Pressure Ulcer Prevention and Management Policy

Lead Manager:	Chief Nurse, Regional Services
Responsible Director:	Executive Nurse Director
Approved by:	Board Clinical Governance Forum
Date approved:	
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Replaces previous version	April 2023

CONTENTS

NHS Greater Glasgow and Clyde Pressure Ulcer Prevention and Management

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version changes	**Comment**
Introduction:	Updated NHS Greater Glasgow and Clyde (NHSGGC) Pressure Ulcer Prevention and Management Policy (2024) for approval
Referral to specialist services (page 11)	Change to policy. All healthcare acquired pressure damage to be referred now to tissue viability.
Orthotic services referrals (page 11, Appendix 6)	More detailed information on when and how to refer to orthotics
Resource page Appendix 8	Updated

Introduction

The purpose of this policy is to ensure that all patients within NHS Greater Glasgow and Clyde (NHSGGC) are systematically assessed, and effective strategies put in place to reduce risk to healthy tissue and facilitate healing of damaged tissue from pressure, shear, friction and moisture.

This policy is applicable to all age groups and should be read in conjunction with the NHS Healthcare Improvement Scotland (HIS) Standards for Prevention and Management of Pressure Ulcers 2020. (1)

Pressure ulcers are described as "an injury that breaks down the skin and underlying tissue". They are caused when an area of skin is placed under pressure and are sometimes known as 'bed sores', 'pressure sores' (2) or pressure injury. Pressure ulcers can occur in any person who has, for example, limited mobility, cognitive impairment, palliative and end of life care needs or who is acutely ill. Other contributory factors include poorly controlled diabetes, poor bladder or bowel function, or poor nutrition and hydration. (3)

Definitions of pressure ulcers

Pressure damage negatively affects quality of life and imposes a significant financial burden on healthcare systems. Pressure ulcers are graded by degree of damage. The Scottish Adaption of the European Pressure Ulcer Advisory Panel (EUPAP) tool supports assessment and grading of pressure ulcers. (Appendix 1)

Device Related Pressure Ulcers (DRPU)

To differentiate device related pressure ulcers (DRPU) from pressure ulcers arising from body weight forces, they are defined as:

'*A DRPU involves interaction with a device or object that is in direct contact or indirect contact with skin...or implanted under the skin, causing focal and localised forces that deform the superficial and deep underlying tissues. A DRPU, which is caused by a device or object is distinct from a PU, which is caused primarily by body weight forces. The localised nature of the device forces results in the appearance of skin and deeper tissue damage that mimics that of the device in shape and distribution.'* (4)

Paediatric patients are particularly susceptible to DPRU. Examples of devices include CPAP masks, endotracheal tubes, orthotic devices, spectacles.

A DRPU is recorded in Datix within a medical device pathway. **PLEASE NOTE A PERSON'S FOOTWEAR IS NOT CONSIDERED A DEVICE UNLESS IT IS A PRESCRIBED ITEM.**

See Appendix 5 Guidance for review and Datix completion for a DRPU.

Scope
This policy applies to all healthcare staff involved in the delivery of healthcare regardless of the care setting. It will support and guide decision making in relation to care interventions whilst promoting quality and integration of a team approach in the prevention and management of pressure ulcers. Person centred care will be underpinned by evidence-based practice regardless of age, gender, sexuality, race, religion or belief and disability.

To support quality improvement in NHSGG&C all healthcare acquired pressure ulcers, as per pathway, are reviewed by Tissue Viability and/or Orthotics to support peer review, appropriate grading and identification of learning.

Pressure ulcers can be classed as being unavoidable or avoidable.

Unavoidable pressure damage
'An unavoidable pressure ulcer' means that an individual developed a pressure ulcer even though the care provider had evaluated the individual's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with an individual's goals and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate'. (1,5)

Avoidable pressure damage
Conversely, development of 'an avoidable pressure ulcer' means that there has been an omission in the individual's prescribed care and one or more of the following has occurred:

- inaccurate evaluation of the individual's clinical condition and pressure ulcer risk factors
- interventions were not defined or implemented consistently with patients' needs, goals and recognised standards of practice within the organisation
- unsuccessful monitoring and evaluation of the impact of the interventions
- interventions not revised appropriately (5,6)

Any grade 2 and above healthcare acquired pressure ulcer require a Datix to be completed. This is discussed in more detail in sections 5.7 of this policy.

Roles and Responsibilities

3.1 Healthcare Staff
All healthcare staff caring for patients have a shared responsibility for the prevention and management of pressure ulcers.

Ongoing responsibility for the review and monitoring, assessment of the patient remains with the nursing/podiatry team caring for the patient.

Community patients on podiatry only caseload must be referred to DNs for holistic review of pressure ulcer risk and pressure redistribution management plan.

Shared responsibilities include ensuring all patients have:

- Pressure ulcer risk assessment using specified risk assessment tool is carried out within set timescale.
- Person centred care plan.
- Pressure ulcer prevention interventions recorded in clinical record.
- Wound assessment chart completed if person has a pressure ulcer, dimensions must be measured and not estimated.
- Contributing to the ongoing risk assessment of patients using the specified risk assessment tool and clinical judgment.
- Contributing to, reviewing, evaluating and updating the person-centred care plan based on ongoing risk assessment of the patient.
- Ensuring there is a formalised process to share pressure ulcer prevention and person-centred care plans with the multidisciplinary team, relatives/carers, and care at home services.
- Providing the patient and relative/carer, as appropriate, with information in a suitable format and recording in clinical record when this information was given and in what format.
- If patient information is not provided, this should be documented within the clinical record.
- Patients have a documented assessment to determine the requirement for additional pressure redistributing equipment.
- Ensuring that pressure redistributing equipment (footwear, cushion, seating, mattress, turn assist platform) are readily available and that manufacturer's instructions are followed. An electric profiling bed should be used when appropriate to maximise pressure redistribution, including using knee bend if appropriate.
- Recording pressure redistribution equipment in place in clinical record.
- In the event that equipment cannot be accessed this must be escalated to line manager and documented within the clinical record. Staff must not use pressure redistributing equipment, including foot protection, mattresses, or beds if they are not competent in the use.
- All healthcare acquired Grade 2 and above pressure ulcers are referred to appropriate specialty: as per community and in patient pathways. (Appendix 3)

3.2 Senior Charge Nurses/ Community Team Leads

Senior Charge Nurses and Community Team Leads are responsible for ensuring that all patients have:

- Pressure ulcer risk assessment using specified risk assessment tool is carried out within set timescale.
- Person centred care plan.
- Pressure ulcer prevention interventions recorded in clinical record.
- Wound assessment chart completed if person has a pressure ulcer, dimensions must be measured and not estimated.
- All healthcare acquired Grade 2 and above pressure ulcers are referred to tissue viability.

- Pressure redistributing equipment (footwear, cushion, seating, mattress, turn assist platform) are readily available. And an electric profiling bed is used when appropriate to maximise pressure redistribution.
- All staff are competent in the use of equipment. Staff must not use pressure redistributing equipment, including foot protection, mattresses, turn assist platforms or beds if they are not competent in the use.
- Datix incidents are reviewed and approved within four weeks, unless progressed to SAER.
- Any issues identified from reviews are used to achieve and maintain learning and quality improvement.

An **in-patient** setting is identified as a 'hotspot' (more than one incident in a month or 2 consecutive incidents) then all staff must complete the Moisture Lesion and Pressure Ulcer Competency Assessment. It is the responsibility of Senior Charge Nurses /Senior Nurse Manager /Lead Nurse.

3.3 Chief Nurses/Chief Midwives/Senior Nurses/Professional Nurse Leads/Lead Nurses/Lead Midwives/Line Managers/Senior Charge Nurses and Community Team Leads
The above are individually responsible for ensuring that:

- This policy is monitored at local level through Datix, Microstrategy database and CAIR dashboard.
- Staff maintain and update their knowledge, skills, and competencies in line with their roles and responsibilities, to prevent and manage pressure ulcers.
- Staff are competent in the use of pressure redistributing equipment including cushions, footwear, mattresses, turn assist platformand beds.
- A record of staff training is maintained.
- If clinical area identified as a 'hotspot' then all staff must complete the Moisture Lesion and Pressure Ulcer Competency Framework.

All relevant pressure ulcer prevention and management resources are detailed in **Appendix 8**

- **Tissue Viability Service is responsible for reviewing healthcare acquired pressure damage.**
- **Podiatry is responsible for reviewing all other foot and ankle wounds including inherited pressure damage.**

- See community and In-patient flowcharts **Appendices 3 & 4**

- Supporting line managers and clinical staff in implementing this policy and national guidelines. (HIS) Standards for Prevention and Management of Pressure Ulcers (2020) (1). Scottish Government CPR for feet (2017) (7)
- Provision of education and training in pressure ulcer prevention and management in a variety of formats.
- Provision of specialist clinical advice.
- Provision of specialist advice regarding rental, purchase and availability of pressure redistributing equipment.

- Evaluation of the provision, quality, and uptake of training.
- Ensuring that their individual education and training needs are aligned to professional development frameworks

4.1 Staff Education

NHSGGC demonstrates commitment to the education and training of staff involved in prevention and management of pressure ulcers, appropriate to roles and workplace setting, these are available in **Appendix 8** and include:

- Pressure ulcer prevention and management.
- Guidelines, policies, assessment tools and care planning.
- Application of Quality Improvement methodology for pressure ulcer prevention and management.
- Initial assessment and reassessment of risk, including other contributing factors, for example people with frailty, limited mobility, or diabetes, and those who are malnourished or at end of life.
- Person-centred care planning for prevention and management.
- Assessment, grading, and management of existing pressure ulcers.
- Prevention and management of wound and systemic infection.
- The importance of the multi-professional approach such as access and referral for specialist advice and treatment.
- Annual competency tool

Bespoke education for staff can be provided by Tissue Viability on request.

4.2 Patient information

People at risk of, or identified with, a pressure ulcer (and/or their representatives) must be provided with support and information, in a format appropriate to their needs, about:

- Risk factors associated with pressure ulcers.
- How to prevent pressure ulcers.
- Early identification of signs and symptoms of pressure ulcer development.
- When and who to report any concerns or skin changes to
- Strategies for the management of pressure ulcers, including self-management, equipment, and devices.

When the information is provided it must be recorded in the patient's clinical record, specifying in what format the information was given and the specific date it was given. If the information is unable to be provided, then the reason for not providing the information must be documented in the clinical record.

5.1 Assessment of Risk for Pressure Ulcer Development

An assessment of risk for pressure ulcer development is undertaken as part of initial admission or referral and informs care planning.

An individual's potential to develop pressure ulcers will be influenced by both extrinsic (from out-with the patient) and intrinsic (from within the patient) factors. These factors must be considered when performing a risk assessment and developing a plan of care.

The risk factors must be removed or diminished where possible to prevent pressure ulcers.

A specified risk assessment tool is used to support professional or clinical judgment.

Trained healthcare staff must undertake a formal pressure ulcer risk assessment using the specific tool for the clinical area within the set timescale:

- Within **8 hours** of admission to acute hospital or care home
- Within **8 hours** of admission to neonatal and paediatric intensive care units
- Within **24 hours** of admission to any other care setting (mental health)
- On **the first visit** from community services or teams, for example, community nurse or hospital at home

Each formal risk assessment for pressure ulcer development must include:

- Inspection of the person's skin, particularly areas over bony prominences and areas in contact with equipment and devices.
- Assessment of risk factors and other contributing factors, for example people with frailty, limited mobility, diabetes complications, previous pressure damage, previous amputations and those who are malnourished or at the end of life and non-concordance.
- Assessment of the person's needs within their home or care setting, including positioning, equipment and pressure redistributing devices.
- Identifying self-management strategies for people (and/or their representative).
- Planned review of person-centred care plans and reassessment of risk.

Where an assessment of risk or skin inspection has not been undertaken within the agreed time frames, staff must record within the nursing progress/evaluation notes:

1. The reason, or reasons, the assessment or inspection has not been undertaken.
2. The discussion with the person (and/or their representative), and any agreed actions.

5.2 Person Centred Care Planning for Prevention and Treatment

A person-centred care plan is developed and implemented to reduce the risk of pressure ulcer development and to manage any existing pressure ulcers. The person-centred care plan is:

- Reviewed to ensure it meets the ongoing needs of the person.
- Used to inform handovers, care transitions, shared care, and discharge planning.

The care plan is agreed with the person or their representative and includes:

- The outcome from the risk assessment and skin inspection.

- Identification and management of other risks or contributing factors, e.g., bowel and bladder function, nutritional or hydration status, or diabetes complications.
- A treatment plan for any existing pressure ulcer.
- Frequency of repositioning and requirements for equipment and devices.
- Details of self-management strategies and information.
- Planned reassessment of risk.
- If the patient does not consent to specified Pressure Ulcer Prevention risk assessment, including skin inspection during clinical interventions then a plan to support concordance and informed choice should be implemented, risk(s) discussed with patient/patients representative and escalated to line manager.
- The healthcare professional should follow the person-centred care plan for concordance which should include strategies to engage with the patient/ patient's representative to support Pressure Ulcer Prevention. This should be done at each clinical intervention until they are no longer at risk, transferred or discharged from service.
- Record keeping should be clear, concise and the reason, or reasons, the assessment or inspection has not been undertaken must be documented in patient's notes timeously.

5.3 Re-assessment of Risk

Reassessment of risk for pressure ulcer development or deterioration of an existing pressure ulcer is undertaken as per agreed care plan to ensure safe, effective, and person-centred care. Existing care plans are evaluated and revised:

- When an observed or reported change has occurred in the person's condition or changes are noted on skin inspection.
- When the person (and/or their representative) report a change.
- On planned transfer to another care setting.
- On admission to a different care setting.
- When clinical setting allows.

Where a care plan has not been implemented, followed, or declined by patient healthcare staff must record within the clinical record:

- The reason care has not been delivered such as the person's choice or where there is no access to specific services.
- The discussion with the person (and/or their representative),
- Any agreed actions.

5.4 Assessment Grading and Person-Centred Care Planning for Identified Pressure Ulcers

People with an identified pressure ulcer will have:

- A pressure ulcer assessment, grading, and wound assessment chart undertaken, using NHS GGC approved tools.
- A person-centred care plan for pressure ulcer management, with an identified review period.

- The requirement for equipment, devices and dressings assessed to assist in the management of pressure ulcers and prevention of further skin breakdown.
- Regular reassessment of pressure ulcer and evaluation of person-centred care plans undertaken.

If a pressure ulcer deteriorates it must be:

- Re-assessed and classed as a new pressure ulcer.
- Re-graded.
- Recorded in patient record.
- Referred to Podiatry (if the pressure ulcer was inherited damage) OR Tissue Viability Service (if the pressure ulcer was healthcare acquired)
- Reported in Datix by Tissue Viability (in-patient) or by the healthcare professional who discovers the deterioration (community)

When the grade of an ungradeable pressure ulcer or SDTI is established it must be:

- Re-graded.
- Recorded in patient record.
- Referred to the Tissue Viability Service for confirmation, updating of Datix and review of wound healing plan

5.5 Referral to Specialist Services

Referral for prevention and or management advice can be made to specialist services for any patient.

Tissue Viability

Tissue Viability must review all healthcare acquired pressure ulcers Grade 2 and above. A referral to tissue viability must be made immediately on the initial diagnosis of the pressure ulcer.

Orthotics

Note: Orthotics are an acute based service with no community resource.

In acute wards a referral must be made to Orthotics for foot protection for ulcers Grade 2 or above.
In acute wards a referral must be made to Orthotics for alternative foot protection if feet are showing signs of redness despite two hourly pressure relieving interventions, pressure redistribution mattress in situ and appropriate first line pressure redistribution boots have been fitted.

Referral to Orthotics from acute wards for Grade 1 damage should only be made if the first line pressure redistribution device is:

- Inappropriate,

- Not adequate
- Not being tolerated.

Referrals to Orthotics will not be accepted unless a first line pressure redistribution device has already been tried, Orthotics do not supply these.

In community settings, if the patient develops pressure damage to the foot and ankle despite pressure redistribution management plan being in place, a referral to tissue viability must be made. Tissue Viability will refer to Orthotics if appropriate.

Refer to appendix 6 for guidance on how to refer to Orthotics

WestMARC

A referral can be made to WestMARC for wheelchair adjustment and wheelchair cushion requirements.

5.6 Accessing Pressure Re-distributing Equipment

Patients at risk of developing pressure damage should be nursed on an appropriate surface to reduce the risk.

The use of any pressure re-distributing equipment does not replace the need for repositioning and skin inspection of the patient. Any equipment accessed for the patient must be readily available and:

- Follow a holistic assessment of the patient's needs
- Be continually re-assessed to ensure it remains appropriate to meet the patient's needs.
- Be selected according to local protocol.

All patients nursed on an electric profiling bed should have the bed profiled at knee to reduce the risk of pressure ulcer development in feet if no contraindications present.

Patients at risk of pressure damage to the feet must be fitted with additional foot protection until they are nursed on a pressure redistributing mattress.

If the feet continue to show signs of redness, despite all pressure relieving interventions and pressure redistribution mattress, then pressure redistribution boots must be fitted prior to referring to orthotics for additional foot protection.

Healthcare professionals using pressure redistributing equipment including beds, mattresses, cushions, turn assist platforms and foot protection must:

- Ensure they are competent in the use of the equipment.
- Undertake formal/informal risk assessment prior to use of equipment.
- Follow manufacturer's instructions.
- Ensure equipment is fitted correctly on the patient.

Podiatry, Tissue Viability and Orthotics can be contacted for further guidance on pressure redistributing mattresses, equipment, and bed profiling.

5.7 Datix Electronic Incidence Reporting for Issues Related to Pressure Ulcers

In an In-patient setting a Datix should **not** be completed by healthcare professional prior to specialist review.

Tissue Viability will complete a Datix in partnership with nursing staff for:

• All patients who develop a healthcare acquired Grade 2 and above pressure ulcer.
• Any pressure ulcer that deteriorates and is re-graded to a higher grade.
In a community setting, for any Grade 2 and above health care acquired pressure ulcer, the Datix must be completed by the community nurse who identifies the pressure ulcer. Peer review will be undertaken in line with the referral pathway.

If on a domiciliary podiatry only caseload, podiatry complete Datix and refer to District nurses if concerns of other areas at risk of pressure damage for assessment.

5.8 Transfer of Care

Prior to planned transfer:

- All patients who have been identified as being at risk, or who have an existing pressure ulcer, must have their skin inspected for any damage.
- Patient's skin condition documented in the clinical records.
- Re–evaluate the patient's need for pressure redistributing equipment and transfer pressure redistribution boot protection with patient.
- The receiving care setting must be provided with documented information of patient's skin condition, pressure ulcer condition and care requirements including pressure redistributing equipment.
- The receiving care setting must ensure that they are aware of a patient's skin condition, pressure ulcer condition and care requirements including pressure redistributing equipment.
- If a patient has pressure damage to foot (ankle and below) a referral must be made for follow up by podiatrist on discharge

5.9 SAER/Duty of Candour Trigger

- **All grade 4 avoidable health care acquired pressure ulcers require a SAER**
- **All grade 3 avoidable health care acquired pressure ulcers require local review unless specific additional treatment criteria is met and triggers a SAER**

DoC Legislation and a SAER will be triggered following review by the Tissue Viability Nurse for grade 3 patients if they meet set criteria which includes an increase in the person's treatment as follows:

- Antibiotic therapy due to osteomyelitis
- Surgical debridement
- Sepsis

In addition:

- Pain arising from pressure ulcer lasting more than 28 days as a direct result of the pressure damage
- Increased length of stay due to the pressure damage alone
- Multiple areas of pressure damage at one incident

- **The majority of ungradeable pressure ulcers will be re classified as grade 3 or grade 4** by Tissue Viability **once a grade is established** regardless of how long the wound remains ungradeable. **They will be then follow grade 3 and 4 processes described above.**
- If the re classification of grade takes place after discharge the flow chart in **Appendix 7** should be followed.

Consultation of Policy

This is an update of policy to reflect a change in service delivery and all stakeholders involved in the update and approved at Acute and HSCP Pressure Ulcer Operational Groups and Pressure Ulcer Steering Group

Aim: To develop a robust clinical guideline that can be accessed and utilised across NHSGGC.

Policy Review
This policy will be reviewed by a SLWG (Short Life Working Group) comprising of key stakeholders every three years (August 2027).

Communication and Implementation
Directorate and Partnership Managers will be responsible for communicating and ensuring implementation of this policy to all stakeholders.

Monitoring
Heads of Nursing and Midwifery / Senior Nurses / Professional Advisors / Lead Nurses / Midwives / Line Managers / Senior Charge Nurses / Line Managers / Senior Charge Nurses and/or Team Leaders are responsible at local level to monitor implementation of this policy through Datix, safety cross and pressure ulcer red day review tool.

Impact Assessment
Impact of this Policy will be evidenced through reduction of avoidable pressure ulcers.

References

1. NHS Healthcare Improvement Scotland Standards for Prevention and Management of Pressure Ulcers 2020.

2. NHS Quality Improvement Scotland (2009) Best Practice Statement: *Prevention and management of pressure ulcers.*

3. Gorecki, C., J. M. Brown, et al. (2009). "Impact of pressure ulcers on quality of life in older patients: a systematic review." *Journal American Geriatric Society* 57(7): 1175-83)

4. Gefen A, Alves P, Ciprandi G et al. Device related pressure ulcers: SECURE prevention. *Journal of Wound Care,* 2020;29(Sup2a):S1-S52 https://doi.org/10.12968/jowc.2020.29.Sup2a.S1. Accessed on October 24th 2022)

5. Black JM et al (2011) Pressure ulcers: avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference.

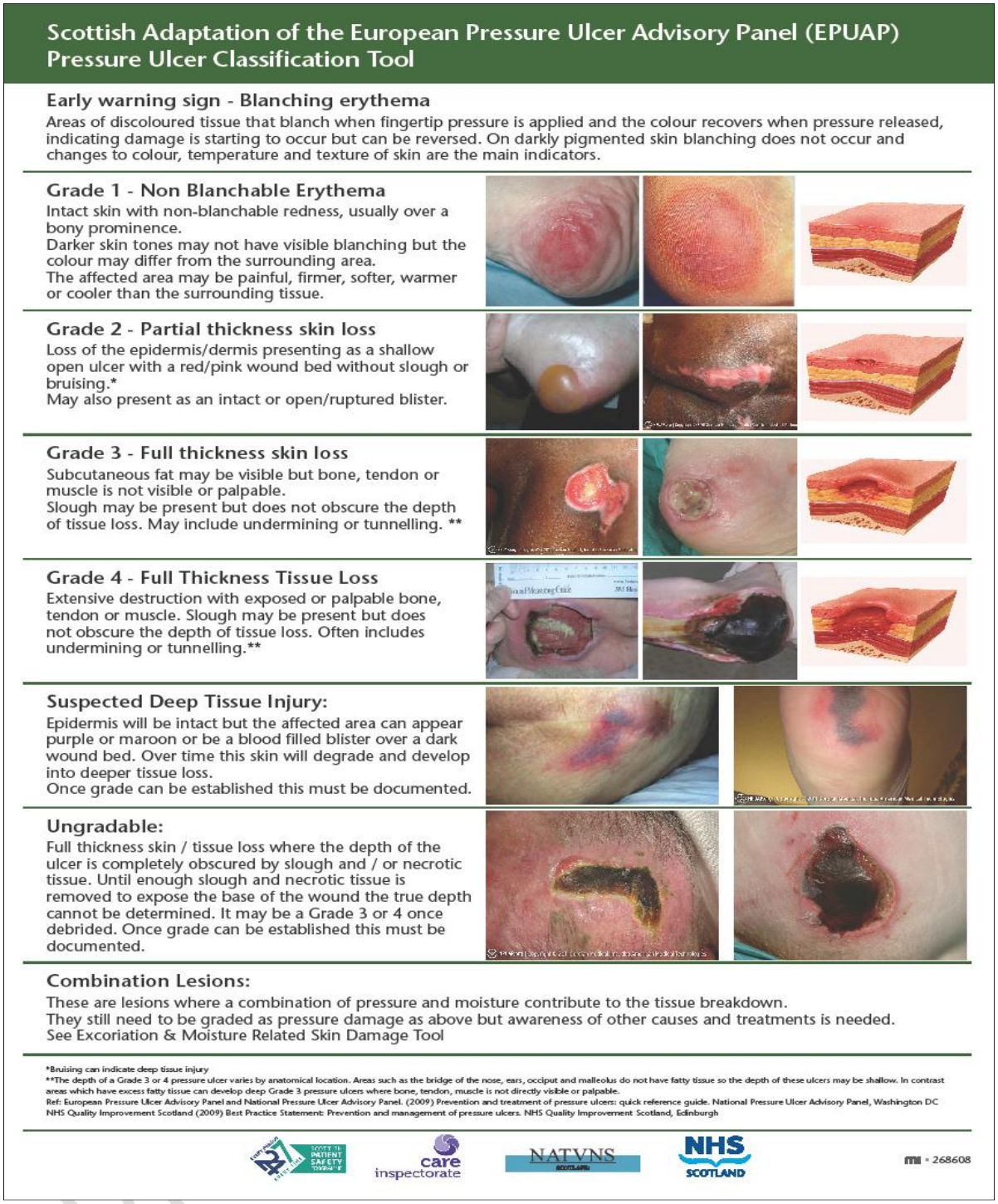
6. *Ostomy Wound Management* 57(2) 24-37 Department of Health (2011a). Defining Avoidable and Unavoidable Pressure Ulcers. London: DOH.HSCP

7. CPR for Diabetic Feet, Scottish Diabetes Foot Action Group 2017.

8. Wounds UK (2021) *Best Practice Statement: Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones.* Wounds UK, London. Available to download from:www.wounds-uk.com

Appendix 1
Pressure Ulcer Classification Tool

The Scottish Adaption of the European Pressure Ulcer Advisory Panel (EUPAP)



Considerations for practice

Bruising can indicate deep tissue injury.

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

Suspected deep tissue damage and **Ungradeable pressure damage** will need regraded to obtain accurate grade by the responsible clinical team at the earliest opportunity.

Skin assessment should be tailored to the individual patient and include the baseline skin tone, this allows changes to be monitored and actions to be implemented (8).

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

Appendix 2 Excoriation and Moisture Related Skin Damage Tool.

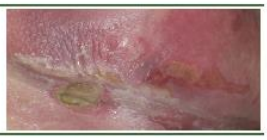
Skin damage due to moisture can present in a number of different ways and this tool aims to support in decision making for treatments.

Scottish Excoriation & Moisture Related Skin Damage Tool

Skin damage due to problems with moisture can present in a number of different ways. This tool aims to help you identify the cause to aid in decision making for treatments.
Moisture may be present on the skin due to incontinence (urinary and faecal), perspiration, wound exudate or other body fluids e.g. locia, amniotic fluid.
Lesions caused by moisture alone should not be classified as pressure ulcers.

Combination Lesions:

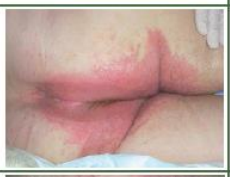
These are lesions where a combination of pressure and moisture contribute to the tissue breakdown. They still need to be graded as pressure damage but awareness of other causes and treatments is needed.
See Pressure Ulcer Grading Tool



Incontinence Related Dermatitis (IRD)

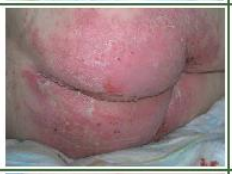
Mild

Erythema (redness) of skin only. No broken areas present.



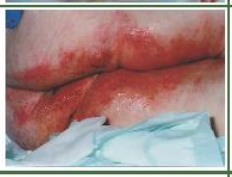
Moderate

Erythema (redness), with less than 50% broken skin.
Oozing and/or bleeding may be present.



Severe

Erythema (redness), with more than 50% broken skin.
Oozing and/or bleeding may be present.



Treatment:

Prevention/Mild IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply Moisturiser +/or skin protectant e.g. barrier cream/film which does not affect absorbency of continence products.

Moderate-Severe IRD:
Cleanse skin e.g. foam cleanser or pH balanced product. Apply liquid/spray skin protectant, OR barrier preparation, if no improvement refer to local guidelines or seek specialist advice.

NB:
Observe for signs of skin infection, e.g. candidiasis, and treat accordingly (do not use barrier films as this will reduce effectiveness of treatment)

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Updated May 2014 Review date: May 2016

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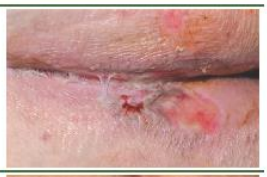
Moisture Lesions:

Skin damage due to exposure to urine, faeces or other body fluids

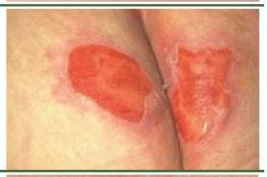
Location

Located in peri-anal, gluteal, cleft, groin or buttock area.
Not usually over a bony prominence.



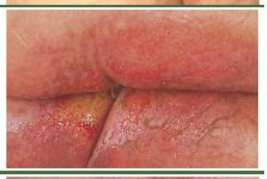
Shape

Diffuse often multiple lesions.
May be 'copy', 'mirror' or 'kissing' lesion on adjacent buttock or anal-cleft.
Linear



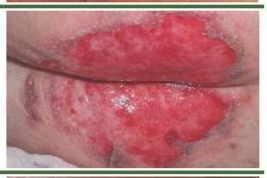
Edges

Diffuse irregular edges.



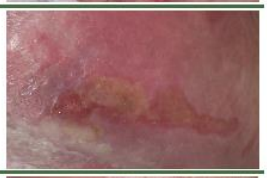
Necrosis

No necrosis or slough.
May develop slough if infection present.



Depth

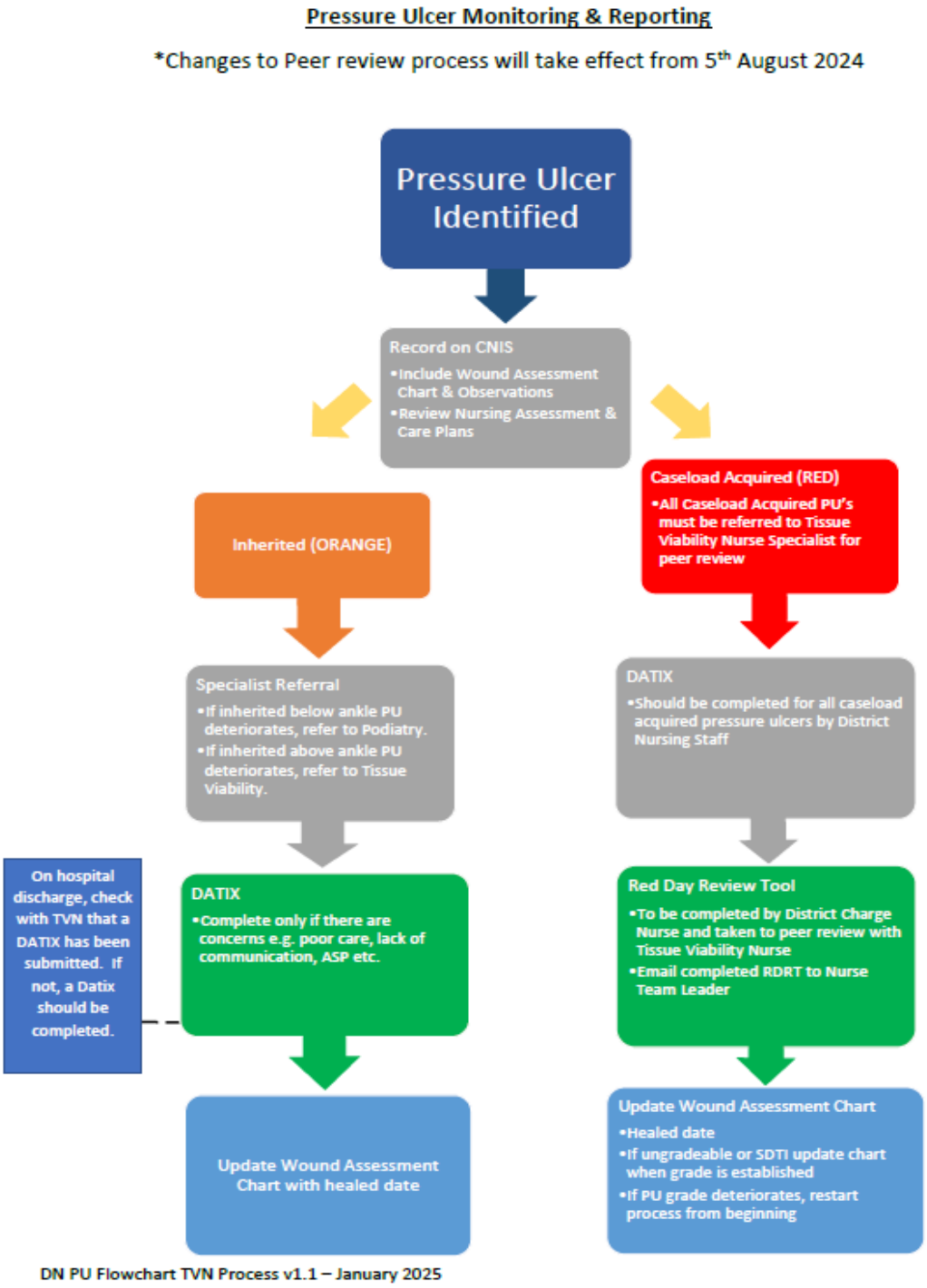
Superficial partial thickness skin loss.
Can enlarge or deepen if infection present.



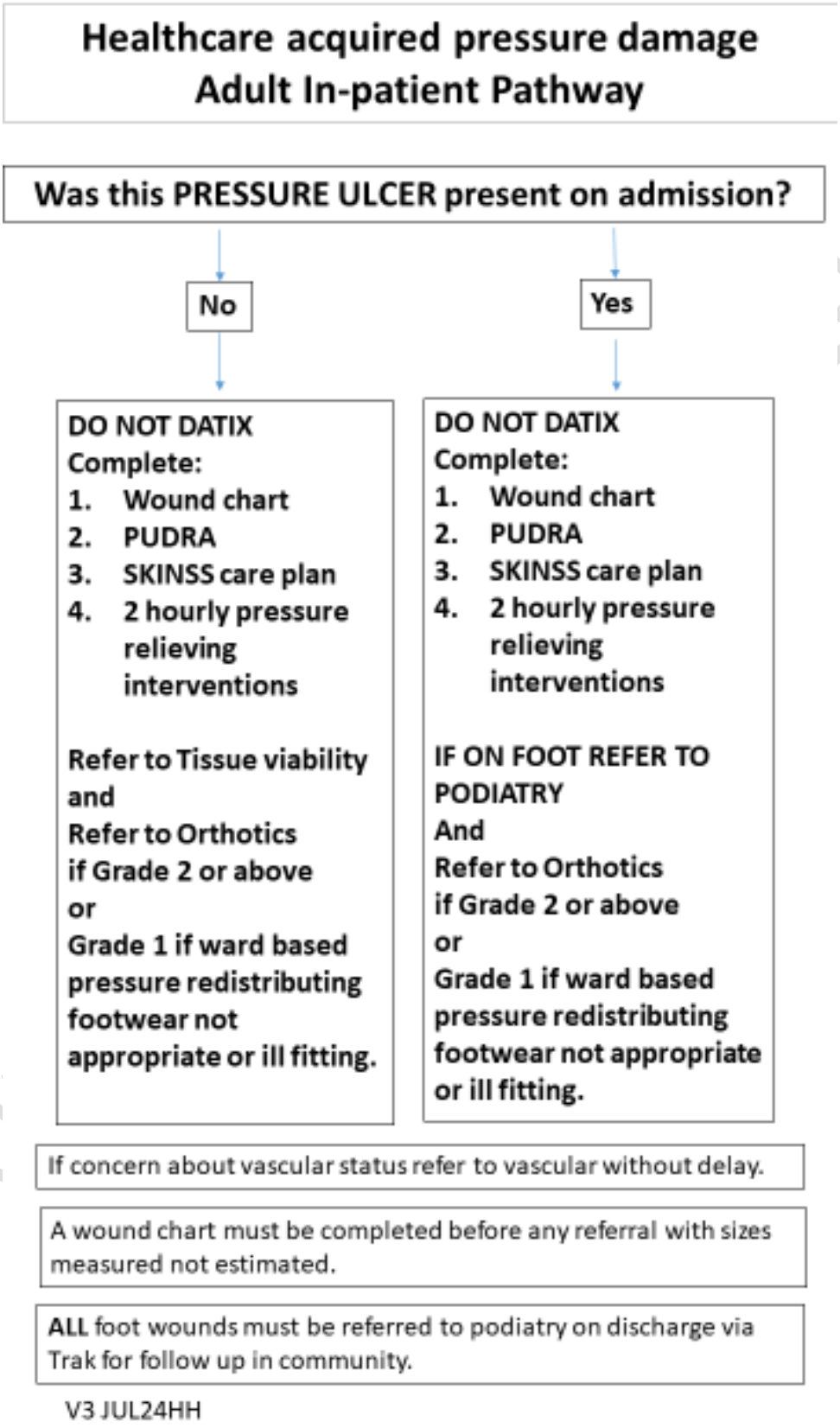
Colour

Colour of redness may not be uniform. May have pink or white surrounding skin (maceration).
Peri-anal redness may be present.

Appendix 3 Community Referral Pathway



Appendix 4 Healthcare Acquired Pressure Damage Adult In-patient Pathway



Appendix 5 Guidance for Review and Datix Completion for a Device Related Pressure Ulcer

A device related pressure ulcer (DRPU) is different from a pressure ulcer. A DRPU involves interaction with a device or object that is in direct or indirect contact with skin or implanted under the skin, causing focal and localised forces that deform the superficial and deep underlying tissues. **PLEASE NOTE A PERSON'S FOOTWEAR IS NOT CONSIDERED A DEVICE UNLESS IT IS A PRESCRIBED ITEM.**

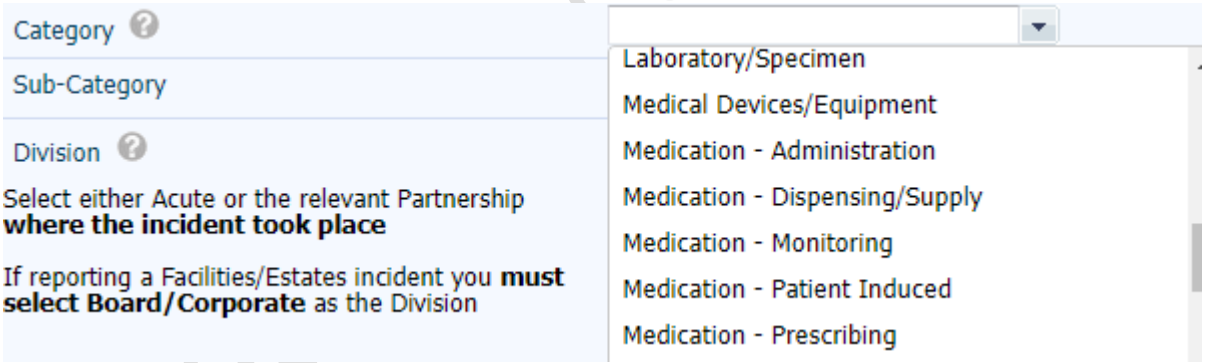
A DRPU is defined as:

A DRPU, which is caused by a device or object, is distinct from a PU, which is caused primarily by body weight forces. The localised nature of device forces results in the appearance of skin and deeper tissue damage that mimics that of the device in shape and distribution.' (5)

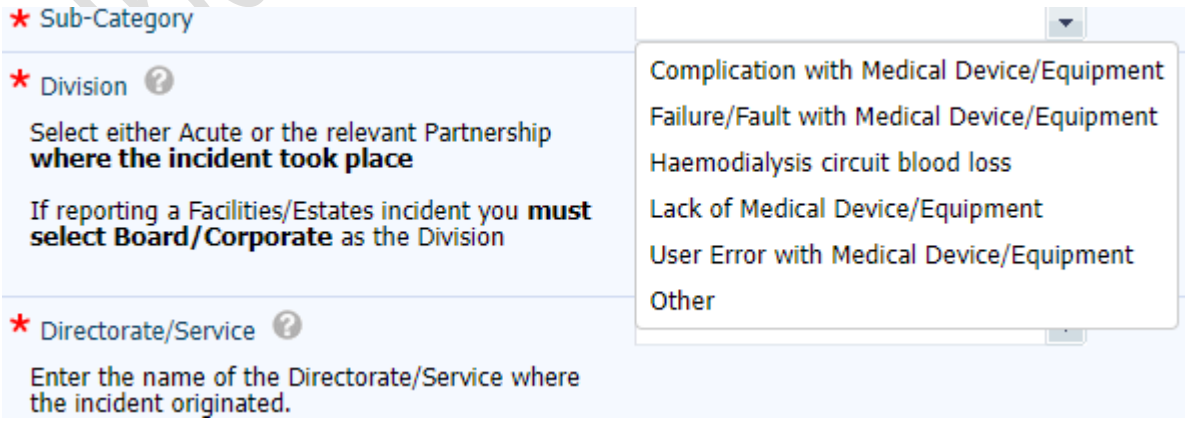
If the damage is caused by a device, then the incident should be referred to Tissue Viability following the same referral pathway for health care acquired pressure damage. A DRPU is recorded in Datix in the Medical devices / Equipment category.

In Acute and in-patient Mental Health the Datix is only completed by a TVN.

In Community the Datix is completed by the case load holder who diagnosis the damage.



Select sub-category



Appendix 6 How to refer to Orthotics

Methods of Referral:

GPs

- Should refer using Sci-gateway

All other Healthcare Professionals

Option 1

- Send an Acute Sci-gateway referral

Option 2

- Send an Internal Referral

Trakcare Guide to creating Internal Referrals

- **Option 3**

Create a Trakcare Referral Letter and send by post to:

Orthotic Department, Lower Ground Floor, Gartnavel General Hospital

(note Trakcare does not send referral letters automatically so if you do not print and post your referral will not be added to our waiting list)

Only if one of the above options is not available

Open the Orthotics electronic referral template

Fill in and email to: **GGC.OrthoticService@ggc.scot.nhs.uk**

Appendix 7 Pathway for any adult being transferred into community from hospital or from community into hospital with a healthcare acquired pressure ulcer. The pathway is the same for both.

Pathway for any adult being discharged into community from hospital with a pressure ulcer or from community into hospital.

Avoidable Grade 3 or avoidable ungradeable Pressure ulcer on body – not feet

Refer to community tissue viability team for follow up using online referral form http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Greater%20Glasgow%20and%20Clyde%20Services/TissueViabilityPtn/Documents/Partnership%20Tissue%20Viability%20Referral.docx

and send to tissueviability.referral@ggc.scot.nhs.uk

Any Pressure ulcer on ankle or any part of foot

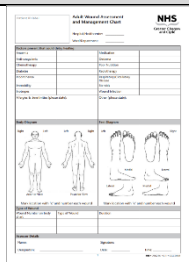
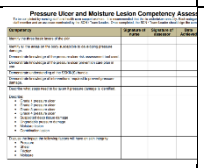
Refer to community podiatry team for follow up via for all pressure damage.

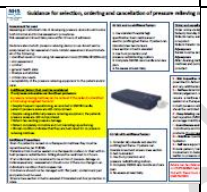
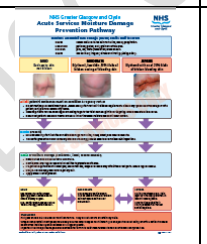
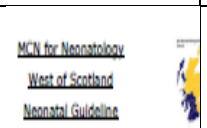
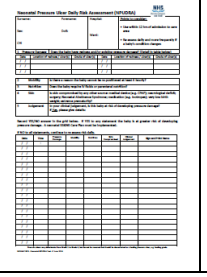
The referral form can be accessed by selecting:
New Request

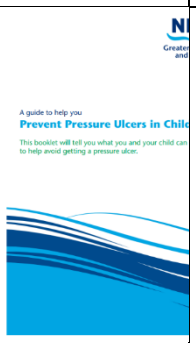
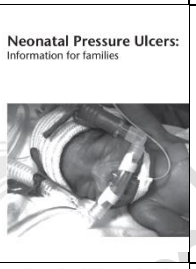
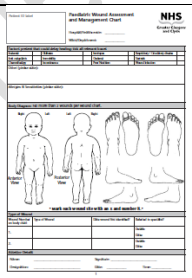
- Other – Adult
- Search for Podiatry in the Sub Category box
- Select Podiatry Out-Patient referral in the item box
- Click Update at bottom right of screen
- In the questionnaire please select the appropriate referral reason. Foot Ulcer or Podiatry Domiciliary visit for housebound patients.
- Answer all questions in bold.
- Please include clinical information to allow triage of the referral in the 'Other Information' box. Without this information the referral may be rejected.
- In 'Estimated Discharge Date' enter date or 't' for today if referring from an outpatient clinic.

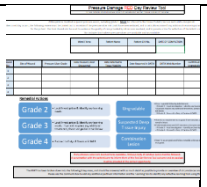
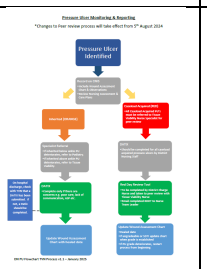
Appendix 8

Pressure Ulcer Prevention Resource Page

Location/ Directorate	Description	Image	Hyperlink
Pressure Ulcer Prevention Resource Page	Adult wound assessment and management chart		scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Acute Resources/Forms/All media.aspx?id=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute Resources%2FAdult Wound Assessment Chart 2%2E1%2Epdf&parent=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute Resources
Pressure Ulcer Prevention Resource Page	Pressure Ulcer and Moisture Lesion Competency assessment		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Acute%20Resources/Forms/All%20media.aspx?id=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute%20Resources%2FAnnual%20Competency%20Document%20and%20Presentation%2FPU%20and%20Moisture%20Lesion%20Competency%202018%2Epdf&viewid=e5a7eb6e%2Deb7d%2D4be5%2Db77e%2Da51f2b4fd5b3&parent=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute%20Resources%2FAnnual%20Competency%20Document%20and%20Presentation
Pressure Ulcer Prevention Resource Page	Pressure Ulcer Prevention Information Leaflet – NHSGGC		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Supporting%20Information/Forms/All%20media.aspx?id=%2Fsites%2FNHSGGCPressureDamageResources%2FSupporting%20Information%2FPrevent%20Pressure%20Ulcer%20Leaflets%20%28various%20languages%29&viewid=21975902%2Ddd5f
Pressure Ulcer Prevention Resource Page	Scottish Adapted European Pressure Ulcer Classification Tool –EPUAP grading tool (Scottish Adaption).		scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Supporting Information/Forms/All media.aspx?id=%2Fsites%2FNHSGGCPressureDamageResources%2FSupporting Information%2FEPUAP grading tool %28Scottish Adaptation%29%2Epdf&parent=%2Fsites%2FNHSGGCPressureDamageResources%2FSupporting Information

Pressure Ulcer Prevention Resource Page	Scottish Excoriation and Moisture Related Skin Damage Tool		https://scottish.sharepoint.com/:p:/r/sites/NHSGGCPressureDamageResources/_layouts/15/Doc.aspx?sourcedoc=%7BE6A24A61-9E71-4B4A-86EA-4404C1D5C9C8%7D&file=Scottish%20Excoriation%20and%20Moisture%20Related%20Skin%20damage%20tool.ppt&action=edit&mobileredirect=true
Acute	PUDRA resources		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/AcuteResources/Forms/Allmedia.aspx?csf=1&web=1&e=6WHiTG&CID=fee32842%2D69f1%2D401a%2D8443%2Da0afb93ae8dd&FolderCTID=0x012000FE8EF75A08910B40A780E95CC7202941&id=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute%20Resources%2FPUDRA&viewid=e5a7eb6e%2Deb7d%2D4be5%2Db77e%2Da51f2b4fd5b3
Acute	Pressure Redistributing Equipment Mattress and cushion ordering selection guidance		https://scottish.sharepoint.com/:b:/r/sites/NHSGGCPressureDamageResources/Acute%20Resources/Mattress,%20Toto%20and%20Cushion%20Information/Mattress%20Product%20Selection%20Guide%20-%20for%20ordering%20and%20cancelling.pdf?csf=1&web=1&e=l08YUA
Acute	Moisture Damage Prevention Pathway		https://scottish.sharepoint.com/:b:/r/sites/NHSGGCPressureDamageResources/Acute%20Resources/332346_4_1%20moisture%20damage%20prevention%20pathway%20final%20version.pdf?csf=1&web=1&e=lFbvKA
Acute	Toto Lateral turning System		https://scottish.sharepoint.com/:b:/r/sites/NHSGGCPressureDamageResources/Acute%20Resources/Mattress,%20Toto%20and%20Cushion%20Information/Toto%20Lateral%20Turning%20System.pdf?csf=1&web=1&e=hSDdOr
Paediatrics	Napkin Care Guide		https://scottish.sharepoint.com/:b:/r/sites/NHSGGCPressureDamageResources/Acute%20Resources/Paediatrics/Napkin%20Care%20Guidelines%20Neonates.pdf?csf=1&web=1&e=S93HIV
Paediatrics	Paediatric Pressure Ulcer Daily Risk Assessment Tool		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Acute%20Resources/Forms/All%20media.aspx?csf=1&web=1&e=6WHiTG&CID=fee32842%2D69f1%2D401a%2D8443%2Da0afb93ae8dd&FolderCTID=0x012000FE8EF75A08910B40A780E95CC7202941&id=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute%20Resources%2FPaediatrics%2FPaediatric%20Pressure%20Ulcer%20Daily%20Assessment%20Tool

	PPUDRA Guidance		
Paediatrics	Prevent Pressure Ulcers in Children		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Acute%20Resources/Forms/All%20media.aspx?csf=1&web=1&e=6WHiTG&CID=fee32842%2D69f1%2D401a%2D8443%2Da0afb93ae8dd&FolderCTID=0x012000FE8EF75A08910B40A780E95CC7202941&id=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute%20Resources%2FPaediatrics%2FPaediatric%20Pressure%20Ulcer%20Leaflet%2Epdf&viewid=e5a7eb6e%2Deb7d%2D4be5%2Db77e%2Da51f2b4fd5b3&parent=%2Fsites%2FNHSGGCPressureDamageResources%2FAcute%20Resources%2FPaediatrics
Paediatrics	Neonatal Pressure Ulcers: Information for families		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Acute%20Resources/Paediatrics/Neonatal%20Pressure%20Ulcer%20Leaflet.pdf
Paediatrics	Neonates NPUDRA		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Acute%20Resources/Paediatrics/Paediatric%20Pressure%20Ulcer%20Daily%20Assessment%20Tool/Neonates%20NPUDRA%20v7%20June%202016-%20final.pdf
Paediatrics	Paediatric Wound Assessment Chart		https://scottish.sharepoint.com/:b:/r/sites/NHSGGCPressureDamageResources/Acute%20Resources/Paediatrics/Paediatric%20Wound%20Assessment%20Chart.pdf?csf=1&web=1&e=VdQsh8
Partnership	Tissue Viability Service Referral Form		https://scottish.sharepoint.com/:w:/r/sites/NHSGGCPressureDamageResources/_layouts/15/Doc.aspx?sourcedoc=%7B312183BF-9C97-47D2-86DD-4070D38D4C53%7D&file=Tissue%20Viability%20Referral%20(Partnerships).docx&action=default&mobileredirect=true
Partnership	Community Nursing website – Pressure ulcer Prevention Resources		https://scottish.sharepoint.com/sites/DistrictNursingWebsite/SitePages/Pressure-Ulcer-Prevention.aspx

Partnership	Red Day Review Tool (Community)		https://scottish.sharepoint.com/:x:/r/sites/NHSGGCPressureDamageResources/Partnership%20Resources/Red%20Day%20Review%20Tool%20(Community)%20v5.7.xlsx?d=w7d7d12ff4b2947b2880804a31c4a2d17&csf=1&web=1&e=iD20xK
Partnership	Community Flowchart		https://scottish.sharepoint.com/:b:/r/sites/NHSGGCPressureDamageResources/Partnership%20Resources/DN%20PU%20flowchart%20TVN%20Process%20v1.1%20-%20Jan%202025.pdf?csf=1&web=1&e=YYBkpG
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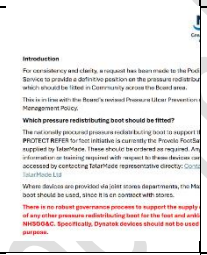
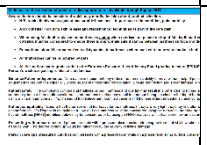
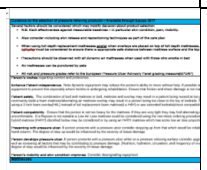
Partnership	Pressure Redistributing Boots in Community Guide		scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Partnership Resources/Forms/All media.aspx?id=%2Fsites%2FNHSGGCPressure DamageResources%2FPartnership Resources%2FPressure Redistributing Boots in Community%2Epdf&parent=%2Fsites%2FNHSGGCPressureDamageResources%2FPartnership Resources
Partnership	TOTO Turing Device community advice		https://scottish.sharepoint.com/:w:/r/sites/NHSGGCPressureDamageResources/_layouts/15/Doc.aspx?sourcedoc=%7B59C82A72-6048-4BF9-80DB-4F5874BAF250%7D&file=TOTO%20Turning%20Aid.docx&action=default&mobileredirect=true
Partnership	Partnership Equipment Selection Guide		https://scottish.sharepoint.com/:w:/r/sites/NHSGGCPressureDamageResources/Partnership Resources/2017 Pressure Equipment Selection Guide.doc?d=w7919e683d2304da294be82a94309755f&csf=1&web=1&e=7fRW8d
Partnership	Equipment non stock ordering guide		https://scottish.sharepoint.com/:w:/r/sites/NHSGGCPressureDamageResources/_layouts/15/Doc.aspx?sourcedoc=%7BD773018B-8E9E-402C-B4EA-76AC208013AD%7D&file=HOW%20TO%20ORDER%20A%20NON%20STOCK%20ITEM.docx&action=default&mobileredirect=true
Partnership	Pressure mattress Selection		https://scottish.sharepoint.com/:w:/r/sites/NHSGGCPressureDamageResources/_layouts/15/Doc.aspx?sourcedoc=%7BE8B8DD48-DD0A-4712-86B2-9B45EB6EA279%7D&file=2017%20Pressure%20mattress%20Selection%20-%20%20SMRP%20amendments%202017.docx&action=default&mobileredirect=true

Partnership	Bedrail risk assessment		https://scottish.sharepoint.com/sites/NHSGGCPressureDamageResources/Partnership%20Resources/Forms/All%20media.aspx?id=%2Fsites%2FNHSGGCPressureDamageResources%2FPartnership%20Resources%2FEQUIPU%20GOOD%20PRACTICE%20ON%20THE%20PROVISION%20OF%20BEDRAILS%20August%202020%2Epdf&parent=%2Fsites%2FNHSGGCPressureDamageResources%2FPartnership%20Resources

*If any of the above link are not working they may have been replace with new resources. All resources can be accessed from the NHSGGC Pressure Damage Resources - Home (sharepoint.com)

Pressure Ulcer Prevention and Management Policy Update Short Life Working Group Members

The list of people below were members of the SLWG who reviewed and updated the 2023 policy.

Member	NHSGGC Role
Gillian Harkins	Clinical Lead Podiatry
Jill McNeill	Lead Nurse HSCP
Gail Morrison	Orthotics Diabetes Team Lead
Julie Braidwood	Highly Specialised Podiatrist
Nicola Greenwood	Specialist/Practice Development Podiatrist
Ruth Potter	Tissue Viability Nurse
Heather Hodgson	Lead Nurse Tissue Viability
Caroline Lilley	Interim Senior Nurse
Veronica Pollard	Tissue Viability Nurse
Karen Stewart	Senior Nurse HSCP