360.2 GUIDELINE FOR PREVENTION AND TREATMENT OF PRESSURE ULCERS

Rationale: to ensure a consistent, evidence based approach to the prevention and treatment of pressure ulcers across the Trust.

Practitioner Requirements:

- The guideline applies to all those caring for patients at risk of developing pressure ulcers.

Parameters of Client Group:

- All patients at risk of developing pressure ulcers.
- All patients with pressure ulcers.
  (It is recognised that patients with spinal injuries or other neurological problems may have very specific requirements not covered in this generic guideline.)

Principles of Care

Identifying individuals 'at risk'

- All patients should have a risk assessment performed and documented within six hours of admission by a member of the multi-disciplinary team specifically trained to do so. This should be made accessible to all members of the team.
- The risk assessment tool used should be appropriate to the client group. Apart from paediatrics, the Trust's Adapted Waterlow Tool (Appendix 1) should be used. It must be remembered that these tools should only be used as an aide memoire and should not replace clinical judgement.
- Skin assessment should be based on the most vulnerable areas of risk for each patient. Typically, heels, ischial tuberosities, femoral trochanters, temporal region of skull, shoulders, back of head and toes. Also parts of the body affected by anti-embolic stockings, other clothing or equipment.
- Healthcare professionals should be aware of signs which may indicate potential pressure ulcer development, e.g. non blanching hyperaemia, blisters, discolouration, localised heat, localised oedema and localised induration. In those with darkly pigmented skin: purplish/bluish localised areas of skin; localised heat that, if tissue becomes damaged, is replaced by coolness; localised oedema and localised induration.
- Reassessments must be performed when there is a change in the patient's condition.
- All patients must be weighed and have a nutrition screen on admission to hospital. Appropriate action should then be taken if a patient is deemed to be nutritionally at risk. See Guideline172 Nutrition Policy.

Preventing pressure ulcers in patients 'at risk'

- Each patient should have an individualised documented plan with evidence of ongoing reassessment.
- All inpatients within the Trust will be placed on a high specification foam mattress with pressure-reducing properties, e.g. Pentaflex, upon admission to a ward area.

- All patients undergoing surgery should be placed on a high specification foam theatre mattress.
- Patients should be cared for on pressure redistributing support surfaces (mattresses and cushions) that meet individual needs, covering the 24-hour period. Decisions about which product to use should be based on the risk assessment score, skin assessment and clinical judgement including comfort. Advice can be sought from Tissue Viability Team or Huntleigh Healthcare Resource Pack contained within the Equipment Library & Competency Folder found on each ward and department.
- Patients should be encouraged to reposition themselves or be repositioned by staff and the frequency determined by the results of skin inspection and individual needs.
- Manual handling devices should be used correctly in order to minimise shear and friction damage. Do not leave under patients.
- Chair sitting should be restricted to less than 2 hours for those acutely at risk – prevention only.
- In the case of patients with skin damage to the sacral or ischial tuberosity regions, consideration should be given to completely restricting chair sitting, e.g. mealtimes only or not at all.
- Seating assessments for aids and equipment should be carried out by trained assessors (e.g. physiotherapists, occupational therapists) where appropriate.
- Where possible, individuals or carers should be taught how to redistribute weight and information on pressure ulcers should be available to patients/carers (Appendix 2) and also how to perform skin inspections.

Treating pressure ulcers

- The same principles should apply as care for patients at risk of developing pressure ulcers.
- The pressure ulcer classification tool adopted by the Trust is the International NPUAP-EPUAP Pressure Ulcer Classification System (Appendix 3).
- In order for the ulcer to improve, all sources of pressure must be removed.
- For information about wound management, please contact Tissue Viability or refer to the Trust's dressings formulary or the Royal Marsden Manual (chapter 48, Wound Management).

Reporting of pressure ulcers

- All pressure ulcers category 2 and above must be reported as a clinical incident on a DATIX form and be photographed by medical photography.
- All category 3 & 4 pressure ulcers should be reported to the Tissue Viability Team.
- All hospital acquired category 4 pressure ulcers should be investigated using the root cause analysis tool (available from risk management) and reported as a Serious Untoward Incident to the SHA.
- All community acquired category 4 pressure ulcers will be reported to the PCT for further investigation.

Audit of pressure ulcers

- There will be an annual pressure ulcer prevalence survey carried out across all three hospitals in the Trust in collaboration with Huntleigh Healthcare.
- The Trust will provide quarterly pressure ulcer incidence data to the PCT Commissioners.
- Each clinical area will complete an audit against the Essence of Care benchmarks.

Evidence Base

April 2003. Essence of Care: Patient focused benchmarks for clinical governance. Modernisation Agency.

DOUGHERTY, L., LISTER S., (eds), 2008. The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Seventh Edition (online). Oxford: Blackwell Publishing.

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC: National Pressure Ulcer Advisory Panel; 2009.

NICE Guidelines (2005). The Prevention and Treatment of Pressure Ulcers. Guideline No 29, National Institute for Clinical Excellence, London.

Waterlow J., 1994. 'Pressure Sore Prevention Manual'.

See also:
Guideline 172 Nutrition Policy
Guideline 186 Organisation-wide Policy for the Management of Incidents, including the Management of Serious Untoward Incidents

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Buckinghamshire Hospitals NHS Trust	

Appendix 1

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NHS Trust

Adapted Waterlow Pressure Ulcer Risk Assessment (revised July 2007)

ASSESSMENT DATE

Patient Label

Build/Weight for Height	
BMI = 20-24.9 (average)	0
BMI = 25-29.9 (above average)	1
BMI > 30 (obese)	2
BMI < 20 (below average)	3

Continence	
Complete/catheterised	0
Urinary incontinence	1
Faecal incontinence	2
Double incontinence	3

Skin Type - Visual Risk	
Healthy	0
Tissue paper	1
Dry	1
Oedematous	1
Clammy, pyrexia	1
Discoloured EPUAP Grade 1	2
Broken/split EPUAP Grade 2-4	3

If score 2 or above please complete Wound Assessment Record

Mobility	
Fully	0
Restless/fidgety	1
Apathetic	2
Restricted	3
Bedbound e.g. traction	4
Chairbound e.g. wheelchair	5

If score 1 or above on admission please complete Falls Assessment Tool

Sex / Age	
Male	1
Female	2
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
81+	5

SUBTOTAL

Nutrition		
Does the patient look thin (BMI)?	Yes	No
Have they lost weight 'unintentionally' in the last 6 months?	Yes	No
If YES what is their usual weight?		
Has the patient lost their appetite in the last six months?	Yes	No

If answer YES to any of the above - a Nutritional Screening Tool Form.

Ward:
Consultant:

Medication	
Cytotoxics (1 point), anti-inflammatory (1 point), long-term/high dose steroids (1 point), anti-embolism stockings (1 point)	Max score of 4

Tissue Malnutrition	
Terminal cachexia	8
Multiple organ failure	8
Single organ failure (respiratory, renal, cardiac)	5
Peripheral vascular disease	5
Anaemia (Hb<8)	2
Smoking	1

Neurological Deficit	
Diabetes, MS, CVA	4 to 6
Motor / sensory	4 to 6
Epidural analgesia	4 to 6
Paraplegia	4 to 6

Surgery / Trauma	
Orthopaedic / Spinal	5
On table > 2 hours #	5
On table > 6 hours #	8

 # Scores can be discounted after 48 hours provided patient is recovering normally.

SUBTOTAL

Total Score	
Subtotal column 1	
Subtotal column 2	
Total Score	
Assessor's Initial	
Trained Nurse Initial	

Action Plan & Equipment Ordered

Mattress	Nimbus	Alphaxcel	Other
Cushion	Static/Foam	Aura	Other

Turning Regime	Frequency		hrs
	Back	Yes	No
	Left side	Yes	No
	Right	Yes	No
	Prone	Yes	No

10+ At Risk **15+ High Risk** **20+ Very High Risk**

For pressure care equipment information please refer to Equipment Library & Competencies Folder or seek advice from the Tissue Viability Team

WZZ 985

Pressure area care

A patient guide

This leaflet contains general information that you will need when you visit us as a patient.

If there is anything else you need to know, please speak to staff on the ward.

Buckinghamshire Hospitals NHS Trust

What is a pressure ulcer?

Pressure ulcers are areas of damage to the skin and underlying tissue. They are also known as pressure sores or bed sores

What causes pressure ulcers?

Pressure ulcers are caused by a combination of:

Pressure: Normal body weight can squash the skin in people at risk and damage blood supply to the area, which can lead to tissue damage.

Shearing: Sliding or slumping down the bed/chair can damage the skin and deeper layers of tissue as a result of shearing

Friction: Poor lifting and moving techniques can remove the top layers of skin. Repeated friction can increase the risk of pressure ulcers.

Where do pressure ulcers develop?

Pressure ulcers usually appear at the site of bony prominences, such as heels; base of the spine; elbows; shoulders and hips. This is because these are the areas that take most weight.

What does a pressure ulcer look like?

The first sign is usually a change in skin colour, which may appear slightly redder or darker than usual. (Reddened areas may be harder to detect on darker skin). Damaged areas will normally feel warmer than the surrounding skin.

If not treated quickly a blister or graze may appear and without appropriate intervention may worsen over time. This can sometimes appear as an area of hard black tissue or as a sore area of green/yellow weeping tissue.

Who is most at risk of developing pressure ulcers?

You may be at risk of developing pressure ulcers for a number of reasons including:

Problems with movement: your ability to move may be limited or you may be unable to move. This may be due to a variety of reasons.

Poor circulation: caused, for example, by vascular disease or heavy smoking, may increase your risk of pressure ulcers.

Problems with sensitivity to pain or discomfort: some conditions (e.g. diabetes, stroke) and some treatments (e.g. epidural pain relief, elastic antiembolitc stockings) may reduce your sensitivity to pain or discomfort so that you are not aware of the need to move.

Moist skin: you may be at increased risk if your skin is damp, caused, for example, by incontinence, sweat or a weeping wound. It is important that your skin is kept clean and dry.

Previous scar tissue: scar tissue will have lost some of its previous strength and is more prone to pressure damage.

Inadequate diet or fluid intake: poor diet may cause you to be malnourished. Lack of fluid intake may lead to dehydration. Losing too much weight can lead to loss of padding over bony points.

Risk Assessment

Risk Assessment: To assess your risk of developing pressure ulcers, a member of the health care team looking after you will examine you and ask you some questions. This will help to identify if you require a specialised mattress/cushion and will assist in planning your care.

What can I do to avoid pressure ulcers?

There are many ways of reducing the risk of pressure ulcers.

Keep moving: Changing your position regularly helps prevent the build up of pressure. If you have limited movement the health care team looking after you will assist you with regular turns in addition to providing specialist mattresses/cushions

Look for signs of damage: check your skin for pressure damage at least once a day. Look for skin that doesn't go back to its normal colour after you have taken your weight off it. Do not continue to lie on skin that is redder or darker than usual. Also watch out for blisters, dry patches or cracks in the skin.

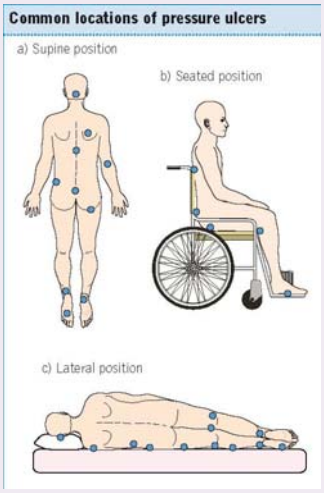
Protect your skin: wash your skin every day using warm water or skin cleansers. Avoid using heavily perfumed soap or talcum powder, as these can soak up the skins natural oils leading to vulnerable dry areas of skin. If you suffer from incontinence please inform your health care team as they can provide pads and barrier preparations to prevent soreness.

Eat a well-balanced diet: make sure you eat a healthy balanced diet and drink plenty of fluids.

If I develop a pressure ulcer what should I do?

Tell your doctor or nurse as soon as possible and follow the advice they give you.

Eat a healthy balanced diet.



Ref: Whiting NL (2009) Skin assessment of patients at risk of pressure ulcers. Nursing Standard vol 24 no. 10 pages 40 - 44

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Appendix 3

International NPUAP-EPUAP Pressure Ulcer Definition

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

International NPUAP-EPUAP Pressure Ulcer Classification System

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. May indicate “at risk” persons.

Category 2: Partial thickness

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 or sero-sanginous 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, incontinence associated dermatitis, maceration or excoriation.

*Bruising indicates deep tissue injury.

Category 3: Full thickness skin loss

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/stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue (adipose) and category/stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep category/stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full thickness tissue loss

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