Lindsey Lodge Hospice

Pressure Area Management Policy

Contents

1.0 Purpose

- This document provides best available evidence, at the time of review, to guide clinical practice, with emphasis being placed on prevention of pressure ulcers.
- This guidance reflects the Hospice adoption of NICE Guidance 'the prevention and treatment of pressure ulcers' April 2014. In conjunction with EPUAP and NPUAP quick reference guide: Prevention and treatment of pressure ulcers.
- Pressure ulcers significantly reduce the quality of life of patients and increase the cost of care.
- The most notable feature of pressure ulcers is that most are preventable. It is up to the multi-disciplinary team to devise strategies for reducing the prevalence of pressure ulcers; to identify patients at risk; and implement effective strategies to reduce risk.
- Specialist advice and ongoing training is available from the Hospital tissue viability clinical nurse specialist.
- There are a variety of considerations and interventions that need to be taken into account in order to prevent and manage pressure ulcers.
- Treatment and care should take into account the patients individual needs and preferences. Recognition will be given to the patient's freedom of choice to accept or refuse advice or care and this must be documented following a full discussion.
- For those patients who are unable to give consent then a two stage test of capacity should be completed and decision and treatment given documented.

2.0 Area

- This guideline applies patients cared for within the Hospice, either within the In Patient or Day Care Unit.

3.0 Duties

- Registered nurses are responsible for undertaking initial and on-going risk assessment and planning, implementation and evaluation of care and delegation of care.
- Pre-Registration Student Nurses may be involved in the risk assessment, planning, implementation and evaluation of care under direct supervision of a registered nurse.
- Health Care Assistants may be involved in risk assessment and planning, implementation and evaluation of care at the discretion of the Senior Nurse and following appropriate training.

4.0 Risk Assessments

- The purpose of risk assessment is to identify actual and potential problems which then inform individualised planning and delivery of care in order to minimise the risk of development of pressure ulcers.

Identifying individuals vulnerable to or at elevated risk of pressure ulcers (In Patient Unit):

- Initial and on-going risk assessment is the responsibility of the multidisciplinary team and should only be carried out by health care professionals who have undergone appropriate training and who are aware of how to initiate formal assessment.

- The patient must be assessed using the Waterlow Score and then commence a pressure area management care plan.
- Initial skin inspection should usually take place within 6 hours of admission to the episode of care.
- Re-assessment should occur at least weekly or if there is a change in the patient's physical/mental condition or any change in the patient's care environment.
- All formal risk assessments should be documented and made accessible to all members of the multidisciplinary team.
- All patients that are identified as being at risk of developing pressure ulceration MUST be provided with an appropriate information leaflet.

Identifying individuals vulnerable to or at elevated risk of pressure ulcers (Day Care Unit)

- Initial and on-going risk assessment is the responsibility of the multidisciplinary team and should only be carried out by health care professionals who have undergone appropriate training and who are aware of how to initiate formal assessment. The patient must be assessed using the Waterlow Score and then commence a pressure area management care plan.
- Patients attending the Day Care Unit at Lindsey Lodge Hospice should have their Waterlow Score risk assessment completed on their first visit.
- Any patients who have any grade of pressure ulcer should be discussed with and reported to the District Nursing team, and documented on Systmone, for ongoing care and requisition of pressure relieving equipment should be considered.
- Re-assessment should be undertaken at least monthly or if there is any change in the patient's general condition
- Patients that are identified as being at risk of developing pressure ulceration MUST be provided with an appropriate information leaflet.

5.0 Risk Factors

List of risk factors are:

- Reduced mobility or immobility
- Sensory impairment
- Acute illness
- Reduced level of consciousness
- Extremes of age <5 or >70
- Previous history of pressure damage
- Vascular disease/poor tissue profusion
- Severe chronic or terminal illness
- Malnutrition/dehydration
- Pressure
- Friction
- Shearing
- Medication affecting healing
- Moisture to the skin
- Restlessness
- Poor skin condition

6.0 Prevention

Skin Assessment

It is important the skin assessment is a key feature of risk assessment as early detection of skin/tissue damage ensures that the appropriate plan of care is implemented thereby minimising of preventing further deterioration.

The existence of a Grade 1 pressure ulcer is a significant risk factor for the development of a more severe ulcer:

- SSKIN should be assessed within the Risk Assessment booklet and also documented after each episode of care within the SSKIN Bundle.
- Frequency should be bases on vulnerability and condition
- Examples of people vulnerable to pressure ulcers include those:
    - With reduced mobility or immobility
    - With sensory impairment
    - With acute illness
    - With reduced level of consciousness
    - With severe chronic or terminal illness
    - With malnutrition/dehydration
    - Undergoing surgery
    - Spinal/epidural analgesia
    - In critical care
    - With orthopaedic problems
    - With spinal injury
    - With diabetes
    - With peripheral vascular disease
    - With a history of pressure ulcers
    - At extremes of age
- Inspect all vulnerable area:
    - If anti-embolic stockings worn, heels should be checked at least daily.
- Encourage individuals (or their carers) to inspect the skin (using a mirror if necessary)
- Look for:
    - Persistent erythema
    - Non-blanching hyperaemia
    - Blisters
    - Localised heat
    - Localised induration
    - Purplish/bluish localised area
    - Localised coolness if tissue death occurs

All skin changes should be documented immediately.

- For those patients who have any grade of pressure ulcer upon initial assessment or within 72 hours of admission then this needs documenting in the pressure area record file.
- All Grade 2, 3,and 4 Pressure Ulceration must be recorded as a Clinical Incident and an Incident form completed.
- All Grade 3 and 4 pressure ulcers should be reported to the Senior Nurse for CQC notification and a **root cause analysis** to be completed.

Positioning

The need for relief of pressure to prevent the development of pressure ulceration is the basic principle and is achieved in a number of ways using a combination of repositioning and may include the provision of equipment to alter pressure intensity or duration:

- Frequency of repositioning will be determined by the patient's tissue tolerance, level of activity and mobility, general medical condition and overall treatment objectives, skin condition and support surface used.
- Consider mobilising, positioning, and repositioning interventions for all patients (including those in beds, chairs and wheelchair users) and include as part of the patients care plan. The repositioning regime must be documented in the patient's care plan.
- Individuals and/or carers, who are willing and able, should be taught how to redistribute weight.
- Acceptability to the patient and needs of the carer(s) should be considered
- All patients with pressure ulcers should actively mobilise, change their position or be repositioned
- The frequency of repositioning should be based on skin assessment not by a ritualistic schedule, however, according to NICE guidelines (2014)

  Those patients whose Waterlow score indicates high risk should change their position or be repositioned **at least** every 6 hours

  Those patients whose Waterlow score indicates a very high risk should change their position or be repositioned **at least** every 4 hours

  Those patient who are assessed as being at risk of, or who have developed pressure ulcers and are sitting in a chair should have an appropriate pressure relieving cushion and should relieve, or be assisted to relieve, their position **at least** every 2 hours.

- Minimise pressure on bony prominences and avoid positioning on vulnerable area/pressure ulcer if present.
- Consider whether sitting time should be restricted to less than two hours per session
- Seek specialist advice on aids and equipment and positions.
- Manual handling devices should be used correctly in order to minimise shear and friction damage.
- After manoeuvring, slings, sleeves or other parts of the handling equipment should be removed from underneath individuals unless specifically designed to be left insitu.
- Ensure that the Hospice Uniform Policy is adhered to i.e. no stoned rings, short nails therefore attempting to minimise risk of skin trauma

Pressure Relieving Devices

Choose pressure relieving devices on the basis of:

- Risk assessment (Waterlow Score)
- 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 (patients with spinal or pelvic fractures must be nursed of a high risk static foam mattress until fracture stabilised)
- Acceptability of carer/healthcare professional to reposition patient

- Patient weight
- Cost considerations
- Consider all surfaces used by patient
- Patients should have 24 hour access to pressure relieving devices and/or strategies
- Change pressure relieving device in response to altered level of risk, condition or needs
- All patients being nursed within the Inpatient Unit will be nursed on a profiling bed with a high risk pressure relieving mattress which has the ability transform to a dynamic alternating air system mattress or a bariatric bed with a mattress with an integrated air system.
- The following **MUST NOT** be used as pressure relieving devices:
    - Water filled gloves
    - Synthetic sheepskins
    - Doughnut type devices

    This list however is not exhaustive so please contact the Hospital Tissue Viability Team for advice if not familiar with requested pressure relieving devices.

Mattresses

Mattresses/support surfaces have two primary functions:

- To redistribute pressure in order to prevent formation of pressure ulcers
- To provide a comfortable surface for the patient

Support interface pressure is the measurement of pressure between the patient and the support surface. It is highest over bony prominences.

Pressure reducing equipment is based on the principle that the greater the surface area in contact with the support surface, the lower the interface pressure.

Pressure relieving equipment (alternating surfaces) change the interface pressure on the skin over a period of time by periodically deflating air cells under the body, thus redistributing the pressure on the soft tissue.

Ensure

- Mattress does not elevate patient to an unsafe height
- Patient is within the recommended weight range for the mattress
- Risk assessment for use of bed rails must comply with local policy

    Patients' who have capacity and to whom the risks and benefits of pressure area care and relief of pressure equipment have been explained and decline all or part of the care plan should sign an informed refusal form. It is expected that some negotiation takes place, for example if a patient does not wish to be woken during the night for pressure area care, it could be a reasonable suggestion that they receive pressure area care prior to going to sleep and then be woken in the morning to continue the management plan.

Nutrition

Provide nutritional support to patients with an identified deficiency

Decisions about nutrition support/supplementation should be based on:

- Nutritional assessment using MUST- Malnutritional Universal Screening Tool (MUST assessment see Hospice Nutritional Care policy)
- General health status
- Expert input (dietitian/specialists)

7.0 Assessment

Assessment of Pressure Ulcer

Assess

- Cause (i.e. Pressure, friction shear)
- Site/location
- Dimensions
- EPUAP grade (European Pressure Ulcer Advisory Panel – see definitions)
- Exudate amount and type
- Local signs of infection (i.e. pain, erythema, oedema, heat, purulence) (see Hospice antibiotic prescribing guidelines)
- Pain including cause, level, location and management interventions
- Wound appearance
- Surrounding skin
- Undermining/tracking, sinus or fistula
- Odour

Documentation

A Waterlow score assessment should be completed, any pressure ulcers should be recorded on the body map and a treatment/management plan devised. A SSKIN assessment should be completed and ongoing care should be documented within the SSKIN bundle.

Record

- Depth
- Dimensions
- EPUAP or grades
- Support the documentation with photography and/or tracings (calibrated by a ruler and appropriately labelled)
- Document ALL pressure ulcers graded 2 and above as a clinical incident
- Pressure ulcers should not be reverse graded

Reassessment

- Ensure initial and on-going pressure ulcer assessment is undertaken
- Reassess frequently (at least Weekly)

8.0 Treatment of Pressure Ulcer

Options

Choose dressing/topical agent or method of debridement or adjunct therapy based on:

- Ulcer assessment
- General skin assessment
- Treatment objective (i.e. debridement, formation of granulation tissue, epithelialisation)
- Characteristic of dressing/technique
- Previous positive effect of dressing/technique
- Manufacturers indications for use and contraindication
- Risk of adverse events
- Patient preference

Refer to local wound management guidelines and dressings formulary October 2011

Preventative measures

Consider preventative measures

- Positioning (see section 6.2)
- Self-care (see section 6.1)
- Pressure relieving devices (see section 6.3)+
- Nutrition (see section 6.5)
- Ensure that the Hospice dress policy for all staff and dress policy for all staff undertaking clinical duties are adhered to i.e. no rings, short nails minimising risk of skin trauma
- Correct number of carers to undertake safe and appropriate care
- Pain control

Optimum wound healing

Create an optimum wound healing environment using modern dressings for example:

- Film
- Hydrocolloids
- Hydrogels
- Foams
- Alginates
- Soft silicones
- Hydrofibres
- Consider antimicrobial therapy in the presence of systemic and/or local clinical signs of infection (wound care guidelines)
- Consider use of topical negative pressure therapy (see definitions) refer to Tissue Viability Nurse should this treatment be considered

Consider, following discussion with Consultant in charge of patient, a referral to a surgeon on the basis of:-

- Failure of previous conservative management interventions
- Level of risk (anaesthetic and surgical intervention, recurrence)
- Patient preference (lifestyle, abilities and comfort)
- Ulcer assessment

- General skin assessment
- General health status
- Competing care needs
- Assessment of psychological factors regarding the risk of recurrence
- Practitioners experience
- Previous positive effect of surgical techniques

9.0 Monitoring Compliance and Effectiveness

The efficacy of these guidelines will be kept under review and audits of compliance and effectiveness will be undertaken as necessary involving the Hospital's Tissue Viability Link nurse in conjunction with the senior nurses.

Pressure ulcer data will be collected and used in benchmarking against other Hospices within the Hospice UK group.

Compliance and monitoring by the Hospital Tissue Viability Link nurse, Senior Nurse and Community Tissue Viability Specialist Nurse will take place following investigation of incidents or as a result of any changes locally, regionally or nationally in policies that may affect the Pressure Area Management Guidelines. These will be fully discussed and implemented following discussion with the Senior Management Team.

The guidelines will be reviewed in conjunction with the Hospital Tissue Viability Clinical Nurse Specialist, Senior Nurses and Medical Staff at regular intervals in response to the needs of the Hospice.

10.0 References

National Institute For Clinical Excellence: The Prevention and treatment of pressure ulcers. September 2005

European Pressure Ulcer Advisory Panel (EPUAP) 1999 Pressure Ulcer Classification

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

NHS Institute for Innovation and Improvement – High impact Actions for Nursing and Midwifery 009

Hospice Nutritional Care Policy

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust Guidelines for Infection Control in Wound Care 10/08/2012

Hospice Consent to Treatment Policy

Hospice Moving Bariatric Patients Policy

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust Manual Handling Policy (Minimal Lift) 1/6/2012

Hospice Safe Use of Bed Rails (Adult Patients)

11 Definitions

European Pressure Ulcer Advisory Panel & National Pressure Ulcer Advisory Panel 2009

Pressure Ulcer Definition

A pressure ulcer is 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 factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

GRADE 1: Non-blanchable erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching: its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to the adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones and may indicate "at risk" persons.

GRADE II: Partial thickness

Partial thickness loss of dermis presenting as a shallow open ulcer with a re pink wound bed, without slough. May also present as an intact or open/ruptured serum filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

Bruising * indicates deep tissue injury.

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

GRADE IV: Full thickness tissue loss:

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

Full thickness skin or tissue loss – depth unknown

Full thickness tissue loss in which the depth of the ulcer is completely obscured 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 are removed to expose the base of the wound, the true depth cannot be determined.

These lesions are to be assessed as Grade 4 pressure ulcers.

Erythema – redness of the skin

Fascia – A sheath of connective tissue enclosing muscle and other organs.

Hyperaemia – Persistant redness of the skin which may be blanching (goes white on the application of fingertip pressure) or non-blanching.

Necrosis/Necrotic Tissue – Dead tissue. Tissue death of individual cells, groups of cells or localised areas of tissue.

Subcutaneous Tissue – beneath the skin.

Topical Negative Pressure – Non-pharmalogical therapeutic tool which actively modifies the wound healing process by delivering negative (sub-atmospheric) pressure either intermittently or continuously to an open wound. It applies negative pressure to the wound bed and adjacent tissue.

Additional Criteria for Wound Infection

- Abscess
- Cellulitis
- Discharge
- Delayed healing
- Discolouration
- Friable, bleeding granulation tissue
- Unexpected pain/tenderness
- Pocketing/bridging at base of wound
- Abnormal colour
- Wound breakdown

Reverse Grading – reverse grading should not be used when describing a pressure ulcer. A grade 4 pressure ulcer does not become a grade 3 pressure ulcer as it heals. The healing pressure ulcer should be described as a healing grade 4 pressure ulcer.

Moisture Lesions
Moisture lesions, moisture ulcers and incontinence associated dermatitis all refer to skin damage caused by excessive moisture. Due to the location of moisture lesions there is often confusion between pressure ulceration and moisture lesions

Avoidable Pressure Ulcers – '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 are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.'

Unavoidable Pressure Ulcers – '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 are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the

interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence.'

12.0 Consultation

This policy has been circulated to the Hospice Clinical Leaders Group and Quality Assurance Group.

13.0 Dissemination

This policy will be published on the L drive at Lindsey Lodge Hospice. and clinical staff will be made aware of its existence at Induction and at Mandatory training.

14.0 Implementation

Training is available for all existing and new staff, additional training will be provided where required.

REFERENCES:				
Lead Author of Policy; Karen Wright **Responsible Sub-group Quality Assurance** **RATIFICATION DATE BY TRUSTEES 13th April 2017** Review interval 3 years				
To Be reviewed	Review completed	By	Approved By	Circulation
April 2020				

Appendix A

Moisture Lesions

Moisture lesions, moisture ulcers and incontinence associated dermatitis all refer to skin damage caused by excessive moisture. Due to the location of moisture lesions there is often confusion between pressure ulcers and moisture lesions.

There is a clear link between incontinence and the formation of pressure ulceration. It is important that healthcare professionals have the necessary knowledge to differentiate between pressure ulceration and moisture lesions.

Healthcare professionals must be aware that if moisture lesions are not managed appropriately they are likely to worsen and develop secondary pressure ulceration.

	Likely to be a pressure ulcer	**Likely to be a moisture lesion**
Causes	Pressure and/or shear present	Moisture present – urine, faeces, sweat, wound exudate
Location	Tends to be over bony prominence	Lesion limited to natal cleft Not over bony prominence Peri-anal erythema and skin irritation
Shape	Limited to one spot Circular or regular shape, with exception of friction damage caused by dragging	Diffuse – different superficial spots in a 'kissing' shape, at least one caused by moisture
Depth	Partial thickness skin loss – top layer of skin Full thickness skin loss	Superficial, partial thickness skin loss
Necrosis	May be present	No necrosis in moisture lesion
Edges	Distinct	Irregular
Colour	Red skin: non-blanching	Erythema

Appendix B

Full Patient Name Date of Birth NHS Number

Informed Refusal Form For Patients With Capacity

Problem/Condition
Advantages and Disadvantages of the Treatment/equipment/regime
Risks associated with non-concordance
Agreed Alternative

By signing this document, I acknowledge that My Health Professional (name and designation)……. has made the recommendations as stated above, and that they have explained to me the potential benefits and the probable risks of not following the recommendations, which I fully understand.

Therefore, I have made an informed decision and refused consent for this treatment regime at this time, however, I understand that I can discuss the treatment at any time in the future with my Health Professional.

Time	Date	Signature of patient or authorised individual	Relationship of authorised individual
Witnessed by			
Time	Date	Staff Member	Job Title