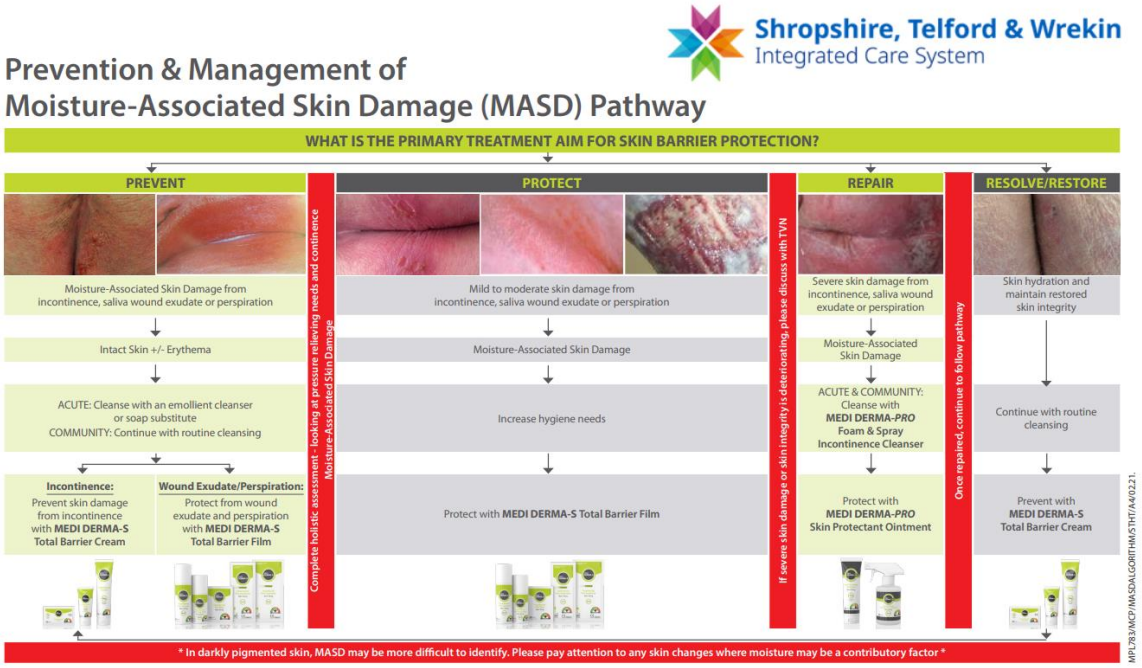
PU vs MASD



Wound Attributes	Pressure Ulcer	MASD	Additional Comments
Cause	Pressure or shear present	Moisture must be present	If both pressure/shear and moisture present it could be a combined lesion
Location	Over a bony prominence	May occur over a bony prominence but pressure and shear should be excluded as causes, and moisture should be present.	A combination of moisture, pressure and friction may cause moisture lesions in skin folds.
Shape	Circular wounds or wounds with a regular shape are most likely, but the possibility of friction injury has to be excluded.	Indistinct superficial spots are more likely. In a kissing ulcer at least one of the wounds is most likely caused by moisture.	Irregular or diverse wound shapes are often present in a combined lesion.
Depth	Partial-thickness skin loss is present when only the top layer of the skin is damaged (cat 2). In full thickness skin loss, all skin layers are damaged (cat 3 or 4)	Superficial depth (partial thickness skin loss). In cases where the moisture lesions get infected, the depth and extent of the lesion can be enlarged/deepened extensively	If friction is exerted on a moisture lesion, this will result in superficial skin loss in which skin fragments are torn and jagged
Necrosis	A black necrotic scab on a bony prominence is a pressure ulcer.	There is no necrosis in MASD	Necrosis softens up and changes colour but is never superficial. Distinction should be made between necrotic scab and a dried-up blood blister
Edges	If edges are distinct, most likely.	Often have indistinct, diverse or irregular edges	Jagged edges are seen in moisture lesions that have been exposed to friction.
Colour	**Red:** if non-blanchable, most likely cat 1 For people with darkly pigmented skin persistent redness may manifest as blue or purple **Red in the wound bed:** granulation tissue and likely cat 2, 3 or 4 **Yellow in wound bed:** slough or softened necrosis, likely cat 3 or 4 **Black in the wound bed:** Black necrotic tissue indicates cat 3 or 4	**Red:** If not uniformly distributed, likely to be a moisture lesion **Pink or white surrounding skin:** Maceration due to moisture	**Red skin:** If the skin (or lesion) is red and dry or red with a white sheen, it could be a fungal infection. **Green in wound bed:** Infection likely.

11.14 Appendix 14

MASD Pathway



Created by the SCHT Tissue Viability Team Version 1
Approved by the STW Area Prescribing Committee: February 2022
Review: December 2023

11.15 Appendix 15

Pressure Ulcer Patient Leaflet

Appendix 15

FINALpressure ulcer information leaflet No