Pressure Ulcer Prevention, Detection and Management Policy

Classification:	Policy
Authors Name:	
Authors Job Title:	Associate Chief Nurse, Tissue Viability Nurse
Authors Division:	Corporate Nursing
Departments/Group this Document applies to:	All Clinical Areas Nursing and Midwives All Doctors Allied Health Professionals

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Guideline to be followed by (target staff): All Clinical Areas/All Staff

To be read in conjunction with the following documents:

Patient Safety Incident Reporting policy ORG/182
Patient Safety Incident Plan ORG/181
Safeguarding Adults Policy ORG/GL/51
Wound care Guideline and Formulary NURS/GL/37
Moving and Handling Policy
Falls Policy https://intranet.mkuh.nhs.uk/safeguarding-and-quality/falls
Milton Keynes University Hospital Incident reporting Policy and Procedure RM/GL/17
Tissue Viability Site MKUH - https://intranet.mkuh.nhs.uk/safeguarding-and-quality/tissue-viability

CQC Fundamental standards:

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

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other

healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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1.0. Policy Statement

Milton Keynes University Hospital NHS Foundation Trust is committed to providing consistent evidence-based quality care in the prevention, treatment, and management of pressure ulcers for all patients. This will incorporate a holistic assessment and demonstrate patient/carer involvement in the care provided.
This policy aims to provide staff within Milton Keynes University Hospital NHS Foundation Trust with the standards, requirements and processes for effective pressure ulcer prevention and management. This policy also describes the accountability framework for Pressure Ulcer Prevention and Management.

2.0. Introduction

A pressure ulcer is a localised damage to the skin and/or to underlying tissue, usually over a bony prominence (or related to medical or other devices) resulting from sustained pressure (including pressure associated with a mechanical force of shear). The damage can present as intact skin or

an open ulcer and may be painful (EPUAP2019). Pressure damage is common in many health settings, affecting all age groups, and is costly in both terms of patient experience, outcomes and resources. Most pressure damage could be prevented, and it is important to have prevention and educational strategies in place based on the best available evidence.

3.0. Aims and Objectives

- To reduce the number of preventable pressure ulcers at MKUH.
- To ensure that all staff are trained to risk assess patients and implement timely prevention measures.
- To provide consistent, individualised, high-quality care in pressure ulcer prevention and management for all patients/clients of Milton Keynes University Hospital (MKUH) NHS Foundation Trust.
- To provide evidence-based guidance on pressure ulcer prevention and management.
- To implement effective pressure ulcer prevention measures, monitor the incidence of pressure ulcers, and ensure proactive actions towards the aims of the policy.

4.0. Scope of the Document

This policy applies to all employed clinical staff, qualified and unqualified, bank and agency staff required to work in clinical areas. This includes but is not limited to medical staff, nurses, allied healthcare professionals (AHP) and healthcare assistants/ Maternity Care Assistants (HCA/MCA). This policy is intended for use predominantly in adult in-patient services and guides other patient areas covered by the Trust. However, it may also be relevant for all other in-patient services and the need for a pressure ulcer risk assessment will be determined by the physical assessment on admission.

5.0. Definitions/Abbreviations

Definitions

Staff: All employees of the Trust including those managed by a third party organization on behalf of the trust.

The Trust: The Milton Keynes University Hospital.

Pressure ulcer: Localised injury to the skin and or underlying tissue, usually over a bony prominence and as a result of pressure, or pressure in combination with shear.

New Hospital-acquired Pressure Ulcer: A new pressure ulcer is damage that occurs whilst the patient receives care from the Trust as an inpatient and is identified post 6 hours of first point of care within the trust.

Present on Admission Pressure Ulcer: A present on admission pressure ulcer is damage identified within 6 hours of first point of care and deemed as developed prior to admission to trust.

Abbreviations

- **TVN** Tissue Viability Nurse
- **RN** Registered Nurse

- **RM** Registered midwife
- **AHP** Allied Health Professionals
- **PU** Pressure ulcers
- **POA** Present on admission
- **ToR** Terms of Reference
- **MASD** Moisture Associated Skin Damage

6.0. Roles and Responsibilities:

6.1. Chief Nurse

- Executive Lead and has overall responsibility for the development, dissemination, and implementation of this policy. The Chief nurse will delegate responsibility to the Deputy Chief Nurse.

6.2. Deputy Chief Nurse

The Deputy Chief Nurse is responsible for:

- Ensuring the Trust meets the Regional and National agendas by implementing and upholding this policy.
- Ensuring arrangements are in place to achieve the policy aims and objectives.
- Ensuring Pressure ulcer reduction strategies maintain a high profile at the board and senior nursing level.
- Implementing this policy across the Trust and ensuring it is integrated into all clinical areas. This includes monitoring compliance and evaluating the effectiveness of this policy.
- Providing leadership support and day-to-day management for preventing and managing pressure ulcers within the Trust.
- Ensuring Trust Boards and Committees receive regular information and reports to inform decision-making and to provide assurance that this policy is effective.

6.3. Consultant Nurse/Lead Nurse for Tissue Viability

The Consultant Nurse/ Lead Nurse for Tissue Viability is responsible for:

- Developing, leading, and managing the MKUH Pressure Ulcer Care and Prevention Pathway.
- Monitoring all reports of pressure ulcers within the trust and implementing the necessary safeguarding measures where required, alongside the Tissue Viability Team
- Developing strategies and policies for preventing, managing, and treating pressure ulcers.
- Providing expert advice regarding pressure ulcer prevention, management and treatment.
- Having oversight of review processes for all hospital-acquired pressure ulcers in line with the Patient Safety Incident Reporting Framework (PSIRF)
- Identifying and analysing themes and trends of new hospital-acquired pressure ulcers and planning appropriate actions/strategies to prevent future harm.
- Developing, implementing, and maintaining a robust system with a clear audit trail for validating and recording pressure ulcer data.

- Maintaining and monitoring a pressure ulcer tracker, liaising with ward and department leads to ensure that actions are evidenced to ensure learning from incidents.
- Supporting the review process of pressure ulcers as part of the Care Review and Learning Panel.
- Working with local community providers and ICBs to ensure learning is shared and good working relationships are maintained in the interests of the patient.
- The Consultant Lead Nurse may delegate to the Tissue Viability Nurses as appropriate.

6.4. Divisional Chief Nurse/Midwife

The Divisional Chief Nurse/Midwife is responsible for:

- Implementing this policy in their division.
- Overseeing all pressure ulcer-related incidents and organising monthly divisional review and learning meetings.
- Developing and monitoring divisional action plans based on the Care Review and Learning panel feedback and after-action reviews.
- Conducting spot-check pressure ulcer care and prevention audits on high-reporting areas as required.
- Reviewing and approving investigations and reports such as complaints and safeguarding referrals associated with pressure ulcers within the set timescales.
- Ensuring the necessary management arrangements and structures are in place to support staff in fulfilling their pressure ulcer prevention, management, and treatment obligation.

6.5. Matrons/ Senior Matrons

The Matron/Senior Matron is responsible for:

- Ensuring all staff follow this policy and the procedural guidelines outlined below.
- Ensuring all staff are current in their knowledge and understanding of preventing and managing pressure ulcers, addressing any education and training needs identified.
- Ensuring all staff practicing within their clinical areas know the requirement to report all pressure ulcer-related incidents.
- Ensuring that their clinical areas undertake and review the findings from the pressure ulcer prevention and management audits.
- Investigating new hospital-acquired pressure ulcer-related incidents, disseminate learning from investigations and ensuring that the appropriate changes are made and embedded in clinical practice.
- Ensuring joint reviews are completed for New Hospital Acquired Pressure Ulcers and improvement actions are initiated within the time frame given time and present learning at the monthly Care Review and Learn Panel.
- Ensuring if a patient is admitted with a pressure ulcer and there are safeguarding concerns, a referral is made to social care for safeguarding purposes.

6.6. Ward Managers

The Ward Manager is responsible for:

- Acting as the clinical lead for tissue viability matters within wards/teams.
- Ensuring that robust systems are in place to report and monitor the quality of response and action to pressure ulcer incidents in their clinical areas.
- Identifying, acknowledging, and reporting the incidence of pressure damage in their clinical area and implement effective strategies to address and improve the issue.
- Participating in and, where appropriate, leading on specific after-action reviews related to pressure ulcers.
- Ensuring mechanisms are in place for pressure ulcer prevention and management audits to be completed and findings shared with their clinical team.
- Ensuring systems are in place to support the ongoing staff training in preventing and managing pressure ulcers.
- Ensuring all staff maintain and update their knowledge, skills and competence in line with their roles and responsibilities to care for patients at risk of pressure damage to deliver consistently high standards of care based on the best available evidence.
- Ensuring that all staff regularly update their knowledge, skills, and competence by their roles and responsibilities in caring for patients who may be at risk of pressure damage.
- Ensuring staff complete appropriate risk assessments, document planned care and care provision within the stipulated timescale and in the appropriate sections of the patients notes.
- Ensuring pressure redistributing footwear, cushions, and mattresses are readily available and utilised as per the patients' risk assessment and skin inspection.
- Ensuring staff reassess and review various pressure ulcer-related assessments within designated timeframes.
- Ensuring that all pressure ulcers New Hospital Acquired and Present on Admission (POA), are reported via the trust's incident reporting system, and this report is accurate in terms of location, aetiology and severity.
- Reviewing all new hospital-acquired pressure damage developed within the care setting (after 6 hours of first point of care provision) and identify learning outcomes and best practices as required.
- Ensuring any actions from investigations are identified and disseminated to all staff to achieve and maintain learning and quality improvement.
- Seeking tissue viability advice and support for educational assistance where required.
- Utilising audit and other data provided to engage in quality improvement activities to reduce pressure ulcer incidence acquired whilst under their care.
- Ensuring local quality improvement and assurance activity is displayed within clinical areas.

6.7. Registered Nurses, Midwives and Nursing Associates

Registered Practitioners are responsible for:

- Undertaking Holistic Risk Assessment of the individual patient
- Identifying patients at risk and undertake risk assessments using the Trusts validated Pressure Ulcer Risk Assessment Tool (Appendix 1) and clinical judgment. Assessing the skin integrity of the patients under their care within 6 hours of admission, transfer and/or a change in their clinical condition to prevent and manage skin damage.
- Liaising with the patient's relatives and family and the multidisciplinary team to formulate strategies and interventions to reduce the risk of tissue damage.
- Ensuring that multidisciplinary patient-focused care plans are in place and interventions are recorded and dated in line with the Trust Record Keeping policy.

- Ordering appropriate pressure relieving equipment in accordance with trust guidance (Appendix 8) and risk assessment.
- Liaising with the patient, their relatives or carers and health and social care professionals regarding preventative strategies.
- Recording incidence of patients who are admitted with pressure ulceration or develop new pressure ulceration during an episode of care by documenting in patients notes and completing a Trust Incident Report.
- Ensuring clinical photograph is obtained of any skin damage and uploaded to the patients notes using appropriate trust devices and apps.
- Devising, documenting, and implementing a care plan to prevent pressure ulcers for patients assessed as at risk and evaluate the effectiveness of this care plan as laid out in this policy.
- Assessing and documenting patient wounds, devising and implementing a care plan based on best practice, and evaluating the effectiveness of interventions.
- Direct provision of care or indirect provision of care by supervising healthcare support workers.
- Referring patients to the Tissue Viability team where the patient's needs are complex, or the level of knowledge/skill within the immediate ward nursing team prohibits effective care delivery.
- Following the care plan developed with the tissue viability team during the referral and consultation process.
- Maintaining their knowledge and competence in caring for patients at risk of developing pressure ulcers and accessing training, assessment and updates on pressure ulcer prevention and management as required.
- Being competent in using all pressure redistributing equipment, including correctly using a profiling bed/mattress to reduce the risk of pressure damage.
- Ensuring pressure redistributing footwear, cushions, and mattresses are readily available and utilised as per the patients' risk assessment and skin inspection.
- Ensuring that when delegating care to Health Care Assistants, they ensure that Health Care Assistants understand this policy and implications for their practice.
- Reporting safeguarding concerns to the Ward Manager, Matron and Trust Safeguarding Team.
- Seek the advice of the Tissue Viability Service where appropriate whilst maintaining the ongoing responsibility for the patient's episode of care.

6.8. Healthcare Support Workers (HCAs)

The Healthcare Support Workers are responsible for:

- Support the patient to maintain their skin integrity.
- Document in a timely manner any pressure ulcer prevention or management measures (i.e continence care, repositioning, offloading) they undertake during all patient interactions on the daily pressure ulcer prevention plan.
- Inform the Registered Nurse looking after the patient of any concerns they may have that might affect the pressure areas care provision. For example, observation of any skin changes documentation, a change in the patient's ability to comply with repositioning, a problem with the equipment etc.

- Ensure they are up to date with their knowledge regarding the prevention and management of pressure ulcers, discussing any education and training needs identified with their line managers.

6.9. The Tissue Viability Team

The Tissue Viability Team is responsible for:

- Acting as expert advisors to the Chief Nurse and the associated corporate and clinical teams.
- Providing clinical leadership and support managers and clinical staff in implementing this policy.
- Updating local policies, guidelines, and procedures in accordance with national and international guidance.
- Ensuring they remain updated with the latest clinical evidence and National and International guidelines on the prevention, management, and treatment of pressure ulcers.
- Providing education and training for staff on pressure ulcer prevention and management in a variety of formats, across settings.
- Providing specialist tissue viability clinical advice, joint assessments and treatment plans when required to support staff and patients where standard interventions have failed to initiate an improvement.
- Ensuring all patient referrals to the Tissue Viability service are actioned within 24-48hrs
- Providing input into the evaluation and purchase of pressure-relieving equipment and associated contracts.
- Maintaining and updating the Tissue Viability intranet page.
- Overseeing the Trusts total bed management contract to ensure the equipment and service is fit for purpose and meets the patient and organization needs.
- Supporting managers/teams with investigations into the development of pressure ulcers.
- Conducting Joint reviews of Cat 3 and 4 Pressure ulcers.
- Participating /supporting After Action Reviews and Care Review and Learning Panel discussions.
- Maintaining and supporting an active tissue viability link practitioner network
- Providing evidence-based expert advice, education, and support to clinical staff.
- Monitoring and validating all new hospital-acquired Pus Category 2 and above across the trust.
- Supporting an active tissue viability champion network.
- Monitoring themes and trends from After action Review analysis of New Hospital Acquired Pressure Ulcers and plan appropriate actions. This will include education strategies to support learning from incidents to prevent future harm to patients.
- Maintaining pressure ulcer tracker.
- Participating in pressure ulcer prevention and management audits.

6.10. Doctors and Allied Health Professionals

The doctors and Allied Health Professionals are responsible for:

- Support the patient to maintain their skin integrity.
- Document any repositioning they may do during all patient interactions on the daily pressure ulcer prevention care plan/repositioning chart.

- Document any skin damage identified during any physical examination of the patient and ensure nursing staff are made aware.
- Inform the nurse looking after the patient of any concerns they may have regarding the patient's skin condition and ability to maintain their pressure areas.
- Ensure they are up to date with their knowledge regarding the prevention and management of pressure ulcers, discussing any education and training needs identified with their line manager.

6.11. The Harm Prevention Group

The Harm Prevention Group is responsible for:

- Ensuring the Trust achieves all local and national performance targets set for the reduction of hospital acquired pressure ulcers.
- Ensuring the pressure ulcer reduction plan remains a high priority on the quality agenda.
- Monitoring pressure ulcer incidence data against internal and external targets and benchmark the Trust's performance.
- Monitoring ward/division compliance with processes and policies via monthly ward reports.
- Reviewing themes and trends for new hospital acquired pressure ulcers.
- Providing assurance to the Trust that there is a process of continued improvement and shared learning.
- Providing timely and proactive support to appropriate staff groups to ensure a reduction in avoidable pressure ulcers by sharing learning from incidents to prevent future harm.

7.0. Implementation and dissemination of the document

This guideline will be maintained on the Clinical tools of the Trust's Intranet under Nursing. The policy will be shared as a reference through training and disseminated within Trust's clinical forums.
The guidance will also be accessible via the Quality page of the Trust intranet and supporting documentation can be located by searching 'Tissue Viability.'

8.0. Procedure for the pressure ulcer prevention and management

Preventing pressure ulcers requires a systematic plan that considers the patient's circumstances. This involves assessing their risk, conducting regular skin assessments, providing appropriate skin care, ensuring they have a suitable surface to lie on, encouraging movement, managing incontinence and moisture, ensuring proper nutrition and hydration, and providing information and assistance when needed.
The 'aSSKINg' framework (NHS Improvement 2018), (assess risk; skin assessment and skin care; surface; keep moving; incontinence and moisture; nutrition and hydration; and giving information or getting help) ensures all essential aspects of pressure ulcer prevention are included in patient care. The process for managing pressure ulcer prevention using the aSSKINg framework is described below.

8.1. A – ASSESSMENT OF RISK

- Early identification of the risk of pressure ulcer development is essential. It is required to allow for appropriate planning of prevention and management measures.
- Risk assessment should only be carried out by registered practitioners who have undergone appropriate and adequate training in pressure area management.

- Pre-registration learners may perform a risk assessment under supervision. It remains the responsibility of the trained nurse to validate and countersign the assessment and implement the appropriate intervention. If knowledge and expertise have been acquired, risk assessment may also be carried out by Allied Healthcare Professionals (AHP).

Risk assessment should include the validated formal risk assessment, Skin inspection and clinical judgment.

- In the Emergency Department a formal pressure ulcer risk assessment should be carried out within four hours of attendance to the department.
- Pressure ulcer risk assessment should be completed using the trusts validated risk assessment tool to support clinical judgment. This tool identifies the patient's risk of developing pressure ulcers and ensures appropriate care and interventions can be implemented. All patients admitted for inpatient treatment will have a formal pressure ulcer risk assessment performed regardless of diagnosis or current condition**.**
- The timing of the risk assessment procedure should be based on the individual and their condition. However, in all instances, **it must be carried out within six hours of admission of admission and within six hours of transfer to any other inpatient clinical area.** The validated formal risk assessment must be completed and documented within the clinical notes. (Appendix 1).
- Reassessment of patients must be completed every 7 days, after a surgical or interventional procedure, a change in the patients clinical condition (improvement or deterioration), or after a change in their care environment following a transfer.
- If a person is identified as being at risk, it is the healthcare professional's duty to ensure that preventative measures are implemented and sustained. The earliest phase of pressure ulcer development may show no outward visible signs of damage. It is therefore essential that individuals at risk are given an immediate prevention plan.
- Any patient assessed as clinically at risk or with tissue damage on admission, is to be commenced on the MKUH Pressure Ulcer Prevention care plan. (Appendix 5).
- Please see Risk assessment flow chart – see Appendix 2 for further guidance.

8.2. S – SKIN ASSESSMENT

Skin assessment is an essential part of a patient's risk assessment and care provision. A risk assessment cannot be completed without an appropriate skin evaluation.
Visual skin changes are the best indicator for identifying early pressure damage (AWTVNF, 2017). Discomfort and pain are also useful predictors to skin and tissue damage (Hall & Guyton, 2010; NPUAP et al, 2014). However, some individuals are unable to feel discomfort or communicate these symptoms, so pain and discomfort should not be relied upon as indicators or predictors of tissue damage.

- Conduct a skin assessment by a trained healthcare professional within 6 hours of first point of care and on transfer to another clinical area.
- Use finger palpation to determine whether erythema or discoloration is blanchable
- Skin assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for:
    - Skin integrity in areas of pressure
    - Colour changes or discoloration (non- blanching erythema may present as colour changes or discoloration particularly in darker skin tones or types)
    - Variation in heat, firmness and moisture

Red flag' risk factors are:

- Skin over a bony prominence that is hot, discoloured and swollen or the patient complains of new onset or change / increase in pain or numbness, and this does not resolve when the patient is repositioned.
- An existing pressure ulcer or scar from a pressure ulcer or other wound in an at-risk area.
- The individual has had a long lie (fall and being on the floor) of more than 1 hour.
- Rapid deterioration in the clinical condition of the patient.
- There is a medical device in prolonged contact with the skin.
- Appropriate preventative action dependent on skin assessment findings should be commenced.
- **Reassessment of skin should occur at least every 8 – 12 hours** – this should be increased for patients at higher risk or who have been identified as having Category 1 pressure damage until resolved.
- Where possible also assess patients' skin and pressure areas during repositioning or other activities (such as toileting, blood pressure monitoring, washing and dressing etc)
- Non-registered healthcare providers should escalate any changes in skin condition immediately to the RN/RM

It may not always be feasible or possible to complete a full skin assessment. In this instance, the reason why a skin assessment is not performed will be documented. Where possible the patient/carer/parent will be asked appropriate questions, and the response will inform future management planning.

Staff should be vigilant when assessing darkly pigmented skin. Visual signs of damage may be difficult to see. For support reviewing darker skin tones see.

Wounds UK (2021) *Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones*. Wounds UK, London.
Available to download from: www.wounds-uk.com

- All skin assessments and findings must be documented at time of identification using the appropriate wound care / pressure ulcer assessments.
- Use Top-to-Toe skin assessment tool on eCare as best practice.
- On each occasion an assessment is made, the documentation must be updated and validated by a registered nurse and documented on the Skin Assessment tool (Appendix 4)

Please see Appendix 3 for most vulnerable Pressure Area Locations

8.2.1. Digital Imaging

Any patient with identified skin damage should be photographed when identified or as soon as feasibly able.

Before taking the photograph, the healthcare professional should:

- Obtain consent and document.
- Carry out a mental capacity assessment if indicated.
- Use appropriate PPE and aseptic techniques.
- Ensure identifiable features are excluded.

- Expose only the area that is to be photographed.
- Ensure the wound has been cleansed.
- Use a sterile paper rule where possible.
- Use the appropriate app, upload to the correct patient record, and then remove from the device as appropriate.
- Patient confidentiality must be always protected, and the patient should not be identifiable.
- When taking photos of intimate areas – protect patients' modesty as much as possible, covering areas that do not require reviewing.
- Photographs should not be sent/uploaded/downloaded to any other site.
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8.2.2. Medical Devices and pressure ulcers

Medical Device related pressure damage can occur when devices have prolonged contact with the skin. This can be on a non-bony prominence and likely to take the shape of the device. Extra care should be taken to check under devices and avoid positioning onto them. Think Right device - there are different devices with different properties. Use the device most appropriate for the requirement.

- Think Right fit? – most devices are available in different sizes and fit. Consider the need for refitting each time the skin is checked.
- Assess – skin under the device every 6- 8 hours, check for redness, inflammation of indentation. Consider the need for dressings or pressure ulcer redistribution aids underneath the device to protect the skin.

8.2.3. Definitions and Classification of Pressure Ulcers

All areas within the Trust will use the 1-4 point pressure ulcer categorisation as outlined in Appendix 15

- Reverse grading should not be used when describing a pressure ulcer. A pressure ulcer retains its worst category of healing. A Category 4 pressure ulcer should therefore be referred to as a resolving Category 4 ulcer as it is healing and a healed Category 4 ulcer when healed.

- Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as "At least" Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration.

- Suspected Deep tissue injuries (SDTIs) should be reported on the trust incident reporting system. The skin change must be recorded within the clinical record and appropriate preventative care delivered as soon as the damage is noted. SDTIs will be reviewed to identify if they elvolve or resolve post implementation of care provision. Categorisation of the SDTI will occur if the pressure ulcer evolves.

8.4. S – SELECTION OF SUPPORT SURFACE

The selection of appropriate support surfaces for pressure relief should be based on a holistic assessment of the individual and not solely on the individual's risk score.

Risk assessment scales are only an aide memoire and should not replace the nurse's clinical judgment.

Factors that influence the choice of support surface should include:

- Risk status
- Comfort
- General condition
- Patient's weight
- Degree of pressure damage
- Patients ability to transfer
- Patient's ability to tolerate a moving surface.
- Availability

Mattress Selection Pathway should be followed based on the risk assessment.
(See Appendix 7 for Mattress Selection Pathway)

If required, further guidance may be sought from:

- Tissue Viability Department
- Service providers' Nurse Advisor
- Bed service Providers – 24-hour helpline

As with risk assessment, it is essential that product selection remains a dynamic process and a review of the support surface should be performed simultaneously with daily risk assessment. Support surfaces should reflect the individual's clinical need and risk status; changes should be made in partnership with staff and patients if appropriate.

All staff that cares for individuals placed on a dynamic support surface must ensure that they are confident in operating the appliance. Attention must be apportioned to:

- CPR (Cardiac Pulmonary Resuscitation) mode
- Basic functions & settings
- Alarms

Any specific product not included in the Service Providers' product range that may be required, may be obtained through an external company. The provision of these products must be authorised by the Tissue Viability Department.

The benefit of pressure-relieving support surfaces should not be undermined by prolonged chair sitting. Appropriate seating arrangements should be made by referral to Physiotherapy and Occupational Therapy who will support with appropriate advice and/or seating aids.

The following **should not** be used as pressure-relieving aids:

Doughnut-type devices – These products are believed to adversely affect lymphatic drainage and circulation which cause rather than prevent ulceration.
Water Filled Gloves – Impossible to redistribute pressure by this localised method.
Sheepskins – sheepskins may be comfortable, however, they neither relieve nor reduce pressure.
Pillows – Hospital pillows have no pressure-reducing qualities and pillows should never be used for this purpose. They can however be used to facilitate positioning such as the 30' tilt.

8.4.1. Managing patients in the Operating Theatre

- NICE identify patients who may be at elevated risk are those undergoing vascular surgery, orthopaedic surgery, surgery classed as major and those with one or more risk factors for pressure ulcers development. Perform risk assessment of patients undergoing surgery by identifying other factors that may occur and will increase the risk of pressure ulcer development.
- Consideration must be given to the length of operation, hypotensive episodes, reduced core temperature and possible reduced mobility post-operatively.

- Use a pressure redistributing support surface on the operating table for all individuals identified to be at risk of pressure ulcer development, positioning and repositioning the patient, when possible, in line with the Moving and Handling Policy.

- Heels should be completely offloaded in such a way that weight is distributed along the leg without focal pressure on the Achilles tendon or calf (the knees should be slightly flexed to avoid popliteal vein compression).

- Pressure redistribution should occur prior to and after surgery (including in the recovery area). Patients should adopt a different posture pre- and post-operative than that during the operation. Risk status and skin integrity should be re-assessed at the handover of care between theatre and ward staff. (EPUAP,2019)

8.4.2. Seating

Remaining seated for extended periods increases the risk of pressure ulcer development over the buttocks.

A person who is at risk of pressure ulcers should not remain seated for longer than two hours in. For patients with existing pressure ulcers, the duration of sitting needs to be agreed upon as part of care planning.

Patients should be encouraged or assisted with making small shifts in their position to relieve pressure whilst seated.

Patients should never be sat on a chair with a pillow as a pressure-relieving surface.

8.4.3. Offloading

The Heel is one of the most common sites for pressure ulceration and can lead to prolonged treatment, reduced mobility, infection and possible amputation.

Offloading or "floating" the heel is recommended to remove pressure on the heel from the bed

- The risk of heel pressure ulcer development is greatly increased in patients with sensory impairment (i.e. neuropathy) and vascular insufficiency, wearing of anti-embolic stockings (AES)/ and unstable fractures. All patients with diabetes should be assessed for neuropathy.

- Assessments of the patient prior to and daily during the use of Anti-Embolic Stockings (AES)/ intermittent pneumatic compression garments/circulation support device and only apply them if it is indicated by Thromboprophylaxis Guideline.

- If AES are used, remove them and inspect the heels at least once every 24 hours. This removal and inspection must be documented in the patient's medical records/care plan.

- Equipment such as heel offloading boots and wedges should be utilised.

- Sliding sheets should be used for manual handling as per guidance to reduce sheer and friction

8.5. K – KEEP MOVING - Repositioning Patients at Risk of Pressure Damage

Encourage patients 'to keep moving' throughout their hospital stay if this is possible.

- People at risk of developing pressure ulcers should be given advice on the benefit and frequency of repositioning and those who are unable to reposition themselves should be repositioned and documented as per the care plan.
- Those who have been assessed as being 'at risk' of developing a pressure ulcer need to change their position frequently at least every 4 hours. If 'high risk', this should be more frequent.
- All patients with a pressure ulcer or 'at risk' of pressure ulcer development will have a documented repositioning schedule using the Daily Pressure Ulcer Prevention Care Plan.
- If the patient's condition changes, a revised repositioning regime needs to be documented.
- Any repositioning schedule must be agreed upon with the patient (if possible). Repositioning should be appropriate to any particular body site at risk e.g., offloading the heels of immobile patients in bed.
- Patients should not be repositioned onto areas of existing pressure damage tissue unless no alternative is available. If an alternative position is not available this needs to be factored into the individual's care plan and reposition schedule.
- Follow KEEP MOVING guidance on eCare and changes in patient positioning are documented on the Rounding grid at the frequency determined by the registered nurse. (Appendix 6 rounding grid)

8.6. I – INCONTINENCE AND MOISTURE

Moisture on the skin surface predisposes to increased friction, shearing and maceration. The patient's skin may be exposed to a number of different fluids (urine, faeces, perspiration and wound drainage/exudate).

Different types of moisture associated skin damage can be found in Appendix 16
Information on the difference between Moisture Associated Skin Damage (MASD) and Pressure Ulcers can be found in Appendix 14

8.6.2. Management

- Complete continence assessment on electronic patient record within 24hrs of admission.
- Promote continence and not Incontinence – focus on toileting and improve mobility

- Wash and dry the skin thoroughly (avoid wet wipes and foam sprays)
- Patients at risk of developing MASD should be identified, and strategies planned and implemented to help prevent MASD.
- A continence assessment should be completed.
- Continence products should be chosen in line with appropriate assessment

MASD will not heal with pressure redistribution aids.

The clinician who assesses an individual to provide an absorbent pad is accountable for that decision; and needs to ensure that the chosen pad is fit for purpose and safe to use at the time of assessment.

8.7. N – NUTRITION AND HYDRATION

8.7.1. Nutrition

If patients are assessed as being malnourished (or at risk of malnourishment) this may lead to the development of pressure damage.
Individuals who already have a degree of damage may find that wound healing may be impaired as a consequence.

- Patients should always have their nutritional status monitored and assessed as part of the holistic assessment.
- Individuals who are identified as being malnourished should be referred for a more detailed screening through a dietitian as per policy. This includes plus-size patients who may be malnourished and require a dietetic referral.

8.7.2. Hydration

- Monitor individuals for signs and symptoms of dehydration.
- Provide and encourage adequate daily fluid intake for hydration for an individual assessed to be at risk of or with a pressure ulcer. This must be consistent with the individual's co-morbid conditions and goals.
- Provide additional fluid for individuals with dehydration, elevated temperature, vomiting, profuse sweating, diarrhea, or heavily exuding wounds.
- Do not offer subcutaneous or intravenous fluids to treat a pressure ulcer in adults whose hydration status is adequate.

8.8. G – GIVING INFORMATION

NICE (2014) advise that staff should offer timely, tailored information to people who have been assessed as being at high risk of developing a pressure ulcer, and their family or carers.
Individual needs should be considered when supplying information to people with degenerative conditions, impaired mobility, neurological impairment, cognitive impairment, and impaired tissue perfusion.
Duty of Candour - Patients and/or carers must be informed of the development of pressure damage and this conversation must be recorded in nursing documentation.

8.8.1. Patient Choice

- The patient's mental health status should be assessed within the context of how it affects their ability to move independently and spontaneously and to follow recommended advice for pressure ulcer prevention and management.
- If concerns identified for capacity a formal capacity assessment should be completed. Patients have a right to decline treatment and have their opinion respected if they have capacity to do so (refer to Mental Capacity Act 2005 and related Trust policy).
- The involvement of the patient or carer in preventing pressure ulcers is vital; an explanation should be given about risk factors, their implications, and strategies for prevention. Their experience in successfully preventing pressure ulcers should be considered when planning care.
- The patient/carer should be involved in long-term care planning.
- If an individual does refuse treatment their reason for refusal should be explored, alternatives considered, and the outcome documented.
- The patient's reason for refusal should be explored. Some patient's may refuse to use the equipment, particularly if the use of that equipment affects their independence. Attempts should always be made to accommodate their wishes.

8.8.2. Patient & Carer Involvement.

Patients can only make a choice when provided with appropriate information and capacity to understand. They will be given information regarding pressure damage, including risk factors and preventative strategies.

- Copies of the Trust Pressure Ulcer Patient Information leaflet should be available in all wards and departments and should be provided to all patients at risk of developing pressure ulcers.
- Patients, where possible, should be actively involved in the care process and selection of the most suitable equipment for their needs. The rationale for using specific equipment should be explained.

9.0. Reporting of Pressure Ulcers

- All pressure ulcers/moisture lesions are to be recorded in the patient's records, reported on the Trust's Incident reporting system, and communicated and duty of candour exercised to the patient/carer/family, the multidisciplinary team and reported at every handover.
- The pressure ulcer/ moisture lesion must be reviewed and validated as per the validation process (See Appendix 12) by the ward sister/ matron or Tissue Viability Nurse.
- An After Action Review is to be undertaken for all Cat 3 and above hospital-acquired pressure ulcers and discussed at the Care review and learning panel to ensure learning is shared. A safeguarding referral is completed depending on the outcome of the safeguarding checklist and Care Review and Learning Panel discussion.
- Deterioration of pressure ulcer- If the condition of the patient changes i.e., further breakdown of skin, or deterioration of pressure ulcer, it should be reported on the Trust's Incident reporting system again. This process applies to all pressure ulcers hospital-acquired or if a patient is admitted with pressure ulcer/s.

10.0. Pressure ulcer management

- All patients with a pressure ulcer should have the pressure ulcer categorised using the EPUAP (2014) classification tool

- A full and detailed wound assessment should be undertaken on first presentation of the pressure ulcer.
- Wound assessments should be carried out by a registered health professional who has had training in wound assessment and management.
- A wound assessment should be undertaken prior to dressing selection and should be repeated at least weekly.
- If the condition of the patient or wound deteriorates the assessment and treatment plan should be re-evaluated and the patient referred to the Tissue Viability Service.
- Ensure regular vital observations are undertaken to monitor any signs of sepsis.
- For wound management, follow wound care guidelines and formulary (NURS/GL/37).

11.0. Safeguarding

There is a recognised link between pressure ulcers and safeguarding issues as may be the result of neglect, either deliberate or by omission

As a minimum patient with a cluster of PUs or cat 3 or above Pus need to be assessed for any evidence of omission of care or neglect and safeguarding referral need to be considered.

12.0. Caring for patients at end of life or palliative care.

Pressure ulcer development and management have particular significance in palliative and end-of-life care owing to the prevalence of mobility issues and the skin changes that can occur with aging and chronic illness.

Pressure ulcer prevention is a priority for patients in end-of-life care.

This includes:

- 2-4 hourly repositioning depending (you can use your clinical judgment to identify if the patient requires repositioning or skin inspection sooner than even 4 hours
- Assess the risk factors and repositioning frequency according to each individual as repositioning less than every 4 hours may be distressing to some end-of-life (EOL) patients or their relatives. The decision must be documented, and the rationale provided. The personalised care plan for the dying patient should be completed.
- If a patient requires pain relief in order to be turned, it should be added to the additional comments.
- Patients who are agitated and restless may need additional skin inspections as there may be a risk of shear and friction.
- Patients at EOL must have adequate pain relief to keep them pain-free and comfortable. If the patient is declining to be repositioned due to pain, please administer pain relief 30 minutes prior to repositioning to increase the patient's tolerance to repositioning.
- If the patient is already on regular pain relief and pain is still not managed, contact the Palliative care Team for further advice.
- Escalate to Matron, the palliative care team, or the Tissue Viability Nurse if there is any concern regarding the prevention /management of pressure damage.

13.0. Discharge /Transfer

- The Nurse in Charge will inform other departments of continued preventative care needs when a patient with a pressure ulcer, or who is assessed as 'at risk', is transferred to another area, e.g., patients requiring x-ray, Discharge Lounge, physiotherapy etc.
- The Patient's Daily Pressure Ulcer Prevention Care Plan should be updated prior to discharge or transfer to ensure any specific issues are highlighted and ongoing preventative care is documented by the receiving department/institute.
- On transfer or discharge from hospital patients should have a reassessment of their skin integrity. This should be documented accurately and should include information concerning risk assessment, existing pressure ulcers and current treatment. Obtain clinical photography if appropriate.
- A minimum of 3 days supply of dressings (if required for discharge) should be supplied, and any equipment needed to support discharge should be ordered prior to the patient being medically optimized for discharge date
- An appropriate referral to health professionals in the community should be completed (District Nurses/Community TVN/ Practice Nurse) when wound care is required.
- Prior to discharge the patient should be assessed for need of equipment and care provision for the prevention and management of pressure ulcers and appropriate discharge planning sought.

14.0. Education and Training

All clinical staff who are in contact with patients will complete the online training module on pressure ulcer prevention and management on an annual basis.
Supplementary training may be given to specific areas upon request and at the discretion of the Tissue Viability Service.
All educational material will incorporate the latest developments within the specialty educational input from the Trust's service provider as negotiated

15.0. Statement of evidence/references

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14.0. Governance

14.1. Document review history.

Version number	Review date	Reviewed by	Changes made
4.6	**September 2022**		Review and update of complete guideline

14.2. Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
	Chief Nurse	07/12/2023	08/02/24	Content change	yes
	Head of Service Improvement	07.03.23	14.04.23	Content change	Yes
	Divisional Chief Nurses	07.03.23	02/06/23	Content Change	Yes
	Head of Risk and Clinical Governance	07.03.23	11.04.23	Format change	Yes
	Chief Nursing Information Officer	07.03.23	11.04.23	eCare dating guidance	Yes
Harm Prevention Group	Medicine Surgery Maternity Pediatrics	11/04/2023	14/04/23	Content Change	Yes
Nursing Midwifery and Therapy Advisory Group	Senior Leadership	15/05/23	01/06/23	Content change	Yes
	Deputy Chief Nurse	10/04/2024	10/04/2024	Content Change	Yes

14.3. Audit and monitoring

Audit/Monitoring Criteria	Tool	Lead	Frequency of Audit	Responsible Committee/Board
Weekly and Monthly monitoring of hospital acquired pressure ulcers and moisture lesions	Weekly and monthly SPC	Ward Manager/Matron	Weekly Monthly	Harm Prevention Group NMTAG Trust Board
After Action Reviews of all hospital acquired category 2,3,4, unstageable and deep tissue injuries and identification and dissemination of learning.	After Action Review and safeguarding checklist	Associate Chief Nurse	Monthly	Care Review and Learning Panel Harm Prevention Group
Use of guidance by clinical practice	Quality Review Meeting	DCN	Monthly	Patient Safety Board
Analysis of Trends in reported Pressure ulcers	Ward Performance Meeting	Chief Nurse	Monthly	Nursing Midwifery and Therapy Advisory Group Patient Safety Board Quality and Clinical Risk Committee Trust Board

Pressure Ulcer Prevention and management	Report	Associate Chief Nurse	Quarterly	Patient Safety Board Quality and Clinical Risk Committee

14.4. Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	**Corporate**	**Department**	**Directorate of Patient Care**
Person completing the EqIA		**Contact No.**	**01908995884**
Others involved:		**Date of assessment:**	
Existing policy/service		**New policy/service**	

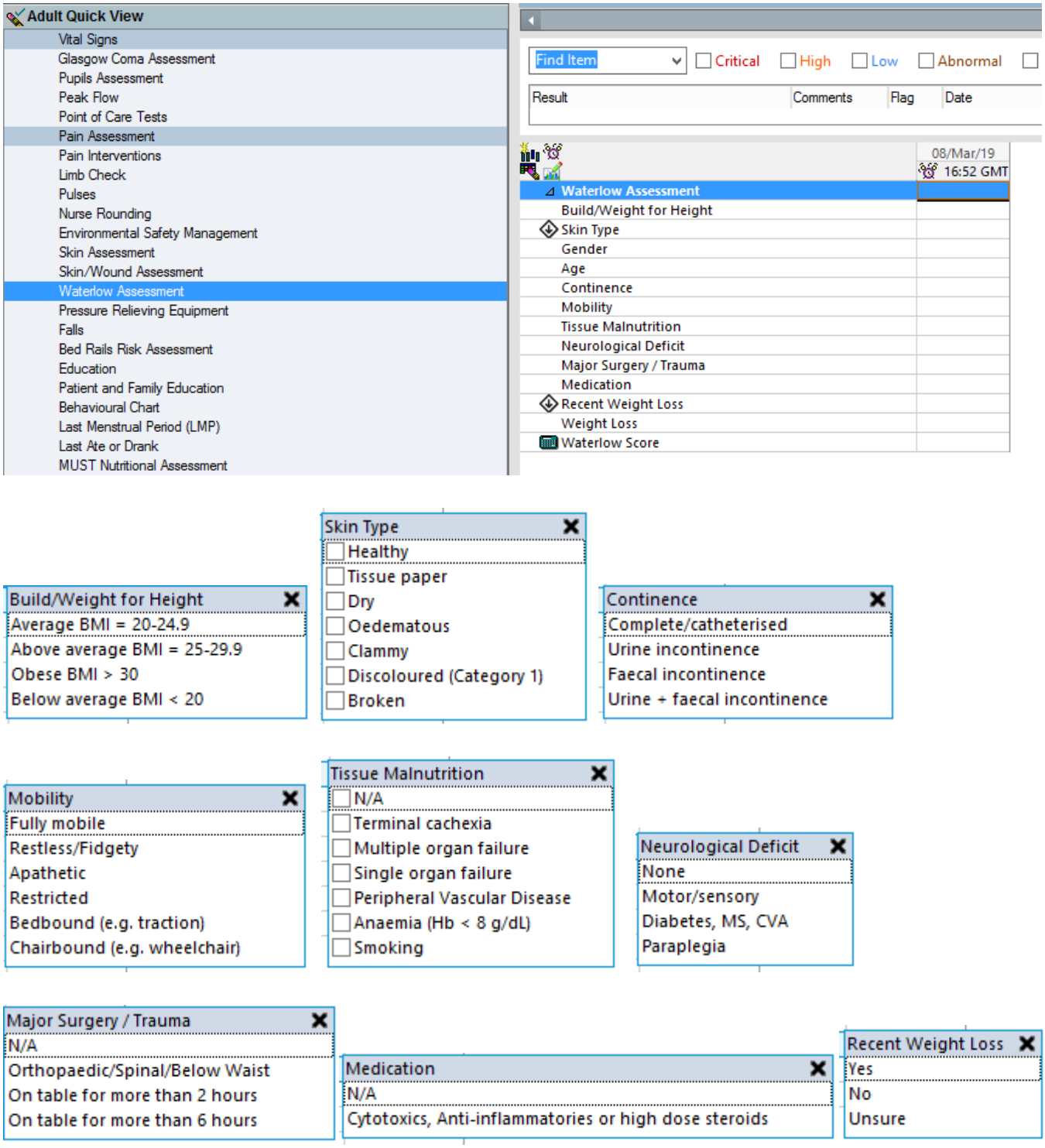
Will patients, carers, the public or staff be affected by the policy/service?	Staff, patients, public
If staff, how many/which groups will be affected?	All staff

Protected characteristic	**Any impact?**	**Comments**
Age	NO	
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	**Circulation to senior staff, ward managers and appropriate groups**
How are the changes/amendments to the policies/services communicated?	**Trust intranet**

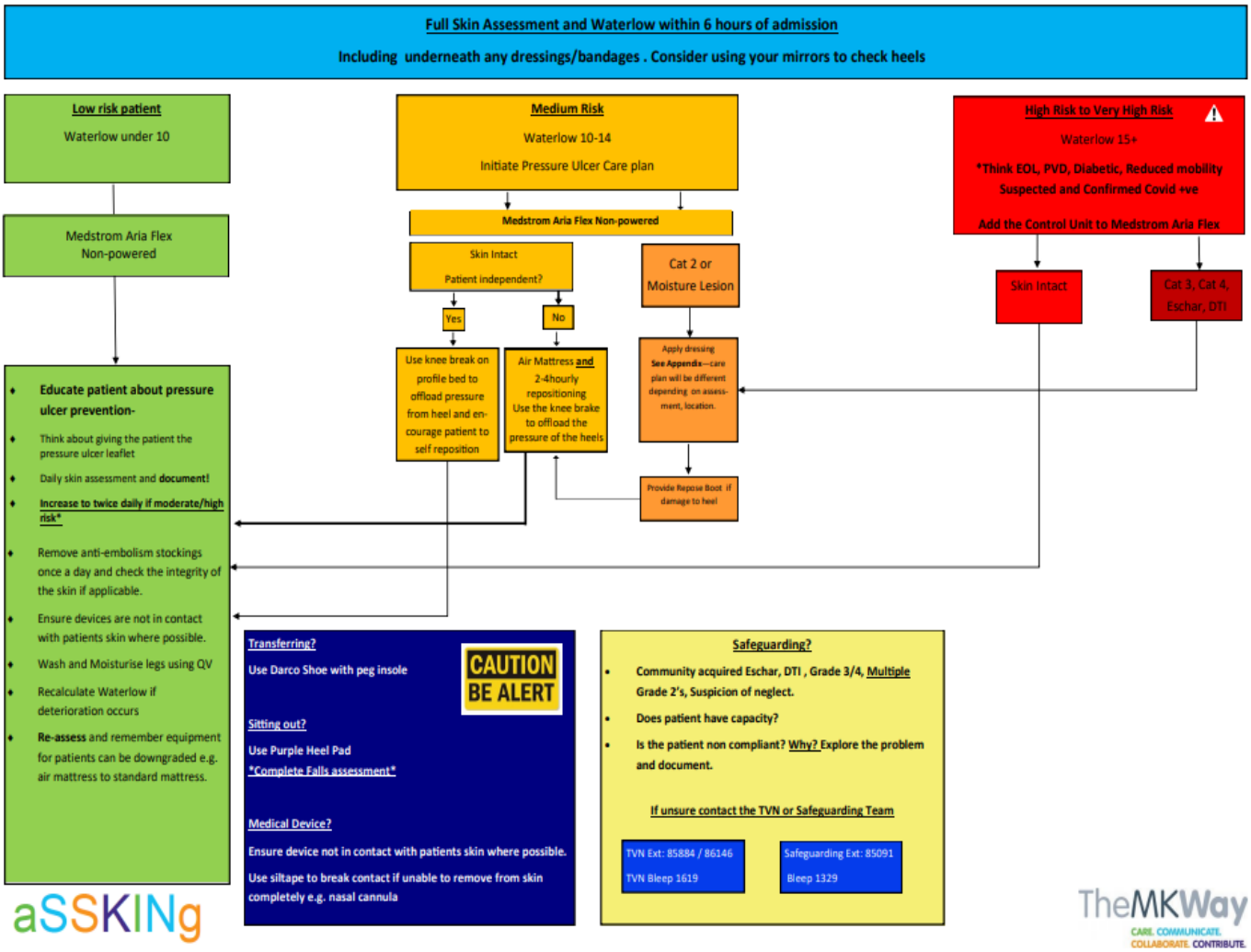
Appendix 1 Waterlow Risk Assessment

This is current eCare assessment – this may have altered please check eCare guide



Appendix 2 Full Skin Assessment and Waterlow Risk Assessment Flow Chart

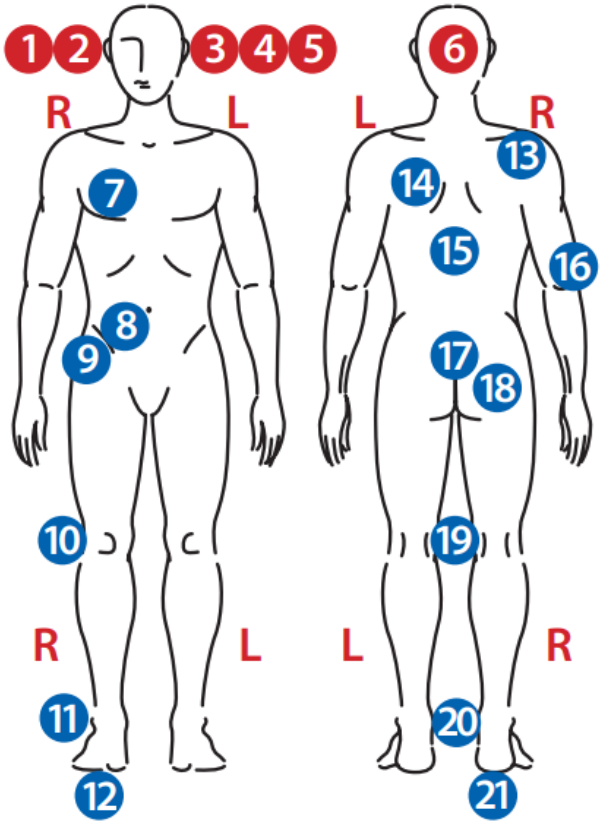
https://intranet.mkuh.nhs.uk/wp-content/uploads/2019/03/A4-TVN-flowchart.pdf



Appendix 3 Vulnerable Pressure Area Locations

Adapted from a diagram by Christine T Berke and Barts Health NHS Trust

Pressure ulcer locations



Head

Face

1. Forehead
2. Cheeks
3. Ears
4. Nose (NIV)
5. Lips/chin

Back of head

6. Occiput

Body

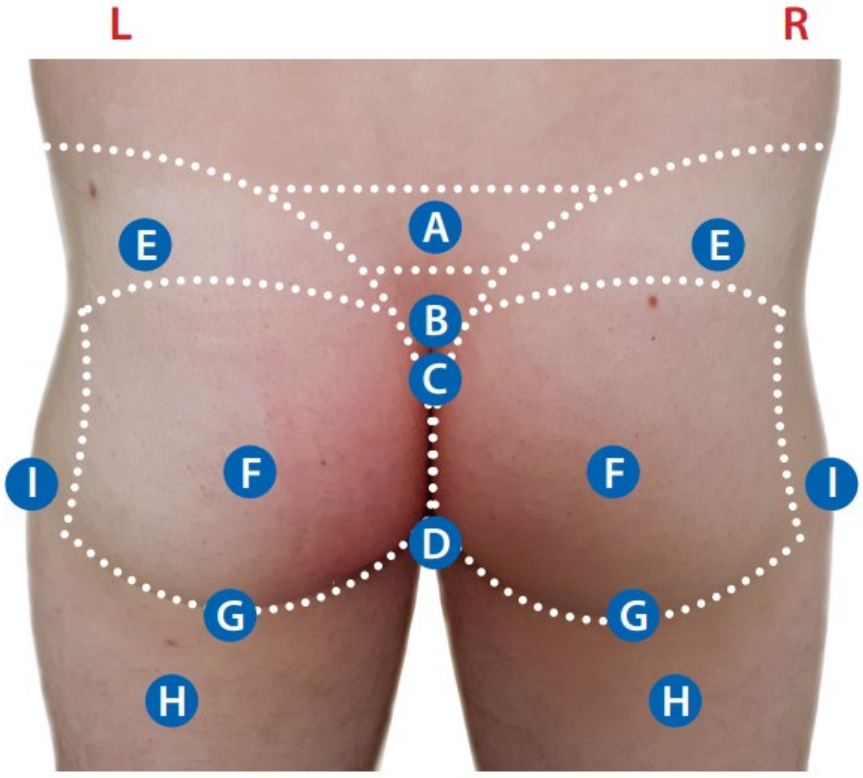
Front

7. Thoracic area incl ribs
8. Anterior iliac crest
9. Trochanter (hip)
10. Lateral knee & patella
11. Lateral malleolus (ankle)
12. Toes

Back

13. Shoulder
14. Scapula
15. Spinal column
16. Elbow
17. Sacrum/coccyx
18. Buttocks
19. Medial knee
20. Medial malleolus (ankle)
21. Heel

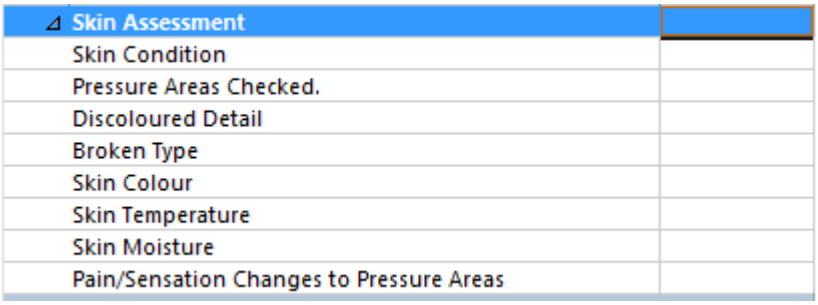
Anatomical locations

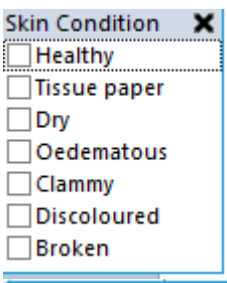


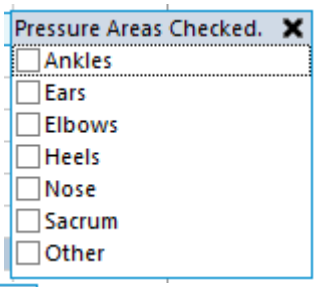
A. Sacrum
B. Coccyx
C. Intergluteal (natal) cleft
D. Perianal area
E. Sacral iliac crest
F. Buttocks
G. Ischial tuberosity
H. Posterior thigh
I. Trochanter

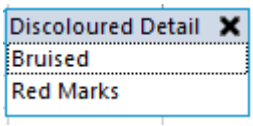
Appendix 4 Skin Assessment on eCARE

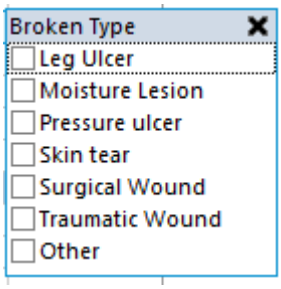
This is current eCare assessment – this may have altered please check eCare guide

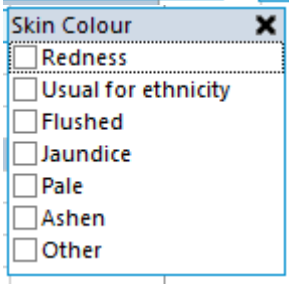


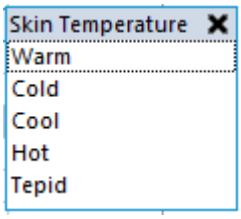


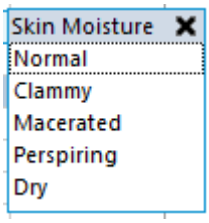


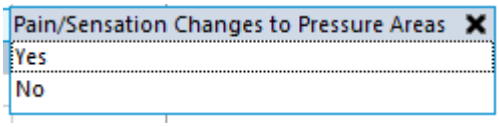












Appendix 5 Pressure Ulcer Management Care Plan on eCARE

This is current eCare assessment – this may have altered please check eCare guide

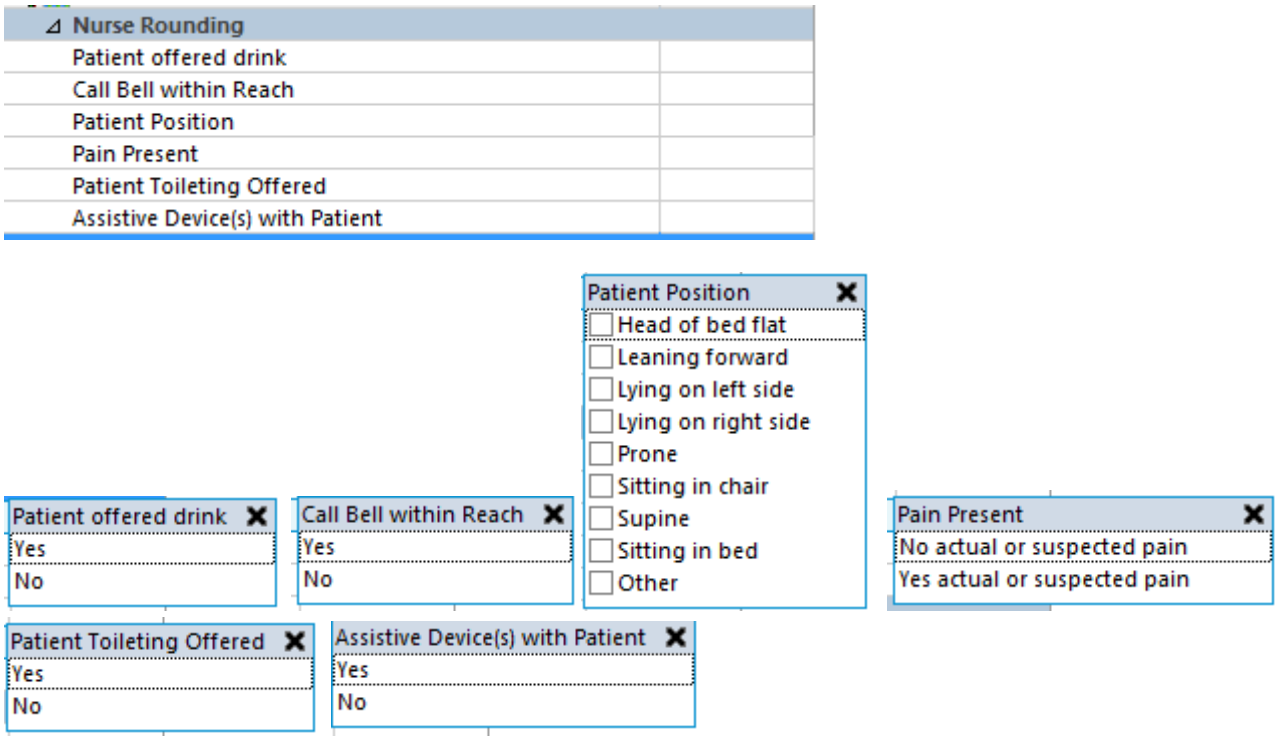
Pressure Ulcer Prevention/Wound Care Management Plan, Pressure Ulcer Prevention-HIGH/VERY HIGH (Planned Pending)	
Outcomes	
☑ Pressure areas remain intact	
☑ Understands Pressure Ulcer prevention education	
☑ Information Leaflet + Given	
☑ Information Discussed with Patient	
Interventions	
Waterlow is currently assessed once a week (inside Safety Assessment). If more frequent documentation is required, please navigate to Assessments/Fluid Balance and document when needed	
Reassess Waterlow if condition changes or transfer to a new clinical area	
SURFACE - Provide pressure relieving therapy according to Trust policy	
☑ Pressure Relieving Equipment Requested	Requested Start Date/Time T;N, once ONLY
☑ Pressure Relieving Equipment Installed	
SKIN - Ensure you check all pressure areas	
☑ Skin Assessment	Requested Start Date/Time T;N, every TWELVE hours
KEEP MOVING	
Ensure patients continence is reviewed	
NUTRITION - Ensure nutrition needs are met	
☑ Nutrition Plan of Care	Requested Start Date/Time T:N, Constant Order
Consider Safeguarding issues	
☑ Education Pressure Ulcer Prevention	Requested Start Date/Time T;N, once ONLY
☑ Add Diagnosis - At Risk of Pressure Ulcer	
☑ Pressure Ulcer Prevention - HIGH/VERY HIGH Plan of Care	Requested Start Date/Time T;N, Once, Constant Order, Pressure Ulcer Prevention - H/VH Plan
☐ Pressure Relieving Equipment	Requested Start Date/Time T;N, once ONLY
☐ Remove Anti-embolic stockings/Slipper Socks	T;N, every TWELVE hours
☑ Wound Dressing Reminder	Requested Start Date/Time T;N

Pressure Ulcer Prevention/Wound Care Management Plan, Pressure Ulcer Prevention - LOW/ MEDIUM (Planned Pending)	
Outcomes	
☑ Pressure areas remain intact	
☑ Understands Pressure Ulcer prevention education	
☑ Information Leaflet + Given	
☑ Information Discussed with Patient	
Interventions	
Waterlow is currently assessed once a week (inside Safety Assessment). If more frequent documentation is required, please navigate to Assessments/Fluid Balance and document when needed	
Reassess Waterlow if condition changes or transfer to a new clinical area	
SURFACE - Provide pressure relieving therapy according to Trust policy	
Please select Skin Assessment if patient is MEDIUM risk	
☐ Skin Assessment	Requested Start Date/Time T;N, every TWENTY FOUR hours
☑ Education Pressure Ulcer Prevention	Requested Start Date/Time T;N, once ONLY
KEEP MOVING	
Ensure patients continence is reviewed	
NUTRITION - Ensure nutrition needs are met	
Consider Safeguarding issues	
☑ Pressure Ulcer Prevention - LOW/MED Plan of Care	Requested Start Date/Time T;N, Pressure Ulcer Prevention - L/M Plan
☐ Pressure Relieving Equipment	T;N, once ONLY
☐ Remove Anti-embolic stockings/Slipper Socks	T;N, every TWELVE hours
☑ Wound Dressing Reminder	Requested Start Date/Time T;N

Pressure Ulcer Prevention/Wound Care Management Plan, Pressure Ulcer Management (Planned Pending)	
Outcomes	
☑ No deterioration in pressure ulcer	
☑ Improvement of pressure ulcer	
☑ Wound Status	
Interventions	
☑ Skin/Wound Assessment	Requested Start Date/Time T;N, every TWENTY FOUR hours
SURFACE - Provide pressure relieving therapy according to Trust policy	
Please refer all Category 3 and 4 Pressure Ulcers or if suspected Hospital acquired Grade 2	
☐ Referral to Tissue Viability	
Check Clinical Notes for Tissue Viability recommendations, else follow wound care guidelines	
Wound Management Formulary - Click on link icon on left	
Please ensure pain is documented and managed.	
KEEP MOVING	
Ensure patients continence is reviewed	
NUTRITION - Ensure nutrition needs are met	
Consider Safeguarding issues	
☑ Pain Assessment	Requested Start Date/Time T;N, every FOUR hours
☑ Pressure Ulcer Management Plan of Care	Requested Start Date/Time T;N, Pressure Ulcer Management Plan
☑ Wound Dressing Reminder	Requested Start Date/Time T;N
☐ Pressure Relieving Equipment	T;N, once ONLY
☐ Remove Anti-embolic stockings/Slipper Socks	T;N, every TWELVE hours

Appendix 6 Rounding grid on eCARE

This is current eCare assessment – this may have altered please check eCare guide



Appendix 7 Mattress Selection Pathway

Milton Keynes Hospital NHS
NHS Foundation Trust

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Improved Patient Outcomes

Mattress Selection Pathway

This equipment tool is designed as a **guide only** and should always be used in conjunction with clinical judgement. Assess each patient's need for pressure care equipment by current level of **risk, mobility, weight, skin bundles** in place and care plans in action. Always **reassess** each patient regularly. Please select from the following pathways and choose appropiate equipment. **ALL PATIENTS MUST BE REPOSITIONED DESPITE WHAT SURFACE THEY ARE ON.** ***All patients to have a Waterlow score completed on admission within 6 hours following patient transfer to another clinical area or if their clinical condition changes.***

PATHWAY A		PATHWAY B	PATHWAY C Liase with TVN Team	PATHWAY D Liase with TVN Team
Waterlow: ≤ 9 Low risk	Waterlow: 10 – 14 At risk	Waterlow: 15+ Very high risk	Waterlow: 15+ Very high risk	Patient has multiple pressure ulcers or unable to tolerate Pathway B
Patients with NO pressure ulcers	Patients with NO pressure ulcers	• All adult patients with pressure ulcers • Patients with #NOF • Diabetic patients • Amputee patients	• All complex patients with multiple comorbidities • End-of-life patients who are difficult./challenging to reposition • Patients unable to tolerate repositioning • Deteriorating pressure areas on Aria Flex with pump • Category 3 or 4 pressure damage and unable to offload adequately	• All complex patients with multiple comorbidities who are unable to tolerate Pathway B • Patients with severe contractures • Deteriorating on Heritage Digital Turning Mattress • Multiple pressure ulcers, reducing turning surfaces capacity • End-of-life patients • Patients with significant pain issues
Skin checks to be complete on every shift, including under medical devices	Skin checks to be complete on every shift, including under medical devices	Skin checks to be complete on every shift, including under medical devices	Skin checks to be complete on every shift, including under medical devices	
 Aria Flex Semi-dynamic surface Max patient weight: 227kg	 Aria Flex Semi-dynamic surface Max patient weight: 227kg	 Aria Flex with PUMP Dynamic surface Max patient weight: 227kg	 Heritage II Digital Turning Surface Dynamic surface Max patient weight: 254kg	 Dolphin Therapy Max patient weight: 248kg Patients still require position changes whilst on Dolphin Therapy. Please do not use repose or wedges.

Appendix 8 Mattress Management and Protocol

Milton Keynes Hospital NHS
NHS Foundation Trust

medstrom
Improved Patient Outcomes

Mattress Management and Protocol

This equipment tool is designed as a **guide only** and should always be used in conjunction with clinical judgement. Assess each patient's need for pressure care equipment by current level of **risk, mobility, weight, skin bundles** in place and care plans in action. Always **reassess** each patient reguarly. Please select from the following pathways and choose appropiate equipment. **ALL PATIENTS MUST BE REPOSITIONED DESPITE WHAT SURFACE THEY ARE ON.** ***All patients to have a Waterlow score completed on admission within 6 hours following patient transfer to another clinical area or if their clinical condition changes.***

PATHWAY A	PATHWAY B	PATHWAY C Liase with TVN Team	PATHWAY D Liase with TVN Team
Aria Flex **Semi-dynamic**	**Aria Flex** **Dynamic**	**Heritage Digital Turning System**	**Dolphin Therapy**
Location: On all beds	**Location:** Stored in bed store	**Location:** Stored in bed store	**Location:** Medstrom Service Centre
Considerations: Suitable for all patients	**Considerations:** Review current patients with pumps and step down if clinically appropiate to do so	**Considerations:** Have you completed the Dolphin/Heritage checklist? Review if patients are clinically appropriate for a turning mattress system Have you discussed with TVN?	**Considerations:** Have you completed the Dolphin/Heritage checklist? Have you discussed with the TVN or Clinical Advisor? Has Associate Chief Nursing authorised the request? Out of hours - has authorisation been given from the Silver on Call Manager?
Obtaining product: Contact Support Services to deliver from the bed store	**Obtaining product:** If unable to step patients down, please contact the Medstrom Equipment Coordinator on **mkpumps@medstrom.co.uk** to request a pump **Monday to Friday, 9am to 3pm** Weekends and out of hours Support Services If unable to get a pump, please escalate to the Matron both in and out of hours for next steps	**Obtaining product:** Contact Medstrom customer services 24/7/365 on **0845 371 7171**	**Obtaining product:** Contact Medstrom customer services 24/7/365 on **0845 371 7171**
Following patient discharge: Clean between each patient admission, unzip and check inside for stains and damage	**Following patient discharge:** Ensure all pumps are cleaned and given to the Equipment Coordinator when they visit the wards. This is to ensure adequate supply across the Trust.	**Following patient discharge:** Clean, deflate and send back to bed store for Medstrom to decontaminate and service	**Following patient discharge:** Clean, deflate and contact Medstrom to collect from ward area
Fault reporting: If any damage/staining/odour report to Medstrom 24/7/365 via customer services on: **0845 371 1717**	**Fault reporting:** Contact Medstrom 24/7/365 via customer services on **0845 371 1717** to report a fault	**Fault reporting:** Contact Medstrom via customer services 24/7/365 on **0845 371 1717** to report a fault If there is a fault and the mattress deflates, ensure the patient is placed on an alternative surface	**Fault reporting:** Contact Medstrom via customer services 24/7/365 on **0845 371 1717** to report a fault If there is a fault and the mattress deflates, ensure the patient is placed on an alternative surface

Appendix 9 Dolphin/Heritage digital II Decision Tool Checklist

TheMKWay

NHS Milton Keynes University Hospital NHS Foundation Trust

Dolphin/Heritage Therapy Decision Tool

Before considering Dolphin Therapy, please make sure your patients pain relief and repositioning is maximised

Complete **ALL** the following Questions.

Skin		Comment
Does the patient have unstageable, category 4 or multiple pressure ulcers which cannot be adequately offloaded?	Yes	
Does the patient have a deteriorating pressure ulcer that cannot be adequately offloaded?	No	
Is the patient's skin deteriorating as they are on an end-of-life care plan and are unable to be repositioned?	No	
Is the patient still in pain following a review of their pain management which is impacting their ability to be repositioned as often as required?	No	

Mobility		
Is the patient bed bound with limited ability to reposition or be repositioned and their skin is marking despite 2 hourly repositioning?	Yes	
Does the patient have less than 2 positions they are able to be positioned in?	Yes	
Is the patient unable or unwilling to be compliant with position changes due to their clinical condition – with all possible solutions exhausted relating to position changes – for example – pain reviewed, manual handling needs addressed?	Yes	

Continence		
Is the patient incontinent of urine or faeces or both – with significant associated skin damage?	No	

Nutrition		
Does the patient have significant issues with nutritional intake?	No	
Is their BMI less than 18?	No	
Is the MUST score greater than 2?	No	

You need 3 or more "Yes" to meet criteria for Heritage mattress
You need 4 or more 'Yes' to meet the criteria for Dolphin Therapy

Discuss the Decision tool outcome with your ward Matron for clinical nursing advice
Discuss the Decision tool outcome with Tissue Viability Team on bleep 1619
Out of Hours please contact the Medstrom Clinical Adviser on 08453711717
Dolphin Therapy can **ONLY** be approved by a TVN or Medstrom Clinical Adviser
If Dolphin is NOT approved, please document the advice given.

Signature/name of approver .....Date.....

Draft V1 22/05/23

As a teaching hospital, we conduct education and research to improve healthcare for our patients. During your visit students may be involved in your care, or you may be asked to participate in a clinical trial. Please speak to your doctor or nurse if you have any concerns.

Chief Executive: Joe Harrison
Chair: Alison Davis

Appendix 10 MUST Nutritional score & Nutritional Risk Assessment

This is current eCare assessment – this may have altered please check eCare guide

MUST Nutritional Assessment		
Method Used to Assess Height		
Height/Length Measured	cm	
Weight Measured	kg	
Weight 3-6 Months Ago	kg	
% Weight Loss	%	
Body Mass Index Measured	kg/m2	
Mid Upper Arm Circumference (cm)	cm	
BMI Score		
Weight Loss Score		
Acute Disease Effect Score		
Overall Risk of Malnutrition		

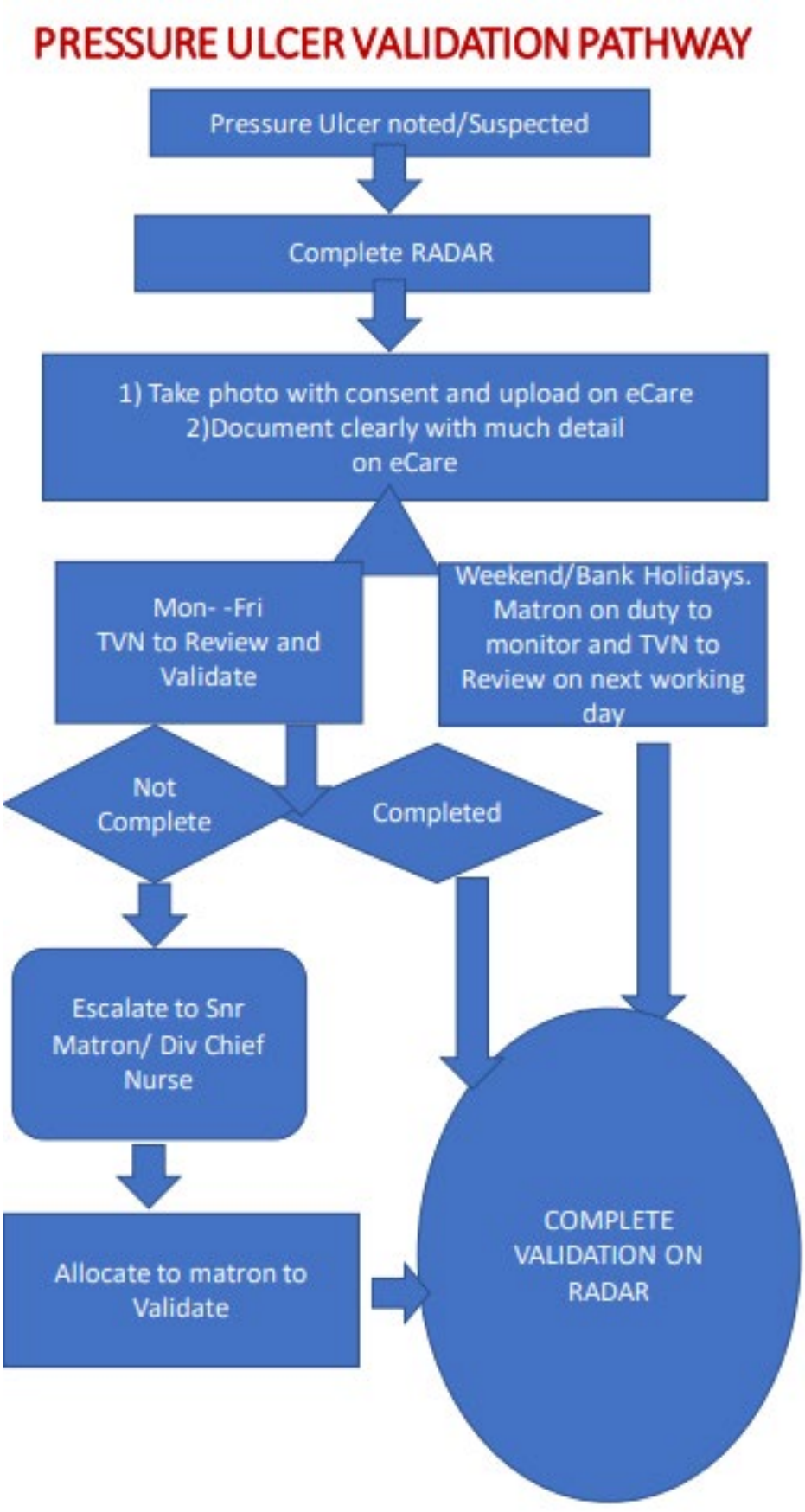
Method Used to Assess Height
Height Stick
Self Reported
Relative Reported

BMI Score
>20 (>30 Obese) kg/m2
18.5 - 20 kg/m2
<18.5 kg/m2

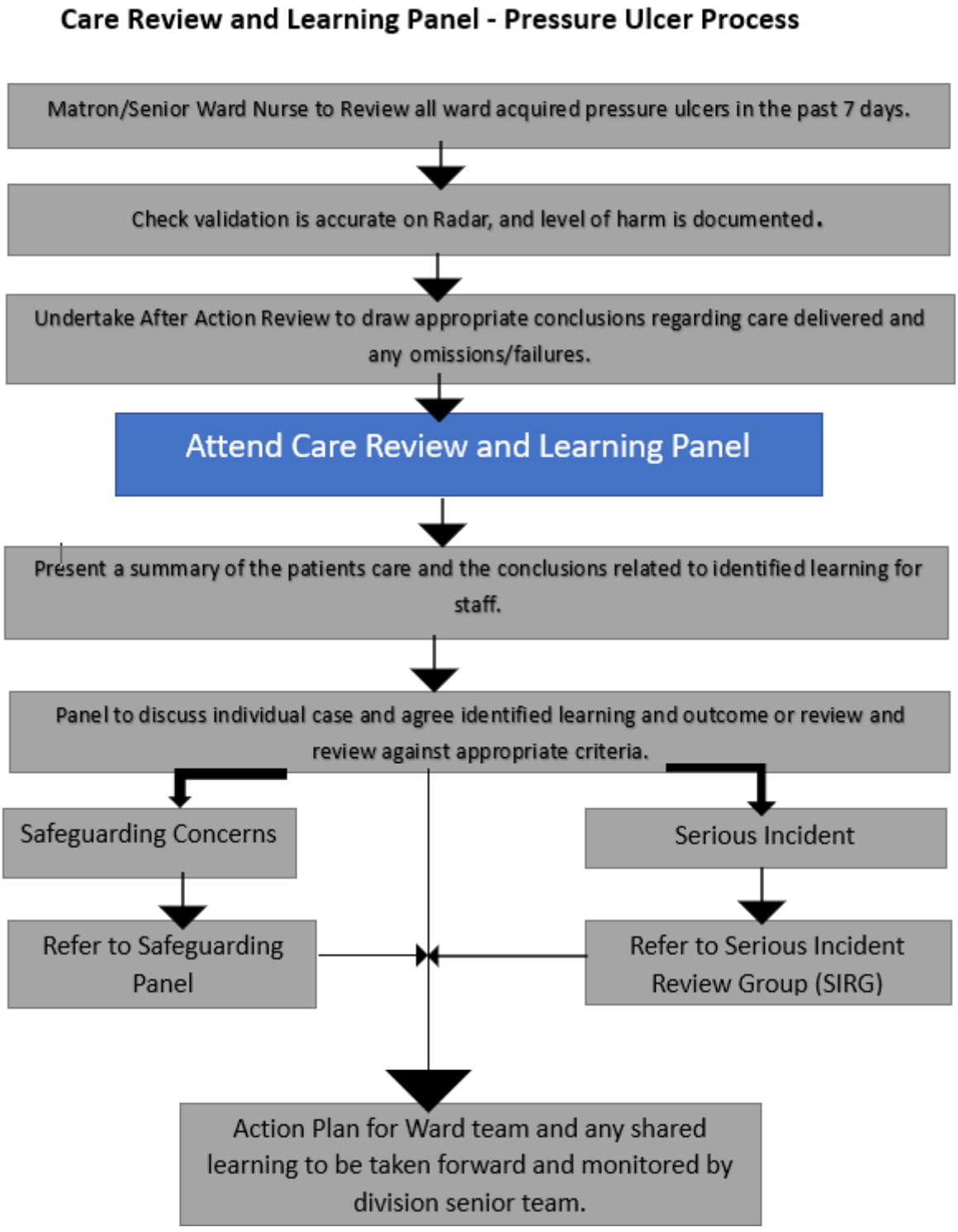
Weight Loss Score
No weight loss
<5%
5 - 10%
10 - 15%

Acute Disease Effect Score
Patient Not Acutely Ill
Patient Acutely Ill and/or No Nutritional Intake >5 Days

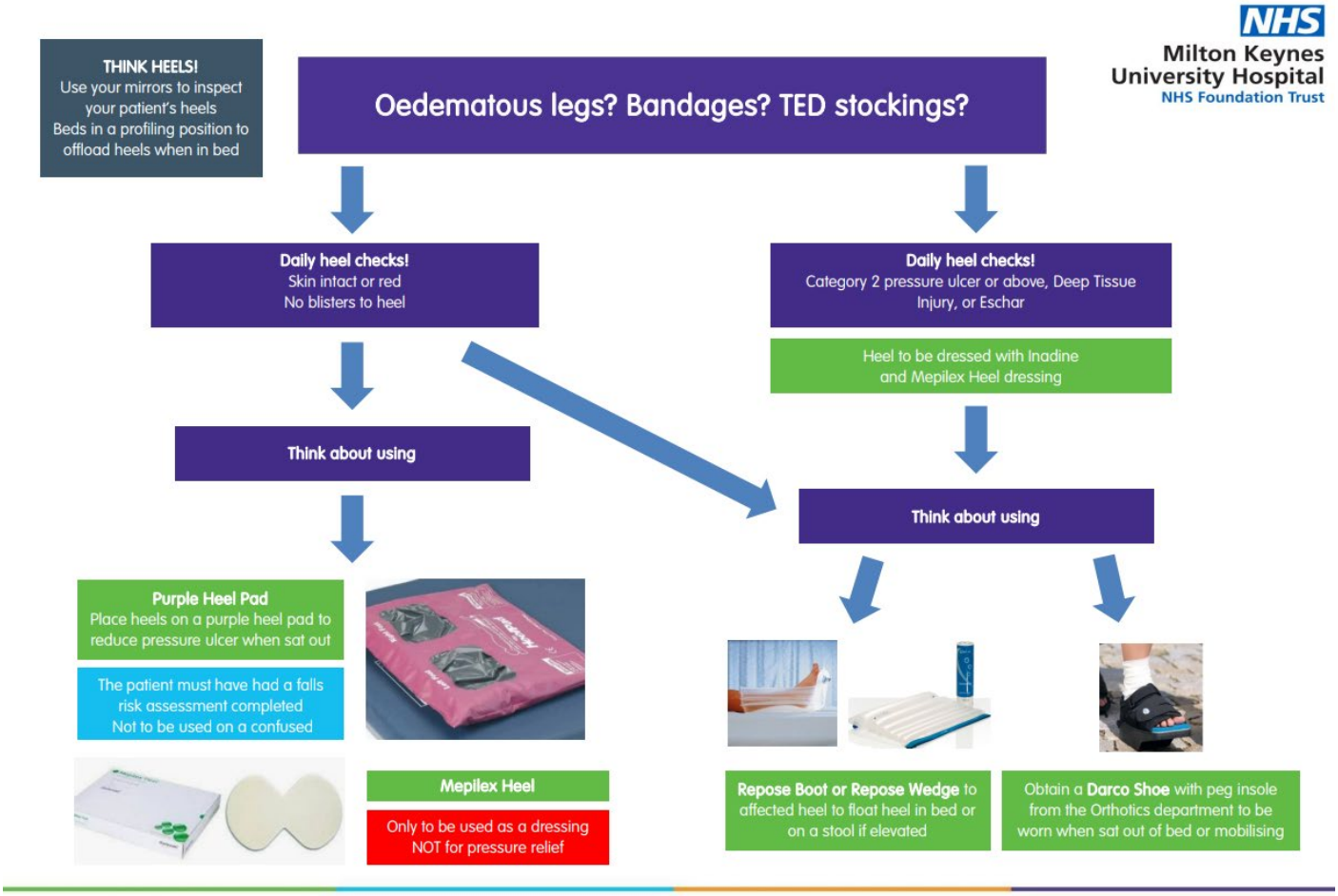
Appendix 11 Validation and Reporting



Appendix 12 Care Review and Learning Panel process



Appendix 13 Heel protection process

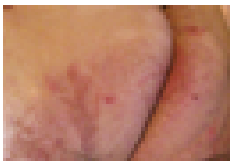
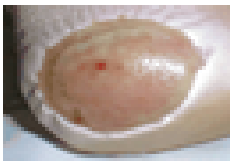
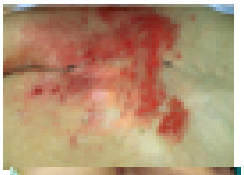
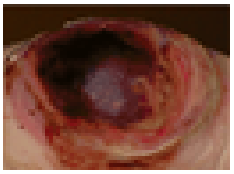
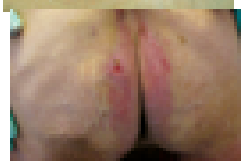
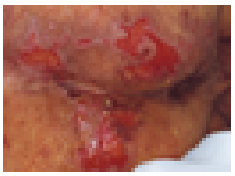
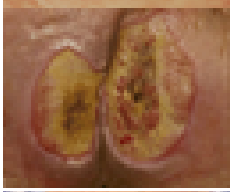
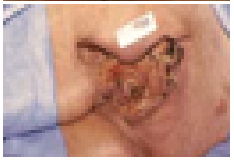
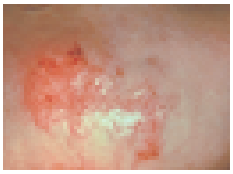
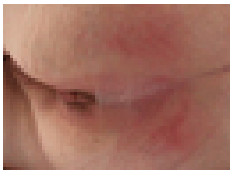


Appendix 14 Differences between a Moisture lesion and Pressure ulcer.

Milton Keynes Hospital NHS

Teaching aid to spot the differences between a Moisture lesion and a Pressure ulcer

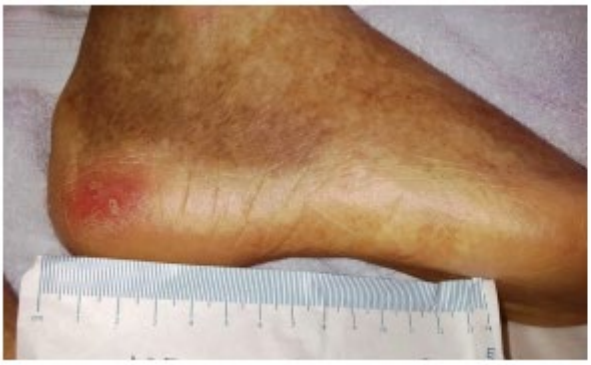
Differentiation Between Moisture Lesions and Pressure Ulcers

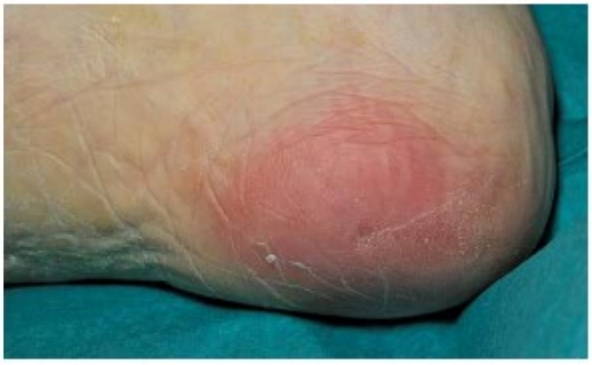
Moisture Lesions		Pressure Ulcers	
	**LOCATION** A combination of moisture and friction may cause moisture lesions in skin folds, but most commonly they are experienced in the anal cleft.		**LOCATION** A pressure ulcer is most likely to occur over a bony prominence.
	**NECROSIS** There is no necrosis in a moisture lesion.		**NECROSIS** A black necrotic scab on a bony prominence is a pressure ulcer.
	**SHAPE** Diffuse, different superficial spots are more likely to be moisture lesions. In a lasting ulcer (copy lesion) at least one of the wounds is most likely caused by moisture.		**SHAPE** Circular wounds or wounds with a regular shape are most likely pressure ulcers, however, the possibility of friction injury has to be excluded.
	**EDGES** Moisture lesions often have diffuse or irregular edges.		**EDGES** If the edges are distinct, the lesion is most likely to be a pressure ulcer.
	**DEPTH** Moisture lesions are superficial (partial thickness skin loss). In cases where the moisture lesion gets infected, the depth and extent of the lesion can be enlarged.		**DEPTH** Pressure ulcers vary in depth depending on classification.
	**COLOUR** If redness is not uniformly distributed, the lesion is likely to be a moisture lesion.		**COLOUR** If redness is non-blanchable, then is most likely a pressure ulcer. For people with darkly pigmented skin, persistent redness may manifest as blue or purple.

www.ebmedu.com Defloor T, et al, Differentiation between pressure ulcers and moisture lesions. European Pressure Ulcer Advisory Panel Review, Volume 6, Issue 4, 2005.

Appendix 15 Pressure Ulcer Categorisation

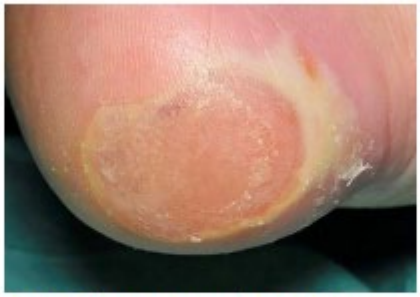
Category 1: Non blanchable Erythema Intact skin - In lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding area. The area may be painful, firm,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



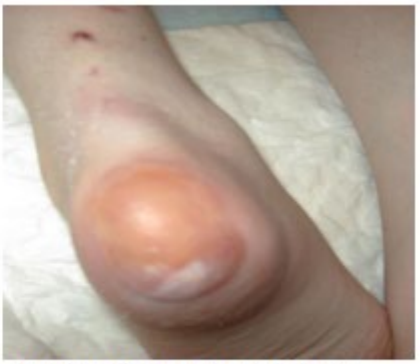


Category 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister or as a shiny or dry shallow ulcer without slough or bruising*. This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.

An intact serum-filled blister

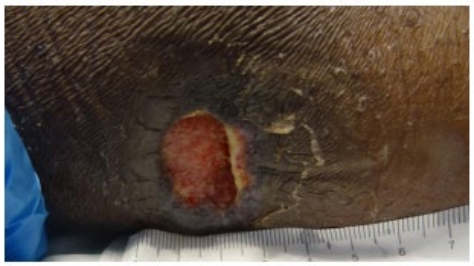


A shallow open ulcer with a red pink wound bed without slough



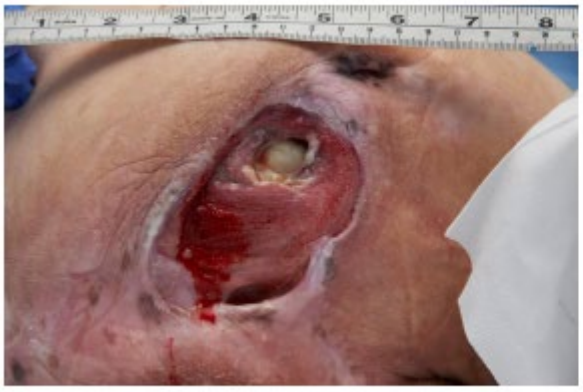
A superficial ulcer with a collapsed blister

Category 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough or necrosis may be present. May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

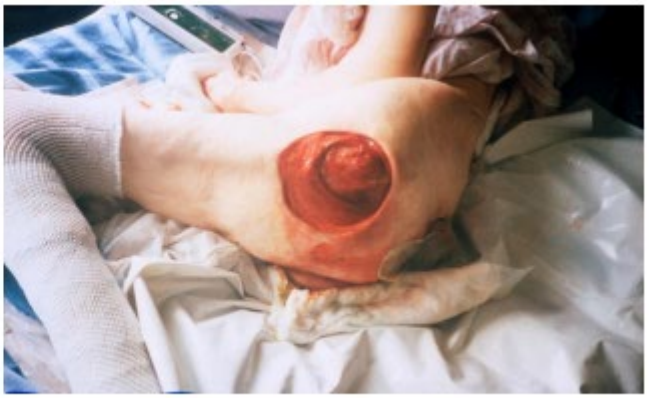


Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

Category 4: 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 4 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 4 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.

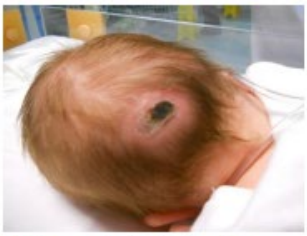


In this wound, the bone is clearly visible

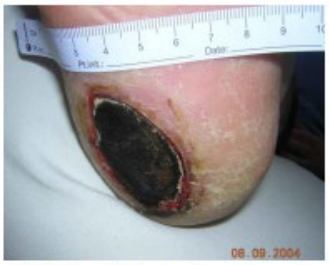


This wound shows exposed muscle

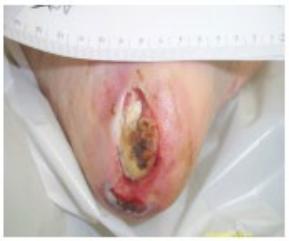
Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration.



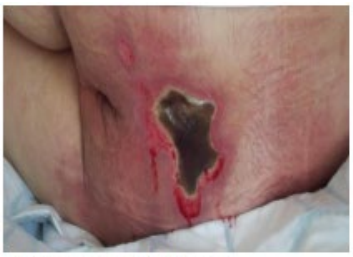
This occipital ulcer is covered by softening necrosis



This heel ulcer is covered by hard dry eschar



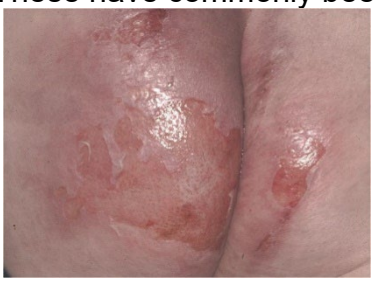
The necrotic cap on this heel has softened and started to separate



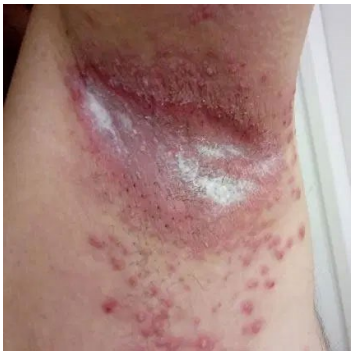
Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

Appendix 16 Different types of Moisture Associated Skin Damage

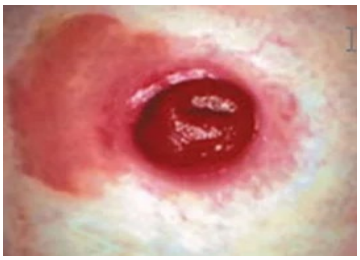
Incontinence Associated Dermatitis (IAD): damage caused when urine and faeces make prolonged contact with the skin. These have commonly been referred to as moisture lesions.



Intertriginous dermatitis (Intertrigo)*:* when 2 surfaces of skin are in contact with one another, friction and moisture e.g. under arms, groins, under breasts.



Peri-stomal dermatitis: sore and excoriated skin around stoma.



Appendix 17 – IAD Pathway Version

Prevention and treatment of Incontinence Associated Dermatitis (IAD)

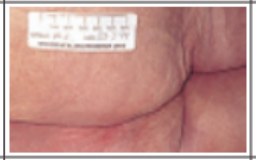
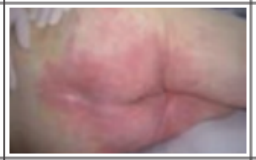
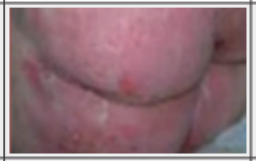
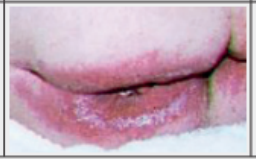
NHS
Milton Keynes University Hospital
NHS Foundation Trust

For patients who are incontinent of urine and/or faeces

Please ensure appropriate continence assessment is completed.

Step down

Step up

	Clinical presentation*		Clean the skin	Barrier product	When to use	How much to use (see reverse)
Prevention	**At risk of IAD:** Incontinence, healthy, intact skin, no erythem **If patient has infected stool or frequent liquid stool, treat as Severe IAD**		Cleanse with QV Wash and pat dry	3M™ Cavilon™ No Sting Barrier Film 	Apply **once** per day	Apply even coat to the entire area to be treated Allow the area to dry for at least 30 seconds or until touch dry 
Management	**Mild IAD:** Skin is moist – erythematous areas, skin is intact		Cleanse with QV Wash and pat dry	3M™ Cavilon™ No Sting Barrier Film 	Apply **once** per day	Apply even coat to the entire area to be treated Allow the area to dry for at least 30 seconds or until touch dry 
	Moderate IAD: Skin is wet – spreading Erythematous skin Up to 50% of affected skin is broken Oozing/bleeding may be present		Cleanse with QV Wash and pat dry	3M™ Cavilon™ No Sting Barrier Film 	Apply every 12–24 hours	Apply even coat to the entire area to be treated Allow the area to dry for at least 30 seconds or until touch dry 
High risk	**Severe IAD:** More than 50% of affected skin is broken (moisture lesions) Oozing and/or bleeding may be present		Cleanse with QV Wash and pat dry	3M™ Cavilon™ Advanced Skin Protectant If there is no improvement after 2 weeks please refer to a TVN 	Apply every 72 hours e.g. Monday and Thursday	Apply even coat to the entire area to be treated Allow the area to dry for at least 30 seconds or until touch dry 
	IAD with fungal involvement: Wet, erythematous skin with white pustules		Cleanse with QV Wash and pat dry	Refer to patients' medical team	Refer to patients' medical team	No barrier film to be applied

Tissue Viability contact: EXT 86022

If you have any deterioration or concerns, please refer to TVN.

*IAD Severity Categorisation Tool taken from Beeckman D et al. Proceedings of the Global IAD Expert Panel. Incontinence-associated dermatitis: moving prevention forward. Wounds International 2015.

How is 3M™ Cavilon™ No Sting Barrier Film applied?

- Skin should be clean and dry prior to application of Cavilon no sting barrier film
- Apply a uniform coating of the film over the entire treatment area
- When using the spray bottle, hold the spray nozzle 10–15cm away from the skin and apply in a smooth, even coating over the entire treatment area while moving the spray in a sweeping motion
- If an area is missed, reapply to that area only after the first application has dried (this will take approximately 30 seconds)
- If Cavilon no sting barrier film is applied to an area with skin folds or where there is other skin-to-skin contact, make sure that the skin contact areas are separated and allow the coating to dry before returning skin to the normal position
- Applying too many layers may make the skin feel stiff

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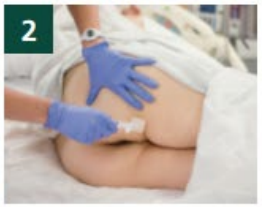
How is 3M™ Cavilon™ Advanced Skin Protectant applied?

Keep the applicator pointed in a downward position for approximately 10 seconds to allow fluid into the foam sponge. The fluid flows by gravity so you don't need to maintain pressure on the lever.

Fluid will not completely saturate the sponge to the edges.

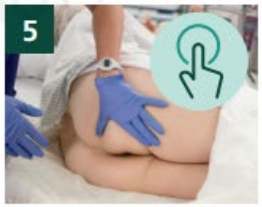


Apply Cavilon Advanced skin protectant by gently wiping the foam sponge across the affected area and surrounding skin. Use an even, sweeping motion with minimal overlap of product. The applicator may be used in any direction.

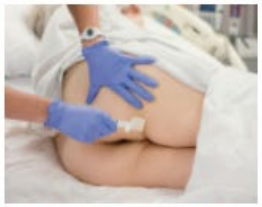
There is no need to push down on the applicator during application. Additional pressure is not needed and can result in excessive wetness or pooling of fluid.

Continue application until the entire area to be treated has been covered. It is important to apply the product to all skin that is exposed to moisture such as faeces and/or urine.

Allow the area to dry for at least 30 seconds or until touch dry. If an area is missed, wait until the fluid has dried completely before applying additional product.



If Cavilon Advanced skin protectant is applied within a skin fold or other area of skin-to-skin contact, make sure that the skin surfaces are separated to allow the fluid to dry completely touch dry before allowing skin to return to the normal position.



Reapply the product 2 times per week. Cavilon Advanced skin protectant is waterproof and is not removed by routine cleansing. More frequent application may result in build-up of the product.

Additional information

Please note that 30 seconds is the minimal drying time recommendation. Drying time can be different for every patient/resident depending on skin type, the severity and the cause of skin breakdown. Drying time can range from 30 seconds and in some cases can take up to 5 minutes or longer. Please ensure that you allow the right amount of drying time and the skin is 'touch dry'. For example, this is particularly important if the patient/resident is wearing an incontinence pad.

The film will wear off and does not require removal. In the event you do want to remove the product, use an adhesive remover that contains hexamethyldisiloxane (HMDS) or silicone polymer.

It's advisable to use an adhesive remover containing HMDS or silicone polymer anytime you remove an adhesive dressing or tape from an area that has been covered with Cavilon Advanced skin protectant.

solventum

Verson1 Author: TVN Milton Keynes University Hospital Date of review : 07/2025