A Reference Guide for Community Health Care Teams

*To be used in conjunction with the; Nottingham CityCare Partnership Policy for the Prevention of Pressure Ulcers*

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**Pressure Ulcer Prevention**

- Patient centred care planning
- Risk assessment
- Equipment needs
- Skin & continence assessment
- Skin care
- Undertake nutritional screening
- Repositioning
- Evaluate effectiveness

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[Links]
- www.stopthepressure.com/sskin
- http://www.stopthepressure.com/path/
- www.npuap.org/Pressure
- www.epuap.org

This leaflet was created in partnership by the Tissue Viability Teams of Nottingham City Care Partnership; County Health Partnerships and Bassetlaw Health Partnerships and supports EPUAP (2009) and SHA (2012) Guidelines for the Prevention of Pressure Ulcers.

Supported by an educational grant from BSNmedical
Risk assessment

- All patients will be screened using the Braden tool at first visit
- Braden reassessment will be repeated monthly or at each visit if seen 3 monthly/6 monthly/annually or if they have deterioration in their condition or on hospital discharge.
- Risk assessment should support not replace clinical judgement
  - A Braden score (Appendix 1) or clinical judgement that indicates the patient is at risk of pressure ulcer development indicates that a SSKIN bundle will be implemented (Appendix 2, Appendix 3)
  - For patients at risk the patient and/or carer will be given an information leaflet (Appendix 4) and an information plan (Appendix 5)

Skin assessment

- Initial skin assessment will be undertaken during Braden risk assessment
- Patients and carers will be shown how to undertake the skin tolerance test to observe for early signs of tissue damage
- The skin tolerance test is not reliable for patients with dark skin so observe for change in tissue temperature, texture, pain and discolouration (see p4) and record this on the skin assessment
- Skin damage will be classified using the staging adapted from the European Pressure Ulcer Advisory Panel (2009) (see p5)
- The frequency of skin inspection will be based on individual need according to risk status and will be recorded no more than once a day on the Sskin Bundle
- Wounds and skin conditions will be accurately recorded using wound measurements, anatomical location and photographs
- The skin will be observed for damage from appliances, devices and tubing
- The anatomical areas will be described accurately as per diagram below;

![Diagram of anatomical areas](image-url)
Skin Inspectors
Have you checked your patient’s most vulnerable pressure areas today?

Take your BEST SHOT!

What to look and feel for?
- Redness/ erythema - non-blanching when finger pressure applied
- Pain, soreness
- Warmer or cooler area over bony prominence
- Boggy feeling
- Hardened area
- Discolouration – dark red, purple, black
- Broken skin/ ulcer

N.B. Document any changes & continue to monitor closely!!!
The Skin Tolerance Test

Normal hyperaemic response to pressure

Press finger over reddened area for 15 seconds, then lift up finger.

If the area blanches, it is not a stage 1 pressure ulcer. If it stays red, it is a stage 1 pressure ulcer.

Darkly pigmented skin does not blanch. Signs to look for in early tissue damage include purple discolouration, skin feeling too warm or cold, numbness, swelling, hardness or pain.

Reporting

- All stages of pressure ulcers whether acquired or inherited stages 1-4 will be reported via the organisation’s incident and serious untoward incident reporting policies and procedures. A Root Cause Analysis (RCA) will be completed for all acquired stage 3 and 4 pressure ulcers.
- All incident reports must include the site and stage of the ulcer, if the pressure ulcer is acquired or inherited and whether it is avoidable or unavoidable.
- All incident reports will include if the pressure ulcer is Acquired or Inherited,
  - Acquired pressure damage – damage that occurs whilst the patient is receiving care from Nottinghamshire Healthcare Trust either as an in-patient or in the community
  - Inherited pressure damage – pressure ulcer present on admission when admitted into services within Nottinghamshire Health care NHS Trust
- All acquired avoidable and unavoidable stage 3 and 4 pressure ulcer will be reported as a STEIS incident to comply with organisational policy and procedure and Midlands and East Guidelines (2012)
  - Avoidable – all pressure ulcers are deemed to be avoidable unless they meet the specific criteria listed below
  - Unavoidable - means that the individual developed a pressure ulcer even though their condition and pressure ulcer risk had been evaluated; goals and recognised standards of care that are consistent with individual needs has been implemented; the impact of these interventions had been monitored, evaluated and recorded and the approaches had been revised
- All stage 3 and 4 pressure ulcers will be referred to Tissue Viability Nurses
- Follow Safeguarding Triggers Pathway if safeguarding concerns are raised (see p12)
<table>
<thead>
<tr>
<th>Stage 1: Non-blanching erythema</th>
<th>Stage 2: Partial thickness</th>
</tr>
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<tbody>
<tr>
<td>Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, bluish tinge. Stage I may be difficult to detect in individuals with dark skin tones. May indicate &quot;at risk&quot; persons.</td>
<td>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 or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Note that bruising may indicate deeper tissue injury. This stage should not be used to describe skin tears, tape burns, moisture lesions, maceration or excoriation.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Stage 3: Full thickness</th>
<th>Stage 4: Full thickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough or eschar may be present and may include undermining and tunnelling. Wounds covered with 100% eschar or slough are stage III. The depth of a Stage III pressure ulcer varies by anatomical location. The ear, occiput and malleolus do not have fatty tissue and Stage III ulcers can appear shallow. In contrast, fatty areas appear deeper. Bone/tendon is not visible or directly palpable.</td>
<td>Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a Stage IV pressure ulcer varies by anatomical location as for stage III. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis likely to occur. Exposed bone/muscle is visible or directly palpable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suspected Deep Tissue Injury: skin intact</th>
<th>Moisture Lesion: not a pressure ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purple localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. A thin blister may develop over a dark wound bed. The wound bed may become covered by thin eschar. Changes may be rapid exposing additional layers of tissue despite optimal treatment.</td>
<td>Redness or partial thickness skin loss involving the epidermis, upper dermis or both. Caused by excessive moisture to the skin from urine, faeces or sweat. This is not a pressure ulcer but must not be confused with a stage II pressure ulcer which is caused by pressure not moisture.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Combined Lesion: a pressure ulcer and moisture lesion – record as a pressure ulcer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A skin lesion caused by a combination of pressure, shear, friction and moisture. May occur over bony prominences and there may also be skin damage in the perineal area, the natal cleft and between the thighs. The lesions may be partial or full thickness in appearance and may range from non-blanching erythema to necrotic and sloughy wounds. These wounds are at risk of infection.</td>
<td></td>
</tr>
</tbody>
</table>
Repositioning

- Patients who are identified at risk will have a repositioning regime planned
- Assessment of mobility needs to include all aspects of movement including sitting times, ability to reposition and methods of transfer
- Frequency of repositioning should be determined by patients tissue tolerance, skin assessment and existing pressure damage
- Repositioning should be influenced by the support surface and the patient risk status
- Transfer aids should be used to reduce friction and shear
- Avoid repositioning over existing erythema
- Patients with existing sacral/buttocks tissue damage of stage 1 and 2 should have a pressure relieving cushion and should not sit without being repositioned for more than 2 hours
- Patients with stage 3 and 4 sacral/buttock pressure damage ideally should not sit out, if this is essential for holistic care this should be around mealtimes only with a high risk cushion
- Principles of the 30° tilt can be used for patients in bed (see p7)
- Chairs, seats and cushions need to provide the correct sitting height for the patient, to prevent increasing pressure, friction and shearing

Equipment

- Refer to the equipment flowchart (see p8)
- Ensure at risk heels are off loaded and pressure is distributed evenly along the calf without putting pressure on the Achilles tendon particularly for patients with arterial disease, diabetes or oedema
- Use pressure reducing pads over awkward areas
- If a patient is a permanent wheelchair user, the wheelchair cushion should be provided by Wheelchair Services. Refer to the Wheelchair Services if a further assessment of cushion needs is required

Concordance

- Provide full explanations of pressure ulcer preventive care, including equipment in use, to the patients and carers. This must be supported with the patient information leaflet and information plans
- Assess patients mental capacity for understanding decisions about pressure ulcer prevention and where non-concordance is an issue
- For patients who do not have capacity, preventative care must be delivered in their best interests
- Discuss and record reasons why patients/carers are declining pressure redistributing equipment and are not able to follow the plan of care
### Principles of the 30° Tilt

The following pictures illustrate the procedure whilst the patient is lying in the recumbent position. The bed should be raised to waist level. Two extra pillows are necessary for this procedure and a third pillow can be used lengthways to support the other leg if required.

#### Stage 1
The patient should be lying in the middle of the bed, with their head comfortably supported by two pillows. The lower pillow should be positioned to ensure support for the neck.

![Stage 1](image1.png)

#### Stage 2
The patient should be rolled towards one side of the bed. A pillow is positioned to support the lumbar region and shoulder. This tilts the patient on to one buttock and lifts the sacrum clear of the mattress.

![Stage 2](image2.png)

#### Stage 3
The full length of the leg should be supported by “moulding” a pillow around it. The heel should be overhanging the end of the pillow to relieve pressure and care should be taken to avoid pressure being applied to the back of the leg or calf.

![Stage 3](image3.png)

#### Stage 4
An additional pillow may be used to support the other leg, if required. Tuck the pillow behind the Achilles tendon and ensure that the space behind the knee is supported by the edge of the pillow. Do not use the full bulk of the pillow to support this leg as this will distort the bodies’ alignment and cause the patient discomfort. Again, the heel should be clear of the mattress.

![Stage 4](image4.png)

#### Stage 5
The following picture demonstrates the final position of the patient.

![Stage 5](image5.png)

**NB. In the event of foot drop occurring, please refer to physiotherapy for further advice**
A Guide for the provision of support surfaces

The equipment protocol is designed as a guide only and should always be used in conjunction with your clinical judgement. Equipment is ordered on line via British Red Cross.

AT RISK

BRADEN 16-11

NO PRESSURE DAMAGE

YES

AT RISK

BRADEN 16-11

STAGE 1-2 PRESSURE ULCER

HIGH RISK

BRADEN < 11

STAGE 1-2 PRESSURE ULCER

Supreme alternating overlay
Atmosair 4000
CTE – Alpha X Cell
Repose mattress
Repose cushion
Flotech Visco contour cushion
Flotech Solution cushion

YES

Very High Risk

BRADEN < 11

STAGE 3 PRESSURE ULCER

YES

Is the patient able to change position in bed and chair?

Very High Risk

BRADEN < 11

STAGE 4 PRESSURE ULCER

NO

Softform mattress
Double or single Propad
Bariatric Alova Visco mattress
Basix cushion
Castellated foam cushion

Is the patient able to change position in bed and chair?

Royal replacement alternating mattress
CTE–Biwave;AlphaResponse;Nimbus
Wondermat Low air loss
CTE–Breeze
Bariatric Royal Extra

Advise not to sit out but if essential, use the Flotech Solution cushion
Skin Care

- When a non blanching red area develops, remove pressure immediately and the patient should avoid being positioned on this area until it has resolved.
- If this is not possible pressure relieving equipment should be used to relieve pressure from the area.
- Do not massage areas of pressure damage.
- Use patting instead of rubbing when drying at risk skin.
- Use skin emollients instead of soap for cleansing to hydrate at risk skin and prevent drying.
- Protect skin with barrier products if exposed to excessive moisture.
- Follow moisture lesion guidance for identification and care of moisture lesions (see p10).
- Complete a full continence assessment with diagnosis and a treatment plan.
- Identify a toileting regime where appropriate.
- If continence pads are prescribed, ensure they fit correctly and that the product is changed appropriately using wetness indicators.

Nutrition & Hydration

- Screen and assess the nutritional status of individuals at risk using the Malnutrition Universal Screening MUST tool.
  - Practical advice on nutritional support to improve dietary intake should be provided for all patients with a MUST score of >0 as detailed in the Nottinghamshire Sip Feed Guidelines Quick Reference Guide.

(See Appendix 6 - the MUST Tool and Nottinghamshire Sip Feed Guidelines)

- All patients with a stage 3 or 4 pressure ulcer should be referred to dietetic services, in addition all the following steps should be taken:
  - Food first advice should be given.
  - 1.5 kcal/ml sip feeds should be prescribed in line with the Guidelines.
  - A food diary should be started.
- Ensure the patient is adequately hydrated 30ml/kg per day, approximately 6-8 cups, unless fluid is restricted.
- Enteral or parental nutrition may be necessary when oral nutrition is inadequate or not possible.
Flow chart for the prevention and management of moisture lesions

1. Is the skin frequently moist with urine only?
   - Yes: Complete a full continence assessment
     - Ensure patient is toileted regularly
     - Reassess continence status
     - Ensure pads and pants are worn and fit correctly
     - Consider if pads need to be changed more often
     - Cleanse the moist area of skin with water only and clean cloths
     - Do not use soap
     - Apply Cavilon barrier cream thinly following each cleansing episode

   - No: Is the skin frequently contaminated with faeces only?

2. Is the skin frequently contaminated with faeces only?
   - Yes: Establish cause of faecal incontinence. Consider infection and stool sample
     - Cleanse soiled area with an emollient (e.g., Cetraben) and clean cloths
     - Apply Zinc and Castor Oil barrier cream following each cleansing episode
     - Consider urinary sheath or regular toileting
     - Establish cause of faecal incontinence; consider infection and if a stool sample is required
     - Cleanse contaminated area with an emollient and clean cloths
     - Apply Cavilon barrier cream where pads are worn for urinary incontinence
     - Apply Zinc and castor oil where pads are not worn
     - Avoid the use of all other barrier creams

   - No: Is the skin frequently contaminated with urine and faeces?

3. Is the skin frequently contaminated with urine and faeces?
   - Yes: Is the patient catheterised or using a urinary sheath?
     - Yes: Establish cause of urinary incontinence
     - Cleanse and apply Zinc and Castor Oil barrier cream following each cleansing episode
     - Consider urinary sheath or regular toileting
     - Establish cause of faecal incontinence; consider infection and if a stool sample is required
     - Cleanse contaminated area with an emollient and clean cloths
     - Apply Cavilon barrier cream where pads are worn for urinary incontinence
     - Apply Zinc and castor oil where pads are not worn
     - Avoid the use of all other barrier creams
     - For first line treatment to excoriated tissue; Apply Flamazine thinly to the affected area as often as cleansing is required for up to 10 days
     - Allow 15 minutes for absorption of the Flamazine before reapplying the inco pad
     - After 10 days continue with Cavilon barrier cream only if required
     - Contact Tissue Viability if the moisture lesion is not resolved or if further advice is required

   - No: Is there a moisture lesion present?

4. Is there a moisture lesion present?
   - Yes: Continue with regular skin assessment
     - Follow the advice from the start of the flow chart

   - No: Start prevention early
1. All patients must have a Braden Risk Assessment and MUST Score on the first Community visit.

2. If a patient is at risk of pressure ulcers a Sskin bundle must be implemented.

3. All patients must have a Braden Risk Re-Assessment monthly or at each visit if seen 3 monthly/6 monthly/annually or if they have deterioration in their condition or on hospital discharge.

4. The Sskin bundle must be evaluated when the Braden is reassessed.

5. All patients at risk of pressure ulcer development must be provided with the information leaflet and information provided to the patient must also be documented.

6. The patient information plan must be completed and given to the patient or the carer

If a patient has a pressure ulcer remember to do and document the;

1. Braden score
2. Stage and location of the pressure ulcer
3. Wound assessment tool
4. Origin of the pressure ulcer whether acquired or inherited
5. Pressure relieving equipment the patient currently has, if not what has been ordered and the date it arrives.
6. Repositioning regime advised
7. Dressing regime
8. Verbal advice given to the patient
9. Any written information given to the patient
10. Report all stages of pressure ulcers as a clinical incident and document the incident number in the patient’s records

If the patient has a stage 3 or 4 pressure remember;

11. Refer to Tissue Viability Team
12. Refer to a dietitian having completed the MUST Tool
13. Consider if Hb and albumin need to be checked
14. If the ulcer is on the heel an ABPI needs to be undertaken prior to any debridement
15. Complete an incident form and document the incident number in the patient’s records. Refer to incident reporting and SUI policies and procedures
16. Organisation - acquired pressure ulcers will require a Root Cause Analysis
To determine if the identification of a pressure ulcer on an individual receiving professional support (in a care home, hospital or from domiciliary care of nursing agency care) should result in a safeguarding referral the following triggers should be considered.

**IF IN DOUBT** → Initiate Safeguarding Adults Procedures → Discuss with senior manager → Record decision and reasons for decision.

<table>
<thead>
<tr>
<th>Possibly NOT Safeguarding at this stage</th>
<th>Possibly Safeguarding</th>
<th>Definitely Safeguarding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. What is the severity (stage) of the pressure ulcer?</strong></td>
<td>Stage 2 pressure ulcer or below – care plan required</td>
<td>Several stage 2 pressure ulcers/ stage 3 to 4 pressure ulcers- consider question 2</td>
</tr>
<tr>
<td><strong>2. Does the individual have mental capacity and have they been concordant with treatment?</strong></td>
<td>Has capacity and declined treatment</td>
<td>Does not have capacity or capacity has not been assessed- continue to question 3</td>
</tr>
<tr>
<td>Has a capacity assessment been completed?</td>
<td>Capacity assessment is recorded.</td>
<td></td>
</tr>
<tr>
<td><strong>3. Full assessment completed and care plan developed in a timely manner and care plan implemented?</strong></td>
<td>Documentation and equipment available to demonstrate full assessment completed, care plan developed and implemented.</td>
<td>Documentation and equipment NOT fully available to demonstrate full assessment completed, care plan developed or care plan implemented BUT general care regime (e.g. nutrition, hydration) not of concern- continue to question 4</td>
</tr>
<tr>
<td><strong>4. This incident is part of a trend or pattern- there have been other similar incidents with this individual or others.</strong></td>
<td>Evidence suggests this is an isolated incident.</td>
<td>There have been other similar incidents</td>
</tr>
</tbody>
</table>

**NOT SAFEGUARDING** → If 2 or more of the above apply - **SAFEGUARDING**

*Always clearly record decision and reasons for decision*
Pressure Ulcers – Safeguarding Triggers- Pathway 2

To determine if the identification of a pressure ulcer on an individual with no professional support (i.e. the only support available is from an unpaid carer/ family member) should result in a safeguarding referral the following steps should be considered.

**IF IN DOUBT**  Initiate Safeguarding Adults Procedures  Discuss with senior manager  Record decision and reasons for decision.

<table>
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<tr>
<td>1. What is the severity (stage) of the pressure ulcer?</td>
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<td>2. Does the individual have mental capacity and have they been concordant with treatment?</td>
<td>Has capacity and declined treatment</td>
<td>Does not have capacity or capacity has not been assessed- continue to question 3</td>
</tr>
<tr>
<td>Has a capacity assessment been completed?</td>
<td>Capacity assessment is recorded.</td>
<td></td>
</tr>
<tr>
<td>3. Unpaid carer raised concerns and sought support at an appropriate time.</td>
<td>Evidence available to show concerns raised and support sought – e.g. from GP, DN, SW.</td>
<td>Evidence NOT CLEAR that concerns were raised or support sought in a timely manner.</td>
</tr>
<tr>
<td>4. Full assessment completed and care plan developed in a timely manner and care plan implemented?</td>
<td>Evidence available to show unpaid carer cooperated with assessment and has implemented care plan</td>
<td>Evidence of partial cooperation or implementation of care plan- some aspects may have been declined e.g. certain equipment.</td>
</tr>
<tr>
<td>5. This incident is part of a trend or pattern – there have been other similar incidents or other areas of concern</td>
<td>Evidence suggests that this is an isolated incident</td>
<td>There have been other similar incidents or other areas of concern</td>
</tr>
</tbody>
</table>

**NOT SAFEGUARDING**  If 2 or more of the above apply Safeguarding  **SAFEGUARDING**

Always clearly record decision and reasons for decision.
### Appendix 1 – The Braden Risk Assessment Tool and Guidelines

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
<th>Mobility</th>
<th>Nutrition</th>
<th>Friction and Shear</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Impairment</td>
<td>4 Rarely Moist</td>
<td>4 Walks Frequently</td>
<td>4 No Limitations</td>
<td>4 Excellent</td>
<td>4</td>
</tr>
<tr>
<td>Slightly Limited</td>
<td>3 Occasionally Moist</td>
<td>3 Walks Occasionally</td>
<td>3 Slightly Limited</td>
<td>3 Adequate</td>
<td>3 No Apparent Problem</td>
</tr>
<tr>
<td>Very Limited</td>
<td>2 Very Moist</td>
<td>2 Chairbound</td>
<td>2 Very Limited</td>
<td>2 Probably Inadequate</td>
<td>2 Potential Problem</td>
</tr>
<tr>
<td>Completely Limited</td>
<td>1 Constantly Moist</td>
<td>1 Bedbound</td>
<td>1 Completely Immobile</td>
<td>1 Very Poor</td>
<td>1 Problem</td>
</tr>
</tbody>
</table>

Has the skin been assessed? Yes / No. If no; state reason Does the patient have pressure relieving equipment currently? Yes/No. If yes state type. Has the pressure ulcer information booklet been given to the patient and /or carer Yes/No? If no; state reason. Is pressure damage present Yes/No? If yes; record stage, size and site of pressure damage.

#### SENSORY PERCEPTION

**Ability to respond meaningfully to pressure related discomfort:** For example: Advanced dementia CVA, Alcohol or drug effects Peripheral neuropathy

1. **Completely Limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.
2. **Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.
3. **Slightly Limited:** OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
4. **No Impairment:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.

#### MOISTURE

**Degree to which skin is exposed to moisture** Includes leaking wounds or macerated heels

1. **Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, Dampness is detected every time patient is moved or repositioned.
2. **Very Moist:** Skin is often, but not always moist. Linen or clothing must be changed at least daily
3. **Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.
4. **Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.

#### ACTIVITY

**Degree of physical activity**

1. **Bedbound:** Confined to bed.
2. **Chairbound:** Ability to walk severely limited or non-existent. Cannot bear weight and/or must be assisted into chair or wheelchair.
3. **Walks Occasionally:** Walks occasionally during day, but for very short distances with or without assistance. Spends majority of each shift in bed or chair.
4. **Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.

#### MOBILITY

**Ability to change and control body position**

1. **Completely Immobile:** Does not make even slight changes in body or extremity position without assistance.
2. **Chairbound:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
3. **Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.
4. **No Limitations:** Makes major and frequent changes in position without assistance.

#### NUTRITION

**Usual food intake pattern**

1. **Very Poor:** Never eats a complete meal. Rarely eats more than 1/3 or any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NII by Mouth and/or maintained on clear liquids or IV’s for more than five days OR Albumin levels< 30
2. **Probably Inadequate:** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receive less than optimum amount of liquid diet or tube feeding OR Albumin levels< 30
3. **Adequate:** Eats over half or most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on tube feeding or TPN regime which probably meets most of nutritional needs.
4. **Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

#### FRICITION AND SHEAR

1. **Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.
2. **Potential Problem:** Moves freely or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints of other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.
3. **No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.

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**Braden Risk Assessment Tool and Guidelines**

<table>
<thead>
<tr>
<th>Score</th>
<th>Date</th>
<th>Time</th>
<th>Signature</th>
<th>Print Name</th>
<th>Designation</th>
</tr>
</thead>
</table>

A SCORE OF 10 OR LESS INDICATES THAT A PERSON IS AT RISK OF PRESSURE ULCER DEVELOPMENT. A SCORE OF 10 OR LESS INDICATES A POTENTIALLY HIGHER RISK.

V1.0 January 2013 Review date: January 2016
Appendix 2 – The Community SSKIN Bundle

### PRESSURE ULCER PREVENTION SSKIN BUNDLE: COMMUNITY SERVICES
For all patients with a Braden score of 16 or less (or at risk using clinical judgement): **Implement a SSKIN Bundle**

<table>
<thead>
<tr>
<th>PATIENT’S NAME:</th>
<th>NHS NUMBER:</th>
<th>CASELOAD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRADEN SCORE:</td>
<td>DATE:</td>
<td>SIGNATURE:</td>
</tr>
</tbody>
</table>

**Information plan given to patient/carer**  Yes □ No □
**Prevention information booklet given to patient/carer**  Yes □ No □
**State all disciplines involved in the care provision:**

<table>
<thead>
<tr>
<th>S</th>
<th>SURFACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a mattress and cushion in accordance with the Braden Risk Score and Equipment Flow Chart.</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mattress Ordered:</th>
<th>Date ordered:</th>
<th>Date delivered + fitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cushion ordered:</td>
<td>Date ordered:</td>
<td>Date delivered:</td>
</tr>
<tr>
<td>Other (state item)</td>
<td>Date ordered:</td>
<td>Date delivered:</td>
</tr>
</tbody>
</table>

**Wheelchair user**  Y □  N □  ?
**If yes, Is a pressure reducing cushion in use in this?**  Y □  N □

<table>
<thead>
<tr>
<th>S</th>
<th>SKIN INSPECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess and record skin state on each visit  (but no more than once a day)</td>
<td></td>
</tr>
<tr>
<td>Carry out the skin tolerance test and observe for red patches of skin (erythema).</td>
<td></td>
</tr>
<tr>
<td>Record the skin evaluation using the staging as follows and ensure location is recorded:</td>
<td></td>
</tr>
<tr>
<td>No evidence of <em>new</em> pressure damage / Blanching erythema / Stage 1 / Stage 2 / Stage 3 / Stage 4</td>
<td></td>
</tr>
</tbody>
</table>

**Record frequency of skin assessment**– circle one; daily / twice weekly / weekly / monthly / 3 monthly

<table>
<thead>
<tr>
<th>K</th>
<th>KEEP MOVING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record current regime of movement.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Morning:</th>
<th>Afternoon:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evening:</td>
<td>Night:</td>
</tr>
</tbody>
</table>

**Repositioning Regime Advised:**

**Method of Transfer:**

<table>
<thead>
<tr>
<th>I</th>
<th>INCONTINENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess continence state</td>
<td></td>
</tr>
<tr>
<td>Assess if the patient’s skin is prone to moisture</td>
<td></td>
</tr>
</tbody>
</table>

**Is the patient incontinent of urine**  Y □  N □
**Faeces**  Y □  N □
**Double**  Y □  N □

<table>
<thead>
<tr>
<th>N</th>
<th>NUTRITION and HYDRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure the MUST score is completed on the initial assessment and reassessment in line with MUST guidance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUST Score:</th>
<th>Review Date of MUST:</th>
</tr>
</thead>
</table>
**PATIENT'S NAME:**

<table>
<thead>
<tr>
<th>NHS NUMBER:</th>
<th>CASELOAD:</th>
</tr>
</thead>
</table>

**Date DD/MM/YY**

**Time – use 24 hour clock**

**S SURFACE**

Is the mattress in use?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Is the cushion in use?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Is other (state) .................in use?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Is the above equipment working effectively?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Is the patient comfortable?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

* If NO to any of the above please add additional information

**S SKIN INSPECTION**

Is there evidence of pressure damage to:

**B** Buttocks (ischial bones)  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**E** Elbows  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**S** Sacrum  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**T** Trochanter (hips)  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**S** Spine  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**H** Heels  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**O** Occiput  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**T** Toes  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Other please state  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

* If YES to any of the above please add additional information

If the patient declines skin inspection record reason and action taken in the box below

**K KEEP MOVING**

Is the current regime of movement being adhered to according to the patient/carer?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Is the current regime effective  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

* If NO to any of the above please add additional information

**I INCONTINENCE / MOISTURE**

Is the skin moist?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

Has the patient had a continence assessment?  
Y☐ N☐ NA☐ Y☐ N☐ NA☐ Y☐ N☐ NA☐  

* If YES to the above please add additional information

**N NUTRITION**

Is the patient eating and drinking adequately?  
Y☐ N☐ Y☐ N☐ Y☐ N☐  

**ADDITIONAL INFORMATION** – Add any additional information required from your evaluation above

**S** Support Surface

**S** Skin inspection

**K** Keep moving

**I** Incontinence/moisture

**N** Nutrition

Signature and print name
The Sskin Bundle is a bundle of care that involves fundamental components of pressure ulcer preventative interventions. It is crucial to remember that if only one of those components was to be omitted in the delivery of healthcare for patients at risk, the consequence is likely to be the development of a pressure ulcer.

- The Sskin Bundle will be completed for all patients identified to be at risk of developing a pressure ulcer, i.e. with a Braden score of 16 or less or deemed to be at risk by your clinical judgment
- The patient will have a full skin assessment in conjunction with the Braden and this will be recorded on the Braden tool
- A registered practitioner will initiate the Sskin Bundle and complete all the unshaded sections on the first sheet. This includes:
  - Patients name, NHS Number and case load and Braden score
  - The specific mattress and cushion ordered and the date of the order, delivery and fitting
  - The frequency of skin assessment based on your clinical judgement of the patient’s need; daily / twice weekly / weekly / monthly / 3 monthly
  - The patient's current regime of movement in relation to when they get up or go back to bed or mobilise to the toilet
  - The advise you have given to the patient and/or carer regarding repositioning
  - The MUST score and date to review this
- The shaded areas are the specific components of the Sskin Bundle that you are responsible for initiating.
- Any member of the healthcare / social team can complete the 2nd page of the Sskin Bundle
- If the patient is known to the District Nursing Services for 3 / 6 / 12 monthly interventions (including continence assessment) and is at risk of developing a pressure ulcer, the registered nurse will offer advice to the patient and/or carer and provide the Trust information booklet on preventing pressure ulcers. The advice will be recorded in the patient’s records.
  - If pressure relieving support surfaces are ordered at this point, a follow up visit will be arranged to evaluate the effectiveness of the support surfaces
- If the patient is receiving healthcare from Intermediate Care, Crisis Response, Stroke Services or the Falls Prevention teams;
  - A Braden risk assessment will be carried out on the first visit.
  - If this visit is not undertaken by a registered clinician, the assessment will be carried out by a competent health care worker.
  - If the patient is found to be at risk of developing pressure ulcers, the Healthcare worker will inform the registered clinician within the team of this risk.
  - The registered clinician within the team will implement the Sskin Bundle
- If the patient is having additional support from care agencies, the registered clinician will perform the Braden assessment and initiate the Sskin Bundle on first visit.
- If other agencies are involved please encourage them with support to complete the second page of the SSKIN bundle.'
**SSKIN BUNDLE – CARING FOR YOUR SKIN MATTERS**

**PRESSURE ULCER PREVENTION FOR CARE HOMES**

For all patients with a Braden Score of 16 or less: Complete one form every day.

<table>
<thead>
<tr>
<th>S</th>
<th>Surface</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide: a mattress and cushion in accordance with the Risk Assessment Score and Equipment Flow Chart.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K</th>
<th>Keep moving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record the code in the skin evaluation and add location</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I</th>
<th>Incontinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record the code of position change in the column below;</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N</th>
<th>Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess for moisture caused by urine, faeces, sweat or wound exudate.</td>
<td></td>
</tr>
</tbody>
</table>

REPOSITIONING REGIME. Record the specific regime for this patient including the frequency of repositioning in bed and when sitting out. *For example: change position every 3 hours when in bed and do not sit out for longer than 2 hours.*

**SURFACE.** Mattress in place: Cushion in place: Method of transfer:

<table>
<thead>
<tr>
<th>Time</th>
<th>Skin evaluation, including location</th>
<th>Keep moving, position change</th>
<th>Incontinence/moisture evaluation</th>
<th>Action taken/comments</th>
<th>Initials</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800</td>
<td>5x7 left ischium 3x2cm</td>
<td>K9</td>
<td></td>
<td>Cushion upgraded to Repose air cushion. Matron informed.</td>
<td>AP</td>
<td>HCA</td>
</tr>
<tr>
<td>0900</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000</td>
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<td>1100</td>
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<td>1200</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Skin evaluation, including location</td>
<td>Keep moving/position change</td>
<td>Incontinence/moisture evaluation</td>
<td>Action taken/comments</td>
<td>Initials</td>
<td>Designation</td>
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<td>0600</td>
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<tr>
<td>0700</td>
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<td></td>
</tr>
</tbody>
</table>
The Sskin Bundle is a bundle of care that involves five fundamental components of pressure ulcer preventative interventions. It is crucial to remember that if only one of those components was to be omitted in the delivery of healthcare for residents at risk, the consequence is likely to be the development of a pressure ulcer.

- Every resident will have a Braden risk assessment performed within 2 hours of admission and on transfer back from a hospital stay.
- The resident will have a full skin assessment in conjunction with the Braden and this will be recorded on the Braden tool. If a pressure ulcer is identified (all stages), a referral must be made to the District Nursing Team on the same day.
- The Sskin Bundle will be completed for all residents identified to be at risk of developing a pressure ulcer, i.e. with a Braden score of 16 or less or deemed to be at risk by clinical judgement, for example, if the resident is not mobile.
- A new Sskin Bundle will be completed each day.
- A Care Assistant who has undergone competency based training will perform the Braden assessment and initiate the Sskin Bundle. On the Sskin Bundle the Care Assistant will record:
  - The resident’s name, NHS Number and the name of the care home
  - The Braden Score and if the patient is at risk
  - The date of each day
  - The Care Assistant’s signature and name
- The shaded areas in grey identify each component of the Sskin Bundle. This is the plan of care to prevent pressure ulcers from developing.

**SURFACE**

*Provide a mattress and cushion in accordance with the risk assessment score and equipment flow chart.* The type of mattress and cushion you provide is coded and this must be entered into the box stated “mattress in place and cushion in place”. The resident’s method of transfer will also be recorded here, for example; hoist, rotunda, assistance with one.

**SKIN EVALUATION**

*Assess and record skin state at least twice daily.* Assessment of the resident’s skin is coded. This will be recorded on the chart in the column headed Skin Evaluation.

For example if at 10am, the resident is repositioned; the skin will be assessed at this time. If the resident has no new pressure damage the code SA will be recorded. If the patient is found to have new damage, the stage of the pressure ulcer will be coded and action taken will be recorded. For example, if a stage 1 pressure ulcer is identified on the resident’s sacrum, the code ST1 and sacrum will be recorded and action taken will then be recorded.

**KEEP MOVING**

*Record the repositioning regime and the frequency of repositioning for the resident in bed and sitting out of bed.* This will be recorded in the box headed “REPOSITIONING REGIME” as per example on the Sskin Bundle.

**INCONTINENCE/MOISTURE EVALUATION**

*Assess for moisture caused by urine, faeces, sweat or wound exudate.* On repositioning or changing the residents pad, the skin will be assessed for wetness and this will be coded in the column headed Incontinence/Moisture Evaluation. For example if the skin is found to be wet, the code I2 will be recorded along with the action taken.

**NUTRITION**

*Ensure a nutritional assessment is completed within 24 hours of admission and refer to the dietitian as per protocol and refer to dietitian if the patient has a stage 3/4 pressure ulcer.*
Appendix 4 – Patient Information Leaflet

What can you do to avoid pressure ulcers?

**Look for signs of damage** -
- If you are able, check your skin regularly or ask a relative or carer to do this for you. Do not confuse bed blemishes or redness with pressure ulcers, particularly on areas at risk of skin breakdown.

**Keep moving** -
- One of the best ways to prevent a pressure ulcer is to relieve the pressure by regularly changing your position.
- This can be as simple as standing and walking or using the toilet for a few minutes every hour.
- If you are lying down, try to turn yourself every two to four hours, or more if you are at risk.
- If you are in bed, try and change your position without digging your heels into the bed as this can cause damage.
- Try not to slide down the bed as this can damage your skin.

**Protect your skin** -
- Wash your skin using warm water or pH neutral soap cleansers. Do not rub or massage your skin if this can cause damage.
- Do not use heavily perfumed soap or talcum powder.
- If you have continence problems, please inform your health care team.

**Eat a well balanced diet** -
- Aim to eat a balanced diet - having regular meals which include fruit, vegetables, starch, protein and dairy foods will help achieve this.
- Have a variety of fluids, include at least 6-8 glasses or drinks daily. Your health care team may refer you to a dietitian for advice.

How your healthcare team can help you

**Assessment** -
- A member of your health care team will complete a risk assessment to identify if you are at risk.
- If the health care team is concerned they may refer you to the Tissue Viability Team who are clinical nurse specialists specifically trained in this area.

**Surface** -
- Following assessment pressure relieving mattresses and cushions will be provided.

**Skin assessment** -
- You or your carer will be advised to undertake regular assessments of your skin.

**Keep moving** -
- You will be advised about repositioning using the correct equipment.

**Incontinence** -
- Your skin will be assessed for the presence of moisture and advice will be given to help keep your skin clean and moisturised. A continence assessment may be needed to help manage your continence.

**Nutrition** -
- Your nutritional intake will be assessed and advice will be given to help you maintain a balanced diet. If you are at risk, supplements may be prescribed and a referral to a dietitian will be discussed with you.

Preventing Pressure Ulcers
A guide for patients and carers

**Skin Integrity**

Nutrition

Incontinence

More information is available at: www.your-turn.org.uk

Image date Sept 2012
Review date Sept 2014

Created in partnership with Tissue Viability and community services provided by: Nottingham CityCare Partnership
Rushcliffe Health Partnerships

Health at the heart of the city

V1.0 January 2013 Review date: January 2016
INFORMATION PLAN FOR PATIENTS

Name of Patient: ___________________________ NHS Number: ___________________________

Further to our assessment you have been found to:

☐ Be at risk of developing a pressure ulcer

☐ You have developed a pressure ulcer which is close to the skin surface
   (State location) ___________________________
   You have developed a pressure ulcer which extends into the deeper
   tissues (state location) ___________________________

The following advice will help to reduce the risk of a pressure ulcer developing and help to heal the pressure ulcer you currently have and reduce the risk of it deteriorating.

S = SURFACE
A pressure relieving mattress and cushion will help relieve pressure.

K = KEEP MOVING
Repositioning and movement will also help relieve pressure.

I = INCONTINENCE
An excess of moisture will delay healing and increase the risk of skin breakdown.

N = NUTRITION
A balanced diet will assist healing and reduce the risk of pressure ulcer development.

If your dressing falls off it needs to be replaced.

Please contact Health Care Team - Tel: ___________________________ if you have any concerns.
This plan will be updated as appropriate.

Signature: ___________________ Name of clinician: ___________________ Date: __________
Recipient Signature: __________ Print: __________ Date: __________
INFORMATION PLAN FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

Name of Patient: ……………………………………   D.O.B. ………………………………………………
NHS Number: ………………………………………  Care Home: …………………………………………

(Tick as appropriate)

☐ Is at risk of developing pressure ulcers
☐ Has a superficial pressure ulcer (state location) _____________________
☐ Has a full thickness pressure ulcer (state location) _____________________

The following advice will reduce the risk of pressure ulcer development and assist any existing pressure damage to heal and reduce the risk of it deteriorating.
- Please ensure the patient has the following pressure relieving equipment and it is used at all times:

Mattress: ________________________________ Cushion: _______________________________

S = SURFACE
Please ensure the following settings/checks are followed in relation to the above equipment.

S = SKIN EVALUATION
Please ensure the following skin inspection regime is followed:

K = KEEP MOVING
Please ensure the following repositioning regime is followed:

I = INCONTINENCE
Please ensure the following continence management regime is followed:

N = NUTRITION
Please ensure the following dietary advice is followed:

If the patients dressing comes off please ensure the following occurs:

Please contact Health care Team - Tel: _____________________ if you have any concerns or need to discuss this patient. This plan will be updated as appropriate.

Signature: ____________________ Name of Clinician: ____________________ Date: ________________
Recipient Signature __________________ Print: ____________________ Date: ________________
Information plans are tools that provide patients and carers with written information of the advice given by the clinician on all aspects of pressure ulcer prevention in conjunction with the Preventing Pressure Ulcers Information leaflet for patients. The tools aim to support the patient and/or carer to prevent pressure ulcers and also provide supporting evidence that advice has been given to them by the clinician.

There are two versions of the information plans
1. For giving to patients and carers (if appropriate) who are residing in their own home
2. For patients and their carers who are providing care for patients in a residential home

The information plans should
- Record the advice given to the patient / carer
- Be clearly written and understood by the patient / carer
- Support patient engagement
- Be relevant and patient specific

Ensure the patient’s name and NHS number is always recorded.
Ensure the patient’s pressure ulcer risk is identified or if the patient currently has any pressure damage.
Record the type of pressure redistributing mattress and cushion that has been provided in the Care Home / patient’s home

Both versions of information plans are based on the concept of the SSKIN Bundle and are subdivided into the five sections which should include the following information, for example;

**SURFACE**
Record advice given on how the equipment you have provided should be maintained and/or how the pump works and that an electrical supply may be required at all times.
Include simple equipment checks, how to clean the equipment and who to report faults to.
Include what the equipment can/cannot be covered with and if it is appropriate to take pressure reducing cushions/boots if the patient is going on outings or on holiday.

**SKIN**
Record advice given on how the skin should be assessed and record that the clinician has demonstrated the skin tolerance test.
Identify specific aspects of the patient’s skin that may be at risk and using the Pressure Ulcer Information leaflet, describe the visible signs of early tissue damage.
Record how often the skin should be assessed.

**KEEP MOVING**
Record advice given on a realistic repositioning regime that has been agreed between the clinician and the patient / carer. Ensure the regime for day and night is clearly recorded, as this may vary. Recommend maximum times for the patient to sit out of bed.
Consider and allow for manual handling issues and what additional equipment is in use such as the rotunda frame, hoist or a sling.

**INCONTINENCE**
Record continence management plans that are already in place.
Record advice given relating to cleansing and drying the skin and using the patient information booklet, describe the visible signs of a moisture lesion.
Record advice given in relation to toileting regimes use of emollients and barrier creams where appropriate.

**NUTRITION**
Record nutritional advice given following the completion of the MUST assessment tool.
Consider discussing meal options and referring to the food first/little and often leaflets. Include advice given from GP/Dietician on SIP feeds if known.

*Please ensure the patient / carer sign the plan, then give one copy to the patient / carer and file one copy in the patient’s notes.*
Appendix 6 – Nottinghamshire Sip Feed Guidelines

<table>
<thead>
<tr>
<th>BMI kg/m²</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;30 obese</td>
<td>= 0</td>
</tr>
<tr>
<td>&gt;20</td>
<td>= 0</td>
</tr>
<tr>
<td>18.5 – 20</td>
<td>= 1</td>
</tr>
<tr>
<td>&lt;18.5</td>
<td>= 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unplanned weight loss in past 3 months</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>= 0</td>
</tr>
<tr>
<td>5 – 10</td>
<td>= 1</td>
</tr>
<tr>
<td>&gt;10</td>
<td>= 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient is acutely ill and there has been or is likely to be no nutritional intake for &gt; 5 days</th>
<th>Score 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.B. These criteria only apply to patients who have suffered a severe CVA, Traumatic Brain injury or similar</td>
<td></td>
</tr>
</tbody>
</table>

Score =

Total malnutrition risk ‘MUST’ *score =

Score 1 = medium risk score
Score 2 = high risk
Score 4 = very high risk

Key points:
1. **Food First** - SIP feeds are supplements and should not usually be used as a substitute for food,
2. Assess deteriorating patients **early** - malnutrition worsens outcomes

MANAGING MEDIUM RISK PATIENTS MUST SCORE 1

- Set treatment goal: e.g. prevent further weight loss/ promote weight gain, improve nutritional status and/or promote wound healing. Record ‘MUST’ score in patients’ notes. Read code 687C
- Check for underlying causes: e.g. control pain/nausea; treat any constipation/diarrhoea, check for medications that may affect appetite etc.
- Use the Food First approach. Use the “Food and Fluid Check list” to identify problems and talk through “Little & Often” sheets with patient and/or carer

MANAGING HIGH RISK PATIENTS MUST SCORE 2-3

- As medium risk plus:
  - Recommend over the counter (not FP10) Complan, Build Up drinks etc and document agreed actions.
  - Ensure usage and overall dietary intake is monitored either in own home or Care Home.
  - If there is no improvement after 2-3 weeks or MUST score = 3 Initiate 1 week’s trial prescription for 1.5 Kcal/ml sip feed 1 x BD to be sipped slowly between meals. **N.B. patient should meet ACBS indications** - see over
  - Remember that Care and Nursing Homes are responsible for feeding their patients
  - Use milk based sip feeds in preference to juice based ones as these have a higher nutritional content Juice style can be used if patients dislike milky drinks, or cannot tolerate milk based varieties.
  - **N.B. Juice style sip feeds should only be used for patients with diabetes if their blood glucose levels can be adequately monitored and their medication adjusted appropriately.**
  - Talk through “Using a Sip feed” leaflet with patient and/or carer to improve compliance. If supplement is tolerated, arrange acute prescription for 1 month’s supply of preferred flavours, review 3 monthly.
  - If a brand is not tolerated continue trialling different brands until a suitable supplement has been identified.

MANAGING HIGH RISK PATIENTS MUST SCORE 4 + OR WITH STAGE 3-4 PRESSURE ULCERS

As all above, plus refer for Specialist Dietetic Advice:

CityCare area/South of the County - Nottingham Community Nutrition and Dietetic Service 0115 8834327
North of the County - Nottingham County Health Partnership Nutrition and Dietetic Service 01623 676025

The Dietitian will review the needs of the patient and will update all relevant healthcare/medical professionals involved in their care. When appropriate, the Dietitian will discharge the patient either to the referring health professional or to their GP for monitoring.

ON GOING MANAGEMENT AND REVIEW

If the treatment goal is achieved:
Supplements should be reduced gradually to ensure progress is maintained. Continue to monitor for 3 months.

If the treatment goal is not achieved: There will be some patients with long term conditions who will continue to have an on-going need for supplements as defined in the ACBS criteria. These patients should be reviewed every 3-4 months to ensure compliance. If necessary refer for Specialist Dietetic advice.

Or use easy MUST tool calculator available at [http://www.bapen.org.uk/must-calculator.html](http://www.bapen.org.uk/must-calculator.html)

Appendix 6 – Nottinghamshire Sip Feed Guidelines

Or use easy MUST tool calculator available at [http://www.bapen.org.uk/must-calculator.html](http://www.bapen.org.uk/must-calculator.html)

Key points:
1. **Food First** - SIP feeds are supplements and should not usually be used as a substitute for food,
2. Assess deteriorating patients **early** - malnutrition worsens outcomes

MANAGING MEDIUM RISK PATIENTS MUST SCORE 1

- Set treatment goal: e.g. prevent further weight loss/ promote weight gain, improve nutritional status and/or promote wound healing. Record ‘MUST’ score in patients’ notes. Read code 687C
- Check for underlying causes: e.g. control pain/nausea; treat any constipation/diarrhoea, check for medications that may affect appetite etc.
- Use the Food First approach. Use the “Food and Fluid Check list” to identify problems and talk through “Little & Often” sheets with patient and/or carer

MANAGING HIGH RISK PATIENTS MUST SCORE 2-3

- As medium risk plus:
  - Recommend over the counter (not FP10) Complan, Build Up drinks etc and document agreed actions.
  - Ensure usage and overall dietary intake is monitored either in own home or Care Home.
  - If there is no improvement after 2-3 weeks or MUST score = 3 Initiate 1 week’s trial prescription for 1.5 Kcal/ml sip feed 1 x BD to be sipped slowly between meals. **N.B. patient should meet ACBS indications** - see over
  - Remember that Care and Nursing Homes are responsible for feeding their patients
  - Use milk based sip feeds in preference to juice based ones as these have a higher nutritional content Juice style can be used if patients dislike milky drinks, or cannot tolerate milk based varieties.
  - **N.B. Juice style sip feeds should only be used for patients with diabetes if their blood glucose levels can be adequately monitored and their medication adjusted appropriately.**
  - Talk through “Using a Sip feed” leaflet with patient and/or carer to improve compliance. If supplement is tolerated, arrange acute prescription for 1 month’s supply of preferred flavours, review 3 monthly.
  - If a brand is not tolerated continue trialling different brands until a suitable supplement has been identified.

MANAGING HIGH RISK PATIENTS MUST SCORE 4 + OR WITH STAGE 3-4 PRESSURE ULCERS

As all above, plus refer for Specialist Dietetic Advice:

CityCare area/South of the County - Nottingham Community Nutrition and Dietetic Service 0115 8834327
North of the County - Nottingham County Health Partnership Nutrition and Dietetic Service 01623 676025

The Dietitian will review the needs of the patient and will update all relevant healthcare/medical professionals involved in their care. When appropriate, the Dietitian will discharge the patient either to the referring health professional or to their GP for monitoring.

ON GOING MANAGEMENT AND REVIEW

If the treatment goal is achieved:
Supplements should be reduced gradually to ensure progress is maintained. Continue to monitor for 3 months.

If the treatment goal is not achieved: There will be some patients with long term conditions who will continue to have an on-going need for supplements as defined in the ACBS criteria. These patients should be reviewed every 3-4 months to ensure compliance. If necessary refer for Specialist Dietetic advice.
Specified ACBS indication conditions for the prescription of nutritional supplements are:

- Disease related malnutrition including
  - Head, neck and oesophageal tumours
  - Severe COPD – FEV1<30% and MUST score of 2 or more
  - Patients with a complex chronic conditions requiring specialised feeds
- Dysphagia related to: Stroke and other Neurological conditions e.g. MND, MS.
- Pre-operative preparation of malnourished patients
- Following Total Gastrectomy, Intractable malabsorption, Proven Inflammatory bowel disease, Short bowel syndrome, Bowel fistulae
- Renal failure on CAPD or haemodialysis

### 1.5Kcal/ml Sip Feed Formulary

<table>
<thead>
<tr>
<th>Milk/yoghurt Style/fibre rich</th>
<th>N.B. Flavour ranges may change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortisip Bottle</td>
<td>Neutral, Vanilla, Toffee, Orange, Strawberry, Banana, Tropical Fruit, Chocolate</td>
</tr>
<tr>
<td>Fresubin Energy</td>
<td>Vanilla, Strawberry, Chocolate, Blackcurrant, Banana, Neutral, Lemon, Tropical Fruits, Cappuccino</td>
</tr>
<tr>
<td>Ensure Plus Milkshake style</td>
<td>Banana, Blackcurrant, Caramel, Chocolate, Coffee, Fruits of the Forest, Neutral, Orange, Peach, Raspberry, Strawberry, Vanilla. (starter packs are available)</td>
</tr>
<tr>
<td>Resource Energy</td>
<td>Apricot, Chocolate, Strawberry &amp; Raspberry, Banana, Coffee, Vanilla</td>
</tr>
<tr>
<td>Fortisip Yoghurt Style</td>
<td>Raspberry, Peach &amp; Orange, Vanilla &amp; Lemon.</td>
</tr>
<tr>
<td>Ensure plus yoghurt style</td>
<td>Strawberry Swirl, Orchard Peach, Pineapple Twist, Orange Burst</td>
</tr>
<tr>
<td>Fresubin Energy Fibre</td>
<td>Strawberry, Chocolate, Cherry, Caramel, Vanilla, Banana</td>
</tr>
<tr>
<td>Fortisip MultiFibre</td>
<td>Vanilla, Strawberry, Orange, Chocolate, Banana</td>
</tr>
<tr>
<td>Ensure Plus Fibre</td>
<td>Banana, Chocolate, Forest Fruits, Raspberry, Strawberry, Vanilla</td>
</tr>
<tr>
<td>Complan Shake</td>
<td>Box contains 4 sachets of either: Vanilla, Strawberry, Chocolate or Banana flavoured powder. Each sachet to be made up with 200ml Full Fat milk. (starter packs are available)</td>
</tr>
<tr>
<td>Juice style</td>
<td>Apple, Fruit punch, Grapefruit, Lemon &amp; lime, Orange, Peach, Pineapple, Strawberry.</td>
</tr>
<tr>
<td>Ensure Plus Juice</td>
<td>Apple, Pear &amp; Cherry, Orange, Raspberry &amp; Blackcurrant</td>
</tr>
<tr>
<td>Resource Fruit</td>
<td>Blackcurrant, Forest Fruit, Orange, Lemon, Apple, Strawberry, Tropical</td>
</tr>
<tr>
<td>Fortijuce</td>
<td>Apple, Orange &amp; Pineapple, Citrus Cola, Melon, Blackcurrant, Lemon &amp; Lime, Cherry</td>
</tr>
<tr>
<td>Fresubin Jucy</td>
<td>Tomato, Chicken (packs of 2 x 200ml cartons)</td>
</tr>
<tr>
<td>Savoury Style</td>
<td>Chicken, Mushroom available in tins only</td>
</tr>
</tbody>
</table>

For further dietary restrictions e.g. vegan, halal or milk free please contact the relevant Dietetic Department.

### Other Prescribable Nutritional Supplements

A variety of other nutritional support products are available on prescription, however the nutritional content of these products varies considerably. Therefore they have not been included in the formulary and should be prescribed under the advice of a Registered Dietitian. They include:

- Specialised sip feeds (e.g. high protein sip feeds, 2 kcal/ml sip feeds)
- Milk shake Powders
- Semi-solid desserts
- High energy fat emulsions
- Soluble Glucose polymers
- Liquid and powder supplements, providing calories, protein and other micronutrients