

NHS FORTH VALLEY

**PRESSURE ULCER RISK ASSESSMENT
& PREVENTION GUIDELINE**

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This document can, on request, be made available in alternative formats

Management of Policies Procedure control sheet

(Non clinical documents only)

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1. Introduction

This guideline is for staff within NHS Forth Valley to assist in the delivery of care that is patient centred and reflecting on current practice. It forms part of an area wide approach to the prevention and management of Pressure ulcers including Safety cross, SSKIN Care Bundle, care and comfort round releasing time to care and the clinical care standard and procedures.

2. Policy Statement

The aim of this document is to ensure health care professionals work in partnership with patients, carers and other Health and Social Care providers deliver a standardised, seamless pressure ulcer prevention framework, supporting equality in healthcare and clinical governance. Dissemination of the guideline within local areas will be the responsibility of the Senior Charge Nurses. The guideline is not to be used in isolation but incorporated into all appropriate education and training within primary and secondary care.

3. Scope

This policy is relevant to all staff caring for patients in inpatient areas in Acute / Community Hospitals and patients own home.

4. Definitions

The term Pressure Ulcer will be mentioned in this guidance and it relates to all grades of pressure ulcer.

5. Pressure Ulcer Definition

Pressure ulcers are described as “an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and are sometimes known as ‘bed sores’ or ‘pressure sores’”.¹ Pressure ulcers can occur in any person, regardless of age, who has, for example, limited mobility, cognitive impairment, palliative and end of life care needs or who is acutely ill. Other contributory factors include poorly controlled diabetes, poor bladder or bowel function, or poor nutrition and hydration. The first sign that a pressure ulcer may be forming is usually red or discoloured skin, which may get progressively worse and eventually lead to an open wound. The most common places for pressure ulcers to occur are over bony prominences.

The incident of pressure ulcers is of concern to all health care providers. Although the elderly population presents with the highest number of pressure ulcers, any patient regardless of age, may develop a pressure ulcer. The costs associated with the management and treatment of pressure ulcer can be measured in financial, social and human terms. Patients who develop pressure ulcers suffer from varying factors such as, pain, insomnia and loss of confidence in health care providers and this will inevitably result in more nursing time and resource requirement.

Pressure ulcers have been identified as a key quality indicator (DOH, 1993) and suggested that monitoring of incidents was a high priority issue for health care organisations. In addition they recommended that authorities reduce the incidence of

pressure ulcers by 5% - 10% annually. Health Care Improvement Scotland has developed standards - Prevention and Management of Pressure Ulcers Standards (2019).

These standards have been developed for the prevention and management of pressure ulcers within health and social care services and take into account national health and wellbeing outcomes⁶ and national Health and Social Care Standards.⁷ In addition, they support the principles of *realistic medicine*⁸ recognising the importance and value of informed choice, putting patients and service users at the centre of care decisions, and multidisciplinary working.

6. Skin Care

Skin health is integral to both physical and psychosocial health (ISTAP, 2018), which can have an effect on patients' quality of life, and can in turn affect partners, family, friends and even carers. (BPS 2018)

When assessing any patient whether in the hospital setting or at home (including those at end of life care) a full skin assessment is necessary to determine integrity and condition in order to promote its functional capacity and prevent complications from its failure to function.

Skin inspection should be undertaken regularly and the frequency determined in response to changes in the patient condition. This can be recorded on the SSKIN(skin ,support ,keep moving incontinence ,nutrition) bundle sheet or the care and comfort round sheet for each patient. Although it is recommended practice to re-inspect at a minimum of every shift (hospital) or visit to the patient (community), it may require to be more frequently dependant on the condition of the patient.

There is also a Clinical standard on Skin Care available on the intranet.

http://www.nhsforthvalley.com/documents/qi/ce_guideline_clinicalcaresstandards/ccs-skin-pressure-area.pdf

7. General Risk Factors

There are numerous causes of pressure ulcers and these can be split into two categories, either intrinsic (internal environment), or extrinsic (external environment) and can occur on any part of the body where external pressure acts upon a bony prominence which are commonly known as pressure points (NES 2017).

The most common sites are:

Back of head, ear, shoulder, elbow, hip, buttocks, thigh, knee, leg, ankle, heel, toes.

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 patient is sitting or lying. (Waterlow 2013)

Extrinsic Factors

There are three main extrinsic factors, which are: -

* Pressure – by unrelieved pressure over a sustained period of time (Barbanel 1990, Versluysen 1986 & Bliss 1988). There is no scientific agreement within the literature as to the intensity and duration of the applied pressure that would result in tissue damage. Versluysen (1986) claimed that any periods exceeding 2 hours would cause damage. Whereas Kosiak (1961) suggested that not only would external pressure greater than 30

– 40 mmHg result in tissue damage, that a relatively low pressure maintained for a long period of time produce greater damage than a high pressure for a short time. In 2010, Jaul agreed with Kosiak suggestions. External pressure over bony prominences will decrease the skin blood flow causing lack of nutrients and oxygen in the tissues (Clark 2004). This may show as a persistent blanching or non-blanching erythema.

* Friction – if the patient is lifted incorrectly it can cause the skin to be dragged in a brisk movement across a surface, causing damage to the dermis. This may show as a graze or blister.

* Shear – caused by the patient slipping or sliding down a bed or chair due to poor positioning and support. This results in the skin remaining in the same position, whilst the underlying body structures are moving in an opposite direction, thus causing tearing or shearing of the underlying tissue and micro-circulation.

Pressure, shear and friction in isolation will not lead to the development of a pressure ulcer in healthy individuals. There are many intrinsic and extrinsic factors that can contribute to a pressure ulcer developing.

Intrinsic Factors

There are several predisposing intrinsic factors, which contribute to the overall condition of the patient and the susceptibility of them developing a pressure ulcer. These are as follows: -

* Health & Nutritional Status – The skin and other tissues are constantly being produced and repaired. A balanced diet providing the essential vitamins, minerals, proteins, carbohydrates and fats is needed to ensure that the skin maintains a healthy state. In the case of malnutrition, tissue is broken down and a reduction in cell repair occurs (Bacher, 1990). Prolonged malnutrition causes generalised weight loss, subsequently leading to less mechanical protection over the bony prominence. In underweight individuals there is a reduction in collagen and elastin therefore they are unable to absorb a mechanical load as efficiently. Obese individuals have a greater amount of fat aiding dissipation of pressure. Yet due to their size they are at a higher risk from pressure, shear and friction. Poor nutrition can be a contributory factor to developing pressure ulcers. An assessment is required in those patients deemed to be at higher risk of skin damage. The tool used to assess patients in NHS FV is the MUST tool.

* Mobility – Skin receptors detect pressure sending a signal to the brain, triggering a movement to alter the position of the body through times of sleep and being awake and a healthy individual will constantly alter their position. If an individual is chair or bed ridden, they are considered to be at greater risk of pressure ulcer development. (EPUAP, NPUAP 2009).

* Incontinence – Moist skin is 5 times more likely to become ulcerated than dry skin. Constant exposure to moisture can macerate the skin (Mackelbust and Seiggreen 2001). In 2011, Cooper stated that the combination of increased moisture combined with bacterial and enzymatic activity can result in the breakdown of vulnerable skin. It is important to consider the difference between a moisture lesion and the development of a pressure ulcer. When assessing take into account the location, shape and depth of the damage (Evans, Stephen-Haynes 2007).

* Neurological Factors – Receptors and nerves in the dermis and muscles belong to the autonomic nervous system this operates without conscious control. Conditions such as, diabetes mellitus, multiple sclerosis, stroke and spinal cord injury affect the nerve impulses, therefore the individual may not respond to pressure or temperature changes, hence be at risk of developing a pressure ulcer. (Morris 2010)

* Vascular Factors – Individuals with circulatory conditions will have a reduced local tissue oxygenation and delivery of nutrients, which are primary causes of pressure ulcer formation. Patients suffering from arteriosclerosis, cardiac failure, diabetes mellitus and lung disease will be placed in a higher risk category.

* Drug Therapies – Specific drug therapies can lead to a delay in wound healing such as steroids which inhibit epithelial proliferation, impair the inflammatory response and reduce the migration of leukocytes and macrophages. Cytotoxic drugs interfere with cell proliferation.

Radiotherapy: Refer to Best Practice Statement: Skincare of patients Receiving Radiotherapy (www.healthimprovementscotland).

Extrinsic Factors

- Age
- Culture
- General Health
- Dehydration/Oedema
- Mobility
- Known or suspected skin conditions
- Allergies
- Medication history e.g. cytotoxic, anti inflammatory drugs, steroids.
- Tissue Viability history i.e. history of previous ulcers
- Hygiene
- Symptoms of skin problems – itching, dryness

8. Identifying Patients at Risk

Modern day nursing advocates a holistic and patient centred approach to the nursing of individual patients. A holistic assessment should therefore include identification of the level of risk of a patient developing a pressure ulcer or the risk of an existing pressure ulcer deteriorating.

To allow a practitioner to successfully measure the severity of the risk, various tools have been developed allowing this measurement to take place. A pressure ulcer risk assessment is a tool that allows a system of scoring, this draws the practitioners attention to the risk category of those patients who require preventative measures when caring for them (Birchall, 1993).

The aim of a risk assessment (including skin inspection) is to prevent and reduce the likelihood of developing pressure ulcers and/or the further deterioration of any existing pressure ulcers (NICE 2014)

The best practice statement, 'The prevention and management of Pressure Ulcers' (Prevention and Management of Pressure Ulcers Standards 2016) recommends that individual patients should have both formal and informal risk assessments undertaken by trained individuals. In addition, BPS advocates the formal assessment should include the

use of a risk assessment scale although stresses the importance that the scales must act as aide memoir and not replace clinical judgement.

Essentially there are two issues of interest with regard to risk assessment. First, the fundamental problems of identification and agreement of specific risk factors which predispose to pressure ulcer development. Second the issue of validity and reliability of assessment scales and their predictive ability in the identification of patients at risk.

Within NHS Forth Valley the risk assessment tool of choice is the Braden scale (appendix 1)

For patients in the Emergency Department and Clinical Assessment Unit, the Preliminary Pressure Ulcer Risk Assessment Chart (PPURA) is utilised (appendix 3). If risk is identified and full Braden Assessment should be completed and plan initiated.

9. Stage 1 Assessment in Darkly Pigmented Skin

Points to consider when assessing darkly pigmented skin:

- The colour of intact dark skin remains unchanged (does not blanch) when pressure is applied over a bony prominence.
- Localised skin colour changes occur at the site of pressure. These colours will differ from the patient's/client's usual skin colour.
- A circumscribed area of intact skin may feel warm when touched. As tissue changes colour, the intact area of skin will feel cool to touch when fingers or the back of the hand is used. You should not wear gloves during an assessment as they diminish sensitivity to changes in skin temperature.
- If the patient/client has had a pressure ulcer previously, that area of skin becomes lighter before resuming back to its original colour.
- The localised area of skin may be purplish/bluish or violaceous (eggplant colour). This is comparable to the erythema or redness seen in persons with lighter skin tones.
- There is localised heat (inflammation) when compared with surrounding skin. The localised area of warmth eventually will be replaced by an area of coolness which is sign of tissue devitalisation
- Oedema (non-pitting swelling) may occur with an induration more than 15mm in diameter. The skin is taut and shiny.
- The patient/ client complains of or indicates current or recently relieved pain or discomfort at sites to the caregiver to be predisposed to pressure ulcer development.

Bennet (1995)

More information available www.healthimprovementscotland/improvement

Timescales

A pressure ulcer risk assessment should take place within 6/8 hours of the start of admission to the episode of care. For community care this should be at first visit.

Re-assessment

For some patients the initial assessment will identify that they are not at risk of developing a pressure ulcer therefore re-assessment for this group of patients would only occur if there is a change in their condition which increases the risk (see section general risk factors).

Patients classed as at risk, or highly at risk of developing a pressure ulcer should have planned re-assessment date recorded in the nursing records as well as an individualised care plan.

10. Clinical Judgement

Pressure ulcer risk assessment is a vital part of the holistic assessment and the practitioner's clinical judgement is paramount when planning the patient care and allocating resources.

Pressure ulcer risk assessment tools must not replace clinical judgement but support the decision of the practitioner and to complement their clinical decision making.

11. Pressure Ulceration Classification

The use of a classification system enables an accurate description of tissue damage with the aim to provide a consistent method of skin assessment using a numerical score. The Scottish Adapted European Pressure Ulcer Advisory Panel- Grading Tool (Appendix 2)

12. Types of Hyperamia/Erythema

There are 4 main types of hyperaemia. These are as follows: -

Reactive Hyperaemia – This happens to all people and presents as a red mark following any positional change. Reactive hyperaemia is a good indication of the body's natural response to pressure ischaemia (Torrance 1983) and the reaction is proportional to the duration of the pressure.

Hyperaemia – This is a vascular response to a trauma and occurs approximately 5 to 30 minutes after the trauma has occurred resulting in anoxia and a build up of metabolites. (Anton 2005)

Blanching Hyperaemia – This is a persistent red mark, which blanches (flashes white when pressed).

Non – blanching Hyperaemia – This is a persistent red mark which does not blanch (stays red when pressed).

13. Relationship between Moving and Handling and Pressure Ulceration

Moving and handling techniques have a major role in the prevention of pressure ulceration formation. Inappropriate moving and handling practices may not only contribute to the development of pressure ulceration but their presence may have implications on how a client may be positioned or moved that may reflect on their rehabilitation management.

Moving and Handling maybe described as, '*Facilitating the movement of an individual from one position to another*' (Disabled Living Foundation 2001) and will depend on the individual's condition.

For example:-

- Independent using equipment
- Independent without using equipment
- Dependent upon others for assistance
- Totally dependent on others

Healthcare professionals need to ensure all moving and handling equipment is correctly identified, prescribed and utilised to meet the needs of the individual. Training in Manual Handling is mandatory. NHS Forth Valley is responsible for ensuring that healthcare workers are regularly updated in techniques required to use equipment safely.

The safe use of equipment involves achieving the transfer as intended and preventing unnecessary injury to client or handler in the process and this includes acknowledging the potential of tissue damage that can occur during these activities.

ISSUES SURROUNDING Bariatric Patients

Refer to local policy on Bariatric guidance for NHS Forth Valley

http://www.nhsforthvalley.com/documents/ig/policies_areawide_riskmanagement/manual_handling_bariatric_patient_policy.pdf

14. Paediatric Pressure Ulcer Prevention

Although the management of wound sites in children and neonates is essentially the same as adults, pressure ulcer risks differ to an adult. Similar to wound care, factors such as general health, nutrition plus level of activity must be considered. Children are dependent upon parents/carers to carry out their needs. Young skin, in particular, neonates is susceptible to injury and alterations in integrity.

Babies may be vulnerable to dietary inadequacies such as dehydration and anaemia, they also have limited storage space therefore require dietary supplements and additional fluids daily. A child's growth is extensive therefore they require extra protein and encouragement to eat. The teenage diet consists of 70% snacks and they infrequently sit down to eat. These factors and more need consideration in relation to the skin integrity and healing process. The risk assessment tool used in NHS Forth Valley is the Glamorgan tool (2009).

PREDISPOSING FACTORS

Children when ill are at risk from developing pressure ulcers. Predisposing factors to a child's skin to damage whilst in hospital are: -

- Incontinence
- Wearing nappies
- Nutritional deficits
- Infections
- Temperatures
- Immuno-compromised children.

Children with special needs are especially at risk due to lack of mobility and are sometimes confined to their bed or wheelchair. They are often unable to take part in their own care. Allergies or skin infections in children could cause the child to have an acute "rash" for periods of time until the source agent is identified.

The above factors will increase the child's risk from developing a pressure ulcer. In addition, these risk factors increase when a child is hospitalised because they have often become acutely ill or deteriorated at home or have planned surgery that can reduce their mobility even further. Also, parents/carers can lose control over their normal daily routine that could potentially increase pressure ulcer risk further.

AREAS AT RISK TO DAMAGE

Areas most at risk in children are: -

- Pressure points/bony prominences i.e. heels, elbows, back of the skull
- Ear lobes
- Sacrum
- Nappy areas

Children, babies and neonates are at risk from the incorrect use of equipment, application of splints and developing sensitivities to dressings. Children in some cases are totally dependent upon parents, carers or nurses for all their needs including the safe positioning of their limbs and their overall safety.

15. Re-positioning and Support

Over the past decade, a rapid growth has occurred in the amount of equipment available for re-positioning and support, this includes both pressure re-distributing devices and moving and handling equipment.

The aim of preventing pressure ulcers should be a three-fold approach:

1. Educating patients and their carers should be our first goal.
2. The correct and updated education of the multi-disciplinary team in the re-positioning and support of patients.

This should include:

The use of turn charts

The positioning of the patient in the 30 degree tilt

3. To include the use of pressure reducing/redistributing devices and moving and handling equipment.

Pressure re-distributing equipment falls into two main groups.

Pressure reducing equipment works by increasing the area by the body in contact with the surface, thereby spreading the load and reducing the effects of pressure.

Examples of these are:

Visco elastic foam mattress

Air filled mattresses

Pressure relieving systems work by providing pressure relief to different parts of the body at regular intervals.

Examples of these are:

Dynamic mattress replacement systems

Dynamic overlay systems

16. ALTERNATIVE SOLUTIONS

It is important that simple practices and methods for reducing pressure should be implemented amid all this technology. The measures, combined with regular turning and moving patients include:

Bed cradles to relieve pressures on the heels from the weight of the bedclothes.
The use of any incontinence aids eg incontinence pads with pressure relieving equipment is not recommended.

17. MANAGING THE PATIENT WHO IS CHAIRBOUND

Individuals who are considered to be at risk should restrict chair sitting to less than 2 hours) but while seated patients should be encouraged to carry out movements to alleviate pressure (Stockton et al 2002). To encourage movement by lifting off the seat rolling from side to side or leaning forwards and backward within the support of the seat is sufficient to change the direct pressure of sitting in one position.

Consideration should be given to the need for a air filled cushion /pressure redistributing devices for each patient identified at risk.

18. PATIENT/ CARER EDUCATION

Patients and carers, who are able and wish to, should be educated and informed in pressure ulcer prevention. This should include risk factors, risk assessment, preventative measures and holistic care. This will enable partnership in decision making to empower patients and improve concordance. Patient leaflet should be offered (appendix 4).

19. MANAGEMENT OF EQUIPMENT

INFECTION CONTROL

CLEANING

STORING

REFER TO LOCAL POLICIES AND PROCEDURES ON INFECTION CONTROL

http://www.qifv.scot.nhs.uk/CE_Guidance.asp?topic=Infection%20Control

20. DOCUMENTATION

The NMC Guidelines for records and record keeping confirms that documentation is an integral part of nursing which serves to protect the welfare of patients and clients (NMC 2008). It also reflects on the standard of professional practice and can provide accurate evidence of progress in the management of pressure ulcer prevention.

Nurses must document all decisions and reasons why they were made. Care plans relating to pressure ulcer prevention should show

- Risk assessment score and time carried out
- The grade of tissue damage
- Evidence of a nutritional risk assessment
- Evidence of reassessment as necessary or laid down by local policies
- Equipment chosen and when put in place for patient use. If resources on equipment are limited and has not been supplied, an alternative is used, this should be documented
- Informed consent for use of equipment
- Concordance of the patient and carer's
- If equipment was changed or discontinued and the reasons
- Any other preventative strategies employed
- Notes of any teaching done to carers in relation to prevention

MONITORING WITHIN NHS FORTH VALLEY

SAFETY CROSS and SKINN BUNDLE

The collection of data on the incidence of pressure ulcers is shown through the safety cross, (appendix 4).

This single sheet collect data on a monthly basis and forms part of the other pieces of work surrounding Better Health Better Care and is closely linked to the leading better care, clinical quality indicators and hospital acquired infection work streams (www.scottishgovernment).

The SSKIN bundle (appendix 5) is a plan of care that should be implemented when there is concern over a person's skin or there is an ulcer present. This will allow all involved in the care to see when and what care has been delivered and at what time. It forms part of the documentation required to be used when a patient is identified at risk. This document has been incorporated into the care and comfort round paperwork.

The reporting of any new pressure ulcer grade 2 and above should be recorded on an IR1 form as well following local reporting guideline.

21. TRANSFER OF CARE

It is vital that good communication occurs between the health care settings prior to and during the transfer of care of a patient.

Any patient classed, as 'at risk' of pressure ulcers or those that have existing pressure ulcers must have an adequate transfer plan formulated, along with appropriate referrals to the relevant health care workers. This needs to occur as soon as possible, allowing ample time for other health care settings/teams to prepare for the patients transfer

PREVENTION OF PRESSURE INJURY ASSESSMENT

Record your answer in the grid below Y – Yes N – No

If the answer is **NO** to any statement or there is a notable change in the patient's condition, undertake a Braden risk assessment and consider any other relevant assessment

Date	Time	Person is fully mobile without equipment or assistance	Person is fully continent	Person appears well nourished and able to eat /drink	Skin to pressure points satisfactory and intact (observed)	Review these questions every 24 hours if no initial risk identified	Braden requires completion	Signature	Skin description – i.e.: Redness, Skin Broken, Blister/Ulcer	Action Taken:

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk. Undertake and document risk assessment within 8 hours of admission to every ward or department or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol Complete care and comfort round chart. Consider contributing factors, frailty, diabetes, end of life care.				DATE								
				TIME								
Sensory Perception – Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.								
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry. Linen only requires changing at routine intervals.								
Activity – Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.								
Mobility – Ability to change and control body position	1. Completely Immobility Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitations Makes major and frequent changes in position without assistance.								
Nutrition – Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ½ of any food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube	3. Adequate Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most	4. Excellent Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.								

	clear liquids or IV's for more than 5 days.	feeding.	of nutritional needs.								
Friction and Shear –	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.								
Indicate appropriate number and add for total score										TOTAL SCORE:	
SIGNATURE:											
TOTAL BRADEN SCORE INDICATES THAT THE PATIENT IS:		EQUIPMENT AND ACTION WHICH SHOULD BE CONSIDERED FOR EACH "AT RISK" CATEGORY:									
17+ : NOT AT RISK		<ul style="list-style-type: none"> Depending on patient's individual requirements an overlay may be required for comfort e.g. Repose/Propad 									
15 – 16 : LOW RISK		<ul style="list-style-type: none"> Pressure reducing mattress e.g. SOFTFORM/PENTAFLEX Mattress Overlay e.g. Repose Daily skin inspection should be documented in care plan or nursing notes 									
12 – 14 : MODERATE RISK		<ul style="list-style-type: none"> If skin is intact, use pressure reducing mattress e.g. SOFTFORM/PENTAFLEX Mattress overlay e.g. .Repose <p>OR</p> <ul style="list-style-type: none"> If skin is broken up to a Stage 2 pressure ulcer, Mattress overlay e.g. Repose or an active pressure relieving mattress overlay e.g. Soft form premiere active ,Tamora(Community) Daily Braden risk assessment Twice daily skin inspection and document in care plan or unified notes Implement turning schedule – reposition changes 2-4 hrly and document in care plan 									
9 – 11 : HIGH RISK		<ul style="list-style-type: none"> If skin is broken up to a Stage 3 pressure ulcer Alternating Dynamic Pressure System, e.g. Softform premiere active ,Tamora (Community) NIMBUS (Acute) Daily Braden risk assessment Implement turning schedule – reposition changes 2-4 hrly and document in care plan Skin inspection at each reposition change and document in nursing notes 									
6 – 8 : SEVERE RISK		<ul style="list-style-type: none"> If skin is broken up to a Stage 4 pressure ulcer Alternating Dynamic Pressure System e.g. NIMBUS, (Community only Softair,Tamora) Daily Braden risk assessment Implement turning schedule – reposition changes 2 hrly and document in care plan Skin inspection at each reposition change and document in nursing notes 									
When an area of redness or discolouration is noted further action is required. Skin inspection, findings and action taken must be documented in patient health records		<ul style="list-style-type: none"> If patient is out of bed, a pressure reducing / relieving seating system comparable to the equipment used on the bed should be considered, e.g. Repose, Active Seat Cushion. Patients should be encouraged to reposition at least every 30 minutes and be assisted if unable to do so In community setting this can be advised. 									

SPECIALISED EQUIPMENT		
TYPE OF EQUIPMENT / AID	DATE COMMENCED	DATE DISCONTINUED
Contact Tissue Viability Service for advice and support 01324 673747		

BRADEN RISK ASSESSMENT CHART

Scottish Adapted European Pressure Ulcer Advisory Panel (EPUAP) Grading Tool

NATVNS
2012

Early warning sign - Blanching erythema

Areas of discoloured tissue that blanch when fingertip pressure is applied and the colour recovers when pressure released, indicating damage is starting to occur but can be reversed. On darkly pigmented skin blanching does not occur and changes to colour, temperature and texture of skin are the main indicators.

Grade 1 - Non Blanchable Erythema

Intact skin with non-blanchable redness, usually over a bony prominence.

Darker skin tones may not have visible blanching but the colour may differ from the surrounding area.

The affected area may be painful, firmer, softer, warmer or cooler than the surrounding tissue.



Grade 2 - Partial thickness skin loss

Loss of the epidermis/dermis presenting as a shallow open ulcer with a red/pink wound bed without slough or bruising.*

May also present as an intact or open/ruptured blister.



Grade 3 - Full thickness skin loss

Subcutaneous fat may be visible but bone, tendon or muscle is not visible or palpable.

Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunnelling.**



Grade 4 - Full Thickness Tissue Loss

Extensive destruction with exposed or palpable bone, tendon or muscle. Slough may be present but does not obscure the depth of tissue loss. Often includes undermining or tunnelling.**



Suspected Deep Tissue Injury:

Epidermis will be intact but the affected area can appear purple or maroon or be a blood filled blister over a dark wound bed. Over time this skin will degrade and develop into deeper tissue loss.



Ungradable:

Full thickness skin / tissue loss where the depth of the ulcer is completely obscured by slough and / or necrotic tissue. Until enough slough and necrotic tissue is removed to expose the base of the wound the true depth cannot be determined.

It may be a Grade 3 or 4 once debrided



Combination Lesions:

These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage as above but awareness of other causes and treatments is needed. See *Excoriation & Moisture Related Skin Damage Tool*

*Bruising can indicate deep tissue injury

**The depth of a Grade 3 or 4 pressure ulcer varies by anatomical location. Areas such as the bridge of the nose, ears, occiput and malleolus do not have fatty tissue so the depth of these ulcers may be shallow. In contrast areas which have excess fatty tissue can develop deep Grade 3 pressure ulcers where bone, tendon, muscle is not directly visible or palpable.

Ref: European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. (2009) *Prevention and treatment of pressure ulcers: quick reference guide*. National Pressure Ulcer Advisory Panel, Washington DC
NHS Quality Improvement Scotland (2009) *Best Practice Statement: Prevention and management of pressure ulcers*. NHS Quality Improvement Scotland, Edinburgh

Updated: Jan 2014 Review date: Jan 2016

www.tissueviabilityscotland.org

Pressure ulcer safety cross

Month _____ Year _____

Ward/Care home _____

- Green No new pressure ulcer found
- Orange Admitted with pressure ulcer
- Red New pressure ulcer found (ward/care home acquired)



		1	2		
		3	4		
		5	6		
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	



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PRESSURE ULCER SAFETY CROSS



MONTH / YEAR		WARD / AREA			
Date	PATIENT I.D. CHI NO.	PU LOCATION ie. Hip, Heel etc	GRADE 2 and above Any new grade 2 or above pressure ulcers must have IR1 completed	Transferred from ie. Home, Ward etc	IR1 number

Date	PATIENT I.D. CHI NO.	PU LOCATION ie.Hip, Heel etc	Grade 1	Transferred from ie. Home, Ward etc	

Only record Grade 2 or above pressure ulcers on IR1 (blister at pressure points are Grade 2)
 Send completed Safety Cross to Tissue Viability Service mailbox : fv-uhb.tissueviability@nhs.net

This information leaflet is to help you understand pressure ulcers (formerly known as bedsores) – how they occur and how they can be prevented.

Pressure Area Care

If you have to stay in bed or you spend long periods sitting in a wheelchair or armchair you may be at risk of developing pressure damage to an area of skin – usually over a pressure site (see picture opposite). A pressure ulcer can develop in only a few hours and you may be offered a pressure relieving mattress or cushion such as the equine support cushion/mattress for the bed or chair. This can help reduce pressure to the common pressure sites of the body.

What can you do to help? – on the chair

If possible try to take the weight off any vulnerable areas every 15 minutes or so by leaning forward and pushing up on the arms of the chair or you could roll buttocks from side to side for short spells.

Whilst in bed

If possible try to change your position at least every 2 hours, alternating between your back and both sides. Your nurse/s may need to help you do this properly so that you do not drag your skin along the sheets as this can contribute to developing pressure ulcers.

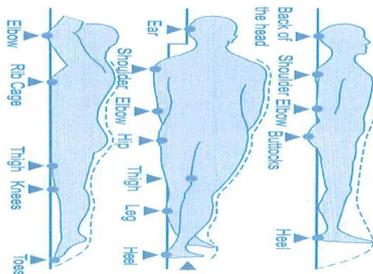
Pillows can be useful to stop your knees and ankles touching each other, especially when you are lying on your sides.

If your condition permits, the best way to avoid getting a pressure ulcer is to get out of your bed or chair for a short walk during the day.

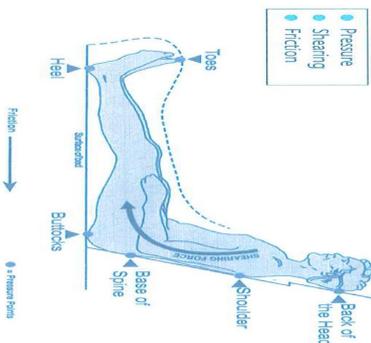
Diet and fluids

Poor diet and lack of fluids may affect your overall health – eat a well balanced diet and drink plenty of fluids.

Common sites for pressure ulcers



Main ways that pressure ulcers arise



As you may have observed, most pressure ulcers occur over a bony prominence.

Kind permission has been granted to use this diagram by the Tissue Viability Society.

Information for Patients/Carers

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Pressure Area Care



Patient Appointments/Cancellations

If you have an enquiry about an appointment or would like to cancel it, please call 01324 566249 or email: FAUJHB.RTT@nhs.net

If you can't go let us know!
Every month around 2,000 people across Forth Valley fail to turn up for hospital appointments. This costs the NHS millions of pounds each year and increases waiting times. So if you are unable to attend or no longer require your hospital appointment please let us know so we can offer it to someone else.

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Date/ Time:

Pressure Ulcer Risk Score

Name

CHI

DOB:

or attach label

SSKIN CARE BUNDLE

√ = care delivered R = REFUSED O = OFF WARD V = VARIANT (record in Evaluation Sheet)

Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly **Daily Weekly**

Record date here

Time – record using 24 hour clock

1. Surface – tick when checked

Mattress appropriate (please state)

Cushion appropriate (please state)

Functionality/integrity check of equipment performed

2. Skin Inspection – tick when checked or Y/N

All pressure areas checked

Redness present Y/N

3. Keep moving – tick when position patient is in when encouraged/assisted to move

B Right side

E Left side

D Back

CHAIR

4. Incontinence – tick when checked Have you completed an assessment (if required)

Urine

Bowels

5. Nutrition – tick when checked Have you completed an assessment (if required)

Diet (please state)

Fluids (please state)

Supplement(s) (please state)

Initials

References

Anton L (2005) Pressure ulcer prevention in older people who sit for long periods. *Nursing Older People* .(18) 4 ,p29-35

Barbanel J.C. (1990) Movement Studies during sleep cited in Bader D, (1990) *Pressure Sores – Clinical Practice and Scientific Approach* London McMillan Press Ltd

Bennett.AM. Report of the Task Force on the Implications for Darkly Pigmented Intact Skin in the Prediction and Prevention of Pressure Ulcers. *Advances in Wound Care: Special Report*. 1995; 8 (6): 34-35

[Best Practice Statement: Skincare of Patients Receiving Radiotherapy](#) NHS Quality Improvement Scotland (2004)

Best Practice Statement (2009) – Prevention and Management of Pressure Ulcers. NHS Health Improvement Scotland

Best Practice Statement (2013)-Eliminating pressure Ulcers , Wounds UK

Best Practice Statement (2018): maintaining skin integrity, Wounds UK

Best Practice Document (2018) ISTAP Best Practice Recommendations for the Prevention and Management of Skin Tears in Aged Skin

Birchall, L (1993) Making Sense of Pressure Sores Prediction Calculators *Nursing Times* May 5, Vol 89 No 18 pages 34 – 37

Bliss, M.R. (1988) Prevention and Management of Pressure Sores *Post Graduate Update* 36pp 2258 – 2268

Clark,M (2004) *Pressure Ulcers: Recent advances in Tissue Viability*

Cooper P (2011) Incontinence induced pressure ulcers ,*Nursing and residential care* .(4) 5 ,p216-221

Department of Health (1991) *The Health of the Nation A Consultative Document for Health in England* HMSO London.

Department of Health (1993) *Pressure Sores; A Key Quality Indication* HMSO London.

Department of Health (1998) *A First Class Service: Quality in the New NHS*. London: Department of Health.

Disabled Living Foundation 2001 *Handling People Pack* DLF London

Evans J ,Stephen-haynesJ (2007) Identification of superficial pressure ulcers. *Journal of wound care* 16(2) :54-6

www,.EPUAP .co.uk (2009)

Glamorgan (Adapted) Risk Assessment Tool (2009) NHS QIS, NATVNS (Scotland)

Hibbs, P.P (1988) *Pressure Area Care for the City of Hackney Health Authority* London, St Bartholomew's Hospital

Jaul, E (2010) Assessment and management of pressure ulcers in the elderly p311-325

Kosiak, M (1961) Etiology of decubitus ulcers *Archives Physical and Medical Rehabilitation* 42 pp 19 – 29

Lewis, T, Grant, R. (1925) observations upon reactive hyperaemia in man *Heart* 12 pp 73 – 120

Maklebust,J,Seiggreen M ,(2001) *Guidelines for the prevention and management of pressure ulcers* 3rd ed Pennsylvania

Morris C (2010) *Pressure Ulcers :Aetiology and identification .nursing and residential care .(12) 3 .p124-127*

National Institute for Health and Care Excellence. *Pressure ulcers: prevention and management of pressure ulcers*, CG179. 2014
Available from: <http://www.nice.org.uk/guidance/cg179>

www.nice.org.uk

NMC (2002) *Guidelines for records and record keeping*. Nursing & Midwifery Council London.

Prevention and Management of Pressure Ulcers(2017) NHS Education for Scotland

Reid J, Morison MJ 1994 Towards consensus, classification of pressure sores *Journal of Wound Care* 3 3 157-160

Stockton L, Parker L, (2002); Pressure relief behaviour and the prevention of pressure ulcers in wheelchair users in the community; *Journal of Tissue Viability*; 12;3; 84 - 99

Torrance C 1983 *Pressure sores, aetiology, treatment and prevention*. Croom Helm London

Waugh,A and Grant A (2006) Ross & Wilson, Anatomy and Physiology in Health and Illness. Churchill Livingstone.

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