PREVENTION OF PRESSURE ULCER

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Policy Statement
Residents generally are becoming more frail or they are admitted in long term residential care later on in life . Multi-agency working is becoming more and more part of day-to-day working. The management of pressure sores should be viewed as a multi-agency approach where early intervention is paramount for the health and wellbeing of our residents.

The Policy
Pressure ulcer, sometimes known as "bed sores" or "pressure sores" are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They can range in severity from patches of discoloured skin to open wounds that expose underlying bone or muscles. As an organisation we work closely with health professionals and our residents to prevent the development of pressure sores. Pressure sores are graded according to their severity and have been classified by NHS as follows.

a) **Grade one:** A grade one pressure ulcer is the most superficial type of ulcer. The affected area of skin appears discoloured: it is red in white people, and purple or blue in people with darker-coloured skin. Grade one pressure ulcers do not turn white when pressure is placed on them. The skin remains intact, but it may hurt or itch. It may also feel either warm and spongy, or hard.

b) **Grade two:** In grade two pressure ulcers, some of the outer surface of the skin (the epidermis) or the deeper layer of skin (the dermis) is damaged, leading to skin loss. The ulcer looks like an open wound or a blister.

c) **Grade three:** In grade three pressure ulcers, skin loss occurs throughout the entire thickness of the skin. The underlying tissue is also damaged, although the underlying muscle and bone are not. The ulcer appears as a deep, cavity-like wound.

d) **Grade four:** A grade four pressure ulcer is the most severe type of pressure ulcer. The skin is severely damaged and the surrounding tissue begins to die (tissue necrosis). The underlying muscles or bone may also be damaged. People with grade four pressure ulcers have a high risk of developing a life-threatening infection.

Pressure Sore Risk Assessment (PSRA)
Many residents will be somewhat "at risk" from developing pressure sores, especially those unable to get out of bed, those with little mobilisation or those in wheelchairs. Therefore, it is inevitable that the use of a recognised assessment tool is incorporated into the initial and subsequent care planning process. If resident has a pressure ulcer when our service commences record of its size and position is made (a photograph is taken if appropriate) and the health professional informed.
The initial calculation and score should be ascertained, if possible, either before commencement of the service or within 24 hours; this reading to be comprehensive and thorough. This home uses the Waterloo assessment tool. The assessment tool is not a substitute for sound clinical judgement it is an adjunct and a means of helping to identify those residents at risk and informing the district nurse as soon as possible.

Predisposing Factors to Pressure Sore Formation
The following may be contributory factors to pressure ulcer formation:

a) Undue or prolonged pressure (a person is not mobile and requires assistance to move in bed, chair)
b) Friction
c) Shearing forces, e.g. ill-fitting shoes

d) Repeated forces
e) Incontinence
f) Poor nourishment or dehydration
g) Chronic illness, e.g. vascular disease and diabetes
h) Simple moving and/or washing
i) Rubbing together of skin surfaces
j) Immobility/reduced mobility
k) Impaired circulation, e.g. related to smoking or blood disorders (i.e. anaemia)
l) Shock
m) Age
n) Decreased consciousness/mental awareness
o) Reduced sensation, e.g. multiple sclerosis
p) Medications, e.g. steroids sedatives
q) Pain

Planning for the Prevention of and / or Care of Pressure Sores:

a) **Assessment:** As discussed previously, skin inspection and documentation using a recognised scoring system is vital. Record the presence of or potential for a pressure sore in the care plan and report to the RGN in charge who will refer to a Tissue Viability Nurse (TVN). Tissue Viability Nurse will advise how the following will be carried out in relation to individual residents.

b) **Diet:** Nutrition is an essential factor in the prevention and treatment of pressure sores. The following aspects will need consideration:

i. A good fluid intake, unless otherwise indicated
ii. Sufficient calories to meet energy requirements: increased when wounds present
iii. Sufficient protein intake; additional vitamins and extra fibre can be useful
iv. Food supplements/fortification of food should be used for residents whose appetite is poor. Consultation with the GP and family may be useful in this instance.

a) **Movement:** Movement is the body's natural defence against pressure. Repositioning may be required more frequently depending on the condition of the resident. This applies to all residents who spend much of their time in bed or in their chair unable to move themselves.

b) **Care of the Skin:** Skin integrity should be maintained where possible. The skin only needs careful washing absolutely necessary. Frequent washing will remove the skin's natural oils, which form a barrier to infection. A mild soap can used to minimise the change of pH in the skin. The skin must be dried by patting. Only specific, **prescribed** emollients and creams may be used. These should only be used where necessary, and sparingly, as they can interfere with the effectiveness of incontinence products. All creams and emollients must be documented on the resident's MAR.

c) **Continence Planning:** It is essential that thorough assessment is undertaken by qualified professionals for any resident who is incontinent; this is to ensure that a comprehensive programme is formulated for keeping pressure ulcer formation to a minimum, and maintaining skin integrity.

d) **Aids:** These will be recommended by the TVN or Occupational Therapist (OT). Pressure relief aids should:

i. Provide a surface that conforms to body weight
ii. Reduce frictional sores.

e) **Evaluation:** This must be according to criteria identified within the Care Plan, and incorporating the same assessment tool used in the initial assessment. The Tissue Viability Nurse / OT should be involved at all stages, and a GP as required. The aims of preventative procedures are as follows:

- To identify those residents who are at risk from developing pressure sores
- To work with nursing staff to promote prevention or in treating pressure sores
- To compile individualised care/support plans, incorporating the rationale to prevent the formation of pressure sores
- To encourage the residents' co-operation in the objectives of prevention

- To encourage healing where a pressure sore is established
- To monitor the incidence of pressure sores
- To continually reassess/review residents deemed “at risk”.

Regulation 20 Duty of Candour
When a pressure sore of Grade 3 or above develops after the person has started to use the service a Notification must be sent to CQC, as required under the above Regulation and refer to the LA safeguarding multi-agency.

Training Statement
All staff will be given appropriate training in relation to the prevention of pressure ulcer, and associated subjects such as nutrition, and moving and handling.

Related Policies
Duty of Candour
Infection Control
Moving and Handling
Nutritional and Hydration
Notifications