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

However, despite improvements in technology and medical advances, the incidence of pressure ulcers is increasing. Nearly 700,000 people in the UK are affected by pressure ulcers each year across all care settings, including people in their own homes (NHS Midlands and East, 2016; Blenman et al, 2017). Every pressure ulcer has a tangible effect on the patient. This includes pain, the need for additional nursing interventions, damage to their sense of self, leading to depression or social isolation, due to wound symptoms such as odour. The drive to prevent harm is at the forefront of the argument for investment of time and money in pressure ulcer prevention (NICE, 2015; Ellis, 2017). Every setting where care is delivered, whether home, hospital or care home, faces challenges in delivering pressure ulcer prevention — pressure ulcers also affect the morale of clinical staff, because they are still considered to be an indicator of poor nursing care, affecting the quality of life of patients and their families (Chamanga, 2016; Tingle, 2016; Ellis, 2017).

Remember...

Since 2014, the Department of Health (DH) has focused on reducing avoidable harms in an attempt to save 6,000 lives while improving patient safety and saving money. As well as pressure ulcers being recognised by the DH as a classic ‘avoidable harm,’ the NHS Outcomes Framework lists pressure ulcer prevention as a key focus area and pressure ulcers are routinely reported via the NHS Safety Thermometer.
commonly used tools in the UK are Waterlow (2005), Norton (Norton, et al, 1992) and Braden (Bergstrom et al, 1987).

**STAGING PRESSURE ULCERS**

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

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

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

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

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

**MANAGEMENT OF PRESSURE ULCERS**

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

The main management interventions include:

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

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

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

**Positioning and reduction of pressure and shear**

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

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

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

**Wound care**

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

**Practice point**

Staging pressure ulcers is not a way of monitoring their progress, as they do not proceed from one stage to the next (Defloor and Schoonhoven, 2004; Beldon 2014). Likewise, a stage 4 ulcer does not become a stage 3 as it heals, but should be viewed as a healing stage 4 ulcer.
and 4 pressure ulcers may need advanced wound dressings that support an optimum wound healing environment, e.g. hydrocolloids, hydrogels, foams, soft silicones and hydrofibres, and negative pressure wound therapy (NPWT) may be considered if the wound is large, deep and heavily exuding. These wounds should be referred to a specialist (NICE, 2015).

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

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

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

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

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

**REFERENCES**
Department of Health (2011) *Safe Care:* DH, London

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