# Pressure Ulcer Prevention Policy

**Introduction**

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes will commit to the following quality statements, that relate to prevention of pressure ulcers in our homes.

Quality Statements associated with this policy:

Learning Culture - We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe Systems, Pathways and Transitions - We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safeguarding - We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Involving People to Manage Risks - We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Safe Environments - We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and Effective Staffing - We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people’s individual needs.

Medicines Optimisation - We make sure that medicines and treatments are safe and meet people’s needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Assessing Needs - We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

Delivering Evidence-based Care and Treatment - We plan and deliver people’s care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

How Staff, Teams and Services Work Together - We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services

Monitoring and Improving Outcomes - We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Consent to Care and Treatment - We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, Compassion and Dignity - We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating People and Individuals - We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics

Responding to People's Immediate Needs - We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person Centred Care - We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs

Care Provision, Integration and Continuity - We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Listening to and Involving People - We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Partnerships and Communities - We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, Improvement and Innovation - We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

**Equality Statement**

Elizabeth Finn Homes is committed to equal rights and the promotion of choice, person centred care and independence.

This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

**Scope**

The scope of this policy is to provide guidance for all staff on:

- Strategies to prevent and reduce the risk of residents from developing pressure ulcers,
- Escalation of concern to healthcare professionals,
- How to ensure best and evidence-based practice is implemented, and
- How to work in a multi-disciplinary team with healthcare professionals and other social care providers.

This policy and procedure are provided for the regulated activity of accommodation for persons who require nursing or personal care.

**Key Points**

All staff within the organisation have a responsibility and role in prevention of pressure ulcers, and to ensure pressure ulcer reduction strategies maintain a high profile.

The presence of a pressure ulcer creates a number of difficulties psychologically, physically and clinically to the resident and family.

Pressure ulceration occurs when the skin and underlying tissues are compressed for a period of time, between the bone and the surface, on which the resident is sitting or lying.

- A pressure ulcer occurs over a bony prominence.
- It is an area of localised damage to the skin, and underlying tissue.
- It can be caused by pressure, shear, friction and/or a combination of these.

There are a number of stages of pressure ulcers defined by the European Pressure Ulcer Advisory Panel Classification System (EPUAP).

- Stage I: non-blanchable
- Stage II: partial thickness
- Stage III: full thickness skin loss
- Stage IV: full thickness tissue loss
- Unstageable: full thickness skin or tissue loss
- Suspected Deep Tissue Injury: Depth Unknown

**Policy Statement**

The following, from 'Pressure ulcers: revised definition and measurement, Summary and recommendations,' June 2018, provides indicative information about the nature of the problem:

'Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. Finding ways to improve the prevention of pressure damage is therefore a priority for policy-makers, managers and practitioners alike.'

Pressure ulcers are common in care settings and represent a significant burden of suffering for residents and carers, as well as being costly to treat. The presence of a pressure ulcer creates a number of difficulties psychologically, physically and clinically to the resident, carer and family. Pressure ulcer prevention and management should be person centred and an integral part of care assessment and planning, which requires a multi-disciplinary approach.

Pressure ulcers are preventable, and it is everyone's responsibility to reduce the risk of residents developing them whilst in their care.

**The Policy**

Elizabeth Finn Homes are committed to working in partnership with residents, carers, family and health care and social care professionals to minimise the risk of pressure ulcers and skin damage to residents.

This policy sets out the organisation's strategy for achieving this including:

- Responsibilities.
- Risk assessment and management.

- Strength-based assessment of need.
- Person-centred care planning.
- Identification and implementation of best and evidence-based practice.
- Staff training.
- Effective policies and procedures.
- Supporting nutrition and hydration.
- Escalation of needs to healthcare and social care professionals.
- Multi-disciplinary team working.

Responsibility

All staff within Elizabeth Finn Homes have a responsibility and role in prevention of pressure ulcers. See 'Pressure ulcers'.

The Registered Manager's Responsibility.

- Has overall responsibility for the safety of residents, ensuring we meet all the statutory requirements.
- Is to ensure pressure ulcer reduction strategies maintain a high profile.
- Is responsible for the development and implementation of training, policies and guidelines which are evidence-based and reflect best practice to support pressure ulcer prevention and reduction.
- Ensures education and training is provided to all staff.
- Develops strategies to continuously reduce incidence of pressure ulcers.
- Promotes a zero-tolerance approach to pressure ulcer development and ensure that any Grade 3 and 4 pressure ulcers are investigated using the Root Cause analysis (RCA) and action plans developed.
- Uses Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry guidance 2018 to assess the need for referral to Safeguarding (Appendix 1).
- Reviews incidence data, observes trends and works with other local health professionals to reduce occurrence of pressure ulcers.
- Ensures pressure ulcer prevention equipment and resources are available and fit for purpose.
- Leads on the development of audit tools.

Staff's Responsibility:

Staff must adhere to the policy:

- Only undertake activities which you are trained and competent to deliver, e.g. risk assessments.
- Ensure that you are trained in pressure ulcer prevention.
- Any skin damages/changes noted reported to the manager or, if urgent, directly to the resident's GP.
- Any pressure ulcer or skin damage identified must be reported.

Risk Ulcer Risk Assessment and Management

Elizabeth Finn Homes employs The Waterlow Assessment Risk Tool.

The completion of the Waterlow Risk assessment is the responsibility of the senior staff trained to undertake risk assessments, care assessment and care planning. All residents should be assessed using the pressure ulcer risk assessment tool. Staff undertaking care assessments and reviews are trained in the use of the Waterlow risk assessment tool, and the actions to follow where there are concerns identified.

Updated risk assessments will be undertaken when the resident's needs or condition changes that could increase their risk of a pressure ulcer including (but not exclusively):

- Significantly limited mobility (for example, people with a spinal cord injury),
- Significant loss of sensation,

- A previous or current pressure ulcer,
- Malnutrition,
- The inability to reposition themselves, or
- Significant cognitive impairment.

Additional factors that can significantly weaken skin and increase the risk of damage and developing a pressure ulcer include:

- Age 70+ as older people are more likely to have mobility problems and skin that is more easily damaged through dehydration and other factors.
- Moisture-associated skin damage (MASD)
    - Incontinence-associated dermatitis (IAD).
    - Intertriginous dermatitis (ITD), involving inflammation of the skin folds relating to perspiration.
    - Periwound MASD due to wound fluid leakage.
    - Peristomal MASD caused by leakage from stoma edges.
- Obesity.
- Medical conditions that affect blood supply, make skin more fragile or cause movement problems – such as:
    - Diabetes.
    - Peripheral arterial disease.
    - Kidney failure.
    - Heart failure.
    - Multiple sclerosis (MS).
    - Parkinson's disease.

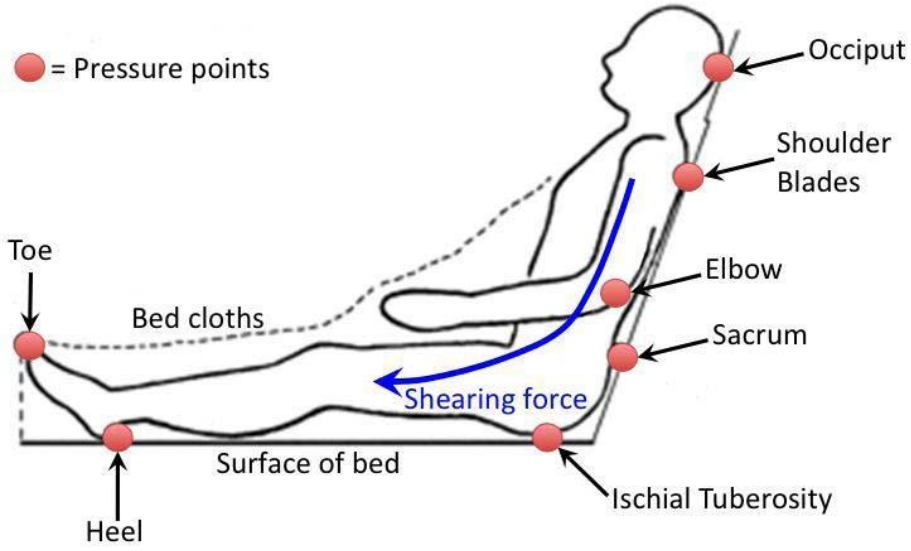
Further information can be found at 'Pressure Ulcers,' NHS.

Note: risk assessment tools should be used as an aide and not replace clinical judgement or negate staff concerns. For example, if a resident has gone from mobile to bedbound or chairbound, then risks will increase significantly and therefore extra vigilance on skin integrity and raising concerns to healthcare professionals is imperative, even if their risk assessment score still does not raise a concern.

Skin Assessment

Skin inspection and assessment should occur regularly based on the risk score, instructions in the care plan, and/or when needs change, e.g. a resident's mobility significantly decreases or other risk factors develop.

Assess skin condition of the resident immediately on admission to the service, especially bony prominences including sacrum, heels, hips, ankles, elbows, occiput and buttocks (diagram below).




- Record the results of the Waterlow assessment and include them within the care plan with relevant action that needs to be followed. Include areas of concern on a body map diagram.
- The staff member must report any concern for skin integrity, areas of soreness or risks of pressure ulcer to the Registered Manager or most senior person on duty for escalation to the GP, or appropriate healthcare professional or, if urgent, contact the GP directly.
- Where an existing skin and pressure ulcer management plan is in place this will be recorded within the Waterlow Assessment AND the Skin Integrity Assessment, including any treatment being provided, e.g. creams and lotions. Prescribed medication for topological application will be recorded within the medication risk assessment and medication care plan.
- On initial assessment any areas of redness, concern or existing known or treated pressure sore damage will be recorded on a body map and photographed. All relevant information of the existing or treated skin damage or pressure ulcers will be recorded and included within a wound chart and the wound treatment care plan.
- Dressing should be ordered and sourced, as prescribed by GP, in line with local formularies.
- Contact details of healthcare professionals treating the resident will be recorded within the assessment and care plan for advice and escalation as appropriate.
- Residents and carers who are willing or able, should be taught to assess their own skin and take ongoing responsibility, as appropriate, to promote independence. The organisation will work in the best interests of the resident and in compliance with the Mental Capacity Act 2005.
- Residents and carers will be provided with a pressure ulcer prevention leaflet available from local NHS resources including CCG or Secondary Care.
- The condition of the skin will be assessed including:
    - Persistent erythema (reddening of the skin).
    - Non-blanching hyperaemia (redness which does not disappear on relief of pressure).
    - Blisters.
    - Discolouration.
    - Localised heat.
    - Localised oedema (build-up of fluid in tissue and swelling).
    - Localised induration (loss of pliability and elasticity of skin).
- Identifying discolouration on residents with dark skin may be difficult and care should be taken not to rely solely on visual inspection. Erythema has traditionally been the main factor in recognising pressure damage, but staff need to consider the temperature, texture and presence of oedema to carry out a true skin assessment in residents with darkly pigmented skin.

**Any concerns must be escalated to the resident's GP or other relevant healthcare professional through the office or, if urgent, directly.**

- Any existing or acquired pressure ulcers should be categorised using the European Pressure Ulcer Advisory Panel Classification System (EPUAP):

There are a number of stages of pressure ulcers defined by the panel:

  - Stage I: non-blanchable
  - Stage II: partial thickness
  - Stage III: full thickness skin loss
  - Stage IV: full thickness tissue loss
  - Unstageable: full thickness skin or tissue loss
  - Suspected Deep Tissue Injury: Depth Unknown

- Where pressure damage is present, a comprehensive wound assessment will be completed. A tracing of the wound should be made and, where possible, a photograph should be taken.
- Note: pressure ulcers should not be reverse/down categorised. For example, a grade 4 does not become a grade 2; this should be documented as 'Healing category 4'.

**Categorisation of skin damage and pressure ulcers is a clinical decision made by an appropriately qualified healthcare practitioner and is provided for information to care staff.**

Other relevant Assessments

As part of the assessment process, new residents will also be risk assessed in the following areas, and outcomes from these will be used to support the pressure ulcer risk assessment process for that individual:

- Nutritional status and hydration
- Moving and handling assessment
- Pain assessment
- Continence assessment
- Mental health/capacity assessment

Documentation

- Record details of the assessments in the resident's assessment documentation and care plan.
- Ensure the date and time of the assessment is recorded and the information is signed by the assessing member of staff. Name and status should be written in block capitals.
- Care provided will be evaluated and progress documented in the resident's care notes for each episode of care relating to skin care.
- Where there is a pressure ulcer or skin integrity plan in place then information regarding application of medication, lotions and/or creams will be recorded in the care notes and/or the topical medication administration record (TMAR).
- Where there is an identified pressure ulcer risk then the care plan will include actions to be taken at each visit, e.g. check skin integrity of heels, buttocks, elbows and apply cream/lotion in line with TMAR.
- Where instructions are provided from healthcare professionals on the management of skin conditions, this will be recorded within the care plan and MAR/TMAR as required and actioned as part of daily care and support.
- Where staff seek advice and input from healthcare professionals, this will be recorded in the care notes and plan, including times, date, healthcare professionals' name, role, telephone number and advice given. If advice is provided by email, this will be added to the care plan, and a note in the care notes instructing staff of the advice provided.

Care Planning

Each resident will have in their care plan a Waterlow risk assessment and a Skin integrity risk assessment with any professional advice and actions required to ensure skin integrity and to minimise the risk of pressure ulcers.

All residents identified as at risk of pressure ulcer development (for example any resident with a Waterlow score greater than 15), will have a written pressure ulcer prevention plan incorporating:

- Positioning and repositioning schedule
- Pressure relieving equipment
- Nutritional requirements
- Pain management
- Continence management

This will be developed in partnership with the resident's GP, or other relevant healthcare professional managing their skin integrity, and incorporated within their care plan.

Where aids are provided to support the resident, e.g. pressure care beds, staff will be provided with training to use these to effectively support the resident to minimise risks of pressure ulcers.

Positioning

- Residents with an elevated risk and/or pressure ulcer, should be encouraged to actively mobilise, stand hourly (where it is safe to do so) and rest lying on their side for short periods in the day.
- Where possible, residents should be taught to reposition themselves and redistribute their weight and carers should be shown how to assist.
- Residents who are 'at risk' of pressure damage or have pressure damage, should be repositioned and the frequency of repositioning determined by the results of skin inspection and individual needs, not by a ritualistic schedule.
- Repositioning should take into consideration other relevant matters, including the resident's medical condition, their comfort, the overall plan of care, the support surface and attendance of formal and informal carers.
- Residents should be positioned in such a way as to minimise the impact on bony prominences and pressure ulcers.
- Residents should be positioned appropriately to reduce the effect of shear and friction forces.

A re-positioning schedule will be agreed with the resident and healthcare professionals and documented on a repositioning chart, within the care plan. A repositioning chart or turning clock will be used as deemed necessary for individual residents ( for example, poor continence, or a Waterlow assessment result greater than 21.)

Seating

Residents are at a higher risk of pressure ulcer development when sitting out of bed if they are unable to mobilise and the seating is not designed for pressure management and/or the aids being used are not matched to the resident's needs. Factors which increase risk are:

- Inability to reposition
- Incorrect / inappropriate chair, seating or aids
- Inability to redistribute weight
- Incontinence
- Poor nutrition and hydration

Where there are concerns for the resident identified within the risk management process (e.g. high risk identified within Waterlow Risk Assessment), and no existing pressure ulcer management plan is in place, or the resident's needs have changed, then concerns will be escalated immediately to the resident's GP or other relevant healthcare professional to request an assessment.

The staff assessing the resident will support in developing a pressure ulcer management plan. The referral to the GP or healthcare professional will include a request for review to identify aids to provide support, e.g. pressure management chair.

Heel Ulcer Prevention Management

The incidence of pressure ulcer on the heels is high and need careful consideration and management as they can lead to prolonged medical intervention, infection and necrosis leading to amputation and, if septicaemia or gangrene occur, even death.

Residents should be encouraged to mobilise wearing good fitting footwear.

When residents are in bed or elevating the legs, the heels should be 'free-floating.' This can be achieved by the use of:

- Heel lifts, heel protectors, troughs and pillows placed lengthways.
- Anti-embolism stockings should be removed twice daily for a maximum of 30 minutes and skin inspected, in agreement with the GP practice or district nurse.
- The resident should be informed of when, how and frequency of removal of any compression, anti-embolism stockings and importance of skin inspection by their GP practice or district nurse.

Moving and Handling

Skin damage can be minimised by using correct positioning, transferring and repositioning techniques and the use of aids.

For example: hoists, sliding sheets, pillows, bed cradles and other aids.

- Complete the resident moving and handling risk assessment within 24 hours of admission to the service.
- Write a plan of care to meet the resident's moving and handling needs.
- Residents should be encouraged to move independently where possible. If assistance is required, safer handling techniques should be employed. Refer to the Moving & Handling Policy.
- When hoisting residents, hoist slings must be the correct size and properly fitted. Hoist slings should not be left under residents.
- The use of four section electric profiling beds can contribute to reducing pressure, friction and shearing forces if the bed is used to its full potential:

    - Raise the end of the bed (reverse Trendelenburg).
    - Use the auto contour mechanism (raises the foot end when head end is raised).
    - Use the knee-break facility to minimise sliding.
    - Remove slings, slide sheets or other parts of the handling equipment after moving the resident.
    - Do not use sheets to move resident unless they are slide sheets.

Pain

- Residents who are in pain will be reluctant to reposition and relieve pressure.
- Residents' pain should be assessed individually, using local pain assessment tools and aids.
- A plan of care will be developed with the resident, so the pain is controlled.
- Staff will work with the resident and healthcare professionals to ensure an effective pain relief plan is in place.
- This will be detailed in the care plan and the Medication Administration Record.

Pressure relieving equipment

These devices will be provided by either our organisation, social services or NHS commissioners. Elizabeth Finn Homes preferred supplier for all pressure relieving equipment is OSKA. Please see OSKA product guide for items available.

Pressure relieving mattresses, cushions and devices do not replace the need for resident repositioning.

Mattresses:-

Pressure relieving support surfaces aim to reduce the magnitude and/or duration of pressure between the individual and support surface.

Choice of pressure relieving support surface should be made by a registered nurse or other healthcare professional who is trained and competent in pressure ulcer risk assessment, prevention and management.

Decisions on type of surface should be based on:

- Social assessment and support
- Pressure ulcer risk assessment
- Category (Grade) of pressure ulcer
- Ability to reposition
- Length of time spent out of bed
- Comfort
- Resident's weight and height
- General health
- Acceptability by the resident
- Requirement for bed side rails

For general guidance on equipment selection refer to the service equipment manual or the local product selection guides for specific information for the clinical area.

Cushions:-

All residents who sit out of bed and are at a high risk of a pressure ulcer should be provided with a pressure relieving cushion or chair with integrated pressure relieving properties. Elizabeth Finn Homes preferred supplier for all pressure relieving equipment is OSKA. Please see OSKA product guide for items available.

A specialist chair may require a referral to a physiotherapist or occupational therapist via primary or social care.

Safe Use of Equipment

When using equipment and aids to support the resident it is important to consider the impact of the equipment on other aspects of safety e.g. falls.

Consider:

- Ensure mattress does not elevate the individual to an unsafe height where side rails are in place. If this is the case, please ensure a full bed rail risk assessment is in place.
- Ensure the individual is within the recommended weight range for the equipment.
- Remember: when re-assessing residents' risk – think 'does the resident still require this equipment?'

Audit and Maintenance of Equipment

Equipment can deteriorate due to age and usage, therefore all pressure relieving equipment should be checked and maintained in good working order according to manufacturer's guidelines. Equipment that is provided by our organisation will be maintained in accordance with manufacturer instructions by [equipment maintenance]. Where equipment has been provided by another organisation, we will work with them to ensure equipment is maintained and serviced in accordance with manufacturer instructions.

Refer to manufacturer's guidance on maintenance and decontamination processes in line with Infection Prevention & Control Policy.

Foam Mattress and Cushion Auditing

Audits should be carried out regularly. The Bed Rail Risk Assessment should be used to evidence a monthly audit. All pieces of equipment should be checked for:

- Condition of the cover
- No stains
- Splits
- Tears

Electrical and mechanical equipment should be serviced in line with manufacturer warranty and guidance. Staff must not use equipment which is out of service period or which they believe to be faulty or unsafe. Where staff have concerns, they must raise these with the Registered Manager or most senior person on duty. Where the equipment is provided by our organisation the issue will be escalated to the Registered Manager. Where equipment is provided by another agency the Registered Manager or most senior person on duty, will follow up with the relevant organisation responsible for servicing the equipment.

Maintain and Protect Skin Integrity

An individual's skin may be exposed to a variety of moist substances, which may make it more susceptible to shearing, friction and injury.

When moving and handling residents, all staff should take care not to damage a resident's skin and should:

- Not wear rings (other than a plain wedding bands) or watches when turning or repositioning residents, and nails should be kept short and nail varnish removed.
- The skin should be kept well hydrated.
- If the resident is at high risk of skin damage or incontinent, they should be advised to use an emollient soap substitute (e.g. aqueous cream, emulsifying wax) to wash and apply moisturisers regularly.
- The resident's skin should be thoroughly dried using a patting motion, particularly over vulnerable areas. Do not use a rubbing motion or massage when drying as this causes friction forces and is associated with tissue damage.
- Talcum powder should not be used because of its tendency to cake, thereby increasing friction, clogging the pores and increasing risk of infection and skin damage.

Incontinence Management

All residents will be assessed for their continence needs, and a plan developed where required to support them.

- Incontinence should be managed effectively.
- Assess the resident and develop a plan of care.
- Request input from specialist incontinence service where appropriate.
- Barrier creams should be used with caution as they can clog the pores in the pad and effect efficacy.

Nutritional Status

The following is extracted from 'Eat well, drink well and keep the skin well: Key nutrition and hydration messages to prevent pressure ulcers and promote wound healing, NHS Improvement January 2018':

'Nutrition and hydration play a key role in keeping the skin healthy – so think EAT – evidence, assessment, take action – when assessing an individual's risk of developing a pressure ulcer (and the healing of existing pressure ulcers or wounds)'.

Evidence:-

- Many nutritional risk factors have been identified in the development of pressure ulcers.
- Risk factors include low body mass index (BMI), malnutrition, nutritional deficiencies, unintentional weight loss, an impaired ability to eat independently and obesity.
- Obesity is an independent risk factor for developing a pressure ulcer, and the risk is further increased if the individual is obese and is malnourished.
- International guidance recommends using a nutritional screening tool to assess an individual's risk of malnutrition, and also assessing their weight history, weight loss and ability to eat independently.
- The National Institute of Health and Care Excellence recognises nutrition deficiencies as a risk for developing pressure ulcers and supports the use of oral nutritional supplements for patients with identified nutritional deficiencies.
- Early identification and treatment of individuals who are malnourished or at risk of it are vital in preventing pressure ulcer development and promoting wound healing.

Assessment:-

- All residents should be screened on admission or first visit for nutrition and hydration risk and reassessed regularly using assessment tools.
- All residents should receive a well-balanced diet in accordance with their wishes.
- All residents should have their body mass index (BMI) calculated on assessment or first visit where possible and repeated in line with risk assessed need.
- If the resident has a poor intake, a personalised food chart should be commenced.
- Residents with pressure ulcer(s) should be referred to the dietician for further assessment through their GP if there are any concerns.
- Refer for specialist advice as required.
- Provide residents advice on well-balanced diet and protein-energy foods.
- Aim for two litres of fluid per day where this does not conflict with clinical advice and be respectful of residents' wishes.

**Training**

All staff should be familiar with this policy and will have training on pressure ulcer prevention, risk assessment and planning of care within their induction programme and annual update training.

All Registered Nurses and Senior Care Assistants must undergo and complete the Elizabeth Finn Homes ASSKING competency each year.

A record of individual staff members' education and training will be maintained by the Registered Manager.

Staff will be assessed annually for competence at the ASSKING competency review, supervisions and observations to ensure they are competent in the management of pressure ulcer risk.

Under no circumstances must any nurse operate the devices unless they have attended appropriate training, and feel competent to safely undertake the task.

Each nurse must have a good working knowledge of the equipment and its functions.

Care Staff:

Once care staff have received training and are deemed competent, as recorded within their training file, they can:

- Assess risk of pressure ulcer development
- Manage a Grade 1 pressure ulcer
- Document clearly and escalate any deterioration to the manager

Safeguarding Adults and Skin Damage

Skin damage has a number of causes, some relating to the individual residents, such as poor medical condition, and others relating to external factors such as poor care or lack of resources (equipment or staffing).

It is recognised that not all skin damage can be prevented and, therefore, the risk factors in each case should be reviewed on an individual basis before a safeguarding referral is considered. Not all pressure ulcers in adults at risk are the result of neglect.

If there are concerns that observed pressure damage may be the result of neglect or omissions of care, please refer to the Safeguarding Adults Policy.

**Reporting of Pressure Ulcers**

- All care staff are responsible for reporting pressure ulcers.
- An incident form will be completed for all identified category 2 - 4 pressure ulcers.
- Report multiple site grade 2, and individual site grade 3 – 4 pressure ulcers to CQC and safeguarding using Appendix 1: Guidance for completing the adult safeguarding decision guide, page 17: (Safeguarding Adults Protocol)
- A grade 4 pressure ulcer requires a full root cause analysis investigation.
- The resident's GP will be informed that the individual has a pressure ulcer.
- Elizabeth Finn Homes will fully comply with its duty under Regulation 20: Duty of candour, to act openly, honestly and to formally apologise where through its, or its staff's, actions residents have come to harm, or could in the future, or have died.

**Process for auditing compliance and effectiveness**

The following processes will be used to monitor the impact of the Policy:

- Audit of Clinical and Quality Compliance
- Audit of safeguarding incidents
- Audits of accidents and incidents
- Client complaints
- Client surveys
- Other feedback received

Themes and trends will be identified from the monitoring and compliance activities to identify learning and continuous improvement activities associated with the management of pressure ulcer prevention.

This policy will be evaluated and reviewed annually to ensure that it meets current evidence and best practice and is in line with current regulations and legislation.

**References and further reading opportunities**

Pressure ulcers

Pressure ulcers: revised definition and measurement

Prevention and Treatment of Pressure Ulcers: Quick Reference Guide

Duty of Candour

Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry issued by Department of Health and Social Care

NICE Pressure ulcers; prevention and management Clinical guideline CG179

Pressure ulcers Quality standard (QS89)

NICE Nutritional support in adults QS24

Waterlow

NHS Improvement Pressure ulcers: revised definition and measurement

International Guidelines Prevention and Treatment of Pressure Ulcers: Quick Reference Guide

| Review date | Next Review Date |
|---|---|
| April 2024 | April 2027 |