Derbyshire County Council Adult Care
Tissue Viability & Pressure Ulcer Prevention

Approval and Authorisation

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Change History

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<td>V 2</td>
<td>October 2013</td>
<td>Jane Parke</td>
<td>Review update and combine guidance and trigger tool</td>
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<td>V3</td>
<td>March 2018</td>
<td>Emma Benton</td>
<td>Complete review in consultation with Health</td>
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<td>V4</td>
<td>May 2019</td>
<td>Emma Benton</td>
<td>Review. No changes.</td>
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This document will be reviewed on a regular basis – if you would like to make any comments, amendments, additions etc. please email Emma Benton – emma.benton@derbyshire.gov.uk or Phil Robson phil.robson@derbyshire.gov.uk.
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Pressure Ulcers

Introduction

Pressure ulcers are preventable in many cases saving our clients from pain and anguish. The introduction of Standards for the prevention and management of pressure ulcers, and a tool to help assess peoples risk of acquiring pressure ulcers have been developed to be proactive rather than reactive. Litigation against hospitals, nursing and residential homes is on the increase, but use of this policy will help to reduce the likelihood of it happening.

Aim

The aim of this policy is to:
- prevent the development of avoidable pressure ulcers for clients and effectively manage inherited and avoidable pressure ulcers;
- Embed practice on pressure ulcer prevention and management across all Adult Care, so as to reduce the overall incidence of all pressure ulcers.

Pressure Ulcers

Pressure ulcers are caused by a mixture of factors and are complex in their formation. We can only prevent them by being aware of clients’ risk factors well before an ulcer starts.

Care workers need an awareness of the risk factors associated with, and the signs to look for as it is their responsibility to notify a manager if they suspect a pressure sore on a resident or client.

A manager is responsible for using the DCC assessment risk trigger contained in this document, to identify the level of severity and refer to a District Nurse if this scores 8 or more.

A qualified nurse is responsible for the Risk Assessment and any referral into Safeguarding.

Definitions

Acquired pressure ulcer: Is a pressure ulcer that develops or deteriorates after 72 hours of being on a provider service caseload or hospital admission

Avoidable Pressure Ulcer: "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following;
- evaluate the person’s clinical condition and pressure ulcer risk factors;
- plan and implement interventions that are consistent with the persons needs and goals;
- achieve recognised standards of practice;
- monitor and evaluate the impact of the interventions;
- revise the interventions as appropriate.

Exported pressure ulcer: Is a pressure ulcer that is under care of our DCHS or community hospital that is identified by another care setting within 72 hours of admission.
Inherited pressure ulcer: Is a pressure ulcer that is identified within 72 hours of admission to community hospital or admission to a health caseload.

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

Serious incidents (SI): All pressure ulcers which are discovered in hospital or in a community setting will require an investigation. This investigation will look to see whether any lessons can be learned and improvements made to for future care. In cases where there appears to be a connection between an act or omission in care which might have led to moderate, or more severe harm, with key learning; the case will be reported onto the NHS Strategic Executive Information System (STeIS). These more serious cases will be subject to formal investigation using a Root Cause Analysis (RCA) approach. Again the investigation will look towards what can be learned for the future and not to apportion any blame.

Shear: Is where the skeleton moves forward, backward or sideways and the skin stays firmly adhered to the surface it is in contact with - this will tear the small blood vessels apart.

Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had undertaken all the steps above or the individual concerned refused to adhere to prevention strategies in spite of education of the consequences of non-adherence. People who are critically ill with issues with blood flow (haemodynamic) or spinal instability or who are deemed to be terminally ill and on the End of Life Care Pathway may not be able to tolerate repositioning at the optimum frequency for pressure ulcer prevention.

Grade – Pressure Ulcer Grading Chart NHS Midlands and East

Grade 1
- Discolouration of the skin which does not change colour when light pressure is applied (non-blanchable erythema of intact skin).
- Warmth, swollen (oedema), inflammation (induration) or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching). Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple.

Grade 2
- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Check for moisture lesion (see full explanation on page 5).

Grade 3
- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- Ulcer is superficial without bruising (bruising appearance and blood filled blister would indicate deep tissue injury).
• Bone/tendon is not visible or directly palpable.

**Plus: Unclassified PU - now Grade 3**
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, dead tissue known as an eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.

**Grade 4**
Full thickness tissue loss to the extent that the exposed bone or tendon could be touched (palpable).

**Moisture Lesions show as:**
- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.

**Risk Assessment**
Pressure ulcer risk status may change rapidly or gradually, where subtle changes in the client’s condition may go unnoticed over time. Therefore it is recommended that reassessments should be monitored frequently. It is important that the frequency of pressure ulcer risk assessment be individualised to the person’s unique setting and circumstances.

Staff must immediately contact the qualified nurse to ask for a Risk Assessment as soon as the risk tool indicates or if there is an unexplained mark.

**When a client is first admitted in to a residential setting it is important to identify any marks. This must be done through the use of a body map to highlight any areas for concern. When the body map is being completed, discuss with the client any history of pressure sores or any concerns about a sore or mark they have now.**
The Risk Trigger Components

A client may become ill or their condition changes in some way, which could indicate an increase in risk. Pressure ulcers can be seen to develop if there is a change in one or more of the following:

- nutrition
- mobility
- continence
- medication
- skin

Guidance on Scoring the Risk Trigger (in the electronic client system)

Nutrition

Elderly people may not synthesise food nutrients readily. If problems arise a solution needs to be found quickly. Adequate fluid intake is very important. Every client should maintain an adequate level of hydration.

Problems with eating (Scores 1)

This can be for many reasons, e.g. broken dentures, slight strokes, and sore mouth due to ulcers or gum disease, a sore throat or something more serious. If the cause proves to be something which does not have a short-term solution nutritional supplements should be given.

Loss of appetite (Scores 1)

Apart from the fact that nutrients are not being taken in, what has caused this sudden lack of appetite. Often the underlying cause is also a risk factor.

Obvious weight loss (Scores 2)

This could indicate a severe underlying illness particularly. With age, we may replace protein and collagen with fat, which will mean that an obvious reduction in weight may not occur.

Obvious weight gain (Scores 2)

If a rapid weight gain is seen it needs to be assessed, as to whether this is due to fluid retention (which may indicate heart failure or kidney diseases etc.,) or be due to malnourishment if the wrong foods are being eaten.

Mobility Changes (Score in one section only)

We all need to move to keep the circulation to our tissues healthy and keep our joints mobile. Many elderly people become less mobile due to many factors, none more so than arthritis or mental illness, etc.

Sitting or lying still for hours on end will cause pressure sores, as the small blood
vessels will be crushed preventing nutrients and oxygen reaching the tissues. This will lead to the death of tissues resulting in a pressure ulcer (Decubitus Ulcer).

**Reduction in mobility/bedrest during the day (Scores 2)**

A client who has a reduction in mobility is in danger of acquiring a pressure sore. Staff in a residential setting should assist the client to change position slightly, hourly when in a chair, and 2 hourly whilst in bed. Tilt and turn regimes should be learned and used to aid mobility and circulation. In the instance of reduced night movement due to sedation, see Medication Problems score section below and appendix 2 for ‘Repositioning Chart’.

**Agitation/restlessness (Scores 2)**

If a client becomes agitated they will be restless and possibly more mobile than usual. This can cause skin damage from cuts, bruises, falls, friction, shear etc.

All of the above things can cause a pressure sore to start to form.

**Needing (mechanical/physical) help to get out of bed/chair (Scores 5)**

For any client who requires assistance to move about, there is a risk of pressure sores forming and they should be assisted to move hourly whilst in a chair and 2 hourly whilst in bed. A client who suddenly becomes reliant on staff for movement is definitely at risk. See appendix 2 – Repositioning Chart.

N.B. A client who has bilateral leg amputations has the same risk as someone who can walk, but cannot get out of the chair without assistance.

**Incontinence**

A normally continent client has no risk from urine or faeces on the skin. If, however, a client becomes incontinent of urine or faeces, then they will have a greater risk of getting an ulcer.

**Urine (Scores 1)**

Urine and air together cause skin to become softened and very weak. Thus it will become weakened and ulcerate easily.

**Faeces (Scores 2)**

The acid in faeces will make the skin very sore and weak and very prone to the formation of pressure ulcers.

**Double incontinence (Scores 3)**

The combined chemical reaction of urine and faeces on the skin puts the risk higher.
Medication Problems

There are many medicines, which can cause skin problems and also difficulties with absorption of nutrients. However, there are some risks that can be spotted early.

Iron (Scores 2)

If, for instance, a client becomes anaemic and the GP starts them on Iron tablets, it is an indication that there is a reduction in the amount of oxygen reaching the tissues.

Sedation/Night sedation (Scores 2)

If a client requires sedation, then they may become less mobile. They need therefore to be treated as a reduced mobility. Night sedation, newly prescribed, will make the client less likely to move about the bed whilst asleep.

Conditions or Illness

There are many long-term illnesses, which in later life may change and cause more problems.

Unstable diabetes (Scores 3)

Diabetics are very prone to skin problems especially on feet and lower legs for many complex reasons. However if the condition becomes unstable skin becomes very vulnerable.

An acute illness e.g. chest infection (Scores 2)

Any sudden acute/mental health illness, (e.g. chest infection, heart disease, flu etc), in the elderly can cause changes in nutrition, mobility, continence, etc. Beware of these.

Skin Conditions

Some clients will already have a skin problem e.g. Psoriasis, Eczema, etc.

Psoriasis, Eczema, etc. (Scores 3)

These long-term skin problems can have acute episodes or flare-ups. During these times the skin may be very vulnerable to the development of pressure ulcers.

Sudden appearance of marks (Scores 8)

If a client develops marks, which do not fade quickly on any part of the body, especially buttocks, hips, heels, elbows, ears, shoulders, ankles etc., then these red, purple, blue or black marks need a qualified nurse to assess them.

If a mark appears which doesn’t change colour when light pressure is applied, steps should be taken to ascertain the cause.

Trigger tools “What to do next”
Depending on the score from the risk trigger take the following action:

Scores 0 or 1 - Reassess on review of care plan.
Scores 2 – 4 - Continue to assess risks at least monthly.
Score 5 – 7 - Assess risks at least weekly.
Score 8 & over - Request a visit from your qualified nurse to do a full risk assessment.

Summary

Any one or any combination of these problems reaching a total of 8 or more should be a trigger for making contact with a qualified nurse, who will do a risk assessment. See appendix 1 Tissue Viability Flowchart

If in doubt mark higher and speak to the District Nurse. Prevention is better than the cure.

Next steps in residential

Following a risk assessment being completed by the District Nurse that has identified as having a pressure sore of grade 3 or above. A Care Quality Commission (CQC) notification MUST be completed. An Adult Safeguarding Decision Guide assessment should be completed by a qualified member of staff who is a practicing Registered Nurse (RN). Depending on the score of this assessment the Registered Nurse then taken one of the following courses of action.

IF YES (scores 15 or above):
Discuss with the person, family and/or carers, that there are safeguarding concerns and explain the reason for treating it as a concern for raising a safeguarding enquiry. They will then:
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 (scores less than 15)
Discuss with the person, family and/or carers, and explain reason why they are not treating it as a safeguarding enquiry. They will explain why it does not meet criteria for raising a safeguarding concern with the local authority, but then emphasis the actions which will be taken.
1. Action any other recommendations identified and put preventative/management measures in place.
2. Follow local pressure ulcer reporting and investigating processes.
3. Record decision in person’s records.

*Source: Safeguarding Adults Protocol, Pressure Ulcers and the interface with a Safeguarding Enquiry January 2018

When there is an admission from hospital with a pressure sore identified check the information received, case note and immediately complete the risk trigger on the client’s electronic record and ensure the GP has been informed to instigate District Nurse visits. A CQC notification must be completed for a Grade 3 or above and then the process for a safeguarding decision followed as above.

If there is an admission from hospital where there is a suspected pressure sore that
has not been identified by them, make a case note, complete a Hospital Discharge Concerns Form and complete the risk trigger and make an immediate referral made to the District Nurse. Upon confirmation of a grade 3 or above pressure ulcer a CQC notification must be completed and the process for a safeguarding decision followed as above.

All equipment and instructions given for the care of the client must be followed. Appendix 2 – repositioning chart.

**Next steps in home care**

There is no requirement from CQC to complete a notification when a client in their own home develops a pressure sore. Referrals for Safeguarding will be made by the District Nurse using the same process as for Residential Next Steps above.

When a client returns from hospital with a pressure sore identified, check the information received, case note and immediately complete the risk trigger on the client’s electronic record and ensure the GP has been informed to instigate District Nurse visits.

If there is a discharge from hospital where there is a suspected pressure sore that has not been identified by them, make a case note, complete a Hospital Discharge Concerns Form and complete the risk trigger and make an immediate referral made to the District Nurse.

If a pressure sore is suspected as having started during the normal course of care where there has been no discharge from hospital the care worker should notify a manager for the risk trigger to be completed.

All equipment and instructions given for the care of the client must be followed by the care workers.

**Training**

Tissue Viability training must be part of the induction process and must be refreshed every 3 years for all staff groups.
## Useful Links

- [http://www.nhs.uk/Conditions/Pressure-ulcers/Pages/Introduction.aspx](http://www.nhs.uk/Conditions/Pressure-ulcers/Pages/Introduction.aspx)
- [http://guidance.nice.org.uk/CG179](http://guidance.nice.org.uk/CG179)
- [http://nhs.stopthepressure.co.uk/care-homes.html](http://nhs.stopthepressure.co.uk/care-homes.html)
- [https://carehomecompanion.uk/good-skin-care](https://carehomecompanion.uk/good-skin-care)
- [http://nhs.stopthepressure.co.uk/docs/PU-Grading-Chart.pdf](http://nhs.stopthepressure.co.uk/docs/PU-Grading-Chart.pdf)

Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry  January 2018
Appendix 1

Residential Tissue Viability Flowchart

New Client
Or
Client returning from hospital

Staff to complete body map and any marks reported to duty manager

Duty manager completes the electronic tissue viability assessment for the client

Scores 0 - 1
Reassess when due

Score 2 - 4
Continue to reassess risks at least monthly

Scores 5 - 7
Assess risks at least weekly

Scores 8 and over
Contact DN for immediate risk assessment

CQC notification Grade 3 or above
Adult Safeguarding Decision Guide assessment completed by a registered nurse

All equipment provided clearly labelled and kept with the client

DO NOT IGNORE ANY MARK – PREVENTION IS BEST!!

Version 0.1
Repositioning Chart

Name
Date:

Frequency of repositioning

- Position should be changed by at least 30 degrees at each time of positioning.
- Check seating position.
- Avoid postures that apply pressure over existing pressure ulceration.
- Avoid slouched positions, which will put skin under added stress.
- Check shoes, clothing or other devices are not causing additional pressure problems.

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Version 0.1