GUIDELINES FOR THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS IN ALL CARE SETTINGS

Author: Tissue Viability Team
Approved by and date: IP&C Assurance Group – February 2019
Any other linked Policies:

CRM001 – Risk Assessment Policy, CRM002 – Incident Policy including near miss and Serious Incidents, CLP006 – Policy for Consent to Examination or Treatment, ICPr010 - Hand Hygiene Procedure, ICP002 - Standard Precautions Policy, ICPr001 - Cleaning and Disinfection Policy, ICPg006 - Aseptic Non-Touch Technique Policy, CLPr011 Safe & Effective use of Bedrails

Procedure number: CLPg003
Version control: Version : 5
# TABLE OF CONTENTS

1. **INTRODUCTION** .................................................................4

2. **DEFINITIONS** ....................................................................5

3. **TISSUE VIABILITY TEAM** ..................................................5

4. **GUIDELINE PROCESS** .......................................................6
   4.1. Assessment 6
   4.2. Reassessment 7
   4.3. Risk Factors 7
   4.4. Prevention 8

5. **SURFACE - PRESSURE ULCER PREVENTATIVE EQUIPMENT (SSKIN)** ...............................................................9
   5.1. Equipment Ordering 10
   5.2. Seating 11
   5.3. SKIN INSPECTION (SSKIN) 11
   5.4. KEEP MOVING – Positioning (SSKIN) 12
   5.5. INCONTINENCE MANAGEMENT (SSKIN) 13
   5.6. NUTRITION (SSKIN) 13
   5.7. Transfer of Patients 13
   5.8. Clinical Incident Reporting 14

6 **TRAINING** ..............................................................................15
   7.1 Mandatory Training 15
   7.2 Specific Training not covered by Mandatory Training 16

7 **MONITORING COMPLIANCE WITH THIS DOCUMENT** ............16

8 **EQUALITY CONSIDERATIONS** .............................................16

9 **REFERENCES AND BIBLIOGRAPHY** ....................................17

10 **APPENDIX 1** PRESSURE ULCER GRADING SYSTEM .............18

11 **APPENDIX 2** WATERLOW RISK ASSESSMENT TOOL .............19

12 **APPENDIX 3** AN EXAMPLE OF A SSKIN CARE BUNDLE ..........20

13 **APPENDIX 4** GENERIC RECOMMENDATIONS FOR PRESSURE RELIEVING MATTRESSES AND CUSHIONS ..........................22

14 **APPENDIX 5** REPOSITIONING CHART ...................................23

15 **APPENDIX 6** NORTHAMPTONSHIRE FLOW CHART FOR REPORTING OF PRESSURE ULCERATION .....................................ERROR! BOOKMARK NOT DEFINED.
<table>
<thead>
<tr>
<th>Version No.</th>
<th>Date Ratified/Amended</th>
<th>Date of Implementation</th>
<th>Next Review Date</th>
<th>Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td>15/06/2015</td>
<td>01/08/17</td>
<td>Amended</td>
</tr>
<tr>
<td>4</td>
<td>01/07/17</td>
<td>01/08/17</td>
<td>01/08/20</td>
<td>Amended in line of recent changes.</td>
</tr>
<tr>
<td>5</td>
<td>01/02/19</td>
<td>01/02/19</td>
<td>01/02/22</td>
<td>Amended in line with NHSI Recommendations</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply. Typically they occur in a person confined to bed or a chair by an illness and as a result they are sometimes referred to as 'bedsores', or 'pressure sores'.

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Also, the use of equipment such as seating or beds which are not specifically designed to provide pressure relief can cause pressure ulcers. As pressure ulcers can arise in a number of ways, interventions for prevention and treatment need to be applicable across a wide range of settings including community and secondary care. This may require organisational and individual change and a commitment to effective delivery.

(NICE, 2014)

This guideline aims to:

- Prevent harm / lapses in care that may result in the development of pressure ulceration within all Northamptonshire Healthcare NHS Foundation Trust care settings.
- Ensure a holistic and standardised approach to ensure pressure ulcer prevention and their management reflects current research findings.
- Work within the National Institute for Health and Clinical Excellence (NICE) Guidance for Pressure Ulcer Management - CG179 April 2014.

- ensure that:
  - Assessments are carried out on patients to assess the potential risk.
  - Equipment and resources, necessary for pressure ulcer prevention or their management are utilised effectively throughout the Trust.
  - All pressure relieving equipment purchased or hired is reviewed and evaluated as necessary.
  - Staff receive appropriate education and training in the prevention and management of pressure ulcers.
  - Patients and carers are given both verbal and written advice if required on reducing the risk of pressure ulcer development.
  - If a pressure ulcer develops, despite these preventative measures, the optimum healing environment is achieved.
  - To ensure that assessment and subsequent management of potential areas of pressure ulcer development is carried out by suitably trained staff for all patients admitted to Northamptonshire Healthcare NHS Foundation Trust.
  - To reduce further risk to patients with pressure ulcers and aid healing of the pressure ulcer/s.
2. DEFINITIONS

2.1. A Pressure Ulcer
A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful (NHSI, 2018)

2.2 Medical Device related Pressure Ulcer
Pressure ulcers that result from the use of devices designed and applied for diagnostic purposes (NPUAP, 2015)

2.3 Lapses in Care - Pressure Ulcer
‘Lapses in care’ means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:
- Evaluate the person’s clinical condition and pressure ulcer risk factors
- Plan and implement interventions which are consistent with the person’s needs and goals, and recognised standards of practice.
- Monitor and evaluate the impact of the interventions
- Or revise the interventions as appropriate (Department of Health 2011)

2.4 No Lapses in Care - Pressure Ulcer
‘No Lapses in Care’ means that the person receiving care developed a pressure ulcer even though the provider of the care did all of the following:
- Evaluated the person’s clinical condition and pressure ulcer risk factors
- Planned and implemented interventions that are consistent with the person’s needs and goals and recognised standards of practice
- Monitored and evaluated the impact of the interventions
- Revised the approaches as appropriate

Or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence (Department of Health 2011)

3. TISSUE VIABILITY TEAM
Tissue Viability Nurses are available during office hours for advice and support with more complex patients.

NHFT:
TVN NHFT 01933 235804 / nhft.tissueviability@nhs.net

Northamptonshire Acute NHS Hospitals:
TVN KGH 01536 492000 bleep 703
TVN NGH 01604 523231 / 01604 523230 Bleep 4541
4. GUIDELINE PROCESS

4.1. Assessment

All patients must have a documented pressure ulcer risk assessment completed within 6 hours of admission or on admission to the caseload by a health care professional.

If there are exceptional circumstances as to why this cannot take place, this should be recorded in the patient’s notes and carried out at the earliest opportunity.

Assessing an individual’s risk of developing pressure ulcers should involve both informal and formal assessment procedures. This should include the categorisation of pressure ulcers, ensuring that dressings are removed prior to assessment.

All patients will be risk assessed using the Waterlow Risk Assessment Tool (2005) (Appendix 2) as part of a holistic assessment.

People with diabetes are at special risk of developing pressure ulcers or of an existing pressure ulcer deteriorating. NICE CG 19; Prevention and Management of Foot Problems advocates referral to a specialist diabetic foot team within 1 working day for any new foot ulceration in diabetes patients.

All patients will have their current degree of risk of developing a pressure ulcer and the category, site, clinical description and date of occurrence of any tissue damage documented in their clinical records. These should be accessible to all members of the health care team involved in their care.

All patients identified as being at risk of developing a pressure ulcer must have a care plan, which identifies the interventions / actions required to prevent a pressure ulcer. The care plan should be negotiated, where possible, with the patient and where appropriate, with their carer.

Care planning should take into account patients’ individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions where appropriate.

Assessment should include the agreed involvement of the patients / carers and the information given. An NHFT patient information leaflet should be provided and discussed to the patient / carer if appropriate.

Associated nutritional and patient handling assessment should also be undertaken as the results of these contribute to the pressure prevention assessment.

All formal assessments of risk should be documented / recorded in the clinical record and made accessible to members of the multidisciplinary team.
4.2. Reassessment

Full formal reassessment by a health care professional will take place at regular intervals;

- Hospital in-patients at least weekly
- Adult mental health inpatient areas at least monthly
- Patients in their home or residential home at least monthly
- Patients receiving Day Care at each planned review
- Patients attending Equipment & Wheelchair Clinics at each planned review

Reassessment will include the following:

- Review of Waterlow pressure ulcer risk assessment tool.
- Skin inspection which will include all bony prominences and high risk areas (if appropriate)
- Review of pressure ulcer category (pressure ulcer category should not be reversed e.g. Category 4 healing to Category 3)
- Ongoing use of SSKIN bundle tool / pathway (Appendix 3)
- Evaluation of the effectiveness of the interventions and prevention strategies identified in the care plan.

All patients should be reassessed immediately if their condition changes

Frequency of completion of care plan/SSKIN bundle for patients at risk of pressure ulceration is recommended weekly for inpatients or 4 weekly for community patients. The principles of S.S.K.I.N. however should be considered and documented as appropriate on every inpatient shift / community visit. A patient who is bedbound / chair bound may need a daily skin inspection, but a patient that is independently mobile may need a weekly or monthly skin inspection or a more appropriate discussion about skin integrity.

4.3. Risk Factors

The following areas are contributory risk factors to Pressure Ulcer Development:

- Pressure
- Shearing
- Friction
- Reduced level of mobility.
- Sensory impairment
- Incontinence
- Reduced level of consciousness
- Acute, chronic and terminal illness
- Co morbidity e.g. systemic signs of infection or blood supply
- Pain
- Medication
- Posture
- Cognition, psychosocial status
- Previous pressure damage
- Extremes of age
- Nutrition and hydration of the skin
- Moisture to the skin
Skin inspection should be based on assessment of the most vulnerable areas of risk for each patient. These are typically:

- Heels
- Sacrum
- Ischial tuberosities (buttocks)
- Parts of the body affected by the wearing of anti-embolic / compression stockings
- Parts of the body where friction or shear is exerted in the course of the patients activities of daily living
- Parts of the body where there are external forces exerted by equipment e.g. hoists and clothing
- Elbows
- Temporal region of the skull
- Shoulders
- Femoral trochanters (hips)
- Back of head
- Toes
- Ears
- Spine

Healthcare professionals should look for the following signs that may indicate pressure ulcer development:

- Persistent erythema (Flushing of the skin)
- Non blanching hyperaemia (discolouration of the skin that does not change when pressed)
- Blisters
- Discoloration
- Localised heat
- Localised oedema
- Localised indurations (abnormal hardening)
- Purplish/bluish localised areas
- Localised coolness if tissue death has occurred

4.4. Prevention

The Key components of prevention are highlighted by the SSKIN Care Bundle Care Plan / Pathway (See Appendix 3, an example of a SSKIN Care Plan).

The SSKIN Bundle should be completed if Waterlow score 10 +

Frequency of completion for very high risk patients is recommended at every shift for inpatients or every contact for community patients. If this is not appropriate, rationale must be identified and prescribed frequency documented. For example, a patient who is bedbound / chairbound may need a daily skin inspection, but a patient that is independently mobile may need a weekly or monthly skin inspection or a more appropriate discussion about skin integrity.
5. **SURFACE - PRESSURE ULCER PREVENTATIVE EQUIPMENT (SSKIN)**

Appropriately trained professionals should carry out assessments for the use of aids and equipment. Selection of pressure ulcer prevention equipment should be based upon:

- Waterlow risk assessment
- Pressure ulcer category (if present)
- Location and cause of the pressure ulcer (if present)
- Skin assessment
- General health
- Lifestyle and abilities
- Critical care needs
- Acceptability and comfort
- Ability of the carer
- Patient weight
- Cost considerations

Staff should also consider all surfaces used by the patient. Patients should have 24-hour access to pressure relieving devices and/or strategies. Pressure relieving devices should be changed in response to altered level of risk, condition or needs.

The use of pressure relieving devices should be considered in the following situations:

- As a first line preventative strategy for people at increased risk as identified by holistic assessment.
- When an individual’s previous history of pressure ulcer/prevention and/or clinical condition indicates that he / she is best cared for on a high tech device
- Use high-specification foam mattresses for adults with a pressure ulcer. If this is not sufficient to redistribute pressure, consider the use of a dynamic support surface (alternating air mattress) (NICE, 2014).

Refer to Generic Recommendations for Pressure Relieving Mattresses and Cushions (Appendix 4)

**NHFT Recommends:**

Patients with a category 1-2 pressure ulcer should as a minimum provision be placed on a high specification foam mattress/cushion with pressure reducing properties and be closely observed for skin changes.

Patients with a category 3-4 pressure ulcer should as a minimum provision be placed on an alternating or combination air/foam mattress / cushion or a sophisticated continuous low-pressure system (for example, low air loss, air flotation, viscous fluid).
All mattresses and cushions have a minimum / maximum weight limit (check manufacturers guidelines). If the patient’s weight is outside these parameters, the equipment will not function efficiently. In these cases alternative appropriate equipment should be sourced.

When introducing pressure relieving / reducing equipment it is important to consider a number of changes that may introduce falls, slips or new postural/positioning problems. Consider the following issues:

- Do feet remain planted on the floor once pressure equipment is fitted to chair or bed?
- Are arms of chair still accessible to assist leverage during sit to stand?
- Is the patient able to push themselves back into the chair if they slide forwards? (If not, then Contour Repose recliner cushion may not be a safe option)
- Does equipment restrict movement or reduce independence levels during bed and chair transfers?
- Does equipment restrict mobility? e.g. Systam or Repose Heel Protectors
- When replacing or upgrading pressure relieving / reducing mattresses check spacing between rails is within NHFT bed rail risk assessment guidelines
- If prescribing Repose equipment, are the patient / carers / relatives able to maintain this equipment i.e. check inflation level correct
- Consider referral to Occupation Therapy if required

5.1. Equipment Ordering

Inpatient Care Environments

Some ward areas will have a stock of pressure relieving equipment and this should be used as appropriate.
- Note - if equipment held needs repair / service please request through the Estates / Facilities Department.

The need for any other items of equipment has to be identified and confirmed as essential by a senior member of staff present on the ward. Staff should follow the normal ordering non-stock procedure for one off purchases or for short term hire refer to the Procedure for Hiring/Renting of Pressure Relieving Equipment via ArjoHuntleigh UK.

Community Care Environments

Patients own homes
Equipment must be ordered through the Northamptonshire Integrated Community Equipment Service (ICES) in accordance with Prescriber Guidelines and Ordering Criteria for Pressure Care Catalogue Items.

Residential and Nursing Homes
Equipment must be in accordance with the Protocol for the Provision of equipment into Care Homes (Residential and Nursing) from the Integrated Community Equipment Service.
5.2. Seating

Individual risk assessments should be undertaken for each patient with reference to getting out of bed (Moving and Handling Policy HSC010, 2016).

Positioning of individuals who spend substantial periods in a chair or wheelchair should take into account; distribution of weight, appropriate height, width, seating length of the chair, postural alignment and support of the feet.

Patients who require a pressure reducing/relieving mattress should sit in a chair with an equivalent cushion (if appropriate)

Consider whether sitting time should be restricted to less than 2 hours at a time or if complete bed rest should be considered.

5.3. SKIN INSPECTION (SSKIN)

Offer adults who have been assessed as being at risk of developing a pressure ulcer a skin assessment by a trained healthcare professional. The assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for:

- skin integrity in areas of pressure
- colour changes or discoloration
- variations in heat, firmness and moisture (for example, because of incontinence, oedema, dry or inflamed skin).

Use finger palpation to determine whether erythema or discolouration (identified by skin assessment) is blanchable. Healthcare professionals should be aware that non-blanchable erythema may present as colour changes or discolouration, particularly in darker skin tones or types (NICE, 2014).

Any skin damage should be documented / recorded in the patient’s clinical record using International NPUAP- EPUAP Pressure Ulcer Classification System 2009 NHS Midlands and East Version, incorporating NHSI Recommendations 2018 (Appendix 1)

A registered nurse should assess and document the following as part of a holistic assessment. A wound assessment tool should be used.

- Body Map
- Record Wound Dimensions:
  - Depth (including any undermining edges)
  - Length
  - Width
• Photograph if possible as per Guide to Consent for Examination or Treatment (DOH 2009)
• Categorise using Midlands Grading East Tool (Appendix 1) (Pressure ulcer category should not be reversed)
• Cause of pressure ulcer development e.g. pressure, shearing, friction etc.
• Location of ulcer(s)
• Exudate, type, colour and amount
• Local signs of infection
• Pain, including cause, level, location and management interventions
• Wound appearance
• Appearance of surrounding skin
• Presence of undermining / tracking, sinus or fistula
• Odour
• Report (Datix) all pressure ulcers Category 2 and above as a clinical incident as per Incident Policy (CRM002 2017)
• Individual care planning and treatment to meet the patients’ needs

**Wound Dressing Selection**
Consideration should be made to creating the optimum wound healing environment by using modern dressings for example hydrocolloids, hydrogels, foams, films, alginates, and soft silicones.

The choice of dressing/topical agent or method of debridement or adjunct therapy should be based on:
• Ulcer assessment.
• General skin assessment.
• Treatment objective.
• Characteristic of dressing/technique.
• Previous positive effect of dressing/technique.
• Manufacturer’s indications for use and contraindications.
• Risk of adverse events.
• Patient and carer preference.

Antimicrobial therapy should be considered in the presence of systemic and/or local signs of clinical infection.

5.4. **KEEP MOVING – Positioning (SSKIN)**
Consider mobilising, positioning and repositioning interventions for all patients (including those in beds, chairs and wheelchair users). Acceptability to the patient and the needs of the carers should be considered.

All patients with pressure ulcers should be encouraged to actively mobilise, change their position or be repositioned frequently.

Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every 6 hours. If they are unable to reposition
themselves, offer help to do so, using appropriate equipment if needed. Encourage adults who have been assessed as being at high risk of developing a pressure ulcer to change their position frequently and at least every 4 hours. Document the frequency of repositioning required (NICE, 2014). NHFT Recommends: Frequency should be based on individual need; this may be as frequent as every 1 – 2 hours in very high risk patients.

Teach individuals and carers who are able how to re-distribute the individual’s weight. Offer written Patient Information if appropriate.

Position to minimise pressure on bony prominences and avoid positioning on pressure ulcer if present (if possible)

Consider whether sitting time should be restricted to less than 2 hours per session.

Seek specialist advice on aids, equipment and positions if required.

Record using a repositioning chart / schedule agreed with the patient whenever possible. (Appendix 5).

Consider using passive movements for patients with poor mobility.

5.5. INCONTINENCE MANAGEMENT (SSKIN)

Consider Continence Assessment / referral to Continence Service if required.

Use a barrier preparation to prevent skin damage in adults who are at high risk of developing Moisture Associated Skin Damage (MASD), as identified by skin assessment (such as those with incontinence, oedema, dry or inflamed skin) (NICE, 2014).

5.6. NUTRITION (SSKIN)

Provide nutritional support to patients with an identified deficiency and refer to dietician if necessary.

Decisions about nutritional support/supplementation should be based on:
• MUST score (Using The Malnutrition Universal Screening Tool)
• General health status
• Patient preferences
• On expert advice from dietician/specialist

5.7. Transfer of Patients

Prior to transfer of patients between care environments staff must liaise with the appropriate services detailing the patient’s requirements. This may not be possible for urgent admissions to acute settings. Healthcare workers responsible for patients moving between care settings should provide the following information to the subsequent care giver:
• Patient pressure ulcer risk status
• Type of redistributing mattress / cushion required - advance notice
should be given when transferring or discharging a patient with elevated risk of pressure ulceration with specific needs

- Existing pressure damage, inclusive of size, category and location
- Previously healed ulcers including category
- Incontinence issues / management
- Any on-going nutritional support
- The wound care plan should be communicated to the subsequent provider prior to or on transfer if possible

Patients and carers should be informed of the risk of developing pressure ulcers, especially when being transferred between care settings.

5.8. Clinical Incident Reporting

In accordance with Trust Incident Policy CRM002, all patients with a New or POA pressure ulcer category 2, 3 or 4 must have this reported as a clinical incident on the Trusts DATIX. Those cases thought to have caused a patient serious harm will be reported as a Serious Incident. Monthly prevalence data will be collected via the Safety Thermometer Tool. Due to the recent recommendations from NHS Improvement, the following definitions have changed as below:

<table>
<thead>
<tr>
<th>Previous Definition</th>
<th>New Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
<td>Category</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Wound bed visible for assessment</td>
</tr>
<tr>
<td></td>
<td>Category 3</td>
</tr>
<tr>
<td></td>
<td>If slough or necrosis obscuring wound base – <strong>Unstageable Category 3</strong> (until debrided, then categorise Category 3 or 4)</td>
</tr>
<tr>
<td>Pressure Ulcer (caused by a medical device)</td>
<td><strong>Medical Device Related Pressure Ulcer</strong> e.g. Category 2(d)</td>
</tr>
<tr>
<td>Inherited</td>
<td><strong>POA</strong> (Pressure Ulcer on Admission)</td>
</tr>
<tr>
<td></td>
<td>72 hour rule discontinued.</td>
</tr>
<tr>
<td>Acquired</td>
<td>New</td>
</tr>
<tr>
<td>Avoidable</td>
<td><strong>Lapse in care</strong></td>
</tr>
<tr>
<td>Unavoidable</td>
<td><strong>No lapse in care</strong></td>
</tr>
<tr>
<td>Moisture Lesion</td>
<td><strong>MASD</strong> (Moisture Associated Skin Damage)</td>
</tr>
<tr>
<td><strong>New Datix Categories</strong></td>
<td><strong>Category 2</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Category 3</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Category 3 Unstageable</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Category 4</strong></td>
</tr>
<tr>
<td></td>
<td><strong>DTI</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Category 2(d)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Category 3(d)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Category 3 Unstageable(d)</strong></td>
</tr>
</tbody>
</table>

(d) = Device related pressure ulcer
• Deep Tissue Injuries (DTI) or Blood filled blisters caused by pressure injury – report on Datix as DTI. If the DTI evolves into pressure ulceration, Datix as the category (e.g. Category 3) it becomes. If it resolves, the incident will remain on Datix as a DTI.

If community nurses are visiting a patient infrequently e.g. every three months for a catheter change or B12 injection, ensure Waterlow Score and SSKIN Bundle (if Waterlow 10+) are completed at each visit. Ensure all appropriate pressure ulcer prevention equipment / advice / leaflet has been provided (SSKIN Advice leaflet for Residential Homes, Pressure Area Care leaflet for patients in their own homes). Ensure the patient and / or carer are aware how to contact you if any pressure area concerns and document this conversation on SystmOne. If all of these actions are completed and the patient develops a pressure ulcer prior to your next scheduled visit, this will be classed as POA not New.

The health care professional who first identifies that a patient has a pressure ulcer is responsible for completing the Datix incident form.

The following must be recorded in the `description of the incident` text box:

- Cause
- If the patient was admitted to caseload with the pressure ulcer/s
- Where the pressure ulcer originated if known, e.g. home, Nursing Home etc.
- Category of pressure ulcer/s.
- Clinical description to include: wound appearance and dimensions.
- Location on the body.
- Current equipment and interventions being currently used i.e. repositioning plan.

If the patient has a pressure ulcer and there are any factors which may suggest neglect then the incident should also be reported to the Safeguarding of Vulnerable Adults team. Form available at link below: [https://northamptonshire.firmstep.com/default.aspx/RenderForm/?F.Name=jveJqHjZc6r](https://northamptonshire.firmstep.com/default.aspx/RenderForm/?F.Name=jveJqHjZc6r)

A copy of this form should also be sent to the Trust Safeguarding Lead for Vulnerable Adults.

See Reporting Process for Patients with Pressure Ulceration (Appendix 6)

6 TRAINING

7.1 Mandatory Training

There is no mandatory training associated with this policy.
7.2 Specific Training not covered by Mandatory Training
Training sessions are delivered regularly throughout the year by the Tissue Viability Team. Staff can book a place through ESR. Attendance should be based on an individual’s training needs as defined within their annual appraisal or job description. An e-learning module is also available.

7.3 Competency Assessment
A Competency Tool will be implemented as part of trust training sessions.

7 MONITORING COMPLIANCE WITH THIS DOCUMENT
The table below outlines the Trusts’ monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Method of monitoring</th>
<th>Individual responsible for the monitoring</th>
<th>Monitoring frequency</th>
<th>Group or committee who receive the findings or report</th>
<th>Group or committee or individual responsible for completing any actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>To be addressed by the monitoring activities below.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with this guideline including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Timeliness of photographs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Completion of risk assessments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• consent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitored as part of Pressure Ulcer Prevention Audit</td>
<td></td>
<td>Service Managers/Operational Managers/Team Leads</td>
<td>Quarterly</td>
<td>Infection Prevention &amp; Control Assurance Group</td>
<td>Service Managers/Operational Managers/Team Leads</td>
</tr>
</tbody>
</table>

Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.

8 EQUALITY CONSIDERATIONS
The author has considered the needs of the protected characteristics in relation to the operation of this policy and protocol to align with the outcomes with IP&C Assurance Framework. We have identified that ensuring that communication reaches all vulnerable groups. The service has been designed to ensure communication relevant to any pressure ulcer issues reaches all sections of the community. This includes taking into consideration communication barriers relating to language or specific needs to reach the whole population. TVN’s work closely with multi agency groups and community partners where appropriate we will undertake engagement and outreach activity with targeted action to relevant groups to follow NHS Improvements communication
framework. Some groups are particularly vulnerable in relation to their protected characteristics, e.g. age, ethnic minority communities and disability and where we identify that, the expectation is that staff will meet the needs appropriately.

9 REFERENCES AND BIBLIOGRAPHY

- NICE Clinical Guidance for Pressure Ulcer Management 179 (April 2014)
- NHS Improvement (June 2018) Pressure ulcers: revised definition and measurement, Summary and recommendations
- The European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) 2009 Pressure Ulcer Treatment Quick Reference Guide. Available from http://www.epuap.org/guidelines/Final_Quick_Treatment.pdf
APPENDIX 1 PRESSURE ULCER GRADING SYSTEM – TO FOLLOW WHEN AVAILABLE FROM NHSI 2019
11 APPENDIX 2 WATERLOW RISK ASSESSMENT TOOL

**WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY**
RING SCORES IN TABLE. ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED.

<table>
<thead>
<tr>
<th>BUILD/WEIGHT FOR HEIGHT</th>
<th>SKIN TYPE VISUAL RISK AREAS</th>
<th>SEX AGE</th>
<th>NUTRITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI (20 – 24.9)</td>
<td>HEALTHY TISSUE PAPER DRY</td>
<td>MALE 1</td>
<td>A - HAS PATIENT LOST WEIGHT RECENTLY</td>
</tr>
<tr>
<td>ABOVE AVERAGE: BMI (25 – 29.9)</td>
<td>OEDEMATOUS</td>
<td>FEMALE 2</td>
<td>0.5 – 5kg - 1</td>
</tr>
<tr>
<td>OBSE</td>
<td>CLAMMY, PYREXIA DISCOLOURED</td>
<td>14 - 49</td>
<td>YES – GO TO B</td>
</tr>
<tr>
<td>BMI &gt; 30</td>
<td>STAGE 1 PRESSURE ULCER</td>
<td>50 - 64</td>
<td>5 - 10kg - 2</td>
</tr>
<tr>
<td>BLOW: AVERAGE BMI &gt; 20</td>
<td>STAGE 2 - 4</td>
<td>65 - 74</td>
<td>NO – GO TO C</td>
</tr>
<tr>
<td>BMI = WT(kg)/ HT (m²)</td>
<td>81 +</td>
<td>75 - 80</td>
<td>UNSURE – GO TO C &amp; SCORE 2</td>
</tr>
<tr>
<td>CONTINENCE:</td>
<td>81 +</td>
<td>81 +</td>
<td>UNSURE - 2</td>
</tr>
<tr>
<td>COMPLETE/</td>
<td>FULLY</td>
<td>0</td>
<td>C - PATIENT EATING POORLY/LACK OF APPETITE</td>
</tr>
<tr>
<td>CATHETERISED</td>
<td>RESTLESS/PIDDITY</td>
<td>1</td>
<td>NO – SCORE: 0</td>
</tr>
<tr>
<td>URINH INCONT.</td>
<td>APATHETIC</td>
<td>2</td>
<td>YES - SCORE: 1</td>
</tr>
<tr>
<td>FAECAL INCONT.</td>
<td>RESTRICTED</td>
<td>3</td>
<td>SPECIAL RISKS</td>
</tr>
<tr>
<td>URINARY + FAECAL</td>
<td>BOUND</td>
<td>4</td>
<td>TISSUE MALNUTRITION</td>
</tr>
<tr>
<td>INCONTINENCE</td>
<td>E.G. TRACTION</td>
<td>5</td>
<td>8 - DIABETES, MS, CVA</td>
</tr>
<tr>
<td></td>
<td>CHAIRBOUND</td>
<td></td>
<td>8 - MOTOR SENSORY</td>
</tr>
<tr>
<td></td>
<td>E.G. WHEELCHAIR</td>
<td></td>
<td>5 - PARAPLEGIA (MAX OF 6)</td>
</tr>
<tr>
<td>SCORE</td>
<td></td>
<td></td>
<td>MAJOR SURGERY OR TRAUMA</td>
</tr>
<tr>
<td>10+ AT RISK</td>
<td></td>
<td></td>
<td>ANAEMIA (Hb &lt; 8)</td>
</tr>
<tr>
<td>15+ HIGH RISK</td>
<td></td>
<td></td>
<td>2 ORTHOPAEDIC/SPINAL</td>
</tr>
<tr>
<td>20+ VERY HIGH RISK</td>
<td></td>
<td></td>
<td>ON TABLE &gt; 2 HR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ON TABLE &gt; 6 HR</td>
</tr>
</tbody>
</table>

**SPECIAL RISKS**

| TISSUE MALNUTRITION    | NEUROLOGICAL DEFICIT |
|                       |                       |
| TERMINAL CACHEXIA      | 8 - DIABETES, MS, CVA |
| MULTIPLE ORGAN FAILURE| 8 - MOTOR SENSORY    |
| (RESP, RENAL, CARDIAC) | 5 - PARAPLEGIA (MAX OF 6) |
| PERIPHERAL VASCULAR    | MAJOR SURGERY OR TRAUMA|
| DISEASE                |                         |
| ANAEMIA (Hb < 8)       | 2 ORTHOPAEDIC/SPINAL   |
| SMOKING                | 1 ORTHOPAEDIC/SPINAL   |

**MEDICATION**

- CYTOTOXICS, STEROIDS, ANTI-INFLAMMATORY MAX OF 4
12 APPENDIX 3 - AN EXAMPLE OF A SSKIN CARE BUNDLE

Care Plan for ____________________________________________

SSKIN Care Bundle

Complete if Waterlow score 10 +
Refer to NHFT Pressure Ulcer Prevention Guidelines
Evaluation notes must be completed if variances identified

NHS Number:
Date of Birth:
Contact Details:
Date Printed:
Implementation Date:
Review Required:
Care Needed:

Pressure Ulcer Prevention
To reduce the risk of pressure ulcer development
To prevent the deterioration of known pressure ulcers
To promote patient comfort
To reduce localised pressure, shear and friction to at risk areas of skin
To monitor the efficacy of intervention.
To provide care and management as per Marsden Manual of clinical procedures.

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Responsibility</th>
<th>Date Performed</th>
<th>Performed By</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed verbal consent for student contribution to the assessment process</td>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and the provision of hands-on care/treatment gained from the patient.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use Training Statement template</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informed verbal consent for assessment and treatment gained from patient</td>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete /Update Waterlow assessment tool</td>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use Waterlow assessment template</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Surface- Mattress/cushion must be upgraded/downgraded as individual’s condition dictates. Document type of mattress/cushion used on evaluation sheet**

| Consider if the current mattress is appropriate                           | Nurse          |                |              |           |
| Consider if the current cushion is appropriate                            | Nurse          |                |              |           |
| Has the functionality/integrity check of equipment been performed         | Nurse          |                |              |           |

Skin Inspection- Check all pressure areas. If pressure damage present record category/grade on evaluation
<table>
<thead>
<tr>
<th>Have all pressure areas been checked</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there Pressure damage or Pressure Ulceration present. If so implement wound assessment and care plan templates</td>
<td>Nurse</td>
</tr>
<tr>
<td>Pressure ulcer(s) grade 2 and above should be reported as a local incident according to the Northants local reporting process.</td>
<td>Nurse</td>
</tr>
</tbody>
</table>

**Keep moving – Patients must be repositioned even when high specification equipment is being used**

<table>
<thead>
<tr>
<th>Is 24 hour repositioning chart in place if appropriate</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider mobilising, positioning and repositioning interventions and their acceptability to the patient and their carer and record advice given</td>
<td>Nurse</td>
</tr>
</tbody>
</table>

**Incontinence - Assess for incontinence.** Moisture increases the risk of skin breakdown. Document the method of incontinence management used on evaluation sheet

<table>
<thead>
<tr>
<th>Ensure effective continence management if appropriate</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage maintenance of adequate personal hygiene and skin care</td>
<td>Nurse</td>
</tr>
<tr>
<td>Consider the use of skin care barrier products and document prescribed treatment</td>
<td>Nurse</td>
</tr>
</tbody>
</table>

**Nutrition** - Weight loss, obesity and dehydration can increase the risk of skin breakdown. Encourage a high protein/high calorie diet and fluids to assist wound healing. Document any actions taken on evaluation sheet

<table>
<thead>
<tr>
<th>Complete the nutritional risk assessment. Use MUST template</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has nutritional advice been given if appropriate</td>
<td>Nurse</td>
</tr>
<tr>
<td>Are food charts in place if appropriate</td>
<td>Nurse</td>
</tr>
<tr>
<td>Is referral to GP/Dietician indicated</td>
<td>Nurse</td>
</tr>
<tr>
<td>Offer educational information and advice as appropriate to diagnosis</td>
<td>Nurse</td>
</tr>
<tr>
<td>Use Pressure Ulcer - Information Leaflet NICE CG 29 template</td>
<td>Nurse</td>
</tr>
<tr>
<td>Evaluation Notes Use Care Plan Additional Notes. template</td>
<td>Nurse</td>
</tr>
<tr>
<td>Activity recording - Read Codes Use Read Code new template</td>
<td>Nurse</td>
</tr>
<tr>
<td>Ongoing care and evaluation recorded in SystmOne</td>
<td>Nurse</td>
</tr>
</tbody>
</table>
13 APPENDIX 4 - GENERIC RECOMMENDATIONS FOR PRESSURE RELIEVING MATTRESSES AND CUSHIONS

This is a quick general guide to assist the practitioner when selecting equipment. It does not replace clinical judgement. Refer to specific manufacturers recommendations. Equipment should only be prescribed after full holistic assessment taking account of patients’ general condition, mobility and patient preference.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Equipment Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterlow 10-14</td>
<td></td>
</tr>
<tr>
<td>(No Pressure Ulcers)</td>
<td>High specification foam replacement mattress</td>
</tr>
<tr>
<td></td>
<td>High specification foam cushion</td>
</tr>
<tr>
<td>Waterlow 10-14</td>
<td></td>
</tr>
<tr>
<td>(PU Category 1 or 2)</td>
<td>High specification foam replacement mattress</td>
</tr>
<tr>
<td></td>
<td>High specification foam cushion</td>
</tr>
<tr>
<td>Waterlow 10-14</td>
<td></td>
</tr>
<tr>
<td>(PU Category 3 or 4)</td>
<td>Alternating mattress / alternating or combination</td>
</tr>
<tr>
<td></td>
<td>air/foam mattress / cushion</td>
</tr>
<tr>
<td></td>
<td>Low air loss (discuss with TVN)</td>
</tr>
<tr>
<td>Waterlow 15-19</td>
<td></td>
</tr>
<tr>
<td>(No Pressure Ulcers)</td>
<td>Viscose Elastic mattress / cushion</td>
</tr>
<tr>
<td>Waterlow 15-19</td>
<td></td>
</tr>
<tr>
<td>(PU Category 1 or 2)</td>
<td>Viscose Elastic mattress / cushion</td>
</tr>
<tr>
<td>Waterlow 15-19</td>
<td></td>
</tr>
<tr>
<td>(PU Category 3 or 4)</td>
<td>Alternating mattress / alternating or combination</td>
</tr>
<tr>
<td></td>
<td>air/foam mattress / cushion</td>
</tr>
<tr>
<td></td>
<td>Low air loss (discuss with TVN)</td>
</tr>
<tr>
<td>Waterlow 20+</td>
<td></td>
</tr>
<tr>
<td>(No Pressure Ulcers)</td>
<td>Alternating mattress / alternating or combination</td>
</tr>
<tr>
<td></td>
<td>air/foam mattress / cushion</td>
</tr>
<tr>
<td></td>
<td>Low air loss (discuss with TVN)</td>
</tr>
<tr>
<td>Waterlow 20+</td>
<td></td>
</tr>
<tr>
<td>(PU Category 1 or 2)</td>
<td>Alternating mattress / alternating or combination</td>
</tr>
<tr>
<td></td>
<td>air/foam mattress / cushion</td>
</tr>
<tr>
<td></td>
<td>Low air loss (discuss with TVN)</td>
</tr>
<tr>
<td>Waterlow 20+</td>
<td></td>
</tr>
<tr>
<td>(PU Category 3 or 4)</td>
<td>Alternating mattress / alternating or combination</td>
</tr>
<tr>
<td></td>
<td>air/foam mattress / cushion</td>
</tr>
<tr>
<td></td>
<td>Low air loss (discuss with TVN)</td>
</tr>
</tbody>
</table>

If the patients skin condition or pressure ulceration continues to deteriorate the equipment must be upgraded as soon as possible.

If the patient’s condition changes they must be reassessed and provided with the appropriate equipment as soon as possible.

Healing pressure ulcers should not be reverse categorised. Previous pressure damage should be considered when selecting pressure preventative equipment.
14 APPENDIX 5 – REPOSITIONING CHART

Repositioning Chart

Date .................

<table>
<thead>
<tr>
<th>Time</th>
<th>Chair</th>
<th>Sit in bed</th>
<th>Left side</th>
<th>Right side</th>
<th>Back</th>
<th>Signature and Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PATIENT HAS PRESSURE DAMAGE TO THEIR SKIN

(The term ‘Grade’ is now ‘Category’)

NHS – Pressure Ulcer Category 2, 3 or 4?

Care Homes – Pressure Ulcer Category 2, 3 or 4 which developed after admission?

Complete Incident Reporting Form Datix (NHS)

OR regulation 18 (2) (Care Homes)

YES

No routine incident report required, but may indicate “at risk” person. Ensure appropriate measures are in place.

Follow the NCC Procedures for Safeguarding Children or Vulnerable Adults

Send evidence of assessments and interventions with Safeguarding Notification

YES

NO

NHS – are there any factors which might suggest neglect or omission / lapse of care? See “Guidance for triggering a Safeguarding Vulnerable Adults Procedure” page 3

---------

-----

Care Homes – ALWAYS complete Safeguarding alert

Further Action for Pressure Ulcer Management

- Inform Ward / Unit Manager or Team / Clinical Facilitator
- Complete / update assessment and care plans e.g. SSKIN Bundle
- Appropriate pressure relieving equipment in use e.g. mattress & cushion
- Apply appropriate wound care products (Northants Dressing Formulary)
- Complete Infection Prevention Risk Assessment Tool
- Record any referrals e.g. Social Services / GP / Dietician
- Provide advice leaflet for patients & carers
- Consider Mental Capacity and assess accordingly

If the pressure ulcer deteriorates, complete additional incident form(s). Document that the ulcer has been reported previously and the previous category. Reconsider if there are any factors which may suggest neglect or omission / lapse of care.
Guidance for triggering a Safeguarding Vulnerable Adults Procedure for a Patient with Pressure Ulceration

Have all reasonable steps been taken?
If there are concerns about whether reasonable steps to prevent the problem had been taken, the care that was given should be assessed against trust policy or NICE Guidance (CG 179).
Advice is available from your Tissue Viability Team for a second opinion and to evaluate the information collected.
If a safeguarding notification is deemed necessary, evidence of the decision making process below should be included in the referral. If possible please give opinion regarding whether there were any lapses in care.

Are there any factors which might suggest neglect or omission/lapse of care?
Not all pressure ulcers in a vulnerable adult are the result of neglect. Neglect can be understood as an act or an omission of care, which is not in accordance with accepted practice (local policy or NICE Guidance - CG 179).

Some key questions to consider:
• Was the pressure ulcer new whilst in your care or present on admission from another trust?
• Was a Pressure Ulcer Risk Score (i.e. Waterlow Score) carried out?
• Was there a specific pressure ulcer prevention care plan e.g. SSKIN Bundle?
• Was the care plan adhered to and reviewed at appropriate intervals?
• Was there documented evidence of contributory factors such as, arterial insufficiency (poor blood supply - increased risk in patients with diabetes, cardiac or renal impairment), end stage palliative care, poor fluid & nutritional intake?
• Did monitoring show changes in the presentation of the skin (e.g. persistent change in colour, temperature of skin etc.) that should have triggered the need for intervention or the seeking of more expert assistance?
• Was the appropriate expert assistance sought?
• S Skin Inspection - was the patient’s skin assessed at appropriate intervals?
• S Surface – was equipment provided in a timely manner, set up correctly, monitored and used appropriately?
• K Keep Moving – was the patient repositioned appropriately? Repositioning schedule advised? Repositioning chart in place?
• I Incontinence – was incontinence / moisture managed effectively?
• N Nutrition – was MUST tool completed at appropriate intervals and referral to Dietician made if required?

• There was a lapse(s) in care if there was inadequate assessment, planning or evaluation of care. This would include omissions in assessments, repositioning and equipment provision. Consider Safeguarding Referral.
• There was no lapse in care if there was adequate assessment, planning and evaluation of care. This would include if the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence (Department of Health 2011). If the individual appears not to have mental capacity to make informed decisions regarding pressure ulcer prevention, then evidence of Mental Capacity Assessment must be documented.

Reporting Process for the Incidence of Pressure Ulcers
Useful Contact Information

**Tissue Viability Nurses**: Contact for advice & support regarding prevention and management of pressure ulceration.

**NHFT**:  
- 01933 235804

**KGH**:  
- 01536 492000 bleep 703

**NGH**:  
- 01604 523231 / 01604 523230
- Bleep 4541 Office 3251

**NHS Nene and NHS Corby CCG Quality Monitoring Team (Nursing Homes and Domiciliary Care)**:

Cath Ratcliffe 01604 651416 or 07818 533190  
Darren McGregor 01604 651751 or 07748 322912  
Marilyn Levins 01604 651752 or 07818 533188

**Northamptonshire County Council**

Adult Care Team (SOVA Referrals)  
Tel: 0300 126 1000  
[https://www3.northamptonshire.gov.uk/councilservices/adult-social-care/safeguarding/Pages/default.aspx](https://www3.northamptonshire.gov.uk/councilservices/adult-social-care/safeguarding/Pages/default.aspx)

**NGH Safeguarding Adults Lead**: Tracy Keats 01604 523218 or Bleep 8054 via 01604 634700  
**KGH Safeguarding Adults Lead**: Jacqueline Barker 01536 491572 or 01536 492000 bleep 878  
**NHFT Safeguarding Adults Lead**: Cath Kennedy 01536 494484 / 07920 234727 Jackie Noble