Guideline on Pressure Ulcer Assessment Prevention and Management for Adults

Is this document a:

Policy [ ] Procedure [ ] Protocol [ ] Guideline [Yes]

Public Health Nursing Department
Laois/Offaly and Longford/Westmeath

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PART A: Outline of PPPG Steps

Title: Guideline on Pressure Ulcer Assessment, Prevention and Management

PRESSURE ULCER ASSESSMENT, PREVENTION AND MANAGEMENT ALGORITHM

ASSESSMENT

I. Detailed Nursing, Medical, psychosocial, and Environmental history (see section 2.3.1)

II. Clinical Risk Assessment (see section 2.3.2)

III. Skin Assessments (see section 2.3.3)

OUTCOME OF ASSESSMENT

Following your comprehensive assessment steps I. To III. above, patients found to be at risk of developing pressure ulcer or actively having a pressure ulcer, the nurse must complete an individualised written preventative/management core care plan (appendix 9) guided by the SSKIN bundle (appendix 14) and the patient should be referred to appropriate members of primary care team (MDT)

INTERVENTION

Using SSKIN Bundle

S- Surface: Assess all surfaces that client comes in contact with.

Ensure client is offered correct surface for their needs.

S- Skin Inspection: Early inspections mean early detection. Advise client & carers on inspection of skin integrity.

K- Keep moving: Encourage clients to keep mobile and to reposition when lying and sitting.

I- Incontinence/moisture:

Client's skin need to be kept clean and dry.

N-Nutrition/hydration: Encourage clients to have the correct dietary and fluid intake.

Pressure ulcer present - NO

No pressure ulcer but identified as been at risk of pressure ulcer development

Implement the preventative strategies in the SSKIN bundle. Implement core care plan on pressure ulcer prevention and management (appendix 9).

Observe on-going skin integrity and client's condition and continually re-assess, evaluate and implement changes to care plans as appropriate.

Provide pressure ulcer client information booklet to all clients and carers.

Document all interventions both verbal and written with client, family and carers and other healthcare professionals.

Reassess changes in client's condition, using SSKIN bundle and update care plans to reflect necessary interventions.

Pressure ulcer present - YES

Upon discovery of a pressure ulcer, PHN/CRGN to Report to ADPHN and TVN & complete NIRF form within 24 hours for all stage pressure ulcers and forward to ADPHN.

The TVN will provide a joint visit to all clients with stage 3 and 4 pressure ulcer to provide advice in relation to staging and on-going management. **Stage 3 or 4 Pressure Ulcers are classified as Serious Reportable Events (SREs) and must be identified on NIMS as SREs with follow up decision-making review by ADPHN with completion of the preliminary assessment form (appendix 24) and review report (appendix 26) to be completed by the line manager as per the HSE's 2018 Pressure Ulcers: A Practical Guide for Review Document.**

Implement the SSKIN strategies in relation to management of the pressure ulcer and prevention of further deterioration of existing pressure ulcer or development of new pressure ulcers and involvement of Primary Care Team as appropriate. Implement core care plan on pressure ulcer prevention and management (appendix 9).

Refer to wound management policy in relation to management of pressure ulcer.

Adhere to open disclosure policy 2017 with client and family at all times.

Provide pressure ulcer client information booklet to all clients and carers.

Document all interventions both verbal and written with client, family and carers and other healthcare professionals.

Ensure that all information relating to existing pressure ulcers is communicated upon admission to acute setting /respite via the following methods: (transfer letter to be completed for all admissions to respite (appendix 20)/ social report to be completed for all admissions to the acute

PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

This document aims to guide best practice in the promotion of healthy skin integrity and the prevention and management of pressure ulcers by:

- Providing nurses with guidance on the early identification of patients at risk of pressure ulcer development.
- The provision of preventative interventions.
- Providing guidance for all nurses in the Public Health Nursing Service, Laois/Offaly and Longford/Westmeath in the assessment, prevention and management of pressure ulcers.
- Informing and standardising evidence based practice.

1.2 Scope

This Guideline applies to all nurses in the Public Health Nursing Service in Laois/Offaly and Longford/Westmeath involved in the assessment, prevention and management of pressure ulcers and to all patients in receipt of a Public Health Nursing Service.

1.3 Objective(s):

All Public Health Nursing staff will adhere to evidence based practice in the early identification, prevention, reporting and management of Pressure Ulcers in the community setting.

1.4 Outcome(s)

To prevent the occurrence of pressure ulceration and ensure provision of timely, safe, patient centred care to all patients within the Public Health Nursing service in Laois/Offaly and Longford/Westmeath in line with best practice standards.

1.5 PPPG Development Group:

Tissue Viability Working Group (See Appendix 16)

1.6 PPPG Governance Group:

Directors of Public Health Nursing in Laois/Offaly and Longford/Westmeath (See Appendix 17).

1.7 Supporting Evidence: Legislation and other related Policies:

- Nursing and Midwifery Board of Ireland (2014) The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.
- Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework.
- Nursing and Midwifery Board of Ireland (2015), Recording Clinical Practice Professional Guidance to Nurses and Midwives.
- Health Service Executive (2017), Quality and Risk Management Policy
- HSE National Wound Management Guidelines (2018) Office of Nursing and Midwifery Services Director.

- Health Service Executive (2017) HSE Integrated Risk Management Policy.
- Available online from:https://www.hse.ie/eng/about/qavd/riskmanagement/risk-managementdocumentation/hse%20integrated%20risk%20management%
- 20polcy%202017.html
- Health Service Executive (2018) Incident Management Framework
- Availableonlineat:https://www.hse.ie/eng/about/qavd/incidentmanagement/hse-2018-incident-management-framework-guidancestories.pdf
- HSE (2018) Pressure Ulcers a Practical Guide for Review https://www.hse.ie/eng/about/qavd/incident-management/pressure-ulcers-a-practical-guide-for-review.pdf
- Health Information and Quality Authority (2012) National Standards for Safer Better Healthcare. Cork: HIQA. Available online from:http://www.hiqa.ie/standards/health/safer-better-healthcare
- Government of Ireland (2018) Data Protection Act. Dublin: Government Publications. Available online http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html
- Government of Ireland (2014) Freedom of Information Act. Dublin: Government Publications
- Health Service Executive (2019) National Consent Policy. Quality and Patient Safety Division. Available online at:https://www.hse.ie/eng/about/who/qid/other-quality-improvementprogrammes/consent/national-consent-policy-hse-v1-3-june-2019.pdf
- Health Service Executive (2019) Open Disclosure Policy: Communicating with Patients Following Patient Safety Incidents. Available online fromhttps://www.hse.ie/eng/about/who/qid/other-quality-improvementprogrammes/opendisclosure/hse-open-disclosure-full-policy-2019.pdf
- Wound Management Guideline Laois/Offaly, Longford/Westmeath reference PHN 021 (available via the Intranet)
- The Management of Referrals to the Tissue Viability Nursing Service in Longford/ Westmeath and Laois/Offaly .PHN 002
- HSE (2019) Infection Prevention and Control Guidelines
- Interim Guideline on Infection Prevention and Control Practice for the Public Health Nursing Service during Covid-19 reference number PHN055
- HSE (2019) Guideline on Best Practice in Care Planning, Nursing Documentation and Use of Abbreviations in the Public Health Nursing Service in Laois/Offaly & Longford/Westmeath (PHN 014)

1.8 Glossary of Terms

Avoidable Pressure Ulcers	When a pressure ulcer develops as a result of not doing one or more of the following; • Evaluate the patient's clinical condition and pressure ulcer risk factors. • Define and implement interventions that are consistent with patient's needs, goals and recognised best practice. • Monitor and evaluate the impact of the interventions and review the interventions as appropriate. (HSE 2018).
Bottom out	Expression used to describe inadequate support from a mattress or seat cushion as determined by a hand check. If, when a fist is pressed into the surface of a mattress or seat cushion the supporting base can be felt the item is said to have 'bottomed out' and is no longer able to provide pressure relief.
Blanchable Erythema	Reddened area on the skin that temporarily turns white or pale when pressure is applied with the fingertip. It is usually due to a normal reactive hyperaemia.
Clinical Judgement	Clinical judgement is the conclusion or enlightened opinion at which a nurse arrives following a process of observation, reflection and analysis of observable or available information or data (Phaneuf, 2008).
Concordance	the state of there being agreement or similarity between things
Denudation	A term used to describe losing the outside layer of skin, the epithelium.
Full Replacement alternating pressure device	A dynamic therapy pressure mattress powered by pumps using air flow to reduce pressure at the interface between patients and surface, Sidel 2018.
FROP – Falls Risk	The FROP is a falls risk assessment tool for the elderly.
Friction	The resistance to motion in a parallel direction relative to the common boundary of two surfaces, e.g., when skin is dragged across a coarse surface, such as bed linen, HSE 2018.
Hyperaemia	The presence of excess blood in the vessels supplying part of the body.
Malnutrition	The lack of proper nutrition; inadequate or unbalanced nutrition, not getting enough calories, protein, or micro nutrients.

(**MMSE**) The Mini–Mental State Examination	A questionnaire that is used extensively in clinical and research settings to measure cognitive impairment. It is commonly used in medicine and allied health to screen for dementia.
MUST –Malnutrition Universal Screening Tool	Nationally recognised and validated screening tool to identify adults who are malnourished or at risk of malnutrition.
Nurse	A person registered in the Live Register of Nurses and includes a Midwife, (NMBI 2015).
Non-powered pressure redistribution support surface	Any support surface not requiring or using external sources of energy for operation, (HSE 2018).
Pressure	Pressure is a perpendicular load or force exerted on a unit of area. This is the major cause of pressure ulcer formation over a bony prominence or pressure area. Several factors play a role in determining whether pressure is enough to create an ulcer. The pathological effect of excessive pressure on soft tissue can be attributed to: • Intensity of pressure • Duration of pressure • Tissue tolerance (NPUAP-EPUAP 2014)
Pressure-reducing/-relieving	Any measure that reduces or relieves the normal force per unit of skin surface areas.
Pressure Ulcer:	A localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or compounding factors are also associated with pressure ulcers: the significance of these factors is yet to be elucidated. (NPUAP-EPUAP 2014)
Risk assessment	Is the combined effort of identifying and analyzing potential events that may negatively impact individuals health and well-being, (HSE 2012)
Reposition	To place something in a different position or to adjust or alter position.
Shear	Trauma caused by tissue layers sliding against each other; results in disruption or angulation of blood vessels.
SSKIN Care Bundle	A tool which defines and ties best practices together. The bundle also makes the actual

	process of preventing pressure ulcers visible to all. This minimizes variation in care practices. The five step process for pressure ulcer prevention include the following elements: **S-** Surface: make sure the patient is on the right surface S-Skin inspection: early inspection means early detection. Show patients and carers what to look for. K- Keep patients moving. Encourage mobility and repositioning I-Incontinence/moisture: your patients need to be clean and dry. N- Nutrition/hydration: help patient have the right diet and adequate fluids(NQIP2014)
Unavoidable Pressure ulcer:	Unavoidable" means that the patient receiving the care developed a pressure ulcer even though the provider of care had: • Evaluated the patient's clinical condition and pressure ulcer risk factors. • Planned and implemented interventions that are consistent with the patient's needs and goals, and recognised standards of practice. • Monitored and evaluated the impact of the interventions. • Reviewed the interventions as appropriate. • Or the individual patient refused to adhere to prevention strategies in spite of education of the consequences of non-adherence. (WOCNS, 2009)
Waterlow risk assessment scale	A risk assessment tool used to estimate the risk of pressure ulcer development in a given patient
30° Tilt	The 30- degree tilt is a patient repositioning technique, which can be achieved by rolling the patient 30-degrees to a slightly tilted position, with pillow support at the back. See appendix 6

2.0 DEVELOPMENT OF PPPG

The document focuses on pressure ulcer assessment, management and prevention. The evidence relating to pressure ulcer management and prevention was collected, collated and critically appraised and used to update the exiting Guidelines on pressure ulcer assessment, prevention and management PHN026.

We wish to acknowledge the Public Health Nursing Department Mayo, Galway and Roscommon Community Healthcare West for sharing their draft policy.

2.1 Summary of the Evidence/Literature Search Strategy

The findings of this review should be viewed alongside the following limitations. The possibility that the search did not identify all relevant clinical evidence cannot be excluded and inclusion of evidence only in the English language may have introduced a degree of bias as a consequence of the exclusion of evidence from different cultural contexts.

There is general evidence in the literature (See Literature Search Appendix 1) that appropriate pressure ulcer assessment, prevention and management is associated with significant cost savings both financially and for the patient's quality of life. However, prevention methods encompass a wide range of interventions, the efficacy and cost of some of which are dependent on the characteristics of the patient population and of the facilities and resources available.

Pressure ulcer assessment, prevention and management are a significant quality issue for patients.

The Guideline Review Group took into consideration the available evidence, expert opinion (national and international), economic considerations and potential benefits for the patients in identifying the recommendations including the educational recommendations when developing the pressure ulcer assessment, prevention and management guideline.

The guideline development group highlighted that these recommendations should be used in conjunctions with nurses clinical judgement and experience. A multidisciplinary approach and/or referral to another specialist should be considered.

2.2 Resources Necessary to Implement this Guideline

A budget impact analysis was not undertaken however the resources required to implement the guideline recommendations have been considered. This guideline provides clear guidance for the assessment and treatment of pressure ulcers.

Patients with pressure ulcers, that are not healing, are at increased risk of morbidity and mortality if not managed appropriately.

Adequate staffing is a critical requirement to ensure that all measures are adhered in the assessment, prevention and management of pressure ulcers. The main costs associated with the implementation of this guideline are the costs required for structured education and updates for all Public Health Nursing Staff working in Laois/Offaly and Longford/Westmeath. Additional cost may be incurred in the printing and lamination of algorithms and patient information booklets for health centres.

2.3 Outline of PPPG Steps/Recommendations for Pressure Ulcer Assessment, Intervention and Prevention

2.3.1. Assessment:

A comprehensive assessment will be undertaken on the patient that reflects the intrinsic and extrinsic risk factors (appendix 3) that have the potential to impact on pressure ulcer formation, prevention and management (HSE, 2018).

On identification of a risk for pressure ulcer development, a pressure ulcer risk assessment, utilising the Waterlow score, must be completed on the first community home visit.

The registered nurse using clinical judgement must repeat the Waterlow where deterioration in a patient's condition is evident and post hospital discharge.

The comprehensive assessment includes:

- Detailed nursing, medical, psychosocial and environmental history as per client care record (master file)
- Clinical Risk Assessment
- Skin Assessment

2.3.2 Clinical Risk Assessment:

The following tools are required to complete the clinical risk assessment;

Tool	Comments
Waterlow Score	To assess risk of a patient developing a pressure ulcer.
FROP	To assess the risk of the patient falling
MMSE	To assess the cognitive ability of the patient
Pain Scale	To assess patient pain status
MUST	Nutritional assessment tool
Level 1 Continence Assessment	To assess continence status.
Barthel score	To measure performance in activities of daily living.

All information obtained from the comprehensive assessment will serve as a basis to identify measures that will alleviate, reduce or minimise the negative effects of identified factors.
PHN's/CRGN'S will document all findings and develop and implement a care plan for patients identified as being at risk of developing pressure ulcers.

2.3.3. Skin Assessments:

2.3.3.1 Skin inspection should be carried out with patients consent at the first visit as part of the assessment and documented in the clinical record (National Consent

Policy, 2017). If consent for this assessment is refused, this needs to be clearly documented in the patient's records (NMBI, 2015).

When the patient verbally consents to skin inspection, the PHN/CRGN must carry out a full skin inspection, with particular attention to the bony prominences as follows: (Appendix 5).

- Heels, sacrum, elbows, temporal region of skull, shoulders, back of head, ears and toes.
- Femoral trochanters (hip); ischial tuberosities;
- Parts of the body affected by anti-embolic or compression hosiery.
- Parts of the body where pressure, friction or sheer is exerted in the course of the individuals daily living activities;
- Parts of the body where there are external forces exerted by equipment and/or clothing.
- Other areas should be inspected as necessitated by the patient's condition.

(NICE,2003).

The frequency of skin inspection is based on the clinical judgement of the nurse and the patient's presentation/any deterioration in the patient's condition.

2.3.3.2 Previous pressure damage should be recorded if noted on inspection or reported by patient and carer as these areas are more at risk for subsequent pressure damage.

2.3.3.3 Identify and record the condition of the skin: dryness, cracking, broken, erythema, maceration, fragility, heat and induration.

2.3.3.4 Where there is a pressure ulcer present, a wound management care plan should be commenced, refer to national wound management policy and local policy (HSE National Wound Management 2018, PHN021).

2.3.3.5 The nurse should assess for the following signs which may indicate pressure ulcer development:

- persistent erythema;
- non blanching hyperaemia previously identified as non-blanching erythema,
    - Blisters.
    - discolouration,
    - localised heat, localised oedema and localised indurations
- localised pain See (appendix 4) for pain scale.

2.3.3.6 To identify non-blanching erythema, use the finger pressure method to assess whether skin is blanchable or non-blanchable :

- Finger pressure method — a finger is pressed on the erythema for three seconds and blanching is assessed following removal of the finger.

2.3.3.7 In those with darkly pigmented skin, the nurse should be aware of the following signs which may indicate pressure ulcer development

- purplish/bluish localised areas of skin;
- Localised oedema and localised induration.
- Localised pain.

2.3.3.8 The HSE Classification System 2018 should be used to stage all pressure ulcers (Appendix 2).

2.3.3.9 Patients, carers/HCA and families must be instructed on how to undertake skin assessment in line with their care plan and recognise the early signs of tissue damage. Skin inspection, should be part of the patients routine personal care.

2.3.3.10 The nurse should request the carer/ HCA or those delegated with responsibility for care to report any skin changes to the nurse.

2.3.3.11 Patients who are willing and able should be encouraged following education to inspect their own skin and report any changes to the nurse.

2.4 Intervention

Following your comprehensive assessment steps I. to III. as per algorithm, patients found to be at risk of developing pressure ulcer or actively having a pressure ulcer, the nurse must complete an individualised written preventative/management core care plan (appendix 9) guided by the SSKIN bundle (appendix 14) and the patient should be referred to appropriate members of primary care team (MDT).

The SSKIN Care Bundle

The SSKIN Care Bundle tool defines and encompasses best practices (appendix 14). The bundle is an actual process for preventing pressure ulcers which minimizes variation in care practices. The five step process for pressure ulcer prevention includes the following elements:

S: Surface: make sure the patient is on the right surface

S: Skin inspection: early inspection means early detection. Show patients and carers what to look for.

K: Keep moving: encourage patient to keep mobile and to reposition when lying and sitting.

I: Incontinence/moisture: Patient's skin needs to be kept clean & dry.

N: Nutrition/hydration: encourage patient to have the correct dietary and fluid intake, (NQIP2014).

S- Surface

1. The nurse will order the appropriate pressure relieving device for each patient based on the outcome of the clinical risk and skin assessment. A flow chart and

description to aid decision making of the available mattress and cushion type is available, see appendix 8 & 10.

2. These devices should be requested and used when assessed as required. The nurse must refer to the Mattress Selection Guide (Appendix 8) in order to ascertain which mattress will be most appropriate taking all other factors into account.
3. If a client requires a high-specification pressure relieving mattress the PHN/RGN must contact the Tissue Viability Nurse in order to discuss mattress selection and plan of care. A home visit by the TVN may be required.
4. The process to be followed when ordering or cancelling pressure relieving equipment is directed by the process flow diagram (Appendix 12 & 13).
5. Support surface and positioning needs should be assessed and reviewed regularly and determined by the results of skin inspection, patient comfort, mobility and general medical condition.

6. If there is any change in the patient's condition, improvement or deterioration, review of equipment needs to occur.

5. Repositioning should always occur when patients are on pressure relieving devices.

6. Avoid plastic draw sheets, incontinence sheets and tightly tucked in sheet/sheet covers, especially when using specialist bed and mattress overlay systems, as they increase pressure, especially on the feet.

7. Name of device and date device acquired should be documented in patients chart and the patient/carer is educated and demonstrated on the correct use and maintenance of this equipment.

8. The patient/carer responsible for care should contact the 24 hour helpline (sticker to be found on mattress pump) if they are aware or suspect any leaks or damage in the mattress.

9. Use pillows, foam wedges or bean bags to keep bony prominences from direct contact with each other (e.g. knees and ankles) and/or refer to Occupational Therapist for assessment.

10. The following devices should not be used as pressure relieving aids

- Water filled gloves
- Sheep skins
- Ring cushions
- Pillows as chair cushion

11. Patients, carers/HCA and families should be instructed on the process of inspecting skin integrity for damage due to medical devices.

12. Positioning of clients who spend substantial periods of time in a chair or wheelchair should take into account distribution of weight, postural alignment and support of feet.

- Seating assessment for aids and appliances for people with postural defects or functional impairments should be carried out by trained assessors, e.g. occupational therapists.

- If sitting in a chair is necessary for individuals with pressure ulcers on the Ischia, coccyx or sacrum, limit sitting to three times a day in periods of 60 minutes or less.

13. **Cushion selection**

The PHN/CRGN may provide a static pressure relieving cushion to clients at risk of pressure ulcer development (Appendix 10) using the following criteria;

- Patients who do not have active pressure ulceration but are sitting for long periods due to reduced mobility.
- Upon identification of pressure damage the PHN/CRGN will provide a static pressure relieving cushion.
- If no improvement of skin integrity post provision of the pressure relieving cushion and education of patient/carers on pressure relief, then the CRGN/PHN must refer the patient to OT for assessment.

S- SKIN

1. For all patients identified as been at risk of skin damage, or using pressure relieving equipment, frequent skin inspection needs to occur based on the nurse's clinical judgement and patient need.
2. The skin should be kept clean and free from all potentially irritating substances or those that substantially alters the skin ph. The use of emollients is recommended. Treat dry or flaky skin with a topical moisturiser.
3. Soap should be avoided where possible. Emollients can be added to water.
4. Water should be warm, not hot.
5. After cleansing of the skin, a non-perfumed PH neutral moisturiser or barrier cream should be used. This cream should be applied by stroking movement in the direction of the hair growth (Penzer & Finch, 2001).
6. Avoid excessive rubbing / massaging over bony prominences as this does not prevent tissue damage and may cause additional damage (HSE 2018).

K- Keep Moving: Mobility/Positioning/ repositioning

1. Patients who are at risk of pressure ulcer development or on pressure relieving devices and who are unable to reposition independently, require repositioning at a frequency that may be determined by considering the following factors;
    - Level of activity and mobility
    - General medical condition
    - Overall treatment objectives

- Skin condition
- Tissue tolerance
- Comfort

(NPUAP/EPUAP, 2014).

2. Unless contraindicated by an unstable fracture or an unstable joint, the patient should be repositioned using a 30 degree tilt (Appendix 6).

3. Positioning of individuals who spend substantial periods of time in a chair or wheelchair should take into account distribution of weight, postural alignment and support of feet.

4. Repositioning of patients should ensure that;

- prolonged pressure on bony prominences is minimised
- bony prominences are kept from direct contact with one another
- Friction and sheer damage is minimised.
- Time in prone position should be limited if possible.

5. Prevention/ Management of Pressure Ulceration to Heels

- Ensure that heels are free of the surface of the bed. The knee should be kept in slight flexion
- Use a pillow positioned lengthways under the calves to elevate the heels (floating heels)
- Advice and education will be given to the client/carer re inspection the skin of the heels at regular intervals.
- Management of Stage 1 and 2 pressure ulcers includes floating the heels off of the bed surface using either pillow or heel suspension device.
- Management of stage 3,4 and depth unknown pressure ulcers, in liaison with the TVN, includes placing the leg in a device that elevates the heel from the surface of the bed, completely off-loading the ulcer
- Stable, intact eschar on heels should not be debrided. The eschar acts as a natural barrier to infection by preventing the bacteria from entering the wound.
- Check heels daily for “bogginess” around the eschar, edema, redness, drainage or overt signs of infection which would require a change of treatment in consultation with TVN.

6. The management of a patient in a sitting position is important. While appropriate pressure relieving devices are in place, it may be necessary to advise patient/carers /HCA to restrict the sitting time to less than 2 hours.

7. The nurse may identify a need for manual handling devices to assist with transfers

and repositioning of patients, this should involve Occupational therapy and physiotherapy assessment, an MDT approach.

8. Manual handling devices should be used correctly as per manufacturer's instructions and such equipment should be removed from underneath the patient when the task has been completed, in order to minimise shear and friction damage.

9. The nurse should identify their learning needs in relation to using this equipment to their line manager and appropriate training should be provided for the nurse.

10. Patients/carers/HCA should be taught how to distribute weight and reposition. Re-positioning chart (see Appendix 7) is available and can be incorporated into individual patient care plan as appropriate.

- By using the 30% tilt (Appendix 6).
- Avoid postures that increases pressure, such as the Fowler's over 30 degree or 90 degree side lying or the semi-recumbent position.
- If sitting in bed avoid elevation of head of bed or slouched position that places pressure and shear on the sacrum and coccyx (HSE 2018).

11. Patients will be referred to physiotherapy services for a mobility assessment if necessary.

I – Incontinence: moisture and Incontinence associated dermatitis

1. All nurses should identify and document the source of moisture – perspiration, wound exudate, urinary or faecal ostomy effluent, urine and/or faeces.

2. All nurses should be aware of the duration of exposure, volume and consistency of the moisture source.

3. Nurses should document skin reaction to moisture sources and associated factors – inflammation, erythema, maceration, denudation, erosion, and signs of infection.

4. All patients should have a continence assessment performed if incontinence is a contributing factor to breakdown in skin integrity.

5. Nurses should identify skin care products, continence containment products, dressing and stoma care products in use at the time of assessment.

6. Excess moisture due to incontinence, should be eliminated where possible and interventions put in place to protect the skin.

7. Gentle cleansing with a product with a balanced pH, and use of a skin protectant following each major incontinence episode or skin protectant that does not require application after every incontinence episode.

8. Impervious plastic draw sheets and mattress covers should be avoided as these causes the build-up of perspiration on the skin.

9. A care plan for the skin care regime and regular changing of continence products should be complied, implemented and education given to patient and carers,

10. If continence is interrupting the healing of a pressure ulcer, urinary catheterisation may need to be considered.

N- Nutrition

1. The Nurse will include nutritional assessment as an essential component in the assessment, prevention and management of pressure ulcers, the MUST tool must be completed as per local policy requirements.

2. Other nursing observation should include.

- Unintentional weight loss
- Obvious thin /wasted appearance (loss of muscle mass/subcutaneous fat)
- Poor appetite/disinterest in food/decreased food intake (Insufficient energy intake).
- Altered taste/smell
- Change in food preference/avoiding certain foods e.g. meat
- Poor skin integrity/pressure sores/ localised or generalised fluid accumulation

3. Nutritional screening should be repeated for patients with or at risk of pressure ulcers when there is a clinical concern or deterioration in condition.

4. The fluid intake of a person with wounds should be closely monitored. Adjustments should be made as necessary based on the patient's condition and fluid loss through exudate.

5. Refer to Dietetics as appropriate.

2.4.1 Reporting of pressure ulcers

It is the responsibility of the CRGN/PHN to complete a National Incident Report Form (NIRF) (based on the most up to date NIRF) to report any of the following circumstances to their line manager within 24 hours of discovery;

a. Any newly acquired pressure ulcer/s regardless of stage.

b. Stage 1 pressure ulcers, which are considered as persistent non-blanching erythema that does not resolve within 24 hours.

c. Existing pressure ulcers which progress/ deteriorate to a stage 3 or 4 pressure ulcer.

d. Non-blanchable redness and purple /maroon discolouration of intact skin combined with a history of prolonged unrelieved pressure/ shear.

It is estimated that it could take 3-10 days from the initial insult causing the damage, to become a stage 3 or 4 pressure ulcer. In such circumstances , when completing section G of the NIRF(Person), in the section "musculoskeletal/soft-tissue", select 'other' and enter 'non-blanchable redness and purple/maroon discolouration of intact skin'.

e. When the pressure ulcer is stageable a further NIRF form should be completed denoting the stage of the pressure ulcer.

f. If during the period from initial insult to the staging of the pressure ulcer, the client

is moved from community service, i.e. respite, long-term care, acute admission, the need for completion of the incident report for the pressure ulcer should form part of the handover of care.

g. There is no requirement to report pressure ulcers which are present at the time of first contact in the community post discharge from a facility, rather these should be noted in the client record of the service user and their care plan should reflect any actions required to prevent further deterioration. This is because there is an expectation that this has already been reported by the service in which the client was previously being cared for.

h. The PHN/CRGN who identifies the pressure ulcer is responsible for;

- Notifying the ADPHN and ANP/TVN immediately
- Completing the NIRF within 24 hours of detection of pressure ulcer/s

i. Stage 3 and Stage 4 pressure ulcers if acquired since admission to the community service are classified as Serious Reportable Events (SRE's) and must be identified on the NIRF as SRE. Decision making in relation to the review of Pressure Ulcer Incidents is based on the categorisation of the incident, which requires a graduated and proportional level of review (i.e. Comprehensive, Concise and Aggregate) and should be considered in line with the HSE Incident Management Framework (2018). Thus, the incident category applied to the pressure ulcer will lead the appropriate review process to follow. The Preliminary Assessment to Assist Review Decision Making (Part A) form (Appendix 3 of the HSE's 2018 practical guide to pressure Ulcers); appendix 24 within this guideline is to be completed by the line manager and forwarded to the QPS Advisor. The outcome of this assessment will lead to the appropriate decision to complete either a comprehensive or concise review (via an established decision meeting). Pending outcome of this meeting, the Preliminary Assessment to Assist Review Decision Making (Part B) form (Appendix 3 of the HSE's 2018 practical guide to pressure Ulcers); appendix 25 within this guideline is to be completed by the line manager. Subsequently, the pressure ulcer review report template report (appendix 26) will then be completed by the line manager (ADPHN/CNM) as per the HSE's 2018 Pressure Ulcers: A Practical Guide for Review Document in discussion with the QPS advisor.

j. Ensure open disclosure to patient and family is adhered to at all times.

Assessment and Categorisation of the Incident

The purpose of assessing and categorising an incident is to determine the level and approach of review that is required. Categorisation is based on the level of harm sustained as a consequence of the pressure ulcer. The level and approach of review must be proportionate to the harm sustained as a result of a Pressure Ulcer.

Based on the outcome of this assessment pressure ulcer incidents are categorised as follows;

Category 1 Incident Major/Extreme - Pressure Ulcers of any grade which are o associated with septicaemia resulting in death; or resulting in permanent disability such as an amputation.

Category 2 Incident Moderate - Stage III & IV Pressure Ulcers not associated with septicaemia resulting in death; or not resulting in a permanent disability. These incidents are also classified as Serious Reportable Events (SREs) if acquired since admission to the service.

Category 3 Incident Minor/Negligible - Stage I & II Pressure Ulcers

(Pressure Ulcers: A practical guide for review, HSE 2018).

A proportionate and responsive review of all stages of pressure ulcers when identified can assist in detecting factors that caused and contributed to the development of the pressure ulcer. Such information can then be used to implement improvement initiatives that could prevent subsequent tissue damage to the individual and prevent other service users in developing a pressure ulcer. It also gives assurance that appropriate governance structures and processes are in place, as required by the HSE Incident Management Framework (2018). Decision making in relation to the review of Pressure Ulcer Incidents should be completed in line with the Pressure Ulcers: A practical guide for review, HSE 2018 - page 12.

2.4.2 Documentation

1. Patients found to be at risk of developing pressure ulcer and those with existing pressure ulcer/s should have an individualised care plan/core care plan on pressure ulcer prevention and management completed as per PPG (PHN014) and guided by the SSKIN bundle template (appendix 9) and the SSKIN Bundle Pressure Ulcer Prevention Strategy Chart (appendix 23).
    - The SSKIN Bundle Pressure Ulcer Prevention Strategy Chart must be completed on initial assessment of a patient where they have been identified at risk of a pressure ulcer or actively have a pressure ulcer.
    - The SSKIN Bundle Pressure Ulcer Prevention Strategy Chart must be repeated using clinical judgement where there is any evidence of deterioration in the patients' condition and following discharge from hospital
2. The appropriate preventative measures must be documented, dated and timed in the patient's care plan as per NMBI guidelines Recording Clinical Practice Guidance to Nurses and Midwives (NMBI 2015).
3. The appropriate intervention according to the care plan must be documented, dated and timed at each visit/contact as per NMBI guidelines Recording Clinical Practice Guidance to Nurses and Midwives (NMBI 2015).
4. Skin changes should be documented immediately in the patient's progress notes.
5. All instruction and advice both verbal and written in relation to management and prevention of pressure ulcer should be given to carers, family member, home help, HCA (both HSE and agency) should be documented in the patient's notes.
6. If the client has an active pressure ulcer, the wound management core care plan and relevant documentation must also be initiated as per policy number PHN021.

2.4.3 Re-assessment/ On-going Review and Evaluation

1. The frequency of re-assessment for patients at risk of pressure ulcer development/re-assessment of existing pressure ulcers should be guided by the nurse's clinical judgement of the nurse and the patient's presentation and any deterioration in the patient's condition.

2. Include a comprehensive skin assessment as part of nursing intervention to evaluate any alterations to skin. SSKIN bundle should be used for this assessment and incorporated into the patient care plans.

3. Any improvement or deterioration of the patient's condition should be reflected in the care plan based on this re-assessment.

2.4.4 Continuing care.

Ensure that all information relating to existing pressure ulcers is communicated upon admission to acute setting /respite facility via the following methods: (transfer letter to be completed for all admissions to respite (appendix 21)/ social report to be completed for all admissions to the acute sent via PHN service liaison nurse .

2.4.5 Education

Patients and carers will be educated by the nurse on the prevention of pressure ulcers and the care of the patient should a pressure ulcer develop.
Patient/ family or carers are advised by the nurse to inform them of any changes in skin or patient condition immediately.

The following written information booklet should be provided:

Preventing and Treating Pressure Ulcers: Information for Patients, Families and Carers (Appendix 15).

2.4.6 Promoting patient concordance

The PHN/CRGN should:

- Provide full explanations of pressure ulcer preventive care to the patients and carers. This must be supported with the patient information booklet and plan of care as above in 2.4.5
- Assess patient's mental capacity/decision making ability in relation to pressure ulcer prevention where non-concordance is an issue using the MMSE score and with altered MMSE consider onward referral to specialist service where appropriate; example GP, psychiatry of later life (POLL).
- For patients who do not have capacity, preventative care must be delivered in their best interests (HSE,2019)).
- Discuss and record reasons why patients/carers are declining pressure redistributing equipment and are not able to follow the plan of care.
- If the Client chooses not to adhere to the recommended plan of care following discussion and both verbal and written education of the risk factors, the PHN/RGN is required to carry out a risk assessment as per HSE Integrated Risk Management Policy (HSE, 2017) and refer to Tissue viability Nurse . Examples of situations of non-concordance would include;
    - Refusal of recommended equipment required to prevent or treat pressure ulcers
    - Inappropriate use of provided equipment despite written and

verbal education

- Refusal of client or carer to follow through with a plan of care despite verbal and written education
- Refusal of client to allow carers to provide care which would benefit the clients' well-being.

3.0 GOVERNANCE AND APPROVAL

3.1 Outline Formal Governance Arrangements

The governance group for Laois/Offaly and Longford/Westmeath PHN service is the Directors of Nursing for Public Health.(See Appendix 13).

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

This guideline was developed in line with the National PPPG'S Framework for the development of PPPG'S

3.3 Attach any copyright/permission sought.

NIL

4.0 COMMUNICATION AND DISSEMINATION

4.1 Describe communication and dissemination plans:

All relevant staff is emailed by the DPHN informing them that the guideline is available on the policy portal system. Education will be carried out in each sector with appropriate resources available.

5.0 IMPLEMENTATION

5.1 Describe implementation plan listing actions, barriers and facilitators and timelines

This will be for implementation immediately with planned education in each region delivered by TVN in conjunction with area Assistant Directors of Public Health Nursing.

5.2 Describe education/training plans required to implement the PPPG:

Education will be carried out in the use of the guideline. The National Wound Management Guideline (2018) will be a used as a resource.

5.3 Identify lead person(s) responsible for the implementation of the PPPG.

This guideline will be signed off by the governance group as agreed and it will be the responsibility of each member of nursing staff employed in the Laois/Offaly and Longford/Westmeath PHN service to implement this in practice with the support of the Tissue Viability Nurses in each region.

5.4 Outline specific roles and responsibilities.

Director of Public Health Nursing (DPHN)

- Disseminates this guideline electronically to all nurses working in Laois/Offaly and Longford/Westmeath Public Health Nursing Services.
- Makes arrangements for audit of this guideline.
- Makes arrangements for review and updating of this guideline in accordance with the recommended review date or sooner if evidences warrant this.
- Identifies on-going educational opportunities for staff to enhance their knowledge and skills in this area.
- Seeks through the HSE to have the resources made available to facilitate the provision of care that reflects best practice.

Assistant Director of Public Health Nursing (ADPHN):

- Ensures that each registered nurse has access to this guideline and completes regular audits of staff adherence and compliance.
- Inform staff of the availability of education and training with regards pressure ulcer assessment and prevention and arranges training in conjunction with the TVN as required.
- Identifies educational needs of staff and ensures these are achieved.
- Follows managerial responsibilities in respect of all aspects of this guideline.

` **Advanced Nurse Practitioner (ANP)/Tissue Viability Nurse (TVN):**

- Working with the Director of Public Health Nursing, Assistant Directors of Public Health Nursing and Practice Development Co-Ordinator, advising and assisting in the implementation of systems and process to provide high quality standardised pressure ulcer prevention and management services.
- Providing clinical leadership by advising and assisting with the assessment, planning and evaluation of care on prevention and treatment of pressure ulcers.
- Providing advice and education on pressure ulcer risk assessment, pressure relieving/reducing supports and correct implementation of prevention and management of individual patients.
- Clinical audit will be carried out by the TVN with support of sector ADPHN
- The TVN will monitor incidence and prevalence of pressure ulcers in the community.
- Provide clinical support to staff on pressure ulcer prevention/management.

The PHN/CRGN

- Is accountable for his/her practice under the scope of practice framework and must ensure he/she reads the guideline and signs the confirmation form (appendix 22).
- Adheres to these guidelines on pressure ulcer assessment, management and prevention in the community.
- Develops and maintains competence with regard to all aspects of pressure ulcer assessment and prevention and management ensuring that their knowledge, skills and practice are up to date.
- Acknowledges any limitation in competence, identifies his/her learning needs and discusses ways in which these needs will be met with his/her line manager.

6.0 MONITORING, AUDIT AND EVALUATION

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

The audit and monitoring of this guideline will be carried out by the ANP/TVNs in post with the support of the ADPHN for the sector.

7.0 REVISION/UPDATE

7.1 Describe procedure for the update of the PPPG:

This guideline will be up-dated three yearly or sooner if new evidence is released.

7.2 Identify method for amending PPPG if new evidence emerges.

The working group will reconvene and analyse new evidence available and review PPPG accordingly within the 3 year cycle.

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APPENDICES

Appendix 1: Search Strategy Development

Name	Subject Coverage
Core	
Cochrane Library Cochrane Reviews Other reviews Trials	Intervention & diagnostic reviews Critically appraised and re-structured abstracts Register of clinical trials
Medline	Three different versions: PubMed, OVID Medline & EBSCO Medline
Embase	European studies, and conference abstracts
Web of Knowledge	conference abstracts, citation searching
SCOPUS	Largest abstract and citation database of peer-reviewed literature: scientific journals, books and conference proceedings. Delivering a comprehensive overview of the world's research output in the fields of science, technology, and Medicine.
Subject / study dependant	
CINAHL	Nursing and allied health
Web of Knowledge	Social Science
ERIC	Education

Grey Literature was also searched

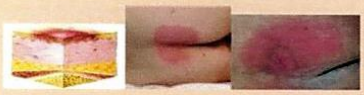
Name	Note
GoogleScholar http://scholar.google.com/	Extensive range of articles in a range of related subject areas. Many Open Access articles and specialist articles are available.
OpenGrey (http://www.opengrey.eu)	Resource for information on Grey Literature in Europe
NLM (National Library of Medicine, US) (http://www.ncbi.nlm.nih.gov) • NLM Databases: http://www.nlm.nih.gov/nichsr/db.html NLM Library Catalogue: • http://locatorplus.gov/	*Databases Indexed:* Health Services Research Projects in Progress (HSRProj) Health Services & Sciences Research Resources (HSRR) Health Services/Technology Assessments Texts (HSTAT)

Institutional repositories: • OpenDOAR (http://www.opendoar.org/) • Bielefeld Base (http://www.base-search.net/Search/Advanced) • Lenus (http://www.lenus.ie/hse/) • RIAN (http://rian.ie/) • e-publications@RCSI (http://epubs.rcsi.ie/)	Digital collections of scholarly output from academic and professional organisations International European Irish – HSE Irish – academic RCSI
Social Science Research Network (http://ssrn.com/)	Number of specialized research networks in each of the social sciences. Includes an abstracts database of forthcoming papers and working papers as well as Electronic Paper Collection of full text documents. Good for health service topics.
Websites of relevant professional organisations	Irish Nurses & Midwives Organisation https://www.inmo.ie/ *Royal College of Nursing* https://www.rcn.org.uk/ *American Nurses Association* http://nursingworld.org/

Appendix 2. HSE 2018 Pressure Ulcer Category/Staging System Recommendation

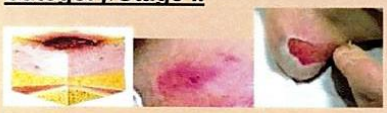
Definition: ***"A pressure ulcer is a localised injury to the skin and / or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance has yet to be elucidated"***

Category / Stage I



Category/ Stage I: Intact skin with non – blanchable redness of a localised area usually over a bony prominence. Discolouration of the skin, warmth, odema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching. The area may be painful, firm, soft, warmer or cooler as compared to adjacent skin. (EPUAP 2009)

Category/Stage II

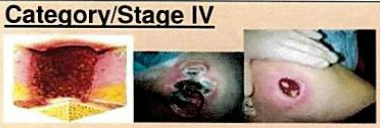


Category / Stage II: Partial thickness skin loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough. May present as an intact or open/ ruptured serum filled blister filled with serous or sero- sanginous fluid. Presents as a shiny or dry shallow ulcer without slough or bruising. (EPUAP 2009).

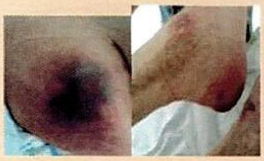
Category/Stage III

Category / Stage III: Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. The stage may include undermining or tunnelling (EPUAP 2009).

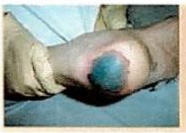
Category/Stage IV



Category / Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunnelling. Exposed bone / muscle is visible or directly palpable (EPUAP 2009).



In individuals with non-blanchable redness and purple/maroon discoloration of intact skin combined with a history of prolonged, unrelieved pressure/shear, this skin change may be an indication of emerging, more severe pressure ulceration i.e. an emerging **Category/Stage III or IV Pressure Ulcer**. Clear recording of the exact nature of the visible skin changes, including recording of the risk that these changes may be an indication of emerging more severe pressure ulceration, should be documented in the patients' health record. These observations should be recorded in tandem with information pertaining to the patient history of prolonged, unrelieved pressure/shear.
It is estimated that it could take **3-10 days** from the initial insult causing the damage, to become a **Category/Stage III or IV Pressure Ulcer** (Black et al, 2015).



Stable eschar (dry adherent, intact without erythema or fluctuance) on the heel serves as the body's biological cover and should not be removed. It should be documented as at least Category / Stage III until proven otherwise.

HSE 2018

Appendix3: **Extrinsic and Intrinsic Factors**

Identification of at-risk factors

Intrinsic Factors

- Immunosuppression
- Reduced mobility or immobility
- Moisture
- Inactivity
- Faecal and urinary incontinence
- Decreased level of consciousness
- Infection
- Circulatory diseases, for example, peripheral vascular disease, cardiac disease
- Personal hygiene
- Neurological diseases, for example, multiple sclerosis
- Weight distribution
- Treatment regimens
- Poor nutritional status / malnutrition and dehydration
- Drugs that effect mobility, for example, sedative
- Anaemia
- Malignancy
- Patient handling methods
- Advanced age
- Fracture
- Chronic systemic illness or terminal care
- Sensory impairment
- Acute illness
- Smoking
- Radiotherapy

Extrinsic Factors

Pressure

- Shearing
- Friction

HSE, 2018

Appendix 4 Pain Scale

Numerical Rating Scale

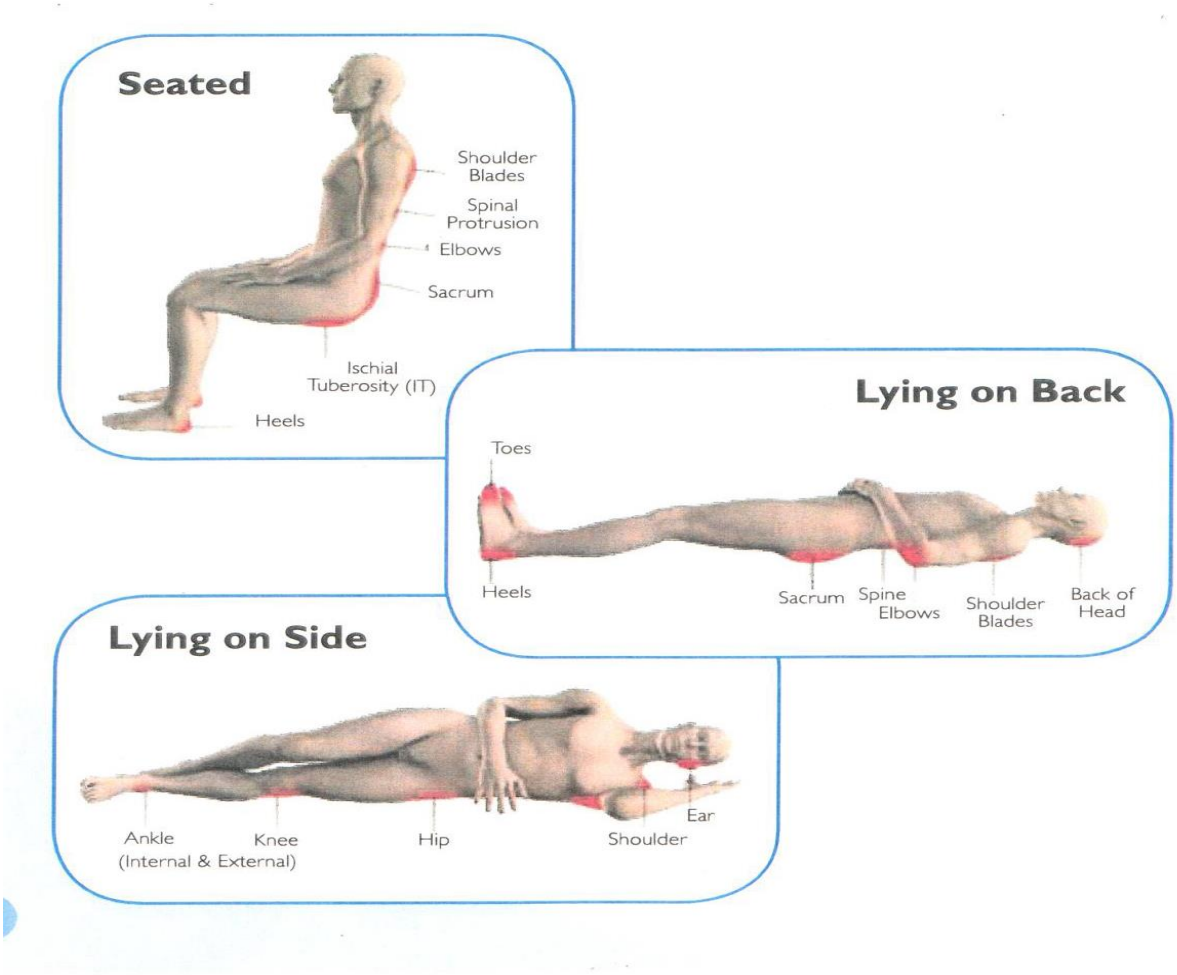
Instructions: Show the pain scale to the resident. Verbally read the scale to the resident and wait for a reply. On the 0-10 pain rating scale, 0 means no pain and 10 means the worst pain possible. The middle of the scale around 5 is moderate pain. A 2 or 3 would be mild pain, but 7 and higher is severe pain. Repeat the directions if the resident is having difficulty; use words other than "pain": aching, cramping, sore, uncomfortable, stiff, dull, pressure, burning, shooting. If the resident does not like it or understand it, switch to another scale. Always use the same scale for each follow-up assessment. Document the scale used as the Numerical Rating Scale (NRS).

0-5 Numerical Rating Scale

0-10 Numerical Rating Scale

(HSE,2018)

Appendix 5 Bony Prominences



(HSE,2018)

APPENDIX 6: 30 DEGREE TILT

Semi-recumbent position			
	The patient's lower back should be positioned as far into the pillows as possible, to support the lumbar spine. Plump or fold the lower pillow if necessary		The legs are supported as in diagram 3 and 4 of the recumbent position. Ensure the heels are clear of the mattress and the feet are correctly positioned.
	An additional pillow is placed underneath the others. The corner is carefully positioned under the buttock to '*tilt*' the body and give clearance to the ischial tuberosities and sacrum		The full semi-recumbent 30º '*tilt*' position
Recumbent position			
	Lie the patient in the centre of the bed. Use one or two pillows to support the head and neck.		The patient's lower back should be positioned as far into the pillows as possible, to support the lumbar spine. Plump or fold the lower pillow if necessary
	Use a further pillow to support the lumbar region and shoulder. This 'tilts' the patient onto one buttock and lifts the sacrum clear of the mattress. Use your hand to check this clearance		An additional pillow gives further comfort to any unsupported areas of the other leg
	The full recumbent 30º '*tilt*' position		It may be necessary to use an extra pillow to prevent 'foot drop'

Moore et al, 2011

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Appendix 7

Laois/Offaly and Longford/Westmeath PHN Service

Repositioning Chart

Patient name:_____ DOB:_____

Waterlow score on initial assessment:_____Date:__/__/____
Current Waterlow score: _____ Date:__/__/____
Woundcare strategy in place Yes No N/A
Pressure sore incident form sent (if applicable) Date:__/__/___
Pressure relieving device: Yes No
Type being used:_____Date provided:__/__/____

Date	Time 24hr	Position	Comment	Signature

PATIENT NAME:_____ DOB:_____

DATE	TIME 24 HR	POSITION	COMMENT	SIGNATURE

Appendix 8: Mattress Selection Guide

Criteria for mattress selection are based on EPUAP Guidelines (2014) and HSE Guidelines (2018). Mattress specification, including manufacturer' special considerations and precautions are also considered.
A Waterlow Score in isolation, is not an indication to make an appropriate mattress selection, this requires a full holistic assessment of the client.

Mattress Type	PRODUCT	WATERLOW SCORE	PREVENT	Treat	SPECIAL PRECAUTIONS	REQUISITIONED BY
Static Overlay	Repose/Simcare	10-20	✓	Non blanching erythema/Grade 1	Use in single or double beds. Check pressure daily. Max. Weight 139lbs. Avoid direct contact with heat or sharp objects.	PHN/CRGN
Static Replacement Mattress	Pressureguard CFT, Dynaform	15-20+		Grade 1-2 pressure ulcers	Client must be able to independently weight shift. Non-powered dynamic mattress	PHN/CRGN
Dynamic mattress Replacement	Aircare 8/Domus Auto/Elite/ASX/ Airexpress/Integ rity/phase 3/Pro 2000/Simple Plus 4ft/Delta Plus 4ft/Tamora/P280 /Agryll	20+	✓	Grade1-2 pressure ulcers	Useful for patients with repositioning difficulties. Air-alternating mattress. Client will require a repositioning schedule.	PHN/CRGN
High-Specification Dynamic Mattress Replacement	Autosure Float/Virtuosso/ Procare Auto	20+	✓	Grade1-4 pressure ulcers	Automatically adjusts pressures to patient weight. For consideration in the highly compromised patient with significant weight loss. 39 stone weight limit. Client will require a repositioning schedule.	PHN/CRGN IN CONSULT WITH TVN
Rotational Mattress	Scanturn/ Rhythm Turn	20+	√	Grade1-4 pressure ulcers	Continuous lateral rotation therapy. Can customize how long the patient is held in a turn position, from 15min. to 1 hour Weight limit up to 300lbs. For consideration in clients who cannot be manually turned due to shortness of breath,anxiety or physical limitations.	PHN/CRGN IN CONSULT WITH TVN

Mattress selection guide developed by Mary Costello, RANP Tissue Viability Laois/Offaly and Elaine Durkin, PHN, TVN Longford/Westmeath

Appendix 9: CLIENT CORE CARE PLAN - PRESSURE ULCER PREVENTION AND MANAGEMENT

Name:	**Date of Birth:**
Client problem/concern/need: is at risk of /has developed a pressure ulcer	**Problem No.**
Related to :	
Goal: (Use Client's Name) Assist_____to maintain his/her skin integrity and prevent development/deterioration of a Pressure Ulcer	
Provide_____with appropriate Pressure Ulcer Prevention and Management Care Strategies	
Other:	

Date/ Time 24hr Commenced	**Nursing Intervention/Action**	**Signature**
Obtain **consent** for assessment and provision of pressure relief products as required		
Carry out a full holistic nursing assessment incorporating all aspects of SSKIN. **Assessment of Mobility** - Observe for level of mobility, document findings, refer to Physiotherapy if required.		
Use Barthel Index to establish client's degree of independence		
Use Waterlow Risk Assessment tool to assist the identification of clients at risk of pressure ulcer development.		
Skin Inspection-Observe skin integrity and document findings		
Bladder/Bowel Continence -Assess for incontinence using a Level 1 Assessment if required		
Nutrition Screening - Use the MUST Screening to identify clients risk of malnutrition		
Educate_____and/or family member regarding appropriate pressure ulcer prevention		
Provide Client with 'Preventing and Treating Pressure Ulcers' Booklet (2013)		
Select appropriate pressure relieving devices as per PPG PHN026		
Commence repositioning regime as required		
Provide first line dietary advice and refer to Community Dietitian as per MUST Guideline		
Refer to Occupational Therapy if seating/positioning/assessment re higher spec cushion is required PHN026		
Provide with PHN/CRGN's contact no.		
Respect_____dignity and privacy at all times.		
Other client specific actions:		
Liaise with / Refer to following disciplines if required:(Tick box)		
Physiotherapist ☐ Occupational Therapist ☐ Tissue Viability Nurse ☐ Continence Advisor ☐		
Dietician ☐ Leg Ulcer Clinic ☐ G.P. ☐		
DOCUMENT FINDINGS AND RECORD REVIEW/EVALUATION IN THE CLIENT/EVALUATION PROGRESS NOTES		
Frequency of Review and Reassessment:The PHN/CRGN using her/his clinical judgement should conduct a review and holistic assessment as per Core Care Plan and as indicated by any change in the individual's condition (NPUAP/EPUAP 2014)		
Reference: HSE Dublin Mid-Leinster Guideline on: Pressure Ulcer Prevention and Management for Adults; Laois/Offaly & Longford/Westmeath (2022) PHN026 (Version 3. May 2022)		

Appendix 10 – Cushion Selection Guide

Criteria for cushion selection is based on EPUAP Guidelines (2014) and HSE Guidelines (2018). Cushion specification, including manufacturers special considerations and precautions are also considered.
A Waterlow Score in isolation, is not an indication to make an appropriate cushion selection, this requires a full holistic assessment of the client.

Cushion Type	PRODUCT	Treat	SPECIAL PRECAUTIONS	REQUISITIONED BY
Static Cushion	Repose/Trio/ Relax Easy/ Memoflex	Non blanching erythema/Grade 1	May be provided to clients at high risk or active ulceration whilst awaiting OT assessment.	PHN/CRGN
Dynamic cushion Replacement	Aircare 8/Talley/ Pro2000/Elite/ Eclipse	Immobile patients with active ulceration .	Provision only in partnership with OT and TVN services	TVN/OT
Dynamic High Specification cushion replacement	Virtuosso	Immobile patients with active ulceration .	Provision only in partnership with OT and TVN services	TVN/OT
Dynamic Full Chair Pad	Eclipse/ Pro3000	Grade1-4 pressure ulcers Immobile patients with active ulceration .	Provision only in partnership with OT and TVN services	TVN/OT

ALL OTHER HIGH SPECIFICATION STATIC CUSHIONS ARE ONLY PROVIDED BY THE OT SERVICE FOLLOWING AN OT ASSESSMENT

Developed by Mary Costello, RANP Tissue Viability Laois/Offaly and Elaine Durkin, PHN, TVN Longford/Westmeath

Appendix 11: WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

(J. Waterlow 1985 Revised 2005)

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED.

Patient's Name:_____ Date of Birth: _____

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE – VISUAL RISK AREAS		SEX		MALNUTRITION SCREENING TOOL (MST) Nutrition Vol. 15. No 6. 1999 Australia		
AVERAGE		Healthy	0	Male	1	**A.** HAS PATIENT LOST WEIGHT RECENTLY	**B:** WEIGHT LOSS SCORE	
BMI 20 – 24.9	0	Tissue Paper	1	Female	2	Yes – Go to B	0.5 – 5 kg	1
ABOVE AVERAGE		Dry	1			No – Go to C	5 – 10 kg	2
BMI 25 – 29.9	1	Oedematous	1	AGE		Unsure go to C and score 2	10 – 15 kg	3
OBESE		Clammy/Pyrexia	1	14-49	1		>15kg	4
BMI > 30	2	DISCOLOURED		50-64	2		Unsure	2
BELOW AVERAGE		Grade 1	2	65-74	3	**C:** PATIENT EATING POORLY OR LACK OF APPETITE No = 0 Yes = 1	**NUTRITION SCORE** If >2 refer for Nutrition Assessment/Intervention	
BMI < 20	3	Broken /Spots Grade 2-4	3	75-80	4			
BMI =Wt (kg) / (Ht) (m²)				81+	5			

CONTINENCE		MOBILITY		SPECIAL RISKS			
				TISSUE MALNUTRITION		**NEUROLOGICAL DEFICIT**	
Continent/ Catheterised	0	Fully Mobile	0	Terminal Cachexia	8	Diabetes, MS. CVA	4-6
		Restless/Fidgety	1	Multiple Organ failure	8	Motor/Sensory	4-6
Urine Incontinence	1			Single Organ Failure (Resp, Renal, Cardiac)	5	Paraplegia (Max of 6)	4-6
Faecal incontinence	2	Apathetic	2	Peripheral Vascular Disease	5	**MAJOR SURGERY OR TRAUMA**	
Urinary & Faecal Incontinence	3	Restricted	3	Anaemia Hb < 8	2	Orthopaedic/Spinal	5
		Bedbound/Traction	4	Smoking	1	On Table > 2hrs	5
		Chairbound eg Wheelchair	5			On Table > 6hrs	8
				Medication - Cytotoxics, Long Term/High Dose Steroids, Anti-inflammatory (Max of 4)			

Score: (10+ At Risk) (15+ High Risk) (20+ Very High Risk) Patient's Score: _____

Nurse's Signature_____Date_____Time_____

Reassessment date if at risk: _____

ALL STAGES OF PRESSURE ULCERATION: REPORT AND INCIDENT FORM COMPLETED:
YES NO

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE – VISUAL RISK AREAS		SEX		MALNUTRITION SCREENING TOOL (MST) Nutrition Vol. 15. No 6. 1999 Australia		
AVERAGE		Healthy	0	Male	1	**A.** HAS PATIENT LOST WEIGHT RECENTLY	**B:** WEIGHT LOSS SCORE	
BMI 20 – 24.9	0	Tissue Paper	1	Female	2	Yes – Go to B	0.5 – 5 kg	1
ABOVE AVERAGE		Dry	1			No – Go to C	5 – 10 kg	2
BMI 25 – 29.9	1	Oedematous	1	AGE		Unsure go to C and score 2	10 – 15 kg	3
OBESE		Clammy/Pyrexia	1	14-49	1		>15kg	4
BMI > 30	2	DISCOLOURED		50-64	2		Unsure	2
BELOW AVERAGE		Grade 1	2	65-74	3	**C:** PATIENT EATING POORLY OR LACK OF APPETITE No = 0 Yes = 1	**NUTRITION SCORE** If >2 refer for Nutrition Assessment/Intervention	
BMI < 20	3	Broken /Spots Grade 2-4	3	75-80	4			
BMI =Wt (kg) / (Ht) (m²)				81+	5			

CONTINENCE		MOBILITY		SPECIAL RISKS			
				TISSUE MALNUTRITION		**NEUROLOGICAL DEFICIT**	
Continent/ Catheterised	0	Fully Mobile	0	Terminal Cachexia	8	Diabetes, MS. CVA	4-6
		Restless/Fidgety	1	Multiple Organ failure	8	Motor/Sensory	4-6
Urine Incontinence	1			Single Organ Failure (Resp, Renal, Cardiac)	5	Paraplegia (Max of 6)	4-6
Faecal incontinence	2	Apathetic	2	Peripheral Vascular Disease	5	**MAJOR SURGERY OR TRAUMA**	
Urinary & Faecal Incontinence	3	Restricted	3	Anaemia Hb < 8	2	Orthopaedic/Spinal	5
		Bedbound/Traction	4	Smoking	1	On Table > 2hrs	5
		Chairbound eg Wheelchair	5			On Table > 6hrs	8
				Medication - Cytotoxics, Long Term/High Dose Steroids, Anti-inflammatory (Max of 4)			

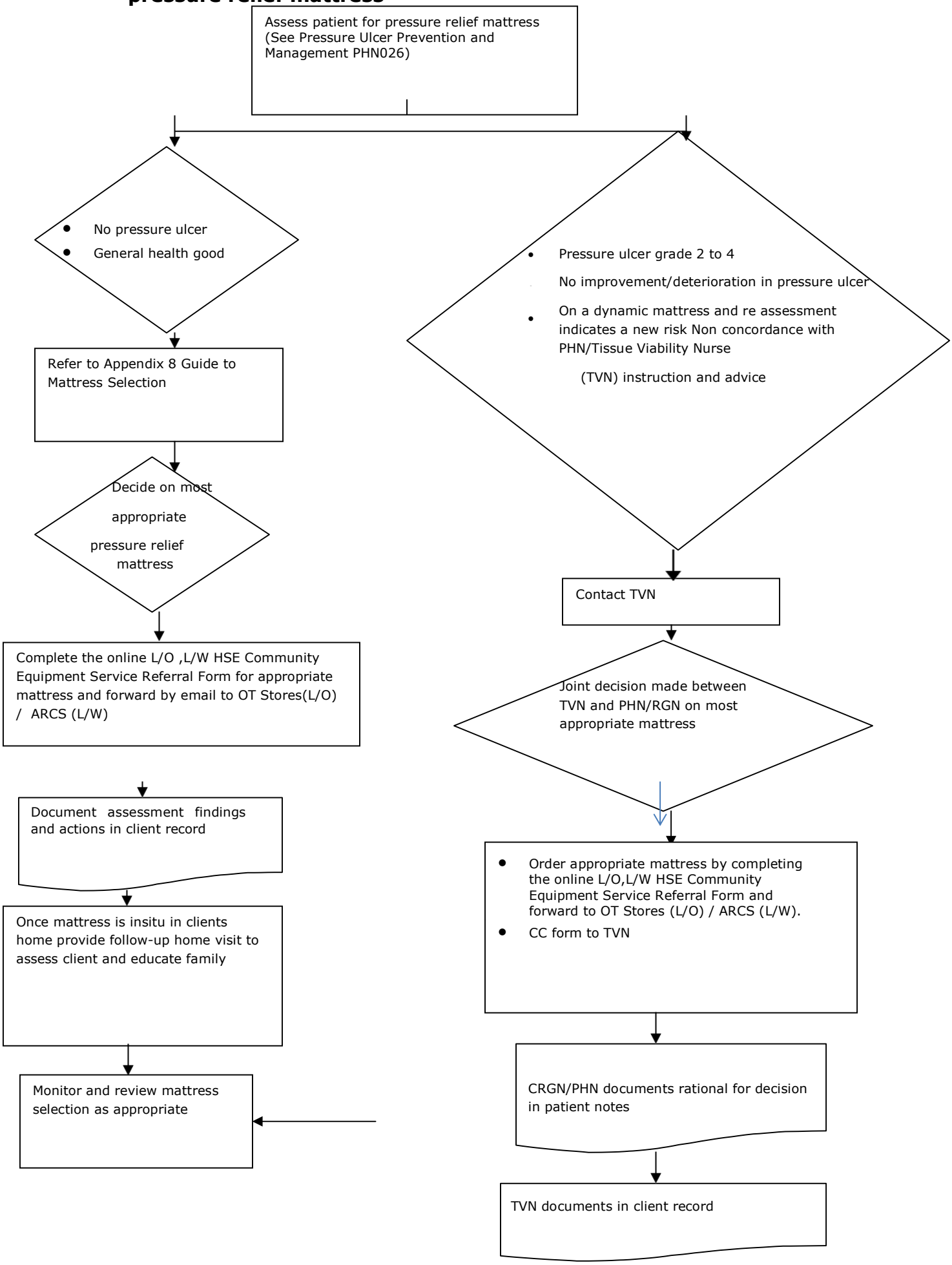
Score: (10+ At Risk) (15+ High Risk) (20+ Very High Risk) Patient's Score: _____

Nurse's Signature_____Date_____Time _____

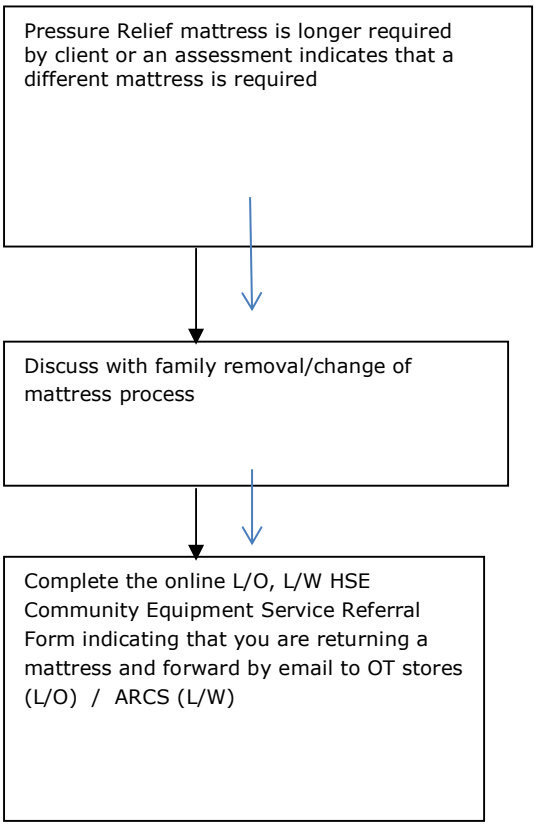
Reassessment date if at risk: _____

ALL STAGES OF PRESSURE ULCERATION: REPORT AND INCIDENT FORM COMPLETED:
YES NO

Appendix 12: Process to be followed when ordering a pressure relief mattress



Appendix 13: Process Flow Map to be followed when returning pressure relief mattress



Appendix 14: SSKIN Bundle Chart

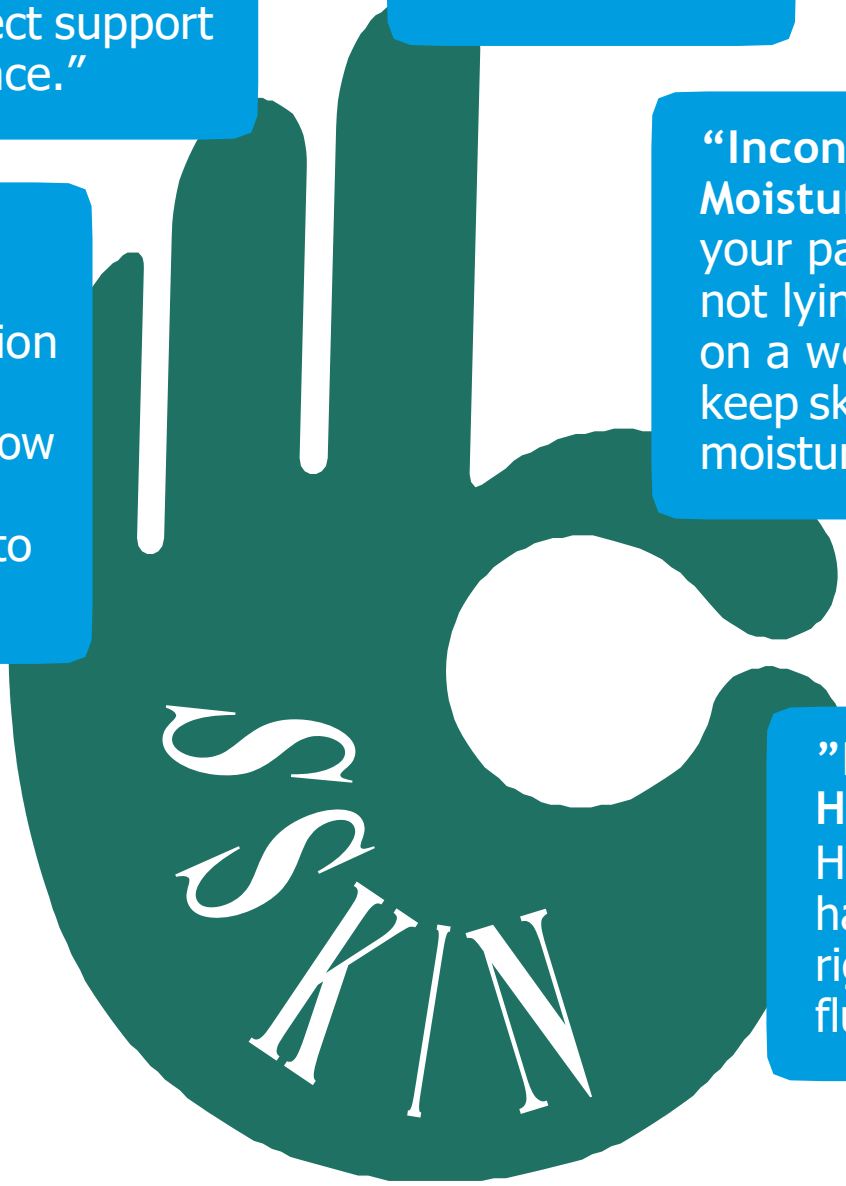
to Zero
Pressure Ulcers

"**Surface:** Make sure your patients are seated and lying on the correct support surface."

"Keep your patient moving."

"**Incontinence/ Moisture:** Make sure your patients are not lying or sitting on a wet surface, keep skin clean and moisturised."

"**Skin Inspection:** Early inspection means early detection. Show patients and carers what to look for."



"**Nutrition/ Hydration:** Help patients have the right diet and fluid intake."

Quality Improvement Programme National

QPS DNE
Regional Quality & Patient Safety
Dublin North East

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Royal College of Physicians of Ireland

Appendix 15 Patient info Booklet

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Preventing and Treating Pressure Ulcers

Information for Patients, Families and Carers

This booklet was developed by:

Mary Costello, Tissue Viability RGN Laois/Offaly Public Health Nursing Services.
Elizabeth Delaney,Tissue Viability PHN Longford/Westmeath Public Health Nursing Services.
Kathleen Griffin Practice Development Co-ordinator for PHN services Laois/Offaly and Longford/Westmeath.

(It is adapted from Pressure ulcers – prevention and treatment. National Institute for Health and Clinical Excellence, United Kingdom, 2005)

Acknowledgements

We would like to thank the following for their involvement and contribution in the development of this booklet:

- Patients and Carers that provided valuable feedback and comments.
- Public Health Nurses and Community Registered General Nurses in Laois/Offaly and Longford/Westmeath.
- National Adult Literacy Agency.

Contents

What is a pressure Ulcer?

A pressure ulcer is damage to the skin and the flesh and muscle under the skin. This flesh and muscle if often called 'tissue'.

Pressure ulcers are usually caused by:

- Pressure – the weight of your body pressing down on the skin. This can happen if you sit or lie in the one position for any length of time.
- Shear - this is when the layers of your skin and flesh are forced to slide over one another. It can happen when you slide down, or are pulled up, in the bed or chair or when you are transferring to or from your wheelchair.
- Friction – rubbing the skin.

How does a pressure ulcer start?
The first sign that a pressure ulcer may be forming is usually red or purplish patches on the skin. These may get worse over time and eventually lead to an open sore. The most common places to get pressure ulcers are the bony areas around the bottom, heel, elbow, ankle, shoulder, back and back of head.

Is a pressure ulcer the same as a bed sore?
A pressure ulcer may also be called a bed sore or pressure sore. However, you don't need to be in bed to get a pressure ulcer.

Are there different types of pressure ulcers?
There are four grades of pressure ulcer depending on how deep the ulcer is.
Grade 1 – an area of discolouration, swelling or heat that won't go away
Grade 2 – the ulcer is on the surface of the skin and may look like a blister.
Grade 3 – the ulcer is deeper but does not reach the bone
Grade 4 – the ulcer is deep and may go down to the bone

Who gets pressure ulcers?

Anyone can get a pressure ulcer, but some people are most at risk of developing one than others.

You may be at risk of getting a pressure ulcer if you:

- Have problems moving and cannot change your position without help;
- Cannot feel pain over part or all of your body;
- Are unable to control your bladder or bowels;
- Are seriously ill or undergoing surgery;
- Have had pressure ulcers in the past or have one now;
- Don't eat well and don't drink enough water
- Are very old or very young;
- Have a damaged spinal cord and cannot move or feel your bottom or legs;
- Are older and have suffered an injury, for example, a broken hip;
- Are a smoker
- Are pregnant.

Your community nurse will assess whether you are at risk of developing a pressure ulcer. This will involve examining you and asking you some questions.

If your community nurse feels you are at risk, they will recommend ways to prevent a pressure ulcer developing. These are described in the next section.

If your community nurse feels you are not at risk, they will recommend another assessment if your condition changes.

Preventing pressure ulcers

Pressure ulcers can develop quickly if you are unable to move - sometimes within an hour.

Without care, pressure ulcers can be serious. They damage not just your skin but also the deeper tissues under your skin. Pressure ulcers can cause pain. They can become infected. Severe pressure ulcers can destroy the muscle or bone under the skin and can take a long time to heal. In rare cases, pressure ulcers can cause blood poisoning or bone infections and so can be life-threatening.

Keep moving

One of the best ways to prevent a pressure ulcer is to reduce pressure on bony areas of your body. You can do this by moving around and changing your position as much as possible.

Your healthcare professional will advise you and your carer how to:

- Sit and lie correctly
- Adjust your sitting and lying position;
- Use support equipment;
- Support your feet;
- Keep a good posture.
- They will also advise you how often you need to move or be moved.

If you already have a pressure ulcer, you should change your sitting or lying position regularly to allow the ulcer to heal and to avoid further damage. This applies whether you are in bed, on a chair or in a wheelchair. If you cannot move by yourself, your carer will need to help you to change your position.

Your healthcare professional will work with you and your carer to find ways to help you move around and change position.

Use of support mattresses and cushions

Different types of mattresses and cushions can help reduce the pressure on bony parts of your body and so help prevent pressure ulcers. Your healthcare professional will work with you to decide which supports are best for you.

You, your carer and your healthcare team should consider all of the surfaces that you come in contact with. Your community nurse will examine you regularly and talk to you and your carer to find out whether your needs have changed and whether another type of support would work better.

If you are at risk, or have a grade 1 or 2 pressure ulcer, you will get a special foam mattress. This type of mattress moulds to your body, helping to relieve pressure and stop ulcers from developing. If you have a grade 3 or 4 pressure ulcer, you will get a more sophisticated mattress, for example an alternating pressure system. This is a mattress that gently moves beneath you. It helps you feel more comfortable.

Check your skin

You or your carer should check your skin regularly for signs that a pressure ulcer may be developing. You may need to use a mirror to see areas such as your bottom or heels.

What to look for:

- Red patches on your skin that don't go away (if you are light-skinned)
- Bluish or purplish patches on your skin that don't go away (if you are dark-skinned)
- Blisters or damage to your skin
- Patches of hot skin
- Swelling
- Patches of hard skin
- Patches of cool skin

If you or your carer notice any possible signs of damage, you should tell your community nurse immediately.

Your community nurse will also check your skin regularly. How often they check your skin will depend on your level of risk and general health.

Eat well

Eating a healthy diet and drinking enough water is very important if your pressure ulcer is to get better. Your community nurse will talk with you about your diet and how you might improve it. They may also refer you to a dietician for specialist advice.

Assessing pressure ulcers

If you have a pressure ulcer, a community nurse will examine it as soon as possible after it appears and at regular intervals after that.

Your community nurse will talk to you to try and understand what caused the pressure ulcer. They will write in your notes where the pressure ulcer is, how big it is and what it looks like. They may use tracings to do this.

Your community nurse will also check for signs of infection, such as a change in the colour of your skin, swelling, heat or smell. They will also ask how much pain the ulcer is causing you.

All information will help your community nurse to grade your pressure ulcer. They will then work with you to choose the best treatment for your pressure ulcer.

Your community nurse may also refer you to see a Tissue Viability Nurse (TVN) who will provide you with specialist knowledge and expertise on the prevention and management of pressure ulcers.

Treating pressure ulcers

Your community nurse will agree a plan of care with you. This will include regular checks of your pressure ulcer for changes.

Your healthcare professional will work with you to find the best ways for you to move around, change position and use supports, such as a special mattress or cushion.

The type of support will depend on:

- What grade your pressure ulcer is;
- Where the pressure ulcer is on your body;
- Your general health;
- How comfortable the support is for you; and
- Whether you can change position on your own or whether there is someone who can help you change position.

Your pressure ulcer may need other treatments to help it heal. These treatments may include dressings and removing damaged skin. If you have signs of an infection, your healthcare professional may treat it with an antibiotic or use special dressings that kill bacteria and help the ulcer to get better quicker.

If you need to have damaged tissue removed, this may be done with special dressings or you may need to see a surgeon who will cut away the damaged tissue.

Seeing a surgeon

Sometimes, even with the best treatment, pressure ulcers may not heal. If your pressure ulcer does not heal properly, your family doctor (GP) may refer you to a surgeon to assess your wound.

More Questions?

If you have any questions about preventing or treating pressure ulcers, or about the care that you are receiving, ask your doctor, public health nurse, community nurse or other member of your healthcare team.

You can also find information about preventing and treating pressure ulcers on the following websites

www.nice.org.uk
www.hse.ie

Some words explained

Carer
A carer is someone who is providing an ongoing, significant level of care to a person who is in need of that care in the home, due to illness or disability or frailty. (DOH, 2012).

Healthcare professional
A member of your healthcare team such as a doctor, public health nurse, Community nurse, physiotherapist or occupational therapist.

Pressure Ulcers
Also called bed sores or pressure sores. The medical name is decubitus ulcers.

Booklet approved by:

Bridget Catterson, Director Public Health Nursing Services Laois/Offaly &
Virginia Pye, Director Public Health Nursing services Longford/Westmeath
Version 1/2/2013

Literacy proofed and edited by the National Adult Literacy Agency (NALA)

Plain English
Approved by NALA

Designed & Printed by Modern Printers (056) 7721739

Appendix 16: TVN Working Group

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Anne Moore	ADPHN Laois/Offaly
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Claire Devaney	ADPHN Longford/Westmeath
Fionola Gill	ADPHN Longford/Westmeath

Appendix 18 History of Revisions

Document Control no. PHN026	Revision no. 3
Addition	Cushion selection grid
Update	Mattress selection grid
Addition	SSKIN Bundle
Update	Classification of pressure ulcers , HSE ,2018
Update	Reporting of Pressure ulcers , HSE, 2018

Appendix 19: Pressure Ulcer Reporting and Notification

A National Incident Report Form (NIRF) should be completed when the following occurs;

a. A newly acquired pressure ulcer, regardless of stage. *This will include a stage 1 pressure ulcer that does not resolve within 24 hours*.
b. Existing pressure ulcers which progress/ deteriorate to a stage 3 or 4 pressure ulcer.
c. Purple /maroon discolouration of intact skin combined with a history of prolonged unrelieved pressure/ shear, i.e. depth unknown.
d. When a suspected deep pressure and shear induced tissue damage, depth unknown pressure ulcer becomes stageable a further NIRF form should be completed denoting the stage of the pressure ulcer.

If during the period from initial insult to the staging of the pressure ulcer, the client is moved from community service, i.e. respite, long-term care, acute admission, the need for completion of the incident report for the pressure ulcer should form part of the handover of care.

There is no requirement to report pressure ulcers which;
are present at the time of first contact in the community post discharge from a facility.
There is an expectation that this has already been reported by the service in which the client was previously being cared for.

The PHN/CRGN who identifies the pressure ulcer is responsible for;

- Notifying the ADPHN
- Completing the NIRF within 24 hours

Stage 3 and Stage 4 pressure ulcers if acquired since admission to the community service are classified as Serious Reportable Events(SRE's) and must be identified on the NIRF; followed up by a preliminary assessment and report by ADPHN

Appendix 20: Nursing Transfer Form to Community Nursing Unit (CNU)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Nursing Transfer Form to Community Nursing Unit (CNU)

Patient's Name: _____ Admission Date: _____
Address: _____
Discharge Date: _____Next Admission: _____
Date of Birth: _____ Next of Kin: _____
Phone No. _____ Relationship: _____
G.P : _____Phone No. _____

Home Conditions: Lives Alone ☐ With Partner/family ☐ With Carer☐
Diagnosis: _____

Barthel Score: ___MMSE: ____FROP____ History of Falls: No: ☐ Yes: ☐ MUST score____

Mobility: Independent: ☐ Requires Assistance: ☐ Please specify: _____

Hygiene: Independent: ☐ Requires Assistance: ☐ Please specify: _____

Dressing: Independent: ☐ Requires Assistance: ☐ Please specify: _____

Nutrition: Independent: ☐ Requires Assistance: ☐ Please specify: _____

Continence: Continent: ☐ Incontinent: ☐ Toileting programmes special aids/continence products in use Details:_____

Catheter in situ: ☐ Date inserted: _____ Type/Size: _____
Normal Bowel Pattern: _____Constipation: _____Diarrhoea: _____
Faecal incontinence: _____ Stoma: _____ Appliance Type: _____

Laxatives: Laxatives: Yes: ☐ No: ☐Suppositories/Enema's Used: Yes ☐ No ☐
Waterlow Assessment Score: _____ Date Waterlow completed: _____

Pressure ulcer present yes/no: _____If yes indicate stage of pressure ulcer:_____

NIRF completed on (date):_____

Condition of Skin/Dressings required: _____

Nursing Interventions being carried out: _____

Any other relevant Information: _____

Please ensure a G.P letter and current prescription accompanies the patient on admission

Nurses Signature: _____**Date:** _____Health Centre: _____

Phone No.:_____Fax No:_____

Appendix 21: Guideline Audit Tool

1	**Were you aware of the existence of this guideline?**	**Yes**	**No**	**Comment**
2	**Did you find this guideline easy to understand and use?**			
3	**Did you use this guideline to guide your practice?**			
4	**Is there evidence that the correct risk assessment procedure was adhered to?** **(1) Was the Waterlow score calculated correctly?** **(2) Was the management appropriate for the patient using clinical judgement in combination with the Waterlow score identified?**			
5.	**Was the pressure ulcer reported using the NIRF?**			

Appendix 22: Signature Sheet

Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

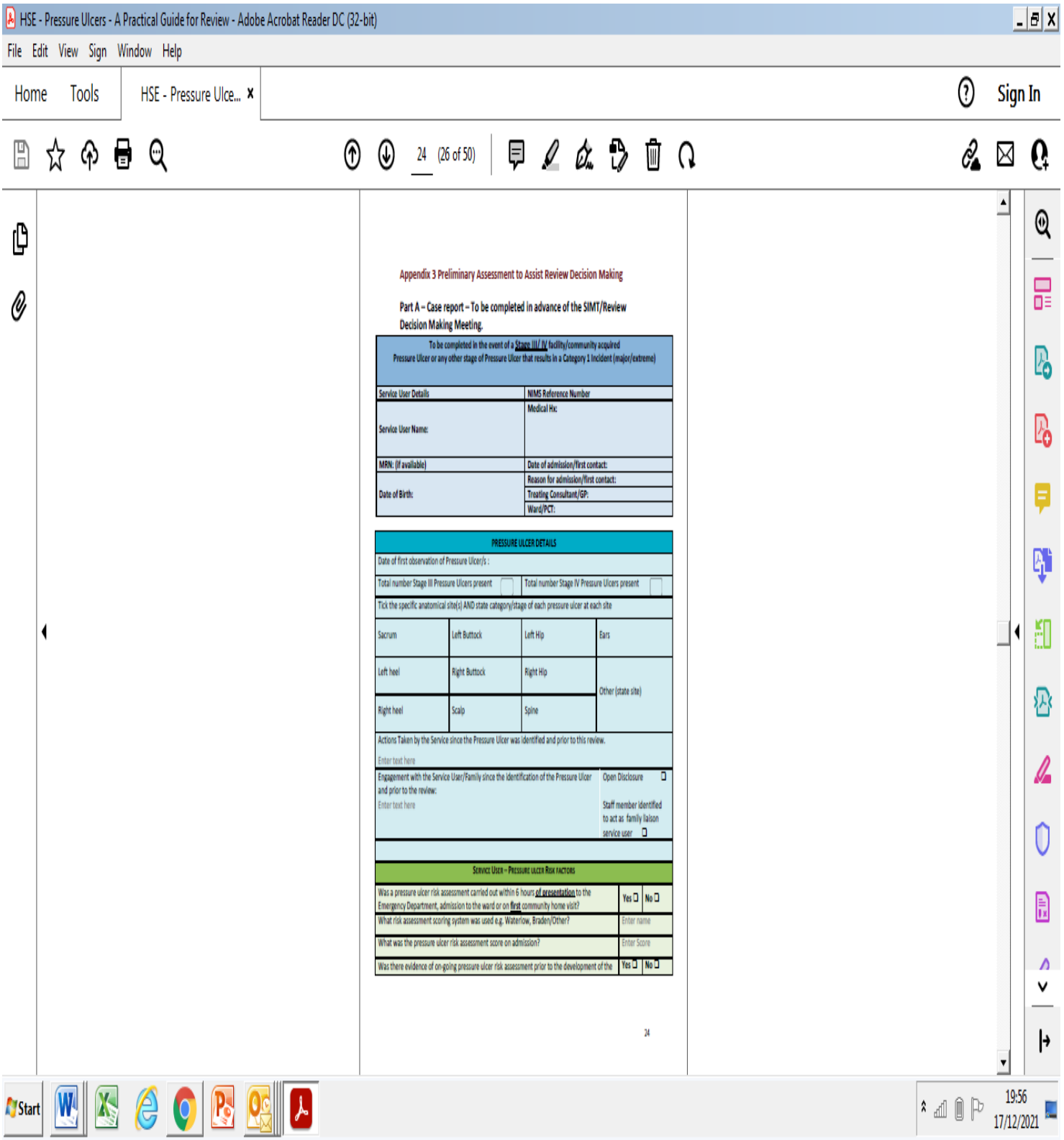
Print Name (Staff member)	Signature (staff member)	Location of Work	Date

Appendix 23 SSKIN Bundle Pressure Ulcer Prevention Strategy

LAOIS/OFFALY & LONGFORD/WESTMEATH PUBLIC HEALTH NURSING SERVICE SSKIN BUNDLE PRESSURE ULCER PREVENTION STRATEGY								
PATIENT NAME						**DOB**		
DATE								
TIME (24 hr)								
SURFACE	**CONSIDER ALL SURFACES THAT CLIENT IS IN CONTACT WITH**							
MATTRESS TYPE HIGH SPEC AIR STANDARD AIR FOAM								
CUSHION TYPE LOW- MEDIUM RISK/ NURSING HIGH RISK /OT								
HEEL PROTECTORS Y/N								
SKIN INSPECTION	INSPECT SKIN AT BONY PROMINENCES AT FIRST ADMISSION TO SERVICE, IF EVIDENCE OF DETERIORATION OF CONDITION, ON RETURN FROM HOSPITAL ADMISSION AND AS PER CLINICAL JUDGEMENT							
PRESSURE AREAS CHECKED Y/N								
IF EVIDENCE OF PRESSURE INJURY STATE **SITE/STAGE**								
KEEP MOVING	FREQUENCY OF REPOSITIONING WILL BE INFORMED BY SKIN INSPECTION							
BEDBOUND ADVISED FREQUENCY OF REPOSITIONING								
CHAIR ADVISED FREQUENCY OF REPOSITIONING								
INCONTINENCE	**INCONTINENCE SKIN CARE REGIMEN IMPLEMENTED**							
PERIANAL SKIN HEALTHY Y/N								
NUTRITION	**ENCOURAGE A BALANCED DIET AND IMPLEMENT MUST AS PER GUIDELINE**							
MUST COMPLETED DATE								
SUPPLEMENTS Y/N								
SIGNATURE								
PRESSURE ULCER PREVENTION INFORMATION BOOKLET GIVEN **YES NO**								
Revised version of the SSKIN Bundle Chart; HSE Pressure Ulcers A Practical Guide for Review								

Appendix 24: Preliminary Assessment to Assist Review Decision Making

(See pages 24 to 27 of document; Pressures Ulcers -A Practical Guide for Review – HSE 2018)



Appendix 3 Preliminary Assessment to Assist Review Decision Making

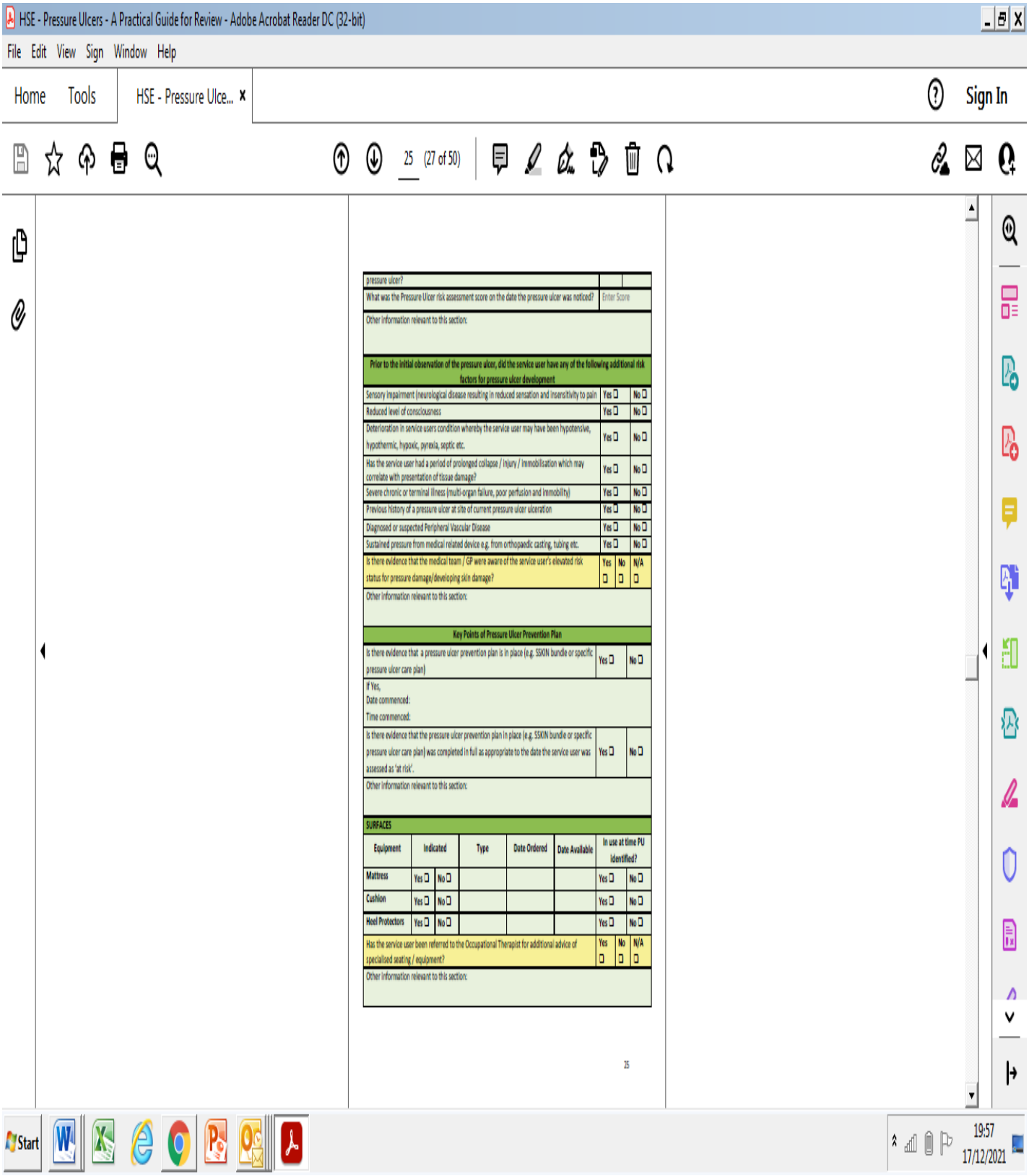
Part A – Case report – To be completed in advance of the SIMT/Review Decision Making Meeting.

To be completed in the event of a Stage III/ IV facility/community acquired Pressure Ulcer or any other stage of Pressure Ulcer that results in a Category 1 Incident (major/extreme)	
Service User Details	NIMS Reference Number
Service User Name:	Medical Hx:
MRN: (if available)	Date of admission/first contact:
Date of Birth:	Reason for admission/first contact: Treating Consultant/GP: Ward/PCT:

PRESSURE ULCER DETAILS			
Date of first observation of Pressure Ulcer/s :			
Total number Stage III Pressure Ulcers present ☐		Total number Stage IV Pressure Ulcers present ☐	
Tick the specific anatomical site(s) AND state category/stage of each pressure ulcer at each site			
Sacrum	Left Buttock	Left Hip	Ears
Left heel	Right Buttock	Right Hip	Other (state site)
Right heel	Scalp	Spine	
Actions Taken by the Service since the Pressure Ulcer was identified and prior to this review. Enter text here			
Engagement with the Service User/Family since the identification of the Pressure Ulcer and prior to the review: Enter text here			Open Disclosure ☐ Staff member identified to act as family liaison service user ☐

SERVICE USER – PRESSURE ULCER RISK FACTORS		
Was a pressure ulcer risk assessment carried out within 6 hours of presentation to the Emergency Department, admission to the ward or on first community home visit?	Yes ☐	No ☐
What risk assessment scoring system was used e.g. Waterlow, Braden/Other?	Enter name	
What was the pressure ulcer risk assessment score on admission?	Enter Score	
Was there evidence of on-going pressure ulcer risk assessment prior to the development of the	Yes ☐	No ☐

24



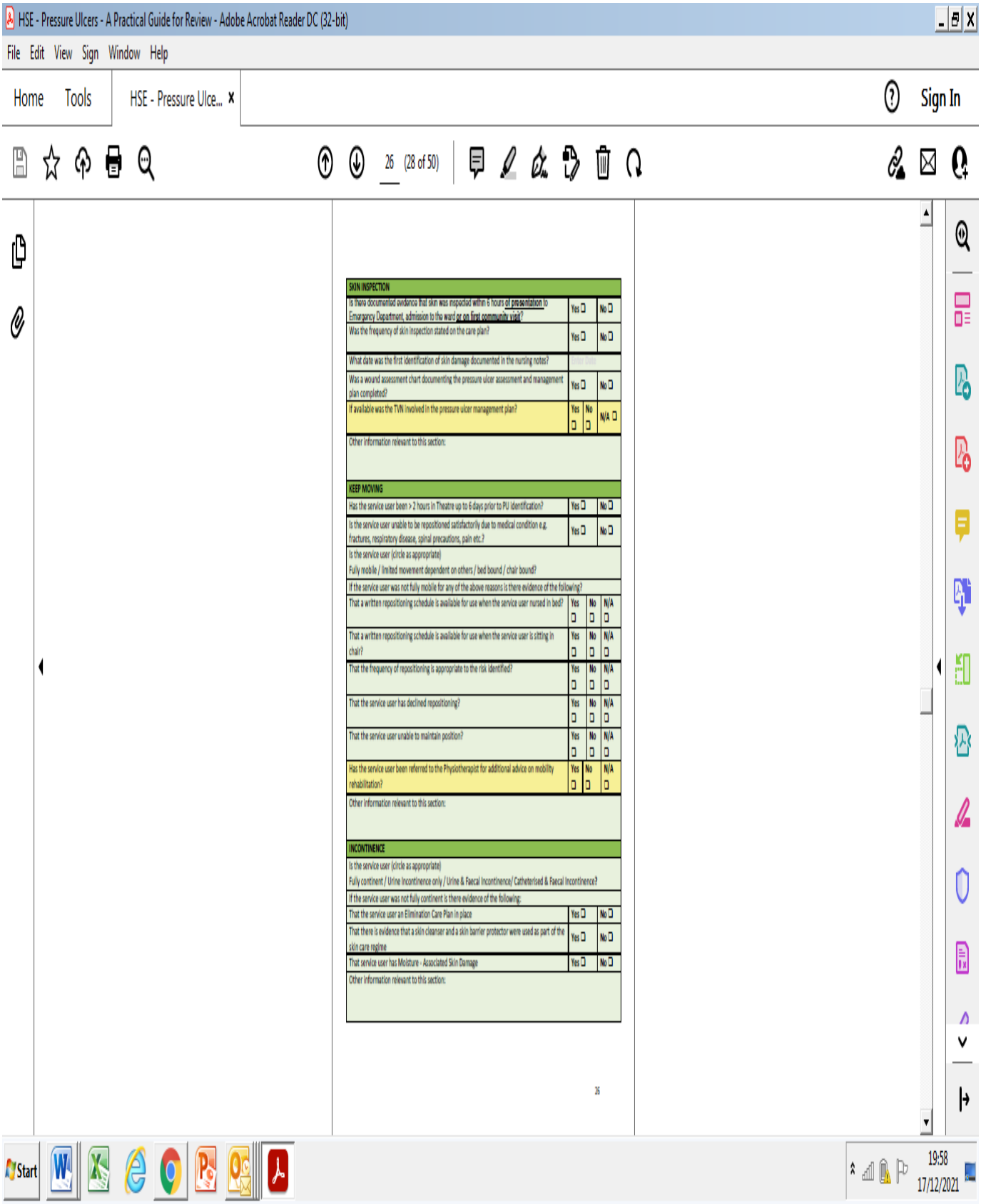
pressure ulcer?			
What was the Pressure Ulcer risk assessment score on the date the pressure ulcer was noticed?	Enter Score		
Other information relevant to this section:			
Prior to the initial observation of the pressure ulcer, did the service user have any of the following additional risk factors for pressure ulcer development			
Sensory impairment (neurological disease resulting in reduced sensation and insensitivity to pain	Yes ☐	No ☐	
Reduced level of consciousness	Yes ☐	No ☐	
Deterioration in service users condition whereby the service user may have been hypotensive, hypothermic, hypoxic, pyrexia, septic etc.	Yes ☐	No ☐	
Has the service user had a period of prolonged collapse / injury / immobilisation which may correlate with presentation of tissue damage?	Yes ☐	No ☐	
Severe chronic or terminal illness (multi-organ failure, poor perfusion and immobility)	Yes ☐	No ☐	
Previous history of a pressure ulcer at site of current pressure ulcer ulceration	Yes ☐	No ☐	
Diagnosed or suspected Peripheral Vascular Disease	Yes ☐	No ☐	
Sustained pressure from medical related device e.g. from orthopaedic casting, tubing etc.	Yes ☐	No ☐	
Is there evidence that the medical team / GP were aware of the service user's elevated risk status for pressure damage/developing skin damage?	Yes ☐	No ☐	N/A ☐
Other information relevant to this section:			
Key Points of Pressure Ulcer Prevention Plan			
Is there evidence that a pressure ulcer prevention plan is in place (e.g. SSKIN bundle or specific pressure ulcer care plan)	Yes ☐	No ☐	
If Yes, Date commenced: Time commenced:			
Is there evidence that the pressure ulcer prevention plan in place (e.g. SSKIN bundle or specific pressure ulcer care plan) was completed in full as appropriate to the date the service user was assessed as 'at risk'.	Yes ☐	No ☐	
Other information relevant to this section:			

SURFACES

Equipment	Indicated		Type	Date Ordered	Date Available	In use at time PU identified?	
Mattress	Yes ☐	No ☐				Yes ☐	No ☐
Cushion	Yes ☐	No ☐				Yes ☐	No ☐
Heel Protectors	Yes ☐	No ☐				Yes ☐	No ☐

Has the service user been referred to the Occupational Therapist for additional advice of specialised seating / equipment?	Yes ☐	No ☐	N/A ☐
Other information relevant to this section:			

25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SKIN INSPECTION
Is there documented evidence that skin was inspected within 6 hours of presentation to Emergency Department, admission to the ward or on first community visit?
Was the frequency of skin inspection stated on the care plan?
What date was the first identification of skin damage documented in the nursing notes?
Was a wound assessment chart documenting the pressure ulcer assessment and management plan completed?
If available was the TVN involved in the pressure ulcer management plan?
Other information relevant to this section:
KEEP MOVING
Has the service user been > 2 hours in Theatre up to 6 days prior to PU identification?
Is the service user unable to be repositioned satisfactorily due to medical condition e.g. fractures, respiratory disease, spinal precautions, pain etc.?
Is the service user (circle as appropriate)
Fully mobile / limited movement dependent on others / bed bound / chair bound?
If the service user was not fully mobile for any of the above reasons is there evidence of the following?
That a written repositioning schedule is available for use when the service user nursed in bed?
That a written repositioning schedule is available for use when the service user is sitting in chair?
That the frequency of repositioning is appropriate to the risk identified?
That the service user has declined repositioning?
That the service user unable to maintain position?
Has the service user been referred to the Physiotherapist for additional advice on mobility rehabilitation?
Other information relevant to this section:
INCONTINENCE
Is the service user (circle as appropriate)
Fully continent / Urine Incontinence only / Urine & Faecal Incontinence/ Catheterised & Faecal Incontinence?
If the service user was not fully continent is there evidence of the following:
That the service user an Elimination Care Plan in place
That there is evidence that a skin cleanser and a skin barrier protector were used as part of the skin care regime
That service user has Moisture - Associated Skin Damage
Other information relevant to this section:
Yes No N/A
19:58
17/12/2021


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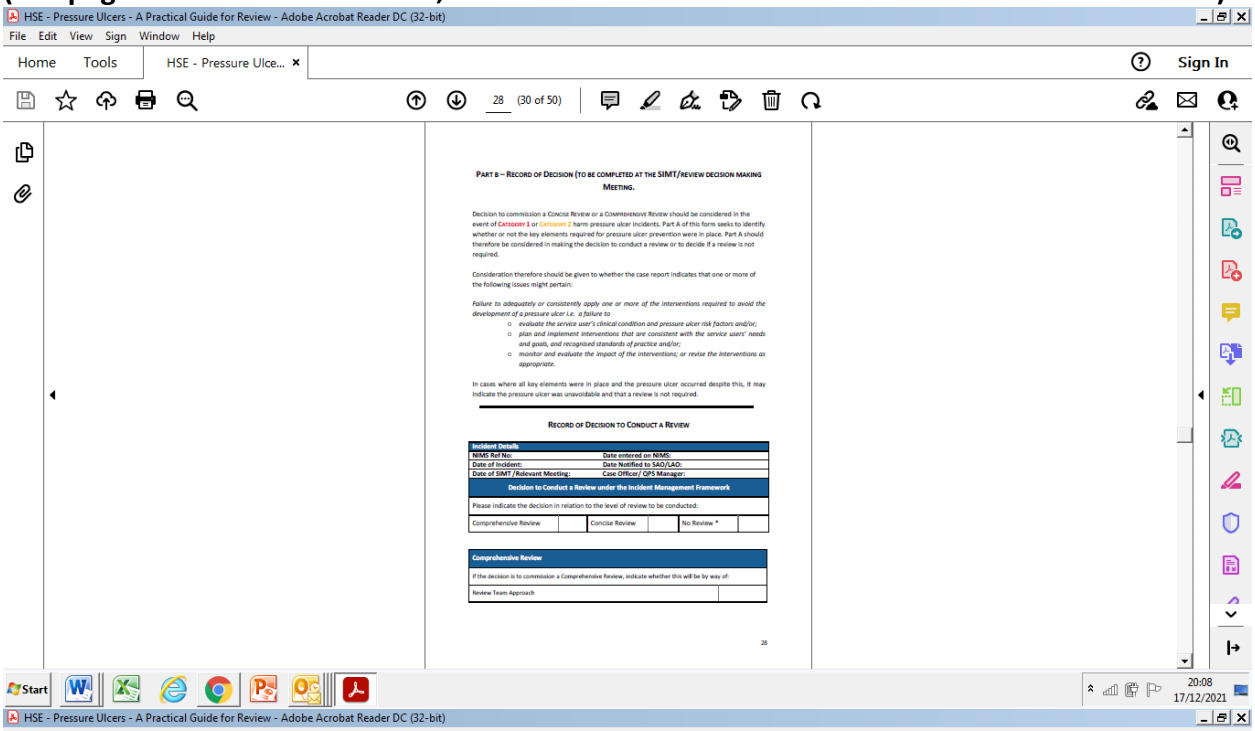
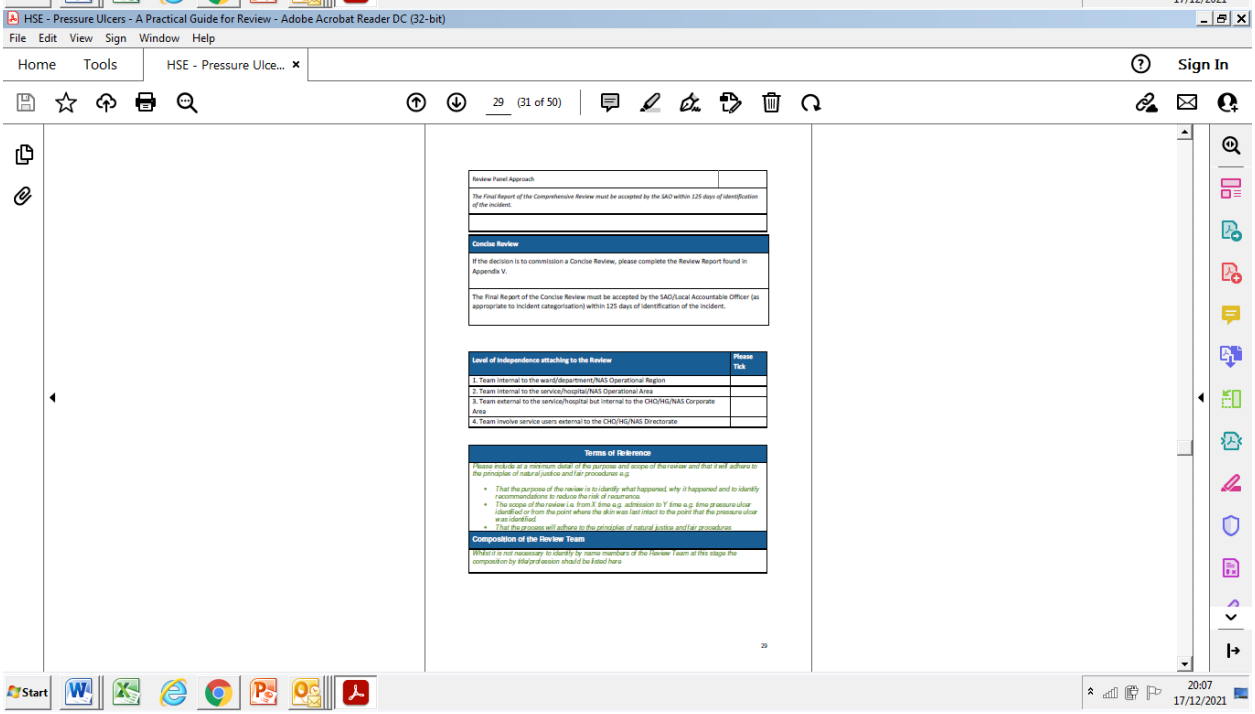
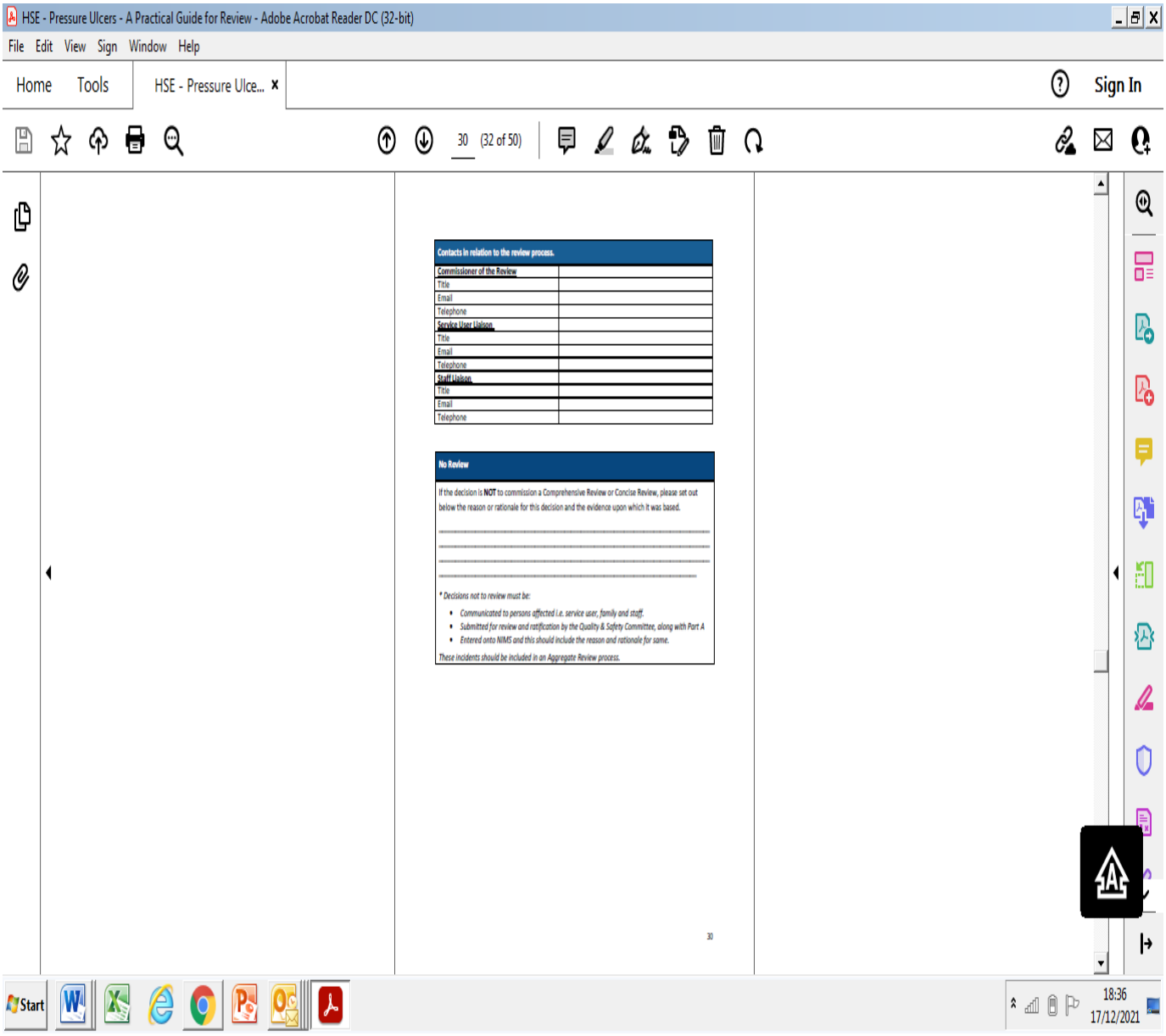
NUTRITION
Has the service user a Body weight BMI < 20 or BMI > 35? Yes ☐ No ☐
Has a Nutritional Risk Assessment been completed? Yes ☐ No ☐
Date of Nutritional Risk Assessment Enter Date
What Nutritional Risk Assessment tool was used?
What was the assessed Nutritional Risk Assessment score?
If indicated by the Nutritional Risk Assessment is there evidence that the service user has been offered nutritional support (such as fortified diet advice or supplements? Yes ☐ No ☐
Has the service user been referred to the Dietician/ Speech & Language Therapist for additional advice / support? Yes ☐ No ☐ N/A ☐
Other information relevant to this section:
INVOLVEMENT OF THE SERVICE USERS FAMILY
Is there evidence that the service user / carer/s were involved with the care plan and agreed with it? Yes ☐ No ☐
Was service user / carer information on pressure ulcer prevention provided? Yes ☐ No ☐
Other information relevant to this section:
STAFFING
What is the approved staffing and skill mix on the ward/unit? (applicable to hospitals and residential units only) Nurse: Enter No. HCA: Enter No. Student: Enter No.
If a hospital/residential unit, what is the bed capacity for the ward/unit?
Have there been any issues in relation to staffing/skill mix in the past week? If yes, please outline details of this in the 'Other information relevant to this section' below Yes ☐ No ☐
Is there evidence that all relevant staff on the ward/unit/community been trained in the pressure ulcer prevention policies of the service? Yes ☐ No ☐
Other information relevant to this section:
COMMUNICATION
Is there documented evidence that the service user's pressure ulcer risk was communicated to the service user, their family? Yes ☐ No ☐
Is there documented evidence that the service user's pressure ulcer risk was communicated to relevant staff? Yes ☐ No ☐
Signature:
Date:
27
Start
20:05
17/12/2021

Appendix 25 PART B – Record Of Decision (To Be Completed At The Simt/Review Decision Making Meeting

(See pages 28 to 30 of document; Pressures Ulcers -A Practical Guide for Review – HSE 2018)



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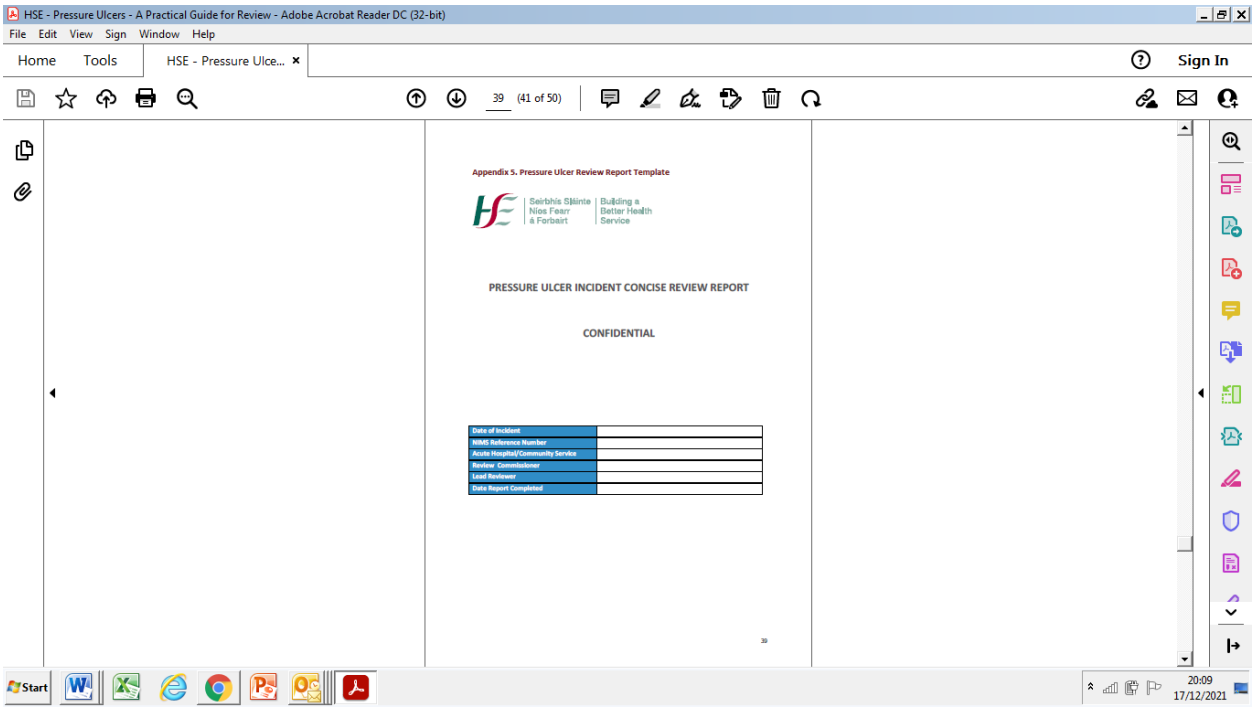
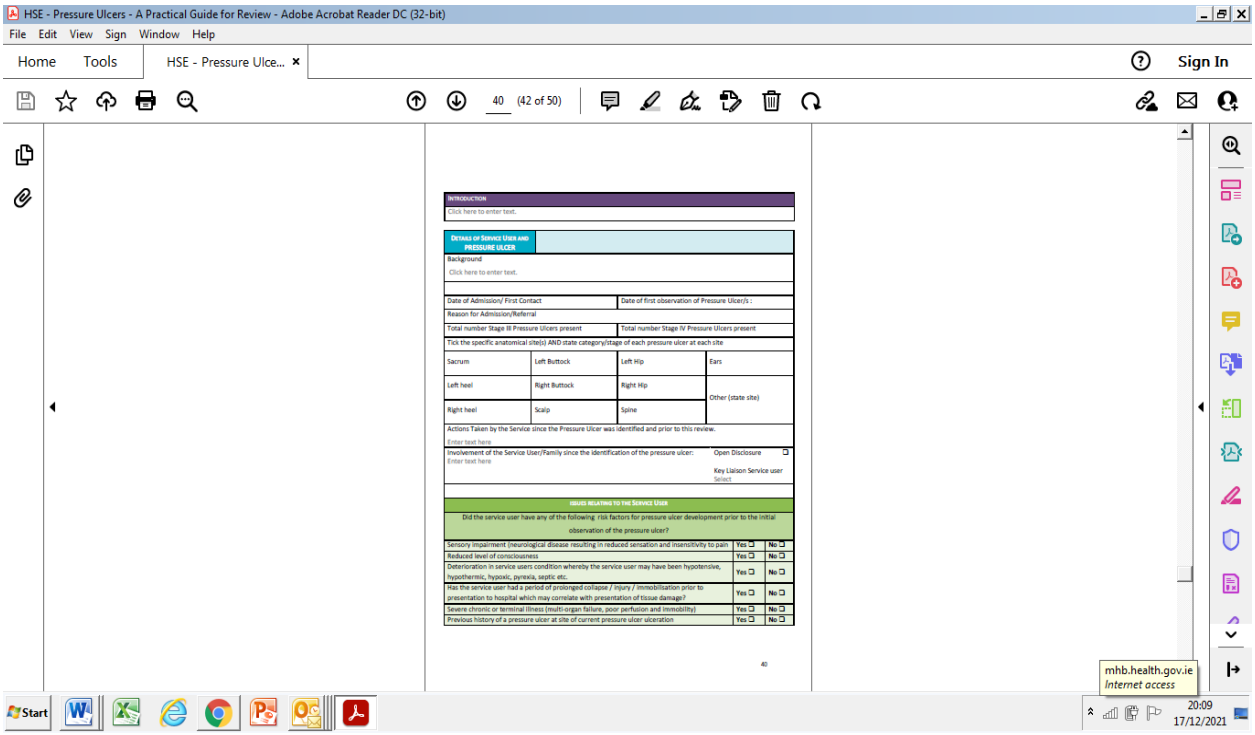
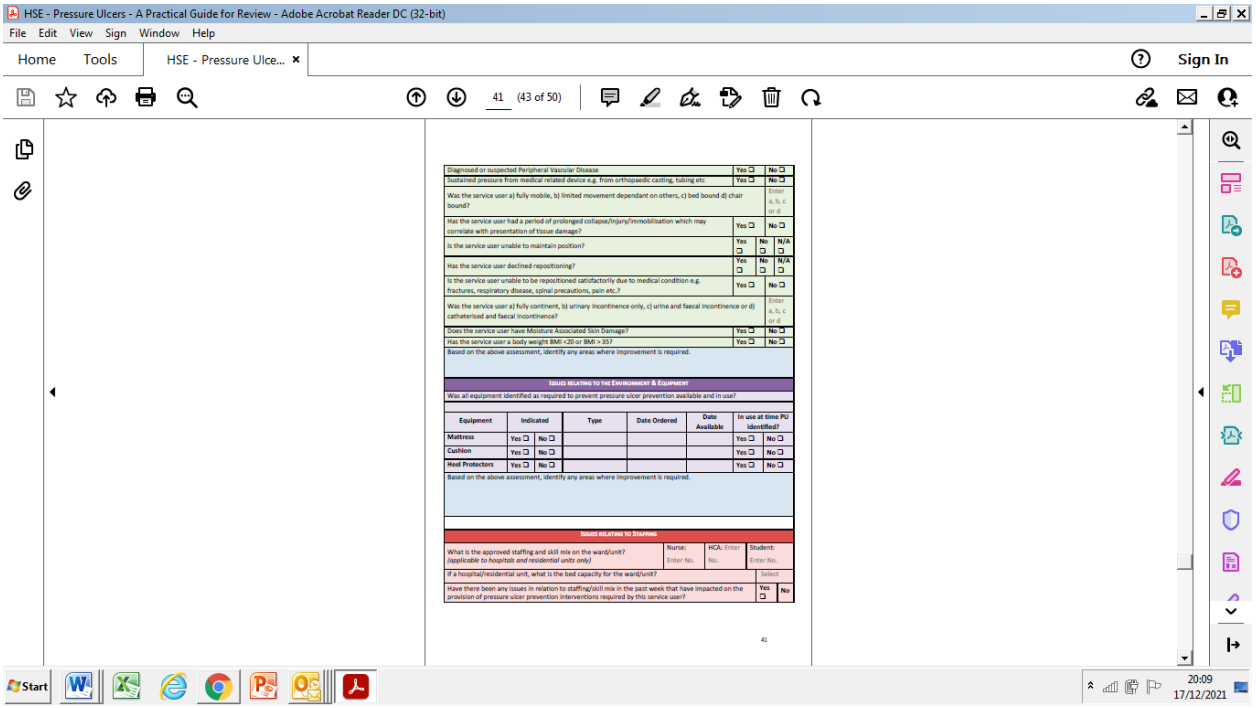
Contacts in relation to the review process.
Commissioner of the Review
Title
Email
Telephone
Service User Liaison
Title
Email
Telephone
Staff Liaison
Title
Email
Telephone
No Review
If the decision is NOT to commission a Comprehensive Review or Concise Review, please set out below the reason or rationale for this decision and the evidence upon which it was based.
* Decisions not to review must be:
Communicated to persons affected i.e. service user, family and staff.
Submitted for review and ratification by the Quality & Safety Committee, along with Part A
Entered onto NIMS and this should include the reason and rationale for same.
These incidents should be included in an Aggregate Review process.
30
Start
18:36
17/12/2021

Appendix 26 Pressure Ulcer Review Report Template
(See Pages 39 to 45 of document; Pressures Ulcers -A Practical Guide for Review – HSE 2018)



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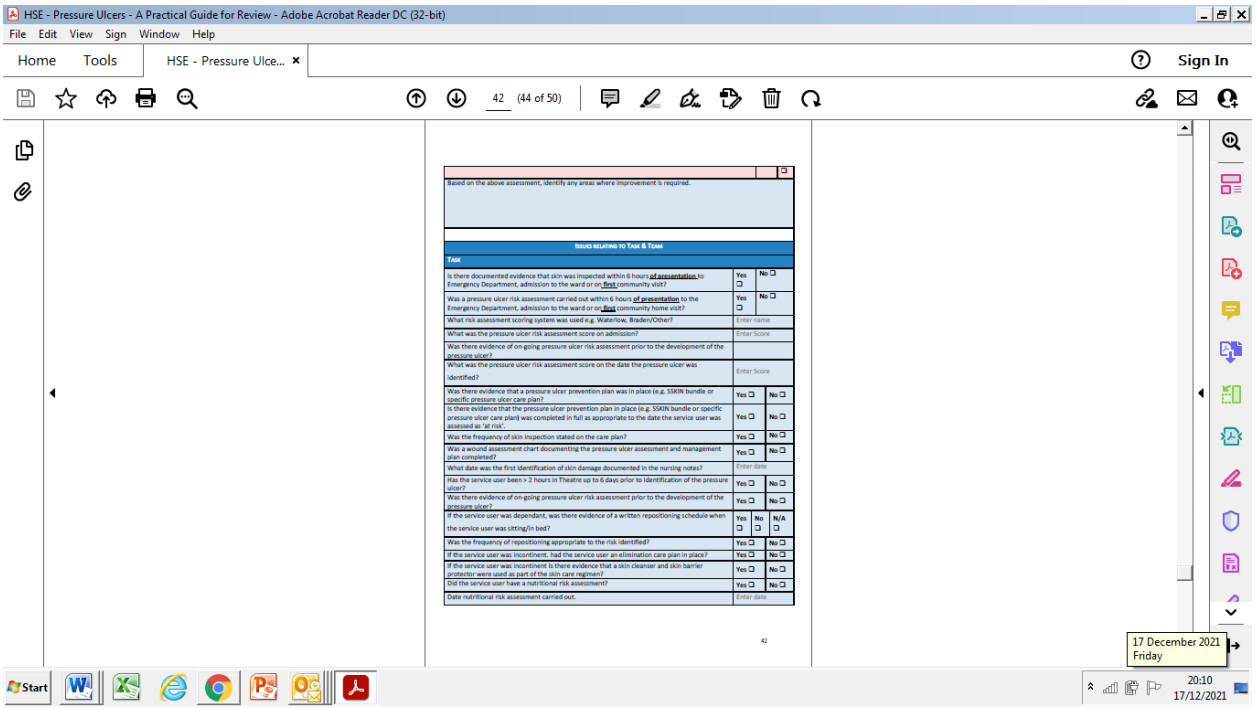
Diagnosed or suspected Peripheral Vascular Disease
Sustained pressure from medical related device e.g. from orthopaedic casting, tubing etc
Was the service user a) fully mobile, b) limited movement dependant on others, c) bed bound d) chair bound?
Has the service user had a period of prolonged collapse/injury/immobilisation which may correlate with presentation of tissue damage?
Is the service user unable to maintain position?
Has the service user declined repositioning?
Is the service user unable to be repositioned satisfactorily due to medical condition e.g. fractures, respiratory disease, spinal precautions, pain etc.?
Was the service user a) fully continent, b) urinary incontinence only, c) urine and faecal incontinence or d) catheterised and faecal incontinence?
Does the service user have Moisture Associated Skin Damage?
Has the service user a body weight BMI <20 or BMI > 35?
Based on the above assessment, identify any areas where improvement is required.
ISSUES RELATING TO THE ENVIRONMENT & EQUIPMENT
Was all equipment identified as required to prevent pressure ulcer prevention available and in use?
Equipment
Indicated
Type
Date Ordered
Date Available
In use at time PU identified?
Mattress
Cushion
Heel Protectors
Based on the above assessment, identify any areas where improvement is required.
ISSUES RELATING TO STAFFING
What is the approved staffing and skill mix on the ward/unit? (applicable to hospitals and residential units only)
Nurse:
HCA:
Student:
If a hospital/residential unit, what is the bed capacity for the ward/unit?
Have there been any issues in relation to staffing/skill mix in the past week that have impacted on the provision of pressure ulcer prevention interventions required by this service user?
20:09
17/12/2021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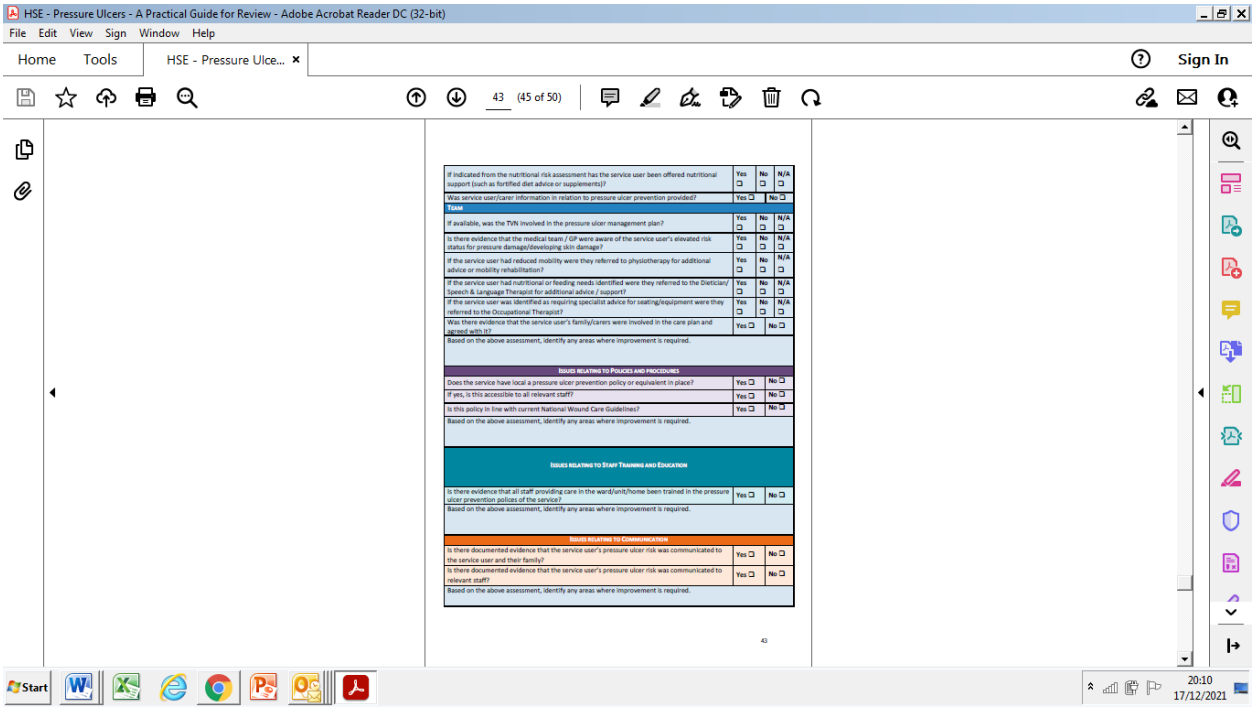
Based on the above assessment, identify any areas where improvement is required.
ISSUES RELATING TO TASK & TEAM
TASK
Is there documented evidence that skin was inspected within 6 hours of presentation to Emergency Department, admission to the ward or on first community visit?
Was a pressure ulcer risk assessment carried out within 6 hours of presentation to the Emergency Department, admission to the ward or on first community home visit?
What risk assessment scoring system was used e.g. Waterlow, Braden/Other?
What was the pressure ulcer risk assessment score on admission?
Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer?
What was the pressure ulcer risk assessment score on the date the pressure ulcer was identified?
Was there evidence that a pressure ulcer prevention plan was in place (e.g. SSKIN bundle or specific pressure ulcer care plan?
Is there evidence that the pressure ulcer prevention plan in place (e.g. SSKIN bundle or specific pressure ulcer care plan) was completed in full as appropriate to the date the service user was assessed as 'at risk'.
Was the frequency of skin inspection stated on the care plan?
Was a wound assessment chart documenting the pressure ulcer assessment and management plan completed?
What date was the first identification of skin damage documented in the nursing notes?
Has the service user been > 2 hours in Theatre up to 6 days prior to identification of the pressure ulcer?
Was there evidence of on-going pressure ulcer risk assessment prior to the development of the pressure ulcer?
If the service user was dependant, was there evidence of a written repositioning schedule when the service user was sitting/in bed?
Was the frequency of repositioning appropriate to the risk identified?
If the service user was incontinent, had the service user an elimination care plan in place?
If the service user was incontinent is there evidence that a skin cleanser and skin barrier protector were used as part of the skin care regimen?
Did the service user have a nutritional risk assessment?
Date nutritional risk assessment carried out.
17 December 2021
Friday
20:10
17/12/2021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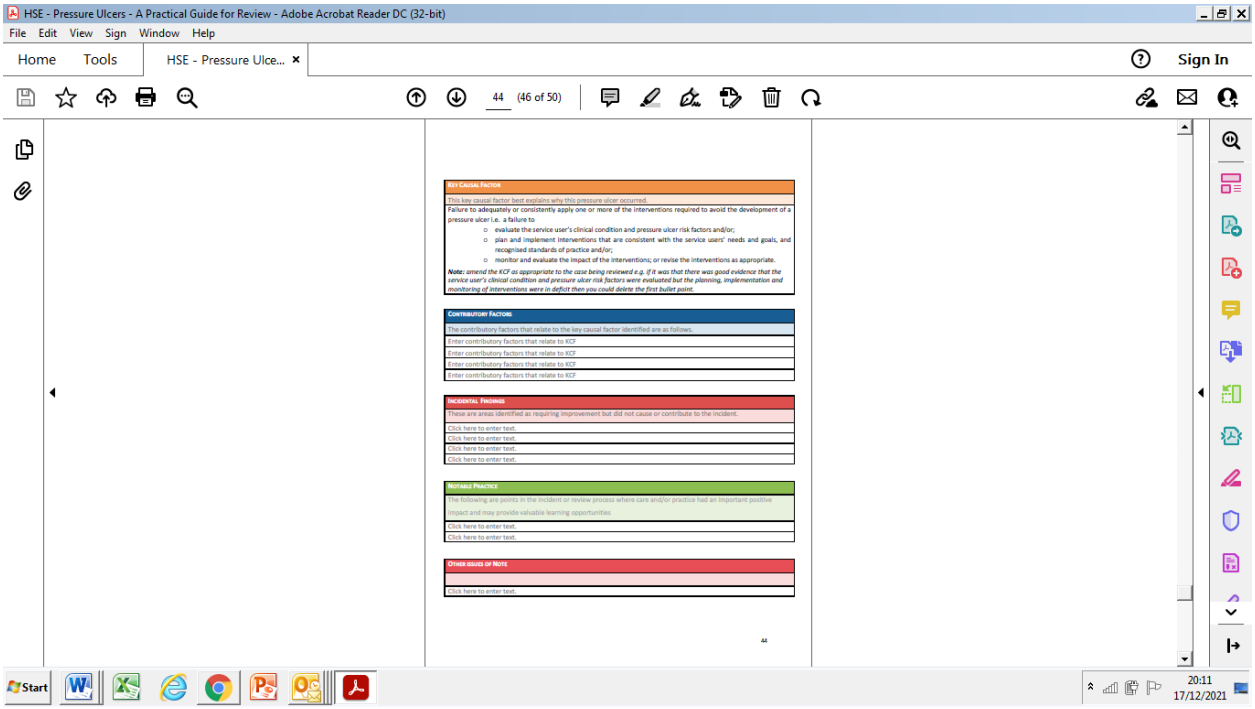
If indicated from the nutritional risk assessment has the service user been offered nutritional support (such as fortified diet advice or supplements)?
Was service user/carer information in relation to pressure ulcer prevention provided?
Team
If available, was the TVN involved in the pressure ulcer management plan?
Is there evidence that the medical team / GP were aware of the service user's elevated risk status for pressure damage/developing skin damage?
If the service user had reduced mobility were they referred to physiotherapy for additional advice or mobility rehabilitation?
If the service user had nutritional or feeding needs identified were they referred to the Dietician/ Speech & language Therapist for additional advice / support?
If the service user was identified as requiring specialist advice for seating/equipment were they referred to the Occupational Therapist?
Was there evidence that the service user's family/carers were involved in the care plan and agreed with it?
Based on the above assessment, identify any areas where improvement is required.
Issues relating to Policies and Procedures
Does the service have local a pressure ulcer prevention policy or equivalent in place?
If yes, is this accessible to all relevant staff?
Is this policy in line with current National Wound Care Guidelines?
Based on the above assessment, identify any areas where improvement is required.
Issues relating to Staff Training and Education
Is there evidence that all staff providing care in the ward/unit/home been trained in the pressure ulcer prevention polices of the service?
Based on the above assessment, identify any areas where improvement is required.
Issues relating to Communication
Is there documented evidence that the service user's pressure ulcer risk was communicated to the service user and their family?
Is there documented evidence that the service user's pressure ulcer risk was communicated to relevant staff?
Based on the above assessment, identify any areas where improvement is required.
43
Start
20:10
17/12/2021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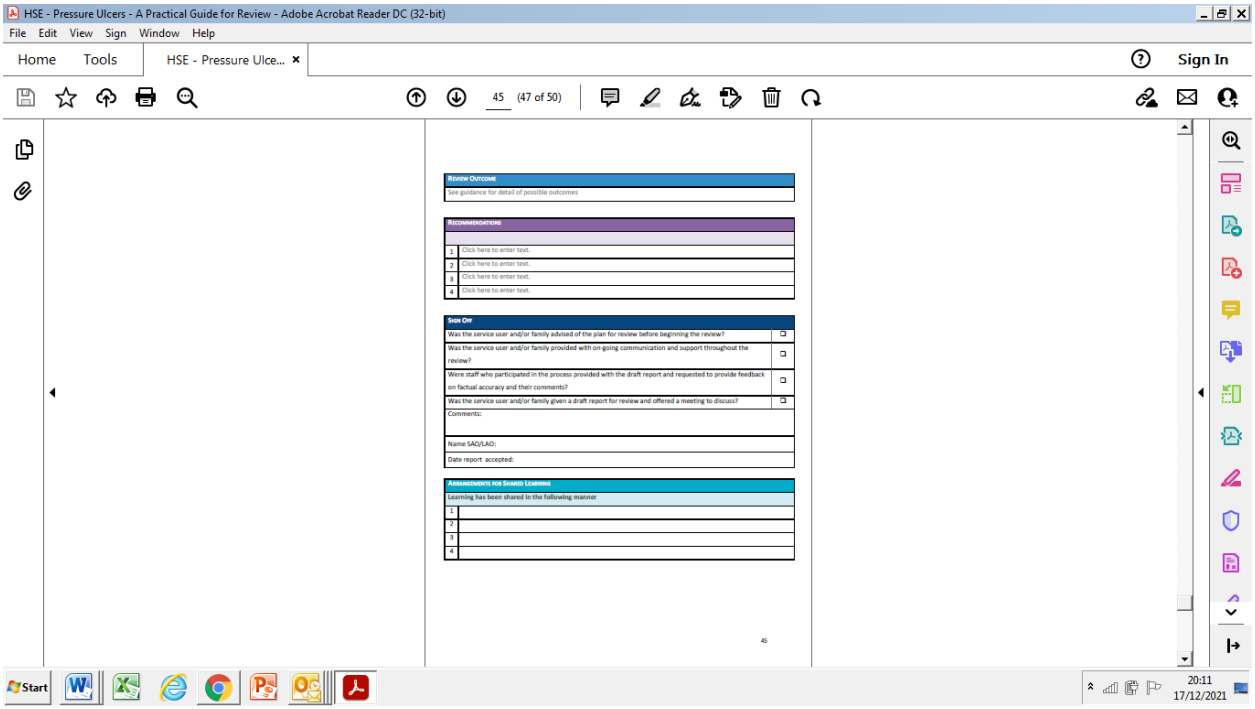
Key Causal Factor
This key causal factor best explains why this pressure ulcer occurred.
Failure to adequately or consistently apply one or more of the Interventions required to avoid the development of a pressure ulcer i.e. a failure to
evaluate the service user's clinical condition and pressure ulcer risk factors and/or;
plan and implement interventions that are consistent with the service users' needs and goals, and recognised standards of practice and/or;
monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
Note: amend the KCF as appropriate to the case being reviewed e.g. if it was that there was good evidence that the service user's clinical condition and pressure ulcer risk factors were evaluated but the planning, implementation and monitoring of interventions were in deficit then you could delete the first bullet point.
Contributory Factors
The contributory factors that relate to the key causal factor identified are as follows.
Enter contributory factors that relate to KCF
Enter contributory factors that relate to KCF
Enter contributory factors that relate to KCF
Enter contributory factors that relate to KCF
Incidental Findings
These are areas identified as requiring improvement but did not cause or contribute to the incident.
Click here to enter text.
Click here to enter text.
Click here to enter text.
Click here to enter text.
Notable Practice
The following are points in the incident or review process where care and/or practice had an important positive impact and may provide valuable learning opportunities
Click here to enter text.
Click here to enter text.
Other Issues of Note
Click here to enter text.
44
Start
20:11
17/12/2021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45 (47 of 50)
Review Outcome
See guidance for detail of possible outcomes
Recommendations
1 Click here to enter text.
2 Click here to enter text.
3 Click here to enter text.
4 Click here to enter text.
Sign Off
Was the service user and/or family advised of the plan for review before beginning the review?
Was the service user and/or family provided with on-going communication and support throughout the review?
Were staff who participated in the process provided with the draft report and requested to provide feedback on factual accuracy and their comments?
Was the service user and/or family given a draft report for review and offered a meeting to discuss?
Comments:
Name SAO/LAO:
Date report accepted:
Arrangements for Shared Learning
Learning has been shared in the following manner
1
2
3
4
45
Start
20:11
17/12/2021

Appendix 27

Pressure Ulcer Prevention and Management Documentation Quick Guide

This guide does not replace the need for you to be fully knowledgeable of the relevant PPPGs namely:

- Guideline on Pressure Ulcer Assessment, Prevention and Management for Adults 2021 Version No: 03 Approval Date: December 2021 Revision Date: December 2024
- HSE Dublin Mid-Leinster, Guideline on Nutritional Screening of adults by community nurses using the 'Malnutrition Universal Screening Tool' ('MUST') and first line dietary management including the use of Oral Nutritional Supplements, HSE Dublin Mid-Leinster for counties Laois, Offaly, Longford, Westmeath. PHN015 CNDS023 4
- Health Service Executive (2017) HSE Integrated Risk Management Policy.

Quick Guide

COMPLETION OF THE WATERLOW SCORE:

On identification of a risk for pressure ulcer development, a pressure ulcer risk assessment, utilising the Waterlow score, must be completed;

1. On the first community home visit.

The Waterlow Score **must then be repeated** in the following circumstances;

1. Where there is any evidence of deterioration in the client's condition
2. Upon identification of the new onset of pressure ulceration
3. Upon discharge from hospital

COMPLETION OF THE CORE CARE PLAN FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

When the Waterlow Score identifies that a client is at risk of pressure ulcer development, i.e. a Waterlow Score of 10+, a core care plan must be placed in the client's chart.

The core care plan is individualised by completing the client's name, clinical details and reported goals of care.

COMPLETION OF THE SSKIN BUNDLE PRESSURE ULCER PREVENTION STRATEGY CHART

The SSKIN Bundle Pressure Ulcer Prevention Strategy Chart must be completed as follows:

1. On initial assessment of a client when they have been identified at risk of a pressure ulcer development (Waterlow score of 10+)

The SSKIN Bundle Pressure Ulcer Prevention Strategy Chart **must be repeated**;

1. Where there is any evidence of deterioration in the client's condition
2. Upon identification of new onset of pressure ulceration
3. Upon discharge from hospital

PROVISION OF THE PREVENTING AND TREATING PRESSURE ULCERS: INFORMATION FOR CLIENTS, FAMILIES AND CARERS BOOKLET

The booklet will be provided to the client and carer on identification of risk of pressure ulcer development (Waterlow 10+)

COMPLETION OF RISK ASSESSMENT IN THE CASE OF NON CONSENT

If the client chooses not to consent to the recommended plan of care following provision of both verbal and written education of the risk factors, the PHN/CRGN is required to carry out a risk assessment as per HSE Integrated Risk Management Policy (HSE, 2017) and inform the client and carer of the completed risk assessment.

(Risk Assessment Template available in Pressure Ulcer Prevention and Management Folder)

COMPLETION OF MUST ASSESSMENT

The MUST Assessment Tool must be completed as per local policy (PHN015) for clients 75 years and over, admitted to the PHN caseload.

Nutritional screening **must be repeated;**

1. For clients at risk of pressure ulcers development (Waterlow score 10+)
2. Upon identification of new onset of pressure ulceration
3. When there is a clinical concern or deterioration in the condition.

COMPLETION OF THE LAOIS/OFFALY AND LONGFORD/WESTMEATH PHN SERVICE REPOSITIONING CHART

Clients/carers/HCAS should be taught how to distribute weight and reposition.

The repositioning chart is available (pre-printed) (PHN026, Appendix 7) and can be incorporated into the individual client care plan as appropriate.

Clients who should require a repositioning chart in the home are;

1. Clients on complete bedrest
2. Clients who are high dependency and are requiring hoisting from bed to chair.

HSS Care managers should be contacted by the CRGN/PHN when a repositioning chart is placed in the home. It is the responsibility of the Care Manager to instruct their staff in the completion of the repositioning chart and also of their responsibility to communicate any changes in skin integrity to their manager.

Pressure Ulcer Prevention and Management Documentation: A Quick Guide

Prepared By Mary Costello, RANP Tissue Viability March 2022