4LSAB Multi-Agency Pressure Ulcer Guidance

January 2025

1. Introduction

This guidance has been created using the updated protocol published by the Department of Health and Social Care[1]. It outlines what steps staff need to take when they are concerned that a pressure ulcer may have arisen due to poor practice, neglect or abuse, or an act of omission, and whether the local authority safeguarding duties are triggered.

Those at risk of pressure ulcers are cared for in many different settings across health and social care, including their own home. Terminology used in these settings may vary - the terms patient, resident, service user and clients are all often used. For the purpose of this guidance the term individual or person will be used throughout.

A helpful beginning point is the principle of wellbeing. As stated in the Care and Support statutory guidance[2], wellbeing is a broad concept and it's described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships

[1] Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk)
[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

- suitability of living accommodation
- the individual's contribution to society.

This principle requires all agencies to work together to achieve the best outcomes for the individual. The Care Act 2014 clearly lays out the duties of relevant partners to cooperate, including (but not only) local authorities and NHS bodies. This requires a shift of approach from one dominated by processes and tick boxes to a person-centred model that begins with the person at the centre of the concerns and fully involves them or their representative as appropriate. The response to the presence of pressure ulcers should involve the individual and their family, explaining the concerns and seeking their views.

2. Aim

The aim of this guidance is to support partner agencies to identify pressure ulcers as primarily an issue for clinical investigation rather than a safeguarding enquiry led by the local authority. This is designed to support with the clinical investigation/safeguarding requirement rather than clinical management of a pressure ulcer. Indicators for when a person presenting with a pressure ulcer may additionally need to be referred to the local authority safeguarding team are included.

3. Consideration of Safeguarding

The Care Act 2014 says that the safeguarding duties (under section 42) apply where a local authority has reasonable cause to suspect that an adult in its area:

- has needs for care and support (whether or not the local authority is meeting any of those needs).
- is experiencing, or at risk of, abuse or neglect.
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Safeguarding is about protecting an individual's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risk and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted - including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Safeguarding adults is used to describe all work to help adults with care and support needs stay safe from abuse and neglect.

An adult at risk may therefore be a person who:

- is old and frail due to ill health, physical disability or cognitive impairment.
- has a learning disability.
- has a physical disability and/or a sensory impairment.
- has mental health needs.
- has a long-term illness or condition.
- misuses substances or alcohol.
- is a carer, such as a family member or friend who provides personal assistance and care to adults and is subject to abuse.
- may lack the capacity to make a relevant decision and is need of care and support.

4. Background

Pressure ulcers may occur as a result of neglect. Neglect may involve the deliberate withholding, or unintentional failure, of a paid, or unpaid, carer to provide appropriate and adequate care and support. Neglect and acts of omission include:

- ignoring medical, emotional or physical care needs.
- failure to provide access to appropriate healthcare and support or educational services.
- the withholding of the necessities of life, such as medication, adequate nutrition and heating.

In some instances, this is highly likely to result in significant preventable skin damage.

Where unintentional neglect may be due to a family member or friend struggling to provide care or not knowing the signs of developing pressure ulcers or why the person they care for is at risk, an appropriate response would be to offer a care needs assessment for the adult at risk and a carers assessment for those in the caring role (these referrals are made via the relevant Local Authority).

If there are concerns around potential neglect where family members are not accepting care/equipment this requires professional curiosity and an open and honest conversation about the potential risks involved. In these circumstances it can be highly distressing to talk with unpaid/informal carers about abuse and neglect, particularly where they have been dedicated in providing care but have not been given advice and support to prevent pressure ulcers.

Where unintentional neglect may be due to a paid carer struggling to provide care or not knowing the signs of developing pressure ulcers or reasons why the person they care for is at risk, an appropriate response would be to seek support from the commissioners of the package of care and right size the care package, ensuring that the carer has the support and equipment to care safely.

Skin damage has several causes. Pressure ulcers are caused by sustained pressure, including pressure associated with shearing, where the person's individual tissue tolerance and susceptibility to pressure has been overcome. External shear forces occur due to movement of the skin and deeper tissue relative to a supporting surface, such as when an individual slides down the bed when in a semi-recumbent

sitting position. This results in distortion of the soft tissue layers, including the blood vessels. Shearing skin damage commonly occurs at the person's sacrum (base of the spine) and heels. Internal shear forces can occur within the soft tissue layers due to both compression and external shear forces.

Some causes of skin damage relate to the individual person, including factors such as the person's medical condition, reduced mobility and immobility, lack of sensation, poor blood supply, poor nutrition and hydration. External factors may contribute to this, including:

- poor care
- poor communication between carers and nurses
- ineffective multi-disciplinary team working
- lack of access to appropriate resources such as equipment and staffing

In line with shared decision making, when advising an individual who has mental capacity relating to their self-care and prevention of pressure ulcers, it is important to establish that the person:

- has understood the advice shared
- can put the advice into practice and chooses to do so
- has any necessary equipment and knows how to use it
- understands the implications on their health needs of not following the advice

Where an individual is deemed to have capacity and chooses not to agree to follow the advice, compromise and alternatives must be discussed and agreed upon, if possible. Where an individual chooses not to follow any or some of the advice, an agreement to revisit the conversation with the individual must be made, and detailed clear documentation of the discussion must be recorded in the patient's notes. It may be appropriate to ask the individual to sign a statement acknowledging their wishes and add this to the patient's record.

When evidence indicates that the individual is neglectful in caring for themselves or the environment, staff should seek further advice from a senior lead within their organisation with the relevant knowledge and skills, and where appropriate make a referral to the Local Authority for self-neglect.

It is recognised that not all pressure ulcers can be prevented and the risk factors for each person should be reviewed on an individual basis and an appropriate care plan agreed that is regularly and frequently reviewed.

5. Categories

Definitions of pressure ulcer categories can be found in the National Wound Care Strategy Programme (NWCSP)[3]

Cases of category 1 and 2 pressure ulcers must be considered as requiring early intervention to prevent further deterioration or damage. Early intervention to prevent skin damage should also be considered for people with vulnerable skin. For example, where pain is experienced over at-risk areas or under devices, or when blanching erythema (area of redness that disappears on applied pressure) occurs or when skin colour and texture changes in darker skin tones.

Severe skin damage, such as pressure ulcers, may be indicated in some instances by multiple category 2 or single category 3 or 4 ulcers. However, they could also be indicated by the impact the pressure damage has on the person affected (for example, pain).

It is recognised that severe pressure ulcer damage can already be present and yet not visible on the skin's surface. Therefore, it is important to be vigilant for anything that indicates damage to the skin or underlying tissues, most commonly reports of pain or numbness, then changes in the tissue texture or turgor (rigidity), change in

[3] https://www.nationalwoundcarestrategy.net/wp-content/uploads/2024/02/NWCSP-PU-Clinical-Recommendations-and-pathway-final-24.10.23.pdf

temperature and finally changes in colour - remembering that not all skin tones show redness.

Skin damage that is established to be because of urinary and faecal incontinence and/or moisture alone should not be recorded in the notes as a pressure ulcer but should be referred to as moisture association skin damage to distinguish it and be recorded separately. However, where this might be as a result of neglect or poor clinical oversight, it should be explored and not ignored.

Skin damage that has been determined as combined, that is, caused by both moisture and pressure, must be recorded in the individual's notes as a pressure ulcer.

Medical Device Pressure Ulcers

Skin damage that is determined to be as a result of pressure from a device, such as from casts or ventilator tubing and masks, must be recorded as a pressure ulcer.

Quality and Care

If a professional has concerns regarding poor practice, they must ensure **appropriate escalation** through existing agency reporting systems. These arrangements must be clearly set out in local guidance for staff.

6. Safeguarding Concern Assessment Guidance

The Adult Safeguarding Decision Guide for Individuals with Severe Pressure Ulcers can be found in Appendix Three.

A history of the development of the skin damage should first be obtained by a clinician, usually a nurse. Where there is concern from the clinician assessing the individual that it is suspected there has been abuse or neglect that can be directly

associated with the pressure ulcer, there is a need to raise it as a safeguarding concern.

If the person has recently been transferred from another setting with a pressure ulcer ideally gather as much information as possible and refer to the relevant Local Authority safeguarding team, i.e., from where the pressure ulcer was acquired. For example, the Local Authority where the hospital is based. Full body check (and mapping if required) should be completed with consent when an individual is transferred from one setting to another.

7. Adult Safeguarding Decision Guide

If a concern is raised that a person has severe skin damage, you should:

- complete the Adult Safeguarding Decision Guide (see Appendix Three)
- raise an incident immediately as per organisation policy.

Guidance for completing the Adult Safeguarding Decision Guide for Individuals with Severe Pressure Ulcers can be found in Appendix Two.

The decision guide should be completed by a qualified member of staff who is a practising registered nurse (RN) with experience in wound management.

The adult safeguarding decision guide should be completed immediately or within 48 hours of identifying the pressure ulcer of concern. In exceptional circumstances this timescale may be extended but the reasons for extension should be recorded.

The outcome of the assessment should be documented on the adult safeguarding decision guide. If further advice or support is needed with regards to making the decision to raise a safeguarding concern to the local authority, the professional's duty supervisor, line manager, or safeguarding team should be contacted.

The safeguarding decision guide assessment considers six important questions that together indicate a safeguarding decision guide score. This score should be used to

help inform decision making regarding escalation of safeguarding concerns related to the pressure ulceration. It is not a tool to risk assess for the development of pressure damage.

The threshold for raising a concern is 15 or above in most instances. However, this should not replace professional judgement. The questions and scores are outlined in Appendix Three which provides the full decision-making tool and recording document.

The six questions are:

1. Has the person's skin deteriorated to either category 3 or 4 or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess or visit?
2. Has there been a recent change, that is within days or hours, in their clinical condition that could have contributed to skin damage? For example, infection, pyrexia, anaemia, end of life care (skin changes at life end), critical illness, emergency hospital visit.
3. Was there a pressure ulcer risk assessment or reassessment with an appropriate pressure ulcer care plan in place, and was this documented in line with the organisation's policy and guidance?
4. Is there a concern that the pressure ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services?
5. Is the level of damage to skin inconsistent with the person's risk status for pressure ulcer development? For example, no risk factors that align with the category of pressure ulcer that has developed.
6. Question 6 has 2 parts - which part you ask depends on the person.

Answer question 6a if the person has capacity to consent to every relevant element of the care plan:

- Were the risks and benefits explained and understood by the person?

- Was a plan of care agreed in line with shared decision making and has the person chosen to follow the relevant aspects of the plan?

Answer question 6b if the person has been assessed as not having mental capacity to consent to any or some relevant aspects of the care plan:

- Was the relevant care undertaken in the person's best interests, following the best interests checklist in the Mental Capacity Act?
- This should be supported by documentation - for example, capacity and best interest statements and record of care delivered.

Guidance on completing the Adult Safeguarding Decision Guide at Appendix Two gives example background questions to ask when completing the adult safeguarding decision guide.

Photographic evidence to support the report should be provided wherever possible. Consent for this should be sought as per local policy but great sensitivity and care must be taken to protect the identity of the individual.

A body map can be found in Appendix Four should this not already be available to complete on the individual's electronic record.

The body map should be used to record skin damage and can be used as evidence, if necessary, later. If two workers observed the skin damage, they should both sign the body map where possible.

Documentation of the pressure ulcer should include as a minimum:

- site
- size - including its maximum length, width and depth (in centimetres)
- tissue type
- category

8. If there is a safeguarding concern

Local safeguarding partners are responsible for child protection policy, procedure and guidance at a local level. Working together with other relevant agencies, they must co-ordinate and ensure the effectiveness of work to protect and promote the welfare of children, including making arrangements to identify and support children at risk of harm.

9. Appendix One

Severe skin damage identified, i.e.:

- Multiple category 2, or
- Single category 3 or 4

Where an individual has been transferred into the care of the organisation, contact to be made with the transferring organisation to ascertain if the Adult Safeguarding Decision Guide has been completed / any action taken

Referral to local healthcare services (unless already in receipt of such service) for history of skin damage to be assessed by a clinician, i.e. nurse

Complete the Adult Safeguarding Decision Guide inc. Body Map *to be completed by a RN within 48 hours

Decision Guide Score 15+, or Professional judgement determines safeguarding concern

Complete incident reporting immediately, as per organisation policy

No

Yes

Discuss outcome with the individual, family and/or carer

Action any recommendations identified and put preventative or management measures in place

Discuss concerns with the individual, family, and/or carer

Safeguarding concern to be raised with the relevant Local Authority Adult Safeguarding Team

Follow local pressure ulcer reporting and investigating processes

Record decision in individual's record

Hampshire Adult Services

Multi Agency Safeguarding Hub (MASH) | Health and social care | Hampshire County Council (hants.gov.uk)

Isle of Wight Adult Services

Report a concern

Portsmouth Adult Services

PCC-Safeguarding-Concern-Form-FV-2023.docx (live.com)

Southampton Adult Services

Adult social care - Make a professional safeguarding referral | Southampton City Council

Appendix Two

Guidance on completing the safeguarding decision guide

Use the following criteria when completing the adult safeguarding decision guide for individuals with severe pressure ulcers.

History

Include any factors associated with the person's behaviour that should be taken into consideration - for example, sleeping in a chair rather than a bed.

Medical history

Ask questions such as:

Does the person have a long-term condition or take any medication which may impact on skin integrity? For example, rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), chronic oedema or steroid use.

Is the person receiving end of life care?

Does the person have any mental health problems or cognitive impairment which might impact on skin integrity? For example, dementia or depression.

Monitoring of skin integrity

Ask questions such as:

Were there any barriers to monitoring or providing care - for example, access or domestic or social arrangements?

Should the illness, behaviour or disability of the person have reasonably required the monitoring of their skin integrity (where no monitoring has taken place prior to skin damage occurring)?

Did the person decline monitoring? If so, did the person have the mental capacity to decline such monitoring?

Were any further measures taken to assist understanding? For example, person's information, leaflets, ward leads, team leader and senior nurses?

If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?

Were there any other notable personal or social factors which have affected the person's needs being met? For example, history of self-neglect, lifestyle choices and patterns, substance use, unstable housing, faith, mental ill health, learning disability.

Expert advice on skin integrity

Ask questions such as:

Was appropriate assistance sought? For example, professional advice from a community nurse, clinical lead or tissue viability specialist nurse.

Was advice provided? If so, was it followed?

Care planning and implementation for management of skin integrity

Ask questions such as:

Was a pressure ulcer risk assessment carried out upon entry into the service and reviewed at appropriate intervals?

If expert advice was provided, did this inform the care plan?

Did skin integrity assessment and monitoring at suitable and appropriate intervals form part of the care plan?

Were all of the actions on the care plan implemented? If not, what were the reasons for not adhering to the care plan? Were these documented?

If the person has been assessed as lacking the mental capacity to consent to the care and treatment in the care plan, has a best interest decision been made that care and treatment delivered is in their best interests?

Did the care plan include provision of specialist equipment?

Was the specialist equipment provided in line with local timescales?

Was the specialist equipment used appropriately?

Was the care plan revised within time scales agreed locally?

Care provided in general (hygiene, continence, hydration, nutrition, medications)

Ask questions such as:

Does the person have continence problems? If so, are they being managed?

Are skin hygiene needs being met (including hair, nails and shaving)?

Has there been deterioration in physical appearance?

Are oral health care needs being met?

Does the person look emaciated or dehydrated?

Is there evidence of intake monitoring (food and fluids)?

Has the person lost weight recently? If so, is the person's weight being monitored?

Are they receiving sedation? If so, is the frequency and level of sedation appropriate?

Do they have pain? If so, has it been assessed? Is it being managed appropriately?

Other possible contributory factors

Ask questions such as:

Has there been a recent change (or changes) in care setting or circumstances?

Is there a history of falls? If so, has this caused skin damage? Has the person been on the floor for extended periods? Has the person been seen by the ambulance service, even if not sent to hospital?

Assessment score and next steps

If the decision guide score is 15 or higher (which is a concern for safeguarding), you should:

- discuss with the person, family and/or carers that there are safeguarding concerns, explaining why, and that a safeguarding concern has been raised in order to ensure the right support is offered to those involved.
- refer to local authority via local procedure, with completed safeguarding pressure ulcer decision guide documentation. Include the views and outcome desired of the adult at risk/their family.
- follow local pressure ulcer reporting and investigating processes
- record decision in person's records

If the score is under 15, you should:

- discuss with the person, family and/or carers and emphasise the actions which will be taken to manage the pressure damage and prevent further deterioration.
- action any other recommendations identified and put preventative or management measures in place
- follow local pressure ulcer reporting and investigating processes
- record decision in person's records and add completed decision support guide to records.

Appendix Three

Adult Safeguarding Decision Guide for Individuals with Severe Pressure Ulcers

Patient Name		**Name of staff completing form**	
NHS/Hospital Number		**Designation**	
Date of Birth		**Email**	
Ward/Department/Location		**Contact Number**	
		Date of Assessment	

	Risk Category	Level of Concern	Score	Evidence
1.	Has the patient's skin deteriorated to either category 3/4/unstageable or suspected deep tissue injury, or multiple category 2 from healthy unbroken skin since the last opportunity to assess/ visit	**Score 5 if Yes** e.g. record of blanching / non-blanching erythema /category 2 progressing to category 2 or more		E.g. evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		Score 0 if No e.g. no previous skin integrity issues or no previous contact health or social care services		
2.	Has there been a recent change, i.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anaemia, end of life care, critical illness	**Score 0 if:** Change in condition contributing to skin damage		
		Score 5 if:		

		No change in condition that could contribute to skin damage		
3.	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	**Score 0 if:** Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs **Score 5 if:** Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed **Score 15 if:** No or incomplete risk assessment and/or care plan carried out		State date of assessment Risk tool used Score / Risk level What elements of care plan are in place What elements would have been expected to be in place but were not
4.	Is there a concern that the Pressure Ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services	**Score 0 if:** No / Not applicable **Score 15 if:** Yes		
5.	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk–Category/ category 3 or 4 pressure ulcer	**Score 0 if:** Skin damage less severe than patient's risk assessment suggests is proportional		

		Score 10 if: Skin damage more severe than patient's risk assessment suggests is proportional		
6.	**Answer (a) if** your patient has capacity to consent to every element of the care plan. **Answer (b) if** your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan.			
a.	Was the patient concordant with the care plan having received information regarding the risks of non-concordance?	**Score 0 if:** Patient has not followed care plan and local non concordance policies have been followed.		
		Score 3 if: Patient followed some aspects of care plan but not all		
		Score 5 if: Patient followed care plan or not given information to enable them to make an informed choice.		
b.	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	**Score 0 if:** Documentation of care being undertaken in patient's best interests		
		Score 10 if: No documentation of care being undertaken		

		in patient's best interests		
	TOTAL SCORE:			

Appendix Four

Body Maps

Body maps should be used to record skin damage and can be applied as evidence, if necessary, at a later date.

If 2 workers observed the skin damage, they should both sign the body map.

Person's information

Person's name:

Person's NHS number:

Assessor information

Assessing nurse’s name (print):

Job title:

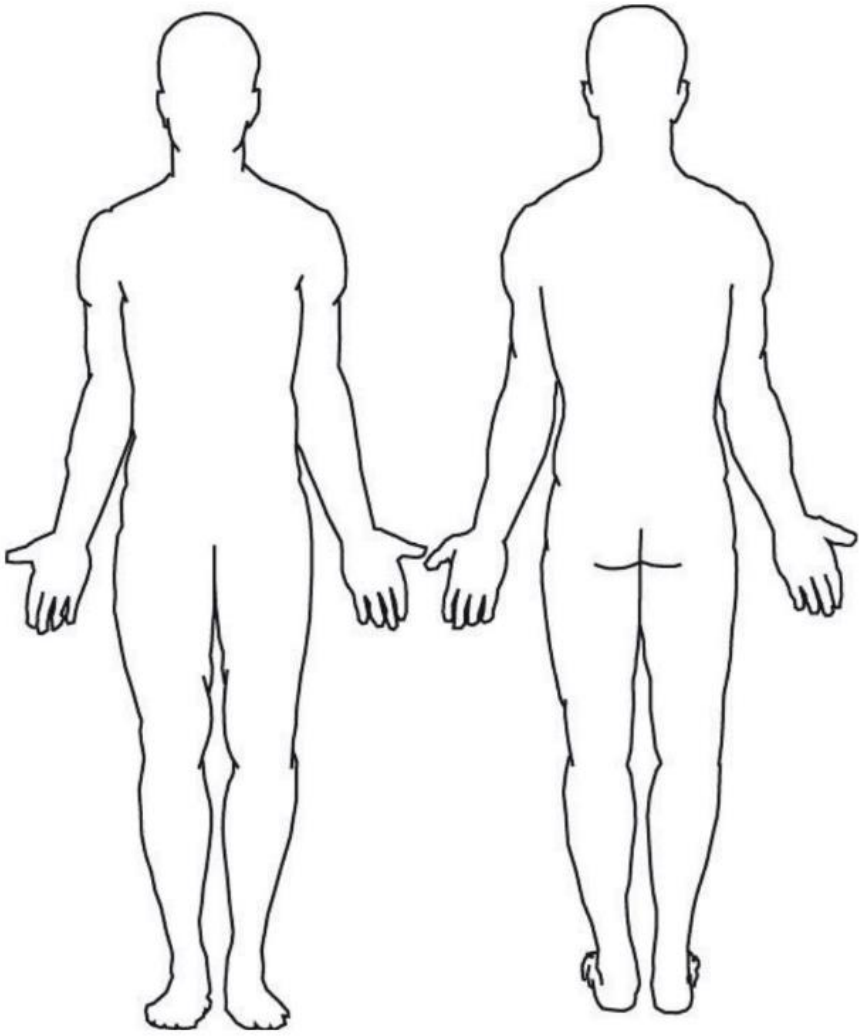
Assessing nurse’s signature:

Note: when using an electronic patient record (EPR), this guide will be completed under one assessor's profile. However, if there is a second assessor present, you should record their name.

Second assessor’s name (print):

Job title:

Second assessor’s signature:



Appendix Five

Safeguarding Referral Information

Hampshire Adult Services

Multi Agency Safeguarding Hub (MASH) | Health and social care | Hampshire County Council (hants.gov.uk)

Office Hours: 0300 555 1386

Out of Hours: 0300 555 1373

adult.services@private.hants.gov.uk

Isle of Wight Adult Services

Report a concern

Office Hours: 01983 814980

Out of Hours: 01983 821105

safeguardingconcerns@iow.gov.uk

Portsmouth Adult Services

PCC-Safeguarding-Concern-Form-FV-2023.docx (live.com)

Office Hours: 02392 680810

Out of Hours: 0300 555 1373

adultsafeguarding@portsmouth.gov.uk

Southampton Adult Services

Adult social care - Make a professional safeguarding referral | Southampton City Council

Office Hours: 02380 834307

Out of Hours: 02380 233344

Hampsh.re and
Isle of Wight Healthcare
NHS Foundation Trust

How to Prevent Pressure Ulcers

A personal guide

Your Name:

www.hiowhealthcare.nhs.uk

Welcome to your personalised guide on how to prevent a pressure ulcer. Your health professional will help to identify any risks you may have and work with you to help prevent a pressure ulcer from developing.

What is a pressure ulcer?

A pressure ulcer is an area of damage to the skin and underlying tissue. They are sometimes known as pressure sores or bed sores. These may be painful.

Why is it important to prevent a pressure ulcer?

Pressure ulcers can have a serious impact on the quality of your life, it is therefore important that you recognise if you are at risk so you can prevent a pressure ulcer from developing.

What causes a pressure ulcer?

Pressure ulcers are caused when the blood supply to certain areas of the body is restricted. This can be caused by three main factors:

Pressure: The weight of the body pressing down on the skin over time

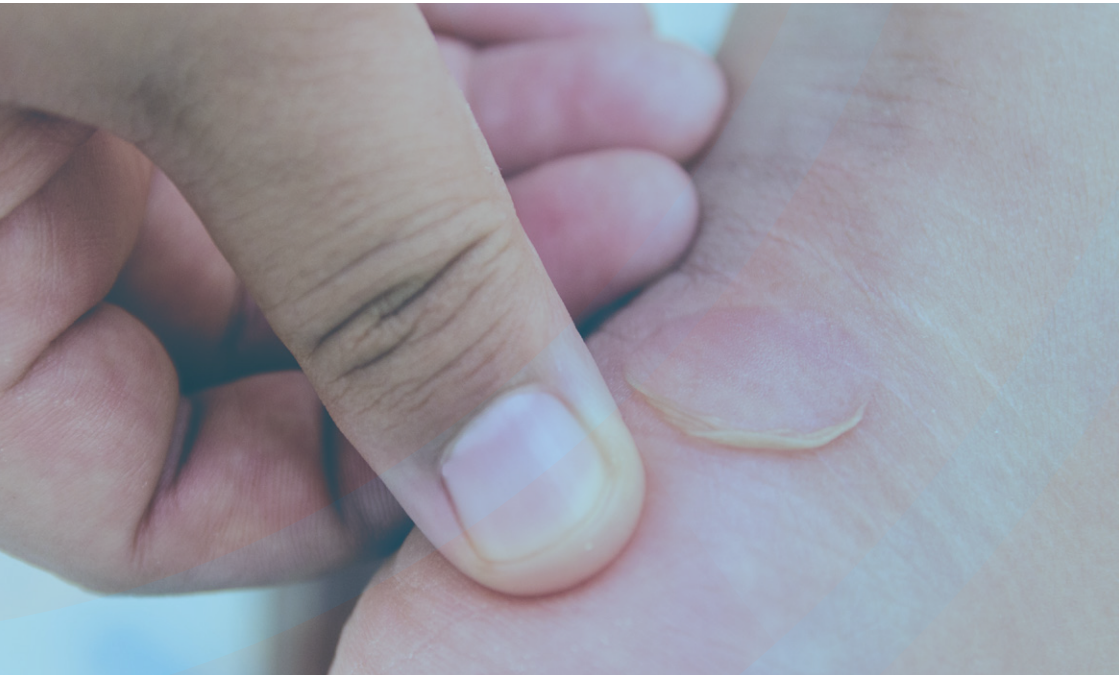
Shearing: Frequently sliding or slumping down the bed/chair can damage the skin and the deep layers of tissue underneath the skin

Friction: Poor moving and handling methods and rubbing of the skin

Are you at risk?

Anyone can develop a pressure ulcer but some people are more at risk than others. You may be more at risk of developing a pressure ulcer if you:

- Are incontinent
- Have poor appetite, diet or do not drink enough water
- Are very old or very young
- Are unable to reposition yourself
- Have poor circulation
- Have cracked broken skin on heels
- Are ill or have suffered an injury, e.g. a broken hip
- Already have a pressure ulcer or if you have had a pressure ulcer in the past
- Have dark skin tones



If you have any of the following you could be at risk

Early signs of a pressure ulcer (please tick as appropriate)

- ☐ Changes in skin colour
- ☐ Purple or bluish
- ☐ Red patches on fair skin (that do not disappear when lightly pressed)
- ☐ Swelling
- ☐ Blisters
- ☐ Shiny/spongy areas
- ☐ Dry patches
- ☐ Cracks and calluses
- ☐ Hard skin
- ☐ Warm, hot or cold areas on your skin
- ☐ Swollen skin over bony areas
- ☐ Pain or numbness

Patient signature: .....

Staff signature: .....

Top Tips: (please tick as appropriate)

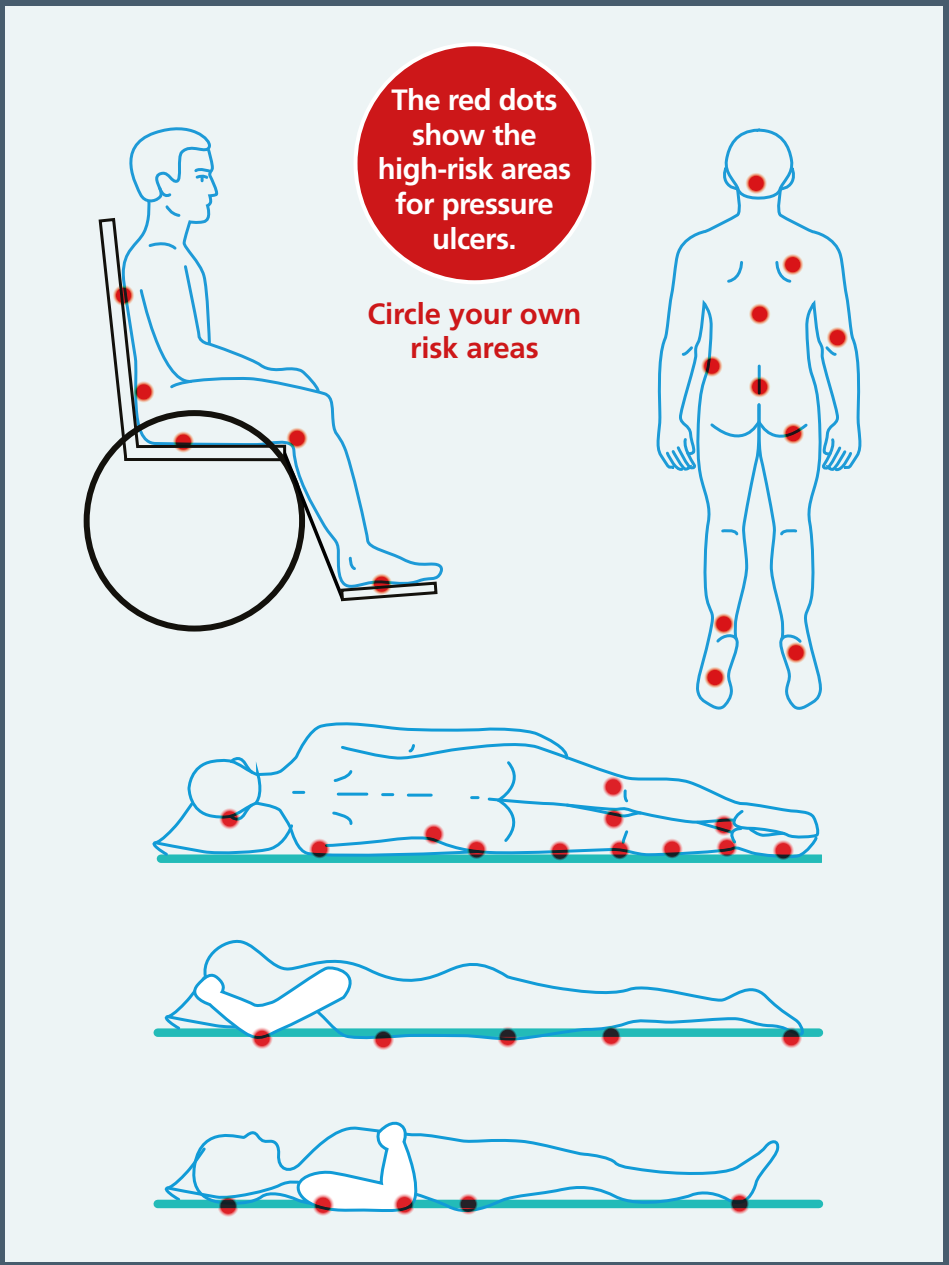
- [ ] Avoid using extra cushions if it makes the seat too high and the armrests too low
- [ ] Even if you have a pressure mattress or cushion aim to change position regularly. Do not cover cushion with a towel or blanket
- [ ] Use pillows in bed to make yourself comfortable by off-loading pressure points such as heels
- [ ] Use a mirror or ask someone to help check areas of skin that are difficult to see e.g. heels or buttocks
- [ ] Do not tightly fold bedclothes or place heavy blankets on your body as this will cause extra pressure on feet and heels
- [ ] If you are using an air mattress make sure you cover it with a loose, not a fitted, sheet with no creases
- [ ] When washing, alway wash using warm water
- [ ] Pat skin dry, do not rub dry
- [ ] If you are incontinent apply a skin barrier product
- [ ] Avoid using multiple continence pads at one time
- [ ] Avoid using talcum powder
- [ ] Keep cool to minimise sweaty skin

Do not use: Water filled gloves

Sheepskin material

Doughnut ring type devices

Common locations of pressure ulcers



Your daily checklist to help prevent pressure ulcers

Date discussed: .....

- If possible change position or stand:
  - If seated: stand every 15 minutes if able
  - If in bed: change position every one to two hours
- Check your skin for any early signs of pressure ulcers
- When you use the toilet, commode or a pad make sure you wash and dry your skin properly
- Moisturise your skin in the direction of hair growth
- Do not rub or massage over a bony part of your body
- Eat a good balanced diet and drink plenty of fluids
- Make sure all your bed linen is clean, dry and crease free
- Use any specialist equipment such as a mattress or a cushion if you have been given one by your health care professional
- Check any specialist equipment is clean and in good repair
- Do not cover your specialist cushion
- Avoid lying or sitting on zips, thick seams or pockets
- Ensure shoes, shoe laces, slippers and socks are not tight or rubbing
- Ensure your armchair is in good repair and comfortable
- Ensure your armchair is supportive and you are able to get your bottom right back enabling you to sit straight

Remember **If your skin feels or looks sore tell your health professional or carer**

What should I do next?

If you have a pressure ulcer or have any concerns about developing a pressure ulcer, please contact your health professional or GP as soon as possible.

Your health professional: .....

Telephone: .....

Addressing concerns and complaints

It is really important to hear feedback, and concerns from patients, carers and families. Feedback helps us know where things have gone well, respond to any problems, and to keep improving our service.

Email: complaints@southernhealth.nhs.uk

Call: 023 8231 1200

Or write to us at: Concerns and Complaints Team, 7 Sterne Road, Tatchbury Mount, Calmore, Southampton SO40 2RZ.

If you require this leaflet in another language, large print or another format, please contact your team who will be able to help you or call our Carers and Patients Support Hub on 023 8231 1206

Email | communications@southernhealth.nhs.uk

hiowhealthcare.nhs.uk

@hiowh_nhsft

@hantsiowhealthcarenhsft

@hantsiowhealthcare_nhsft

We CARE through:

HW0145. October 2024. Review Date: October 2026.

Designed by NHS Creative – CS57377

NHS
University Hospital Southampton
NHS Foundation Trust

How to prevent pressure ulcers

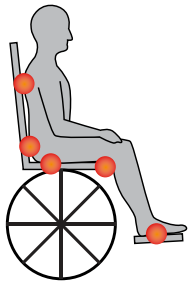
Information for patients, families and carers

This booklet will explain what pressure ulcers (sometimes known as bedsores or pressure sores) are and describe the common causes and steps that can be taken to reduce them. A pressure ulcer can seriously impact the quality of your life and it's important to understand whether you may be at risk, so you can help prevent a pressure ulcer from developing.

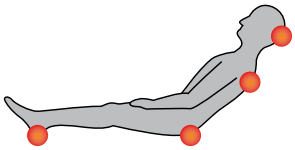
What is a pressure ulcer?

A pressure ulcer is an area of damage to the skin and underlying tissue. The first sign that a pressure ulcer may be forming is usually discoloured skin or localised pain, which may get progressively worse and eventually lead to an open wound. The most common places for pressure ulcers to occur are over bony prominences (where bones are close to the surface of the skin).

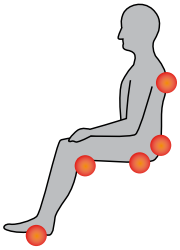
The images below show areas where pressure ulcers can often form:



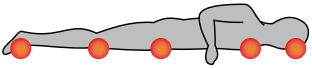
Sitting in a wheelchair



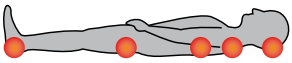
Sitting up in bed



Sitting in a chair



Lying on your side



Lying on your back

Causes

Pressure ulcers develop when the blood supply to an area of skin is disrupted. A lack of blood supply means that oxygen and nutrients don't reach the area as they should, and this causes the skin to break down and an ulcer to form. They occur when an area of the body is placed under pressure for any length of time, and are more likely if a person has to stay in bed, in a chair or in a wheelchair for long periods of time, or is unable to move around or change position easily.

Apart from continued pressure on an area, the following may cause pressure ulcers:

- sliding or slumping down the bed or chair – this can damage the skin and the deep layers of tissue underneath (known as 'shearing')
- poor moving and handling methods can remove the top layers of skin and create friction, which if applied repeatedly can increase the risk of pressure damage
- excessive or prolonged exposure to moisture can also increase the risk of pressure damage developing

The early signs of pressure damage

You may notice one or more of the following:

- changes in skin colour (turning red or dark)
- a feeling of heat or cold in the area
- swelling
- discomfort or pain
- blistering
- other skin damage

Who is at risk of developing a pressure ulcer?

Anyone, whatever their age or mobility, can develop a pressure ulcer but some people are at greater risk than others.

You may be at greater risk if you:

- currently have a pressure ulcer or have had one in the past
- are unable to move certain parts of your body, or change position by yourself
- are seriously ill or undergoing surgery
- have had an injury, for example a broken hip
- have conditions such as diabetes, stroke and nerve or muscle disorders that may reduce sensitivity to pain and discomfort
- have had an epidural or medications which may reduce your ability to move and your sensitivity to pain
- have a poor appetite/diet or do not drink enough fluids
- have a plaster of Paris cast applied to a limb
- are elderly or very young
- have existing broken skin
- have poor circulation
- are incontinent

What to expect when you are admitted to hospital

To assess your risk of developing pressure ulcers, a member of your healthcare team will examine your skin when you're admitted and ask you some questions. This will help us to identify whether you require specialised equipment or other forms of care, and will enable us to provide for your individual needs.

Skin inspection during your time in hospital

During your time in hospital your skin will be examined frequently by a nurse for early signs of damage in all of the areas that are at risk of developing pressure ulcers.

This visual inspection is important because damage can often be seen before it is felt, and because there are some areas of the body which you are unable to see yourself (such as the bottom and back). By regularly examining your skin, it may be possible for us to pick up problems that you're not aware of yet, and act promptly to address them. If damage is identified early we can generally prevent it from getting worse. How often your skin will be examined depends on your level of risk and your general health.

Prevention

One of the best ways of preventing a pressure ulcer is to reduce or relieve pressure on the areas at risk by moving around and changing position as much as possible. If you already have a pressure ulcer, lying or sitting on the ulcer should be avoided as this will make it worse.

At this hospital if you are assessed as being at moderate or high risk of developing pressure damage due to your current condition and skin health, you'll be placed on the 'Turnaround' project. This involves your nurse coming to you every two hours to prompt or assist you in changing your position, helping you go to the toilet if required and ensuring you have a drink available.

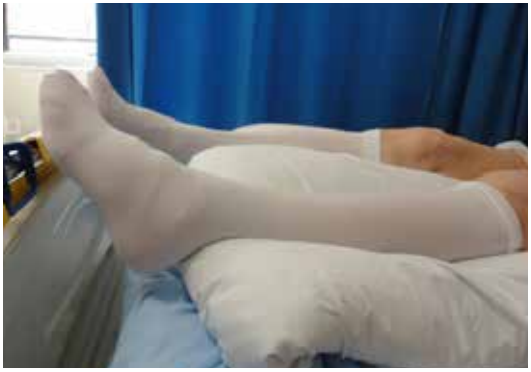
Changing position every two hours ensures the blood flow to the area under pressure has enough time to return to normal. So even if you're sitting in the chair you'll be encouraged to stay there for a maximum of two hours at any one time (sitting in a chair for long periods of time can increase the risk of pressure ulcers developing in the same way that staying in bed can).

Ways to relieve pressure while you are in bed

Some of the steps that can be taken to reduce pressure while you're in bed are explained below. Your nurses will be able to help you with these.

Pillows can be used to relieve any pressure from areas likely to be at risk of developing damage:

Your heels will be raised using a pillow lengthways under each leg to ensure no pressure is applied to your heels or ankles.



Pillows will also be placed in the small of your back to tilt you over approximately 30 degrees (rather than you lying completely on your side).

Air mattresses and cushions

If your condition puts you at increased risk of developing pressure damage, you may have a pump added to the mattress on your bed. These devices feature an automatically regulated airflow able to reduce or redistribute pressure over areas of the body as required. You may also be asked to sit on a pressure-relieving cushion when sitting out of bed in the chair. However, we'll still need to reposition you every two hours.

What you can do to help avoid pressure damage

Keep moving

It's important to keep moving as much as possible. You should:

- Try to reposition yourself (if you're able to) every two hours. If you need help to do this, let your nursing team know, and ensure that they are aware if you have been in the same position for longer than two hours.
- Sit out in your chair for a maximum of two hours at any one time before getting onto the bed, tilted to one side to relieve the pressure.
- If you are able to move independently, we recommend that you get up and have a walk every 15-30 minutes.

Eat well and stay hydrated

Eating and drinking well is important for everyone, but especially for those at risk of developing pressure damage. Make sure you eat a healthy, balanced diet and drink plenty of fluids, and extra protein may help. Meat, fish, eggs and beans are all good sources of protein.

If you're concerned about your nutrition please talk to a member of your nursing team. You may be referred to a dietitian for assessment and advice. If you have an existing pressure ulcer then you may be prescribed supplements to help with wound healing.

Your nurse will talk you through the information contained in this leaflet and if you have any questions don't hesitate to ask.

If you're concerned that you may have or are developing any pressure damage, you should inform a member of your healthcare team immediately.

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Useful links
NHS UK
www.nhs.uk/conditions/pressure-sores

With grateful thanks to Mrs Audrey Ennion

www.uhs.nhs.uk

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