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PRESSURE ULCER RISK ASSESSMENT, PREVENTION AND TREATMENT PROCEDURE	
Introduction and Aim Cardiff and Vale University Health Board (UHB) aims to reduce the risk of our patients developing pressure damage. This will be achieved by:- • Promoting and implementing effective and consistent pressure ulcer risk assessment; • Ensuring that arrangements are in place to prevent pressure ulcers; and • Effective treatment of pressure ulcers should they develop. This Procedure accompanies the Pressure Ulcer Risk Assessment, Prevention and Treatment Policy.	
Objectives The objectives of this document are:- • To prevent avoidable pressure damage • To inform and educate healthcare professionals in pressure ulcer risk assessment and prevention • To ensure correct categorising/grading of pressure ulcers • To ensure reliable delivery of the SKIN bundle • To ensure provision of appropriate pressure relieving equipment	
Scope This procedure and any supporting procedures and guidelines will be implemented by all employees, including those with honorary contracts, whilst providing care to adult and paediatric patients. It will apply in all care settings, including the community.	
Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed. The EHIA found there to be a positive impact.
Documents to read alongside this Procedure	Equality , Diversity and Human rights Policy 2014 Consent to Examination or treatment policy 2016 Appendix a: Illustrative Clinical records- photography, video and audio recordings Mental Capacity Act 2005 Protection of Vulnerable Adults Policy EPUAP (2014) Prevention Ulcer Prevention. Quick Reference Guide.

Approved by	Nursing and Midwifery Board
Accountable Executive or Clinical Board Director	Executive Nurse Director
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<u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.	

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	NA	11/09/2012	NEW Procedure- UHB 155
2	13/02/2018	19/02/2018	The existing Policy and Procedure has been split into separate documents. Revision has been made to original document to reflect current international and national Guidance on Pressure ulcer assessment prevention and treatment Changes made to the Procedure include: Mental capacity Act added to documents to be read alongside. Minor amendments to the flow chart to reflect the changes in Barrier products on the UHB formulary
3	13/08/2020	19/08/2020	Implementation of Purpose T Pressure Ulcer Risk Assessment Tool.

Contents	Page
1. Introduction	4
2. Procedure Statement and Aim	4
3. Scope	4
4. Objectives	5
5. Outcomes	9
6. Education and Training	14
7. Responsibilities	15
8. Resources	16
9. Training	16
10. Audit	16
11. Equality	17
12. Implementation and Distribution	17
13. Review	17
Appendix 1: SKIN bundle	
Appendix 2: Protocol for the Selection of Pressure Support Surfaces/Clinical Algorithm: Pressure Ulcers	
References	

1. INTRODUCTION:

Pressure ulcer risk assessment and prevention is pertinent to all health care professionals and should begin as soon as the patient enters the health care system.

The purpose of the prevention recommendations is to guide evidence-based care to prevent the development of pressure ulcers. This procedure will apply to all vulnerable individuals of all age groups and is intended for the use of health care professionals who are involved in the care of patients and vulnerable people who are at risk of developing pressure ulcers, whether they are in a hospital, long-term care or assisted living at home regardless of their diagnosis or health care needs. It will also help to guide patients and carers on the range of prevention strategies that are available.

Pressure ulcers continue to be a significant complication of hospitalisation affecting all age groups and are costly in terms of resources and individual health outcomes which will result in patient harm, extended hospital stay and possible death. The financial implications of the treatment of pressure damage for the NHS are substantial.

The European Pressure Ulcer Advisory Panel (EPUAP) has agreed a definition and grading system for pressure ulcers. Ulcers can be categorised from I to IV with IV being the most severe. In 2014 EPUAP added unstageable and suspected deep tissue injury (SDTI). Cardiff and Vale University Health Board has adopted this approach.

Guest et al (2015) reported that pressure ulcers accounted for 9% of all wounds managed by the UK NHS. After adjustment for comorbidities the annual cost attributed to these wounds was estimated to be £507-£530 million. It is envisaged due to an aging population that the number of patients with Pressure Ulcers will increase (European Pressure Ulcer Advisory Panel) (EPUAP 2014)

2. PROCEDURE STATEMENT AND AIMS:

Cardiff and Vale University Health Board (UHB) aim to reduce the risk of our patients developing pressure damage. This will be achieved by:-

- Promoting and implementing effective and consistent pressure ulcer risk assessment.
- Ensuring that arrangements are in place to prevent pressure ulcers; and
- Effective treatment of pressure ulcers should they develop.

3. SCOPE:

This procedure and any supporting procedures and guidelines will be implemented by all employees, including those with honorary contracts, whilst providing care to adult and paediatric patients. It will apply in all care settings, including the community.

4. OBJECTIVES:

The objectives of this procedure are:-

- To prevent avoidable pressure damage
- To inform and educate healthcare professionals in pressure ulcer risk assessment and prevention
- To ensure correct categorising/grading of pressure ulcers
- To ensure reliable delivery of the SKIN bundle
- To ensure provision of appropriate pressure relieving equipment

EPUAP PRESSURE ULCER DEFINITIONS AND CLASSIFICATION 2014

The UHB has adopted a common international definition and classification of pressure ulcers to document the level of tissue loss (EPUAP 2014).

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.

Category I: Non-blanchable erythema of intact skin

Intact skin with non-blanchable erythema of a localized 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/ Stage I may be difficult to determine in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).



Category II: 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 blister. 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, perineal dermatitis, incontinence associated dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury (SDTI)*

**Category III: 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 III varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category III ulcers can be shallow.

In contrast, areas of significant adiposity can develop extremely deep Category III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category IV: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling.

The depth of a Category IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/ tendon is visible or directly palpable.



Unstageable: Depth unknown

Full thickness skin 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.

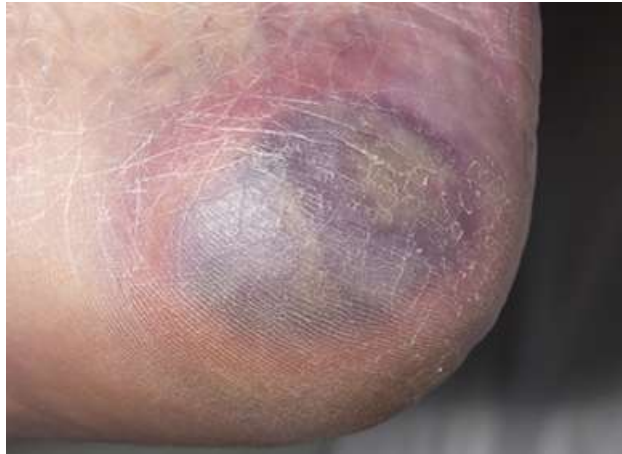
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance). Eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.



Suspected Deep Tissue Injury (SDTI): Depth Unknown

Purple or maroon localized 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 may become covered with thin eschar. Evolution may be rapid exposing additional layers or tissue even with optimal treatment.



SUMMARY OF THE RECOMMENDATIONS TO BE IMPLEMENTED:

- Use a validated pressure ulcer classification system to document the level of tissue loss (EPUAP 2014).
- Educate healthcare professionals about special assessment techniques to be used in darkly pigmented individuals.
- Educate healthcare professionals on differentiating pressure ulcers from other types of wounds (e.g., venous ulcers, arterial ulcers, neuropathic ulcers, incontinence-associated dermatitis/moisture lesions, skin tears, and intertrigo).
- Educate professionals about the appropriate use of the classification system and the appearance of different tissue types at common pressure ulcer sites
- Do not use a pressure ulcer classification system to describe tissue loss in wounds other than pressure ulcers.
- Do not classify pressure ulcers on mucous membranes (EPUAP 2014).
- Consider adults and children with medical devices to be at risk of pressure ulcers; ensuring that medical devices are correctly sized and fit appropriately to avoid excessive pressure.

Key areas for consideration in pressure ulcer assessment and prevention are:-

- Risk assessment – assessing each patient's risk of developing a pressure ulcer and implement appropriate preventive measures
- Identify intrinsic and extrinsic factors which may influence a patient's potential to develop pressure ulcers
- Skin assessment to identify signs of pressure damage
- Use of pressure redistribution equipment and patient repositioning.
- Multi-disciplinary education and training
- Provision of education and information to patients and carers

5. OUTCOMES:

The following provides the framework of assessment, prevention and treatment of pressure ulcers.

5.1 RISK ASSESSMENT AND PREVENTION:

Practice Points:

- Purpose-T (adults) and Glamorgan (paediatrics) risk assessment tools are to be used in conjunction with clinical judgement and not as a tool in isolation from other clinical features.
- Risk assessment must be ongoing and frequency of re-assessment should be dependent on any change in the patient's condition.
- The following risk factors may influence the patient's potential to develop pressure ulcers. These must be considered when performing a risk assessment.
 - Reduced mobility or immobility
 - Spinal cord injury
 - Sensory impairment
 - Acute illness
 - Level of consciousness
 - Extremes of age
 - Vascular disease
 - Severe chronic or terminal illness
 - Previous history of pressure damage
 - Nutritional status e.g. Malnutrition and dehydration

Outcome statements:

5.1.1. All patients will have a risk assessment undertaken by a registered practitioners using Purpose T or Glamorgan Risk Assessment Tool.

5.1.2. All patients will have a risk assessment undertaken within the first **six** hours following the patient's admission to the acute care sector. Risk assessment must be ongoing and frequency of re-assessment should be dependent on any change in the patient's condition.

5.1.3. All patients will have a Pressure Ulcer Risk assessment undertaken on the **First assessment** visit in the Primary Care setting.

5.1.4. Date and time of initial assessment will be clearly documented in the patient care records.

5.1.5. All formal assessment of risk will be documented and made accessible to all members of the multi-disciplinary team.

5.1.6. All patients at risk of developing pressure ulcers will have an appropriate plan of care or implementation of the Skin bundle (appendix 1) prescribed by a registered nurse, which will be documented and evaluated as required.

5.1.7. Patients and carers will be involved in their plan of care as appropriate, patients who are willing and able should be encouraged, following education, to inspect their own skin.

5.2 SKIN INSPECTION:

Practice Points:

- Healthcare professionals will be aware of the following signs which may indicate pressure ulcer development:
 - Persistent erythema
 - Non blanching erythema
 - Discolouration
 - Localised heat
 - Pain
 - Localised oedema
 - Local induration
- Skin inspection will be based on an assessment of the most vulnerable areas of risk for each patient, typically, heels, sacrum, ischial tuberosities, femoral trochanters and occiput, early signs of pressure damage must be documented on a body map.
- Patients with darkly pigmented skin pressure damage may present as: purplish / bluish localised areas on skin localised heat, localised oedema and localised induration.
- Studies have identified pain as a major factor for patients with pressure ulcers (Langemo *et al* 2000, Bale *et al* 2007). Several studies also offer some indication that pain over the site was a precursor to tissue breakdown (EPAUP 2014).

Outcome statements:

5.2.1. Educate professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response localised heat, oedema and induration (hardness).

5.2.2. Inspection of the skin (by a registered nurse) will be conducted at least every 8 hours or at every District nurse visit for patients who are at risk of developing pressure ulcers.

5.2.3. Changes in skin integrity will be documented immediately.

5.2.4. The condition of any existing ulcers will be categorised/graded using the European Pressure Ulcer Advisory Panel (2014) definition and classification and documented within the care notes and a body map completed. All entries should be signed, timed and dated by a registered nurse

5.2.5. Hospitalised patients will have anti-embolic stockings completely removed at **least once** daily and skin inspected **2-3 times a day** in accordance with the nursing care of patients wearing anti-embolic stockings (AES guidelines, 2015)

5.2.6 Observe the skin for pressure damage caused by medical devices (e.g., catheters, oxygen tubing, ventilator tubing, splints, semi rigid cervical collar, and pulse oximeter probes)

5.2.6. Ask patients to identify any areas of discomfort or pain that could be attributed to pressure damage.

5.3. PRESSURE ULCER PREVENTION:

Practice Points:

- Not all support surfaces are compatible with every care setting and should therefore not be based solely on the perceived level of risk for pressure ulcer development or the category of any existing pressure ulcers, nursing staff should take into consideration factors such as the patient's level of mobility within the bed, his/her comfort, the need for microclimate control, and the place and circumstances of care provision.
- Support surface use in a home setting requires consideration of the weight of the bed, the structure of the home, the width of doors, the availability of uninterrupted electrical power, and the ability to promote ventilation of heat from the motor. Smoking on dynamic a mattress is contraindicated due to the risk of combustion, patients that smoke in bed it may be necessary to complete a risk assessment and prescribe an alternative non- powered system to ensure patient safety.
- Re-positioning should also take into consideration the patient's medical condition, their comfort and the overall plan of care.
- Repositioning frequency will be determined by the individual's risk /tissue tolerance, his/her level of activity and mobility, his/her general medical condition, the support surface in use, the overall treatment objectives, and assessments of the individual's skin condition. Repositioning contributes to the individual's comfort, dignity, and functional ability.
- Assess the patient's skin condition and general comfort. If the patient is not responding as expected to the repositioning regime, reconsider the frequency and method of repositioning.
- Avoid subjecting the skin to pressure and shear forces. Use transfer aids to reduce friction and shear. Do not drag the individual while repositioning and discourage the use of pushing up through the heels whilst repositioning in bed.
- Avoid positioning the patient onto bony prominences with existing non-blanching erythema.
- Repositioning in the bed should be undertaken using the 30-degree tilted side-lying position (alternately, right side, back, left side) or the prone position if the individual can tolerate this and her/his medical condition allows.
- Avoid postures that increase pressure, such as the 90-degree side-lying position, or the semi-recumbent position.
- If sitting in bed is necessary, avoid head-of-bed elevation and a slouched position that places pressure and shear on the sacrum and coccyx.

- Free float heels whilst in bed or sitting out with limbs elevated using appropriate offloading devices.
- Record repositioning regimes, specifying frequency and position adopted, and include an evaluation of the outcome of the repositioning regime.
- Ensure that an appropriate manual handling risk assessment is completed and the repositioning regime documented as appropriate.

Education and Training about the role of repositioning in pressure ulcer and the correct methods of repositioning and use of equipment prevention should be offered to all persons involved in the care of patients at risk of pressure ulcer development, including the patient and significant others (where possible and appropriate).

Outcome statements:

All patients and their carers/family where appropriate, will be informed of their increased risk to pressure damage

5.3.1. All patients should be assessed and provided with a suitable support surface according to their level of risk.

5.3.2. Re-positioning schedules will be agreed with the patient, recorded and established for each person at risk of pressure ulcers using the SKIN bundle, where implemented or an appropriate care plan.

5.3.3. Shear and friction damage will be minimised with correct use of manual handling devices and techniques.

5.3.4. After manoeuvring, slings and other parts of the handling equipment **will not** be left under the patient.

5.3.5. Water filled gloves, synthetic sheepskins or doughnut-type device **will not** be used as pressure relieving aids.

5.3.6. Patients or carers, who are willing and able, will be taught how to redistribute their weight.

5.3.7. Patients who are at elevated risk of pressure ulcers will restrict sitting time to less than 2 hours in a chair even with appropriate pressure relief.

5.3.8. Patients and carers will receive a full explanation and written information in the form of the Cardiff and Vale patient education leaflet on preventative measures to reduce the risk of pressure damage.

5.3.9 There should be clear documentation when a patient declines repositioning or appropriate support surfaces, following explanation and advice on the consequences. If cognitive impairment or mental capacity is questionable then mental capacity assessment should be considered.

5.4. PRESSURE REDISTRIBUTING DEVICES:

Practice Points:

- The positioning needs and support surface of all patients should be assessed and reviewed regularly.
- Re-positioning must still occur when individuals are on pressure redistributing devices and documented using the repositioning charts or SKIN bundle communication tool.

Outcome statements:

5.4.1 The patient will be provided with the appropriate support surface to correspond to their level of risk and will be in accordance with the UHB's Protocol for the Provision and Selection of Support Surfaces (Appendix 2).

5.4.2. Examine the appropriateness and functionality of the support surfaces on every encounter with the individual and verify that the support surface is being used within its functional life span, as indicated by the specific manufacturer's recommended test method (or other industry recognised test method).

5.4.3. All beds and dynamic mattresses will be delivered the same day if ordered before 15.00hrs by Medstrom (Acute Sector) depending on availability. Community equipment will be provided within 5 working days depending on availability.

5.4.4. All patients assessed as being vulnerable to pressure ulcers will be placed on an appropriate pressure redistributing surface/cushion/wedge or boots according to the mattress selection criteria (N.B this differs in the community setting - please see guidance relevant to your clinical area).

5.4.5. All patients undergoing surgery and assessed as being vulnerable will be placed on a high spec foam theatre mattress or other pressure re-distributing surface.

5.4.6. All patients with a category III / IV or unstageable pressure ulcer will be nursed on a Promat with Pump / Duo 2 dynamic mattress.

5.5. PRESSURE ULCER MANAGEMENT:

Practice Points:

- Pressure damage must be categorised using the European Pressure Ulcer Advisory Grading system (2014).
- Nursing Documentation will include the following in line with the UHB Wound Assessment Chart:
 - Any changes in skin integrity
 - Site of Pressure ulcer
 - Category of Pressure ulcer
 - Dimensions of area/ulcer
 - Presence of pain, odour, exudate and infection

Outcome statements

5.5.1. All patients with any level of pressure damage will have details of the damage recorded and an incident form completed on DATIX. This will include an accurate recording of the location of the patient when the damage was first noted stating where and when damage occurred. The records will be checked to ensure that a DATIX entry has already been completed to avoid duplication. If the pressure ulcer deteriorates a new incident form is required.

5.5.2. All category III /IV and unstageable pressure ulcers will be photographed by Medical Illustration / CNS Wound Healing in Primary care.

5.5.3. All patients with category III /IV and unstageable pressure ulcers will be referred to the appropriate Clinical Nurse Specialist in Wound Healing /Wound Specialist Podiatrist who will liaise with other Healthcare Professionals as required.

5.5.4. All patients with Unstageable, category III or IV pressure ulcers will be reported to Safeguarding as a VA1 with the exception of those under the care of Medicine Clinical Board and PCIC due to pilot. Health care acquired unstageable, grade III or IV pressure damage will also be investigated by a Senior Nurse using the All Wales RCA investigation tool.

5.5.5. Re-assessment of pressure ulcers will be performed at least weekly by a qualified nurse.

6. EDUCATION AND TRAINING:

All health care professionals will receive relevant training or education in pressure ulcer risk assessment and prevention, which will be structured, organised and comprehensive. Health care professionals with recognised training in pressure ulcer management will cascade their knowledge and skill to their colleagues. The implantation will be decided by each directorate. This forms part of the individual's overall professional development (Knowledge and Skills Framework 2004).

The Wound Healing Directorate has responsibility for training and educational programmes. The Learning, Education and Development Department will keep a record of staff that have undergone training and attended a study day.

There will be access to further departmental education as identified by audit or training needs analysis.

Patients who are vulnerable to or at an elevated risk of developing pressure ulcers and have capacity should be informed and educated about risk assessment, either verbally or with written information. Patient and Carers should be given Cardiff and Vale UHB Pressure Ulcer information leaflet.

7. RESPONSIBILITIES:

The Board

The Board is responsible for ensuring that adequate provision is made to facilitate the implementation and monitoring of this procedure.

The Executive Director of Nursing

The Executive Director of Nursing has delegated responsibility for ensuring the Clinical Boards have the appropriate arrangements in place for the effective implementation of this procedure.

Clinical Board Management Teams

Clinical Board Teams are responsible for ensuring that this procedure is implemented within their Clinical Boards and Directorates/Business Units. Where there are difficulties in the implementation of this procedure they will bring this to the attention of the Executive Director of Nursing or Clinical Board Directors of Nursing.

Directorate Management Teams/ Business Units

Each Directorate/Business unit has a responsibility to ensure that staff are adequately supported and provided with the training to implement this procedure.

Ward/Departmental Managers

Individual managers and practitioners have the responsibility to promote standards of care as recommended by the procedure. Ward/Departmental Managers are responsible for enforcing compliance with the procedure and escalating any problems to their Directorate and Clinical board management teams as appropriate.

Employees

All health care professionals are personally accountable for their practice. Registered nurses have the prime responsibility for ensuring that the care given to the patient is focused on the assessment, planning and evaluations of the patient's needs in relation to pressure damage prevention.

Role of Wound Healing Team

The Wound Healing Team will be responsible for

- Ensuring specialist advice in relation to pressure ulcer risk assessment, prevention and treatment is available through the preparation of relevant policies and procedures
- Planning, measuring, reviewing and auditing pressure ulcer prevalence
- Assessing and devising a management plan for all patients with Category III / IV and Unstoppable Pressure Ulcers
- Planning and delivering study days on pressure ulcer risk assessment, prevention and treatment.

8. RESOURCES:

Where many of the sections of the procedure are achievable within the existing resources, in order to facilitate multi-professional education and training there will be increased resource demands.

9. TRAINING:

Where it would be both impracticable and impossible to educate all staff in all aspects of care and management, as recommended by NICE (NICE 2005), it is recommended that members of the MDT have a basic level of knowledge in order to be NICE compliant (NICE 2005b) it is recommended that a basic level of knowledge related to the level of involvement of staff with patient care should be implemented.

This procedure represents existing practice within the UHB. Any costs associated with the implementation of this procedure will be met by the appropriate Corporate function or Divisions/Directorates as appropriate.

10. AUDIT:

The Wound Healing Directorate with the Preferred Supplier will undertake prevalence/ incidence audits to record accurate pressure damage data. The results of the audit will be used constructively to: -

- evaluate the effectiveness of prevention strategies
- evaluate the effectiveness of appropriate use of resources
- help to identify possible training and educational needs of staff
- identify any shortfalls in resources Utilise the Datix system to provide data to explore any opportunities for improvement in systems and process that support timely pressure ulcer prevention and management

In addition, the number of pressure ulcers will be recorded on the Health and Care Monitoring System (HCMS) monthly.

What audit requirements will there be for out of hospital care?

The number of hospital days between pressure damage will be recorded using the 1000lives Plus Safety Cross.

The findings of these audits will be reported to the Clinical Board/Directorate/Business unit Quality and Safety Groups as appropriate.

11. EQUALITY:

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan and Equality Objectives. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

We have undertaken an Equality Impact Assessment and received feedback on this procedure and the way it operates. We wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was little impact to the equality groups mentioned. Where appropriate we have taken or will make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

12. IMPLEMENTATION AND DISTRIBUTION:

All members of the Multi-disciplinary Team should be aware of the Procedure and, ideally, have had basic education in pressure ulcer risk assessment. The Procedure will be made available on UHB Intranet, clinical portal and internet site. Where staff do not have access to the Intranet their line manager must ensure that a copy of this procedure is accessible

13. REVIEW:

This procedure will be reviewed every 3 years or sooner if appropriate.

SKIN Bundle

Ascension Health in collaboration with the Institute for Healthcare Improvement developed the 'SKIN' bundle that is a synergistic group of interventions to assist in the prevention of pressure damage (Gibbons et al 2006).

The 'SKIN bundle' is a checklist of good practices for managing vulnerable patients, focusing on **S**urfaces, mattresses and cushions on which the patients lay or sit, the need to **K**eeP the patients turning or moving, the need to manage **I**ncontinence and **i**ncreased moisture, and the importance of **N**utrition and hydration in preventing pressure damage.

THE PROTOCOL FOR THE SELECTION AND PROVISION OF SUPPORT SURFACES:

Every individual patient is at risk from tissue damage and requires assessment within 6 hours of admission into the Health Care Setting. Purpose-T and the Glamorgan Risk Assessment Tool are used within the UHB. Risk assessment should be used as adjunct to clinical judgement and not as a tool in isolation from other clinical features.

The protocol is divided into two areas – prevention and treatment.

PREVENTION OF PRESSURE ULCERS:

- ◆ Patients will be nursed on a pressure redistributing mattress according to their individual risk using Purpose - T.
- ◆ Other pressure redistribution devices such as cushions/wedges and boots will also be provided according to their individual risk.

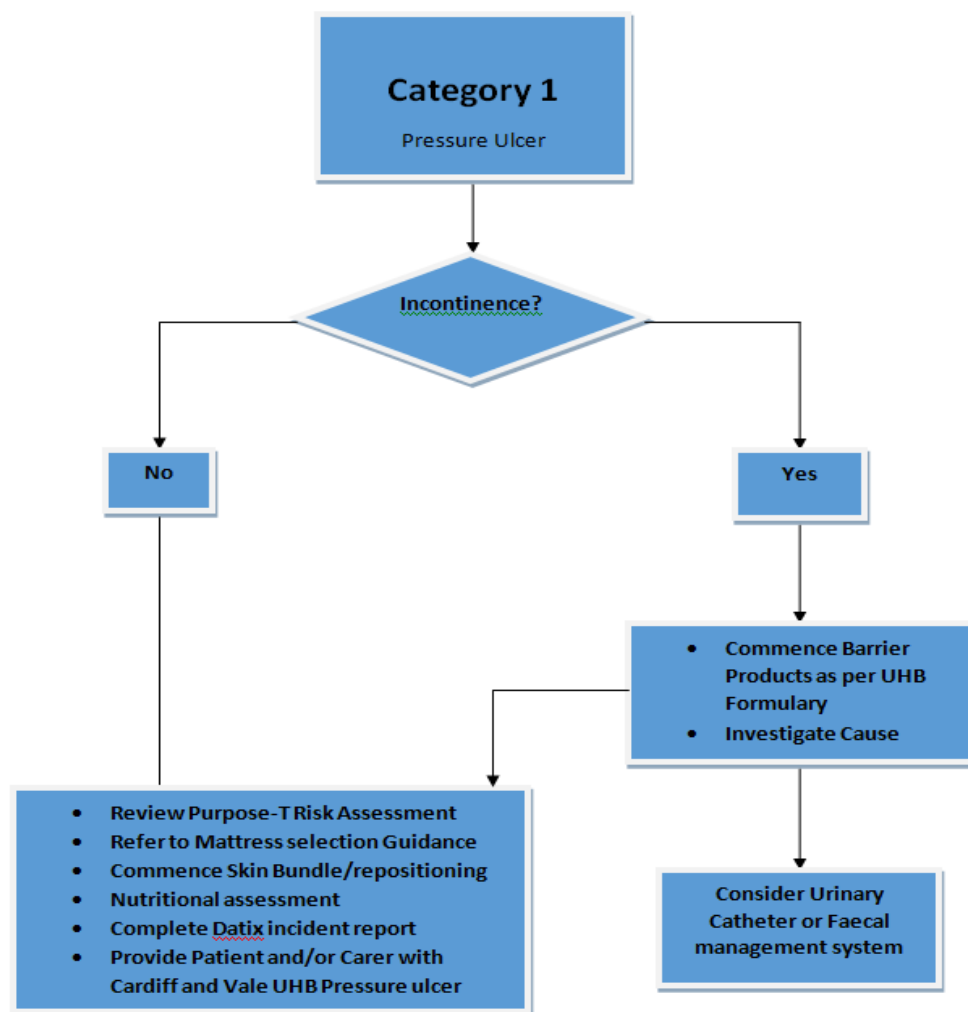
TREATMENT OF CATEGORY I AND II PRESSURE ULCERS:

- ◆ Patients with category I and II pressure damage will be nursed on an appropriate pressure redistribution device according to the mattress selection criteria.

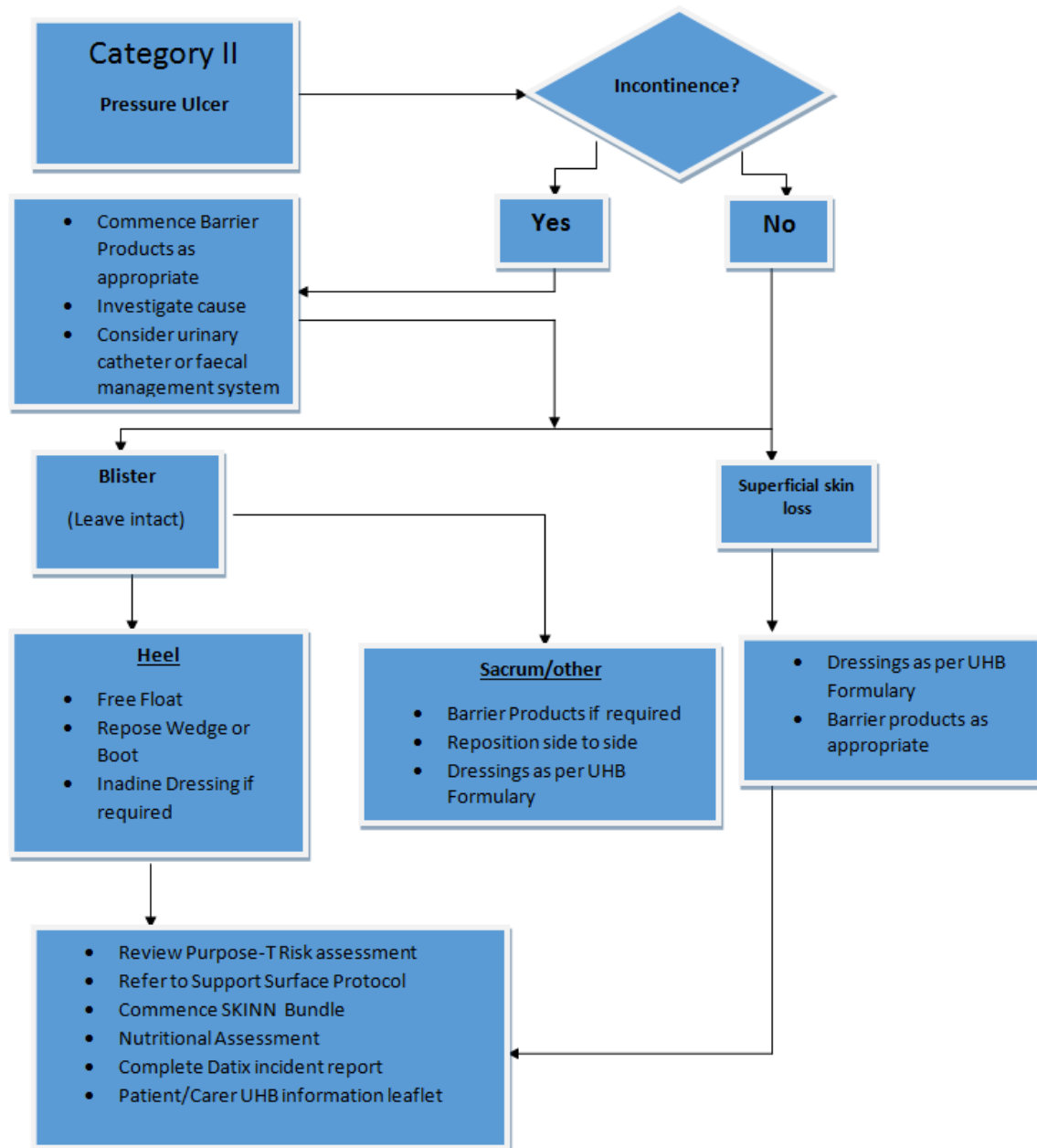
TREATMENT OF CATEGORY III AND IV PRESSURE ULCERS/ SDTI/ UNSTAGEABLE:

- ◆ Patients with category III /IV and unstageable pressure ulcers will be nursed on the appropriate dynamic redistribution device.

Appendix 1



Appendix 2



References

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