National Wound Care Strategy Programme

Pressure Ulcers

Pressure Ulcer Clinical Recommendations and Clinical Pathway

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Working in partnership with

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Introduction

Pressure ulcers are in the 'top ten harms' in the NHS in England[i]. Investigations into the causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers.

Despite national[ii] and international[iii] clinical guidelines, there is currently no up-to-date standardised pathway for implementing these guidelines in England. Consequently, individual health and care organisations develop their own pathways and protocols, which may vary substantially, leading to increased and unnecessary workload and variation in clinical practice.

This clinical pathway (see Appendix 1) identifies what good looks like and offers an evidence-informed standardised pathway of care to guide care to prevent and manage pressure ulcers in England. It demonstrates what best practice should look like and is based on the NICE Clinical Guideline: Pressure ulcers: prevention and management [ii], the NICE Quality Standard: Pressure ulcers [iv] and updated using the EPUAP Pressure Ulcer Guidelines [iii].

The clinical pathway has five phases:

1. Identification of someone at risk of pressure ulcers

2. Risk assessment and diagnosis
    - Including initial screening for risk factors
    - Risk assessment
    - Primary and secondary diagnosis

3. Ongoing care including
    - Preventative care
    - Wound care

4. Review of healing

5. Care following healing

The pathway describes best practice for care in all health and care settings (including hospitals, general practice, and community services as well as care homes and other care providers). It is suitable for use for those with both physical and mental health care needs and seeks to inform and support care delivered by all health and care professionals who care for people at risk of pressure ulcers.

1. Identification of someone at risk of pressure ulcers and immediate care

1.1 Consider whether a patient or client has pressure ulcer risk factors at every contact with a health and social care professionals.

1.2 Respond to a request from an individual, their family or informal carer who has identified risk factors for pressure ulceration.

1.3 'Red flag' risk factors are:

- Skin over a bony prominence is hot, discoloured and swollen or the patient complains of new onset or change / increase in pain, and this does not resolve when the patient is repositioned.
- An existing pressure ulcer or scar from a pressure ulcer.
- The individual has had a long lie (fall and being on the floor) of more than 1 hour[v].
- There is a medical device in prolonged contact with the skin

1.4 Immediate care should include:

- Reposition the patient off the affected area.
- Clean and dress the wound using a sterile dressing as per local policy if the skin is broken.
- Ensure any existing equipment is functioning and in use.
- Take a photograph of any broken skin.
- Seek assistance / escalate care / refer to specialist as necessary.

2. Screening, risk assessment and diagnosis

Initial screening

2.1 Screen everyone receiving care from a health or care professional using the PURPOSE T[1] tool [vi], [vii] (see Appendix 2).

2.2 Base screening and skin assessment on a combination of skin temperature, skin texture, patient reports of pain and discomfort as well as visual assessment when considering skin of different colour and tone.

2.3 If you identify a person at risk, (or respond to a request for a risk assessment) and do not have the appropriate knowledge / skills to carry out screening, provide immediate preventative care that reduces any identified risk and refer to a suitably trained professional.

Risk Assessment

2.4 Undertake a full pressure ulcer risk assessment using the PURPOSE T tool for any person identified as being potentially at-risk following screening.

2.5 If you do not have the appropriate knowledge / skills to carry out a full risk assessment, provide immediate preventative care as defined in your local guidelines and refer to a suitably trained health professional to undertake the full pressure ulcer risk assessment.

2.6 Carry out a risk assessment for people admitted to hospital or a care home with nursing within 6 hours of admission or in a community health care service the first face-to-face visit. This includes virtual contact via telephone or video and may be based on questioning the patient about their skin. Clearly document the risk assessment and whether it was conducted face-to-face or virtually [iv].

2.7 Repeat the screening (and risk assessment as required) following a change in that individual's condition [iii]. For those whose condition is stable, review at regular intervals to monitor for more subtle changes in level of risk.

2.8 Document the outcome of the risk assessment in the clinical or care record along with a pre-stipulated date for review of risk and planned care.

[1] The PURPOSE-T pressure ulcer assessment tool was developed by the NHS for the NHS and is currently the pressure ulcer risk assessment tool with the most robust evidence base.

Diagnosis

2.9 Primary diagnosis:

Document pressure ulcers ensuring they are not confused with similar but different aetiologies such as Incontinence Associated Dermatitis (IAD). Differential diagnosis of pressure ulceration should consider:

- Is there evidence of pressure or shear?
- Is the wound over a bony prominence or under a device?

Are the edges distinct?

2.10 Categorise

Categorise pressure ulcers using categories 1 – 4

Category 1: Non blanchable Erythema

Intact skin - In lighter skin tones this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate “at risk” individuals (a heralding sign of risk).

Category 2: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister or as a shiny or dry shallow ulcer without slough or bruising***.** This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.

Category 3: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as ‘unstageable’) should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient’s records if debridement reveals category 4 pressure ulceration.

Deep tissue injuries (DTIs) should not be recorded as pressure ulcers unless they result in broken skin at which point, they should immediately be categorised and reported.

Outcome of risk

2.11 In line with the PURPOSE T risk assessment and pressure ulcer diagnosis process, combine the outcome of risk assessment and diagnosis together to indicate which of the following pathways should be followed.

No pressure ulcer, not currently at risk

No pressure ulcer but **at risk**

PU Category 1 or above or scarring from previous pressure ulcers.

3. Ongoing care

Care to prevent pressure ulcers.

3.1.1 Plan and deliver individualised care that addresses their presenting risk factors using the aSSKINg Framework (see Appendix 3 for further detail) for anyone identified at risk of pressure ulceration based on the pathway of risk (from the PURPOSE T risk assessment)

Green – no pressure ulcer and not currently at risk

Amber – no pressure ulcer but at risk

Red – Category 1 pressure ulcer or above or scarring from previous pressure ulcer.

aSSKINg Framework	
a	Assess Risk
S	Skin Assessment and Skin Care
S	Surface
K	Keep moving
I	Incontinence
N	Nutrition
g	Give information

Green

Document outcome of risk in the clinical record

Review risk at regular intervals

Amber

Follow the green plan plus:

Implement an individualised plan of preventative care that addresses their presenting risk factors and follows the aSSKINg bundle see appendix 1.

Document outcome of risk in the clinical record

Review care on a regular basis and / or if there is:
a change in that individual's condition
a change in the place of care delivery
Provide information to the patient and / or their carer about the level of risk and what they can do to help reduce the risk.

Red

Follow the plan for Amber Plus:

Complete a full wound assessment [VII] and document in the care record.
Agree a patient centred objective of care.

Implement evidence-informed wound care based on the objective of care.

Consider all patients with a category 3 or 4 pressure ulcer for surgical revision in line with local guidance.

This guidance should consider:

- Does the person have available skin / muscle for surgical revision (this needs to be assessed by a surgeon)?
- Would the individual consider surgical revision?
- Have all reasonable conservative / non-surgical methods been tried to close the pressure ulcer?
- Is the individual fit for surgery or able to become fit for surgery (e.g., through treatment for infection, by improved nutrition)?
- Is the individual able and motivated to adhere to post-operative regimens to prevent pressure ulcer recurrence.

3.1.2 Document the plan of care in their care record

Care to promote healing of existing pressure ulcers

3.2 Plan and deliver individualised care that addresses their presenting risk factors using the aSSKINg Framework for anyone identified with an existing pressure ulcer.

3.3 Perform and document
- A full wound care assessment[2] that is documented in the care record
- Appropriate evidence-informed wound care based on the wound care assessment

3.4 Consider all those with category 3 and 4 pressure ulcers for surgical revision in line with local guidance. This guidance should consider:
- Does the person have available skin / muscle for surgical revision (this needs to be assessed by a surgeon)?
- Would the individual consider surgical revision?

- Have all reasonable conservative / non-surgical methods been tried to close the pressure ulcer?
- Is the individual fit for surgery or able to become fit for surgery (e.g., through treatment for infection, by improved nutrition)?
- Is the individual able and motivated to adhere to post-operative regimens to prevent pressure ulcer recurrence.

4. Review of healing

4.1 Review the effectiveness of treatment plan and escalate any concerns to the relevant clinical specialist at each dressing change.

4.2 Review effectiveness of treatment plan and escalate any concerns to the relevant clinical specialist at weekly intervals. Wounds that are deteriorating should be urgently escalated to the relevant clinical specialist unless this is anticipated e.g., at end of life.

4.3 Assess for reduction in wound size and document using wound imaging at 4-week intervals (or more frequently if concerned).

4.4 Undertake a comprehensive re-assessment at 12 weeks, for patients with wounds that remain unhealed.

5. Care following healing

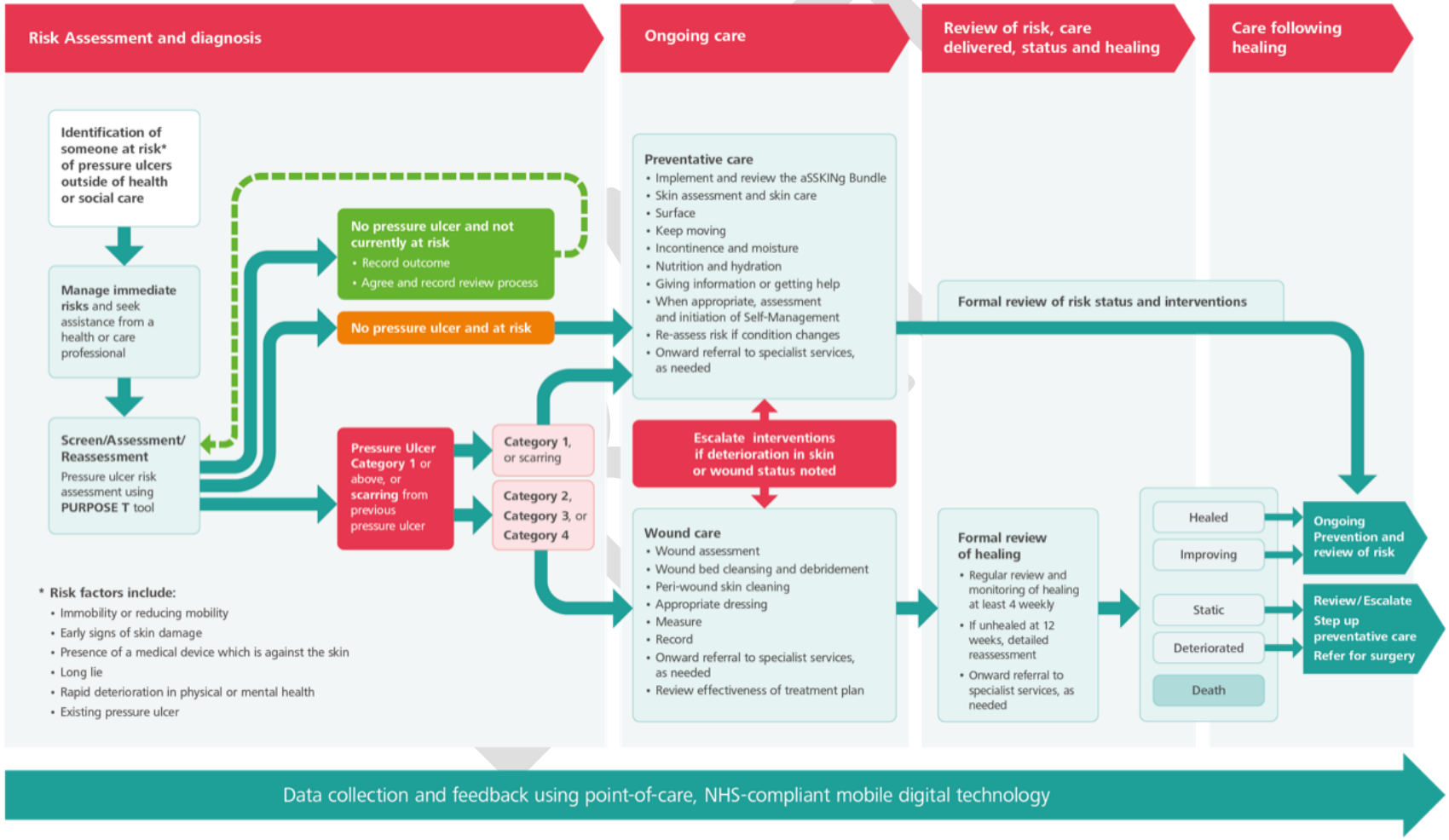
5.1 Determine an agreed process of evaluation of care and review of risk level for all individuals at continued risk.

5.2 Discuss with all individuals and or their carers their specific risk factors and what they or their informal carer's role in preventative care could be.

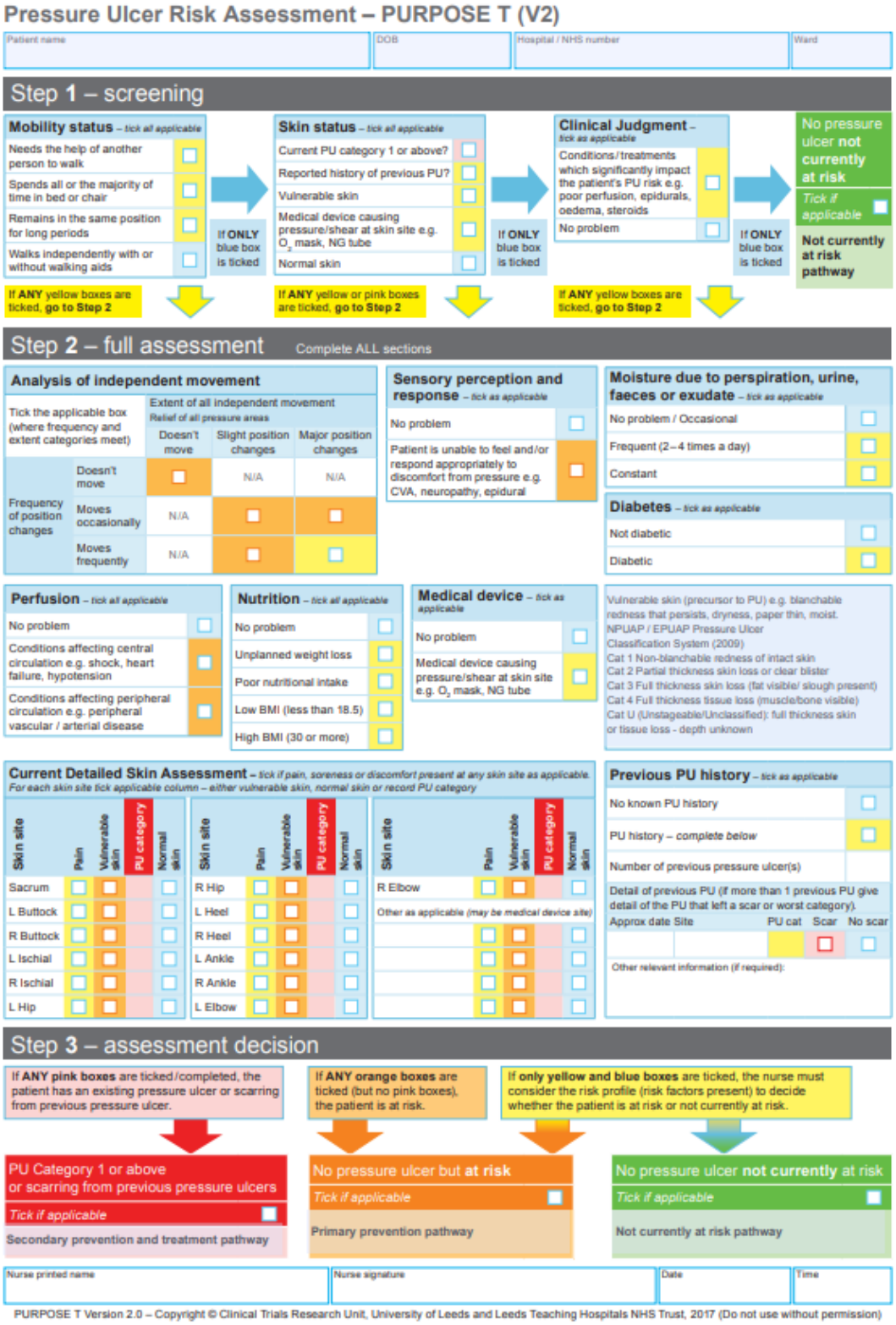
5.3 Provided all individuals at risk with information about their risk factors and treatment plan, this may be in written form, using digital media or verbally but the form of delivery and content must be clearly documented.

5.4 Identify, discuss and incorporate opportunities for supported self-care, into treatment plans as agreed with the individual.

Appendix 1: The clinical pathway



Appendix 2 PURPOSE T risk assessment tool



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Patient name | DOB | Hospital / NHS number | Ward

Step 1 – screening

Mobility status – *tick all applicable*
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If **ONLY** blue box is ticked

Skin status – *tick all applicable*
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If **ONLY** blue box is ticked

Clinical Judgment – *tick as applicable*
- Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If **ONLY** blue box is ticked

No pressure ulcer **not currently at risk**
Tick if applicable
Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*
- No problem / Occasional
- Frequent (2–4 times a day)
- Constant

Diabetes – *tick as applicable*
- Not diabetic
- Diabetic

Perfusion – *tick all applicable*
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – *tick all applicable*
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – *tick as applicable*
- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category*

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable (may be medical device site)				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Previous PU history – *tick as applicable*
- No known PU history
- PU history – *complete below*
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked/completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable ☐
Secondary prevention and treatment pathway

No pressure ulcer but **at risk**
Tick if applicable ☐
Primary prevention pathway

No pressure ulcer **not currently** at risk
Tick if applicable ☐
Not currently at risk pathway

Nurse printed name | Nurse signature | Date | Time

Appendix 3 The aSSKINg framework[ix]

The 'aSSKINg' care bundle is a tool which brings together best practice with the aim of minimising variation in care. The ‘aSSKINg tool is widely used across England so is familiar to many health and care organisations.

	Action	Best Practice
a	**Assess Risk**	• Consider risk factors associated with compromised skin integrity • Undertake risk assessment using the PURPOSE T risk assessment tool or similar evidence based and validated tool for specialist populations • Refer to appropriate members of the interprofessional team • Be aware of safeguarding policies and take appropriate action when necessary.
S	**Skin Assessment and Skin Care**	• Carry out a comprehensive skin assessment • Consider colour, texture and temperature of the skin • Ask the individual to identify any areas that are painful, uncomfortable or numb. • Consider risk factors associated with impaired skin integrity • Identify complex health conditions that affect skin integrity • Implement evidence-based skin interventions to promote skin integrity.
S	**Surface**	• Consider risk factors associated with a range of support surfaces • Consider the range of available equipment, including the mechanism of action, benefits and associated risks. • Identify and undertake relevant seating and handling risk assessments • Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. • Refer to appropriate members of the interprofessional team throughout the patient journey, including discharge planning.
K	**Keep moving**	• Consider level of mobility and risk factors associated with reduced mobility • Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks. • Use relevant formal tools to assess mobility – falls risk, moving and handling risk assessments. • Consider the impact of reduced mobility on an individual's engagement in activities of daily living (ADL) and psychosocial functioning (mood, isolation, social engagement). • Safely use a range of appropriate equipment to promote safe mobilisation – hoists and slings, standing hoists and frames, appropriate seating and mobility aids – to promote individualised plan of mobility and assisted transfers. Refer to appropriate members of the interprofessional team throughout the patient journey, including discharge planning. • Consider the individuals usual daily routine when planning repositioning or activity schedules
I	Incontinence or increased moisture	• Identify the cause of moisture-related skin damage i.e. incontinence, sweat, saliva, stoma effluent, wound leakage • Where possible address the cause of the moisture • Consider whether incontinence-related skin damage is an issue. • Differentiate between aetiologies associated with incontinence. • Consider how increased moisture increases the risk of skin damage caused by shear and friction. • Implement appropriate prevention and management strategies.
N	Nutrition	• Consider the impact of key nutritional concepts in wound healing. • Understand the impact of disease on nutritional need absorption. • Utilise the relevant tools and documentation which should include food and fluid charts, food diaries, MUST, BMI, MUAC, bloods, feeding risks and PEM assessment. • Advise on food fortification, nutritional supplementation, and moderation of dietary restrictions in event of pressure ulceration. • Collaborate to deliver appropriate care with relevant members of the multidisciplinary teams (MDT) (dietician, speech and language therapist, occupational therapist)

g	Give information	• Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies. • Communicate effective and safe use of interventions effectively for the patient, family and within the MDT. • Recognise when clinical concerns need to be escalated. • Promote effective pressure ulcer prevention approaches. • Consider effective resource allocation and escalate concerns when resources are unavailable. • Be aware of safeguarding policies and take appropriate action when necessary. • Use the clinical record as the source of documentation to ensure information is available to all members of the MDT • Use appropriate language to ensure the clinical record can be appropriately used for coding / analytic purposes

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