Pressure Ulcer Management and Prevention Policy

Birmingham and Solihull Mental Health NHS Foundation Trust

Policy number and category	**C 36**	**Clinical**
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Ratifying committee or executive director	**Clinical Governance Committee**	
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Executive Director of Quality & Safety (Chief Nurse)	**Interim Executive Director of Quality and Safety (Chief Nurse)**	
Policy lead	**Physical Health lead Nurse**	
Policy author *(if different from above)*	**Tissue Viability Nurse**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- To ensure that skin integrity, pressure ulcer prevention and management is part of day-to-day clinical practice across the trust, thereby minimising the physical, psychological, and financial costs of pressure ulcers to the service user and trust.
- To provide direction and to standardise practice for Birmingham and Solihull Mental Health Foundation Trust healthcare professionals to ensure adherence to national guidance and best practice.

Policy requirement (see Section 2)

- All service users must be screened for their risk of developing pressure ulcers. This will be undertaken when clinicians complete a physical health assessment on Rio.
- A trust approved risk assessment (**Purpose-T: P**ressure **U**lcer **R**isk **P**rimary **O**r **S**econdary **E**valuation **T**ool) must be undertaken on Rio for all service users within 6 hours of admission to inpatient units. Service users returning to an inpatient unit following extended leave (overnight or longer) or when transferred between trust units must have a purpose-T completed within 6 hours of arrival. This includes services users previously assessed as not being at risk. The trust acknowledges that the pressure ulcer risk assessment is used in conjunction with clinical judgement and not in isolation.
- Service users identified as being at risk of developing a pressure ulcer (or who have an existing pressure ulcer) should have interventions planned to minimise the risk of pressure ulcer occurrence or deterioration.
- Considerations must be given to co-morbidities and mental health presentations that could impact on pressure ulcer development and management.
- Pressure ulcer prevention and treatment plans should include the '**aSSKINg**' principles (**A**ssessment, **S**urface, **S**kin Inspection, **K**eep Moving, **I**ncontinence, **N**utrition and Hydration and **G**iving Information) and be incorporated into their care plan.
- Clinical documentation must be completed to evidence the implementation and effectiveness of the care plan, and this must be available to all individuals caring for the service user. This includes completion of the repositioning and skin inspection tool on the 'inpatient portal' for those identified at risk.

CONTENTS

1 INTRODUCTION

1.1 Rationale (Why)

Pressure ulcers represent a significant cost to the NHS within both the primary and secondary care sectors. It is estimated that pressure ulcer care costs the NHS more than £1.4 million every day (Guest et al. 2017). The financial cost of treating a pressure ulcer ranges from £2,000 (Category 1) to £20,000 (Category 4) calculated using 2016/2017 reference costs (NHS Improvement, 2018).

Pressure ulcers may occur in ANY service user but are more likely in high-risk groups, such as the elderly and those admitted to the trust Dementia & Frailty Service, those with a Body Mass Index (BMI) outside usual perimeters and service users who are malnourished, have continence/moisture related issues, and those with underlying physical health conditions/ comorbidities. Therefore, the principles of practice issued within this policy can be applied to all age/divisional groups within the trust to ensure consistently high standards of care are achieved and maintained for service users who are at risk.

This policy should be read in conjunction with the following documents:
Pressure ulcers: revised definition and measurement (NHS Improvement, 2019)
Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline European Pressure Ulcer Advisory Panel (EPUAP, 2019))
NICE guidelines (NICE, 2014) (NICE, June 2015)
Prevention and Management of Moisture-Associated Skin Damage (MASD) (Wounds International, 2020)

1.2 Scope (Where, When, Who)

This policy applies to all service users admitted to an inpatient unit and to multidisciplinary healthcare professionals involved in the prevention and management of service users who are at risk of developing or have a current pressure sore.

This policy ensures adherence to local, national, and internationally set objectives, guidelines, and recommendations. Therefore, ensuring all service users admitted to an inpatient unit receive consistently high standards of care.

The care of service users and pressure ulcer management whilst residing within their own homes will fall within the remit of the registered general practitioner and primary care services.

Prison Healthcare services will be provided with specialist advice and support about pressure ulcer prevention and management by Birmingham Community Healthcare NHS trust.

The Tissue Viability Team will ensure the pressure ulcer policy and guidelines are current and reflect the latest evidence-linked practice.

1.3 Principles (Beliefs)

Prevention and management of pressure ulcers requires a collaborative multidisciplinary approach. All trust healthcare professionals are responsible for assessing and managing risk and implementing processes to reduce incidences,

prevent the occurrence of pressure ulcers and improving the quality of care the organisation provides.

Pressure ulcers will be categorised using the EPUAP (2019) grading system (European Pressure Ulcer Advisory Panel, 2019) and photographed with consent.

All service users with any category of pressure damage both acquired and inherited (refer to Glossary) will be reported through the clinical incident process (ECLIPSE).

All confirmed Trust acquired category 3 and 4 pressure ulcers will be subject to a Root Cause Analysis investigation to understand any lessons that can be learnt from the event. Root cause analysis reports will be shared with the Physical Health Committee together with any resultant actions arising from the incident. This will enable shared learning across the Trust.

Moisture Associated Skin Damage (MASD) will not be categorised as pressure damage. MASD will also be reported (ECLIPSE). Skin damage caused by a combination of pressure and MASD will be reported via ECLIPSE as a pressure ulcer.

2 POLICY (What)

2.1 All service users must be screened for their risk of developing pressure ulcers, and this will be undertaken when clinicians complete the Physical Health Assessment on admission to the trust (Refer to Physical Health Assessment Policy – C38).

2.2 A trust approved risk assessment (**Purpose-T: P**ressure **U**lcer **R**isk **P**rimary **O**r **S**econdary **E**valuation **T**ool) must be undertaken on Rio for all service users within 6 hours of admission to inpatient units. Service users returning to an inpatient unit following extended leave (overnight or longer) or when transferred between trust units must have a purpose-T completed within 6 hours of arrival. This includes services users previously assessed as not being at risk. The trust acknowledges that the pressure ulcer risk assessment is used in conjunction with clinical judgement and not in isolation.

2.3 Healthcare professionals admitting service users with existing pressure damage are responsible for obtaining further information regarding treatment, history of pressure damage, risk assessment, equipment, wound care, care plans and documentation.

2.4 All service users who are identified as at risk or have pressure damage must have an individualised plan of care developed and implemented in accordance with the aSSKINg principles. This should include referrals to specialist teams to assessment services users' mobility, and ability to reposition independently.

2.5 If the service user refuses the skin inspection or is too unwell the remaining sections of the purpose-T must still be completed to identify risk and commence preventative strategies.

2.6 An assessment of nutritional status must be undertaken using the trust agreed nutritional screening process and appropriate nutritional support implemented (refer to Food and Nutrition Policy – C23).

2.7 Service users identified as at risk or those who have pressure damage should be informed of their individual level of risk and advised on measures for prevention of further tissue damage and their plan of care.

2.8 For service users who have pressure damage present this should be categorised using the EPUAP pressure ulcer classification system.

2.9 All service users with pressure ulcers of category 2 and above should be referred to the Tissue Viability Service for assessment. Pressure ulcers of category 1 can be discussed with the Tissue Viability Service but will not routinely need to be assessed.

2.10 All pressure ulcers should be reported using the Eclipse reporting system.

2.11 Pressure ulcers present on admission should be reported as an inherited pressure ulcer (present on admission to the trust).

2.12 All confirmed trust acquired category 3 and 4 pressure ulcers will be reported to the Governance team and reviewed using the Patient Safety Incident Response Framework. This has replaced the serious incident framework.

2.13 Service users with category 3 or 4 pressure ulcers both inherited or trust acquired who the healthcare professional has concerns regarding clinical practice, must identify, and address their concern with their MDT/NIC/Ward Team, Safeguarding Adult Team and raise their concern with the local authority as per the Safeguarding Adults Policy if deemed appropriate (R&S 26).

2.14 Where the service user's first language is not English, healthcare professionals should involve link workers/approved interpreters.

2.15 When consent is given by the service user digital images of category 2 and above pressure ulcers should be taken and included in the clinical documents section on the Rio system.

2.16 All clinical staff have a responsibility to be open and transparent with service users in relation to their care and treatment. Any patient that is harmed by a provisional of a health service should be informed of the fact, appropriate remedy offered, regardless of whether a complaint has been made. Such incidents should be dealt with under the duty of candour. Requirements of the Duty of Candour are set out in the Health and Social Care Regulations (2014) regulation 20: Duty of Candour (CQC, 2022).

2.17 All service users who are at risk of pressure damage or who have existing pressure damage must be assessed and provided with appropriate pressure relieving equipment.

2.18 For service users who are at risk of pressure damage and are incontinent of urine and/or faeces a continence assessment should be completed, and care plan commenced.

2.19 Any service user presenting with pressure damage will have their wound assessed using the wound assessment chart. Appropriate care will be planned, implemented and evaluated. The trust wound management formulary will be used as a framework for dressing selection Wound Care Products/ APC Formulary (sharepoint.com).

2.20 When planning discharge of service users from inpatient settings who have existing pressure damage or who are at a high risk of developing pressure damage, the registered GP and attached community services team should be informed before the service user is discharged.

3 Procedure

Risk screening assessment and skin inspection

3.1 All service users must be screened for their risks of developing pressure ulcers (Appendix 2 and 3). This will be undertaken when clinicians complete a Physical Health Assessment on admission to the trust (Refer to the Physical Health Assessment Policy – C38). Extrinsic risk factors that impact skin integrity are pressure (when skin and tissue are directly compressed between bone and support surface), shearing forces (skin and tissue are pulled in different directions) friction (when two surfaces move across each other often removing superficial layers of the skin) and moisture sitting on the skin (urine, faeces, sweat).

3.2 All service users must have a pressure ulcer risk assessment (Purpose-T) (Appendix 4) completed within 6 hours of admission to inpatient services. Service users returning to an inpatient unit following extended leave (overnight or longer) must have a purpose-T completed on their return. This includes services users previously assessed as not being at risk. The purpose-T supports the structured review of risk factors (Mobility status, analysis of independent movement, sensory perception and response, moisture sitting on the skin (Perspiration, urine, faeces, or exudate), diabetic status, perfusion (Conditions affecting central circulation) (e.g. shock, heart failure, hypotension), perfusion (Conditions affecting peripheral circulation) (e.g. peripheral vascular / arterial disease), nutrition, medical devises in use, previous pressure ulcer history and a detailed skin inspection) to support the MDT's decision-making process and appropriate care planning.

3.3 Healthcare professionals admitting service users with existing pressure damage should contact the appropriate community healthcare team caring for the service user (if there is anyone) and obtain further information regarding treatment, history of pressure damage, risk assessment, equipment, dressings already used, care plans and documentation. This information should be recorded in the clinical notes on Rio.

3.4 If the service user refuses the detailed skin inspection or is too unwell this can be deferred and reattempted as soon as clinically possible. The clinician should select "refused" in the skin inspection section for each bony prominence listed. The remaining sections of the purpose-T should still be completed within 6 hours of admission to identify underlying risks and commence management of these risks.

3.5 The detailed skin inspection within the Purpose T is for the assessment and documentation of pressure damage only. It is expected that any other identified injuries, scars, or marks are recorded on the Body Map on Rio.

3.6 The detailed skin inspection can be completed either in the form of visual observation or verbal questioning. When pressure related damage is disclosed by the service user (and not seen by the assessing clinical) this should be documented in the clinical notes on Rio.

3.7 The skin inspection should include:

- Checking for non-blanching erythema (reddening of skin that does not turn white when pressed (blanching test).
- Blisters.
- Patches of skin over bony prominences that look bruised.

- Unusual changes to the skin texture that me be related to pressure damage (feeling boggy or spongy).
- Localised heat and oedema.
- Pain or discomfort that may be pressure related.
- Skin damage that may be caused by medical devices (Catheters, NG tubes, oxygen masks, TED stockings).
- Signs of infection (wounds): Erythema, local warmth, swelling, purulent discharge, delayed wound healing beyond expectations, new or increasing pain and Increasing malodour.

3.8 The appearance of pressure damage to darker pigmented skin tones can be more difficult to identify. Clinical signs to observe for include localised heat and a purplish/blue hue, the area may also feel cool, harder and have increased pain and localised oedema. Pressure ulcers are under detected in darker pigmented skin as early damage is harder to see.

3.9 For service users who have pressure damage present this should be categorised using the EPUAP pressure ulcer classification systems (Appendix 5, 6, 7 & 8). Healthcare professionals can assess and grade pressure damage, but category 2 and above injuries will be verified by the Tissue Viability Service.

3.10 All service users who are identified as being at risk or who have existing pressure damage must have an individualised plan of care developed and implemented in accordance with the aSSKINg principles (Appendix 9). When the AMBER or RED purpose-T pathway are indicated on Rio this will trigger the aSSKINg tool on the inpatient portal (scheduled skin inspections and repositioning assessments) (Appendix 10).

3.11 Effective prevention is the key to overall management of pressure damage. Frequency of re-assessments depends on Purpose T assessment in conjunction with clinical judgment of the individual service user's circumstances.

Foot inspection

3.12 It is important to include feet in skin inspection for signs of pressure damage. All service-users who have heels that are at risk must off-load their heels and have pressure relieving heel protectors. All service users with an inherited or trust acquired pressure ulcer to their foot or heel must be referred to the Podiatry service (Appendix 11 and 12). Further guidance can be found on the Podiatry connect page Connect - Search results (sharepoint.com)

Repositioning

3.13 The frequency of repositioning is determined by the service users' level of activity, mobility, and ability to independently reposition. Referral to Physiotherapy or Occupational therapy may be appropriate to complete positioning assessments.

3.14 Consideration should be given to skin and tissue tolerance, general medical condition, overall treatment objectives, comfort, and pain (Refer to the end-of-life policy).

3.15 All service users who are at risk of pressure damage or who have existing pressure damage should be encouraged to actively mobilise, change their position, or be repositioned to relieve or reduce pressure.

3.16 It is important that the service users' level of immobility and inactivity, the need to influence microclimate and shear reduction, the size and weight of the individual, the

number, severity and location of existing pressure sores and other risk factors associates in the development of new pressure sores considered.

3.17 An individual repositioning schedule between 1-4 hourly when in bed will be discussed and agreed with the service user. When sat service-users should reposition 1-2 hourly. Discussion should include their clinical risk factors and the outcome documented in the Rio notes, on the purpose-T and the inpatient portal.

3.18 Service users who use a wheelchair should be assisted to regularly redistribute their weight. An agreed repositioning frequency should be negotiated with the service user considering their level of risk and documented in their care plan. Use of a pressure relieving cushions should be based on the service users individual risk assessment.

Pressure relieving equipment

3.19 All service users who are at risk of pressure damage or who have existing pressure damage should be assessed and provided with appropriate pressure relieving equipment as required (Appendix 13 and Appendix 14). This should be documented in the care plan on Rio and if equipment is in place, it should be checked daily that it is in full working order.

3.20 The Tissue Viability Service will recommend other pressure relieving equipment such as heel protectors and gel pads as necessary to offload pressure from bony prominences. Provision of such equipment does not replace the need for repositioning the service as directed by their individualised care plan.

Aids such as water-filled gloves, synthetic sheepskin and doughnut devices must not be used to relieve pressure.

Moving and Handling, bariatric patients and equipment

3.21 Moving and handling devices will be used appropriately to assist in repositioning to reduce shear and friction. After repositioning, equipment such as hoist slings must not be left underneath the service user. Please refer to the Manual Handling Policy (RS 21) for guidance. A pathway to support the assessment of bariatric service users and how to order specialist equipment including beds and mattresses can also be found here.

Reporting pressure related injury

3.22 All inherited and acquired in our care pressure ulcers and moisture associated skin damage should be reported via the eclipse system. This includes device-related injuries (i.e., oxygen tubing, catheter etc.).

3.23 The circumstances around inherited or trust acquired pressure ulcers should be investigated and a safeguarding referral considered (Refer to safeguarding policy).

3.24 All confirmed trust acquired category 3 and 4 pressure ulcers will be reported to the Governance team and reviewed using the Patient Safety Incident Response Framework. This has replaced the serious incident framework.

3.25 A deteriorating pressure ulcer will need to be reported again via ECLIPSE, this should reference the previous ECLIPSE number and state ‘deterioration’ and the new category of pressure ulcer.

Continence assessment

3.26 All service users who are at risk of pressure damage or who have existing pressure damage AND are incontinent of urine or faeces are at an increased risk of developing

moisture associated skin damage should have a full continence assessment documented. The outcome should be recorded on Rio and they should receive appropriate interventions to reduce the risk of moisture associated skin damage occurring or to treat existing moisture associated skin damage (Appendix 15 and 16). This includes the appropriate use of incontinence aids, pH balanced skin cleansers and skin barrier products (Appendix 17) (Refer to the Trust Continence Resource Folder Useful websites (sharepoint.com)). These should be commenced prior to a referral to the tissue viability service.

Referral to the Tissue Viability Service

3.27 All service users with a category 2 pressure ulcer and above should be referred to the Tissue Viability Service for assessment. Pressure ulcers of category 1 can be discussed with the Tissue Viability Service but will not routinely need to be assessed. Before referral is made it is expected that the ward team will have completed the Purpose T with skin inspection, Body Map, the MUST nutrition tool, mobility, and full continence assessment on Rio.

Referral to specialist Services

3.28 Specialist referrals to allied health care professionals and other specialists should be completed by the person identifying the need in a timely manner and must clearly identify the referral reason. Specialist services include, occupational Therapist, Physiotherapist, Health Instructor, Clinical Moving and Handling Advisor (including Bariatric Support) specialist, Nutrition and Dietetics, Diabetes Support Team, Podiatry Services, and the Continence Advisor (Tissue Viability Nurse).

Referral to Diabetes Service

3.29 If the service user is diabetic, consider a referral to the Diabetes team. Diabetic service users with a wound are at an increased risk of developing an infection and healing times are likely to be delayed (Refer to Physical Health Assessment Policy – C38).

Referral to Nutrition & Dietetic Service

3.30 All service users who are at risk of pressure damage or who have existing pressure damage should have an assessment of their nutritional status using the MUST tool (Malnutrition Universal Screening Tool). At risk service users should be referred to the trust dietetics team for assessment and recommendations when they have an inadequate dietary intake or poor nutritional status. Service users with highly exuding wounds may also require additional nutritional support and education to promote the wound healing process (refer to the nutritional and hydration policy C23).

External referral (Plastics/surgical interventions/Vascular, for example)

3.31 Referral for surgical interventions will be considered by the Tissue Viability Service if there is failure of previous conservative management interventions to the wound or if there is significant deterioration. However, this will depend on the service user's condition and co-morbidities.

3.32 For external specialist referrals a medical review, joint discussion and medic led referral is required.

Clinical images

3.33 When consent is given by the service user digital images of category 1 and above pressure ulcers should be taken and included in the clinical documents section in Rio (National Wound Care Strategy Programme (NWCSP) (2021). Please refer to the trust protocol for taking clinical images (Appendix 18). The Tissue Viability Service will use pictorial evidence to give telemedicine advice at the first point of contact; a full clinical assessment will always follow.

Wound assessment and treatment

3.34 Any service user presenting with pressure and/or moisture related injuries should have their wound assessed using the trust wound assessment chart, (Appendix 19). Appropriate care should be planned in conjunction with the pressure ulcer management guide (Appendix 20), wound treatment pathway (Appendix 21), the purpose-T pathways and aSSKINg principles.

3.35 The trust wound management formulary should be used as a framework for dressing selection (refer to the Tissue viability Service connect pages for the most up to date product list). Products not included in these documents should not be used. However, for specialist requirements please contact the Tissue Viability Team to discuss. The product list has been developed using the Birmingham and Solihull Integrated Medicines Optimisation Committee (BSol IMOC) Area Prescribing Committee (APC) formulary (Wound Care Products/ APC Formulary (sharepoint.com)) (Appendix 22 and 23). Products should be ordered from the trust SSL warehouse using the form available here: Wounds And Continence Order Form V1.1.xlsb (sharepoint.com)

3.36 Reassessment of a pressure ulcer should be completed as clinically indicated in the care plan dependent on wound type and treatment.

3.37 Reverse categorisation should not be used as the pressure damage is healing. Instead, a category 4 pressure ulcer would be referred to as a 'healing category 4 pressure ulcer'.

3.38 Once a pressure ulcer has healed the service user should continue to be reassessed using the Purpose T for pressure area risk prevention.

Wound infection

3.39 If an infected pressure ulcer is suspected or it is not healing as expected refer to your ward medics and the tissue viability team.

- Signs of covert local infection: Hyper granulation Bleeding, friable granulation, epithelial bridging and pocketing in granulation tissue, wound breakdown and enlargement, delayed wound healing beyond expectations, new or increasing pain and increasing malodour.
- Signs of overt local infection: Erythema. local warmth, swelling, purulent discharge, delayed wound healing beyond expectations, new or increasing pain and increasing malodour.
- Spreading infection: Extending induration +/- Erythema , lymphangitis, crepitus , wound breakdown, dehiscence with or without satellite lesions, lethargy or non-specific general deterioration and loss of appetite, inflammation, swelling of lymph glands.
- Systemic infection: Severe sepsis, septic shock, organ failure & death.

Signs and symptoms of infection must be documented in the Rio notes and for wound specific infections the wound assessment form completed. If sepsis is suspected seek urgent medical attention.

Non-compliance

3.40 Where healthcare professionals are unable to implement a plan of care due to service user non-concordance this must be clearly documented. All attempts to mitigate risk, alternative strategies, encouragement, supervision, assistance, reassurance, and on-

going assessment must be documented on Rio and the inpatient portal. Non-concordance must be escalated to the ward manager/matron.

Giving information

3.41 All service users who are at risk of pressure damage or who have existing pressure damage should be informed of their individual level of risk and advised on measures for prevention of further tissue damage and their plan of care.

3.42 Where the service user's first language is not English, healthcare professionals should involve link workers/approved interpreters in communicating the level of risk and their individualised care plan.

3.43 All clinical staff have a responsibility to be open and transparent with service users in relation to their care and treatment. Any patient that is harmed by a provision of a health service should be informed of the fact, appropriate remedy offered, regardless of whether a complaint has been made. Such incidents should be dealt with under the duty of candour. Requirements of the Duty of Candour are set out in the Health and Social Care Regulations (2014) regulation 20: Duty of Candour (CQC, 2022).

Discharge from BSMHFT in-patient services

3.44 When planning discharge of service users from inpatient settings who have existing pressure damage or who are at high risk of pressure damage, the registered GP and attached community services team should be informed before the service user is discharged.

3.45 For service users requiring ongoing wound care and/or need ongoing pressure ulcer assessment and prevention interventions complete a referral to the community District Nurse Team.

3.46 Discharge information should include the sites and category(s) of all pressure ulcers, a copy of the latest risk assessment tool and a summary of the treatment provided in the trust. Provision for pressure relieving equipment and supply of wound care dressings should also be considered on discharge to avoid a gap in care.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	All clinical staff members to include temporary/bank contracted workers and those employed to provide care within the terms of a Service Level Agreement are responsible for: Being aware of the prevention and management of pressure ulcers policy. Following the guidance/principles of good practice outlined by the policy and following the processes to prevent occurrence of pressure ulcers and safely manage a pressure ulcer when discovered. Reporting any concerns via appropriate channels for any identified barriers to compliance with principles underpinning the policy. Identification of any training needs via line management.	(NICE, June 2015)

	Attendance of pressure ulcer prevention and awareness training. Completion of e-learning modules.	
Ward Nurse Nurse Associate Named Nurse	Completion and implementation of assessments and care plans (This includes reviewing and incorporating the TVN assessments and care planning provided in the clinical notes on Rio). Facilitate through joint working with Matrons, Managers, Deputies, Housekeepers and Administrators: Wound care and pressure reducing equipment stock checks and purchasing. The return of rented equipment. Managing, arranging maintenance, repairs, and replacement of equipment. Attending training and ensuring practice is current. Liaising with the ward Tissue Viability Link worker for support in the first instance.	
Dementia & Frailty Service HCP's	Attendance at the yearly harm reduction training sessions organised by the service Matrons.	
Service, Clinical and Corporate Directors	To set strategic context in which the policy will support staff members to follow the guidance and principles, or recommended practice offered.	
Policy Lead	To ensure that the principles underpinning the Policy are based on recognised/agreed Good Practice, Professional Consensus and National/International/Local guidelines. Development and implementation of training and awareness sessions. Audits to monitor implementation.	
Executive Director	To support the implementation and recognition of Trust-wide Policy to standardise trust-wide practice for the prevention and management of pressure ulcer(s), ensuring compliance with all legal and statutory requirements.	
Specialist Tissue Viability Nurse	Responsible for the provision of expert advice in relation to the assessment, prevention, and management of pressure ulcers within the organisation. To provide training to all staff members.	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	July 2023
Number of versions produced for consultation	2
Committees or meetings where this policy was formally discussed	

Physical health committee		
Dementia and Frailty Steering Group		
Where else presented	**Summary of feedback**	**Actions / Response**
Clinical Lead Physiotherapist, Dementia and Frailty Team	Sections 2 & 3 seem very repetitive – could they be streamlined somehow?	Section 2 condensed. This section has key points that are explained in more detail in section 3.
	Should there be slightly separated into sections for risks, assessment, documentation, treatment & referrals? Certainly, a list of risk factors would be helpful in the body of the text; section 2 could do with mention of movement / mobility and positioning e.g., in 2.5 and 2.14.	Re-arranged and subcategories added. Risk factors added into this section. Moving/mobility and positioning added into section 2.
	Section 3.11 could benefit from mobility being mentioned before (repositioning.	Updated.
	Section 4 needs a box for Nursing Staff – assessments, care plans, dressings, and equipment provision; and who should be purchasing, managing, maintaining, repairing, replacing equipment – Housekeepers?	Updated to include clinician responsible for tasks identified.
	Appendix 9 K could be expanded slightly to "… Physiotherapist and Occupational Therapist to review & guide management of posture, transfers and mobility …".	Updated.
	Should there be mention somewhere of Harm Reduction training?	Dementia & Frailty training specific section added to appendix 9.
Acting Senior Infection Prevention and Control Nurse, IPC Team.	Section 3.7-skin inspection-what about infection?	Updated.
	Section 3.29- What are the signs of infection and what should staff look for and document? There may also be scope here to mention Sepsis etc.	Updated. Now in section 3.39.
	Section 8-glossary-add wound infection?	Updated.

	Appendix 11- Podiatry referral form-Is there a digital version of this? We are a paperless Trust.	Yes, word document available on the Podiatry connect page. Rio podiatry assessment form in development.
	Appendix 14- Is there a digital version of this? We are a paperless Trust.	Not currently. Rio wound assessment form in development.
	Appendix 17- APC formulary guide. Visibility is not great; do you have a link to the original that can be included?	Link to website added to the appendix.

6 REFERENCE DOCUMENTS

3M United Kingdom Plc (2019) Pressure Ulcer (PU) Guidance. Available at: file:///Z:/Physical%20and%20Complementary/Tissue%20Viability/Pressure%20Ulcers/PU%20Resources/Pressure%20ulcer%20category%20chart%20&%20MASD.pdf (Accessed 19 December 2023).

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The Health and Social Care Act (2008) regulations 2014. Available at: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk) (Accessed 19 December 2023).

Prevention and Management of Moisture-Associated Skin Damage (MASD) (Wounds International, 2020) Available at: 3m-masd-wounds-international-recommendation-us-version.pdf (Accessed 19 December 2023).

7 RELATED POLICIES AND PROCEDURES.

C 38 Physical Health Assessment
bsmhftnhsuk.sharepoint.com/sites/connect-bu-physicalhealth/Shared Documents/BSMHFT guidelines/Physical Health Assessment Policy.pdf

IC 01 Aseptic and Clean Dressing Procedure
Infection Prevention and Control - IC01 Annex K - Aseptic and Clean Dressing Technique Procedure APR-22.pdf - All Documents (sharepoint.com)

C 57 Clinical Risk Assessment and Management
Policies - Clinical Risk Assessment Policy .pdf (sharepoint.com)

R&s 26 Safeguarding Adults Policy
Policies - Adult Safeguarding Policy .pdf (sharepoint.com)

PSIRF - Patient Safety Incident Response Framework
PSIRF - Patient Safety Incident Response Framework (sharepoint.com)

C 18 Falls Prevention and Management
https://bsmhftnhsuk.sharepoint.com/:b:/r/sites/connect-policies/Shared%20Documents/Policies/Clinical%20Policies/Falls%20Prevention%20and%20Management%20Policy%20.pdf?csf=1&web=1&e=ZcKhh7

C 23 Nutrition and hydration Policy
https://bsmhftnhsuk.sharepoint.com/:b:/r/sites/connect-policies/Shared%20Documents/Policies/Clinical%20Policies/Nutrition%20and%20Hydration%20Policy%20.pdf?csf=1&web=1&e=0N0zBw

C 04 Management of the Deteriorating Patient & Resuscitation Policy C 04
Policies - Management of the Deteriorating Patient Policy .pdf - All Documents (sharepoint.com)

RS 21 Manual Handling Policy and the Care of Inpatient Service Users
Policies - Manual Handling Policy .pdf - All Documents (sharepoint.com)

8 GLOSSARY

Pressure Ulcer	A 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 (NICE, 2014) caused by sustained mechanical loading and deformation of the skin and subcutaneous layers between internal stiff anatomical structures and external surfaces or devices (Kottner et al, 2018)
Inherited	Inherited pressure damage: pressure ulcer present on admission when admitted into services within Birmingham and Solihull Mental Health Foundation Trust.
Acquired	Acquired pressure damage: pressure damage that occurs whilst the patient is receiving care from Birmingham and Solihull Mental Health Foundation Trust as an in-patient
Induration	Localised hardening of soft tissue.
Erythema	Redness of the skin.
Oedema	An accumulation of an excessive amount of watery fluid in cells and tissues.
Moisture Associated Skin Damage (MASD)	Inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, faeces, sweat or wound exudate.
Device related pressure ulcer (DRPU)	A pressure ulcer that has developed due to the presence of a medical device (NHSI, June 2018)
Microclimate	The skin microclimate (temperature, humidity and airflow next to the skin surface) is an indirect pressure ulcer risk factor. Temperature and humidity affect the structure and function of the skin increasing or lowering possible damage thresholds for the skin and underlying soft tissues (Kottner et al, 2018)
Deep tissue injury (DTI)	Purple or maroon areas of intact skin or blood-filled blisters caused by damage to the underlying soft tissues and are known ti deteriorate quickly even under optimal care.

Exudate	Any fluid that filters from the circulatory system into lesions or areas of inflammation. This can be clear fluid or pus-like.
Wound infection	A wound can be defined as infected when the presence and subsequent proliferation of microorganisms leads to a local or systemic response in an individual.

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements
Pressure ulcer risk assessment tool utilised and completed by staff when indicated with identified time frame of 6 hours	Tissue Viability Lead	Insight report	Bi-annual	To report to Physical Health and Nursing Advisory Council
Training Analysis	Tissue Viability Lead	Training Needs Analysis	yearly	To report to Physical Health Committee and Governance

10 APPENDICES

Appendix 1 Equality Analysis Screening Form
Appendix 2 Identifying individuals at risk
Appendix 3 Common sites for pressure ulcer development
Appendix 4 Purpose-T Pathways
Appendix 5 Pressure Ulcer classification guide (for light skin tones)
Appendix 6 Pressure Ulcer classification guide (for dark skin tones)
Appendix 7 Pressure Ulcer classification guide (for Asians skin tones)
Appendix 8 Pressure Ulcer classification guide (for older adults)
Appendix 9 aSSKINg principles
Appendix 10 aSSKING assessment on the in-patient portal
Appendix 11 Podiatry referral form
Appendix 12 Podiatry referral pathway
Appendix 13 Protocol for taking clinical images
Appendix 14 Wound assessment chart
Appendix 15 Pressure ulcer management guide
Appendix 16 Wound treatment pathway
Appendix 17 APC Wound basic product guide
Appendix 18 APC Wound Infection product guide
Appendix 19 Pressure redistributing mattress selection guide.
Appendix 20 Pressure redistributing chair cushions selection guide
Appendix 21 Moisture Associated Skin Damage versus Pressure Ulcers
Appendix 22 Protocol for Managing MASD
Appendix 23 Incontinence skin care protocol
Appendix 24 Useful websites

Appendix 1 - Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Policy	Pressure Ulcer Management and Prevention		
Person Completing this policy	Amanda Groome	**Role or title**	Tissue Viability Nurse
Division	Corporate	**Service Area**	Physical Health
Date Started	11th July 2023	**Date completed**	23 December 2023
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
To ensure that skin integrity, pressure ulcer prevention and management is part of day-to-day clinical practice across the trust, thereby minimising the physical, psychological, and financial costs of pressure ulcers to the service user and trust. To provide direction and to standardise practice for Birmingham and Solihull Mental Health Foundation Trust healthcare professionals to ensure adherence to national guidance and best practice.			
Who will benefit from the proposal?			
All service users admitted to an inpatient unit. All staff involved in the assessment and management of pressure related tissue viability issues.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The policy supports prevention and treatment to support in-patient service-users. It reduces the risk of any current or future pressure ulcer risks (and associated tissue viability issues).			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
No			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			

No, but if dressings or equipment is required the specific units purchase these.				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
No				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*			*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	Not age specific. However more predominant in the older population and people with eating disorders. The policy outlines the need to assess risk of developing pressure ulcers for all age groups as mental health does impact skin integrity.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	Supports the assessment and care planning of pressure ulcer prevention and treatment for people who are bedbound, use wheelchairs and other aids. If there are specific learning disability or sensory issues these are assessed, and care planned for as part of the MDT.

Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			If there are reasonable adjustments required these are explored as part of the individualised care planning process.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships	X			No impact.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			No impact, but if there are specific needs these can be assessed by the perinatal team and/or mother and baby unit.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			X	Skin tone and accurate assessment to manage the risk of pressure ulcers is included within the policy and pressure ulcer category guides are available to support with assessing pressure ulcer categorisation.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			No. However, the needs can be assessed on an individual basis.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area?				

When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			No. However, the needs can be assessed on an individual basis.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			If there are reasonable adjustments required these are explored as part of the individualised care planning process. In regard to the gender reassignment process needs can be assessed on an individual basis.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights	X			Basic rights for all individuals are met, in line with the Human Rights Act. Managing or preventing pressure ulcers assessment and care planning processes incorporate maintaining dignity and respect and least restrictive approaches. This includes the use of equipment and skin/wound care products.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
		No		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
This is outlined within the policy.
How will any impact or planned actions be monitored and reviewed?
This is managed on an individual basis by the clinical team. The policy will be updated with any significant changes in practice and reviewed by the PDMG.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
This policy is available trust wide and can be accessed on the connect policies page by all staff.
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2 - Identifying individuals at risk

Risk assessment is a fundamental part of preventing pressure ulcers.

There are many external factors which predispose a service user to develop a pressure ulcer. The critical determinants or pressure ulcer formation are the intensity and duration of pressure, and the tolerance of the skin and its supporting structure for pressure, shear and friction.

The factors that contribute to pressure ulcer development are divided into two groups:

- Extrinsic – external influences that cause skin distortion – pressure, shearing, friction and moisture.
- Intrinsic – reduced mobility, previous history of pressure damage, sensory impairment, reduced level of consciousness, acute illness, chronic long-term illness, medication, pain, nutrition, extremes of age, incontinence, and terminal illness

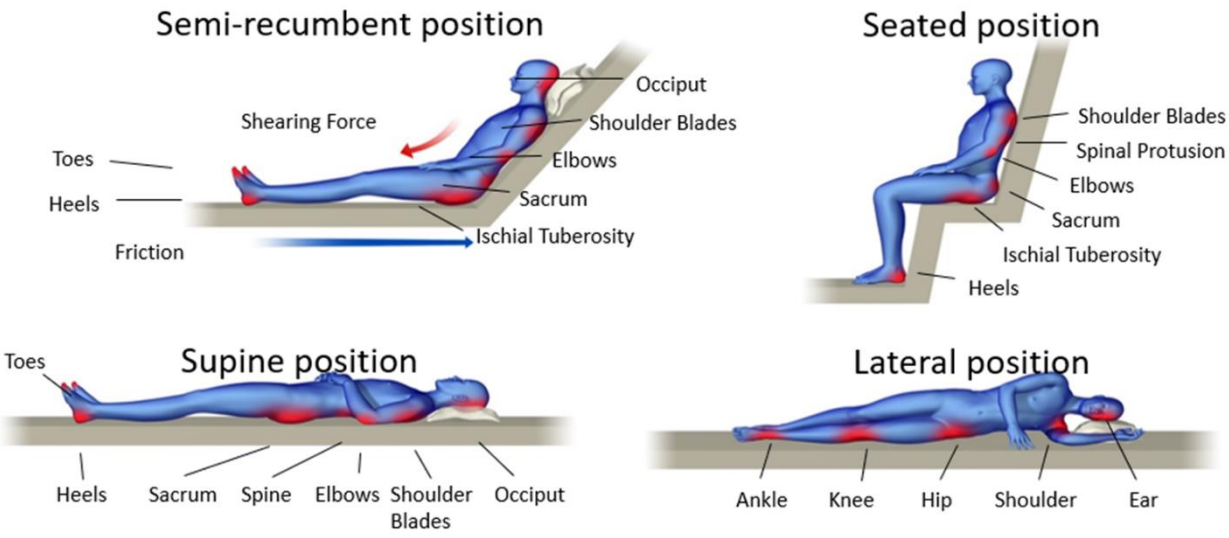
Assessing an individual's risk of developing pressure ulcers should involve both formal and informal assessment:

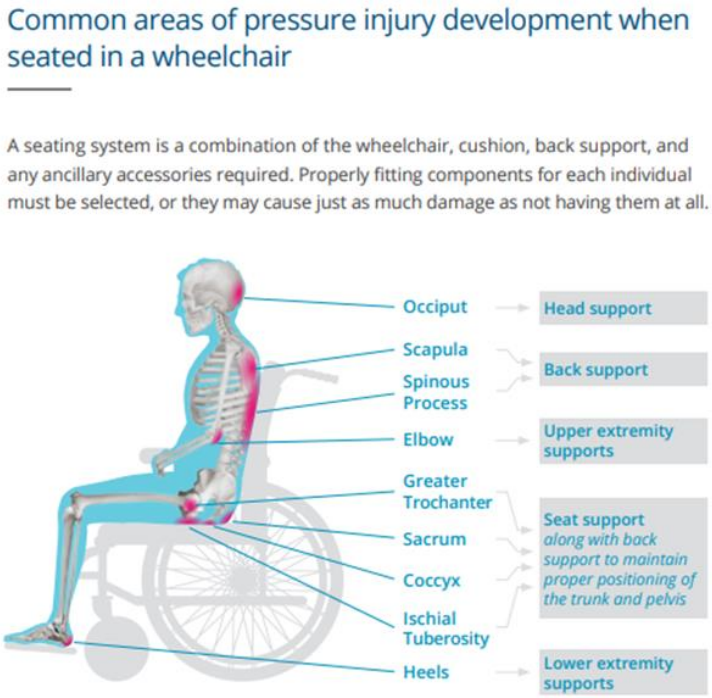
- Formal pressure ulcer risk assessment is undertaken by qualified nursing staff and involves a holistic assessment of the patient including a skin assessment, recording of intrinsic and extrinsic factors and the Purpose-T. Also using clinical judgement, a final level of risk can be decided, and care planned appropriately.
- Risk assessment is an on-going process and should be continually monitored informally.
- The timing of the risk assessment should be based on each individual case.
- A Purpose-T assessment will be documented for any service user identified at risk through the Physical Health screening tool on admission.
- If the service user is considered 'at risk' then part of this assessment should include a description of the service user's skin condition.
- Reassessment should be carried out according to risk score and any change in accordance with service user's condition.
- If considered not at risk on initial Purpose-T assessment, reassessment should occur if there is a change in an individual's condition which increases risk.
- All formal assessments of risk should be documented/recorded and made accessible to all members of the multi-disciplinary team.

Risk assessment tools should only be used in conjunction with clinical decision making:

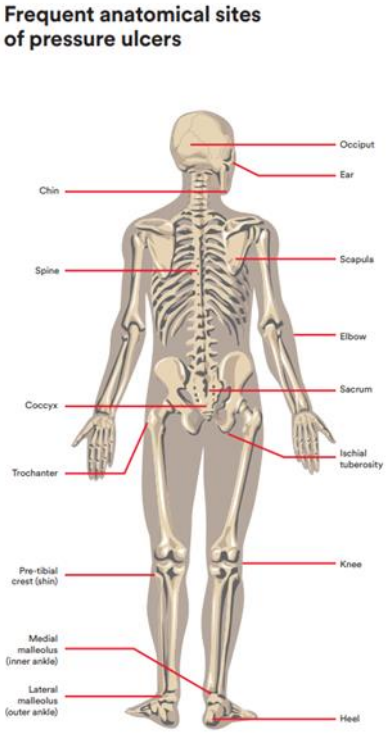
- The Pressure Ulcer Risk Score (Waterlow Score, 1985) is an aid to help health professionals clinical judgement but is only part of the documented evidence that a formal assessment of risk has taken place.
- As all service users are different any specific areas of risk not included in the score should be recorded. These additional factors can affect the level of individual risk.
- The final level of risk should be a combination of risk scoring and clinical judgement and should be expressed as a risk level: no risk, at risk, high risk, very high risk.

Appendix 3: Common sites for pressure ulcer development





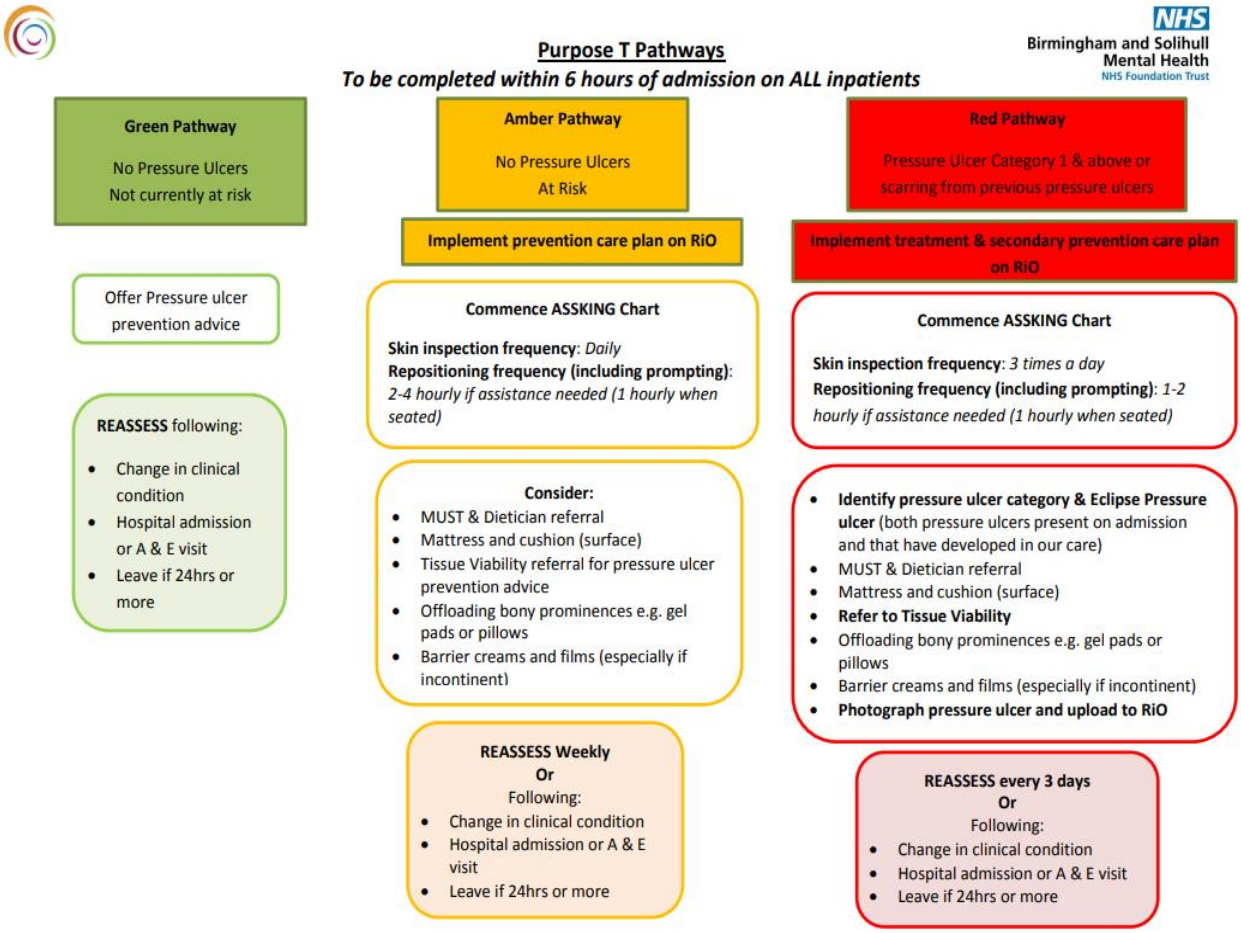
(NPIAP, 2019)



(3M, 2019)

(Reacttored, 2023)

Appendix 4: Purpose-T Pathways



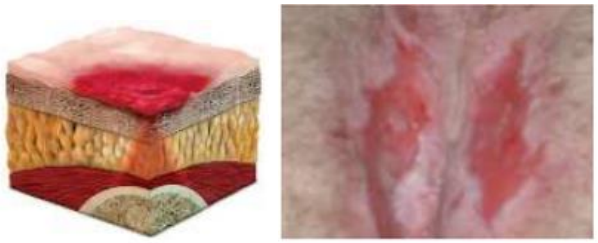
Appendix 5 – Pressure Injury Classification System for Light Skin Tones

Stage 1

Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).

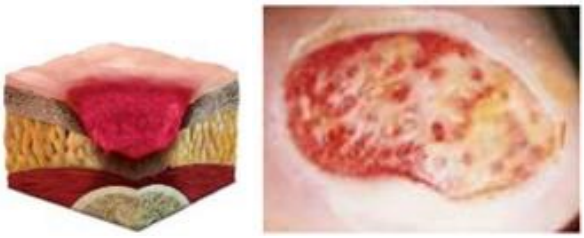
Stage 2

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



Stage 3

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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.

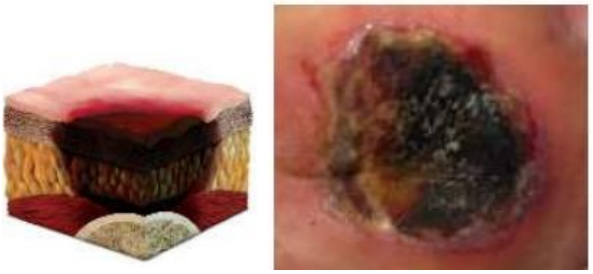


Stage 4

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4
pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable

Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray,green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.



Suspected Deep Tissue Injury

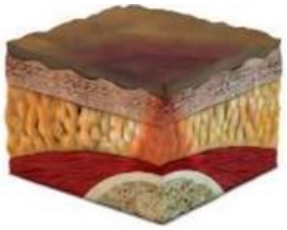
Purple or maroon localised area of discoloured intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed.
The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

adapted from: International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014) published in National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy Dr Keryln Carville, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults. More information and permission for use: www.pppia.org

Appendix 6 – Pressure Injury Classification System for Dark Skin Tones

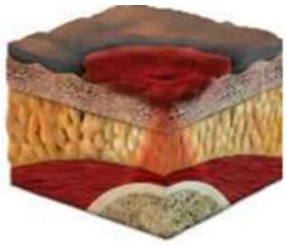
Stage 1

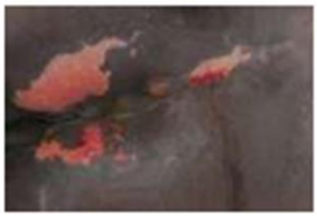
Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).



Stage 2

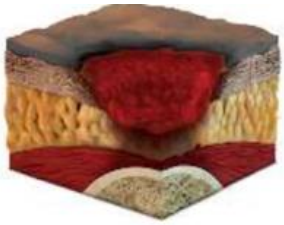
Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.





Stage 3

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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.



Stage 4

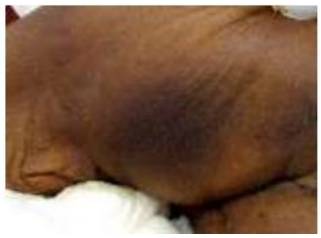
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4
pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable

Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray,green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected Deep Tissue Injury

Purple or maroon localised area of discoloured intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed.
The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

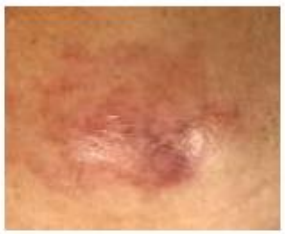


adapted from: International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014) published in National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy Dr Keryln Carville, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults. More information and permission for use: www.pppia.org

Appendix 7 Pressure Ulcer classification guide (for Asians skin tones)

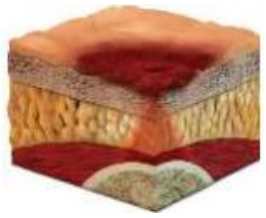
Stage 1

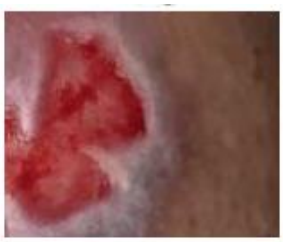
Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).



Stage 2

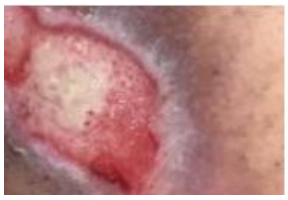
Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.





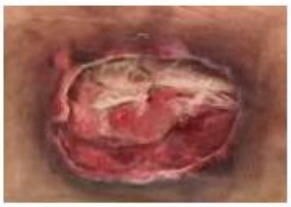
Stage 3

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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.



Stage 4

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

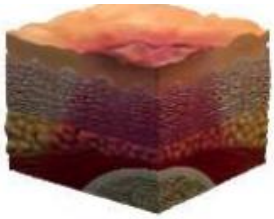


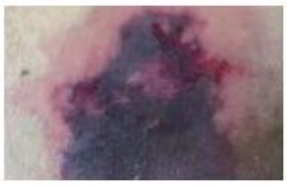
Unstageable

Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray,green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected Deep Tissue Injury

Purple or maroon localised area of discoloured intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed.
The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



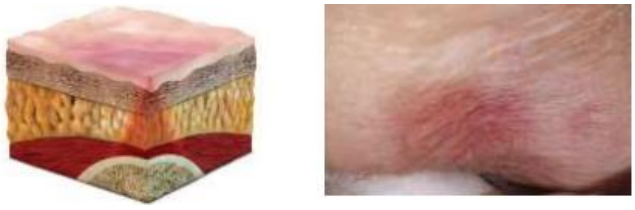


adapted from: International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014) published in National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. 3D graphics: Owned by PPPIA. Photos: All photos courtesy Dr Keryln Carville, used with permission. Also available in this series: PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults. More information and permission for use: www.pppia.org

Appendix 8 Pressure Ulcer classification guide (for older adults)

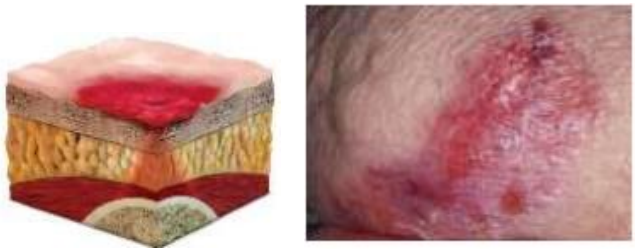
Stage 1

Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).



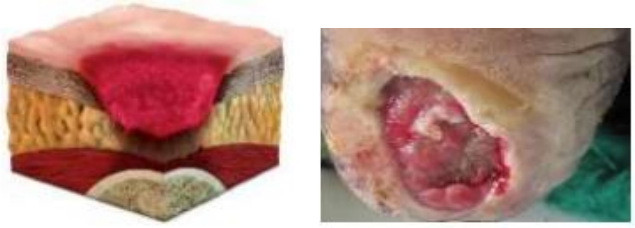
Stage 2

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



Stage 3

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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.



Stage 4

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4
pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable

Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray,green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

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The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

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Appendix 9: aSSKINg Principles

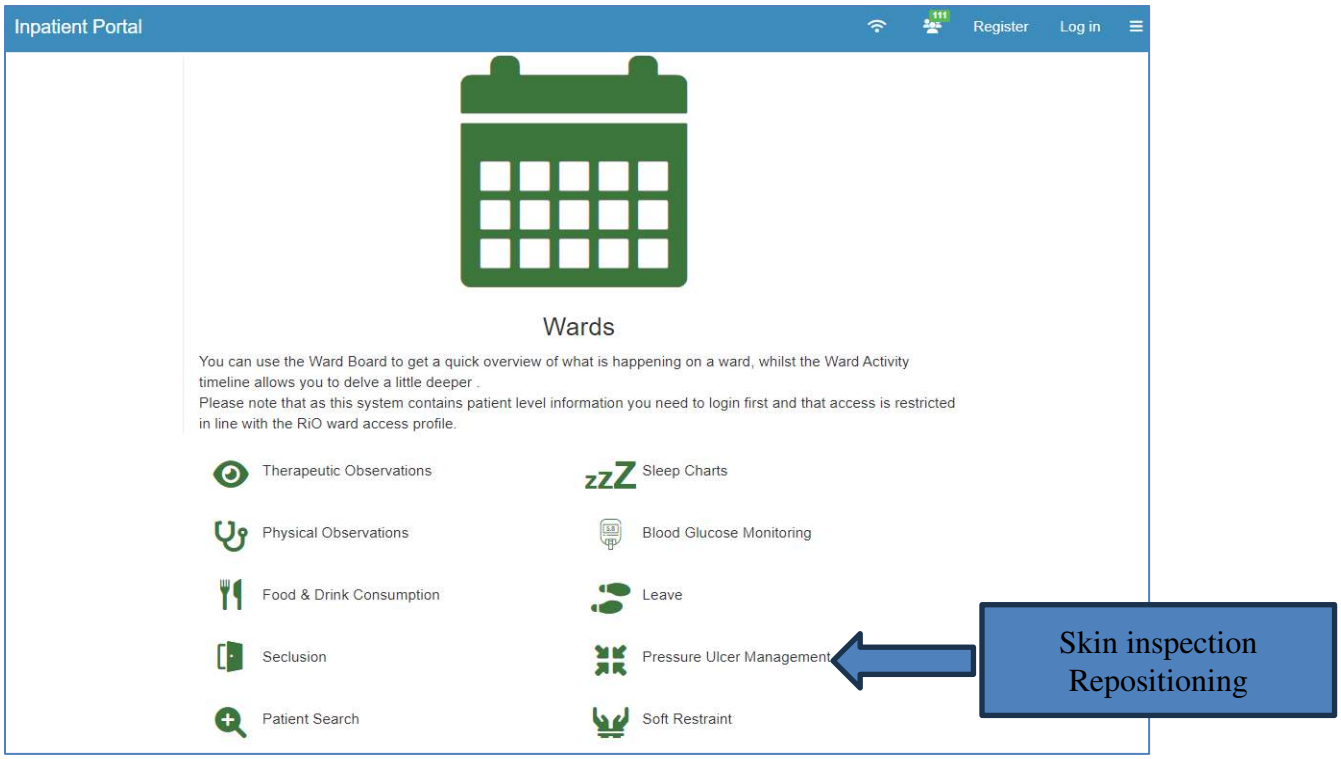
7. Assess Risk

Each individual receiving care within the Trust must have their risk of developing a pressure ulcer assessed.

Aims	Objectives	Actions
A	**Assessment of Risk (Purpose-T)**	*Ensure a pressure ulcer risk assessment (Purpose T) is completed on ALL patients within 6 hours of admission.* Reassess according to need, change in condition, hospital/A&E visit and leave of more than 24 hours.
S	**Surface (In-patient Portal)**	*Make sure your Service users have the right support* Select the appropriate mattress and seating. Reassess aids when Purpose T is reassessed. Change the aids according to clinical needs. Service users with pressure ulceration must not sit out for longer than 2 hours at a time. Assess the Service users seating position and refer to Physio or OT if clinically indicated.
S	**Skin Inspection (In-patient Portal)**	*Early inspection means early detection.* Assess all pressure areas morning, afternoon and night and document on skin inspection chart. Observe for pain, swelling and signs of any skin changes. Document category of pressure ulceration and wound bed tissue type on wound assessment table. Photograph pressure ulcers with consent. Map pressure ulceration on body map chart if unable to photograph.
K	**Keep Moving (In-patient Portal)**	*Keep your Service users moving.* Physiotherapist and Occupational Therapist to review and guide management of posture, transfers and mobility.

		Encourage independent mobility where clinically possible. Encourage independent repositioning. Ensure patient is repositioned and this is documented on repositioning chart. Use appropriate moving and handling aids to move the patient. Elevate heels by using profiling beds or recommended heel off-loading devices.
I	**Incontinence/Moisture (In-patient Portal)**	*Your Service users need to be clean and dry.* Use pH balanced cleansers and ensure skin is well dried. Use barrier product depending on clinical need. Manage continence according to need.
N	**Nutrition/Hydration (In-patient Portal)**	*Help Service users have the right diet and plenty of fluids.* Undertake nutritional risk assessment according to Trust policy and action plan appropriately. For those at risk encourage nutrition and hydration as per guidance. Refer to dietician if clinically indicated.
G	**Giving Information (In-patient Portal)**	To be able to communicate effective and safe use of interventions effectively for the patient, family and within the MDT. Understand and recognise when clinical concerns need to be escalated and be able to promote effective pressure ulcer prevention approaches

Appendix 10 – aSSKINg chart (Inpatient Portal)



Appendix 11: Podiatry referral Form

PODIATRY REFERRAL FORM FOR INPATIENTS (Mental Health)

Patient Details

NHS No.....

Surname..... Mr Mrs Ms

First Name.....

Address.....

.....Postcode.....

Tel..... **DOB**.....

Risk code please circle: Low/ At Risk / High risk/ Active ulcer

BOLD items must be filled in

Please circle/highlight all relevant responses:

Foot Problems

Skin	Normal	Fungal/verrucae	Corn/callus	Infected	Ulceration/Wound
Nails	Normal	Fungal	Thickened	Curved	Ingrowing
Pain	None	Slight	Moderate	Severe	Extreme
Deformity	None	Mild	Moderate	Severe	Extreme

General Medical

Stroke	Chronic lung disease	Neurological
Nephropathy	Mental illness	Rheumatoid Arthritis
None	Neuropathy	Diabetes
Physical Disability	Osteoarthritis	Amputee
Registered Blind	Lower limb ischaemia	

Relevant history (including risk and specific foot/limb problem).

Referrer ..... **Job Title** ..... **Signature** .....

UNIT/WARD .....

Telephone Number ..... **Date** .....

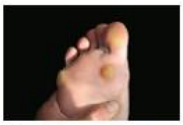
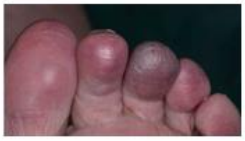
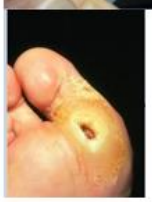
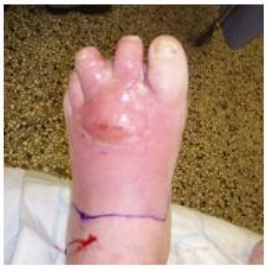
To prevent delays in patient care all sections of this from must be completed and returned by secure email: bchc.podiatry.diary@nhs.net or call **0121 466 7600 : Option 1** to leave a message for the Podiatrist (**Amanda Askew Amanda.askew1@nhs.net**)

Please note: Emergency diabetic foot wounds with clinical signs of sepsis need to be referred to Diabetic foot clinic at BHH or QE, non diabetic via Vascular on call registrar

Appendix 12: Podiatry referral pathway

Diabetes Foot Referral pathway BSMHFT

For: any Patients presenting with a symptomatic foot

Low Risk	At-Risk	High Risk	Active	Emergency
No Vascular disease *(Palpable foot pulses)* **No Neuropathy** (10g monofilament felt at all sites) **No or Mild deformity** **No Risk Factors** **Neglected nails** Verrucae, Fungal nails Fungal foot  infections,	**Vascular disease** OR **Neuropathy** OR **Risk factors** • Callus • Deformity • Evidence of poor self-care  	**Vascular Disease** *(rest pain, signs of ischaemia)* **Neuropathy with pain** **Previous Ulcer/Amputation** 	**Active Charcot** **Cellulitis** **Osteomyelitis** **Gangrene/Necrosis**  	**Extensive tissue loss** **Abscess** **Clinical signs of Sepsis (NEWS2)** 
NON URGENT REFERRAL REQUIRED BCHC Community Podiatry Non urgent but may affect mobilisation and increase risk of falls	NON-URGENT REFERRAL **BCHC Community Podiatry**	URGENT REFERRAL (< ONE WEEK) **BCHC Community Podiatry**	**VERY URGENT REFERRAL (< 1WEEK)** **BCHC Community Podiatry**	VERY URGENT REFERRAL (<48 HOURS) **Refer immediately to Hospital Diabetic Foot Clinic by phone or if non diabetic via Vascular registrar on call at BHH or QE**

Appendix 13: Pressure redistributing mattress selection guide

Pressure Care Mattress Selection Chart

THIS CHART IS A GUIDE ONLY AND SHOULD BE USED IN CONJUNCTION WITH CLINICAL JUDGEMENT AND HOLISTIC INDIVIDUAL PATIENT ASSESSMENT

Please ensure Pressure Ulcer Risk Assessment has been completed and appropriate mattress is obtained

	Green Pathway Not currently at risk NO pressure ulcers	Amber Pathway At Risk NO Pressure Ulcers		Red Pathway Pressure Ulcer Category 1 & above or scarring from previous pressure ulcers	
		Able to relieve own pressure areas	Assisted to relieve pressure areas	Able to relieve own pressure areas	Assisted to relieve pressure areas
Other mattresses including Reposa, Protector 7 and Pineapple	✓				
DynaForm Mercury Foam (crib 7 and sealed) *pressure redistributing* 	✓	✓	✓	Dynaform Mercury MUST be used in seclusion and forensics. Also to be used in acute settings where the wires or fire pose a risk! ✓	
Quattro Plus  *crib 5*			✓	✓	✓
			Crib 5- Pressure Ulcer Risk MUST outweigh the risk of Fire and Ligature. Mattresses are not sealed and need to be connected to an electrical supply		
Quattro Acute  *crib 5* *Please seek Tissue Viability advice*					✓
				Crib 5- Pressure Ulcer Risk MUST outweigh the risk of Fire and Ligature. Mattresses are not sealed and need to be connected to an electrical supply	

How to order:

Mattress	Supplier	Purchased or rented	How to order
DynaForm Mercury	Direct Health Care (DHC)	Purchased *(approx.£209) size of bed base needed*	Find out bed base size- use 100080296 if the size is available if not raise a non-stock requisition on Integra DHC- 0845 459 9831 or sales@directhealthcareservices.co.uk
Quattro Plus	Talley	Rented *(approx. £6 per day)7 day min rental*	Talley 01794 503000 or sales@talleygroup.com – Purchase Order # Required
Quattro Acute	Talley	Rented *(approx.£7 per day) 7 day min rental*	

Appendix 14: Pressure redistributing chair cushions selection guide

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Pressure Care Cushion Selection Chart

THIS CHART IS A GUIDE ONLY AND SHOULD BE USED IN CONJUNCTION WITH CLINICAL JUDGEMENT AND HOLISTIC INDIVIDUAL PATIENT ASSESSMENT

Please ensure Pressure Ulcer Risk Assessment has been completed and appropriate cushion is obtained

Cushion	Risk	Description	Cushion Heights Available
Dyna-Flex 	**High Risk** Purpose T Pathway: GREEN/AMBER	*Combination of visco elastic & CME foam technology, providing not only outstanding pressure re-distribution, but great patient comfort.*	Low Profile Standard
Transflo 	**Very High Risk** Purpose T Pathway: AMBER	*Combination of high density foam and a unique silicone gel 'floatation' system. Incorporating two fluid-filled, vapour-permeable, multi-stretch sacs that are encased within a supportive, heavy-duty foam surround.*	Low Profile Standard
Intelligent Air 	**Very High Risk** Purpose T Pathway: RED	*Incorporates Reactive Airflow technology, a system of air and foam-filled cells with a patented valve system designed to displace and adjust air in response to user body weight and movement.*	Low Profile Standard
Attivo 	**Very High Risk** Purpose T Pathway: RED	*The cushions feature an active, adaptive surface which provides pressure relief and comfort. The versatile ATTIVO power unit benefits from dual-power technology, offering a seamless choice of mains or battery operation. The integral battery will operate the power unit continuously for at least 24 hours when fully charged.*	One size

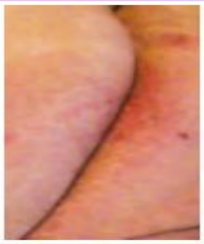
How to order:

Mattress	Purchased or rented	Supplier	How to order
Dyna-Flex	Purchased *(approx.£45.98)*	Direct Health Care (DHC)	Raise a non-stock requisition on Integra DHC- 0845 459 9831 or sales@directhealthcareservices.co.uk
Transflo	Purchased *(approx. £60.92)*		
Intelligent Air	Purchased *(approx. £182.98)*		
Attivo	Rented *(approx.£4 per day) 7 day min rental*	Talley	Talley 01794 503000 or sales@talleygroup.com – Purchase Order # Required

Appendix 15: Moisture Associated Skin Damage versus Pressure Ulcers

Location

MASD



Combination of moisture and friction may cause moisture lesions in skin folds. Most commonly present in the anal cleft.

Pressure ulcers

A pressure ulcer is most likely to occur over a bony prominence.

Necrosis

MASD

There is no necrosis in a MASD.

Pressure ulcers

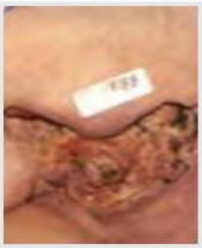
A black necrotic scab on a bony prominence is a pressure ulcer.

Depth

MASD

MASD is superficial (partial thickness skin loss). In cases where MASD gets infected, the depth and extent of the lesion can be enlarged.

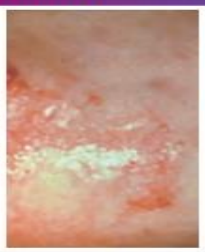
Pressure ulcers



Pressure ulcers vary in depth depending on classification.

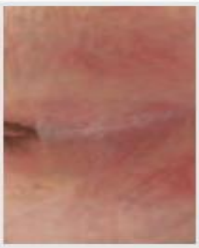
Colour

MASD



If redness is not uniformly distributed, the lesion is likely to be MASD.

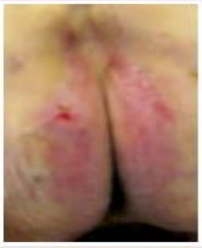
Pressure ulcers



If redness is non-blanchable, this is most likely a pressure ulcer. In dark pigmented skin, persistent redness may manifest as blue/ purple.

Shape

MASD



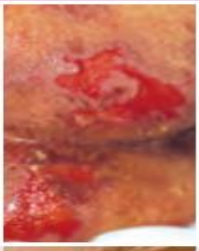
Diffuse, different superficial spots are likely to be moisture lesions. In a kissing ulcer (copy lesion) at least one wound is most likely caused by moisture.

Pressure ulcers

Circular wounds or regular shaped wounds are most likely pressure ulcers. The possibility of friction injury has to be excluded.

Edges

MASD



MASD often has diffuse or irregular edges.

Pressure ulcers

If the edges are distinct, the lesion is most likely to be a pressure ulcer.

Appendix 16: Protocol for managing MASD

Moisture Associated Skin Damage Pathway

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Assessment

General criteria
- Nutritional status
- Allergies
- Mobility
- Previous skin disorder
- Patient bathing/ skin care routine

MASD specific
- Urine or faecal incontinence
- excessive wound exudate
- excessive sweating
- Stoma leakage

Skin is intact but regular reassessment required

There is evidence of skin breakdown

Differential diagnosis

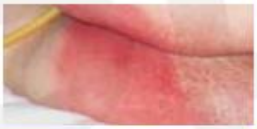
Is the skin damage caused by: (exclude pressure damage as a cause (3M Differentiation guide*)

1. Urine or faecal matter
2. Excessive moisture from sweating
3. Wound exudate
4. Stoma leakage

1 Incontinence Associated Dermatitis (IAD)

Source of MASD
Urine or liquid faeces

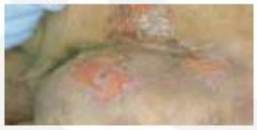
Erythema and inflammation of the skin, erosion and denudation can occur as result of exposure to urine and faeces



2 Intertriginous Dermatitis (MASD within skin folds)

Source of MASD
Perspiration

Mild, mirror image erythema on each side of the skin fold. May have erosion and denudation as result of exposure to chronic perspiration



3 Periwound Dermatitis

Source of MASD
Exudate, adhesive stripping or infection

Erythema and inflammation of skin within 4cm of wound edge, may show denudation or erosion

4 Peristomal and Peri-tube Moisture Associated Dermatitis

Source of MASD
Bodily fluids e.g. urine, faeces, gastric

Inflammation and erosion of skin related to moisture from bodily fluids such as urine, faeces and gastric fluids

Implement skin care regimen

- Ensure patient consent to any skin care practice and treatment
- Control symptoms and treat the underlying cause
- Adopt a multidisciplinary approach
- Moisturise and protect using appropriate barrier product(s), eg 3M™ Cavilon™ Skin care Range
- Educate all care providers on preferred method of skin care
- Remove irritants from skin and protect from further exposure
- Cleanse skin with ph neutral wipes/ cleanser
- Check skin folds for residual faeces/urine
- Use devices/products to wick moisture from affected skin
- Utilise disposable wash basins to reduce cross infection risk

Management

Include patient in all descisions relating to treatment

Complete an assessment and care plan in all instances

1 Incontinence Associated Dermatitis (IAD)

- Refer to Incontinence Skin Care Protocol

2 Intertriginous Dermatitis (MASD within skin folds)

- Examine entire area of the skin fold
- Gently lift the fold without exacerbating traction and fissure formation
- Consider tissue type and treatment aim when selecting treatment
- Avoid products containing chlorhexidine gluconate, alcohol, or perfumes
- Ensure the continued drying of the skin fold
- Cavilon No Sting Barrier Film to be applied every 24 hours. Frequency can be reduced to 48–72 hours in line with skin improvement
- If no improvement within 72 hours or appears infected, please swab and change over to Medihoney barrier cream

3 Periwound Dermatitis

- Base dressing choice on exudate levels
- Consider the potential for wound infection
- If the wound is not healing or progressing, further investigation may be required to establish co-morbidities
- Protect peri-wound area from further breakdown, maceration and adhesive trauma. Apply Cavilon NSBF at every dressing change or as per protocol

4 Peristomal and Peri-tube Moisture Associated Dermatitis

- Consult Stoma Nurse specialist for guidance on appliances
- Protect peri-stomal/peri-tube area from further breakdown, maceration and adhesive trauma. Apply Cavilon NSBF at every pouch/ appliance change or as per protocol

Reassessment and evaluation: record outcomes

Appendix 17: Incontinence skin care protocol

Incontinence skin care protocol

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

	Clinical presentation**		Clean the skin	What to use	When to use	How much to use
Prevention	**At risk** No redness and skin intact		Cleanse skin with Tena 3 in 1 wash after each episode of urine/faecal incontinence	Cavilon Durable Barrier Cream	Apply morning and evening	
Management	**Mild** Red but skin intact		Cleanse skin with Tena 3 in 1 wash after each episode of urine/faecal incontinence	Cavilon Durable Barrier Cream	Apply morning and evening	
	Moderate Red* with skin breakdown		Cleanse skin with Tena 3 in 1 wash after each episode of urine/faecal incontinence	Cavilon No Sting Barrier Film	48–72 hours	Apply an even coat of film to the entire area to be treated
	Severe Red* with skin breakdown		Cleanse skin with Proshield Foam Cleanser after each episode of urine/ faecal incontinence.	Proshield Plus	Apply after every incontinence episode	Apply thin layer to broken skin
	Infected skin		Cleanse skin with Tena 3 in 1 wash after each episode of urine/faecal incontinence	Medihoney® Barrier Cream (ELY374)	Reapply after bathing or each dressing change	Apply to clean, dry skin as required

Appendix 18: Protocol for taking Clinical Images

Pictorial evidence will be provided by the Tissue Viability service or Matrons/Ward Managers and Nursing Staff in the form of a photograph using a digital camera, agreed by Trust Information Technology colleagues as appropriate and compatible with current systems.

Pictorial Evidence relating to Tissue Viability may be undertaken to evidence the assessment or on-going management of wounds/ loss of skin integrity or to record improvement or deterioration. It will also enable the Tissue Viability Service to provide telemedicine advice.

Pictorial evidence in the form of a photograph regarding Tissue Viability will be undertaken with the verbal consent and knowledge of the Service user and documented within the clinical notes. Where consent is not able to be obtained, due to issues surrounding capacity it should be discussed with the multidisciplinary team in order to enable a decision to be taken in the best interests of the Service User.

If a Service User does not wish to have an issue surrounding Tissue Viability Photographed and it is felt that they have the capacity to make this decision, then this will be documented within the Clinical notes.

Pictorial evidence in the form of a photograph will be undertaken at the following junctures within the Service Users journey:

- At initial Tissue Viability Service assessment.
- All pressure damage from Category 1 and above.
- All moisture lesions.
- At 4 -6 weekly intervals to evidence the Service User journey.
- For telemedicine advice from Tissue Viability service.
- Following significant/ demonstrable changes to the Service User in regards Skin Integrity/ wounds management which the Tissue Viability Service feel should be documented and evidenced pictorially.
- To evidence completion of the healing process.

Photographic/ pictorial evidence will only be undertaken for the Purposes as stated.

A designated Digital camera will be utilised to obtain the pictorial/photographic evidence and not for any other Purpose.

The Service Users personal identity (face, identifying features, name, Date of Birth, address Trust Premises and staff members) will be concealed at all times to maintain confidentiality, privacy and dignity in accordance with Trust policy.
Photographs undertaken of the Tissue Viability related issue will be preceded by a photograph of the Service Users Trust identification Number to differentiate and confirm individual Service user photographs.
Photographs/ pictorial evidence will be Up- loaded onto the Service users RIO Clinical Notes at the next available opportunity not exceeding 2 weeks. These will be stored within the Clinical Documentation section under the heading of photographs.

Photographs/ Pictorial evidence will be Up- loaded from the Digital Cameras memory card and immediately deleted and will not be stored on any other system.

Appendix 19: Wound assessment chart

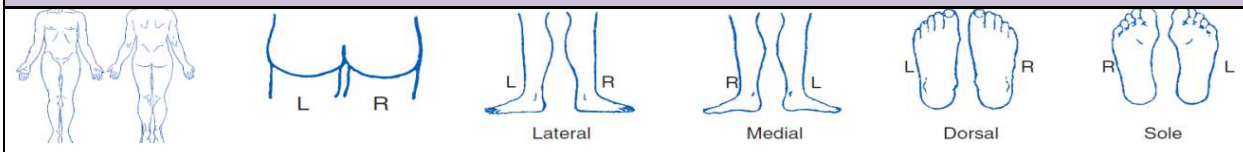
Patient Name: RiO Number:	Type of wound & location: Category (if pressure damage): Eclipse Number:

Does the patient consent to treatment? Y/N

Does the patient have capacity to consent? Y/N

Is the patient under DOLs or MHA, if so please state what section? Y/N section:

Wound Location



Wound Type (please tick)

Pressure Ulcer	Moisture Lesion	Diabetic foot ulcer	Self-Harm Wound
Burn/Scald	Fungating Wound	Sinus/Fistula	Surgical Wound (dehiscence)
Skin Tear/Laceration	Leg ulcer	Haematoma	Other:
Wound duration	Acute (<4 weeks)	Chronic (>4 weeks)	Recurring?

Factors Which May Delay Wound Healing (please tick all that apply)			**How does the patient feel about the wound and future care?**
Immobility	Poor Nutrition	Diabetes	
Urinary Incontinence	Respiratory/circulatory	Medication	
Faecal Incontinence	Smoking/Alcohol/Drugs	Anxiety/Depression/Stress	
Oedema	Steroids	Concordance	
Other:			

Wound Pain Assessment

Severity	0	1	2	3	4	5	6	7	8	9	10

Frequency	on dressing change		On Movement		Continuous		Other	

Initial Assessment		Wound Size		Exudate			
Wound Bed Condition (100%)		(In CM)		Colour:			
Epithelising (pink)	%	Width	cm	**NIL**	**LOW**	**MODERATE**	**HIGH**
Healthy Granulation (red)	%	Length	cm	THIN VISCOSITY		THICK VISCOSITY	
Slough (yellow/brown)	%	Depth	cm	**PHOTOGRAPH TAKEN**		**ODOUR**	
Necrotic (black/brown)	%	Undermining	cm	YES		NO	YES

Over granulation	%	Tracking	cm	DATE		On dressing change
Bone/Tendon/Ligament	%	**Condition of Surrounding Skin**				
Fungating/Malignant		Healthy/Intact	Dry/Cracked	Discoloured		Fragile
Other (i.e. SDTI; blister)		Macerated	Eczematous	Oedematous		Excoriated
Wound Margins	Healthy	Epithelialisation	Rolled	Raised		Other:

INFECTION SUSPECTED Y/N			
Wound swab taken? YES/NO	Date taken:	Result:	Antibiotic therapy? YES/NO

INITIAL WOUND MANAGEMENT PLAN (please tick)

Wound Management Aims:	Debride	Deslough	Protect	Hydrate	Manage Exudate
	Reduce Bacterial Load	Control Odour	Keep Dry (Vascular)	Encourage Granulation	Other:

Debridement Method:				Cleansing Solution:			
Barrier Preparation:				Medical Adhesive Remover:			
Primary Dressing:				Secondary Dressing:			
Retention Method/Bandaging:				Other Instructions:			
Frequency of Dressing Change:							
Reassessment chart completion Frequency:	DAILY	WEEKLY		Next Reassessment Date:			
Referral Required?	TVN	Podiatry	Vascular	Dermatology	Plastics	Dietitian	Other:
Reason for Referral:							

BLOOD TESTS			
HB	Result:	HbA1C	Result:
INR	Result:	WBC	Result:
Albumin	Result:	CRP	Result:

Allergies or skin sensitivities (including dressing products):		
Assessed By:	Name:	Signature:
	Designation:	Date:

Wound Reassessment	
Patient Name: RiO Number	Type of wound & location: Category(GRADE) (if pressure damage): Eclipse Number:

Date:						
Wound Bed Condition (100%)						
Epithelisation	%	%	%	%	%	%
Healthy Granulation	%	%	%	%	%	%
Slough	%	%	%	%	%	%
Black/brown necrotic tissue	%	%	%	%	%	%
Over granulating	%	%	%	%	%	%
Fungating/malignant	%	%	%	%	%	%
Mixed tissue (bone/tendon/ligament)	%	%	%	%	%	%
Other (SDTI; blister)						
Amount & Colour of Exudate (please tick)						
None						
Low						
Moderate						
Heavy						
Colour & Viscosity (thick or thin)						
Size of Wound (cm)						
Width (W)	cm	cm	cm	cm	cm	cm
Length (L)	cm	cm	cm	cm	cm	cm
Depth (D)	cm	cm	cm	cm	cm	cm
Undermining/Tracking	cm	cm	cm	cm	cm	cm
Odour	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**
Wound Pain	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**
Severity (patient's score1-10)						
Infection						
Nil						
Suspected						
Swab sent (date)						
Infection confirmed						
Condition of Surrounding Skin (please tick all that apply)						
Healthy/intact						
Dry/Cracked						
Discoloured						
Fragile						
Macerated						
Eczematous						
Oedematous						
Excoriated						
Wound margins (please state)						
Wound Photographed	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**
Updated Management Plan	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**	**YES/NO**
Cleansing Solution						
Primary Dressing						
Secondary Dressing						
Retention method/Bandaging						
Others (Barrier/adhesive remover):						
Frequency of Dressing Change						
Next Reassessment Date:						
Assessment completed by: (print & Sign)						

Appendix 20: Pressure ulcer management guide

Category 1 (see EPUAP 2019 classification system)	**Category 2** (see EPUAP 2019 classification system)	**Category 3 and 4** (see EPUAP 2019 classification system)
Key Aim: Prevention of further pressure related damage by removal of the source of applied pressure and allowing reperfusion of tissues. ➢ Staff may consider seeking support from the Tissue Viability Service. ➢ Report pressure damage via Eclipse. **Prevention & Management Plan:** • Skin inspection of bony prominences and/ or vulnerable areas. Any issues to be recorded on 'Body Map'. • Complete full risk assessment tool. To be re-assessed 3 times a week or following any change in condition. • Review Seating surfaces-i.e. is this the appropriate level of support for pressure redistribution? • May require seating assessment by Physiotherapist / consider need to source high specification foam or Air flow cushion. • Review mattress- i.e. is it the appropriate level of support for Pressure Redistribution? May need to consider sourcing high specification foam or dynamic mattress. • Consider other contributory factors i.e. moisture/ incontinence, nutrition and take the appropriate action to address the issue. i.e. o Refer to Dietetic Team o Investigate cause of moisture/ incontinence issues and utilise appropriate skin cleansers/ barrier cream/ barrier spray to reduce risk of loss of skin integrity. • A **documented programme of 'Pressure Area Care' should be commenced** - this can be incorporated by staff altering position of service user; encouraging Service User to relieve own pressure areas by standing and/or 30% tilt in a chair or in bed . • Staff should identify the frequency at which the pressure area care should occur and ensure that all non-concordance is also documented: **Recommended baseline minimum:** o 2 hourly whilst in bed on appropriate support surface for need/risk. o 1 hourly whilst seated on appropriate Pressure Redistributing cushion. **Staff should monitor for any deterioration and act / report appropriately.**	**Key Aim:** Recognise the level of pressure related damage to tissues and prevention of further damage by removal of the source(s) of applied pressure and any other contributory factors. ➢ Implementation of a planned programme of care to support/ promote wound healing/ reperfusion. ➢ Staff to ensure the ward manager and matron for the area is aware. ➢ Report pressure damage via Eclipse. ➢ Staff to refer to Tissue Viability Service for assessment and also to verify category of pressure damage. **Implement the basic Pressure Ulcer Management Plan (as detailed in the left hand column)** Staff may need to consider if any additions to the basic plan are required based upon individualised risk assessment i.e. pressure redistributing heel aid equipment, referral to AHP's i.e. Physiotherapist, Dietetics, Podiatrist etc	**Key Aim:** Recognise and report appropriately the level of pressure related damage to tissues and prevention of further damage by removal of the source(s) of applied pressure and any other contributory factors. ➢ Implementation of a planned programme of care to support/ promote wound healing/ reperfusion. ➢ Staff to ensure the ward manager/ matron/and clinical service manager are informed. ➢ Report pressure damage via Eclipse ➢ Staff to refer to Tissue Viability Service for assessment and also to verify category of pressure damage. ➢ Pressure Ulcers which are present prior to admission/ transfer to BSMHFT must be discussed and responsibility agreed with relevant Trust. **Implement the basic Pressure Ulcer Management Plan (as detailed in the left hand column).** Staff may need to consider if any additions to the basic plan are required based upon individualised risk assessment i.e. Pressure redistributing heel aid equipment, referral to AHP's i.e. Physiotherapist, Dietetics, Podiatrist etc.

Appendix 21: Wound treatment pathway

WOUND TREATMENT PATHWAY

Always treat/manage the underlying cause of the wound and address whenever possible, all factors that may delay the healing process

Birmingham and Solihull Mental Health NHS Foundation Trust

NECROSIS	SLOUGH	GRANULATING	EPITHELIALISING	CAVITY	INFECTED
Treatment Objective **Refer to Tissue Viability to Assess if safe to debride ? conservative management** • Aid removal of devitalised tissue if safe. This will reduce bacterial load & reduce risk of infection • Establish extent of any undermining • Allow wound drainage • Reduce odour • Protect peri wound skin • Promote healing	**Treatment Objective** • Aid removal of devitalised tissue if safe • To reduce bacterial load – reduce risk of infection • To establish extent of wound and any undermining • Allow wound drainage • Reduce odour • Manage pain • Promote healing • Protect peri wound skin	**Treatment Objective** • To protect wound bed and peri wound skin • Manage exudate • Manage pain • Maintain moist/ warm environment • Minimise frequency of dressing changes to enable epithelialisation • Promote healing	**Treatment Objective** • Protect new epithelial cell migration and maturation • Removal of dry exudate • Maintain a warm/ moist environment • Minimise dressing frequency • Protect peri wound skin	**Treatment Objective** • Debride any devitalised tissue • Manage exudate • Manage odour • Manage pain • Relieve pressure if this is a contributing factor to cause of wound • Promote healing from the base up • Protect peri wound skin	**Treatment Objective** • Reduce bioburden • Identify causative organism (swab) • Prevent spreading infection • Prevent sepsis • Debride any devitalised tissue • Manage exudate • Manage odour • Manage pain • Promote healing • Protect peri wound skin
Treatment Plan • Dress aseptically using a dressing pack. • Cleanse peri wound skin (.9% Sodium Chloride) if soiled • Protect peri wound skin with Cavilon film • **Primary dressing:** Aquaform Gel, Flaminal Hydro, Comfeel Plus, Comfeel Plus Transparent *(if conservative management use Softpore)* • **Secondary dressing:** may not be required but consider – C-View film, Softpore, C-View post op	**Treatment Plan** • Dress aseptically using a dressing pack. • Cleanse peri wound skin (0.9% Sodium Chloride) if soiled or cleanse wound with Prontosan wound irrigation solution if infection is suspected. • **Debridement**: consider Debrisoft/UCS cloth • Protect peri wound skin with Cavilon film • **Primary dressing** – UrgoClean, Kytocel, Flaminal Hydro/Forte, Algivon (honey) , Comfeel Plus Comfeel Plus Transparent(if low exudate) • **Secondary dressing:** Zetuvit Plus, Biatain Silicone	**Treatment Plan** • Dress aseptically using a dressing pack. • Only cleanse the wound with 0.9% Sodium Chloride if the wound bed is soiled • Gently remove any crusts or skin plaques from wound edges • Protect peri wound skin if exudate levels are high with Cavilon film • **Primary dressing:** Biatain Silicone • **Secondary dressing:** to suit exudate level but may not be required (pad/foam)	**Treatment Plan** • Dress aseptically using a dressing pack. • Only cleanse wound (0.9% Sodium Chloride) if soiled • Consider if dressing is actually required but advise on use of protective barrier film (Cavilon) and use of emollient to intact healed skin • **Primary Dressing:** Biatain Silicone, Comfeel Plus Transparent	**Treatment Plan** • Dress aseptically using a dressing pack. • Cleanse/irrigate wound (0.9% Sodium Chloride) or Prontosan wound irrigation solution if infection is suspected • Protect peri wound skin with barrier film (Cavilon) • **Primary dressing** is dependent on the size of the cavity Consider –Aquacel, Kytocel, UrgoClean, Flaminal Forte • **Secondary dressing:** depends on size and exudate level- Biatain Silicone or Zetuvit Plus	**Treatment Plan** • Dress aseptically using a dressing pack. • Cleanse wound with Prontosan wound irrigation solution,(if lower leg wash in dermol 500 and consider use of Debrisoft/UCS wipes • Antimicrobial dressing to suit presentation of wound bed Primary Dressing-Kytocel, Atruaman Ag, Flaminal Forte/Hydro, Algivon (honey) • Secondary dressing- Biatain Silicone, Zetuvit Plus • Reassess progress every 2 weeks and stop antimicrobial once infection is cleared

Appendix 22: APC Wound basic product guide

BSSE APC Wound Formulary – Quick reference dressings guide.

- Please note this is not an exhaustive list of dressings, but are considered to be suitable initial choices to support the majority of patients in primary care.
- For more detailed guidance and rationale please see BSSE APC Wound formulary at http://www.birminghamandsurroundsformulary.nhs.uk/chaptersSub.asp?FormularySectionID=26
- For complex wounds please consider discussing with Tissue Viability Nurse Specialist, before using other formulary dressing options

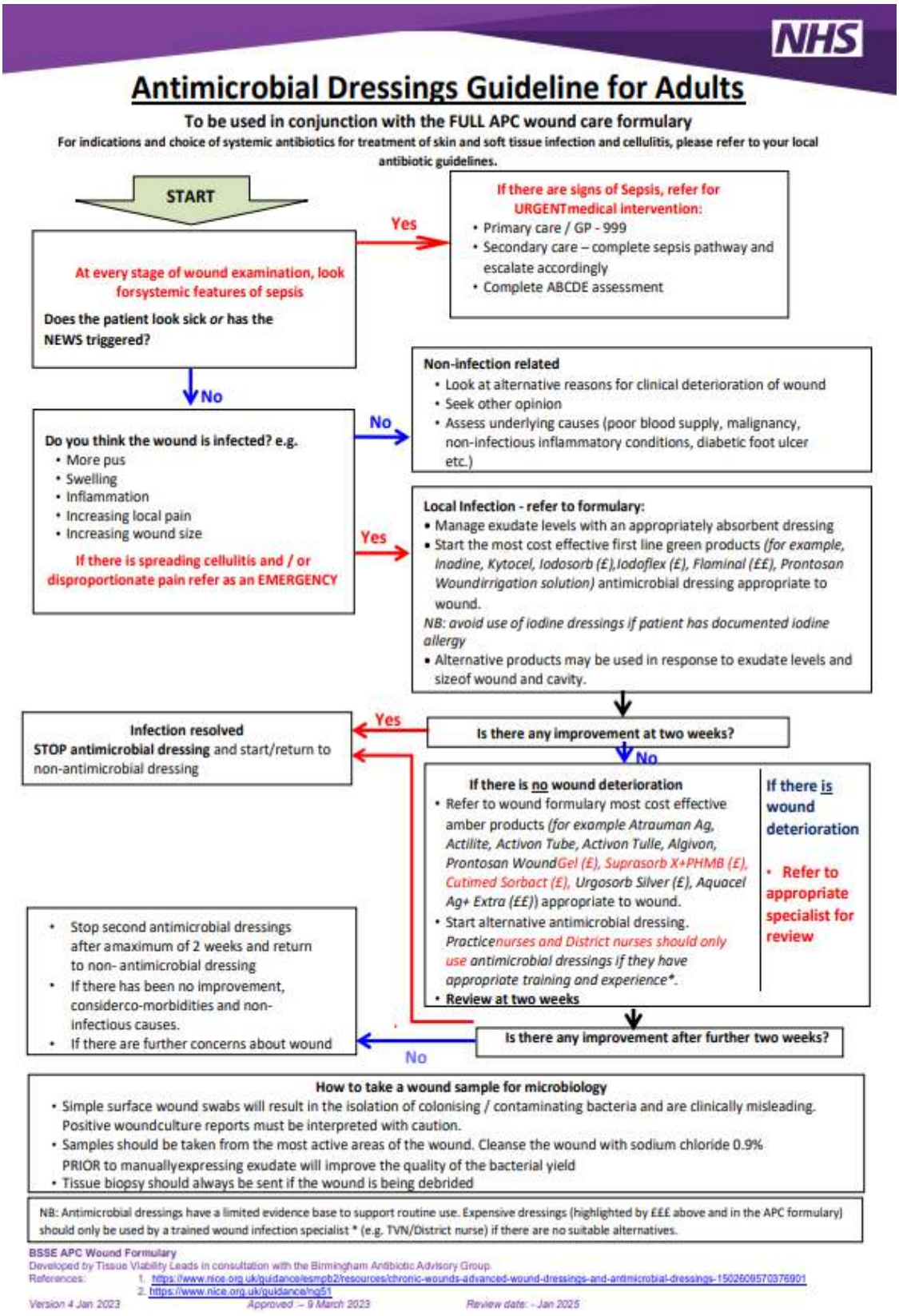
Type of dressing		1st line	2nd line	Specialist
		GREEN		AMBER
Low adherence		Atrauman	NA Ultra	
Absorbent dressings (lightly exuding)		Softpore self-adhesive	Mepore	
Absorbent dressings (moderate to heavy)		Zetuvit E Zetuvit Plus		
Superabsorbent dressings		Eclipse		
Hydrogel		Actiform Cool ActivHeal		
Vapour permeable films and membranes		Hydrofilm		
Soft Polymer Dressings		Urgotul		Mepitel
Hydrocolloids		Duoderm range	Tegaderm hydrocolloid range	Granuflex
Hydrofibre		Aquacel Extra range (excluding Silver)		
Foam dressings		Allevyn range (excluding Silver) Tegaderm foam adhesive Aquacel Foam		Klinderm range excluding superabsorbent PolyMem (excluding Silver) Biatain (exc Silver/Ibu)
Alginate dressings		Sorbsan range (excluding Silver)		Urgosorb (excluding Silver)
Odour absorbent				Carboflex/Clinisorb
*ALL antimicrobial dressings MUST be used in line with the antimicrobial dressing flowchart				
Antimicrobial dressings*	Iodine	Inadine (specific uses only) Iodosorb/Iodoflex		
	Honey			Actilite Algivon Activon Tulle/Tube
	Hydrofibre dressings			Aquacel Ag+ Extra range
	Alginate dressings			Urgosorb Silver range
	Other antimicrobials	Flaminal Forte Flaminal Hydro Kytocel Prontosan wound irrigation solution		Cutimed Sorbact Atrauman Ag Prontosan Wound Gel
Surgical absorbents (not for chronic wound management)		Sterile gauze swabs non- woven 7.5 cm x 7.5 cm only Xupad range		
Dressing packs		Dressit		
Protease Modulating		UrgoSTART Plus range		
Physical debridement pads				UCS Debridement
Adhesive Tapes		Clinipore		Mefix
Bandages / Stockinette Please note:- Silk garments/clothing are NON FORMULARY		Knit band Cotton Stockinette Clinifast		
Support		K lite		
Cohesive		Ko-Flex		
Short stretch		Actico		
Compression		K-Soft (sub compression) Urgo K-Four range (multi-layer) Urgo K-Two range (multi-layer)		
Wound Irrigation		Irripod		
Soap Substitutes		Emulsifying Ointment		
Emollients		Zeroderm cream Zeroderm ointment	Cetraben Pump Cream Liquid Paraffin in White Soft Parrafin (50:50)	
Barrier Preparations		Cavilon Durable Barrier Cream Cavilon no sting Barrier film	Proshield Plus	
Pressure reducing pad		Kerrapro		

Please Note – Sandwell West Birmingham and Solihull health economy Tissue Viability Teams quick reference guides/local guidance may vary.

BSSE APC Wound formulary – Quick Reference Guide V.8 June 2023

Available online: Wound Formulary - quick ref guide - v8.2 Aug 2023.pdf (birminghamandsurroundsformulary.nhs.uk)

Appendix 23: APC Wound infection product guide



Available online: [Algorithm For Antimicrobial Dressings Version 4 Jan 2023.pdf (birminghamandsurroundsformulary.nhs.uk)]

Appendix 24: Useful websites

https://dftbskindeep.com/ (free, open-access bank of high-quality photographs of medical conditions in a range of skin tones)

https://www.woundcarehandbook.com/ (Professionals Guide to Wound Product Selection)

https://societyoftissueviability.org/

https://www.nationalwoundcarestrategy.net/pressure-ulcer/