
GUIDELINES CONTROL DOCUMENT - 1

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POLICY CONTROL DOCUMENT - 2

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<u>SUMMARY OF REVISIONS:</u>	
<p>These guidelines have been completely re written to reflect the key changes in the prevention and management of pressure ulcers over the past few years. They contain recommendations from the updated National guidance set out by NICE (2005) and EPUAP (2009).</p>	

Approval Checklist	✓
Relevant Standard identified (eg CQC registration standard or NHSLA standard) and how the policy meets the standard stated	✓
Sent out for consultation to all unit managers, CDLs, Governance and TV link nurses.	✓
Patient representative (Angie Morris)	✓
Copy to Susan Haynes for approval	✓
Any resource implications for operational services discussed with the Chief Operating Officer	N/A
Monitoring/audit arrangements included	

All guidelines are copy controlled. When a revision is issued previous versions will be withdrawn. Uncontrolled copies are available but will not be updated on issue of a revision. An electronic copy will be posted on the Trust Intranet for information.

Guidance for prevention and management of pressure damage

Introduction

Pressure ulcer incidence rates range between 2.2% and 66% in the UK and it is suggested that approximately 18% of hospitalised patients have a pressure ulcer (EPUAP, 2009).

Pressure ulcers are a significant financial burden to health care systems with an annual cost for pressure ulcer management in the UK being £1.4 to £2.1 billion, equivalent to 4% of the total UK health care expenditure (Bennett, 2004). The cost of treating a pressure ulcer is estimated to be between £1064 (Grade 1) to £10551 (Grade 4) (Bennett, 2004), with the more severe grades of pressure ulcers being higher due to their chronicity and increased complications.

Pressure ulcers present a major health care challenge. It has been recognized that pressure ulcers place a huge financial burden on the health care system and additionally result in a poor quality of life for the patient with an increased risk of morbidity. It is also known that many pressure ulcers are avoidable.

Efforts to reduce occurrence of pressure ulcers need to focus on prevention rather than cure. If we are to manage rates of pressure ulceration best practice needs to be employed by the use of guidelines, educational support and provision of appropriate equipment.

These Guidelines are produced to support the policy on pressure damage prevention and management and will provide support and guidance to all clinical staff involved in pressure damage prevention.

They are supported by national guidance and best practice statements to ensure the most up to date evidence is practiced.

Annual audit will be the process for measuring clinical outcomes and adherence to policy.

Assessment

Initial and ongoing assessments are the responsibility of the registered healthcare professional with the aid and support of the rest of the healthcare team. Good assessment is vital to provide a baseline with which to measure outcomes of care given and enable further evaluation of planned care, this in turn drives future treatment decisions. Good assessment provides efficient communication within the health care team. Inferior assessments will lead to poor clinical outcomes, patient suffering and be a drain on resources (EPUAP 2009)

Assessment should include:

- A complete health/medical and social history.
- Risk assessment
- A focused physical examination which includes the factors that may affect healing (e.g., impaired perfusion, impaired sensation, and systemic infection)
- Vascular assessment in the case of lower extremity ulcers (e.g., physical examination, history of claudication, and ankle-brachial pressure index - Doppler).
- Nutritional assessment - (see Nutrition section of this guideline).
- Pain assessment (see Pain section of this guideline).
- Assessment of the patients views in relation to current goals of care. - If the individual is unable to participate, consult with family and/or significant others.

Risk Assessment

Studies have shown that using a risk assessment tool may be better than clinical judgement alone (Defloor & Grypdonck 2005).

Using a risk assessment tool provides clinicians with a systematic framework to help identify factors that may contribute to the development of pressure ulceration.

Documenting the risk assessment promotes better communication within the Multidisciplinary team, provides evidence that care planning is appropriate and serves as a benchmark for monitoring the individual's progress. (EPUAP, 2009).

Patients should receive an initial risk assessment using the combined Community Walsall risk assessment tool and pressure ulcer risk assessment tool (PURAT). This should be undertaken on the first visit to the patient's home or within 6 hours of admission to a community hospital.

Completing a risk assessment

1. Complete the Community Walsall risk assessment (Appendix 1), calculate the score and document the level of risk.
2. Transfer the score and level of risk to the Pressure Ulcer Risk Assessment Tool/ PURAT (Appendix 2).

3. Document whether there is a history of pressure damage and if yes the grade and anatomical location. **Rationale** – Patients with a history of pressure damage should be classed as ‘high risk’ due to the skin over pressure areas not regaining full tensile strength and therefore being vulnerable.
4. Complete the full assessment found under the heading of **Risk check list (Figure 1)**, using the guidance notes as prompts if necessary (Appendix 2). Document any risks identified and action taken to address the risk.

Figure 1. Pressure Ulcer Risk Assessment Tool check list.

Risk	Factors to consider
Mobility	What is the level of mobility and activity? Consider individuals who are bedfast and/ or chair fast to be at risk of pressure ulcer development. Does mobility need prompting? Does the individual need assistance to mobilise? What prohibits mobility? The less mobile the patient is, the higher the risk of pressure damage. Does the patient require a referral to OT/ Physio to help optimise mobility?
Positioning and posture	Assess the position & posture of the patient when they are sitting in a chair and/ or in bed. Do they change their position at least every 2 hours? If not, why? Consider position of legs/ feet when in a chair – are they at a 90° angle with feet well supported? Is there a bias (a lean) to one side? Does the patient slump or slide? Does the patient look comfortable? There should be 2.5cm of space between the patient and the inside of the chair, too much space may cause the patient to lean. Consider causes of pressure, shearing and friction. What about medical devices – catheters, oxygen tubing etc?
Nutrition and hydration For further guidance on nutrition refer to nutrition section	Complete the MUST nutritional assessment and record result and action to be taken based on your findings. This may include referral to a dietician. What is dietary intake like? Are they consuming adequate calories? How well hydrated are they? (Fluid intake) What are the barriers to good nutrition? This could be poorly fitting dentures, oral thrush, pain, manual dexterity, time allocated for care. Consider asking patient/ carer to keep a food diary.

<p>Skin moisture/ continence</p>	<p>Consider both dry and excessive skin moisture as risk factors. Does the patient perspire excessively? If yes consider why (clothing, room temperature, medication). Is the patient incontinent of urine and/ or faeces? This will make the skin more susceptible to breakdown. What products does the patient use on the skin? Normal soap can affect the natural PH of the skin making it more susceptible to breakdown. Is the patient/ carer aware of this?</p>
<p>Skin assessment (For further guidance refer to skin assessment)</p>	<p>Frequency should be based on vulnerability and condition of patient. Inspect all vulnerable areas. Is there persistent erythema (redness), non-blanching hyperaemia, blisters, localised heat, localised oedema, localised induration (hardness), purplish/ localised areas and localised coolness which may indicate poor blood supply/ ischaemia? Does the patient complain of pain in any specific area? Increased skin temperature may signify infection</p>
<p>Acute, chronic or end of life illness</p>	<p>Which category does the patient fall into and how does this impact on potential risk of pressure damage? For example: Acute – Patient has a chest infection and has become acutely unwell and less mobile as a result, is not eating well and oxygen saturation is reduced - These are all risk factors. Acute conditions change quickly (for the better and worse) so regular monitoring /re-assessment of actions taken is essential. Chronic – How does the chronic illness affect the patient day to day? How independent is the patient? Is the illness stable or likely to progress? Consider long term pressure prevention measures such as equipment. End of life – Consider diagnosis and prognosis. Clinical decisions should be realistic and based on enhancing quality of life, comfort and symptom management.</p>
<p>Cognitive or psychosocial considerations</p>	<p>Has the patient got the mental capacity required to make informed decisions around the prevention of pressure ulcers? Will they be able to follow instructions? If no, who else needs educating re this? Has the patient got any underlying mental health issues that increase the risk of pressure damage (i.e. Depression)?</p>

<p>Co-morbidities (inc pain and medication) For further guidance on pain refer to pain section</p>	<p>Consider diseases that increase the risk of pressure damage such as peripheral vascular disease, diabetes, spinal injury. How does their co-morbidity affect their bloods? Could they be anaemic? Are their blood sugars persistently high? What action needs taking regarding this? Consider extremes of age (the older the patient or the very young, the higher the risk due to skin changes etc). Has the patient pain? Pain leads to reduced mobility. What medication is the patient taking? Do any of them add to the risk? (Steroids, sedatives etc.)</p>
<p>Pressure relieving devices issued</p>	<p>Has the patient been issued with any pressure relieving equipment? How long ago? Have they privately purchased any equipment? Is the equipment being used appropriately? Does the equipment appear to be in good condition? If powered – when was it last serviced? If foam, is it still viable (rebound test)? If a static air, has it been checked for correct pressures? Who does this? Is it recorded? Is it appropriate for the patients needs (weight, comfort, risk level)?</p>

If the patient has existing pressure damage section 2 requires completing.

Action taken	Date undertaken/ comments
<p>Assessment of pressure ulcer</p>	<p>Has the pressure ulcer been formally assessed using a wound assessment form? Have the following been documented – Cause, site/ location, dimensions, grade, exudate amount, wound bed appearance, surrounding skin, undermining, odour, pain, signs of infection? What phase of healing is the wound in? How likely are you to heal the wound? Have you considered a Doppler if the pressure ulcer is on the heel/ foot?</p>
<p>Wound tracing/ photography</p>	<p>Has the assessment been supported by photography and an acetate tracing of wound circumference? Have you gained verbal consent for the photography and documented this in the patients' notes?</p>
<p>Appropriate dressing selection using wound product formulary</p>	<p>Is the dressing appropriate to the aim of treatment? For example if the wound is heavily exuding, is the dressing adequately managing this without causing peri wound maceration? Is the dressing in line with the wound product formulary?</p>

Care plan with clear treatment outcome and re-assessment date.	Is this in place? Are treatment objectives SMART (Specific, measureable, achievable, realistic, timely) Does it reflect that prevention of pressure damage is a priority? Is the patient clear about the treatment plan? Has a re-assessment date been set?
Tissue viability referral for grade 3&4 pressure ulcers	If the pressure ulcer is a grade 3 or 4 a referral to the tissue viability team should be made. Has this been done? Has this been recorded in the patient's notes? The referral does not necessarily trigger a clinical visit; its purpose is to offer support and guidance to clinicians in dealing with these complex wounds.
Clinical incident report (Datix) for grade 2 and above pressure ulcers.	If the pressure ulcer is a grade 2 or above you will need to complete a clinical incident form (DATIX). Has this been done? Have you recorded this in the patient's notes?

Summary of risk assessment

Summary of risk assessment. Re- assessment date.	Following the full risk assessment the assessor should summarise any key risks and transfer any specific actions to the care plan section of the patients' notes. A re-assessment date should be clearly documented.
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Re assessment

Re assessment is necessary to:

- Evaluate the effectiveness of action taken on initial assessment (outcomes).
- To assess whether a patient's condition has worsened or improved as this may warrant changes to the care plan.
- To ensure that any equipment ordered has 1) Been delivered, 2) Has been set up safely, 3) Is being used appropriately, 4) Is acceptable to the patient.

With regards to wound management - reassess if the ulcer does not show signs of healing as expected despite adequate local wound care, pressure redistribution, and nutrition. There should be a 40% reduction in wound size within 6 – 8 weeks. If this is not achieved the wound is unlikely to heal in a 'timely way' (cardinal, Eisenbud, Phillips & Harding, 2008; Kantor & Margolis, 2000). The factors influencing delayed wound healing will need to be addressed.

Re assessment should be carried out using the Pressure Ulcer Risk Assessment Tool documentation (Appendix 1&2). Re assessment dates should be clearly documented in the patients' notes.

Skin Assessment

This should be done on the initial assessment and then regularly thereafter. Frequency should be based on vulnerability and condition of patient.

Inspect all vulnerable areas encouraging individuals (or their carers) to inspect the skin (using a mirror if necessary).

Look for:

- Persistent erythema (redness)
- Non-blanching hyperaemia (when you press the skin gently it does not white then red but stays red)
- Blisters
- localised heat

- localised oedema
- localised induration
- Purplish /bluish localised areas (especially on darker skinned individuals)
- Localised coolness if tissue death occurs.

Reasons for undertaking a skin assessment

Alteration in skin condition may include dry skin, erythema, and other alterations. The presence of non-blanching erythema also increases the risk of further pressure ulcer development.

Localized heat, oedema, and induration (hardness) have all been identified as warning signs for pressure ulcer development. As it is not always possible to see signs of redness on darkly pigmented skin, these additional signs should be considered in assessment.

A number of studies have identified pain as a major factor for individuals with pressure ulcers with some citing that pain over the affected site was a precursor to tissue breakdown. (Langemo, Mellard, Olson & Hunter, 2000).

Many different types of medical devices have been reported as having caused pressure damage (e.g., catheters, oxygen tubing, ventilator tubing, Semi rigid cervical collars, etc.).

Redness to the skin indicates that the body has not recovered from the previous loading and requires further respite from repeated loading. If possible do not turn a patient onto an already reddened area.

Does not use massage for pressure ulcer prevention - Massage is contraindicated in the presence of acute inflammation and where there is the possibility of damaged blood vessels or fragile skin. As well as being painful, rubbing the skin can also cause mild tissue destruction or provoke an inflammatory reaction, particularly in the frail elderly.

Protect the skin from exposure to excessive moisture with good skin care (such as emollients). Advise the patient not to use talc on high-risk sites as it may have a drying effect. The mechanical properties of the stratum corneum (the outermost layer of the epidermis) are changed by the presence of moisture.

Repositioning

The use of repositioning should be considered in all at-risk individuals.

Reasons for considering repositioning

High pressures over bony prominences for a short period of time and low pressures over bony prominences for a long period of time are equally damaging. In order to lessen the individual's risk of pressure ulcer development it is important to reduce the time and the amount of pressure she/he is exposed to.

Repositioning frequency will be determined by the individual's tissue tolerance, his/her level of activity and mobility, his/her general medical condition, the overall treatment objectives, and the assessment of the individual's skin condition.

Assess the individual's skin condition and general comfort. If the individual is not responding as expected to the repositioning regime, reconsider the frequency and method of repositioning.

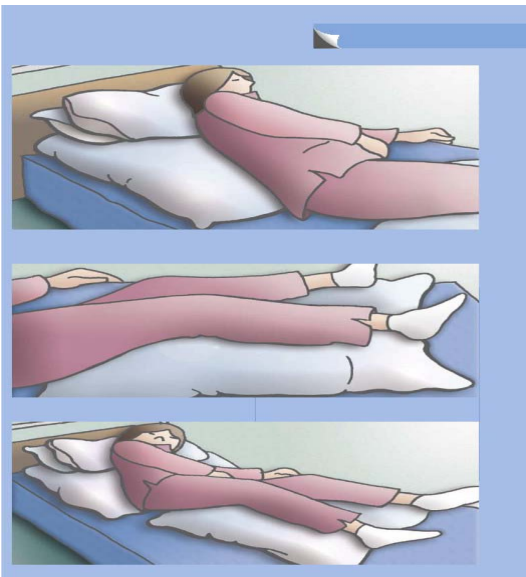
An individual should be repositioned with greater frequency on a non pressure redistributing mattress than on a visco-elastic foam mattress (i.e. Softform premier glide). The repositioning frequency should depend on the pressure redistributing qualities of the support surface. Use transfer aids to reduce friction and shear. Lift, don't drag the individual while repositioning.

Do not leave slings or slide sheets underneath patients as this causes further pressure by creasing or preventing pressure relieving cushions and mattresses from working effectively.

Avoid positioning the individual directly onto medical devices such as catheter tubes or drainage systems.

Avoid positioning the individual on bony prominences with existing non-blanchable erythema.

30°Tilt



Repositioning should be undertaken using the 30 degree tilted side lying position (alternating from right side, back, left side) or the prone position if the individual can tolerate this and her/his medical condition allows. Avoid postures that increase pressure such as the 90 degree side lying position or the semi-recumbent position.

If sitting in bed is necessary avoid prolonged head of bed elevation or a 'slouched' position that places pressure and shear on the sacrum and coccyx.

Repositioning the Seated Individual

Place the feet of the individual on a footstool or footrest when the feet do not reach the floor.

When the feet do not rest on the floor the body slides forward out of the chair. Foot rest height should be adjusted so as to slightly flex the pelvis forward by positioning the thighs slightly lower than horizontally.

When an individual is seated in a chair the weight of the body causes the greatest exposure to pressure to occur over the ischial tuberosities. As the loaded area in such cases is relatively small; the pressure will be high; therefore without pressure relief a pressure ulcer will occur very quickly.

Encourage the patient to stand or change position at least two hourly if it is safe to do so, if not they should have assistance to do this if possible.

Pressure ulcer grading

All pressure ulcers should be graded using the European Pressure Ulcer Advisory Panel Classification System (EPUAP 2009).

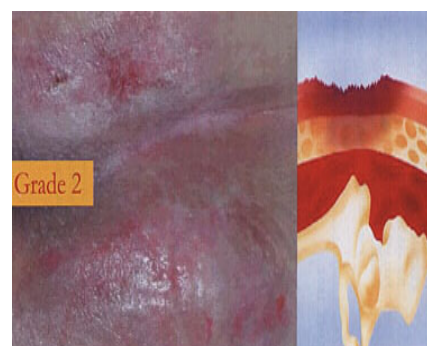
This grading tool has been devised to provide a common international definition and classification system for pressure ulcers (EPUAP 2009)

The grading tool helps us to have a bench mark as to what degree of pressure damage has occurred so all clinicians are describing in the same language. This will have a bearing on healing rates, treatment aims and equipment selection.



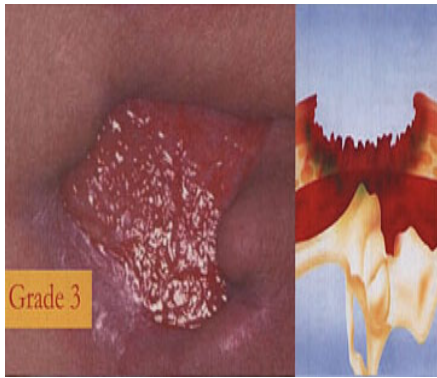
Category/grade I: Non-blanchable erythema

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



Category/grade II: Partial thickness

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



Category /Grade III: Full thickness skin loss

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



Category/grade IV: Full thickness tissue loss

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



Pressure damage to intact skin

Deep tissue damage can occur when skin is still intact it is assumed that this is severe pressure damage and should be treated as such.

This is not to be confused with a sero-sanguinous blister which is a grade 2 and can dry to a deep brown or black colour

Figure 2 - Grade 4 pressure ulcer



This is a sero- sanguinous blister where a blister has filled with blood and has then dried

Figure 3 – Grade 2 pressure ulcer

Reverse Category/grading

Once a pressure ulcer has been classified it cannot be down graded – as the classification is based on the structural damage caused. So for example a grade 4 that has healed will always be a grade 4, but it would be called a healing/healed grade 4 due to it not regaining full tensile strength (International Guidelines, 2009)

Moisture Lesions

There is a great deal of confusion as to what a moisture lesion is and what a pressure ulcer is as it can be complicated by the presence of both .

BOX 3 Distinguishing PUs, moisture lesions/IAD and dressing or tape damage (adapted from ^{24,25})		
PUs	Moisture lesions/IAD	Dressing or tape damage
<ul style="list-style-type: none"> ■ Pressure and/or shear present ■ Generally located over a bony prominence or body area subjected to pressure ■ Regularly shaped wounds are more likely to be PUs than moisture lesions/IAD (NB PUs may also be irregular in shape) ■ Distinct edges ■ Skin erythema is non-blanchable 	<ul style="list-style-type: none"> ■ Often intragluteal, may occur over a bony prominence ■ Pressure and shear should be excluded ■ Moisture is present - eg shining wet skin caused by urinary incontinence or diarrhoea ■ May be diffuse in shape with several closely located areas involved ■ Edges are often diffuse or irregular ■ Superficial unless become infected ■ No necrosis present ■ If redness is not uniformly distributed, IAD or a moisture lesion is more likely than a PU ■ Maceration of surrounding skin may be present ■ Often symmetrical ('copy lesions') 	<ul style="list-style-type: none"> ■ Occurs where dressings or tape have been used ■ May present as skin discolouration, contact dermatitis, or broken, stripped skin ■ Tends to represent the shape of the tape or dressing
		

* IAD = incontinence associated dermatitis (Defloor, Schoonoven, Fletcher et al, 2007)

Nutrition

Reasons for assessing nutritional status

To provide nutritional support to patients with an identified deficiency.

Decisions about nutritional support/supplementation should be based on:

- Nutritional assessment using a recognised tool (The Malnutrition Universal Screening Tool -MUST).
- General health status.
- Patient preference.
- Expert input (dietician / specialists).

Oral nutrition (via normal feeding and/or with additional sip feeding) is the preferred route for nutrition, and should be supported whenever possible.

Oral nutritional supplements are of value because patients at risk of pressure ulcers often cannot meet their nutritional requirements via normal oral food intake. Moreover, oral nutritional supplementation seems to be associated with a significant reduction in pressure ulcer development compared to routine care (EPUAP, 2009).

Provide 30-35 k/calories/kg body weight for individuals with an existing pressure ulcer. Adjustments may need making to the calorific formula and should be based on weight loss, weight gain, or level of obesity. Individuals who are underweight or who have had significant unintentional weight loss may need additional k/calories to cease weight loss and/or regain lost weight.

Offer 1.25 to 1.5 grams protein/kg body weight daily for an individual with a pressure ulcer when compatible with goals of care and reassess as condition changes.

Please refer to EPUAP nutritional guidelines for further information <Z:\Training\Training courses\Pressure Damage prevention & Management training\EPUAP nutritional guidance.pdf>

Assess renal function to ensure that high levels of protein are appropriate for the individual.

Monitor individuals for signs and symptoms of dehydration (Changes in weight, skin turgor, urine output).

Serum albumin

- Albumin is one of the most abundant proteins in the blood (Normal range is 35 – 50g/L) and its main purpose is to maintain osmotic pressure within vascular space.
- Serum albumin has a long half life (approx 20 days) and a large serum pool so by the time levels are below normal a sizeable amount of the pool has been lost.
- Due to this it is considered a 'late indicator' of malnutrition.
- Serum pre-albumin is another status indicator – shorter half life (2 days) thus making it a more timely and sensitive indicator of protein status. However, both of these tests have a limited use as a screening tool for delayed healing and or malnutrition as low results could be due to chronic and/ or inflammatory disease status.

Recommendation - Malnutrition does impact on healing but predicting non healing based on serum albumin is not recommended as standard practice. The use of a robust validated nutritional screening tool (i.e. MUST) is recommended rather than blood analysis.

Pain

Pain is an ever-present problem in patients with pressure ulcers (Langemo, Mellard, Olson & Hunter, 2000). As a protective physiologic mechanism, pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Irrespective of a patient's age or health status, pressure ulcer pain needs to be assessed and treated because it has widespread physical and psychosocial implications for the patient, family, and clinician.

Pathophysiology of pressure ulcer pain

Pressure ulcer pain can be caused by tissue trauma from sustained loads, inflammation, damaged nerve endings, infection, dressing changes, debridement, operative procedures and other treatments. The skin has more sensory nerves than any other body organ (Thomas, 1989). As the pressure ulcer damage expands, chemicals are released that irritate nociceptive nerve terminals. Nociceptive pain is an appropriate physiological response to a painful stimulus and involves acute or chronic inflammation (Popescu & Salcido, 2004). The ulcer erodes through tissue planes and destroys nerve terminals. As peripheral nerves regenerate, the nociceptive terminals send out immature sprouts of nerve tissue that may be hypersensitive to both noxious and non noxious stimuli. A heightened sensitivity to pain in the wound is primary hyperalgesia; a heightened sensitivity to pain in the surrounding skin is secondary hyperalgesia (World Union of Wound Healing Societies, 2004). Infection further irritates free nerve endings and may cause pain.

An assessment of pain should be undertaken and should include an assessment of body language and nonverbal cues (e.g., change in activity, loss of appetite, guarding, grimacing, and moaning).

The use of a pain assessment tool is recommended when measuring pain intensity. (Appendix 4)

The patient's care plan should include strategies to prevent or reduce pain and clear dates for evaluating outcomes.

Organise care delivery to ensure that it is coordinated with pain medication administration and that minimal interruptions follow. Set priorities for treatment.

Encourage individuals to request a 'time out' during any procedure that causes pain.

Reduce pressure ulcer pain by keeping the wound bed covered and moist and by using a non-adherent dressing.

For an individual with pain from a pressure ulcer music, meditation, distraction, conversations, and guided imagery are sometimes beneficial.

Wound care

Patients should receive an initial and ongoing pressure ulcer assessment. This should be in conjunction with the policy for the management of wounds for community based teams (2009).

Sleep

Identify problems associated with the patient's sleep patterns and take steps to correct these.

Research has shown that tissue renewal associated with anabolism (Repair) is greatest at rest or during sleep (Adam & Oswald 1983).

Allowing patients to rest and sleep will enhance the wound healing process.

When planning care, consideration should be given to the promotion of sleep. Support systems reduce but do not eliminate the need for manual repositioning but they can allow a longer period of rest at night. This can be taken into consideration using the "24 hour turning clock". (Appendix 5)

Where their medical condition allows, patients should lie as flat as comfortable in order to aid weight re-distribution. At night the patient should be kept as quiet as possible, with lights kept low.

Equipment

Support surfaces alone neither prevent nor heal pressure ulcers. They are to be used as part of a total programme of prevention and treatment.

When selecting appropriate support surface, factors such as the individual's level of mobility within the bed, his/her comfort the need for microclimate control and the place and circumstances of care provision should be considered. Decisions should be made in partnership with the patient/carers as it has to be acceptable to them. Patients/ carers also have to understand the consequences of refusing equipment when it has been clinically assessed as being required to enhance the patients health care needs.

Beds

When considering a hospital bed, firstly – can the patient's bed be adapted? Patients own beds can:

- Be raised with blocks
- Have bed rails fitted on to divan beds
- Have back raisers attached.
- Have knee raisers attached.
- Support a dynamic replacement system. (The length and width will require measuring first).

Knee breaks on the bed will aid patient positioning but will not always off load pressure on the heels depending on area at risk.

You need to question if a static height will enable staff to give care as the variable height function should be used to assist in dependent /assisted transfers.

Mattresses

When choosing a mattress:

Do not elevate patient to an unsafe height

Ensure patients are within the recommended weight range for the mattress.

For children and small low weight adults ensure:

- Appropriate cell size of mattress
- Appropriate position of pressure sensors within mattress in relation to the child
- Regular monitoring of an alternating pressure mattress with a permanently inflated head end in young children to avoid damage to the head.

Be mindful that not all support surfaces are compatible with every care setting. Support surface use in a home setting requires consideration of the weight of the bed, the structure of the home, the width of doors, the availability of uninterrupted electrical power and the ability to promote ventilation of heat from the motor.

Ensure that fitted sheets are not used on dynamic air mattresses and that the least layers possible are put between the patient and the surface of the mattress.

Be aware that there are various types of mattresses circulating in the community that are classed as old stock. Powered overlays are no longer purchased and supplied due to the safety issues over height and bed rails. If you have a patient on a powered overlay please ensure a risk assessment is undertaken.

Heels

Heel-protection devices should elevate the heel completely (offload them) in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. The knee should be in slight flexion (bent).

Avoid hyperextension of the knee as this may cause obstruction of the popliteal vein and an increased risk of deep vein thrombosis.

If using a pillow under the calves so that heels are elevated this should only be used as a short term solution. Close monitoring is needed to ensure that correct positioning of pillow is maintained.

Avoid use of synthetic sheepskin pads, rings or donut-type devices and water filled gloves.

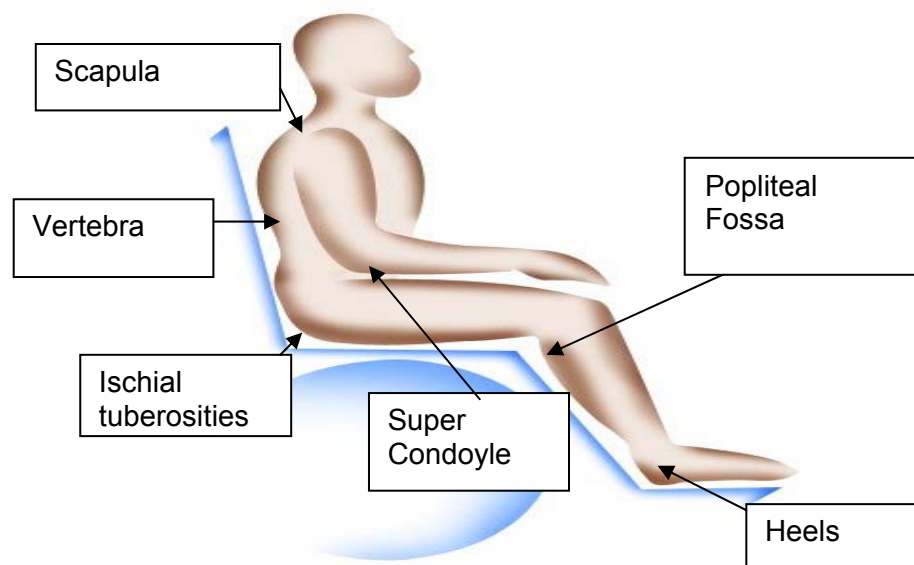
Patient's perfusion or sensation, particularly patients with diabetes, with neurological conditions and those with fixed flexion deformities are at increased risk of heel pressure ulcers.

Seating

If a patient has been prescribed a dynamic mattress and is expecting to sit out for periods of time then this patient will need a high specification cushion as 75% of a persons weight goes through their bottom.

Positioning of individuals who spend substantial amounts of time sitting should take into account the need for pressure distribution, postural alignment and support of the feet

Figure 4 - Areas at Risk for the seated individual



When prescribing cushions consider:

- Dynamics of the chair
- Size of the user
- Weight of the user
- Ability of the user

Do not select cushions or seating solely on their ability to manage tissue loads.

Consider the physical dimensions of the seat – are they appropriate for the individual or should they be adjusted. Does a risk assessment need to be done?

Ensure there is a minimum of 2.5cm clearance between the hip and the side of the seat.

Ensure there is a two fingers width between the popliteal fossa (back of the knees) and the seat

Patients who have been assessed as being at high risk of pressure damage should be assessed as to their individual tolerance to sit out for a specified time but this should not be for any longer than 2 hours at any one time.

Inform the patient, family and/or carers why special seating or cushions may be provided and how to use and maintain equipment. This information should be explained to the individual with supplemental written information provided.

All equipment should be looked after by the patient and prescriber whilst it is out on loan. General cleaning of equipment should be carried out with soap and water (no alcohol based cleaning products) /or as per infection control policy. When equipment is returned it will be decontaminated by the equipment management company. No equipment should be sent back visibly soiled.

Ordering of equipment is through Tissue Viability using the *Referral for the provision of beds, special chairs mattress and cushions form* (appendix 6). The prescriber of equipment will be responsible for the order placed and therefore should have clinically assessed the patient themselves to ensure that appropriate equipment is in place.

As a tissue Viability nurse (TVN) now reviews all equipment orders, they may need to contact you for further information or clarification before the request is processed. This is not them questioning your clinical judgement but a two way conversation exploring clinical need, resource management and supply. It also gives the clinician the opportunity to discuss complex equipment issues.

The clinician making the equipment request will need to liaise with the patient/carer to ensure that they are fully informed of delivery time frames and ensure that there is someone in to accept delivery/collection of equipment.

It is the 'prescribing' clinicians' responsibility to ensure that equipment has been delivered /collected in the time frame requested. This is necessary to ensure that non delivery /collection of equipment doesn't go unnoticed and that returns can be decontaminated and be available to reuse in a timely fashion. (Appendix 7)

Documentation

The community Walsall and pressure ulcer risk assessment tool (PURAT) are to be filled out in full (Appendix 1&2.). Assessment findings and action taken should be recorded in the patient's notes. They are to be signed and dated.

It is advisable to photograph pressure ulcers during your initial assessment (verbal consent is required and should be documented in the patients' notes). This will provide a baseline for measuring outcomes of treatment. The photograph should be labeled with the patient's initials, date of birth or NHS number.

An individual care plan should be instigated in partnership with the patient/carers and a reassessment date identified and documented.

It may be necessary to adjust expectations in the presence of multiple factors that impair wound healing (e.g., persistent malnutrition, poor perfusion, and co-morbidities known to impair wound healing).

If the level of risk changes following reassessment the care plan must be reviewed and updated.

Record repositioning regimes, specifying the frequency and position adopted and include an evaluation of the outcome achieved. Use turning charts to aid communication (Appendix 5).

Clinical incident reporting

All pressure ulcers graded 2 and above should be reported using Safeguard (electronically).

All acquired pressure ulcers of grade 3 and above that have been deemed 'avoidable' will be classed as serious Incidents Requiring Investigation (SIRI) and may be subject to a root cause analysis investigation.

All pressure damage of 3 and above should be referred to Tissue viability on a complex wound form with the reason for referral (i.e. safeguard report of grade 3 or 4 pressure ulcer). The referral will not necessarily result in a clinical visit; its purpose is primarily to support clinicians with what potentially can be complex, slow to heal wounds.

Education

Patients/family /carers

All patients who receive a pressure damage prevention assessment should be issued with a patient leaflet outlining the importance of pressure damage prevention. Once issued, you should document in the patients notes that you have done this (Appendix 9).

Individuals at risk of pressure damage who are willing and able should be informed and educated about risk assessment and resulting prevention strategies. This strategy, where appropriate, should include the carers both formal and informal. The patient and carers information leaflet may be used for this purpose. Any advice given should be documented in the patient's notes.

Patients should have all aspects of their pressure area care discussed with them, have ongoing access to information and have the opportunity to discuss this and its relevance to their individual needs with a registered practitioner. An individualised plan of care should be agreed with the patient following these discussions.

If a patient has a pressure ulcer, teach the individual and his/her family about the normal healing process and keep them informed about progress (or lack of progress) toward healing, including signs and symptoms that should be brought to the professional's attention. Document these discussions in the patients' notes.

Health care professionals

All healthcare professionals should attend the relevant training on pressure damage risk assessment and prevention.

This is advised on joining the PCT and then desirable every 2 years. (Or sooner if clinical competency levels require updating).

Healthcare professionals with recognised training in pressure damage prevention should cascade their knowledge and skills to their local healthcare team

Health care professionals should –

- Understand and follow present guidelines.
- Use guidelines to support clinical decision making.
- Maintain updated knowledge and skills which will underpin clinical competence.
- Educate patient families and carers on pressure damage prevention.
- Make accurate and appropriate choices regarding equipment provision based on a holistic risk assessment/re-assessment.
- Provide accurate data for audit purposes.
- Maintain accurate documentation and records.

Monitoring compliance with and effectiveness of the guidelines

The following processes will be used:

- Annual point prevalence survey of pressure ulcers.
- Quarterly audit of patients notes to measure the use and effectiveness of the pressure ulcer risk assessment tool (PURAT). This is a KPI for community nursing and community hospitals.
- Ongoing analysis of datix reports and subsequent RCA investigations.
- Annual patient satisfaction survey.

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Glossary

Anabolism	Regeneration of new tissue
Induration	A hardening of body tissue
Subcutaneous fat	Layer of fat underneath the skin
Visco –elastic	Consistency and stretch ability of the foam
Sanguineous	Containing blood
Intragluteal	Between the cheeks of the buttock
Popliteal Fossa	Space behind the knee
Super condoyle	Elbow
Ischial Tuberosities	Bone at the rear of the pelvis
Pressure relieving	The removal of all pressure
Pressure dispersing	The spreading out of point pressure
maceration	Soften by soaking/ to break into pieces

WALSALL COMMUNITY PRESSURE SORE RISK CALCULATOR

Name.....

Date of Birth.....

RISK CATEGORIES		SCORE	ASSESSMENT DATES				
LEVEL OF CONSCIOUSNESS	ALERT	0					
	LETHARGIC/CONFUSED	3					
	SEMI-COMATOSE	3					
	COMATOSE	3					
MOBILITY AMBULATION	MOVES WITHOUT ASSISTANCE	0					
	MOVES WITH LIMITED ASSISTANCE	8					
	CHAIRFAST (8 HRS PLUS)	8					
	BEDFAST (12 HRS PLUS)	8					
SKIN CONDITION	HEALTHY	0					
	RASHES/DRYNESS	2					
	INCREASED TURGOR/FRAGILE	4					
	REDNESS	4					
NUTRITIONAL STATUS	WELL BALANCED DIET/STABLE WEIGHT	0					
	POOR APPETITE/WEIGHT LOSS	4					
	VERY POOR/FLUIDS ONLY/NIL BY MOUTH	4					
SUB-TOTAL RISK SCORE (A)							

RISK CATEGORIES		SCORE	ASSESSMENT DATES				
BLADDER INCONTINENCE	NONE	0					
	OCCASIONAL (> 2/24 HRS) OR CATHETERISED	0					
	USUALLY (> 2/24HRS)	1					
	TOTAL (NO CONTROL)	4					
BOWEL INCONTINENCE	NONE	0					
	OCCASIONAL	4					
	TOTAL (NO CONTROL)	6					
CARER INPUT	NO CARER REQUIRED	0					
	ACTIVE CARERS (24 HRS)	0					
	INTERMITTENT CARER (8HRS PLUS)	2					
	OCCASIONAL CARER (0-3 HRS)	2					
SUB TOTAL RISK SCORE							
SUB TOTAL RISK SCORE (A)							
TOTAL RISK SCORE							
TICK IF PATIENT HAS PRESSURE ULCER?							
ASSESSORS SIGNATURE							

WALSALL COMMUNITY PRESSURE SORE RISK CALCULATOR

ADAPTED WALSHALL COMMUNITY PRESSURE ULCER RISK CALCULATOR

The Walsall Community Pressure Ulcer Risk Calculator assists in the identification of the main contributing factors in the development of pressure ulcers. It has been validated for use in the Community/domiciliary environment. ¹ It should be used in conjunction with clinician's professional's judgement and as part of an overall patient/client Care Plan.

1. RISK ASSESSMENT

The columns allow for regular assessment, either at intervals indicated by the patient's level of risk, or should the patient's condition change.

2. RISK CATEGORIES

Score the patient in one area only in each risk category. Record the score in the appropriate column and total the end. From the total risk score, determine the category as:

<4 not at risk	4 - 9 low risk	10 - 14 medium risk	15 + high risk
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3. PRESSURE ULCER GRADING SCALE²

CATEGORY/GRADE 1 – Intact skin with non-blanchable redness of a localized area .Area may be painful, firm, soft, and warmer or cooler compared with adjacent tissue.

CATEGORY/GRADE 2 – Partial thickness loss of dermis presenting as a shallow ulcer with no slough .Can present as a blister.

CATEGORY/ GRADE 3 – Full thickness tissue loss, subcutaneous fat may be visible but bone, tendon and muscle cannot be seen.

CATEGORY/GRADE 4 – .Full thickness Tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present.

4. EQUIPMENT GUIDE

This risk calculator and equipment guide are guidelines only. The equipment guide includes a range of equipment within each section. Selection should be based on comprehensive patient assessment, including physical, social, psychological and environmental factors in conjunction with clinician's professional judgement. These guidelines should be used along side Pressure Damage prevention Guidance and Guidance on prescribing equipment.

Risk Category	Mattress Selection	Cushion Selection
Low	Foam overlay	Foam Foam with Gel
Medium (Prevention)	Foam overlay Foam replacement Static air overlay	Foam Foam with Gel Static air
High (Prevention)	Foam Replacement Alternating Replacement	Gel Alternating
High	Alternating Replacement	Alternating

Appendix 2

Pressure ulcer risk assessment tool – Initial assessment to be completed on first visit or within 6 hours of admission to ward

Patient name -	DOB-	Initial assessment date	Time	By whom
NHS number				
Completed Walsall score and level of risk		Score	Level of risk -	
Pressure ulcer presently exists? Yes/ No				
Grade (EPUAP 1 – 4)				
Previous history of pressure ulcer? Yes/ No. Where anatomically and when, what grade				
Risk check list	Date	Risks identified and action taken		
Mobility				
Positioning and posture				
Nutrition and hydration				
Skin moisture/ continence				
Skin assessment				
Acute, chronic or end of life illness				
Cognitive or psychosocial considerations				

	Date	Risks identified and action taken
Co-morbidities (inc pain and medication)		
Pressure relieving devices issued		
Self care (Inc patient/ carer education)		
Complete this section if patient has existing pressure damage		Action taken
Assessment of pressure ulcer		
Wound tracing/ photography		
Appropriate dressing selection using wound product formulary		
Care plan with clear treatment outcome and re-assessment date		
Tissue viability referral for grade 3 & 4 pressure ulcers		
Clinical incident report for grade 2 and above pressure ulcers		
Summary of risk assessment- Re-assessment date should be clearly stated.		

Signature/ date	
------------------------	--

Appendix 3,

PAIN scales

Title: Date:.....
First Name:..... Patient number:.....
Surname:..... Clinic:

Wong – Baker Pain Scale



PAIN RATING SCALE

Please mark the scale below to show how intense your pain is.
A zero (0) means no pain, and ten (10) means extreme pain.

How **intense** is your pain **now**?

0	1	2	3	4	5	6	7	8	9	10
no pain					extreme pain					

Appendix 4

- Plan your patient's daily turning and movement regime.
- Identify pressure areas, which are at risk
- Ensure patient's Walsall assessment is up to date

Date: _____

Time	Patients Position	Comments	Signature
01:00			
02:00			
03:00			
04:00			
05:00			
06:00			
07:00			
08:00			
09:00			
10:00			
11:00			
12:00			
13:00			
14:00			
15:00			
16:00			
17:00			
18:00			
19:00			
20:00			
21:00			
22:00			
23:00			
24:00			

Patients Position
Aim/Plan

Aim / Plan

- (L) Left side
- (R) Right side
- (F) Front
- (B) Back
- (C) To sit out in chair

Appendix 5

Confidential Information
REFFERAL FOR THE PROVISION OF BEDS, SPECIAL CHAIRS,
MATTRESSES AND CUSHIONS

- For assistance in assessing for the appropriate equipment please refer to the **Guidance on prescribing equipment**.
- Please print clearly as inability to read form will result in delay
- All fields must be completed, any incomplete forms will be returned

Date:	
Swift / NHS Number:	
Clients Name:	
Male <input type="checkbox"/> Female <input type="checkbox"/>	
Date of Birth:	
Telephone Number (including area code):	
Mobile Number:	
Address:	
Postcode:	
Diagnosis:	
Height:	
Weight:	

Swift / NHS Number:	
Clients Name	

Swift / NHS Number:	
Clients Name	

Please indicate the needs by ticking all relevant boxes and send to the relevant fax number

Health Needs	Please Tick <input type="checkbox"/>	Social Needs	Please Tick <input type="checkbox"/>
To assist in end of life care where there are nursing needs		To assist in independent transferring	
Legs with chronic oedema (Chairs Only)		Enabling delivery of social care e.g. transfers/mobility Independence/quality of life	
To provide pressure area care		Enabling a hospital discharge where there are social needs e.g. getting in/out bed, moving and handling issues where there are no nursing needs	
Enabling delivery of nursing care		Supporting carers to assist with transfers and care tasks	
To enable hospital discharge and prevent delayed transfers of care where there are nursing needs		To prevent care home admission	
Prevention of Hospital admission where there are nursing needs			
For Health Needs please fax to Oxfordshire Community Tissue Viability Service on: 01235 205788		For Social and Independent or Functional Needs, please contact Social and Healthcare Services - Access and Enablement team	

TISSUE VIABILITY INFORMATION

Pressure Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of damage	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Grade of damage(EPUAP)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Please specify location of all present or previous pressure damage:	
---	--

Risk of developing pressure damage (according to local risk assessment scale)	Not at Risk <input type="checkbox"/>	Low Risk <input type="checkbox"/>	Medium Risk <input type="checkbox"/>	High Risk <input type="checkbox"/>
---	--	---	--	--

Swift / NHS Number:	
Clients Name	

MOBILITY

Immobile	<input type="checkbox"/>	Hoisted	<input type="checkbox"/>	Transfer with help	<input type="checkbox"/>	Self transfer	<input type="checkbox"/>	Walks unaided	<input type="checkbox"/>
Walking with equipment		<input type="checkbox"/>	Type of equipment used		<input type="checkbox"/>	Wheelchair dependant		<input type="checkbox"/>	

POSITIONING IN BED

Back	<input type="checkbox"/>	Side to Side	<input type="checkbox"/>	Semi - Reclined	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Turning Routine	<input type="checkbox"/>
------	--------------------------	--------------	--------------------------	-----------------	--------------------------	---------	--------------------------	-----------------	--------------------------

Are they independent in moving own position?

Is there help available to reposition patient?

Time in bed		Night Only		Rest during day	
Hours:	Minutes:	Hours:	Minutes:	Hours:	Minutes:

Other (please state):

Equipment to be requested

(Please ensure there are sufficient sockets for any electrical equipment)

EXISTING BED:

Double	<input type="checkbox"/>	Single	<input type="checkbox"/>	Divan	<input type="checkbox"/>	Hospital Bed	<input type="checkbox"/>
						Other(Explain Type)	

Is there another bed in the property that can be moved or adapted to meet their needs?

BEDS AND MATTRESSES:

Profiling Bed:	<input type="checkbox"/>	Bedrails with foam in fills	<input type="checkbox"/>
----------------	--------------------------	-----------------------------	--------------------------

If 4 section bed required please state why:

Swift / NHS Number:	
Clients Name	

MATTRESS:

Foam Replacement / Base Mattress	<input type="checkbox"/>	Repose Mattress Topper	<input type="checkbox"/>	Foam Propad Single Topper	<input type="checkbox"/>
----------------------------------	--------------------------	------------------------	--------------------------	---------------------------	--------------------------

Foam Propad Double Topper	<input type="checkbox"/>	Powered Replacement	<input type="checkbox"/>
---------------------------	--------------------------	---------------------	--------------------------

SEATING:

Riser recliner chair	<input type="checkbox"/>	Small	<input type="checkbox"/>	Medium	<input type="checkbox"/>	Large	<input type="checkbox"/>	Bariatric	<input type="checkbox"/>
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NB: It is not possible to provide a chair colour to match the clients other furniture. If colour is an issue they must make a private purchase.

CUSHION:

Care free (propad)	<input type="checkbox"/>	Repose	<input type="checkbox"/>	Powered	<input type="checkbox"/>	Roho	<input type="checkbox"/>
--------------------	--------------------------	--------	--------------------------	---------	--------------------------	------	--------------------------

Transflo 43cm x 43cm	<input type="checkbox"/>	Transflo 43cm x 46cm	<input type="checkbox"/>	Transflo 43cm x 51cm	<input type="checkbox"/>
----------------------	--------------------------	----------------------	--------------------------	----------------------	--------------------------

Repose Foot Protectors	<input type="checkbox"/>
------------------------	--------------------------

If standard equipment is not sufficient then a request needs to go to SEAG/Priorities Committee

If specialist equipment is required please state type and reason (please attach separate sheet if not enough room): Please check specialist returns library online

--

- **Please attach Millbrook requisition and quote if special order**

Swift / NHS Number:	
Clients Name	

PURPOSE OF ORDER

Admission avoidance	Continuing Care	Long term condition	Prevention	Facilitating Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is equipment required to facilitate hospital discharge from the acute sector (prescriber pays policy): Yes / No

Planned date of discharge	
Discharge from (ward/hospital)	

Awaiting Care Package?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------	-------------------------------------	------------------------------------

Details of planned care package:

Reason for request (please attach separate sheet if not enough room)

Delivery speed is normally 5 working days. If an earlier delivery is required, please state timeframe below (same day, next day, 2 day, 3 day) and a reason for request

Delivery timeframe required	
Please state reason:	

Person to contact for delivery/contact number/special instruction

Have you informed the client that this is NHS/ICES equipment on loan and they are responsible for it while it is their possession and any neglect/damage/disposal may incur a claim from the PCT? Yes / No

Please note: Equipment collection will not be before 5 days after request of collection. Please make client or family aware when discussing provision

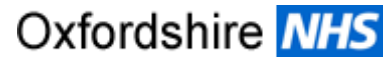
Swift / NHS Number:	
Clients Name	

Name of Assessor/Prescriber: Team	
Designation:	
Address:	
Telephone Number	
Email:	Mobile Number:
GP Surgery TEL No.	

Please note this additional page will be sent to Millbrook by Tissue Viability/ASSESSOR, any missing information may result in a delay in delivery or a non delivery. Please complete fully.



**OXFORDSHIRE
COUNTY COUNCIL**
SOCIAL & COMMUNITY SERVICES
www.oxfordshire.gov.uk



Confidential Information

RISK ASSESMENT ACCESS FORM

USED IN ALL CASES FOR THE PROVISION of BEDS, RISER RECLINER CHAIRS AND HOISTS

All fields must be completed, any incomplete forms will be returned.

Please print clearly as inability to read form will result in delay. NB form electronically available on Millbrook site and best sent this way

DATE:	
CLIENTS NAME:	
ADDRESS:	

Request for: Please Tick √	Bed	Chair	Hoist
Standard (catalogue stock item)			
Special order			
New Provision			
Replacement/repair			

Please attach a quote if special order

Environmental/Access Assessment

2	Bungalow	<input type="checkbox"/>	House	<input type="checkbox"/>	Flat	<input type="checkbox"/>	Cottage	<input type="checkbox"/>	Terrace	<input type="checkbox"/>	Care Home	<input type="checkbox"/>	Warden	<input type="checkbox"/>
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3. Stair Lift	Yes <input type="checkbox"/>	No <input type="checkbox"/>	4. Ramps	Yes <input type="checkbox"/>	No <input type="checkbox"/>	5. Delivery	Upstairs <input type="checkbox"/>	Downstairs <input type="checkbox"/>
---------------	------------------------------	-----------------------------	----------	------------------------------	-----------------------------	-------------	-----------------------------------	-------------------------------------

6. Steps to:	Front door <input type="checkbox"/>	Back door <input type="checkbox"/>	Inside <input type="checkbox"/>	Outside <input type="checkbox"/>	None <input type="checkbox"/>
--------------	-------------------------------------	------------------------------------	---------------------------------	----------------------------------	-------------------------------

7. Parking:	Off Road <input type="checkbox"/>	Own Drive <input type="checkbox"/>	Road side <input type="checkbox"/>	Permit only <input type="checkbox"/>
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8. Other considerations: e.g. pets, infectious diseases, lack of space, obstacles, sanitation:

Yes No

If yes please advise

Risk Assessment for Delivery:

NB. Where possible family/friends must be responsible for moving any furniture. Furniture moved by the delivery men will not be covered on the house insurance. All furniture must be moved PRIOR to delivery. If the company is required to move furniture prior notice must be given and will incur further costs.

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes please explain:
Has the client given their consent for this equipment			
Does the delivery need to be co-ordinated with carers			
Will the delivery men need to move furniture			

New EQUIPMENT FORM FROM Z DRIVE

Appendix 6

Aide Memoire for completing the 'request for the provision of beds, special chairs ,mattresses and cushions' form.

Page 1

Date – date you are filling out this form.

Client Name – try to put the name in full as there are patients with the same or similar names.

Female / Male –please circle one or the other these will be used for audit purposes.

NHS/Swift number is needed on all paper as a correct identifier. This must be filled in on the top of every form as an identifier if the sheets of the form get separated.

Address – please write the full address and post code as this will aid the delivery service to find the property.

Telephone numbers- these will aid smooth communication.

Diagnosis – this will help the tissue viability nurses give correct advice on the type of equipment that will be most suitable. Please give as much detail as possible.

Height and weight – This is very important as all equipment has a safe working load which will need to be considered when advising on choice of equipment. Height is needed as extensions and different types of equipment may be considered. If you do not know the patient's weight (for example the patient is very heavy) Millbrook offer a weighing service but there is a cost for this. Please ensure that all weights and heights are in metric.

Page 2

Health needs – this box will help you to decide whether this equipment is needed to manage the patient's health care needs for example if the patient is dying, delivery of nursing care such as wound dressing, catheterisation and bowel care.

Social needs- this box will help clinicians to decide whether they have social needs and the ability to enable independent transfers.

If you tick just health care you need to send your referral to tissue viability, if the ticks are all social care then you may wish to consider obtaining an occupational therapy assessment first. Referrals can be made to the Access team.

If there are equal ticks in both boxes then you can send to either service.

Tissue Viability Information

We need to know if the patient has a pressure ulcer, what grade/category it is and where it is anatomically as different grades of pressure damage will require specific types of pressure relieving equipment.

Pressure ulcers – please circle yes or no

History pressure damage - please circle yes or no

Grade – please grade with the European Pressure Ulcer Advisory Panel (EPUAP) grading system. If you are unaware of this or need help please contact Tissue Viability.

Location of pressure damage – please state the anatomical sites of both past and current pressure damage.

Risk – you will be able to identify what risk the patient is by doing a risk assessment (Walsall).

Page 3

Mobility - Please circle one of the options. Reduced mobility has been identified as one of the biggest risks to developing pressure ulcers so we need to know the level of patient's mobility and whether they can mobilise independently.

Walking with equipment –please circle if the patient is walking with equipment then state what sort of equipment it E.G. rolator, zimmer frame.

Wheelchair dependent - please circle if they are.

Positioning in Bed – please circle one of the choices. If they have a turning routine what is it? 2 hourly 3 hourly - please state.

Time in bed –please state in hours and minutes how long and at what time of the day or night.

All beds, a lot of the mattress and some cushions are electric these will need an accessible socket for the plug. Ensure that sockets are not over loaded and are in safe working order.

Beds and Mattress

2 section bed frames – this is a community bed which are electric and the head end of the bed elevates to sit patients up and the bed frame goes up and down.

4 section bed frames – are used when patients are unable to maintain position and when positioning of legs are needed

Bedrails with foam in fills – all patients should be risk assessed for using bedrails foam in fills come as standard as a safety consideration to prevent entrapment and skin damage. Bedrails should be considered when ordering a bed when there is a possibility of the patient's condition changing in the short term such as end of life.

Mattress – please circle what you need.

Foam base mattress – this is the standard high specification foam mattress which will be supplied for patients that are up to high risk patients with pressure damage will need a higher grade mattress.

Propads - this is what is sometimes known as an “egg box” this is where the top section of the foam is cut in squares to disperse the pressure.

Repose – air filled static system

Powered replacement – this is a dynamic system which is powered and runs on a 7-10 minute cycle where one cell is inflated whilst the next cell is deflated. This is a whole mattress replacement that is put on the bed frame.

Roho – static air filled system made out of neoprene rubber

Existing bed – we need to assess whether the patients bed is suitable for the identified care needs and to supporting another mattress i.e. A powered system. Powered systems do not fit on a double bed. Different bed rails are needed for divan beds.

Page 4

Seating – please circle which size riser recliner that you need.

Riser recliner chairs come in four sizes. You need to measure the patient's height, hip width (not the circumference it is best to put a book on both side of the patients hips and measure from book to book) and back of the knee to floor.

Please ensure you have informed the patient that they do not get a choice of colour. If they want a colour coordinated riser recliner they have to fund these themselves.

Sizes of chairs can be found in the Millbrook catalogue, it is not the tissue viabilities administrators decision on what size you need .The tissue viability nurses are happy to give guidance if needed.

Cushion's – please circle which cushion you require.

Propad – as in beds

Repose – as in beds

Powered – as in beds

Transflo – foam base with gel inserts, these come in 3 sizes please circle which you need.

SEAG – Special Equipment Advisory Group - any specialised equipment that is over £2,000 needs to be assessed by this group.

Priorities Committee – this is an NHS committee that will look at very expensive equipment that may set a president within the health care economy. As a clinician you have to provide evidence to support the request to supply this equipment. Please see priority committee guidelines.

Specialist equipment – this should only be requested if none of the standard stock is fit for purpose and all other options have been considered. Please check in the specials return's library first before ordering new specials. It is advised that you link with tissue viability and discuss the options first.

If ordering equipment please give as much information possible including description of equipment, the company that make the equipment and the cost or quote from the company if you have it.

Equipment requested – we need to know if the equipment will be used for the short or long term to help us manage our stock levels efficiently.

Purpose of order – please circle one of the five choices.

Page 5

Discharge from acute hospitals – please circle if this is the case.

Generally, acute hospitals will pay for equipment for 28 days to enable quicker discharges.

Dates of discharge are needed to plan delivery and if they are from acute hospital we need to know which ward it is.

Care package – please circle either yes or no

Other situation – awaiting housing, adaptations family dynamics.

Reason for request –you need to demonstrate why you are requesting this equipment, what you have used in the past, why it did not work and why the piece of equipment will benefit the patient.

Delivery – normal delivery is **5 days**. Same day and next day deliveries will require authorisation by the tissue viability lead or a unit manager.

Patient responsibilities – please circle yes or no.

Collection – please ensure that patients and their family are aware that collection time is **5 days**.

Page 6

Assessor /Prescriber – we need to have your name and contact details in case we need to contact you with any queries, it would be helpful to have a mobile/team mobile number in case we need to contact you urgently.

Risk Assessment Access form

This is a Millbrook form that needs to be filled in when requesting a bed or chair for delivery .If this is not filled out the order will not proceed.

NB

Key safe number – This cannot be put on the form due to confidentiality issues. If you need Millbrook to know the number - 1. You must obtain consent from the patient/client. 2) You must talk with Millbrook over the phone to give them this information.

Appendix 7 (note this is available in a leaflet form)

Oxfordshire Community Tissue Viability Service

A service introduction for Patients and Healthcare Professionals

The tissue viability service is nurse led and provides specialist advice and care to patients with complex wounds within the community of Oxfordshire

What does the Service Provide?

The team works in partnership with patients, their carers and healthcare professionals to provide expert wound care advice, specialist healthcare equipment and education that is aimed at promoting no needless skin breakdown

We aim to improve and support high standards of practice through clinical consultations, regular audits, development of guidelines and policies and by delivering formal educational training to healthcare professionals

What is our service for?

To aid and support all healthcare professionals involved in the management of:-

- Complex Wounds and associated diseases e.g. pressure ulcers, leg ulcers, malignant wounds, lymphoedema/chronic oedema
- Pressure ulcer prevention
- The assessment and supply of specialist healthcare equipment

Tissue Viability Team

Sarah Gardner, Clinical Lead
Sarah Warner, Tissue Viability Nurse
Julie Hewish, Tissue Viability Nurse
Audrey Kellar, Administrator
Kay Russell, Administrator

How can a referral be made to our service?

Patients can be referred by their primary Healthcare Professional e.g. GP, Community Nurse, Practice Nurse.

Complex Wound Referral: the referral form must be accompanied with GP summary which includes medication, past medical history, correspondence from other relevant referrals i.e. vascular team.

A Tissue Viability Nurse will contact the referrer within 5 working days to discuss the patient and to arrange a visit if necessary.

Telephone Advice: if requiring some clinical advice, the administration team will take details of the enquiry and a Tissue Viability Nurse will call you back as soon as possible.

Wound Dressing Advice: A wound dressing formulary is available within clinical areas or via the tissue viability intranet site. The educational sections aim to assist practitioners with appropriate dressing selection as part of a holistic wound assessment.

How to contact us:

Patients are advised to contact the nurse/nursing team who usually provides their wound care. For out of hours equipment advice contact Millbrook on the number below.

Customer Service/emergency (out of hours): 0845 2232484

Clinicians can contact the team on:

Telephone: 01235 205786 / 01235 208755

Fax: 01235 205788

Opening Times:

Monday—Friday (except bank holidays)
8:30am-4:30pm

Telephone calls/answer phone messages received after 16:00 will be followed up the next working day.

Useful Telephone Numbers:

For more information regarding formal education courses. Please contact Learning and Development on:

0845 219 1121/1064/1096

Appendix 8

What can I do to avoid pressure ulcers?

There are several ways you can reduce the risk of pressure ulcers.

Keep moving

Changing your position regularly helps keep blood flowing. If you have reduced movement the health care team looking after you will assist you with regular turns in addition to providing specialist mattresses, cushions etc.

Look for signs of damage

Check your skin for pressure damage at least once a day. Look for skin that doesn't go back to its normal colour after you have taken your weight off it. Do not continue to lie on skin that is redder or darker than usual. Also watch out for blisters, dry patches or breaks in the skin.

Protect your skin

wash your skin using warm water or pH neutral skin cleansers. Do not use heavily perfumed soap or talcum powder, as these can soak up the skin's natural oils leading to vulnerable dry areas. If you suffer from incontinence please inform your health care team as they can assess the best way to deal with the problems. Rubbing/massaging skin is bad for it.

Eat a well-balanced diet

make sure you eat a healthy balanced diet and drink plenty of fluids. Extra protein may help.

Author: Tissue Viability Team, Buckinghamshire Hospitals.
Design: Public Relations Department, Winchester and Eastleigh Healthcare NHS Trust

What should I do if I suspect a pressure ulcer?

Tell your doctor or nurse as soon as possible and follow the advice they give you.

Eat and drink as medically advised.

Name _____

You are at low / medium / high risk of pressure ulcers

If you require a translation of this leaflet, please ask your nurse.



no needless skin breakdown

**Pressure Area
Care**
a guide for patients

This leaflet contains general information.

If there is anything else you need to know, please speak to your nurse or doctor.

Patient Safety Federation  safe care for all

What is a pressure ulcer?

A pressure ulcer is an area of damage to the skin and underlying tissue.

They are sometimes known as pressure sores or bed sores.

What causes a pressure ulcer

Pressure ulcers are caused by poor circulation to tissues due to a combination of the following factors.

Pressure

Body weight and some equipment (e.g. anti-thrombosis stockings) can squash the skin and other tissues where parts are under pressure. This reduces the blood supply to the area and can lead to tissue damage.

Shearing

Sliding or slumping down the bed/chair can damage the skin and deeper layers of tissue.

Friction

Poor moving and handling methods can remove the top layers of skin. Repeated friction can increase your risk.

Who is most at risk of developing pressure ulcers?

You may be at risk of developing pressure ulcers for a number of reasons including the following.

Problems with movement

If your ability to move is limited you don't get enough oxygen to the parts under pressure.

Poor circulation

Vascular disease or smoking reduces your circulation.

Moist skin

You may be at increased risk if your skin is too damp, due to incontinence, sweat or a weeping wound. It is important that your skin is kept clean and healthy.

Lack of sensitivity to pain or discomfort

Conditions such as diabetes, stroke, nerve/muscle disorders etc reduce the normal sensations that usually prompt you, or enable you to move. Some treatments (eg epidural pain relief, medication, operations) reduce your sensitivity to pain or discomfort so that you are not aware of the need to move.

Previous tissue damage

Scar tissue will have lost some of its previous strength and is more prone to breakdown.

Inadequate diet or fluid intake

Lack of fluid may dehydrate your tissues. Weight gain or loss can affect the pressure distribution over bony points and healing.

Risk assessment

To assess your risk of developing pressure ulcers, a member of your health care team will examine/assess you and ask you some questions. This will help to identify if you require a specialised equipment or other forms of care, and will assist in providing for your individual needs.

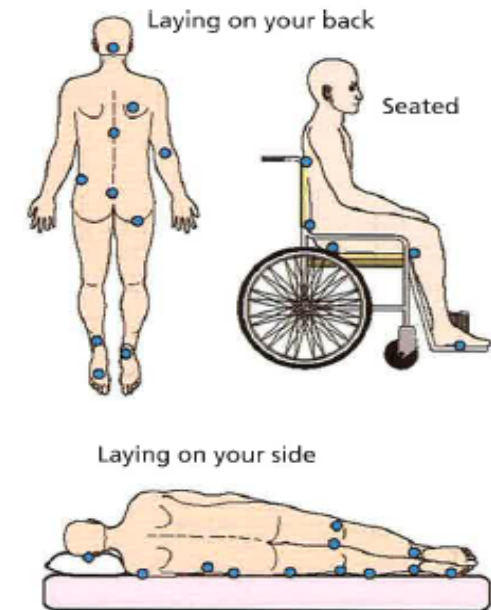
What are the early signs of a pressure ulcer?

You will notice the following signs:

- change in skin colour, redder or darker
- heat or cold
- discomfort or pain
- blistering
- skin damage.

Without appropriate intervention the damage may worsen, developing into hard black tissue or an open wound.

Common locations of pressure ulcers



Reference: Whiting NL (2009) Skin assessment of patients at risk of pressure ulcers. *Nursing Standard* vol 24 no. 10 pages 40 - 44

Appendix 9

Guidance on Assessing and Prescribing Riser Recliner Chairs

You are accountable for what you are prescribing therefore you should not complete equipment forms on the behalf of others.

Chairs will only be issued for health related issues.
If their needs are functional a referral to an OT will be necessary.

Chronic oedema of legs

Chronic oedema is classed as oedema present for more than 3 months that does not reduce with elevation overnight (Moffatt, 2003). This means that riser recliner chairs will not be supplied for acute episodes of lower leg oedema

When completing the equipment form the following information is required -

1. Why has the patient got lower leg oedema?
2. What treatment has been given to manage lower leg oedema?
3. Have you discussed with the patient about going to bed at night and resting on the bed in the day time.
4. Concordance (if they will not go to bed will they put their leg up on a riser recliner?).
5. Have you considered if the footplate of the riser recliner will manage the weight of the patient's legs?(discuss with tissue viability if unsure)

Pressure relief

A riser recliner should not be used as a first line management for pressure damage_prevention.

The standard riser recliners we provide have a tilt and space action which elevate legs higher, but when the chair is in the reclined position it puts increased pressure on the sacral area.

Pressure cushions in riser recliners can provide certain risks to the patients who use them.

1. Some cushions are too deep to sit in the seat well of the chair.
2. If patient are doing independent transfers the cushion can fall off which then becomes a risk for tripping /falling.
3. The cushion can slip when the riser function is used causing patients to slip out of the chair.
4. Patients /family and carers need to be educated on pressure damage prevention and be given written guidance.

Some patient's need specialist seating assessment due to health related needs (i.e. posture) this will need to be referred to an OT.

If a riser recliner chair is being requested for function only they need to be referred to a community OT for assessment.

End of life

As a prescriber you need to consider not only the patients quality of life and health needs against life expectancy but the appropriateness of provision. This will be considered on a case by case basis.

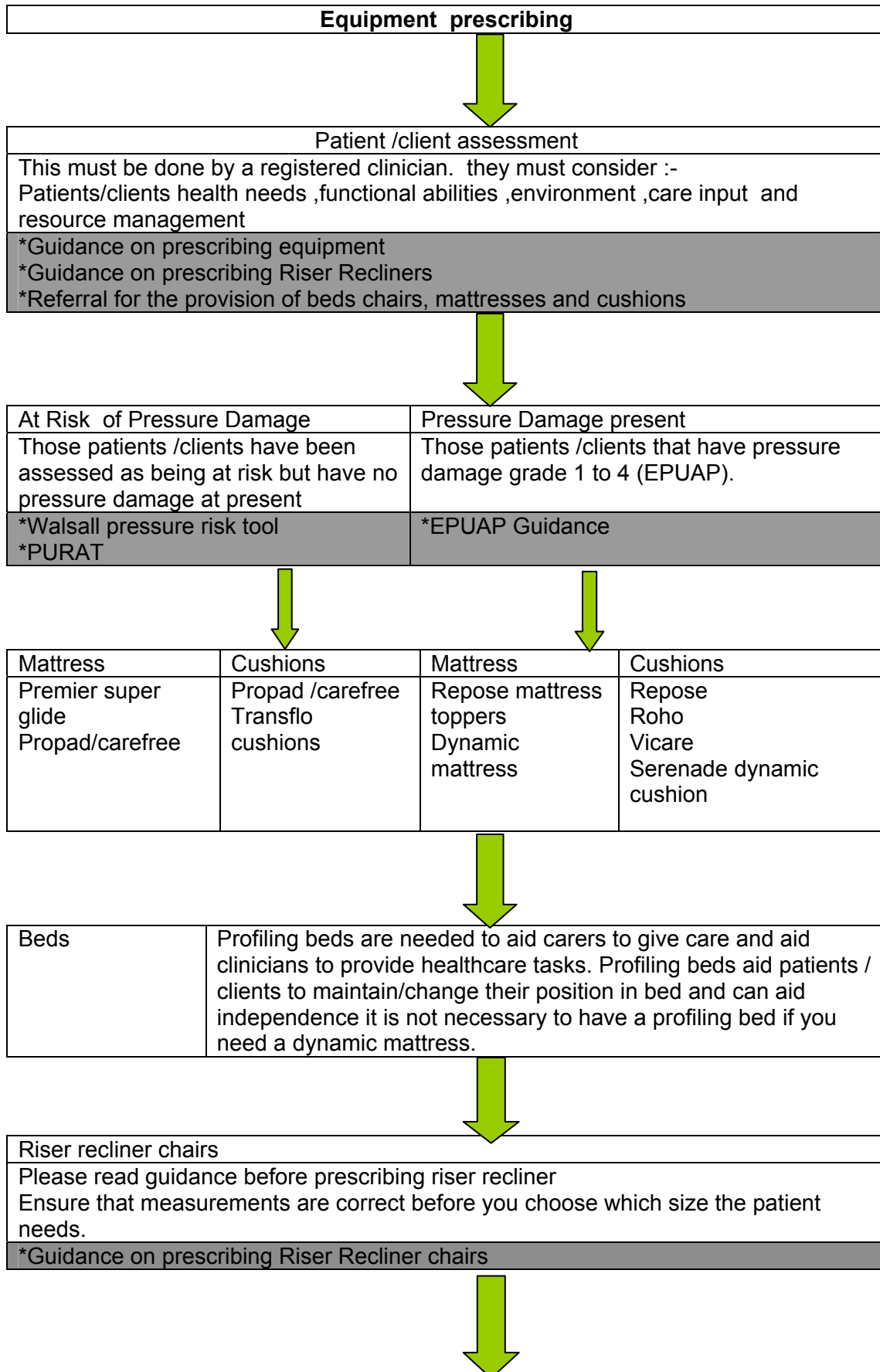
Provision

All riser recliners with be dispensed on a 5 day delivery.

Moffatt CJ, Franks PJ, Doherty D, et al. Lymphoedema: an underestimated health problem. *QJM* 2003; 96: 731-38.

Appendix 10

Flow diagram for equipment prescribing



Bariatric and specialist equipment
If you require non standard equipment please link with the community OT /or provide details and quote for equipment required if this is a high cost item it will need to go to SEAG to decide on who funds it. TV can only give advice on equipment relating to pressure damage prevention and wound care.

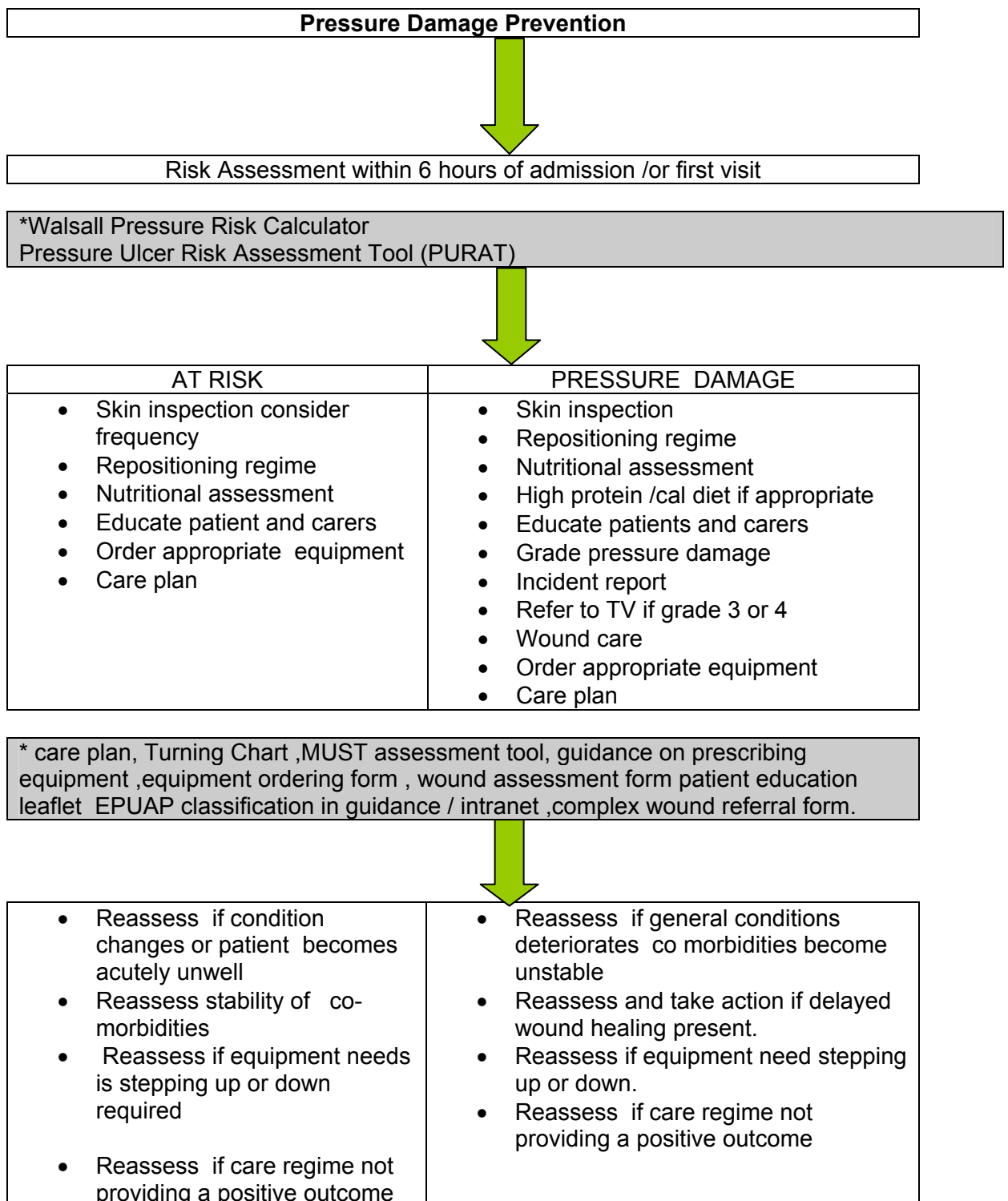


Equipment form
Send into tissue viability by fax – 01235 205788 or via secure email NHS net
Ensure all fields are filled in correctly
Tissue viability scrutinizes all equipment orders
Order placed with Millbrook health care (current equipment management company)
*** Aide memoire equipment form**



Check
All prescribers to check with patient / client that equipment has arrived
***all those areas shaded grey denote tools/guidance to aid selection of equipment**

Appendix 11 - Flow diagram for pressure damage prevention



* Shaded gray areas are a list of tools required to assess and manage pressure damage prevention

Full Equality Impact Assessment Form

This form is an Equality Impact Assessment Form. It is used to review services and policies to ensure fair and consistent services for staff, service users and carers. It is a legal duty to prevent discrimination.

The form consists of two parts. Part 1 is screening to see if the policy or service requires a full assessment. It is through this screening process that you can find out whether the policy or service requires a Part 2.

Part 1

Equality Impact Assessment	
Service Area – Community nursing teams, Community hospitals, 2nd Tier services.	Date: 12/09/11
Title of policy, strategy or service Guidance for the Prevention and Management of Pressure Damage	

Short description of policy, strategy or service:

The aim of these guidelines is to reduce the number of avoidable, newly acquired pressure ulcers within the population of Oxford Health NHS Foundation Trust.

This will be achieved by setting out within the clinical guidance, the key recommendations for preventing or reducing the risk of patients developing pressure damage.

Equipping clinicians with structured, evidence based guidelines will help support clinical decision making which in turn will ultimately lead to improved patient outcomes.

What is the likely positive or negative impact on people in the following groups?

Older or younger people

Reduction in the incidence of pressure damage in patients of all ages who are deemed 'at risk'.

People with disabilities

As above

People from different ethnic/cultural backgrounds (including those who do not speak English as a first language)

Reduction in the incidence of pressure damage in patients of all ages who are deemed 'at risk'.

Men, women or transgender people

The guidelines apply to all genders.

People with different religious beliefs or no religious beliefs

Guidelines apply to people with all religious/ no religious beliefs.

Gay, lesbian, bisexual or heterosexual people
Guidelines apply to all of the above group.
People from a different socio-economic background
Guidelines apply to people from all socio –economic backgrounds.

Evidence
<p><i>What is the evidence for your answers above?</i></p> <p>There is no evidence to suggest that people from any of the above groups are more or less likely to develop pressure damage or should be treated any differently. The guidelines should be 'generically' applied to all of the above groups.</p>
<p>What does available research say?</p> <p>There is no evidence to suggest otherwise</p>
<p>What further research would be needed to fill the gaps in understanding the potential difficulties or known effects of the policy?</p> <p>N/A</p>
<p>Have you thought about consulting/researching this gap? What would you need?</p> <p>N/A</p>
<p>Does the policy need a Full Equality Impact Assessment? <i>(Answer yes to this if evidence has shown you that there will be a significant positive or negative impact on certain groups. If the answer is no then please attach this to your policy/document and send it for sign off with at the same time as the policy or document)</i></p> <p>NO</p>

Part 2

Evidence – please give evidence on how the policy or service is likely to have a significant impact (either or positive or negative) on the below.
Race & ethnicity As above – already commented.
Gender
Age
Disability
Sexual orientation
Religion or belief
Other

Consult Formally
Who needs to be consulted Consultation of key staff already carried out.
Has there been a consultation which would give the information needed? As above
Which types of evidence have been gained (qualitative/quantitative) N/A

Changes to policy/service
If the evidence shows a likely negative impact will the policy/service still go ahead?
If the policy or service is likely to have a negative impact what changes will be made to minimise this impact?
What impact will the policy/service have on promoting equality and eliminating discrimination?

How will you maximise this impact?			
Action Plan			
Action to improve equality on policy/service	Person Responsible	Lead responsible	Date of planned completion

Full Assessment checklist

- ✓ Screening process indicates that full impact assessment is required
- ✓ Team identified to undertake EIA
- ✓ Full impact assessment undertaken using relevant sources of evidence
- ✓ Draft EIA and policy circulated to stakeholders for further consultation and comment
- ✓ Amendments incorporated in the final policy
- ✓ Action plan from EIA agreed with team
- ✓ Robust reporting and monitoring systems are established to reassure any continuing differential impact
- ✓ Service/policy EIA sent to appropriate committee for validation and ratification
- ✓ Copy of EIA and policy sent to Equality and Diversity Lead for publication
- ✓ Document management systems in place to collate evidence from implementation in preparation for next review date.