Wigan Safeguarding Adults Board

Safeguarding Policy in relation to Pressure Ulcers – Including Prevention, Management and Reporting - Protocol and Guidelines

CONTENTS

1 Introduction and Aim

1.1 This policy provides a framework for health and care organisations in the borough of Wigan to draw on when:

1) A pressure ulcer is identified in the course of their duties.
2) How to report identified pressure damage in line with safeguarding procedures and
3) Implementing preventative guidance to staff in all sectors and agencies that may care for people who may be at risk of developing pressure ulcers, and

1.2 It sets out the expectations of the Wigan Safeguarding Adults Board and recognises and incorporates national, regional and local guidelines, principals and procedures advocated within

- WSAB (Wigan Safeguarding Adults Board) Safeguarding Adults Overarching Policy and Procedure (http://wigansafeguardingadults.org/Professionals/Wigan-policy.aspx)
- NHS England - Pressure Ulcers; Revised Definition and Measurement (2018) (https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/)
- The Care Act (2014) – (http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

Other key documents are listed at the rear of this document.

1.3 For organisations providing regulated / non-regulated nursing or health care, residential / domiciliary care and extra care, the policy provides both guidance and a framework for how the prevention and management of pressure ulcers should be undertaken within the context of WSAB's overarching Safeguarding Tier Model.

1.4 **For those organisations who have not yet adopted the model please contact the Safeguarding Team (http://wigansafeguardingadults.org/Board/Contact-us.aspx).**

1.5 The policy also outlines the steps to be taken including whether safeguarding enquiry duties under the Care Act need to be triggered in cases where the staff member is concerned that the pressure ulcer may have arisen as a result of poor practice, neglect/abuse or an act of omission.

1.6 From a governance perspective, each organisation that utilises this guidance is responsible for ensuring that the guidelines and policy is used appropriately and is monitored appropriately. Wigan Safeguarding Adult Boards (WSAB), the Care Quality Commission (CQC) and local Quality Surveillance Groups (QSGs) will want to be reassured that this is the case, this will be done through the Boards quality assurance processes.

1.7 The policy should be applied to the prevention, management and reporting of any tissue damage resulting from pressure.

1.8 This policy has been developed and agreed in the broader context of the implementation of the Care Act (2014) and the drive towards greater integration between health and social care systems. The reporting, treatment and management of pressure ulcers sits comfortably with the core principle underpinning the Care Act namely to promote individuals' well-being.

1.9 The policy aims to ensure consistency in the prevention, management and reporting / recording of pressure ulcers and is designed to assist organisations in applying evidence-based processes that follow national guideline standards as a minimum.

1.10 The reporting element of this document clearly spells out when Pressure Ulcers should be raised as a safeguarding concern in order to decide if a Section 42 Enquiry is required. Indicators to help decide when a pressure ulcer case may additionally need a safeguarding enquiry are included.

1.11 Those at risk of pressure ulcers are cared for in many different settings across health and social care, including in many cases their own home. Terminology used in these settings may vary for example, the term patient, resident, service user, and clients are all often used. For this policy the term individual or person will be used throughout.

1.12 This policy is in line with WWL (Wrightington, Wigan and Leigh NHS Trust) pressure ulcer prevention and management policy and procedures to ensure a consistent and unified approach across all sectors.

1.13 **Whilst the treatment and response to the management of pressure ulcers is predominantly a clinical one the prevention and reporting of them is a *shared responsibility.***

2 Pressure Ulcers – is it a Safeguarding Issue?

2.1 Pressure ulcers may occur as a result of neglect. Neglect and acts of omission may include ignoring medical, emotional or physical needs, failure to provide access to healthcare and support or education services, and/ or the withholding of medication adequate nutrition and heating. This may result in preventable skin damage.

2.2 Neglect may involve the deliberate withholding or unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support. Neglect and acts of omission include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating. In some instances, this is highly likely to result in, significant preventable skin damage.

2.3 Where unintentional neglect may be due to an unpaid carer struggling to provide care an appropriate response would be to revise the package of care and ensure that the carer has the support and equipment to care safely. In these circumstances it can be highly distressing to talk to carers about abuse and neglect, particularly where they have been dedicated in providing care but have not been given the appropriate advice and support to prevent pressure ulcers.

If pressure ulcers are the result of neglect, poor care or they aren't appropriately treated then It is a safeguarding issue the referral process should be adhered to.

2.4 Where concerns are raised regarding skin damage as a result of pressure there is a need to raise it and log it as a safeguarding issue within the organisation. In a minority of cases, it may warrant raising a safeguarding alert to the local authority. This section provides a framework for that process.

2.5 The introduction of the Adult Safeguarding Decision Guide Assessment for service users with pressure ulcers enables a more informed referral process based on individual review of individuals, giving a clear narrative to the referral pathway across all agencies. The Safeguarding Decision Guide Assessment considers six key questions:

2.6 The six questions together indicate a safeguarding decision guide score. This score should be used to help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage. (Appendix 1)

2.7 The Adult Safeguarding Decision Guide Assessment for service users with pressure ulcers should be completed by *a qualified member of member of staff who is a practicing Registered Nurse (RN),* with experience in wound management and where possible not directly involved in the provision of care to the

service user. This does not have to be a Tissue Viability Nurse.

2.8 The Adult Safeguarding Decision tool should be completed immediately or as soon as is practically possible from the time of identifying the pressure ulcer of concern**. Any reasons for delays over 48 hours from the time of identification should be clearly recorded.**

2.9 The outcome of the Adult Safeguarding Decision assessment should be documented on the Adult Safeguarding Decision Guide. Where the score is **15 or higher**, or where professional judgement determines safeguarding concerns, a copy of the completed decision guide, along with a completed safeguarding alert to adult social care, should then be sent to the Adult Safeguarding Team within the local authority. Copies of both should also be retained in the service users' electronic/paper notes.

2.10 Where the score is **below 15**, it should be logged as a Tier 2 safeguarding incident on the WSAB's tier system, this would enable monitoring of said pressure ulcer. The completed decision guide should be retained in the service user's notes.

2.11 The decision as to whether there should be a Section 42 Enquiry will be taken by the local authority, informed by a clinical view. A summary of the decision should be recorded and shared with all agencies involved.

2.12 For service users where the individual has been transferred from hospital to nursing home the Safeguarding decision tool should be available with the body map and discharge letter alerting the establishment that a pressure ulcer has been identified. If this is a HAPU (Hospital Acquired Pressure Ulcer) an internal investigation will have been undertaken, resulting where applicable to a referral to the local authority, therefore there is no requirement to duplicate a referral to the local authority.

2.13 For service users where the individual has been transferred from hospital to residential home/ own homes with care providers the Safeguarding decision tool should be available with the body map and discharge letter alerting the establishment that a pressure ulcer has been identified. If this is a Hospital Acquired Pressure Ulcer, (HAPU) an internal investigation will have been undertaken within WWL, resulting where applicable to a referral to the local authority, therefore there is no requirement to duplicate a referral to the local authority.

A referral to the District Nursing (DN) service at the point of discharge should have been undertaken by the hospital.

2.14 The DN service will be aware of all HAPU's and will follow WWL guidelines for reporting joint care plan to be established.

2.15 For service users where the individual has been transferred to hospital from nursing home the Safeguarding decision tool should be available within the care pack, alerting the establishment that a pressure ulcer has been identified, this will enable WWL to cease duplication of reporting pressure damage.

2.16 For service users where the individual has been transferred to hospital from residential home/ own homes with care providers the Safeguarding decision tool should be available with the care pack alerting the establishment that a pressure ulcer has been identified. If this is a (CAPU) Community Acquired Pressure Ulcer, an internal investigation will have been undertaken within WWL if service user on DN caseload, to cease duplication of reporting pressure damage.

2.17 Photographic evidence / Body maps to support the report should be provided wherever possible and is considered good practice. Consent for this should be sought as per local policy but great sensitivity and care must be taken to protect.

3 Who is at Risk?

3.1 Some people are at higher risk of developing pressure ulcers than others.

Answer these questions – Are any of these statements true for anyone requiring support? If so, they might be at risk of developing a pressure ulcer:

- They have impaired mobility or spend a lot of time in the same position such as sitting or lying down?
- They're incontinent or regularly have wet skin, this may be due to sweat or bodily fluids such as wound exudate or stoma effluent more so for individuals who have no carers in place.
- They have reduced feeling in any part of their body.
- They wouldn't be able to tell anyone about any discomfort, itchiness, or pain especially if they are non-verbal/ learning difficulties/disabilities.
- They have delicate or thin skin.
- They have a poor diet or don't drink enough fluid.
- They're recovering from an illness or surgery, which impacts on their mobility.
- They do repetitive behaviours, such as rocking or rubbing objects which put pressure on area(s) of their body.

If they have other risk factors, think about how long they have part of their body in contact with other things like spectacles, hearing aids, oxygen masks, wrist bands for alarm call buttons or TV remote controls.

4 Identifying and Assessing Risk

4.1 This guidance advocates those set out in Nice Guidance[1] regarding both the definition of risk and assessment of it as follows:

- Adults considered to be **at risk** of developing a pressure ulcer are those who, after assessment using clinical judgement and/or a validated risk assessment tool, are at risk of developing a pressure ulcer.
- Adults considered to be **at high risk** of developing a pressure ulcer will usually have multiple risk factors (for example, significantly limited mobility, nutritional deficiency, inability to reposition themselves, significant cognitive impairment[3]) identified during risk assessment with or without a validated risk assessment tool. Adults with a history of pressure ulcers or a current pressure ulcer are also considered to be at high risk.

4.2 Determining risk is an essential element of holistic pressure ulcer assessment and prevention. The recommended use of a risk assessment tool, which assists objectively is recognised within NICE Guidelines (2014).

Tools include the Braden Scale and the Norton Risk Assessment Scale. This guidance advocates the Waterlow Pressure Ulcer Risk Assessment Tool as it is not only the most widely distributed and used tool, but consistency in utilising the same framework can greatly assist in managing risk when an individual is moved between different health and care setting, for example between hospital acute settings and care / nursing homes.

A copy of the tool is provided at Appendix 2 further downloads and tools are available at the following web site (http://www.judy-waterlow.co.uk/waterlowdownloads.htm)

4.3 Those settings that have in-house medical / nursing staff such as Nursing Homes etc. will provide support for identification and verification of adults at risk. Social care and health services will assist in undertaking a risk assessment and management plan around individuals developing pressure ulcers, ***but you are encouraged to use the Waterlow Risk Assessment to ascertain and log that you need support in that regard.***

4.4 Where a provider does not have access to in-house medical / nursing support (i.e. Domiciliary Care, Extra and Supported Accommodation etc.) we advocate first point of call for individuals in the community

should be their GP and / or district nurses, **01942 807700** at the initial observation of pressure damage.

4.5 This will lead to anyone at risk / high risk having a 'joint care plan for patients requiring pressure ulcer prevention' which might include monitoring the individual's skin and using preventative measures, such as regular repositioning or pressure relieving cushions or mattresses. If their care plan doesn't include this, talk to the individual, their family and/or the healthcare professionals involved. (Appendix 3)

4.6 The Waterlow pressure ulcer risk assessment scoring system has been shown to be the most frequently used system used in the UK acute hospitals. It must be made very clear that like all simplistic scoring systems it cannot scientifically predict with 100% accuracy the chance of a patient developing a pressure ulcer. What it can do is ensure that all patients are assessed objectively to the same system and thereby placed in a priority order for preventative aids. It also provides evidence to management the need to purchase equipment.

4.7 All patients' skin should be assessed taking particular care to the most vulnerable areas on admission to hospital, community / care setting to identify those patients at risk of developing pressure ulcers (Waterlow 2005) and on discharge into community.

4.8 It has been suggested that one major reason why pressure ulcers occur and are often slow to heal is that insufficient care is taken when assessing a patient's risk of developing them (Waterlow 2005). The purpose of assessment is to allow prompt action to be taken and identify patients who exhibit specific risk factors, thus prompting nursing staff to initiate individualised preventative interventions and treatment. Risk assessment tools form an integral component of holistic patient care and are a quick calculator for the practitioner in the clinical area. Once the patient has been identified as being at risk, appropriate action must be taken, failure to do so will put a nurse in breach of code of conduct (NMC 2006).

4.9 Patients who are identified as being at risk of developing pressure ulcers must have a multidisciplinary plan of care detailing interventions required, implemented and evaluated, in accordance with the National Institute of Health and Clinical Excellence clinical guidelines. The assessment of the patient's risk, utilising the Waterlow score, and practitioners' clinical judgement must be undertaken no less than weekly throughout the episode of care and documented in the patient's multidisciplinary notes. Additional assessments documenting both the Waterlow score, and the practitioner's clinical judgement must also be undertaken when changes in the patient's medical condition or environment occur. Weekly is only advisable in acute. Nursing/care home and community settings, i.e District nursing remains minimum monthly.

4.10 For patients whose first language is not English practitioners should involve link workers in communicating the level of risk to the patient. Consideration should be given to providing the information in a format that meets the diverse needs of patients, for example – hard of hearing, partially sighted.

5 Mental Capacity

5.1 Consent for assessment and treatment must be gained from the patient. Gaining consent assumes that the person has capacity to either give or withhold consent. Capacity must be assumed unless there is reason to doubt it (Mental Capacity Act, Department of Constitutional Affairs, 2005). If the patient does not have capacity to consent to treatment, treatment can still go ahead under the Mental Capacity Act (2005) providing that it is in the person's best interest and the appropriate steps have been taken to assess and document this.

5.2 When advising an individual who has capacity, about self-care and prevention of pressure ulcers, it is important to establish that the person has understood the advice, can put the advice into practice, has any necessary equipment, knows how to use it and understands the implications of not following the advice.

5.3 Where it appears that the individual is neglectful in caring for themselves or the environment, staff should in the first instance discuss concerns with other agencies who form part of the multi-disciplinary

plan. A discussion will highlight the potential need to refer to the WSAB Self Neglect Policy and consider a referral within this context.

6 Prevention and Management of Pressure Ulcers

These guidelines ('aSSKINg' – Appendix 4) highlight the key elements in the prevention of pressure ulcers occurring or worsening, they include:

6.1 Identifying the level of risk an individual may be at regarding pressure ulcers.

6.2 Ensuring that an individual's care plan highlights what measures are in place regarding pressure ulcer prevention for the at risk/high risk cohort, and that this is signed off by a medical member of staff / individual.

6.3 That all staff are trained, confident and competent at identifying potential pressure ulcers at an early stage and that your organisation both responds to this information positively and ensures it is logged.

6.4 All individuals receive effective and efficient treatment of any pressure ulcers.

6.5 Category 1 pressure ulcers are managed well and with clinical input that is clearly logged within care plans.

6.6 That your organisation positively welcomes concerns and enquiries from friends and family of individuals and logs these

6.7 Follow the guidance Appendix 2 reducing the risk of pressure damage.

6.8 **All multiple category 2 pressure ulcers and all 3,4, unstageable and deep tissue injury (DTI) pressure ulcers will have the safeguarding decision guide completed and actioned as appropriate.**

This guidance advises that those organisations who have adopted the WSAB Safeguarding Tier Model adopt this framework as regards logging and correct process for wider reporting of all pressure ulcers, this will be addressed within the Recording and Reporting Pressure Ulcers section of the document.

Appendix 1:

ADULT SAFEGUARDING DECISION GUIDE FOR INDIVIDUALS WITH PRESSURE ULCERS

Question	Response Option	Score	Evidence	Score Awarded
Q1. Has pressure damage occurred?	Yes, E.g record of blanching / non blanching erythema / grade 2 progressing to grade 2 or more.	5	Evidence of redness or skin breaks with no evidence of provision of repositing or pressure relieving devices provided.	
	No	0	N/A	
Q2. Has there been a recent change in condition contributing to skin damage?	Yes, change in condition contributing to skin damage	0		
	No, no change	5		
Q3. Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisation's policy and guidance.	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patient's needs.	0	State date of assessment risk tool used. Score/Risk Level.	
	Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed.	5	What elements of care plan are in place?	
	No or incomplete risk assessment and/or care plan carried out.	15	What elements would have been expected to be in place but were not?	
Q4. Is there concern that the pressure ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services?	No / Not applicable	0	N/A	
	Yes	15		
Q5. Is the level of damage to skin inconsistent with the patient's risk	Skin damage less severe than patient's risk assessment suggests is proportional.	0		

Question	Response Option	Score	Evidence	Score Awarded
status for pressure ulcer development? E.g. low risk – Category/Grade 3 or 4 pressure ulcer.				
	Skin damage more severe than patient's risk assessment suggests is proportional.	10		
Q6a. – Answer (a) if your patient has capacity to consent to every element of the care plan. Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Did not follow care plan after receiving information and support	0		
	Followed some aspects of care plan but not all	3		
	Patient followed care plan or not given information to enable them to make an informed choice.	5	Describe information provided.	
Q6b. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan. Was appropriate care undertaken in the patient's best interests, following the best interests checklist in the Mental Capacity Act Code of Practice?	Documentation of care being undertaken in patient's best interests.	0		

Question	Response Option	Score	Evidence	Score Awarded
(Supported by documentation such as capacity and best interest statements and record of care delivered.)				
	No documentation of care being undertaken in patient's best interests.	10		
TOTAL SCORE				

If the score is 15 or over, discuss with the local authority (Safeguarding Team) as determined by local procedures reflecting the urgency of the situation. When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes.

Patient Name: …….. Patient No: ……

Name of Assessing Nurse (print):……

Job Title:……..

Signature:……..

Name of Second Assessor (print):……

Job Title:……

Signature:……..

Additional Guidance for Completing the Adult Safeguarding Decision Guide

History

- Include any factors associated with the person's behaviour that should be taken into consideration e.g. sleeping in a chair rather than a bed.

Medical History

- Does the person have a long term condition or take any medication which may impact on skin integrity; for example Rheumatoid Arthritis, COPD, Chronic Oedema or steroid use.

- Is the person receiving end of life care?

- Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? e.g. dementia / depression.

Monitoring of Skin Integrity

- Were there any barriers to monitoring or providing care e.g. access or domestic/social arrangements.

- Should the illness, behaviour or disability of the person have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)?

- Did the person decline monitoring? If so, did the person have the mental capacity to decline such monitoring?

- Were any further measures taken to assist understanding e.g. patient/service user information, leaflets given, escalation to clinical specialist, ward leads, team leader, and senior nurses?

- If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?
- Were there any other notable personal or social factors which have affected the persons needs being met? E.g. history of self-neglect, lifestyle choices and patterns, substance misuse, unstable housing, faith, mental ill health, learning disability.

Expert Advice on Skin Integrity

- Was appropriate assistance sought? e.g. professional advice from a Community Nurse, Clinical Lead or Tissue Viability Specialist Nurse.

- Was advice provided? If so was it followed?

Care Planning & Implementation for Management of Skin Integrity

- Was a pressure ulcer risk assessment carried out upon entry into the service and reviewed at appropriate intervals?

- If expert advice was provided did this inform the care plan?

- Did skin integrity assessment and monitoring at suitable and appropriate intervals form part of the care plan?

- Were all of the actions on the care plan implemented? If not, what were the reasons for not adhering to the care plan? Were these documented?

- NB: If the person has been assessed as lacking mental capacity to consent to the care plan, has a best interest decision been made and care delivered in their best interests?

- Did the care plan include provision of specialist equipment?

- Was the specialist equipment provided in line with local timescales?

- Was the specialist equipment used appropriately?

- Was the care plan revised within time scales agreed locally?

Care Provided in General (Hygiene, Continence, Hydration, Nutrition, Medications)

- Does the person have continence problems? If so, are they being managed? Are skin hygiene needs

being met? (Including hair, nails and shaving?) Has there been deterioration in physical appearance?

- Are oral health care needs being met?
- Does the person look emaciated or dehydrated?
- Is there evidence of intake monitoring (food and fluids)?
- Has the person lost weight recently? If so, is their weight being monitored?
- Are they receiving sedation? If so, is the frequency and level of sedation appropriate?
- Do they have pain? If so, has it been assessed? Is it being managed appropriately?

Other Possible Contributory Factors

- Has there been a recent change (or changes) in care setting?
- Is there a history of falls? If so, has this caused skin damage? Has the person been on the floor for extended periods?

Concern is raised that a person has severe pressure damage.

Category 3, 4, unstageable, suspected deep tissue injury or multiple sites of category 2 damage (EPUAP, 2014).

1. Complete Adult Safeguarding Decision Guide and raise an incident immediately as per organisation policy.

Score 15 or higher: Concern for safeguarding.

If Yes:

Discuss with the person, family and/or carers, that there are safeguarding concerns explaining the reason for treating the matter as a safeguarding concern and that a safeguarding enquiry has been raised.

1. Refer to local authority via local procedure, with completed safeguarding pressure ulcer decision guide documentation.

2. Follow local pressure ulcer reporting and investigating processes.

3. Record decision in person's records.

If No:

Discuss with the person, family and/or carers, and explain the reason why it is not being treating as a safeguarding concern.

Explain why it does not meet criteria for raising a safeguarding concern with the local authority, but then emphasise the actions which will be taken.

1. Action any other recommendations identified and put preventative/management measures in place.

2. **Log the pressure ulcer as a Tier 2 Safeguarding Incident under WSAB's Safeguarding Tier Alert Model, detailing / referencing point 1 above.**

3. Record decision in person's records.

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE VISUAL RISK AREAS		SEX AGE	
AVERAGE		HEALTHY	0	MALE	1
BMI = 20-24.9	0	TISSUE PAPER	1	FEMALE	2
ABOVE AVERAGE		DRY	1	14 - 49	1
BMI = 25-29.9	1	OEDEMATOUS	1	50 - 64	2
OBESE		CLAMMY, PYREXIA	1	65 - 74	3
BMI > 30	2	DISCOLOURED GRADE 1	2	75 - 80	4
BELOW AVERAGE		BROKEN/SPOTS GRADE 2-4	3	81 +	5
BMI < 20	3				
BMI=Wt(Kg)/Ht (m)^2					

MALNUTRITION SCREENING TOOL (MST) (Nutrition Vol.15, No.6 1999 - Australia	
A - HAS PATIENT LOST WEIGHT RECENTLY YES - GO TO B NO - GO TO C UNSURE - GO TO C AND SCORE 2	B - WEIGHT LOSS SCORE 0.5 - 5kg = 1 5 - 10kg = 2 10 - 15kg = 3 > 15kg = 4 unsure = 2
C - PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0; 'YES' SCORE = 1	NUTRITION SCORE If > 2 refer for nutrition assessment / intervention

CONTINENCE		MOBILITY	
COMPLETE/ CATHETERISED	0	FULLY	0
URINE INCONT.	1	RESTLESS/FIDGETY	1
FAECAL INCONT.	2	APATHETIC	2
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3
		BEDBOUND e.g. TRACTION	4
		CHAIRBOUND e.g. WHEELCHAIR	5

SPECIAL RISKS

TISSUE MALNUTRITION		NEUROLOGICAL DEFICIT	
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5	PARAPLEGIA (MAX OF 6)	4-6
PERIPHERAL VASCULAR DISEASE	5	**MAJOR SURGERY or TRAUMA**	
ANAEMIA (Hb < 8)	2	ORTHOPAEDIC/SPINAL	5
SMOKING	1	ON TABLE > 2 HR#	5
		ON TABLE > 6 HR#	8

MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4

SCORE
10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

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

© J Waterlow 1985 Revised 2005*

Obtainable from the Nook, Stoke Road, Henlade TAUNTON TA3 5LX

* The 2005 revision incorporates the research undertaken by Queensland Health.

www.judy-waterlow.co.uk

Appendix 2: Waterlow score

NHS pressure ulcer Categorisation poster

:

Appendix 3: Care Plan for Patients Requiring Pressure Ulcer Prevention

Joint Care Plan For Patients Requiring Pressure Ulcer Prevention

Patients name: _____ NHS Number:_____ DOB: _____

Date Plan implemented: _____ Review Date: _____

At risk of: pressure ulcer development / further pressure ulcer breakdown (delete as appropriate)

The following treatment is required to prevent further deterioration

Action	**Reason**
Wash the _____ areas ____ times a day with _____ and dry thoroughly	To remove any previously applied creams and to clean the skin
Apply _____ barrier cream _____ a day	To protect the skin and reduce the risk of moisture damage
Assist the patient to change position minimum 2 hourly or at each visit when in bed	To relieve pressure and reduce the risk of pressure damage / further tissue damage (delete as appropriate)
Assist the patient to change position minimum every 15 minutes or at each visit when sat in a chair	To relieve pressure and reduce the risk of pressure damage / further tissue damage (delete as appropriate)
Continue to reiterate advise to the patient on how to change their position and the importance of position changes	To relieve pressure and reduce the risk of pressure damage / further tissue damage (delete as appropriate)
If the patient has a dressing applied to pressure ulcer that has fallen off, contact the District Nurses immediately for advice of follow the advice already given	To reduce the risk of further tissue breakdown and infection
If a red area occurs over a pressure point which does not go white when pressed with the finger or the areas appears 'bruised' contact the District Nurses immediately for advice	To prevent any further tissue damage
If pressure relieving equipment is in place which does not appear to be working correctly and has been supplied by the District Nurses contact them immediately	To prevent any further tissue damage
Any additional patient specific advice/ recommendations agreed:	

Please refer to the Pressure Ulcer Prevention Leaflet and discuss the contents with the District Nurses.

If you still have any concerns contact the District Nurses on _____ for further advice and information.

Signed District Nurse: Print Name:
Signed Carer: Print Name:

Version4/11.2019 /KP/GR/KM

Appendix 4: aSSKINg Tool

The '**aSSKINg**' (assess risk; skin assessment and care; surface selection; keep moving; incontinence and moisture; nutrition and hydration; and giving information or getting help) model ensures all fundamental aspects of pressure ulcer prevention are included in patient care and sets out key principles of pressure ulcer prevention and management.
In incorporating this model across all settings, the WSAB expect that prevention and management plans will be included within paperwork / transition packs, for example between care homes and acute settings and vice versa.

A - **Assess risk**

Consider risk factors associated with compromised skin integrity.
Undertake screening and risk assessment using the PURPOSE T screening and risk assessment tool or similar evidence-based and validated tool which contains as a minimum, the same risk elements.
Refer to appropriate members of the interprofessional team.
Be aware of safeguarding policies and take appropriate action when necessary. Document risk status and timing of review in the clinical record.

S – **Skin assessment and skin care**

Carry out a comprehensive skin assessment including skin under devices where it is safe to do so. Consider colour, texture and temperature of the skin.
Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb. Consider risk factors associated with impaired skin integrity.
Identify complex health conditions that affect skin integrity. Keep the skin clean, dry and well hydrated.
Implement evidence-based skin interventions to promote skin integrity.
Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.

S - **Surface**

Consider risk factors associated with a range of support surfaces including but not limited to beds, mattresses, chairs, cushions, wheelchairs and in vehicle systems.
Consider the impact of offloading devices such as boots or other orthoses. Consider the impact of medical devices and their contact with the skin.
Consider the range of available equipment, including the mechanism of action, benefits and associated risks.
Identify and undertake relevant seating and moving and handling risk assessments.
Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk
of pressure ulcer development.
Refer to appropriate members of the inter-professional team throughout the patient journey, including discharge planning.

K - **Keep moving**

Consider level of mobility and risk factors associated with reduced mobility.
Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks.
Use relevant formal tools to assess mobility - falls risk, moving and handling risk assessments to balance the risk from other harm.
Consider the impact of reduced mobility on an individual's posture, engagement in activities of daily living (ADL) and
psychosocial functioning (mood, isolation, social engagement).
Safely use a range of appropriate equipment to promote self-mobilisation and good posture - hoists and slings, standing hoists and frames, electronic bed frames, appropriate seating and mobility aids, sleep

systems, wheelchairs etc - to promote individualised plan of mobility and assisted transfers.
Refer to appropriate members of the interprofessional team throughout the planning journey, including discharge planning.
Consider the individual's usual daily routine when planning repositioning or activity schedules.
Identify and understand and, where possible, address the cause of any change in mobility level.

I - **Incontinence or increased moisture**

Identify the cause of moisture-related skin damage ie. incontinence, sweat, saliva, stoma effluent, wound leakage. Where possible, address the cause of the moisture.
Consider whether incontinence-related skin damage is an issue. Differentiate between aetiologies associated with incontinence.
Consider how increased moisture increases the risk of skin damage caused by skin and friction. Implement appropriate prevention and management strategies.
Refer to continence services where necessary. Keep the skin clean, dry and well hydrated.
Maintain hydration.

N - **Nutrition**

Consider the impact of key nutritional elements in wound healing.
Understand the impact of disease on nutritional need and nutrient absorption.
Utilise the relevant tools and documentation which should include food and fluid charts, for example, food diaries, Malnutrition Universal Screening Tool (MUST), BMI, MUAC, bloods, feeding risks and PEM assessment.
Advise on food fortification, nutritional supplementation and moderation of dietary restrictions in event of pressure ulceration.
Collaborate to deliver appropriate care with relevant members of the MDT (multidisciplinary teams) (dietician, speech and language therapist, occupational therapist).
Consider the practical elements of maintaining nutrition and hydration including portion sizing, food texture, access and ease of use of implements and good dentition.

G - **Give information**

Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
Consider the patient's level of capacity and perform the necessary checks.
Communicate effective and safe use of interventions effectively for the patient, family and within the MDT.
Recognise when clinical concerns need to be escalated.
Promote effective pressure ulcer prevention approaches.
Consider effective resource allocation and escalate concerns when resources are unavailable. Be aware of safeguarding policies and take appropriate action when necessary.
Use the clinical record as the source of documentation to ensure information is available to all members of the MDT. Use appropriate language to ensure the clinical record can be appropriately used for coding/analytic purposes.
When capturing/using digital images, ensure appropriate consent has been obtained.

Suggested documents and reading

"Reduce the Risk / What to Spot"

- Regularly change position and move as much as is possible – for example walking around, stretching or sitting in different chairs throughout the day.
- Checking skin daily for early signs and symptoms of pressure damage.
- Eat a healthy, balanced diet that contains plenty of protein, a variety of vitamins and minerals, particularly vitamin C and zinc, and plenty to drink. If concerned, ask their GP or healthcare team for a referral to a dietician.
- Ensure that skin is dried thoroughly after washing, but without vigorous rubbing or dragging the towel across the skin.
- Be careful moving or being moved to ensure that skin isn't dragged – where necessary seek advice from a physiotherapist or occupational therapist who may recommend lifting aids or slide sheets.
- Stop or cut down on smoking as it can restrict blood circulation.
- Seek advice from a Nurse or GP about whether prescribed creams or sprays are required to protect skin – particularly people who experience incontinence and moisture.

If you support someone with personal care needs, look out for the following:

- Part of the skin becoming discoloured (people with pale skin tends to get red patches, while people with dark skin tend to get purple or darker patches).
- Discoloured patches not turning lighter when pressed.
- A patch of skin that feels warm, spongy or hard.
- Pain or itchiness in the affected area.

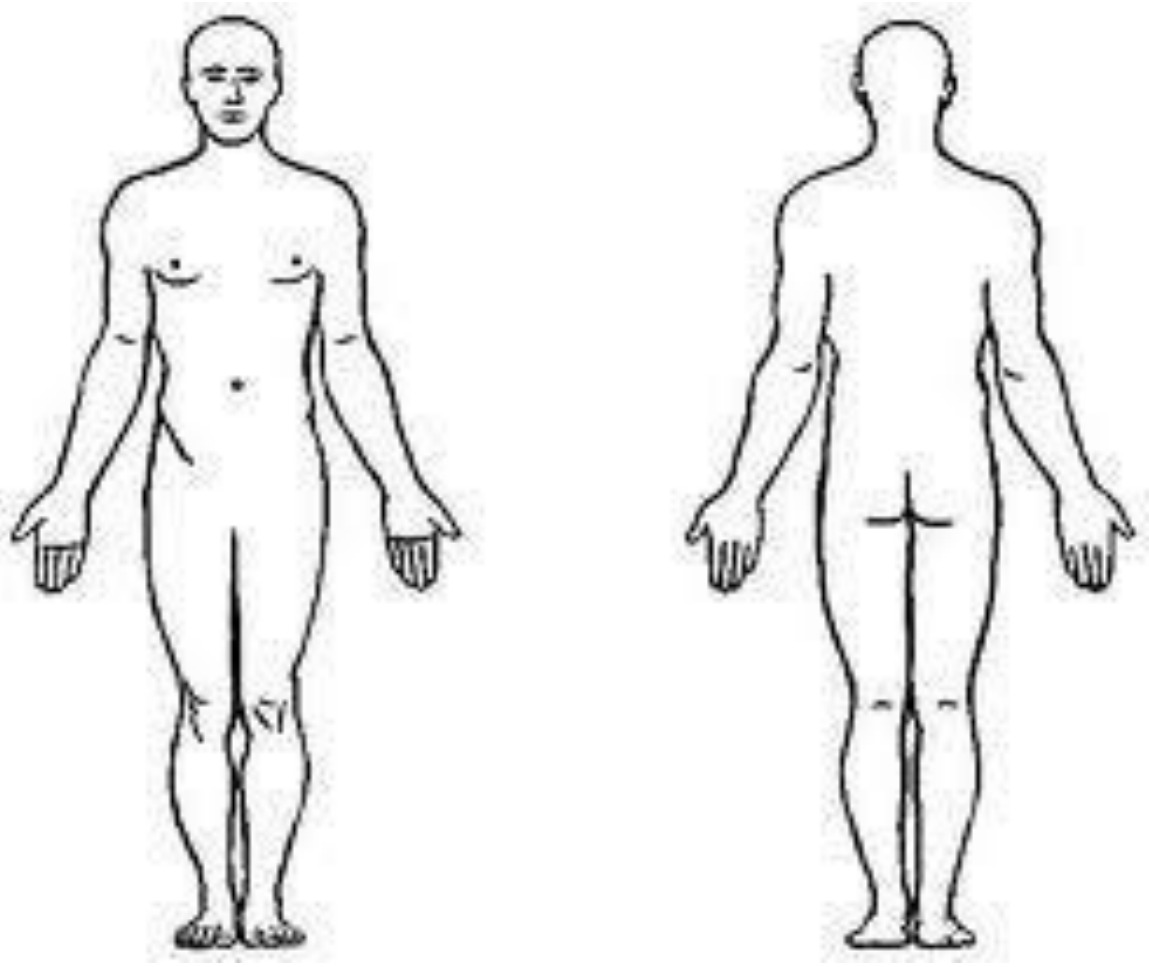
Any of these could be an indicator that a pressure ulcer is developing, and it is important to contact and inform the individuals Nurse or GP of the same.

Seek medical advice immediately if someone has any of the following:

- Red, swollen skin.
- Pus coming from a pressure ulcer or wound.
- Cold skin accompanied by a fast heartbeat.
- Severe or worsening pain.
- Confusion that is unusual for them such as a change to their usual level of understanding and/or behaviour.
- A high temperature (fever) or 38C (100.4f) or above.

Body Map

Body maps should be used to record skin damage and can be applied as evidence if necessary at a later date. If two workers observed the skin damage, they should both sign the body map.



Patient Name: …….. Patient No: ……

Name of Assessing Nurse:……

Job Title:……

Signature:……

Name of Second Assessor:……

Job Title:……

Signature:……

Standard Operating Procedure for Pressure Ulcer Prevention and Management – Care Homes

A-ASSESSMENT Refer to section	Holistic assessment as per department guidelines, including risk assessments and body map; as a minimum MUST, Waterlow and mental capacity.
S-SUPPORT SURFACES Refer to section	Assess requirement for equipment Consider: mattress/seating/devices/offloading heels
S-SKIN INSPECTION refer to section	Full skin inspection on admission to the care home, including body map. Preventative care plan implemented for patients deemed 'at risk' with evaluation dates scheduled. Full skin inspections, from head to toe, to be completed as a minimum daily and escalated as appropriate.
K-KEEP MOVING Refer to section	Determine the patients required individualised repositioning schedule in bed and when seated and document. Consider: M&H assessment etc. Record all repositioning on the turn chart
I-INCONTINENCE Refer to section	Are there any bladder/bowel issues/history of moisture damage? Consider: continence assessment/ barrier cream/product review/referral to stoma specialist nurse/continence service Provide verbal advice to the patient and/ or care giver and reinforce the information by providing moisture associated skin damage leaflet.
N-NUTRITION Refer to section	Ensure MUST score is completed and findings acted upon Refer to dietician if indicated. Provide dietary and fluid intake advice as necessary and provide the Trust 'How to make your meals more nutritious leaflet'. Provide the patient with fluid and food intake charts if required.
G-GIVING INFORMATION Refer to section	Shared decision making between the patient must take place with evidence documented of all decisions and rationale. Provide verbal advice and reinforce with written information in the form of leaflets as mentioned above. Patients who are non-concordant/ lack capacity must have discussions regarding their rationale and any steps taken to resolve any issues.
PRESSURE DAMAGE IDENTIFIED	**Nursing Home:** Photograph weekly, or immediately upon any signs of deterioration Categorise the pressure ulcer Complete wound assessment including care plan with evaluation dates scheduled Refer to local authority for safeguarding if decision tool is 15 or above (see guidance) Category 1/2 – refer to tier 2. Category 3/4/DTI/ Unstageable refer to tier 3 (if score 15 and over) Reassess the patients treatment as per aSSKINg
PRESSURE DAMAGE IDENTIFIED	**Residential Home** Refer to local authority for safeguarding if decision tool is 15 or above (see guidance) Category 1/2 – refer to tier 2- Category 3/4/DTI/ Unstageable refer to tier 3 (if score 15 and above) **Refer to the District Nursing Service** Reassess the patients treatment as per aSSKINg

Suggested Reading

Clay M (2000) Pressure sore prevention in nursing homes. Nursing Standard, 14 (44) pp 45-50

Department of Health (2013) Statement of Government Policy on Adult Safeguarding. Available from: https://www.local.gov.uk/publications [accessed 23rd October 2018].

Department of Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. London: The Stationery Office.

European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (2014) Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline.

Mental Capacity Act (2005) London: The Stationery Office.

National Patient Safety Agency (2012) Pressure Ulcers: Avoidable or Unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference. Available from: https://www.npuap.org/np-content/uploads/2012 [Accessed October 23rd, 2018].

NHS England - Pressure Ulcers; Revised Definition and Measurement (2018) (https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/)

NHS Improvement (2018) Pressure ulcer core curriculum [online]. Available at: https://improvement.nhs.uk/resources/pressure-ulcer-core-curriculum/

NICE guidelines [1] https://www.nice.org.uk/guidance/cg179/chapter/1-recommendations

The Care Act (2014) – (http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

The Human Rights Act (1998) London: The Stationary Office.

Tissue Viability Society. Achieving Consensus in Pressure Ulcer Reporting. JTV 2012. Waterlow 2005 site

(http://www.judy-waterlow.co.uk/waterlow_downloads.htm)

WSAB Safeguarding Adults Overarching Policy and Procedure (http://wigansafeguardingadults.org/Professionals/Wigan-policy.aspx