

and 4 pressure ulcers may need advanced wound dressings that support an optimum wound healing environment, e.g. hydrocolloids, hydrogels, foams, soft silicones and hydrofibres, and negative pressure wound therapy (NPWT) may be considered if the wound is large, deep and heavily exuding. These wounds should be referred to a specialist (NICE, 2015).

Skin care

Incontinence may lead to impaired skin integrity, making a person more vulnerable to pressure ulcer development (NPUAP et al, 2014). As outlined in the SSKIN bundle, effective continence management and prevention of incontinence-associated dermatitis and moisture lesions are, therefore, important for skin health.

Educating patients and their carers/family to follow a good hygiene regimen and keep the skin clean and dry can help to prevent pressure damage, or further skin breakdown. Carers should also be aware of the early signs of skin breakdown and regularly reassess the skin (Blenman, 2017).

Nutrition

Guidelines from NPUAP et al (2014) highlight the essential role that nutrition management plays. Assessment of the person's nutritional state should ensure that they have sufficient energy for metabolism as well as protein, fluid and micronutrients to be able to maintain and repair tissue. When needed, nutritional supplements may help to achieve an adequate supply of nutrients (Taylor, 2017).

Psychosocial considerations

Pressure ulcers can also have a negative impact on patient quality of life and wellbeing. They can be painful, causing anxiety and frustration (NICE, 2015; Ellis, 2017). Discomfort, concerns about odour, as well as the practicalities of pressure-redistributing equipment can restrict patients' lifestyles. To help patients develop coping skills, nurses should listen and discuss with patients how they are feeling (Chamanga, 2016).

CONCLUSION

Pressure ulcer prevention requires systematic care planning based on a sound understanding of risks. Only by regularly assessing individual patients is it possible to determine their needs. Care planned with the SSKIN bundle is more likely to cover the key components of good practice for pressure ulcer prevention.

REFERENCES

- Beldon P (2014) How to accurately identify and record pressure ulceration. *J Community Nurs* **28(5)**: 33
- Bergstrom N, Braden BJ, Laguzza A, Holman V (1987) The Braden Scale for predicting pressure sore risk. *Nurs Res* **36(4)**: 205–10
- Blenman J, Marks-Maran D (2017) Pressure ulcer prevention is everyone's business: the PUPS project. *Br J Nurs* **26(6)**: S16–S26
- Chapman S (2017) Preventing and treating pressure ulcers: evidence review. *Br J Community Nurs* **22(suppl 3)**: S37–S40
- Chamanga E (2016) Addressing pressure ulcer issues. *Independent Nurse* **11**: 28–31
- Defloor T, Schoonhoven L (2004) Inter-rater reliability of the EPUAP pressure ulcer classification system using photographs. *J Clin Nurse* **13(8)**: 952–9
- Department of Health (2009) *NHS 2010–2015: from good to great. Preventative, people-centred, productive*. DH, London
- Department of Health (2011) *Safe Care*. DH, London
- Ellis M (2017) Pressure ulcer prevention in care home settings. *Nurs Older People* **29(3)**: 29–37
- Gaspar A, McEwing G, Richardson J (2009) *Foundation skills for caring*. Palgrave Macmillan UK
- Healthcare Improvement Scotland (2016) *Prevention and Management of Pressure Ulcers: Standards*. Available online: <http://tinyurl.com/hkdc9p>
- McCoulough S (2016) Adapting a SSKIN bundle for carers to aid identification of pressure damage and ulcer risks in the community. *Br J Community Nurs* **21(Suppl)**: S19–S25
- Moore Z, Cowman S (2014) Risk assessment tools for the prevention of pressure ulcers. *Cochrane Database of Systematic Reviews* **2**. CD006471
- National Institute for Health and Care Excellence (2015) *Pressure ulcers*. Quality Standard 89. Available online: www.nice.org.uk/guidance/qs89
- National Institute for Health and Care Excellence (2014) *NICE clinical guideline 179. Skin conditions. Pressure ulcer management: the prevention and management of pressure ulcers in primary and secondary care*. Available online: www.nice.org.uk/guidance/cg179
- National Patient Safety Agency (2010) *NHS to adopt zero tolerance approach to pressure ulcers*. 13 July. NPSA, London. Available online: www.npsa.nhs.uk/corporate/news/nhs-to-adopt-zero-tolerance-approach-to-pressure-ulcers/
- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, Pan Pacific Pressure Injury Alliance (2014) *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline*. Available online: www.npuap.org/resources/educational-and-clinical-resources/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guideline/
- NHS Midlands and East (2016) *Stop the Pressure: helping to prevent pressure ulcers*. Birmingham, NHS Midlands and East. Available online: <http://nhs.stopthepressure.co.uk/>
- NHS Improvement (2016) *SSKIN: Five simple steps to prevent and treat pressure ulcers*. Available online: <https://improvement.nhs.uk/resources/Using-SSKIN-to-manage-and-prevent-pressure-damage/>
- Norton D (1996) Calculating the risk: reflections on the Norton Scale: 1989. *Adv Wound Care* **9(6)**: 38–43
- Qaseem A, Mir T, Starkey M, et al (2015) Risk assessment and prevention of pressure ulcers: a clinical practice guideline from the American College of Physicians. *Ann Intern Med* **162(5)**: 359–69
- Royal College of Nursing (2005) *The management of pressure ulcers in primary and secondary care: A clinical practice guideline*. RCN, London
- Taylor C (2017) Importance of nutrition in preventing and treating pressure ulcers. *Nurs Older People* **29(6)**: 33–9
- Tingle J (2016) Protecting patients: pressure ulcer prevention. *Br J Nurs* **25(20)**: 1146–47
- Waterlow J (2005) *The Waterlow Pressure Ulcer Prevention Manual*. Waterlow, Taunton. Available online: www.judy-waterlow.co.uk/the-waterlow-manual.htm

This piece was partnered by





WOUND CARE PEOPLE
www.woundcare-today.com



Pressure area care



WOUND CARE TODAY

www.woundcare-today.com

Pressure area care

This snapshot learning feature raises awareness of the importance of pressure area care, which can present significant challenges to clinicians and patients, i.e. difficulties in staging, poor inter-agency working, the complex, deteriorating patient being looked after closer to home, sporadic equipment provision, patient monitoring, and pressure ulcer prevention awareness (Chamanga, 2016). Read the feature, then go online and complete the accompanying e-learning module and test to find out more about pressure area care — the CPD points gained count towards revalidation. www.woundcare-today.com/learning-zone/pressure-area-care/module

Pressure ulcer prevention and reduction is a high priority for the NHS. Commissioning for Quality and Innovation (CQUIN) suggests that, based on the NHS Safety Thermometer Pilot (<http://content.digital.nhs.uk/thermometer>), pressure ulcer incidence can be halved in one year, and the tools they cite for achieving this include the National Institute for Health and Care Excellence (NICE, 2014), and National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance guidelines (NPUAP et al, 2014; Chapman, 2017). Pressure ulcers can result in severe harm or even death and research suggests that between 80–95% are avoidable (Tingle, 2016). In relation to the National Reporting and Learning System (NRLS), a review of death and severe harm themes undertaken for 2011/2012 demonstrated that pressure ulcers were the largest proportion of patient safety incidents accounting for 19% of all reports (NICE, 2015).

However, despite improvements in technology and medical advances, the incidence of pressure ulcers is increasing. Nearly 700,000 people in the UK are affected by pressure ulcers each year across all care settings, including people in their own homes (NHS Midlands and East, 2016; Blenman et al, 2017).

Every pressure ulcer has a tangible effect on the patient. This includes pain, the need for additional nursing interventions, damage to their sense of self, leading to depression or social isolation, due to wound symptoms such as odour. The drive to prevent harm is at the forefront of the argument for investment of time and money in pressure ulcer prevention (NICE, 2015; Ellis, 2017). Every setting where care is delivered, whether home, hospital or care home, faces challenges in delivering pressure ulcer prevention — pressure ulcers also affect the morale of clinical staff, because they are still considered to be an indicator of poor nursing care, affecting the quality of life of patients and their families (Chamanga, 2016; Tingle, 2016; Ellis, 2017).

WHO IS AT RISK?

Not every person is at risk of developing a pressure ulcer. Those at higher risk include the elderly, patients in intensive care, as well as stroke, postoperative orthopaedic, spinal cord injury, malnourished and cancer patients.

WHY DO THEY OCCUR?

Pressure ulcers develop because of pressure compromising local tissue blood supply, usually over bony prominences with the lower trunk (sacrum, coccyx, trochanter and ischial tuberosities) and heels being the most common anatomical locations (NPUAP et al, 2014). They can range from superficial damage, involving little more than skin discolouration, to deep ulcers, which extend down to tendon and muscle or bone (Glasper et al, 2009). Pressure ulcers are influenced by intrinsic (internal) and extrinsic (external) factors. Intrinsic involve those relating to the patient's anatomy and physiology, such as age, impaired mobility, poor posture or deformity, underlying medical conditions, for example, neurological conditions such as cerebrovascular accident, or spinal cord injury, impaired nutrition and hydration, previous pressure damage, and incontinence (NPUAP et al, 2014). Pressure and shear are the two main extrinsic factors (Chamanga, 2016).

RISK ASSESSMENT

It is important that information is gathered in a systematic way. There are several risk assessment tools to help staff identify those at greatest risk, but these must always be used in conjunction with sound professional judgement (Moore and Cowman, 2014; NICE, 2014; Qaseem et al, 2015). The most



Remember...

Since 2014, the Department of Health (DH) has focused on reducing avoidable harms in an attempt to save 6,000, lives while improving patient safety and saving money. As well as pressure ulcers being recognised by the DH as a classic 'avoidable harm', the NHS Outcomes Framework lists pressure ulcer prevention as a key focus area and pressure ulcers are routinely reported via the NHS Safety Thermometer.

commonly used tools in the UK are Waterlow (2005), Norton (Norton, et al, 1992) and Braden (Bergstrom et al, 1987).

STAGING PRESSURE ULCERS

As well as comprehensive skin and wound care assessment, it is also important to stage pressure ulcers. The NPUAP (2014) classification to stage pressure ulcers has been recommended as best practice by NICE (2015), Healthcare Improvement Scotland (HIS, 2016) and the Royal College of Nursing (RCN, 2005), as this assesses and establishes the severity and depth of tissue damage, namely:

- ▶ Stage 1 pressure injury: non-blanchable erythema or intact skin
- ▶ Stage 2 pressure injury: partial-thickness skin loss with exposed dermis
- ▶ Stage 3 pressure injury: full-thickness skin loss
- ▶ Stage 4 pressure injury: full-thickness skin and tissue loss
- ▶ Unstageable pressure injury: obscured full-thickness skin and tissue loss
- ▶ Deep tissue pressure injury (DTPI): persistent non-blanchable deep red, maroon or purple discoloration.

Accurate pressure ulcer staging has several benefits, in that it (Chamanga, 2016):

- ▶ Gives an objective assessment and understanding of the extent of tissue damage
- ▶ Assists in planning, implementing and evaluating preventative or treatment regimens
- ▶ Allows appropriate allocation of equipment (i.e. support surfaces)
- ▶ Supports clinical incident reporting (Datix)
- ▶ Generates data which can be used to identify hotspots, tailor training sessions, design prevention and management strategies.

Healthcare professionals should be alerted when pressure ulcers are identified as stage 3/4. These are considered 'never events' (DH, 2009; 2011) for which there should be a zero-tolerance approach (National Patient Safety Agency [NPSA], 2010), and should be reported immediately, as patients are at risk of infection and complications and will need immediate treatment and/or referral to specialist services (DH, 2011).

MANAGEMENT OF PRESSURE ULCERS

The care plan that follows risk assessment should focus on the five-step SSKIN bundle approach associated with pressure ulcer prevention (Ellis, 2017) (*Table 1*). This SSKIN acronym reminds staff what to consider as part of their care plan. Ongoing assessment of a patient's skin while delivering care will help to determine the required frequency of care delivery. For example, if a person's skin is red or marked after being moved at four-hourly intervals, they may need to have three-hourly position changes, alongside delivery of all aspects of the SSKIN bundle on each occasion (Ellis, 2017).

The main management interventions include:

- ▶ Positioning and reduction of pressure and shear
- ▶ Wound care
- ▶ Skin care
- ▶ Nutrition.

Table 1: SSKIN bundle (NHS Improvement, 2016; McCoulough, 2016)

Skin	Keep the skin clean and dry. Regularly inspect the skin and identify areas of blanchable erythema before it becomes non-blanchable erythema
Surface	Ensure the provision of appropriate pressure-reducing or relieving devices. Make sure that the patient is repositioned at regular intervals, which meet with the individual patient's healthcare needs. Consider 30° tilt to position the patient, using pillows below the neck, back and legs
Keep moving	Encourage mobility and regular movement to relieve pressure over bony prominences
Incontinence	Use urinary and faecal management systems and incontinence products when indicated. Keep skin clean and dry
Nutrition	As part of pressure ulcer management or prevention, nutritional status must be assessed. Keep patients well hydrated and implement prescribed diet/nutritional supplements

Positioning and reduction of pressure and shear

Regardless of which support surface a person is using, mobilisation and effective repositioning are central activities for relieving pressure and reducing shear forces. Where possible, a person should be prompted to reposition independently. This is often achieved by combining an appropriate patient support surface with a patient-specific repositioning schedule, which is not based on ritualistic practice. It is also important that position is varied and that loading directly over any single bony prominence is limited over the course of the day.

Selection of support surfaces should be based on a person's level of mobility, comfort, skin microclimate, i.e. perspiration, continence and heat, and any specific needs related to risks associated with amputation, diabetes, peripheral vascular disease, or spinal deformity. Modern support surfaces are broadly categorised as:

- ▶ Reactive (static): providing a constant pressure to the skin and subcutaneous tissue, unless the patient moves or is repositioned
- ▶ Active (alternating): periodically redistributing the pressure beneath the body. These surfaces are recommended for a wide range of patients who cannot be regularly repositioned (NPUAP et al, 2014).

Wound care

Stage 1 pressure ulcers, where the skin is intact, can be treated with simple barrier products, such as films or dressings and barrier creams and then monitored regularly. Stage 2 pressure ulcers, where the skin is broken, will need a dressing. Film dressings are useful for wounds producing a low volume of exudate, as they offer a protective layer while still allowing the wound to be seen without removal (RCN, 2005). Stage 3

Practice point

Staging pressure ulcers is not a way of monitoring their progress, as they do not proceed from one stage to the next (Defloor and Schoonhoven, 2004; Beldon 2014). Likewise, a stage 4 ulcer does not become a stage 3 as it heals, but should be viewed as a healing stage 4 ulcer.