Somerset Partnership NHS
NHS Foundation Trust

PRESSURE ULCERATION: POLICY FOR PREVENTION & MANAGEMENT

To be read in conjunction with Infection Control Policy, Healthcare Clinical Waste Policy, Nutrition Policy and Pressure Ulcer Toolkit

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DOCUMENT CONTROL

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1 INTRODUCTION

1.1 The development of pressure damage remains relatively common in healthcare settings with around 75,000 patient safety incidents reported to the NPSA between 2005 and 2010. Pressure ulcers are costly, both in human and in financial terms.

1.2 The majority of pressure ulcers are believed to be preventable and as such pressure damage prevention has become a key item in the local and national patient safety agenda.

1.3 Somerset Partnership NHS Foundation Trust is committed to a culture of delivering high level care and this includes a zero tolerance policy for the development of avoidable pressure ulceration for all patients accessing services.

1.4 The National Institute for Clinical Excellence has developed clinical guidelines (Guidelines CG179) and these guidelines have been used as the foundation for this policy.

1.5 There has been a plethora of national initiatives launched to promote pressure damage prevention and key aspects of these are contained within this policy.

1.6 The policy is compliant with the South West Quality Improvement Framework for the Prevention & Management of Pressure Ulcers issued by NHS South of England in May 2012.

2 PURPOSE & SCOPE

2.1 This document is relevant to all clinical staff including medical staff, nurses and allied health professionals and designed to

- inform staff of their roles responsibilities in relation to pressure damage
- provide guidance regarding risk assessment and mitigation of risk
- act as a resource for staff caring for individuals with or at risk of pressure damage
- ensure effective monitoring of incidence of pressure damage

3 DUTIES AND RESPONSIBLITIES

3.1 The **Trust** has delegated responsibility to The Pressure Ulcer Best Practice Group who review all incidents of pressure ulcers reported by Somerset Partnership NHS Foundation Trust Staff. The role of the Pressure Ulcer Best Practice Group is to:

- Ensure pressure prevention remains a key focus in the patient safety agenda

- Monitor the numbers of pressure ulcers recorded within the Somerset Partnership NHS Foundation Trust population

- Monitor the organisational pressure prevention action plan

- Ensure all Grade 3 and 4 pressure ulcers are investigated and lessons learnt disseminated

- Monitor themes and trends through the validation process and instigate full Root Cause Analysis where there are recurrent areas of concern or significant harm is caused.

3.2 The Chief Executive Officer has a duty to care for patients receiving care and treatment from the Trust and has overall responsibility for procedural documents, and delegates responsibility as appropriate.

3.3 The Risk Management team will log all reported incidents of Pressure Damage and send this report to the Tissue Viability Service Manager on a monthly basis for validation. . Further information on Untoward Event Reporting can be obtained from the Untoward Event Reporting Policy and Procedure.

3.4 Medical staff are responsible for

- assessment and review of patient's general medical condition

- liaison and referral to other healthcare professionals.

3.5 Practitioner in charge of clinical area/clinical team is responsible for;

- considering and assessing which are the most at risk patients in their patient population and ensuring that appropriate resources are available locally to meet identified needs

- reporting any deficit in resources to their line manager (this includes the need for training)

- supporting the use of an intentional rounding tool/SKIN bundle and monitoring local compliance

- ensuring Datix incident reporting forms are completed for pressure damage of grade 2 and above, and for any deterioration of existing pressure damage including the attachment of the Pressure Ulcer Reporting Form

- must review the number of pressure ulceration incidents noting whether the pressure ulceration is avoidable or unavoidable investigate the

cause of pressure damage, develop local action plans and instigate any local remedial action required

- validation of correct grading of each grade 3 or grade 4 pressure ulcer

- carry out a Root Cause Analysis when requested, where reoccurring themes or serious harm occurs, for patients who develop pressure damage To establish what happened and determine lessons learnt

3.6 Nursing Responsibility to be undertaken by Registered Nurses

- to ensure risk assessments are completed and interventions initiated according to Pressure Ulcer NICE guidelines (Appendix A)

- to ensure a full comprehensive assessment is undertaken, identifying the risks and where appropriate

    - to ensure the patient is nursed on a pressure relieving surface which minimises direct pressure, shear and friction

    - to ensure a repositioning schedule is agreed according to individual patient needs;

    - to ensure that a clear record of advice given or intervention provided is discussed with the patient (and carers when appropriate) and documented in the patient's notes.

- to ensure any inadequate provision of interventions or resources are highlighted to the practitioner in charge;

- Registered Nurses and any other Allied Health Professional report any pressure damage of grade 2 or above to their line manager **and** via the Datix system recording whether this is an unavoidable or avoidable pressure ulcer.

4 EXPLANATION OF TERMS USED

4.1 A **pressure ulcer** is a localised 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 (European Pressure Ulcer Advisory Panel EPUAP 2009).

4.2 The aetiology of pressure ulceration can be complex and is affected by intrinsic and extrinsic factors.

4.3 **Pressure points** on the body are found pre-dominantly on bony prominences (such as hips, heels, sacrum, occiput, bridge of nose, elbows etc).

4.4 **Waterlow score** is a risk scoring tool used to assess a person's risk of developing pressure damage (Refer to Pressure Ulcer Toolkit).

4.5 **MUST** – Malnutrition Universal Screening Tool is a nutrition screening tool

4.6 In determining whether or not a pressure ulcer is avoidable or unavoidable staff must demonstrate that they have followed the Avoidable/Unavoidable checks and that this has been clearly documented.

4.7 **Avoidable Pressure Ulcers**

'Avoidable' means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- Evaluate the person's clinical condition and pressure ulcer risk factors
- Plan and implement interventions that were consistent with the person's needs and goals, and the recognised standards of practice
- Monitor and evaluate the impact of interventions
- Revise the interventions as appropriate

4.8 **Unavoidable Pressure Ulcer**

'Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care had:

- evaluated the person's clinical condition and pressure ulcer risk factors;
- planned and implemented interventions that were consistent with the persons needs and goals;
- recognised standards of practice;
- monitored and evaluated the impact of the interventions
- revised the approaches as appropriate

OR

- the individual person refused to adhere to prevention strategies in spite of education or the consequences of non adherence

In determining whether or not a pressure ulcer is avoidable evidence should be available to demonstrate the actions outlined in the avoidable definition have been demonstrated.

4.9 Definition of Grading

Grade 1

- Intact skin with non-blanching erythema of a localized area usually over a bony prominence.
- Discoloration of the skin, warmth, oedema, hardness or pain may also be present.
- Darkly pigmented skin may not have visible blanching.

Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Grade 1 may be difficult to detect in individuals with dark skin tones.

Grade 2

- Partial thickness skin loss or blister
- 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.

Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This category/stage should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

Grade 3

- Full thickness skin loss
- Subcutaneous fat may be visible
- Some slough may be present
- May include undermining and tunneling
- Bone/tendon is not visible or directly palpable.

Further description: The depth of a Grade 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Grade 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep ulcers

Grade 4

- Full thickness tissue loss with exposed bone, tendon or muscle
- Slough or eschar may be present
- Often include undermining and tunneling

Further description: The depth of a Grade 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. As Grade 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) there is a greater risk osteomyelitis or osteitis

Unstageable

- Full thickness tissue loss where the actual depth of the ulcer is completely obscured by slough and/or eschar in the wound bed
- Until enough slough is removed to expose the base of the wound the true depth cannot be determined but it will be at least a grade 3 ulcer (and potentially a grade 4 ulcer)
- For consistency this type of an ulcer will be graded as a grade 3 initially and if necessary should be graded as a grade 4 on debridement

4.10 Aetiology of pressure ulceration

Pressure damage can affect any individual regardless of age or gender. However the development of pressure ulceration requires one or more of the following key factors to be present

Prolonged Unrelieved Pressure

- Direct unrelieved pressure to the skin will cause an occlusion of capillary blood flow. The exact pressure in mmHg needed to occlude capillary flow is unknown and differs between individuals and is influenced by the patient's physical condition.
- Any impairment in blood supply results in the decreased delivery of nutrients and oxygen to the tissues and the accumulation of toxic metabolites. The duration of the ischaemia will determine whether tissues recover damage or die. Impairment of the lymphatic drainage due to pressure will cause accumulation of toxic metabolites.

Shearing Forces

- Shearing forces allow even low direct pressure to cause large areas of ulceration. Tissue ulceration develops as a result of the deep tissue layers moving in opposing directions leading to damage of the deep

vascular supply. This vascular damage results in full thickness pressure ulceration.

Friction

- Friction forces result from the patient's skin rapidly moving against the bed linen or chair covering. Friction commonly occurs from the incorrect lifting and handling of patients. The ulceration is often superficial but extremely painful.

Moisture

- Excessive moisture caused by sweating, urinary or faecal incontinence can lead to the development of tissue ulceration. Maceration of the skin can give rise to irritation and excoriation decreasing the tensile strength of the skin. Ulcers caused in this way are called moisture lesions and should be differentiated from pressure ulcers.

4.11 INTRINSIC FACTORS

Intrinsic factors place the individual patient at increased risk of pressure ulceration.

Age

It is well accepted that patients over 65 are at greater risk of developing pressure ulceration. Age related tissue changes increase the risk of tissue damage. Neonates and very young children are also at greater risk as their skin is still maturing and their head to body weight is disproportionate.

Acute Illness

Acutely ill patients are vulnerable to developing pressure ulceration. This may be because of heart failure, vasomotor failure, vasoconstriction due to shock, pain, hypotension or temperature change during and after anaesthesia.

Level of Consciousness

A reduced level of consciousness will reduce an individual's awareness and ability to relieve pressure.

Severe, Chronic or Terminal Illness

Multi organ failure, poor perfusion and immobility place patients at greater risk of pressure ulceration.

Previous History of Pressure Ulceration

A previous history of pressure ulceration places the individual at greater risk of developing further pressure ulceration

Nutrition and Hydration

The frail, poorly nourished patient is particularly at risk due to reduced protective padding. Obese patients will also be at risk due to weight-induced immobility, particularly in bed.

Circulatory Problems

Arterial impairment, particularly peripheral vascular disease, will result in the increased risk of pressure ulceration due to lower capillary pressure in the limbs. Cardiac impairments and anaemia will reduce oxygenation and nutrient delivery to tissues, increasing their susceptibility to ulceration.

Sensory Impairment

A reduction in sensation and therefore insensitivity to pain or discomfort can result in a reduced stimulus to move to relieve pressure.

Mental Awareness

Confused, disorientated or unconscious patients, patients with learning disabilities or who lack mental capacity will be at increased risk due to their inability to appreciate the need to avoid direct pressure, friction or shearing forces.

Mobility

Immobile patients need to avoid prolonged direct pressure, shearing and friction forces.

4.12 EXTRINSIC FACTORS

Extrinsic factors relate to the environment in which the patient is managed or treated.

Staffing

The level of staffing, their knowledge base and training affects pressure damage prevention.

Equipment

Pressure relieving equipment, its' inappropriate use, allocation and maintenance will also affect quality of care. Equipment use needs to be continuous so includes a selection of bed, chair and limb supports.

Enforced Immobilisation

The use of traction, plaster of Paris and splints need to be frequently monitored for the development of pressure ulceration.

Medication

Drugs which affect mobility (i.e. sedatives and hypnotics) may increase the risk of pressure ulceration. Drugs affecting immune defence mechanisms (i.e. steroids or anti inflammatory drugs) will affect the tissues and the skin making it more susceptible to ulceration.

Patient Handling

Incorrect moving and handling of patients will increase the risk of shearing or friction forces causing ulceration.

5 ASSESSMENT

5.1 The prevention of pressure ulceration depends on early identification of patients at risk and implementation of an appropriate regime.

5.2 Every adult patient must receive an initial screening assessment of their pressure damage risk (see Pressure Ulcer Toolkit for screening tool). This will occur within two hours of admission to a hospital setting or at the first visit in the community setting. The responsibility for this assessment remains with the registered health professional.

If screening highlights that the patient is at risk of pressure damage then a formal risk assessment (using Waterlow Risk Assessment Tool and Malnutrion Universal Screening Tool - MUST) should take place.

A full skin inspection should be undertaken with the patient‘s consent and any discolouration or ulceration identified must be graded according to the European Pressure Ulcer Advisory classification system.

5.3 The results of the initial screening assessment, Waterlow score and record of skin inspection must be documented in the nursing records along with the grade of any pressure damage (see record keeping guidance within Appendix A). The Pressure Ulcer Assessment Tool can also be used to facilitate record keeping.

5.4 Every inpatient should have a review of their risk assessment when their condition changes and at least every 7 days.

5.5 Community based patients should have a review of their risk assessment when their condition changes, according to clinical need or at planned evaluations.

5.6 Community patients using pressure relieving equipment but with no other nursing need should remain on the nursing caseload and be reviewed at intervals appropriate to their clinical need. Patients or their carers should receive clear information about being vigilant for signs of pressure damage and be given information about triggers that require escalation.

6 MANAGEMENT OF INDIVIDUALS AT RISK

6.1 Patients identified as at risk or with existing pressure ulcers should be nursed on a pressure reduction or pressure relieving surface 24 hours a day according to their level of risk and general condition .

6.2 Patients at risk of or with pressure ulceration must have a written care plan describing the nursing action implemented to prevent or manage pressure ulceration. The plan should be discussed and agreed with the patient prior to implementation. In a community setting the management plan may need to be agreed with carers and/or relatives. Clear triggers which require escalation to a healthcare professional should be identified and agreed. Patient Information leaflets such as the Trust patient leaflet or Triggers for help from Pressure Ulcer Toolkit should be provided and documented.

6.3 Patients at risk of or with pressure ulceration will require regular changes of position in order to prevent prolonged pressure to a specific area of tissue. This may need to be provided by carers or relatives if the individual is unable to reposition themselves. The frequency of repositioning will need to be determined on an individual basis taking into account the condition of the skin. The use of intentional rounding tools/SKIN bundle will facilitate and record this process.

6.4 Patients with Grade 1 or Grade 2 pressure ulceration should be offered a high specification foam mattress with pressure reducing properties. If the pressure ulcer deteriorates or is at risk of deterioration then the mattress must be upgraded to either an alternating airwave mattress or an alternating overlay mattress. Care should be taken when using an overlay mattress as the increased mattress height can cause a risk to some patient groups particularly those who have a history of falls.

6.5 Patients assessed as having Grade 3 or Grade 4 pressure ulceration should be offered either an alternating airwave mattress or an alternating airway overlay.

6.6 In exceptional circumstances the decision may be taken by the Tissue Viability Team to order a specialist mattress.

6.7 The use of bed cradles, light weight bedding, pillows and joint protectors should also be considered for the relief of pressure. Patients with pressure ulceration to their heels will require additional assessment of their arterial status and should be offered aids designed to provide heel protection.(Refer to Pressure Ulcer Toolkit)

6.8 Patients who are able to sit may require a seating assessment. Seating assessments should be carried out by appropriately trained staff (usually an occupational therapist.) If the patient is a wheelchair user then a seating assessment is essential.

6.9 Patients who are able to sit will require an appropriate pressure relieving surface when seated and a seating assessment should be considered.

6.10 As there is a correlation between nutrition and the risk of skin damage patients at risk of developing or with existing pressure damage require a MUST nutritional assessment. Referral to a dietician may be indicated for specific patients groups. Nursing staff should discuss concerns over nutritional issues with the patient's doctor and document the outcome. Patients in a community setting should be assessed and reassessed according to the MUST Patient Care Pathway.

6.11 Moist skin increases the risk of pressure damage so any patient suffering from incontinence should have their skin kept clean and free from moisture. A referral to the Continence Team may be necessary.

6.12 Individuals in pain may be reluctant to change position so the patient's pain level should always be assessed. If the patient complains of pain on movement then a medical assessment may be required to review and adjust analgesia to facilitate repositioning.

6.13 Some patients develop foot ulceration. If the cause of the ulcer is thought to be pressure then this should be recorded as a pressure ulcer. However, care is needed to correctly identify diabetic foot ulceration which is not caused by pressure but by their medical condition

6.14 Children and Young People identified as at risk will be under the care of the Acute Trust and therefore will have a plan of care written by the Acute Trust, this should be followed by Somerset Partnerships Children's and Young Persons staff.

6.15 Specialist Advice

The tissue viability team is a small specialist service and does not offer emergency visits however the team are happy to provide telephone advice for any patient who is at risk or who has suffered from pressure damage. Patients who are referred to the service and require review will be triaged and added to the waiting list.

7. COMMUNICATION

7.1 Record keeping is a vital part of communication and also demonstrates the care provided. National Institute for Clinical Excellence guidelines (CG29) recommend specific information about pressure ulcers is recorded

Record Keeping

In order that pressure ulceration and wound healing is evaluated effectively the following information should be documented in the nursing records

- grade
- site
- size
- classification of wound bed, colour, odour and exudates

Recording Wound Size

All pressure ulcers should be measured on a frequent basis to provide information about the progression of the wound. A medical photograph may be beneficial particularly if the ulcer is difficult to measure or trace. Not all clinical areas have the facility to record digital images but where digital images are taken then this should only be undertaken in accordance with the Consent policy and the Photography Policy.

- Verbal and written permission is obtained from the patient and documented as per Photography Policy
- All photographs must be treated as part of the patient's medical record and the usual confidentiality surrounding patient records maintained.
- If a patient is unable to consent to have a photograph taken, two RNs should document and sign that it is in the best interest of the patient and would enhance evaluation of care or identify neglect.

7.2 Patients at risk of or with pressure ulceration and their carers should receive information about the importance of relieving pressure and reducing friction and shearing forces.

7.3 Verbal information should be supported with patient information leaflets. Somerset Partnership NHS Foundation Trust advocates the Trust's pressure damage leaflets.

7.4 Providing information to the patient is essential but it is not enough in itself to prevent pressure damage. Patients at risk of pressure damage need to be aware of their own vulnerability and be engaged and active in pressure prevention strategies. Patients (and carers) need to be clear about when they should become concerned and know who they should contact should the need arise.

7.5 Where there is an issue of non compliance with recommended treatment plans it is essential to ensure that the choice made is an informed one. Therefore the patient's capacity should always be considered and recorded

in the records. If necessary a best interest assessment should be completed. A safeguarding referral should also be considered.

8 TRANSFER OF PATIENTS

8.1 If a patient is to be transferred into another care setting then the nurse in charge should contact the receiving health provider and inform them of the patients' condition. This should include a copy of the treatment or care plan (including the equipment being used, the turning regime, and any other relevant clinical information). Please refer to Handover for Inpatients Policy and Admission & Discharge Policy.

8.2 On transfer of a patient into a community setting there should be a notification period of a minimum of 48 hours. This is to ensure the most appropriate pressure relieving equipment is installed prior to discharge.

9 REPORTING PRESSURE ULCERATION

9.1 Accurate reporting of pressure ulcers is essential to record the occurrence of pressure damage; develop quality improvement targets; and benchmark across organisations.

9.2 All pressure ulcers from grade 1 to grade 4 should be recorded in the patient's record.

9.3 All cases of pressure ulceration of Grade 2 and above must be reported using the Datix system

9.4 All incidents of grade 2 and above pressure damage must be investigated locally using the Pressure Ulcer Reporting Form. An investigation may be instigated where there is significant harm, or a trend is identified by the Tissue Viability Service Manager in any particular area. .

9.5 All patients with Grade 2 pressure ulceration or above, which subsequently deteriorates to become a higher grade must be reported on DATIX using a Pressure Ulcer Reporting Form stating that this is a deteriorating pressure ulcer.

9.6 Some pressure ulcers will be determined to be unavoidable. Clear criteria have to be met and relevant evidence must be available to support the decision made.

9.7 Each clinical area or Practitioner in charge must review the number of Pressure Ulcer incidents noting whether pressure ulceration is avoidable or unavoidable and improvement targets set locally. The number of days between newly acquired avoidable pressure ulcers whilst under our care should be recorded and displayed.

9.8 National reporting also takes place through the Safety Thermometer which is a care survey instrument used to measure harm. Pressure ulcer

development is one element of the Safety Thermometer and therefore monthly prevalence is reported.

10 SAFEGUARDING ADULTS

Not all pressure ulcers in an adult are the result of neglect or self neglect but they may be an indication of lack of resources, lack of clinical skill or poor practice. As a result consideration at each assessment should be given as to whether a Safeguarding Adults referral should made. See Sompar Safeguarding Adults referral pathway on Sompar intranet for further guidance on this.

10.1 What is Safeguarding?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action (Care and Support Statutory Guidance DH October 2014).

It is important to recognise the risk of abuse or neglect occurring is primarily related to the person's circumstances rather than being a weakness on their part. The risk results from the action or inaction of others and the person concerned is 'at risk' because the person's ability to protect themselves is limited in some way.

This section provides guidance to support the decision making in relation to establishing if there is a need to raise a safeguarding referral in the event of tissue damage occurring

10.2 Who does Safeguarding apply to?

The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

(Care and Support Statutory Guidance DH October 2014).

10.3 An adult at risk may be a person who:

- is frail due to ill health, physical disability or cognitive impairment***;**
- has a learning disability;

- has a physical disability and/or a sensory impairment;
- has mental health needs including dementia or a personality disorder;
- has a long-term illness/condition;
- misuses substances or alcohol;
- is limited in their capacity to make decisions and is in need of care and support.

This list is not exhaustive

***Please note:**

This does not mean that just because a person is frail or has a disability they are inevitably 'at risk'. For example, a person with a disability who has mental capacity to make decisions about their own safety could be perfectly able to make informed choices and protect themselves from harm. In the context of Safeguarding Adults, the vulnerability of the adult at risk is related to how able they are to make and exercise their own informed choices free from duress, pressure or undue influence of any sort, and to protect themselves from abuse.

10.3 **Tissue viability indicators when considering a Safeguarding referral:**

Has there been a:-

- Development of a Grade 3/4 pressure ulcer- intentionally or unintentionally,
- Rapid onset/deterioration of tissue damage
- Skin damage disproportionate to the risk of skin damage
- Unexplained weight loss/dehydration
- Unexplained bruising or injuries of any sort
- Recent change in medical condition
- Reasonable steps taken to prevent skin damage
- Poor physical condition i.e. failure to attend to physical needs such as toileting, dressing and washing
- Poor continence management
- Burns
- Poor or inadequate record keeping and risk assessments
- Leaving a patient unattended for an extended length of time
- Evidence of poor practice or neglect

This is not an exhaustive list and there may be other factors to consider that would trigger a safeguarding referral and described within the Pressure Ulcer Safeguarding Trigger Pathway (refer to Pressure Ulcer Toolkit).

10.4 Neglect or Acts of Omission

This occurs when there are concerns of withholding, either intentionally or unintentionally, help or support necessary to carry out daily living tasks. This can include ignoring medical and physical care needs or failing to provide access to health, social or educational support; the withholding of medication; nutrition and heating.

10.5 Mental Capacity

Where a patient has been assessed as lacking capacity to make a specific decision in relation to care or treatment of the pressure ulcer , any further decision must then taken in the best interests of the patient, and as stated within the Mental Capacity Act 2005.

IF IN DOUBT → Initiate Safeguarding Adults Procedures → Discuss with Lead for Safeguarding, Champions or line manager → Forward an Internal Referral → Record decision and outcome of the decision (Defensible decision making).

This guidance should be used in conjunction with the Safeguarding Adults Multi Agency Policy (2015) and Sompar Safeguarding Adults Policy (2015).

11 TRAINING REQUIREMENTS

11.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

- Infection Prevention and Control Training
- In addition, the Tissue Viability Team provides pressure damage training and dates are available through the training department.

12 EQUALITY IMPACT ASSESSMENT

12.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

13 MONITORING COMPLIANCE AND EFFECTIVENESS

13.1 All Datix incidents relating to pressure damage are reviewed by the tissue viability team who monitor incidence within the Trust.

13.2 **Monitoring arrangements for compliance and effectiveness**

- overall monitoring will be by the Tissue Viability Best Practice Group.

13.3 **Responsibilities for conducting the monitoring**

- local monitoring and reporting to be undertaken by Ward Sisters/Unit Managers/Team Leaders.
- clinical audit standards relating to this procedural document are included as an appendix (Appendix C).

13.4 **Methodology to be used for monitoring**

- Complaints monitoring.
- Local recording of days between acquired avoidable pressure ulcers.
- Safeguarding alerts.
- Pressure ulcer report detailing incident reporting.
- Safety Thermometer returns.
- Serious Incidents Requiring Investigation and action plans.

13.5 **Frequency of monitoring**

- Monthly reporting of all pressure ulcers recorded via Datix to Pressure Ulcer Best Practice Group.
- Monthly monitoring of newly acquired Grade 3 and 4 ulcers via the Pressure Ulcer Best Practice Group.
- Quarterly reports to the Clinical Governance Group.

13.6 **Process for reviewing results and ensuring improvements in performance occur.**

13.6.1 Incidence of pressure damage will be presented to the Clinical Governance Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented. The information will be disseminated through local governance groups.

13.6.2 New Grade 3 and 4 pressure ulcers which develop during an episode of care will be reported and monitored through the Pressure Ulcer Best Practice Group.

13.6.3 The Pressure Ulcer Best Practice Group will review the action plans for all new grade 3 and 4 pressure ulcers and will oversee the organisational action plan.

13.6.4 The audit of results will be provided to staff to raise awareness through What's on at Sompar

14 COUNTER FRAUD

14.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

15 RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

15.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

15.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 11:	General
Regulation 12:	Statement of purpose
Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

15.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

Relevant National Requirements

Department of Health Pressure Ulcer Productivity Calculator
Department of Health Safety Thermometer
National Patient Safety Agency
NICE guidance – Guidelines 7 and 29
High Quality Care for All

16 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

16.1 References

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Clarkson A. Are pressure ulcers an act of nursing negligence? Wound s UK, Vol 3 No 2 (2007)

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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).

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Flanagan M, Pressure sore risk assessment scales, Journal of Wound Care 2, 3, 162 – 167(1993)

Flanagan M Predicting pressure sore risk, Journal of Wound Care, 2, 4, 215 – 218 (1993)

National Institute for Clinical Excellence Pressure Ulcer Risk Assessment and Prevention (April 2001). Inherited Clinical Guideline B. London

National Institute for Clinical Excellence (CG7) Pressure Ulcer Prevention: Pressure ulcer risk assessment and prevention, including the use of pressure-relieving devices (beds, mattresses and overlays) for the prevention of pressure ulcers in primary and secondary care (October 2003)

National Institute for Health and Clinical Excellence (CG179) Pressure ulcers: prevention and management of pressure ulcers
RCN Clinical Guidelines. Pressure Ulcer Risk Assessment and Prevention (June 2000)

South West Quality Improvement Framework for the Prevention & Management of Pressure Ulcers: NHS South of England (May 2012)

16.2 Cross reference to other procedural documents

Consent and Capacity to Consent to Treatment Policy
Development & Management of Procedural Documents
Healthcare Clinical Waste Policy
Learning Development and Mandatory Training Policy
Pressure Ulcer Toolkit
Risk Management Policy and Procedure
Record Keeping and Records Management Policy
Safeguarding Adults at Risk Policy
Staff Mandatory Training Matrix (Training Needs Analysis)

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

Relevant Objective within Trust Strategy

Five year Integrated Business Plan

17 APPENDICES

For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Pressure Ulcer NICE Guidelines
Appendix B	Root Cause Analysis Tool
Appendix C	Clinical Audit Standards

Guidelines: quick reference guide – the prevention & treatment of pressure ulcers

APPENDIX A

Initial and ongoing ulcer assessment is the responsibility of a registered healthcare professional

When perform initial risk assessment in first episode of care (within 6 hours)

Assess risk

Assess
* pressure
* shearing
* friction
* level of mobility
* sensory impairment
* continence
* level of consciousness
* acute, chronic & terminal illness

Risk factors include
* comorbidity (for example, blood
systemic sighs of infection, supply, plain, medication)
* posture
* cognition, psychosocial status
* previous pressure damage
* extremes of age
* nutrition and hydration status
* moisture to the skin

Record
Document the assessment of risk, noting all relevant factors

People vulnerable to pressure

Patient with pressure ulcer

Skin assessment

* Assess skin regularly
* Frequency should be based on vulnerability and condition of patient
* Inspect all vulnerable areas
* Encourage individuals (or their carers) to inspect the skin (using a mirror if necessary)

Look for
- persistent erythema
- non-blanching hyperemia
- blisters
- localized heat
- localized oedema
- localized induration
- purplish/blush localized areas
- localized coolness if tissue death occurs

People vulnerable to pressure ulcers

Examples of people vulnerable to pressure ulcers include people
* undergoing surgery
* in critical care
* with orthopaedic conditions
* with spinal injury
* with diabetes
* with peripheral disease
* with history of pressure ulcers
* at extremes of age

Safe use of mattresses

* Ensure:
  - mattress does not elevate patient to an unsafe height
  - patient is within the recommended weight range for the mattress
* In children, ensure:
  - appropriate cell size of mattress
  - appropriate position of pressure sensors within mattress in relation to the child
  - monitoring of use of alternating pressure mattress with a permanently inflated head end in young children to avoid occipital damage

European Pressure Ulcer Advisory Panel classification system of pressure ulcer grades

Grade 1: non-blanchable Erythema of interact skin. Discolouration of the skin, Warmth, eodema, induration or Hardness may also be used as Indicators, **particularly on Individuals with darker skin**.

Grade 2: partial Thickness, skin loss involving epidermis or dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Grade 3: full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

Grade 4: extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures with or without full thickness skin loss.

Assessment of pressure ulcer

Assess
* cause
* site/location
* dimensions
* stage or grade
* exudates amount and type
* local signs of infection
* pain, including cause, level, location and management interventions
* wound appearance
* surrounding skin
* undermining/tracking sinus or fistula
* odour

Record
* Document
  - depth
  - estimated surface area
  - grade using EPUAP

Support document with photography and/or tracings (calibrated with a ruler)

* Document all pressure ulcers graded 2 and above locally as a clinical incident.
* Pressure ulcers should not be reverse graded

Reassessment
* Ensure initial and ongoing pressure ulcer assessment
* Reassess frequently (at least weekly)

Prevention

All vulnerable patients, including those with a grade 1 - 2 pressure ulcer should receive as a minimum provision, a high specification foam mattress & the ulcer should be closely observed for deterioration

Positioning
* Consider mobilizing, positioning & the repositioning interventions for all patients (including those in bed, chairs & wheelchair users). Acceptability to the patient and needs of the carer should be considered.
* All patients with pressure ulcers needs. Should actively mobilize, change The position or be repositioned with Frequently.
* Minimize pressure on bony prominences & avoid positioning an alternating on pressure ulcer if present.
* Consider whether sitting time should be restricted to less than 3 hours example per session.
* Seek specialist advice on aids and equipment & positions.
* Record using a repositioning chart/schedule

Self care
* Teach individuals and carers (who are willing and able) how to redistribute individual's weight.
* Consider passive movements for patients with compromised mobility.

Nutrition
* Provide nutritional support to patients with an identified deficiency
* Decisions about nutritional support/supplementation should be based on:
  - nutritional assessment using a recognised tool (for example, the Malnutrition Universal Screening Tool (MUST).
  - general health status
  - patient preference
  - expert input (dietician/specialists)

* to find out more about the malnutrition Universal Screening tool see www.?.co.uk

Pressure relieving devices
* Choose Pressure relieving device on the basis of:
  - risk assessment
  - pressure ulcer assessment
  - (severity) if present
  - location and cause of the pressure ulcer if present
  - skin assessment
  - general health
  - lifestyle and abilities
  - critical care needs
  - acceptability and comfort
  - availability of carer/healthcare professional to reposition the patient
  - patient weight
  - cost considerations
* Consider all surfaces used by patient
* Patients should have 24 hour access to pressure relieving and/or strategies
* Change pressure relieving device response to altered level of risk, condition or

As a minimum provision patients a grade 3-4 pressure ulcer should:
* have a high specification foam mattress with pressure overlay or
* have a sophisticated continuous low pressure system (for low air loss, air flotation, viscous fluid).

Treatment of pressure ulcer
* Choose dressing/topical agent or method of debridement or adjunct therapy based on:
  - ulcer assessment
  - general skin assessment
  - treatment objective
  - characteristic of dressing/technique
  - previous positive effect of dressing/technique manufacturer's indications for use and contraindications
  - risk of adverse events
  - patient preference
* Consider preventative measures shown in prevention box
* Create an optimum wound healing environment using modern dressings (for example hydrocolloids, hydrogels, foams, films, alginates, soft silicones)
* Consider antimicrobial therapy in the presence of systemic and/or local clinical signs of infection
* Consider referral to a surgeon

Referral to surgeon
Refer to surgeon on the basis of
* failure of previous conservative management interventions
* level of risk (unaesthetic and surgical intervention recurrence)
* patient preference (lifestyle, abilities and comfort)
* ulcer assessment
* general skin assessment
* general health status
* competing care needs
* assessment of psychosocial factors regarding the risk of recurrence
* practitioner's experience
* previous positive effect of surgical techniques

Reassessment
Reassess on an on-going basis and in particular in the patient's circumstances change

APPENDIX B

Somerset Partnership NHS
NHS Foundation Trust

Pressure Ulcer Investigation

Investigating Officers/Report Authors: Designation Date of Report:

Patient Details: (initials only) DOB: Male/Female Date admitted to service/caseload:

Pressure Ulcer Details: Type: Grade: Size: Location: For patients where there is more than one pressure ulcer – repeat the process above Date Identified: Is this a new pressure Ulcer? YES/NO Deterioration of Pressure Ulcer? From 1 2 3 (circle) Present on admission to service YES / NO Where was the pressure ulcer acquired?

Detail of other services involved in care:

Describe approach taken with patient/and or carers

Brief Description of incident detection and background.

Immediate Actions taken:

Findings   – (see timeline, barrier analysis and/or fishbone)

Conclusions

Recommendations 1. 2. 3. 4. Once the recommendations have been accepted these should be transferred to the Action Plan with the relevant solutions for action (remember test all solutions first – for small test of change guidance see Improvement Programme Extranet site, your trust programme manager, or email Corinne.thomas@southwest.nhs.uk for support with the Model for Improvement.

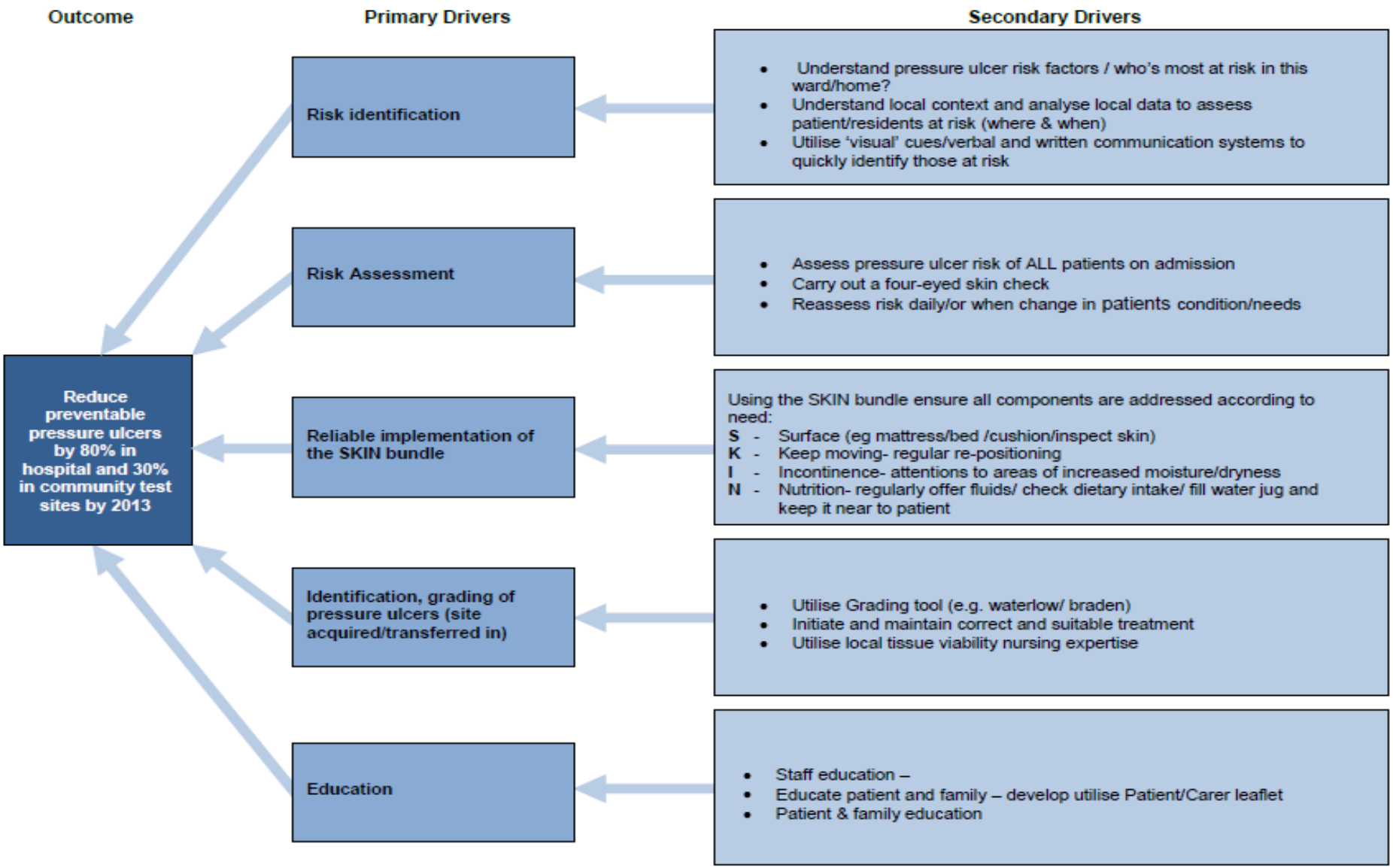
Pressure Ulcer Timeline This table should be completed once all information has been gathered. Describe each intervention, care and treatment or other relevant activity leading up to the incident – these may be over a period of hours, days, weeks or months, but should be listed as each event occurred. Where any problems are identified along the pathway these can be listed in sentence form at the bottom of the chart where the event occurred. Good practice should also be captured where observed. Any missing information requiring clarification or addition later should be noted.

Event date and time						
Event (what actually happened)						
Supplementary (other relevant) information						
Missing information /data gaps						
Good practice identified						
Problems identified						

Pressure Ulcer (barrier) analysis

A barrier is something in place to prevent something from happening. These may be guidelines, policies, procedures actions or physical constraints put in place to protect something. To support this copy of the South West Quality and Patient Safety Improvement Programme Driver Diagram is included in this toolkit. As part of an RCA investigation we need to understand what was or should have been in place to prevent harm, by understanding these we can determine whether they were complied with or whether they need strengthening. From the problems identified through your timeline.

Incident Context:				**Solutions**
Problem to be explored (taken from the problem identification column in the timeline)	**Describe the (barriers/controls/preventative measures that should be in place**	**Did it fail? (yes /no)**	**If Yes, describe WHY it failed, keep asking why until you have the key contributory factor (root cause); for more complex problems use the attached fishbone diagram**	**Describe what action needs to be taken to strengthen the barrier?**


Outcome
Primary Drivers
Secondary Drivers
Reduce preventable pressure ulcers by 80% in hospital and 30% in community test sites by 2013
Risk identification
Understand pressure ulcer risk factors / who's most at risk in this ward/home?
Understand local context and analyse local data to assess patient/residents at risk (where & when)
Utilise 'visual' cues/verbal and written communication systems to quickly identify those at risk
Risk Assessment
Assess pressure ulcer risk of ALL patients on admission
Carry out a four-eyed skin check
Reassess risk daily/or when change in patients condition/needs
Reliable implementation of the SKIN bundle
Using the SKIN bundle ensure all components are addressed according to need:
S - Surface (eg mattress/bed /cushion/inspect skin)
K - Keep moving- regular re-positioning
I - Incontinence- attentions to areas of increased moisture/dryness
N - Nutrition- regularly offer fluids/ check dietary intake/ fill water jug and keep it near to patient
Identification, grading of pressure ulcers (site acquired/transferred in)
Utilise Grading tool (e.g. waterlow/ braden)
Initiate and maintain correct and suitable treatment
Utilise local tissue viability nursing expertise
Education
Staff education –
Educate patient and family – develop utilise Patient/Carer leaflet
Patient & family education

Secondary Drivers	Key change concepts and change ideas for PDSA testing
• **Understand pressure ulcer risk factors** • **Understand local context and analyse local data to assess patient/residents at risk** • **Utilise 'at risk' visual cues, verbal and written communications systems to quickly identify those at risk**	• Educate staff, patient/residents on pressure ulcer factors • Utilise patient/resident and carer information leaflet • Engage with the MDT and develop a shared vision • Set a clear local aim for reducing preventable pressure ulcers • Engage with staff to learn about the barriers to risk assessment being done with 6 hours from admission • Understand the local issues,(who is 'at risk' on this unit/home) • Work with staff to develop a system where at risk patients/residents can be identified easily – Visually – Use of visual cues above the beds/doors of at risk patients/residents to alert staff to patients risk of acquiring a pressure ulcer – Verbally- Incorporate patients/residents at risk into safety briefings/handover processes – Safety Briefings/SBAR approach – Documentation- SKIN Bundle Communication tool
• **Assess Pressure ulcer risk on admission** • **Reassess risk daily/when change in condition**	• Build reliable risk assessment into bundle/rounding process (first steps – see above) • Monitor compliance with on admission Pressure Ulcer risk assessment and aim for >95% compliance by developing a monitoring/feedback and learning loop to improve this process • Monitor compliance with daily re-assessment of risk and increase compliance to >95% by developing a monitoring/feedback and learning loop (incorporate this reassessment into bundle /rounding process)
• **S – Surface/Skin inspection** • **K – Keep moving** • **I – Incontinence/Increased moisture** • **N – Nutrition**	• Reliably implement all elements of the SKIN BUNDLE • All elements of the bundle must be evident and effectively carried out or it will not be counted as compliance • **Surface** - Ensure patient/resident is on the correct surface (mattress/ cushion etc) • Build reminder checks into routine care process and daily re-assessment • Skin Inspection – Inspect skin/pressure areas to identify quickly pressure damage • **Keep Moving** - Ensure patients/residents are encouraged/assisted to move positions regularly dependent on individuals needs Minimise pressure damage by ensuring manual handling equipment is available when turning patients/residents, kept by the bedside of patients/residents who have been assessed as at risk Introduce systems acceptable to all so that ward/care home team can reposition at risk patients/residents or encourage all patients/residents to move themselves at regular intervals Introduce in partnership with the patient/resident a daily goals sheet, which will ensure that both the patient/resident and the wider MDT are aware of how long the patient/resident should be sat out of bed, when anti embolic stockings should be removed, that they should have repose boots (a pressure relieving device for heels) insitu etc

Secondary Drivers	Key change concepts and change ideas for PDSA testing
	• **Incontinence (increased moisture)** - Manage the moisture of patients/residents whose skin is exposed to increased moisture (wound drainage/continence issues/ leaks/discharge/excessive sweating) Ensure skin is kept clean and dry (but note that excessively dry skin presents an increased risk so use barrier creams appropriately) Consider introducing a continence assessment tool which will inform the care plan/ pathway Move supplies nearer to the bedside to enable prompt cleansing when required include a barrier cream, cleansing wipes, incopads Use prompts to remind staff to ask at regular intervals if the patient/resident would like to go to the toilet Where appropriate introduce written guidance for staff for the appropriate use of faecal management systems to protect skin
	• **Nutrition** - Introduce protected mealtimes to ensure patients/residents are not interrupted when eating. Introduce prompts that alert nursing and catering staff to patients/residents who are at risk and may need support at mealtimes, for example 'red tray' Use water jugs with a red lid on water jug so staff know to encourage fluids and to refill Consider use food charts to monitor intake. Alternatively record fluid input/output on SKIN bundle communication tool Use a recognised nutritional risk assessment tool to identify all patients at risk of malnutrition and refer to dietician as appropriate Introduce intentional rounding prompts 'would you like a drink?', 'Can you reach your drink?', or 'soft drink cocktail hour' where juices are served to encourage patients/residents to keep hydrated Ensure patients/residents on fortified supplements receive their drinks. If they find it difficult to tolerate, use condensed "shots"
• Utilise standardized grading tool • Initiate and maintain correct and suitable treatment • Utilise local tissue viability nursing expertise	• Agree use of National pressure ulcer grading tool
	• Make sure staff know about tool to aid with pressure ulcer recognition and assist with their education
	• Utilise the SKIN bundle/rounding approach
	• Work in partnership with patient/residents, their family and MDT members
	• Know how to contact your local tissue viability nurse/other specialist if required
• Staff education - Educate patient and family – utilize Patient/Carer leaflet • Utilise relevant tools (bundle/rounding/SBAR)	• Utilise formal and informal learning opportunities to educate staff about pressure ulcer risk
	• Use patient/resident stories to motivate and inspire staff, to learn from and educate
	• Provide patients/residents and relatives with information on the risks of pressure ulcers on admission or when there is a change in their condition that puts them at risk
	• Educate patients/residents and families as to how they help to minimize pressure ulcer risk whilst in hospital/care home, at home where relevant (e.g. the SKIN bundle)
	• Work with patients/residents and families as co-partners in their care
	• Use the guides for various tools to educate staff on how they could be used in their care

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DATIX INCIDENT NUMBER

PATIENT INITIALS
LOCATION OF INCIDENT

One Line Summary of Incident

Level * review

Date of incident

LOCAL ACTION PLAN

Lead for Local Action Plan:
Date Circulated:
Final Completion Date:

Purpose: **To ensure that all necessary local actions have been taken and learning shared**

LOCAL ACTION PLAN

DATIX INCIDENT NUMBER

PATIENT INITIALS
LOCATION OF INCIDENT

NB: Complete one table for each recommendation detailed in the investigation report/root cause analysis

Item No	Action Required	Lead Responsibility	Target Date for Completion	Progress and Comments	RAG Rating	
1						
Actual Date Completed:						
How have the lessons learnt relating to the action above been disseminated:						
Evidence: *(Embed evidence of actions detailed above)*						

APPENDIX C

Somerset Partnership NHS
NHS Foundation Trust

PRESSURE ULCERATION PREVENTION AND MANAGEMENT CLINICAL AUDIT STANDARDS

30/11/2012

Service area(s) to which standards apply:

X	MH Inpatient (CAMHS)		Community CAMHS	X	CH Specialist Services
X	MH Inpatient (Adult)		C & YP Integrated Therapy	X	MH Specialist Services
X	MH Inpatient (Older)		School Nursing	X	MH Community Adult
X	MH Rehab & Recovery		Health Visitors	X	MH Community Older
X	Community Hospital		CH Rehab	X	Learning Disabilities
	MIU		Musculo-Skeletal	X	District Nurses

Pressure Ulcer Prevention and Management Clinical Audit Standards				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
ASSESSMENT				
1	Every adult patient must receive an initial screening assessment of their pressure damage risk *(Policy para 5.2)*	100%	None	This will occur within two hours of admission to a hospital setting or at the first visit in the community. The responsibility for this assessment remains with the registered health professional. To be recorded in case records or risk screen on RiO
2	Every patient identified as being at risk of pressure ulcers, a formal risk assessment (using Waterlow Risk Assessment Tool) should take place *(Policy para 5.2)*	100%	None	To be recorded in case records or Waterlow Assessment on RiO
3	Any discolouration or ulceration identified must be graded according to the European Pressure Ulcer Advisory classification system (Policy para 5.2)	100%	None	

Pressure Ulcer Prevention and Management Clinical Audit Standards				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
4	Every inpatient should have a review of their risk assessment when their condition changes and at least every 7 days *(Policy para 5.4)*	100%	None	
MANAGEMENT				
5	Patients at risk of or with pressure ulceration must have a written care plan describing the nursing action implemented to prevent or manage pressure ulceration *(Policy para 6.2)*	100%	None	The plan should be discussed and agreed with the patient prior to implementation. In a community setting the management plan may need to be agreed with carers and/or relatives. Clear triggers which require escalation to a healthcare professional should be identified and agreed
6	Patients at risk of or with pressure ulceration will require regular changes of position in order to prevent prolonged pressure to a specific area of tissue *(Policy para 6.3)*	100%	Patient choice	The frequency of repositioning will need to be determined on an individual basis taking into account the condition of the skin.
7	Patients with Grade 1 or 2 pressure ulceration should be offered a high specification foam mattress with pressure reducing properties (Policy para 6.4)	100%	Patient choice	

Pressure Ulcer Prevention and Management Clinical Audit Standards				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
8	Patients assessed as having Grade 3 or 4 pressure ulceration should be offered either an alternating airwave mattress or an alternating airway overlay. *(Policy para 6.5)*	100%	Patient choice	
9	patients at risk of developing or with existing pressure damage require a MUST nutritional assessment *(Policy para 6.10)*	100%	None	
COMMUNICATION				
10	Patients at risk of or with pressure ulceration and their carers should receive information about the importance of relieving pressure and reducing friction and shearing forces. *(Policy para 7.2)*	100%	None	
11	Patients at risk of pressure damage need to be aware of their own vulnerability and be engaged and active in pressure prevention strategies. *(Policy para 7.4)*	100%	Patient choice	Patient involvement should be apparent within the completed Personal Prevention Plan
12	Where there is an issue of non-compliance the patient's capacity should always be considered and recorded in the records (Policy para 7.5)	100%	None	

Pressure Ulcer Prevention and Management Clinical Audit Standards				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
REPORTING				
13	All cases of pressure ulceration of Grade 2 and above must be reported using the Datix system. *(Policy para 9.3)*	100%	None	
14	All incidents of grade 2 and above pressure damage must be investigated. Grade 2 ulcers are investigated locally, whilst grade 3 and grade 4 are investigated as a serious incident requiring investigation *(Policy para 9.4)*	100%	None	