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**Prevention of Pressure Injury Policy**

**[Date of Issue]**

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# Introduction

Pressure ulcers usually develop over an area of bony prominence and, while they are a localised injury to the skin and/or underlying tissue, they can vary in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Any client can develop a pressure ulcer, but some factors increase risk, especially those that result in interface pressure, shear, friction and moisture. Pressure ulcers are a preventable and costly occurrence that act as a key indicator of the quality and experience of client care.

# Policy Statement

[Company Name] are committed to encouraging staff to identify at risk clients in order to support hospital front-line staff and allow for early prevention. Staff should be competent in the assessment of pressure ulcer risk, their identification and categorisation, including:

* those most likely to be at risk of developing a pressure ulcer
* how to identify pressure damage
* how to categorise pressure damage.

# Scope

This policy covers risk assessment, prevention, and treatment in adults at risk of pressure ulcers (also known as bed sores or pressure sores). Its aim is to reduce the risk of getting a pressure injury, including the management of pressure injuries when they occur.

[Clinical Lead Name] is responsible for the ongoing monitoring of all identified pressure injuries, supporting staff and ensuring that the content of this policy continues to reflect Best Practice.

# Definitions

**Pressure Ulcers** have interchangeable descriptors and may be known as bed sores, pressure damage, pressure sores, pressure injuries and decubitus ulcers. Best Practice is to refer to them as a pressure injury. Staff will aim to be clear in their descriptors and be able to differentiate between the early stages of pressure injury through to pressure ulcers. Standardised descriptions are given. Pressure ulcer would generally refer to an open wound, caused by early pressure damage.

**Pressure Injury** refers to the early stages of damage before the injury develops into an ulcer.

# Objectives

* Identify clients at risk of developing skin damage and pressure ulcers and ensure bespoke preventative interventions.
* Provide guidance to clinical staff and those with appropriate competencies on requirements of practice when undertaking preventative care and management treatment which should reflect National Standards.
* Ensure clients get individualised, evidence based, safe, timely pressure ulcer preventative care.
* Ensure all services users receive regular appropriate assessments relevant to their needs and risk scores.
* To ensure National and Local requirements regarding reporting and investigating incidents relating to pressure ulcer prevention and management are followed.

# Procedure and Process

**Pre-Admission, Assessment and Management of Skin**

When necessary, skin should be robustly assessed and physically checked with consent. Where this is not possible for whatever reason, [Company Name] will ensure discussion with the clients, advocates, family/carers, legal representatives, and any other appropriate multi-disciplinary staff about their skin.

**Client Refusal to check/Refusal due to Lack of Capacity**

Where a client refuses to allow their skin to be checked or discussed, staff will offer a rationale and encouragement with honesty, warmth and understanding. Clients may be embarrassed, in pain or just feel uncomfortable about their skin or condition. Staff should refer to a relevant and appropriate [Company Name] policy for further guidance on how to manage clients who refuse management or assessment.

Where a client lacks capacity, the staff approach should be to decide what will work in their best interest.

In either instance, where a physical skin check is not possible, this should be documented, including the reasons why, and how a follow up skin check will be managed.

**New clients**

All individuals who are new to a Domiciliary Care setting should be risk assessed as soon as possible as clients may be put under care with new or ongoing pressure damage that they or relatives may be unaware of. This should initially be documented as Pressure Ulcer in the care notes.

A competent person should do a full skin check and body map with the consent of the client (competent means a staff member who is experienced in observation of skin and can differentiate between wounds and skin conditions).

Body mapping is done to determine the state and presentation of the skin on the whole body, manage any ongoing or new wounds/breaks, identify areas of concern, prevent breakdown, protect integrity and allow for any interventions to be put in place. The staff member doing the skin check should be aware of skin conditions that may need further investigation or clarification, and, whether or not these may need Safeguarding and reporting to CQC. A robust skin assessment should cross reference with:

* Medications (old/new/ongoing)
* Age
* Specific medications
* Lifestyle
* Capacity
* Co-Morbidities
* Dementia/Alzheimer’s
* Unknown reasons

On entering domiciliary care, the following documentation should be robustly completed:

* Waterlow/Braden/Norton or other validated Skin Assessment tool
* Daily Notes
* Body Map
* Guidelines for completion of body mapping
* Any other documentation deemed necessary and appropriate by [Company Name].

A skin assessment includes all skin surfaces from head to toe. Special attention should be given to areas at high risk for pressure injury development such as bony prominences and areas in constant contact with pressure. Particular attention should be given to the occipital area (back of head), sacrum, back, buttocks, heels, elbows and folds in skin where pressure is from body weight (Appendix 2).

If pressure injury, or the beginning of one is suspected at any point during a skin assessment, the appropriate interventions, documentation and reporting should be initiated straight away.

This should include:

* Identifying the stage of the pressure sore (see Appendix 3)
* Photography with consent (if unable to consent staff should document the reasons why consent was not obtainable, and, why the photo needed to be taken)
* Putting appropriate interventions in place
* Liaising with external Multi-Disciplinary Team (Tissue Viability/District Nurse/CCG/Safeguarding/Social Workers/Family/the client).

Skin should be routinely checked for pressure injury at every clinical intervention. Staff should also use the opportunity during routine interventions and care to observe and check skin with a focus on their pressure points.

**Hospital Admission**

When a client has to go into hospital, a copy of the most up to date body map with relevant information about skin and management should be included with the admission documents. This provides clarity to the hospital admissions team who can manage any ongoing pressure injury or wound dressings that may be in place. It also provides a baseline to measure skin when the client returns home.

**Home Re-admission**

Clients may spend time out of their home for a number of reasons, they may have a day outing or stay overnight visiting family or even a hospital admission. If they are away overnight or, for any length of time, a physical skin check should be done on coming back home. Skin can break down rapidly over a very short period of time due to underlying frailty, co-morbidities, medication, and general deterioration in health in the elderly. Best practice would be to check and body map so changes can be questioned and managed and interventions put into place. Staff should always gain consent from those with capacity. Staff should determine if it is within a clients’ best interests to check skin in this context.

Concerns over new changes in skin, dressings, bruising should all be queried with the client, family/individuals, they have spent time with, and/or any other place the client has spent time. Evidence of discussion, intervention and management should follow up any skin concerns noted.

# Procedures

**Communication**

Individuals who have been assessed as being high risk of developing pressure damage, and their families and carers, will be offered timely and bespoke information about their risk and management. They should be inclusive in managing their pressure relief. This information should be delivered by a trained or experienced healthcare professional and include:

* The causes of pressure injury
* The early signs of pressure damage
* Ways to prevent pressure injury
* Implications of having a pressure injury (e.g., treatment options, and the risk of developing injury in the future).

# Capacity

**Immobile Lacking Capacity**

Clients who are fully immobile and unable to reposition themselves, should have their pressure points and skin checked on every positional change and during routine care and when having hygiene needs met. Staff should be highly observant throughout shifts to any skin changes and non-verbal communication that may indicate a change.

**Mobile client lacking capacity**

Clients who lack capacity or have variable capacity can present challenges to gaining consent and physical skin checks due to their underlying conditions and, high mobility. Staff should use the approach that works best for the client with their presentation. Staff should also consider liaising with family members to support the client for best techniques and or/with skin inspections. Staff should be aware that it is not always possible to do physical routine skin inspections in clients who lack capacity, therefore an alternative means must be found to do this. If staff are unable to assess skin, the reasons should be well documented alongside any potential concerns and with further checks during any interventions given.

**Mobile/Immobile client with capacity**

Clients who have capacity should be involved in their own care. Staff should discuss with them why positions and skin checks are essential. Staff should monitor and document skin integrity daily using clinical opportunities, either by visual skin inspection or discussion and verbal questioning regarding changes in skin and possible pressure damage. Clients who are involved in their care and take some ownership are more compliant and have better health outcomes.They should be reminded to mobilise or shift position or be encouraged to move on an agreed frequency.

Any client with capacity that does not wish to mobilise or give themselves pressure relief, should have the reasons clearly documented, with cross reference, in their daily notes and in their care plan under the appropriate section of care (Skin, Capacity, Mobility). Capacity should be documented in any notification and reporting of any pressure injury or ulcers.

# Risk Assessment

Risk assessment is a fundamental part of preventing pressure injury and prescribing care. Many pressure injury risk assessment tools have been developed but these represent only one part of the process. Clinical judgement, informal assessment, formal pressure risk assessments and pre-screening tools are all used to assess risk.

Risk assessment tools encourage a structured approach to assessment, complement experienced clinical judgment and act as an aide memoir for less experienced carers. They should not be used to prescribe equipment or treatment.

A validated skin assessment tool must be used to assess the risk (well-known tools are the Braden, Norton, or the Waterlow). The risk score will determine, alongside clinical judgement, the initial level of intervention and management needed.

[Company Name]’s standardised risk assessments tools and template care plans should be used when assessing risk and planning care.

All clients are potentially at risk of pressure injury and the risk for pressure injury in clients is variable. Risk assessments should be completed on a minimal monthly basis. Additionally, any of these changes’ warrants consideration for a new risk assessment at any time they are identified:

* Changes in medication that include steroids
* Changes in mobility (longer periods of sitting/laying etc)
* Changes in capacity
* Changes in general presentation
* Movement between settings
* Transfer from another setting (e.g., hospital)
* Use of new invasive equipment
* New co morbidities

Adults considered to be at high risk of developing pressure injury will have multiple risk factors identified during risk assessment with or without a validated risk assessment tool. Adults with a history of pressure injury and ulcers or a current pressure injury are also considered to be at high risk.

Contributing risk factors are:

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| **Intrinsic (individual)** | **Extrinsic (external)** |
| Nutrition / hydration | Pressure  Restricted mobility  Devices (surgical frames, casts, appliances) |
| Reduced/limited/ or no mobility | Shearing (poor moving and handling and friction) |
| Age | Moisture |
| Cognitive Impairment (memory loss, forgetfulness) | Surgery |
| Neurological Disorders (Motor Neurone Disease, brain injury, Alzheimer’s etc) See link for the Brain Charity. | Poor hygiene |
| Sensory Impairment (stroke) | Being admitted to a secondary care setting |
| Diabetes and/or diabetic neuropathy | Receiving care in other settings (primary, community, emergency) if they already have risk factors |
| Circulatory Disorders (anaemia, poor vascularisation) |  |
| Incontinence |  |
| Infection |  |
| Medication |  |
| Previous or current non pressure injuries |  |

Interventions to support and manage pressure injury/ulcers should assessed as/when needed and/or if changes occur. These can and should include:

* Pressure cushions/mattresses
* Airflow mattress and cushions
* Balanced nutrition/hydration
* Robust, regular repositions.

# Skin Assessment

All individuals should have a skin assessment done. In practice, assessments can be undertaken at any moment of opportunity (example, toileting, mobilising, therapy, bathing etc). Staff should utilise these opportunities for assessment alongside routine mandatory checks.

Signs of pressure injury can be detected early on, and it is important that staff know what these signs look like, how to differentiate and can identify them in order to be proactive and prevent further pressure injury. Skin should be assessed by a competent healthcare professional. Assessments should consider any discomfort or pain.

Early indicators of pressure injury are:

* Skin which may appear reddened, discoloured (purple or blueish in darker skin), shiny, warm and/or hard to touch.
* The skin should go white under gentle pressure, then back to pink after pressure is removed This indicates good capillary refill. If the area stays white after pressure is removed – blood flow has been impaired and early pressure damage has started.
* Darker skin may not have signs of visible blanching when pressure is applied. Other indicators would be changes in colour or hardness to the area.

Staff should be aware that what is seen on the surface of the skin may only be a small part of the pressure injury which is visible. There may be further hidden damage below the skin surface. Should pressure injury indicators be present, staff should start appropriate preventative action in non-blanching erythema and continue checking this every 2 hours until resolved or further intervention is in place.

Skin should be body mapped and evidenced if pressure injury is present (it is also Best Practice to evidence any skin checks and state when skin is intact). Any damage to skin should be clearly described, measured, photographed, and documented. Wounds and injury should be measured/traced using disposable ruler and/or tape using an aseptic technique.

Pressure injury should be reported as per your [Company Name] policy and to your Local Safeguarding team. Best Practice would be to alert Safeguarding and the CQC to any pressure damage that is identified. This ensures you are being responsive and robust with your communication and notifications and works to build up trust between organisations.

Individuals, who are willing and able and have capacity, should be encouraged, following education, to inspect their own skin. Any informal education and training provided to the client/ family or carer should be recorded and backed up with written client information leaflets. The importance of reporting to the health professional any areas of concern should be stressed.

**Bariatric Individuals**

Maintaining skin integrity in bariatric clients is vital. The bariatric individual is at risk and may sustain pressure damage in unusual sites. A comprehensive assessment of the client’s risk factors should be completed, and the appropriate support equipment selected.

Any refusal to allow skin inspection should be documented and the risks fully explained to the client, family and carers as appropriate.

Checks should be done for:

* Persistent Erythema (i.e., redness over a bony prominence that does not fade within 2 hours).
* Non-blanching Erythema (i.e., persistent area of redness over a bony prominence that does not turn white when light finger pressure is applied).
* Blisters (i.e., these should not be confused with moisture lesions or burns or other types of blisters). Clinical judgement should be exercised.
* Dusky patches or skin over a bony area which look bruised.
* Localised heat, localised oedema, localised induration (hardness within the tissue) or localised coolness if tissue death occurs, may be noted in darker skin tones.
* Any areas of pain or discomfort that might be attributed to pressure damage, especially when using plaster casts/splints. Pain over a bony area may be a precursor to pressure damage.
* Skin damage which may be caused by medical devices (e.g., catheters, oxygen masks Record ALL ASSKING Assessments, noting details of any painful areas possibly related to pressure damage).

**Identifying Pressure Injury**

**(Appendix 3 Applies to Ulcers)**

Identification of pressure injury can, at times, be difficult in the early stages before skin breakdown. [Company Name] should ensure they have an allocated individual who is competent in identifying early stages of pressure injury.

Pressure injuries should be categorised using the International NPUAP‑EPUAP Pressure Ulcer Classification System, as follows (see NPUAP/EPUAP/PPPIA Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, 2014 for more information and pictures to assist in identification):

* Grade I

Non blanchable erythema with intact skin and a non-blanchable redness on lightly pigmented skin. For darkly pigmented skin, this may be blue or purple. The area may be painful, firm, soft and warmer or cooler as compared to adjacent tissue

* Grade II

Partial thickness skin loss that can present as:

* + A shallow open ulcer with a red, pink wound bed, without slough
  + An intact or open/ruptured serum-filled blister
  + A shiny or dry shallow ulcer without slough or bruising
* Grade III

Full thickness skin loss where subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. May include slough (but not enough to obscure the depth of tissue loss), undermining and tunnelling

* Grade IV

Full thickness tissue loss with exposed bone, tendon, or muscle. Often includes slough or eschar on some parts of the wound bed, as well as undermining and tunnelling. Exposed bone/tendon is visible or directly palpable

* Unstageable

Full thickness tissue loss where the base of the ulcer is covered by slough and/or eschar making the depth, and thus the grade, unknown.

* Suspected Deep Tissue Injury (DTI)

Skin is intact, making the depth unknown, and is purple or maroon in colour or has a blood-filled blister due to damage of the underlying soft tissue from pressure and/or shear. Area may be painful, firm, mushy, boggy, and warmer or cooler as compared to the adjacent tissue.

Any pressure injury Grade II or above must be reported to [Clinical Lead Name] for monitoring and further investigation to the appropriate Local Authority and as per Safeguarding requirements. The District Nurse (DN) or, Tissue Viability Nurse (TVN) should be informed so they can come and review and grade the pressure injury. They will ensure an appropriate plan is put into place. This may include clinical management of the wound itself and/or pressure relieving interventions such as increasing the frequency of repositioning, reviewing cushions/mattresses, or even providing extra aids such as wedges or boot to support pressure relief.

Prevention strategies for monitoring should continue in order to prevent the development of any further pressure sores and to continually monitor the existing one(s). This should include the regular re-categorisation of the existing ulcer, usually by the TVN or DN. If the pressure injury has no dressing, reassess at each assessment. If the pressure injury has a dressing, assess at each dressing change. Staff should be aware that because a dressing is on, it should still be assessed for possible deterioration of the pressure injury or that the dressing has become saturated or unclean and needs a change. Staff should not assume that because a dressing is in place the pressure injury can be left until the next check. If staff have concerns around a dressing this should be fed back to [Clinical Lead Name] and the healthcare professional managing the pressure injury. If there are concerns or regulatory reporting requires weekly or ongoing assessment with photos, liaise with the TVN to reach an agreeable outcome so that compliance can still be met.

# Interventions

Pressure injuries cause considerable pain and damage which can lead to increased cost and immobility. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. NPUAP recognises that that some pressure injuries are unavoidable - it states, ‘*causation’ should not be implied by use of the word ‘injury’*. Rather, evidence must be presented to support a theory of causation based on a careful analysis of the preventive care provided (or not provided) to the individual in accordance with acceptable standards of evidence-based pressure injury prevention.

[Company Name] and all staff that deliver care and interventions have a duty to the client. In some circumstances, pressure injuries are unavoidable, but generally, a duty has been ‘breached’ should a pressure injury occur in a client. Evidence must be presented to support all four components (duty, breach of duty, injury, and causation). Injury is only one of four components and has a specific limited definition in law. Further guidance and information is available at NPUAP and the International Guideline on Pressure Ulcer Prevention and Treatment.

# Management

Those at high risk of developing pressure injury should be encouraged to change position themselves. This should be at least every 4 hours and, more frequently if they wish.

If individuals are unable to reposition themselves, assistance and support should be offered with the use of appropriate equipment (if necessary).

**Pressure Redistribution Equipment** - Those who do not already have a pressure relieving mattress and/or cushion, should be provided with these as soon as possible.

**Barrier Creams** *–* These alone should not be used to prevent pressure injury. They should be used at the early stages of pressure injury to help maintain skin integrity and prevent breaks in the skin which can contribute to pressure injuries (e.g., incontinence).

**Dressings**– Dressings should be considered for Grade II, III and IV pressure injury, with an assessment undertaken to determine whether they are appropriate. Consideration must be given to individual pain and tolerance, location of pressure injury, quantity of exudate and the frequency of dressing changes.

# Prevention

Examination of skin over bony prominences can reveal the first signs of pressure injury. At this early-stage ulceration may be prevented. In a client who is recognised as at risk, skin inspection is part of the ongoing risk assessment process.

Skin inspection should occur regularly, and the frequency determined in response to changes in the individual’s condition in relation to either deterioration or recovery. If a client is considered to be at risk, then skin should be inspected for signs of pressure injury at regular intervals.

Skin inspection should be recorded, and problems acted upon robustly and timely. Skin inspection can take place during routine care, taking into account individual consent, preferences, privacy and dignity.

Skin inspection should be based on an assessment of the most vulnerable areas of risk for each individual. These are typically heels, sacrum, ischial tuberosities, and femoral trochanter. Also at risk are parts of the body affected by parts of the body where pressure, friction and shear are exerted in the course of an individual’s daily living activities and parts of the body where there are external forces exerted by equipment and clothing - elbows, temporal region of the skull, shoulders, back of the head and toes and folds of skin where pressure can be high.

**ASSKING Bundle** (See Appendix 1 for further details)

ASSKING skin bundle, replaces the SSKIN bundle and now has two additions (A and G) to further support pressure injury prevention. This bundle is used in the NHS and clinical settings and is strongly recommended to be used as a benchmark within care settings. It is used for planning, assessing, and evaluating care. Use of a validated tool ensures that all providers are assessing in the same way and interpreting those results.

A – Assessment of Risk

S – Skin Inspection and Care

S – Surface

K – Keep your person moving

I – Incontinence and moisture management

N – Nutrition and hydration management

G – Giving Information

**Equipment**

[Company Name] shall ensure that all staff are competent and compliant with handling equipment as per company policy. [Company Name] will ensure all equipment is maintained and fit for purpose as per manufacturer’s instructions.

Devices (mattresses and cushions) come in two main types; those that reduce pressure by spreading the weight and increasing the surface area, and those that relieve pressure by removing the pressure at frequent intervals.

**General Considerations in Decision Making (not exhaustive):**

* Pressure relieving equipment does not replace the need for repositioning and should be used as an adjunct with a repositioning and skin inspection regime that suits the individual and circumstances.
* Decisions about support surfaces should be made following a holistic assessment of a person’s risk, comfort and general health state.
* Individual movement in and out of bed should be considered when considering equipment provision, as air mattresses can impede transferring.
* Environmental assessment should be undertaken particularly when ordering an electric profiling bed for community use. There needs to be room for the bed and an electricity supply / availability of sockets.
* The Medicines and Healthcare products Regulatory Agency (MHRA) is aware of fires starting from lit cigarettes being dropped onto non-fire-retardant bedding covering air mattresses and overlays. For clients at risk (i.e., smokers), consider using alternative pressure care equipment and fire-retardant bedding. Ensure clients are aware of the dangers of smoking in bed.
* Assessment should be on-going throughout an individual’s episode of care and the type of pressure relief support changed to suit any alteration in risk.

**Foam Replacement Mattresses/Cushions - Pressure Re-distribution**

These consist of several layers of different foams and have a pressure reducing action because they allow the individual to ‘sink-in’ thereby spreading the pressure over a greater surface area.

They can be used for individuals who are at risk but who are still relatively mobile so that they can move themselves in bed. High specification foam can be used for high and very high-risk individuals.

They should be cared for according to the manufacturer’s instructions and will require regular checks to ensure their integrity.

They may also require turning at intervals; this is dependent on individual manufacturer’s guidance.

Air filled devices reduce pressure but may need to be re-inflated at intervals.

Gel or fluid filled devices also reduce pressure by spreading weight.

Caution should be taken with the use of air-filled devices, mattresses, cushions with individuals who cannot maintain or rectify their own posture.

**Alternating Air Flow Mattresses – Pressure Relieving**

These work on the principle of cyclic inflation and deflation of air cells over a short period of time. This can be controlled by a dial or by a ‘sensor’ pad which measures the individual’s weight and then alternates the amount of pressure to different parts of the body giving pressure relief.

May lead to an increased risk of falls due to difficulty transferring in and out of bed for some clients.

They can be used on individuals who are at very high risk particularly those who cannot tolerate the movement of an alternating product, for clients who are underweight, or palliative individuals for comfort.

Low air loss mattresses float the individual on air filled cells while circulating air across the skin to reduce moisture and help maintain a constant skin interface pressure. To achieve this, air escapes through small laser cut holes.

Lateral turn low air loss mattresses constantly rotate the individual from side, to back, to side to change pressure points. They can be set at ½ hourly, hourly or 2 hourly intervals. They improve circulation, provide pressure relief, reduce risk of pulmonary complications and stimulate the gastro-intestinal tract without disturbing the individual.

**Electric Profiling Beds Reduce Skin Damage by:**

* Making individual movement easier for the individual, carers and staff, so reducing friction and shear.
* Use of the knee break prevents sliding down the bed reducing friction and shear forces and reduces the pressure and weight exerted on the heel.
* Allowing individuals to change their own position.

**Other Equipment:**

* Friction and shear can be minimised with the use of a slide sheet.
* Manual handling risk assessments should inform the pressure ulcer prevention care planning process and any identified needs addressed with relevant equipment provision e.g., hoist.
* If the individual’s needs are not met by the standard equipment carried by the Equipment / Loan store, please contact the Tissue Viability Nurse/District Nurse for alternative options.

**Reporting of Pressure Injury and/or Ulcers**

Pressure damage should be reported to the [Clinical Lead Name] for general day to day management of the injury. Best practice would be to alert the TVN/DN and CQC to the presence of injury and the steps being taken to manage and reduce risk. This is responsive, well led and shows robust compliance in documentation management and reporting processes.

Pressure ulcers should be seen by a TVN and graded. They should be reported internally via [Company Name]’s incident reporting systems, an RCA should be conducted, and CQC and [Company Name] Local Authority for safeguarding should be contacted – including any specific requirements by the Clinical Commissioning Group.

Reporting should document:

* Where it developed (preadmission or during care)
* The link to the risk score and degree of harm
* Damage related to medical devices should be documented as such
* The definition of a new pressure ulcer is when it is first observed in that setting in the current episode of care.
* All pressure ulcers Grade II and above (including unstageable) should be incorporated into local monitoring systems
* Where skin is damaged by a combination of Moisture Associated Skin Damage (MASD) pressure, [Company Name] will ensure it is reported based on the category of the pressure damage. Moisture related damage to skin should be counted and reported in addition to pressure damage and ulcers.

**Education and Training**

[Company Name] will provide training and education to staff on preventing pressure injury. They will ensure training is mandatory and up to date with Best Practice, including:

* How to carry out a skin and risk assessment
* Who is most likely to be at risk
* How to reposition and when to change frequency
* Information on pressure redistribution equipment
* How to identify pressure damage
* What steps to take to prevent new/further damage
* Who to contact for further information and management
* Discussion of pressure injury prevention with clients and families.

# Monitoring

The effectiveness of this policy will be monitored through routine auditing along with any incident reporting. [Clinical Lead Name] is responsible for identifying and investigating any trends in the development of pressure injury/ulcers and for appropriately escalating and reporting all incidents and any pressure injury that meets, or potentially meets, the threshold of a serious incident.

# Related Policies

* Bariatric Persons Policy
* Confidentiality Policy
* Consent Policy
* Dementia Policy
* Diabetes Policy
* Duty of Candour Policy
* Health and Safety Policy
* Incident Management Policy
* Mental Capacity Act & DoLS Policy
* Safeguarding Policy
* Sepsis Policy
* Training and Induction Policy

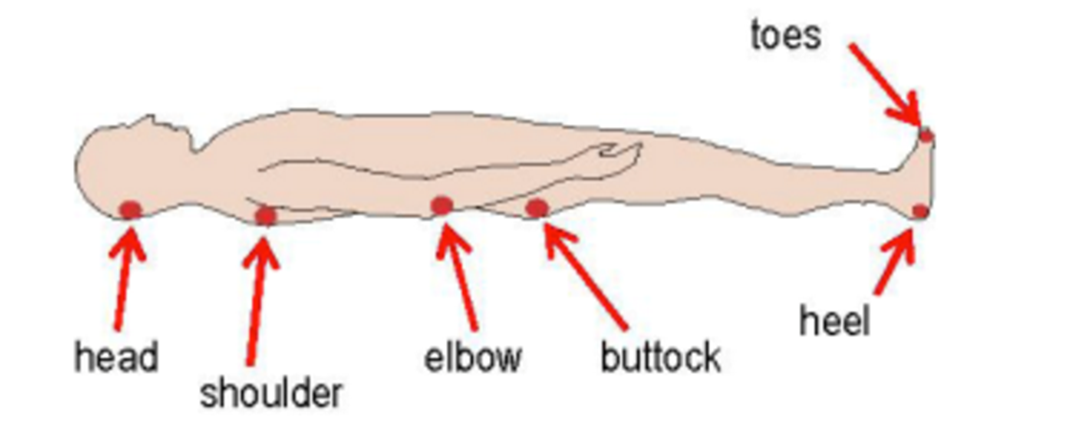
# Legislation and Guidance

**Guidance**

* NICE Clinical guideline [CG179]: Pressure ulcers: prevention and management
* NPUAP/EPUAP/PPPIA, Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, 2014
* NHS Improvement: <https://improvement.nhs.uk/resources/Using-SSKIN-to-manage-and-prevent-pressure-damage/>
* NHS Guidance: <https://www.nhs.uk/conditions/pressure-sores/>
* Public Health England Guidance: <https://www.gov.uk/government/publications/pressure-ulcers-applying-all-our-health/pressure-ulcers-applying-all-our-health>
* The Royal Marsden ‘ASSKING Model’ [(The Royal Marsden)](https://cqccomplianceltd.sharepoint.com/sites/sharedCQC/Shared%20Documents/General/05.%20Operations/02.%20Policies/11.%20QPOL%20TEMPLATES/Care%20Homes/06.%20Archive/Project/5.%20Formatting/MASTER%20Pressure%20Ulcers%20(Care%20Home)%20Policy.docx) Appendix 1
* The Brain Charity [A-Z of Conditions](https://cqccomplianceltd.sharepoint.com/sites/sharedCQC/Shared%20Documents/General/05.%20Operations/02.%20Policies/11.%20QPOL%20TEMPLATES/Care%20Homes/06.%20Archive/Project/5.%20Formatting/MASTER%20Pressure%20Ulcers%20(Care%20Home)%20Policy.docx)
* [National Pressure Injury Advisory Panel (npiap.com)](https://npiap.com/)
* Tissue Viability Society [Pressure Ulcer and Wound Reporting](https://cqccomplianceltd.sharepoint.com/sites/sharedCQC/Shared%20Documents/General/05.%20Operations/02.%20Policies/11.%20QPOL%20TEMPLATES/Care%20Homes/06.%20Archive/Project/5.%20Formatting/MASTER%20Pressure%20Ulcers%20(Care%20Home)%20Policy.docx)
* NHS Improvements Implementing the Pressure Ulcer Framework in Local Reporting Systems
* [Guidance-for-reporting-pressure-ulcers.pdf (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2021/09/Guidance-for-reporting-pressure-ulcers.pdf)

# Diagram Description automatically generatedAppendix 1 ‘ASSKING Model’

# Appendix 2 - Common Sites of Pressure Injury



Diagram

Description automatically generated

# Appendix 3

# Summary of Review

|  |  |
| --- | --- |
| Version | 1 |
| Last amended | [Date of Issue] |
| Reason for Review |  |
| Were changes made? |  |
| Summary of changes |  |
| Target audience | Care staff, Managers |
| Next Review Date | [Date of Review] |