NHS
Dorset
Clinical Commissioning Group

NHS Clinical Commissioning Group

Dorset Multi-Agency Framework for the Prevention and Management of Pressure Ulcers



PREFACE

This Framework sets out the aims for a consistent approach to the prevention and management of pressure ulcers across the Dorset Integrated Care System.

All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this procedural document. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live version on the CCG intranet.

All CCG procedural documents are published on the staff intranet and communication is circulated to all staff when new procedural documents or changes to existing procedural documents are released. Managers are encouraged to use team briefings to aid staff awareness of new and updated procedural documents.

All staff are responsible for implementing procedural documents as part of their normal responsibilities, and are responsible for ensuring they maintain an up to date awareness of procedural documents.

A	SUMMARY POINTS

- This framework is applicable to all settings where pressure ulcers are identified or where people may be at risk. It applies to all staff groups in health or social care settings where pressure ulcers are at risk of occurring.

- The framework aligns with agreed national definitions of pressure ulcers and outlines the local implementation of reporting and monitoring to support quality improvement.

B	ASSOCIATED DOCUMENTS

CCG Quality Framework 2018

CCG Procedure for the Management of Serious incidents 2018

Pan Dorset Safeguarding Adults Board Policy and Procedures

Dorset Nutritional Care strategy (2013) and Hydration pathways available on www.dorsetforyou.com/nutritional-care-strategy;

Equip for Living Prescriber Guidance http://www.equipforliving.com/

Dorset Commissioning Partnership, Dorset Care framework, Service Specification for care and support in a care home (with or without nursing) 2017

C	DOCUMENT DETAILS

Procedural Document Number	22
Author	Jaydee Swarbrick
Job Title	Head of Nursing and Quality, Safety and Safeguarding
Directorate	Quality
Recommending committee or group	Pan Dorset Pressure Ulcer prevention virtual group Pan Dorset Patient Safety Leads Group
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D	**CONSULTATION PROCESS**		
Version No	**Review Date**	**Author and Job Title**	**Level of Consultation**
3	14 August 2019	Jaydee Swarbrick, Head of Nursing and Quality (Safety and Safeguarding)	ICS Partners; NHS Dorset Clinical Commissioning Group, Bournemouth Borough Council, Dorset County Council, Poole Borough Council, Dorset County Hospital NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust, Poole Hospital NHS Foundation Trust, Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust. Members of the Virtual pressure ulcer prevention strategy group, Members of the Pan Dorset Patient Safety Leads Group.

E	**VERSION CONTROL**				
Date of issue	**Version No**	**Date of next review**	**Nature of change**	**Approval date**	**Approval committee /group**
April 2014	1	April 2016	New policy	13 May 2014	Directors Group

22 June 2016	2	22 June 2018	Reviewed	22 June 2016	CCC
11 July 2019	3	11 July 2021	Change procedural document from Strategy to Framework. Update to reference Integrated Care System, NHS Improvement Revised Definitions	11 July 2019	ICS Clinical Reference Group – Directors of Nursing

F	**SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES**		
Evidence		**Hyperlink (if available)**	**Date**
Pressure ulcers: revised definition and measurement. Summary and recommendations. NHS Improvement		https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_20June2018.pdf	June 2018
EPUAP (European Pressure Ulcer Advisory Panel) Prevention and Treatment of Pressure Ulcer: Clinical Practice Guideline		http://www.epuap.org	2014
Department of Health NHS Outcomes Framework 2016 to 2017		https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf	2016
Pressure ulcers: prevention and management, NICE Clinical Guideline CG179		https://www.nice.org.uk/guidance/cg179/evidence	April 2014

NHS Serious Incident Framework	https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf	March 2015
NHS Safety Thermometer (NHS Improvement) CQC, Adult Social Care; information for providers	https://www.safetythermometer.nhs.uk/ https://www.cqc.org.uk/guidance-providers	2013 – current June 2018
Reporting a Serious incident to the Strategic Executive Information System (StEIS), NHS Improvement	https://improvement.nhs.uk/resources/steis/	March 2018
Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS, NHS Improvement	https://improvement.nhs.uk/documents/5114/Guidance_for_reporting_pressure_ulcers.pdf	March 2019
Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675192/CSW_ulcer_protocol_guidance.pdf	January 2018
Pan-Dorset Multi-Agency Safeguarding Policies and Procedures Manual, Pan Dorset Safeguarding Partnership Department for Education, Guide to Children's Homes regulations including the quality standards.	https://pandorsetscb.proceduresonline.com/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/463220/Guide_to_Children_s_Home_Standards_inc_quality_standards_Version__1.17_FINAL.pdf	2019 April 2015

Using SSKIN to manage and prevent pressure damage, NHS Improvement	https://improvement.nhs.uk/resources/Using-SSKIN-to-manage-and-prevent-pressure-damage/	July 2017
Royal Marsden NHS Foundation Trust, aSSKINg Bundle	https://vimeo.com/319978899	March 2019
Vowden P, Vowden K Diabetic foot ulcer or pressure ulcer? That is the question. The Diabetic Foot Journal 18: 62-6		2015
Karen Ousey, Paul Chadwick, Leanne Cook (2011) Diabetic foot or pressure ulcer on the foot? Wounds UK, Vol 7, No 3		2011

G	**DISTIBUTION LIST**		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
☑	☑	☑	☑

DORSET MULTI-AGENCY FRAMEWORK FOR THE PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

1.0 RELEVANT TO

1.1 This framework is applicable to all settings where pressure ulcers are identified or where people may be at risk. It applies to all staff groups in health or social care settings where pressure ulcers are at risk of occurring.

1.2 This framework sets out clear standards and expectations for both providers and commissioners.

2.0 INTRODUCTION

2.1 This framework has been produced in order to set out a consistent and clear approach on the prevention and management of pressure ulcers across all health settings, applying to all age groups.

2.2 Prevention and measurement for improvement through the consistent delivery of best practice within the health and social care community are the key issues within the body of the framework.

3.0 SCOPE

3.1 There has been much work undertaken already in Dorset NHS health providers and also in Dorset care homes, re-ablement services and day care services to identify and prevent pressure ulcers occurring. In order to see further sustained improvement, an integrated approach is now required which relies on ensuring the consistent delivery of best practice in all care settings and within someone's own home rather than an over reliance on performance management of individual organisations.

3.2 It is the intention that this framework is applied by all health and social care providers. To support the aims and standards it is the expectation that each organisation will develop its own local policy that is aligned to the principles of this framework.

4.0 PURPOSE

4.1 This framework sets out to provide a consistent approach to the prevention and management of pressure ulcers in **all** health and social care settings and in peoples own homes in Dorset.

4.2 The commissioners and providers of health and social care in Dorset, through the Pressure Ulcer Working Group, have consistently promoted a culture of delivering high quality care coupled with an ambition to deliver

the very best care to people. The collective aspiration is to achieve harm free care and to use the learning from incidents of pressure ulceration to improve care quality and people's direct experience.

4.3 The Pressure Ulcer Working Group is now a virtual forum which continues to maximise engagement with national and local priorities such as; Stop the Pressure campaign, the NHS Safety thermometer, Patient Safety and Quality Improvement groups. Members of the working group are listed in Appendix A.

4.4 This framework has been co-produced by the Pressure Ulcer Working group, the Dorset Patient Safety Leads group and the Integrated Care System (ICS) Clinical Reference Group (Directors of Nursing) for implementation within both commissioning and provider organisations in Dorset.

5.0 DEFINITIONS

5.1 This document is termed as a framework to provide a broad overview to support the consistent approach to prevention and management of pressure ulcers within the ICS. Each organisation will have specific policies and procedures in relation to personal care and risk assessment that reflect the principles in the Dorset framework.

5.2 The term all age groups include neonates, infants, children and young people for the broad purposes of this document in line with the published NICE guidance, Clinical Guideline 179. The terms 'community service and 'acute hospital' in this document also broadly apply to all services commissioned within these settings such as maternity, neonatal and children's services.

5.3 A pressure ulcer is defined as localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.[1] A pressure ulcer that has developed at the end of life due to skin failure is no longer referred to as a 'Kennedy ulcer' and should be classified in the same way as all other pressure ulcers.

5.4 Device related pressure ulcers are defined as those that result from the use of devices designed and applied for diagnostic or therapeutic purposes.[2]

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[1] NHS Improvement, pressure ulcers: revised definition and measurement, summary and recommendations. June 2018.

[2] National Pressure Ulcer Advisory Panel's (NPUAP) 2015

5.5 The definition of a pressure ulcer on admission (POA) should be that it is observed during the skin assessment undertaken within 6 hours of admission to an inpatient service and at first visit from community nursing service. This replaces the previous term 'inherited' or external.

5.6 The definition of a new pressure ulcer within a setting is that it is first observed after 6 hours of admission and within the current episode of care. This replaces the previous term 'acquired' or internal. It is recognised that internal language in organisations may take a while to catch up in terms of language in policies and procedures and the current and new wording will be excepted during the transition period.

5.7 Moisture associated skin damage may occur over a bony prominence as well as within skin folds and known moist areas. However, pressure and shear should be excluded as causes, and moisture should be present. Moisture is not exclusively about continence and can be as a result of excess salivation, perspiration etc. A combination of moisture and friction may cause moisture associated skin damage in skin folds. Peri-anal redness and skin irritation is most likely to be a moisture associated skin damage.[3]

5.8 Further definitions for pressure related skin damage (moisture associated skin damage excluded) are clarified in Appendix B; Identification and categorisation of pressure ulcers.

6.0 ROLES AND RESPONSIBILITIES

6.1 As a collaboration of Health and Social care organisations in Dorset the Directors of Nursing and Quality as part of the ICS Clinical Reference Group will work together across the system to ensure quality of care is maintained and improved.

6.2 Each member of the pressure ulcer working group is responsible for seeking organisational support for the principles of this Framework and the implementation of the recommendations.

7.0 PREVENTION AND MANAGEMENT OF PRESSURE ULCERS

Prevalence

7.1 Pressure ulcers are a known avoidable harm associated with health and care delivery. Despite the national and local initiatives associated with

[3] EPUAP (European Pressure Ulcer Advisory Panel) Prevention and Treatment of Pressure Ulcer: Clinical Practice Guideline 2014

High Impact Actions, Quality Innovation, Productivity and Prevention (QIPP), patient safety investigations and campaigns such as “stop the pressure” prevalence remains a concern.

7.2 Evidence from the data collected through the Safety Thermometer suggests that 1,700 – 2,000 people a month develop pressure ulceration in England and in the year April 2015 - March 2016 24,674 people were affected. It is estimated that pressure ulceration costs the NHS more than £3.8 million per day.

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7.3 NHS Improvement have recognised that systems used to monitor and report pressure ulcers at local, regional and national level are not standardised and as a result issued the revised definition and measurement document for pressure ulcers in 2018.

Measurement for improvement

7.4 It is vital that processes as well as outcomes are measured to ensure an understanding of which part of the process needs strengthening in terms of reliability.

7.5 Examples of outcome measures:

- number of new pressure ulcers;
- location of the individual when the pressure ulcer was identified i.e. home, hospital;
- category of pressure ulcer;
- rate of occurrence of new pressure ulcers per 1,000 bed days.

Organisations should decide what outcome measures are most appropriate and relevant to their care settings and all relevant information should be produced to front line staff at team level in order to drive improvement.

7.6 Examples of process measures:

- percent compliance with risk assessment within an agreed period since admission to service;
- Level of compliance with SSKIN bundle (Appendix C) or similar.

Causes of pressure ulcers

7.7 Pressure ulcers can occur in anyone but are more likely in high risk groups, such as the elderly, people who are obese, malnourished or who have continence problems as well as people with certain skin types and those with particular underlying conditions (Pressure ulcers: prevention and management, NICE Clinical Guideline CG179, April 2014). Further detail of the categories of pressure ulcers is included at Appendix B; Identification and categorisation of pressure ulcers.

7.8 The factors causing pressure ulcers are divided into two groups:

- **intrinsic** – including disease, medication, malnourishment, age, dehydration/fluid status, lack of mobility, incontinence, skin condition and weight:

- **extrinsic** –external influences which cause skin distortion including pressure and shearing forces.

7.9 Performance management of provider organisations has historically led to significant amount of time spent trying to determine what avoidable and unavoidable harm is. NHS Improvement (2018) have recommended that these terms should no longer be used. The rationale is to move from focussing on 'proving' if an incident was unavoidable to using a range of definitions in practice and to be consistent with other categories of patient safety incidents. In Dorset it has been agreed to move to the term 'externally reportable' for pressure ulceration that meets the criteria for reporting under the NHS Serious Incident Framework (2015).

7.10 It is recognised in Dorset that pressure ulceration to the foot of a service user has not always been recorded as a patient safety incident. The Dorset Working group recommend that these should be reported and investigated in the same way as other pressure ulcers if they meet the criteria regardless of body site, recognising that generally only ulceration to the heel(s) can be categorised as pressure ulcers.[4] A number of these may be classified a device related pressure ulcer.

Prevention of pressure ulceration

7.11 This framework sets out to support best practice in the prevention of

[4] : Vowden P, Vowden K (2015) Diabetic foot ulcer or pressure ulcer? That is the question. The Diabetic Foot Journal 18: 62-6
Karen Ousey, Paul Chadwick Leanne Cook (2011) Diabetic foot or pressure ulcer on the foot? Wounds UK, Vol 7, No 3

pressure ulceration for people cared for in all care settings and within their own homes. Each organisation has a responsibility to maintain patient safety and prevent harm throughout the patient's journey. Appropriate prevention strategies will promote a positive culture of patient safety as well as minimise the risk of loss of reputation and the risk of litigation to the organisation.

7.12 Preventing skin damage should be an integral part of care delivery and requires a collaborative, interdisciplinary approach requiring each member of the team to take responsibility for assessment and management, including comprehensive skin inspection.

7.13 The diagram (Appendix D) highlights the Dorset multi-agency pressure ulcer prevention and treatment pathway and aligns with the principles in the NICE Clinical guideline (CG 179) published in 2014 which clearly outlines the principles for prevention of pressure ulcers in all ages groups. There are primary drivers within the pathway for the prevention of pressure ulceration:

- skin inspection;
- assessing the risk of pressure ulceration;
- reliable implementation of prevention strategies such as the SSKIN bundle;
- identification and categorisation of pressure ulcers;
- education.

Skin inspection

7.14 A comprehensive skin inspection is part of the risk assessment process and should occur regularly depending on vulnerability and condition of patient. Previous pressure ulceration should be recorded, as the tensile strength of the skin will be reduced.

7.15 In community settings patients, carers, and relatives will be empowered and encouraged to regularly inspect and review pressure areas in between contacts from health professionals. This should include clear guidance for triggering an escalation.

Assessing the risk of pressure ulceration

7.16 This involves understanding the context within which the health and/or social care professional is working and where the most "at risk" patients

may be in that population. The process of initial screening tool should be carried out on all people on admission to any care setting and at the commencement of a care service being provided within an individual's own home. It is the process of understanding if that person is at risk of developing a pressure ulcer "today". This can be a simple yes/no question.

7.17 If the answer to the question is yes, then the person should be formally assessed using a recognised clinically validated assessment tool. In Dorset a range of clinically validated tools are used including the Waterlow score and Purpose T.

7.18 It is the responsibility of each organisation to ensure that their organisational process includes the use of a formal assessment tool that complies with NICE guidance (2014). It is a requirement that the formal assessment of those identified as potentially vulnerable to developing a pressure ulcer is clearly documented along with a plan to reduce these risks.

7.19 Prompt skin inspections and pressure ulcer risk assessment is vital as this will often point to the origin of the ulceration. The initial risk assessment and formal assessment where appropriate, must therefore take place within 6 hours of admission to a health care setting, or at the first face to face contact within a community service.

Re-assessment

7.20 The skin inspections and re-assessment process should be continuous and responsive to any change in the person's condition or environment. It is recommended that high risk service users should have their assessment reviewed on each contact in a care setting. It is recognised that this will be challenging for service users cared for at home, but it is important that high risk service users in this care setting also have robust reassessment plans in place.

7.21 All assessments of people at risk of developing, or with existing pressure ulcers should include a holistic assessment of care needs such as; mobility and falls, nutrition and hydration, continence, pain, diabetes and should consider the cognitive ability of the person to make decisions relating to their care through a mental capacity assessment. Each organisational prevention strategy must therefore ensure that the appropriate links are made at both a strategic and operational level.

Implementation of prevention strategies

7.22 Organisational prevention strategies will be able to demonstrate that staff are routinely and regularly monitoring people at risk of developing

pressure ulcers. It is recommended that all organisations within the scope of this framework adopt the use of recognised interventions to support this process. These should include:

- recognised repositioning strategies such as intentional rounding;
- SSKIN bundle (Appendix C). Some NHS organisations are looking

  to develop the SSKIN bundle with the inclusion of a – for assess risk and g – for giving information and educating patients (aSSKINg), however this is currently not a validated tool.

7.23 People at risk of, or with pressure ulceration, will require regular changes of position in order to prevent prolonged pressure to a specific area of tissue. For those at home this may need to be provided by carers or relatives if the individual is unable to reposition themselves. The frequency of repositioning will need to be determined on an individual basis taking into account the condition of the skin, equipment in place and level of risk and this should be clearly stated in the care plan.

7.24 The use of a repositioning strategy will facilitate and record this process and each organisation should implement a process of regular contact with patients/service users to assess skin integrity.

Record keeping

7.25 Record keeping is an essential element of care delivery ensuring that pressure ulceration and wound healing is evaluated effectively. The following information to be documented in the care records for all pressure ulcers:

- classification of wound bed, colour, odour and exudate;
- category;
- site;
- size.

7.26 All pressure ulcers should be measured as clinically indicated, on a minimum four weekly basis to provide information about the progression of the wound. A photograph should be taken, particularly if the ulcer is difficult to measure or trace. Not all clinical areas have the facility to record digital images but where digital images are taken then this should only be undertaken in accordance with the Consent Policy of the

organisation. An updated photograph to record wound progress should be taken every four weeks until the wound is healed.

7.27 It is essential that information regarding skin assessments is handed over when people transfer between different service providers.

Access to specialist equipment

7.28 People identified with an existing pressure ulcer or at significant risk of developing pressure ulceration should be cared for on a pressure reduction, redistribution or relieving surface 24 hours a day according to the skin inspection, the level of risk and general condition.

7.29 Each provider, including care homes with and without nursing, should have a basic level of equipment for the prevention of pressure ulcers for service users with the exception of custom made items. This includes; pressure relieving cushions, heel and joint protectors, high specification foam mattresses, alternating airwave overlay or alternating replacement mattresses, hybrids or other appropriate static and dynamic equipment. The supplier, maintenance and supply arrangements should be determined locally in accordance with the relevant national guidance.

7.30 Access to additional specialist equipment is via the Integrated Community Equipment and Adaptations Service for Bournemouth, Poole and Dorset (Equip for Living Service). This service requires all equipment prescribers to belong to the eligible Local Authority and NHS services commissioned or authorised by Bournemouth, Christchurch and Poole Council, Dorset Council and NHS Dorset Clinical Commissioning Group. All charges for equipment will be aligned with the Equip for Living service agreements.

Statutory reporting

7.31 All pressure ulcers, irrespective of category should be recorded in the patient's/service users record. All pressure ulcers of category 2 or above including Deep Tissue Injury (DTI) and unstageable pressure ulcers should be reported into the local reporting system.

7.32 Pressure ulceration is considered harm to people and therefore should be reported as a patient safety incident within the organisational risk management, reporting and learning system. Patient safety incidents (NHS funded care only) are also reported to the National Reporting and Learning Service (NRLS) which in turn shares data with the Care Quality Commission (CQC) to inform regulatory inspections. Specific guidance on reporting to the NRLS is available in the NHS Improvement guidance document published in March 2019.

7.33 Historically there has been a view that people who develop pressure ulcers within 72 hours of admission are not deemed as having acquired it in the receiving care setting. This is now deemed irrelevant in clinical practice by NHS Improvement due to the complexity of patient pathways. Therefore, all POA should be reported in local reporting and learning systems.

7.34 It is recommended that all device related pressure ulcers should be reported and identified by using the appropriate category followed by the notation (d) e.g. category 3 (d) to allow accurate measurement.

7.35 All pressure ulcers that occur at the end of life should be included in monitoring systems and not classified separately. A new code will be introduced to local reporting systems to ensure these are identified within the relevant stage of care.

7.36 Local reporting and learning systems should include the reporting of both the number of ulcers and the number of people with ulcers. Each Provider is recording pressure ulcers on admission or during the episode of care (per patient). If multiple pressure ulcers are present at time of reporting, the highest category is recorded. Duplication will happen and systems are not sufficiently sophisticated within the ICS to allow for a single record and reporting system.

7.37 Moisture associated skin damage and sloughy moisture lesions (a "combination lesion") should be counted and reported in addition to pressure ulcers in local systems. Where skin damage is caused by a combination of moisture and pressure, the damage will be recorded as the category of pressure ulcer.

7.38 The NHS and Local Unitary Authority Commissioners will have mechanisms in place to monitor the occurrence of pressure ulcers across all commissioned services in their local health community in order to monitor the effectiveness of local strategies and also to identify specific organisational issues.

7.39 Only pressure ulcers that meet the criteria for a Serious Incident (SI) i.e. the impact of harm, should be reported to the commissioners via the Strategic Executive Information System (STEIS). These will be known as 'externally reportable' ulcers in reports.

7.40 Pressure ulcers category 3 or above that occur in an adult social care setting are a statutory notification to the CQC as a reportable serious injury to a person using the service. The notification form is a requirement of compliance with registration in these settings. Where serious harm occurs in children's residential settings there is a requirement to report to Ofsted as the regulator of these services.

7.41 Clusters of reportable pressure ulcers can be declared, at the discretion of the commissioner where a cluster has occurred in one clinical service, care setting. Such a cluster may also be the subject of a safeguarding alert, for more information see Appendix E.

Safeguarding

7.42 Pressure ulcers are considered an important part of the safeguarding process and each local Safeguarding Board has guidance in place to ensure that people with pressure ulcers are referred into the safeguarding process appropriately which align with the NHS reporting mechanisms. The care provider of service users who are self-funding, or not in receipt of NHS care will be required to complete the ADASS Adult Safeguarding Decision Guide for individuals with severe pressure ulcers (Appendix E). Further guidance can be found in the Multi agency safeguarding policies from https://www.dorsetforyou.gov.uk/care-and-support-for-adults/information-for-professionals/dorset-safeguarding-adults-board/reporting-a-concern.aspx

7.43 Where there are any child safeguarding concerns these should be referred directly to the Multi Agency Safeguarding Hub in accordance with Dorset the Safeguarding policies.

7.44 Organisations are responsible for ensuring that local processes are clearly identified within organisational policies and reinforced through local training.

8.0 TRAINING

8.1 Ensuring staff are competent and confident to deliver safe and high quality care remains a key requirement for all health and social care providers. The Framework supports the use of standardised education tools based upon the agreed principles using on-line or face-to-face methods.

8.2 Each organisation will have systems in place locally to facilitate sufficient access to both taught and practice based clinical training. This should be supported by appropriate audit systems in order to provide assurance of compliance with the Framework.

8.3 The role of public health specialists in the prevention agenda is a strategic objective of the ICS. The need for health and social care staff to be well informed, confident and able to communicate key messages about prevention, early detection and appropriate management of pressure ulcers to the public is therefore a priority.

8.4 At community level, there are a number of people who may be vulnerable to pressure ulceration but only have contact with health professionals through their General Practitioner and Practice Nurses. Primary Care Services will have mechanisms in place to educate primary care staff in relation to this Framework and to engage with their patients about the importance of skin checks and caring for their skin.

8.5 The Framework supports a collaborative approach to on-going training in all provider organisations and encourages organisations to enable access to training sessions for staff regardless of their employing organisation. In addition, all relevant staff should receive the appropriate training in the assessment, prescription and provision of pressure redistributing or relieving equipment and should be aware of the need to review this provision.

9.0 CONSULTATION

9.1 This Framework has been shared with stakeholders in the Pressure Ulcer Working group, the Dorset Patient Safety Leads group and the Dorset Clinical Reference Group. Comments and feedback have been incorporated in line with the national guidance issued by NHS Improvement in June 2018.

10.0 RECOMMENDATION AND APPROVAL PROCESS

10.1 This Framework provides recommendations for individual organisational policy, professional roles, procedures and patient information within providers. The Clinical Commissioning Group in conjunction with the three local authorities in Dorset, Bournemouth and Poole will maintain a role in oversight of compliance with this Framework through the Quality Surveillance group (QSG).

10.2 This Framework will be ratified by the Directors of Nursing as part of the ICS Clinical Reference Group.

11.0 COMMUNICATION/DISSEMINATION

Public Engagement

11.1 The risk of sustaining pressure ulceration is often seen to be the problem of the health or social care professional; however, the individual at risk is central to successful prevention. Using the principles of adult safeguarding, Empowerment, Prevention, Protection, Partnership, Proportionality and Accountability the desires and wishes of the individual should be considered.

11.2 This is particularly important when people suffer a life changing event or illness that significantly increases their risk of being susceptible in the future to pressure ulceration and consideration to the application of the Mental Capacity Act needs to be applied. If the individual has capacity, it is important to work with the patient and their carers to highlight the risk and actions to mitigate risk. Consideration for a referral to Adult Safeguarding should be undertaken if the individual is self-neglecting to the point where harm is occurring, an outcome of this referral may be the use of the Multi-Agency Risk Management (MARM) process https://www.dorsetforyou.gov.uk/care-and-support-for-adults/information-for-professionals/dorset-safeguarding-adults-board/dorset-safeguarding-adults-board-pdfs/multi-agency-risk-management-marm-guidance.pdf . If the individual lacks capacity, best interest decision making will be required. https://www.dorsetforyou.gov.uk/care-and-support-for-adults/information-for-professionals/mental-capacity-act-and-dols-team/mental-capacity-act-mca-and-deprivation-of-liberty-safeguards-dols-team.aspx .

11.3 It is, however, recognised that a true partnership involves more than just giving information. People should be able to access information easily and be provided with the tools to help them assess their own vulnerability to development of pressure ulcers, how to prevent them and who to contact should they be concerned. This is particularly important for those patients cared for at home by relatives and carers.

11.4 Existing policies relating to people's choice are relevant to all spheres of care and non-concordance with pressure ulcer prevention strategies will unfortunately continue to be an issue on occasion. Where a patient is deemed to have capacity to understand the risks associated with pressure ulcers, they should be given information and guidance to support them to be included within the choices of treatments available to them. If the patient is deemed to lack capacity to consent to treatment, a best interest decision should be made. Following a best interest decision, if the patient who lacks decision-specific capacity continues to be non-conformist in the delivery of treatment; legal advice should be sought and consideration for an application to the court of protection may be required. All organisation should have clear processes in place to manage this.

11.5 All provider organisations should ensure that they have a broad range of information and tools available for the public in order to encourage and support their participation in the prevention and management of pressure ulcers. All information should be culture and language specific, at the appropriate literacy level and easily accessible.

Communications

11.6 The Framework will be communicated to the wider health and social care services and the general public via the CCG website. The November 'Stop Pressure Day' is annually marked in most organisations and includes awareness raising of this Framework.

12.0 IMPLEMENTATION

12.1 This Framework provides a vision, themes and standards that are clear and understandable for both commissioners and providers of care. Successful implementation will require a health community commitment with a common sense of purpose and a shared goal of harm free care which all partners can sign up to.

12.2 The procedural document outlines the requirement of organisations to ensure the national standards for categorisation and measurement of pressure ulcers to be implemented from April 2019.

12.3 Section 7.36 acknowledges IT systems need to develop to allow for a single record and reporting system. This will be explored further as the ICS Digital work stream progresses.

12.4 Competency frameworks are being developed within individual organisations with a view to working towards a pan Dorset approach to include all settings e.g. Primary Care, independent community based Allied Health Professionals. This will be achieved through the Virtual Working Group and will be incorporated to this Framework at a subsequent review.

13.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THE DOCUMENT

13.1 The outcomes following the implementation of this Framework will be monitored and as a result will inform the subsequent review of the procedures and processes.

13.2 Each organisation should have a process in place for monitoring compliance with the organisational pressure ulcer prevention strategies that align with this Framework. The reporting and monitoring will be internally presented to trust boards and externally through contractual reporting to the CCG.

13.3 Any areas of concern identified in relation to the prevention and management of pressure ulcers will result in the requirement for an improvement plan. This will be reviewed by the appropriate organisation

or ICS committee/group. Actions will be recorded in the committee/group minutes.

13.4 The Dorset Patient Safety Leads Group will continue to monitor and review the Framework and report concerns to Directors of Nursing and QSG.

14.0 DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

14.1 The document is reviewed every two years to take account of any changes in national guidance. Necessary changes throughout the year will be issued as amendments to the Framework. Such amendments will be clearly identifiable to the section to which they refer and the date issued. These will be clearly communicated within organisations.

15.0 EQUALITY IMPACT ASSESSMENT

Equality Assessment Form

Document title: Dorset Multi-Agency Framework for the Prevention and Management of Pressure Ulcers
What are the intended outcomes of this work? This Framework sets out to provide a consistent approach to the prevention and management of pressure ulcers in all health and social care settings and in peoples own homes in Dorset.
Who will be affected? Staff, Patients/Service users and Public

Evidence
What evidence have you considered? NICE Guidance European Pressure Ulcer Advisory Panel (EPUAP) National Pressure Ulcer Advisory Panel (NPUAP) Department of Health Outcomes Framework NHS Improvement recommendations, NHS Safety Thermometer requirements ADASS Adult Safeguarding guidance CQC registration requirements NHS Serious incident framework
Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.* Not relevant
Gender *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).* Not relevant
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.* Not relevant
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

Applicable to all age ranges
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.* Not relevant
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.* Not relevant
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.* Not relevant
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.* Not relevant
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.* Not relevant
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.* Not relevant

Engagement and involvement
Have you engaged stakeholders in gathering evidence or testing the evidence available? If not what do you intend to do? Yes all key stakeholder have been involved in the development of the strategy
How have you engaged stakeholders in testing the policy or programme proposals? If not what do you intend to do? This Framework has been in place for 4 years and consistently tested and applied
If you have engaged groups please list below and include who was involved, how they were involved and the key outputs:

Groups engaged	Date and type of engagement	Outputs from activity
Pressure Ulcer Working group	Via email 28/08/2018	Revisions incorporated and recirculated on 29/05/2019
Patient Safety Leads Group	Via email 28/08/2018	Discussed at themed meeting on 05/12/19. To consider amendments and defer implementation until NHS Improvement deadline of April 2019. Document recirculated 29/05/19 ahead of the June Patient Safety Leads Meeting (12/06/19).
Directors of Nursing Group		

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

This Framework provides broad principle applicable in all areas of health and social care it is not applied differently in any specific areas. It is recognised that some groups are at greater risk in the population, however the clinical guidance ensures this is part of the multi-factorial risk assessment and care planning for individuals.

Equality Act 2012– *the CCG is bound by the public sector equality duty and is required to evidence how in its decisions it is delivering the following. Please outline how your work and the service will contribute to these.*

Eliminate discrimination, harassment and victimisation

This Framework is intended for all staff and service users in Dorset Health and Social Care organisations

Advance equality of opportunity

The Framework sets standards for all ICS organisations

Promote good relations between groups

The Framework promotes collaborative working between organisations and with service users.

What is the overall impact of your proposals or decision? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?* None

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.* None

Action planning for improvement: *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*
Please give an outline of your next steps based on the challenges and opportunities you have identified. Action Plan not required

Name of person who carried out this assessment: Jaydee Swarbrick
Date assessment completed: 29 May 2019
Date assessment was signed:

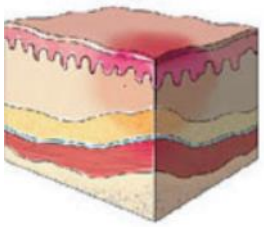
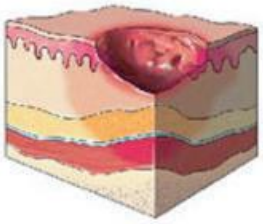
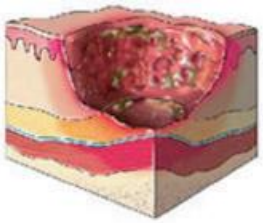
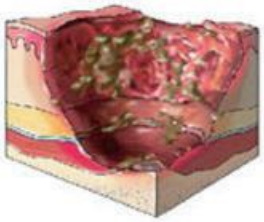
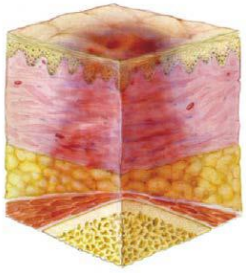
APPENDIX A

PRESSURE ULCER WORKING GROUP (Virtual) MEMBERSHIP	
Name and Job Title	**Organisations**
Director of Nursing and Quality	NHS Dorset Clinical Commissioning Group
Head of Nursing and Quality (Quality Improvement)	NHS Dorset Clinical Commissioning Group
Head of Nursing and Quality (Safety and Safeguarding)	NHS Dorset Clinical Commissioning Group
Quality Improvement Manager	Dorset Council
Tissue Viability Nurse	Poole Hospital NHS Foundation Trust
Contracts team Manager	Bournemouth, Christchurch and Poole Council
Patient Safety Lead	The Royal Bournemouth & Christchurch NHS Foundation Trust
Tissue Viability Nurse Specialist/Manager	Dorset HealthCare University NHS Foundation Trust
Community Nursing Service Lead	Dorset HealthCare University NHS Foundation Trust
Tissue Viability Nurse Specialist Lecturer Practitioner/Leg Ulcer Specialist	Dorset HealthCare University NHS Foundation Trust
Tissue Viability Nurse	Dorset County Hospital NHS Foundation Trust
Development Nurse – Clinical Programmes	West Hampshire Clinical Commissioning Group

APPENDIX B

IDENTIFICATION AND CATEGORISATION OF PRESSURE ULCERS

The recent clarification from NHS Improvement in June 2018 recommends that all organisations should continue to follow the current system used in the recognised international guidelines (NPUAP/EPUAP/PPPIA 2014) incorporating categories 1,2,3,4, unstageable ulcers and deep tissue injury (DTI) and as descriptors.

	**Category 1** Non-blanchable redness of a localised area usually over a bony prominence (intact skin)
	**Category 2** Partial thickness skin loss of dermis with shallow open ulcer, with red/pink wound bed WITHOUT slough or bruising
	**Category 3** Full thickness skin loss. Subcutaneous fat may be visible but NOT bone, tendon or muscle exposed. Slough may be present
	**Category 4** Full thickness tissue loss with exposed bone, tendon or muscle
	**Suspected deep tissue injury** Purple or maroon localised area of discoloured intact skin or blood-filled blister
Unstageable	

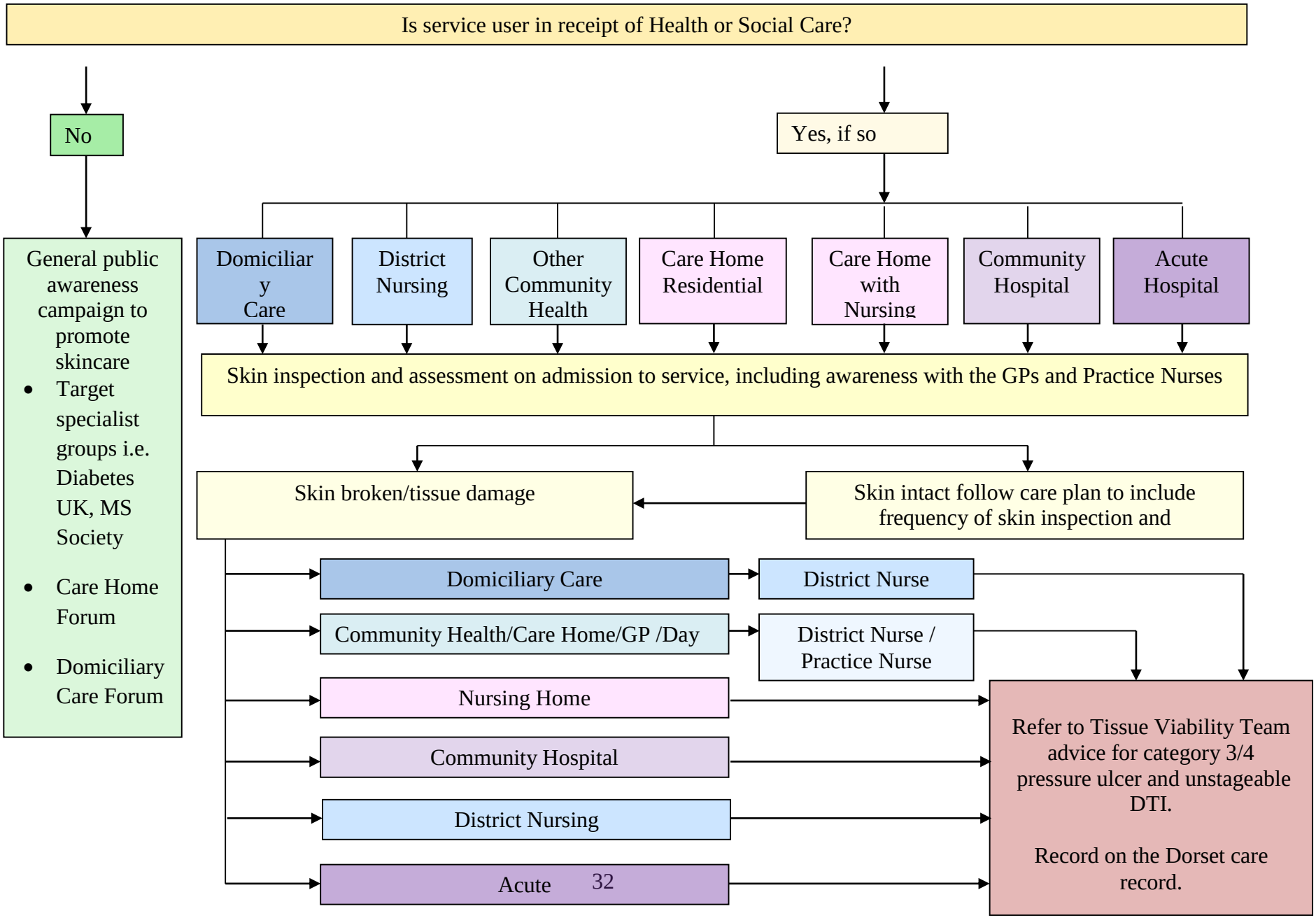
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough or eschar is removed to expose the base of the wound, the true depth, and therefore the category cannot be determined

At an organisational level it is important that there is a sufficient level of confidence in how the categories are assessed and it is recommended that a process to validate the categorisation is applied. All people with a Category 3, 4 unstageable of DTI pressure ulcer in a health or social care setting should be seen and assessed by a suitably qualified professional. The process to access advice and support or referral to Tissue Viability specialist advice is outlined in the flowchart developed to support this framework at Appendix D.

SSKIN Care Bundle general example **APPENDIX C**

Name																									
Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly																									
Date																									
Time – record using 24 hour clock																									
Surface																									
Mattress appropriate (please state)																									
Cushion appropriate (please state)																									
Functionality/integrity check of equipment performed																									
Skin Inspection																									
All pressure areas checked																									
Redness present Y/N																									
Keep moving																									
B E D	Right side																								
	Left side																								
	Back																								
CHAIR																									
Incontinence																									
Urine																									
Bowels																									
Nutrition																									
Diet (please state)																									
Fluids (please state)																									
Supplement(s) (please state)																									
Initials																									

Dorset Multi Agency Pressure Ulcer Prevention/Treatment Pathway **Appendix D**



APPENDIX E

Guidance of pressure ulcers

All agencies should be aware of the national indicators to support Health and Social care providers in determining when safeguarding issues may arise.

The NHS has a robust reporting mechanism through application of adverse incident reporting framework with their own organisation.

Care provider of service users who are self-funding, or not in receipt of NHS care will be required to complete the ADASS Adult Safeguarding Decision Guide for individuals with severe pressure ulcers (appendix 3)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675192/CSW_ulcer_protocol_guidance.pdf

https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/

Adult Safeguarding Decision Guide for individuals with severe pressure ulcers