UNDER REVIEW

SOLIHULL PRACTICE GUIDANCE No 1 **Pressure Ulcers Safeguarding Adults**	Working Together to safeguard adults in Solihull

1.1 Introduction & Key Definitions

Pressure ulcers can develop very quickly and without appropriate intervention they can become very serious. Any pressure ulcer can be painful and cause patient suffering but severe pressure ulcers can destroy the muscle or bone and in extreme cases they can cause infection and become life threatening.

A **pressure ulcer** has been defined as an area of localised damage to the skin or underlying tissue **caused** by **pressure** and **shear** or a combination of both (epuap.org.com).

Pressure – the weight of the body pressing down on the skin

Shear - the layers of the skin are forced to slide over one another or over deeper tissues, for example when you slide down, or are pulled up, a bed or chair or when you are transferring to and from your wheelchair.

Friction – rubbing the skin.

95% of pressure ulcers are avoidable. The Department of Health (DH) has clarified the following as what an *avoidable* pressure ulcer is and what an *unavoidable* pressure ulcer is:

Avoidable Pressure Ulcer: "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- evaluate the person's clinical condition and pressure ulcer risk factors;
- plan and implement interventions that are consistent with the persons needs and goals, and
- recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had:

- evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and
- recognised standards of practice;
- monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or

- the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence".

For further definition see GLOSSARY on page27.

1.2 Risk Factors

Anyone can get a pressure ulcer but some people are more at risk than others. Identifying those at higher risk will help identify appropriate prevention measures. The factors that make people most at risk are listed below:

- Pressure caused by reduced mobility or immobility (e.g. in bed or chair including wheelchair)
- Poor nutritional input
- Person sliding down or being dragged up the bed
- Medication e.g. night sedation or strong pain killers, steroids
- Moisture (incontinence, leaking wounds, perspiration)
- Extremes of age (over 65, under 5)
- Significant change in a person's health such as chest infection etc
- Friction (the rubbing of the skin causing superficial abrasions, blisters etc)
- Shearing (the tearing and stretching of the skin caused by a patient sliding down or being dragged up the bed, combined with the patients weight).
- Person with contracture (see glossary for definition)
- Extremes of weight
- Previous history of pressure damage
- Lack of feeling/sensation in the skin
- Long term chronic illness
- Reduced consciousness
- Casts/splints/plaster of paris, neck collars etc.
- Masks – e.g. Oxygen masks, CPAP masks, Non Invasive Ventilation (NIV) etc.

1.3 Prevention

It is better to prevent pressure ulcers from developing than to have to treat them.

Key to prevention is the assessment process, making sure people have the right support, early inspection will lead to early detection, keep people moving, clean, dry and well hydrated with a good diet.

As 95% of pressure ulcers are avoidable the following will help to prevent significant pressure ulcers from occurring and thus reducing the harm to individuals.

NHS Midlands and East identify the following five simple steps to prevent and treat pressure ulcers.

1.4 Assessment

Early identification of people at high risk of pressure ulcers will ensure preventative measures can be implemented quickly. The use of a formal risk assessment tool, such as the Waterlow Risk Assessment Tool, will ensure all risk factors are assessed in a consistent way.

Paper based risk assessments should not be completed in isolation but in conjunction with a thorough skin inspection of the most at risk areas and professional/clinical judgement.

Risk assessments must be completed:

- On all people requiring care.
- At regular intervals.
- If an individual's care needs change

Visual skin assessments must be carried out each time personal care is given.

Solihull recommends that the following forms in this document are used.

a. **Tissue Viability Assessment Tool** (Ref: Waterlow)
   It is strongly recommended this assessment tool is only completed by a qualified health staff member.

b. **Body Map**
   This tool can be used by health and social care staff and informal carers.
   It can be used in two ways – in conjunction with the Skin Inspection Form or on its own.

This document also contains the following for reference:

o The most common places for pressure ulcers diagrams

o Quick test – How at risk are you?

1.5 Interventions

Preventative measures should be tailored to the individual's needs. The following preventative interventions should be considered for all people identified at risk.

The following will help to prevent significant pressure ulcers from occurring and thus reducing the harm to individuals.

NHS Midlands and East identify the following **five simple steps** to prevent and treat pressure ulcers.

Surface
Skin Inspection
Keep moving (repositioning)
Incontinence and moisture
Nutrition and hydration

SURFACE - Aids and Equipment – making sure people have the right support

There are many different types of mattresses and cushions that can help to reduce the pressure on bony parts of the body and help prevent pressure ulcers.

All Health and Social care providers must ensure that people using their services are provided with equipment and aids that meet their needs and promote their comfort, safety and dignity.

It is important to note that specialised equipment will not eliminate the need for regular turning or changing positions.

Care providers must check and review equipment on a regular basis to ensure it is in good working order and continues to appropriately meet the individual's needs.

Skin Inspection – Early inspection means early detection. Show people and carers what to look for

Skin inspection provides essential information for pressure ulcer prevention. Regular inspection of vulnerable parts of the body will enable early detection of tissue damage. Skin should be inspected for any redness or change of colour.

If it is not possible to see redness on the skin of people with darkly pigmented skin, then it should be assessed for the following signs:

- Darkening of the skin on pressure point areas– it may look like a bruise.
- Localised heat
- Localised swelling
- Localised hardening of the skin
- A later stage of tissue damage would be blistering or a break in the skin.

Any skin changes noted should be documented immediately and discussed with the patient and the multidisciplinary team.

The areas of the body that are most vulnerable are typically:

- Heels
- Sacrum/base of the spine
- Buttocks
- Hips
- Elbows
- Back or side of head
- Ears
- Bridge of nose
- Shoulders
- Toes
- Parts of the body that are affected by the wearing of anti-embolic stockings
- Parts of the body where pressure, friction or shear is exerted in the course of their daily activities e.g. on the hands of wheel chair users
- Parts of the body where there are external forces exerted by equipment and clothing e.g. catheters, intravenous lines, shoes.

Keep Moving – (repositioning) - Mobility

One of the best ways of preventing pressure ulcers is to reduce or relieve pressure on the areas of skin that are vulnerable. This can be done by **encouraging or assisting the patient to move or change position as often as needed** to prevent persistent redness of the skin. If a patient already has a pressure ulcer, lying or sitting on this area should be avoided as much as possible.

The following is recommended:

- At risk people should have an individual care plan, identifying a repositioning regime and preventative actions such as equipment etc.
- Individuals should be given advice about how to change their position in bed/chair, how often to do this and how to do so safely to prevent shear.
- People that need support to move or transfer should be assisted in a way that reduces the risk of friction or shearing.
- If a patient's skin condition is deteriorating despite a regular and frequent turning regime then a specialist mattress and/or cushion should be used **AND** specialist advice from the District Nurse and/or Tissue Viability Nurse must be sought.

Incontinence and Moisture - Continence Management

If skin is exposed to moisture for long periods of time it can become macerated, resulting in a loss of integrity and tissue damage.

The most common causes of moisture are:

- Urinary and/or faecal incontinence
- Perspiration
- Wounds

The following is recommended:

- Use of foam cleansers instead of soap and water
- Barrier products may be required but should be used sparingly as per the manufactures recommendations and local formula. If the cause of the 'redness' is not clear and there is a combination of moisture and pressure – see specialist advice.
- Use of incontinent pads should be chosen depending on the individuals needs and fitted correctly.
- Urinary catheterisation should be viewed as a last resort.

Nutrition and hydration

Eating well and drinking enough fluids is very important to help reduce people's risk of developing pressure ulcers and effective wound healing.

At risk patients should have nutritional assessment carried out and/or referral to dietician services for dietary advice.

Full records of what high risk individuals eat and drink in a day will help to identify if someone is eating and drinking sufficiently. Regular weighing of individuals at risk is also important.

1.6 Skin Care

Skin that is dry, sensitive, fragile or thin will be more susceptible to becoming damaged by friction and shearing.

Things to consider:

- Do not rub skin but pat it dry
- If the patient insists on using talcum powder, they should be advised to use it sparingly.
- Keep beds and chairs free from crumbs and wrinkles
- Check clothing and footwear for prominent seams or zips that may cause skin damage.

1.7 Lead Agency for Care Plan

It is important to identify who has lead responsibility for organising and coordinating an individual's care plan. This is particularly important for people living in their own home who may be receiving services from more than one agency or organisation and for self-funders.

The agency with lead responsibility will be responsible for ensuring all risks and changes in an individual health and care are reported to them so they can ensure new care plans or changes to care plans are developed and communicated to all those involved so they can be successfully implemented.

The following the matrix identifies who will take read responsibility for the development and implementation of care plans.

	Adult Social Care	CHC Nurse	District Nurse	Residential / Nursing Care Home	Domiciliary Care Agency	Hospital
Self funder			✓ If a district nurse is involved they will assume lead responsibility	✓ The home will take lead responsibility until such time as district nurses become involved	✓ The agency will take lead responsibility until such time as district nurses become involved	
Social Care funded	✓					
CHC funding		✓				
Direct payment or Personal Budget	✓					
NHS patient or campus complex						✓

NOTE: Health care will always maintain professional responsibility if involved.

1.8 Record Keeping, Information Sharing and Reporting

Good record keeping is essential to demonstrate full assessments have been completed and to identify the care or treatment required.

The following records ***must*** be kept in relation to pressure ulcers:

- Assessments (including risk and skin assessments)
- Individual care plan
- Consent to treatment
- Daily records of care given
- Date and details of referral to District Nurses
- Copies of any notifications to the regulator (e.g. CQC) or internal reporting such as clinical incidents
- It is mandatory for qualifies nurses to report all Grade 2, 3 and 4 pressure ulcers as a clinical incident.

1.9 Capacity

An individual's mental capacity to understand the care plan and to be compliant with the treatment or not will need to be considered and may need to be assessed. If an individual is not compliant with the treatment i.e. will not agree to specialist equipment, to regularly move and change position, etc a mental capacity assessment must be considered.

The Mental Capacity Act 2005 (MCA) is underpinned by 5 guiding principles, which everyone must follow – these are:

1. an assumption of capacity
2. supporting people to make their own decisions
3. people have the right to make unwise decisions
4. where someone lacks capacity staff must act in the person's best interests
5. where someone lacks capacity any action we take on their behalf must generally be the least restrictive option.

If an individual **lack capacity** to agree to treatment and equipment this must be assessed, recorded and a **Best Interest** decision made.

It may be necessary to also consider **the capacity of relatives** who are caring for the individual – especially is they are reluctant or refusing the assessment, care plan or equipment.

1.10 Training & Education

All staff involved with the health and care of adults at risk must have access to training, information and guidance on Pressure Ulcers. Such training, information and guidance must be appropriate to their role and responsibilities. The requirements of Regulators must be met.

All staff must update their training and learning every 2 years. This can be achieved in a variety of ways:

- Formal training courses
- CQF module
- DVD
- Reading
- Conferences
- On line learning such as www.stopthepressure.com

Organisations must have a record system which details staff have met this requirement.

1.11 Further Reference Materials

The following websites provide good up to date guidance:

www.nice.org.uk

www.stopthepressure.com

www.your-turn.org.uk

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1.12 Pressure Ulcers –Safeguarding Triggers

To determine if the identification of a pressure ulcer on an individual **receiving professional support (in a care or nursing home, hospital or from a Domiciliary care or nursing care agency)** 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 the decision

		Possible NOT safeguarding at this stage	Possibly Safeguarding	Safeguarding
1.	What is the severity (Grade) of the pressure ulcer?	Grade 2 pressure ulcer or below – care plan required	Several Grade 2 pressure ulcers / Grade 3 & 4 pressure ulcers – consider question 2	Grade 4 and other issues of significant concern.
2.	Does the individual have mental capacity and have they been compliant with treatment? Has a capacity assessment been completed?	Has capacity and has refused treatment. Capacity assessment is recorded	Does not have capacity or capacity has not been assessed – continue to question 3	Assessed as NOT having capacity and treatment NOT provided
3.	Full assessment completed and care plan developed in a timely manner and care plan implemented?	Documentation and equipment available to demonstrate full assessment completed, care plan developed and care plan implemented	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.	Little or no documentation available to demonstrate a full assessment has been completed, or care plan developed or care plan implemented AND general care regime (e.g. nutrition, hydration) is of concern.
4.	This incident is part of a trend or pattern – there have been other similar incident with this individual or others	Evidence suggest this is an isolated incident.	There have been other similar incidents.	Evidence demonstrates this is part of a pattern or trend.
		NOT SAFEGUARDING BUT RAISE AN ALERT	**MORE THAN TWO OF THE ABOVE – SAFEGUARDING MAKE AN ALERT/ REFERRAL**	**SAFEGUARDING MAKE A REFERRAL**

UNDER REVIEW

1.13 Pressure Ulcers –Safeguarding Triggers

To determine if the identification of a pressure ulcer on an individual receiving **NO professional support (i.e. 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 the decision

		NOT safeguarding at this stage	Possibly Safeguarding	Safeguarding
1.	What is the severity (Grade) of the pressure ulcer?	Grade 2 pressure ulcer or below – care plan required	Grade 3 & 4 pressure ulcers – consider question 2	Grade 4 and other issues of significant concern.
2.	Does the individual have mental capacity and have they been compliant with treatment? Has a capacity assessment been completed?	Has capacity and has refused treatment. Capacity assessment is recorded	Does not have capacity or capacity has not been assessed – continue to question 3	Assessed as NOT having capacity and treatment NOT provided.
3.	Unpaid carer raised concerns and sought support at an appropriate time.	Evidence available to show concerns raised and support sought – e.g., from GP , DN, SW	Evidence NOT CLEAR that concerns were raise or support sought in a timely manner.	No support sought.
4.	Full assessment completed and care plan developed in a timely manner and care plan implemented?	Evidence available to show unpaid carer cooperated with assessment and has implemented care plan	Evidence of partial cooperation or implementation of care plan – some aspects may have been refused – e.g. certain equipment	NO cooperation and refusal to implement care plan and or purposeful neglect.
5.	This incident is part of a trend or pattern – there have been other similar incident or other areas of concern.	Evidence suggest this is an isolated incident.	There have been other similar incidents or other areas of concern	Evidence demonstrates this is part of a pattern or trend
		NOT SAFEGUARDING BUT RAISE AN ALERT	**MORE THAN TWO OF THE ABOVE – SAFEGUARDING MAKE AN ALERT/ REFERRAL**	**SAFEGUARDING MAKE A REFERRAL**

1.14 The Safeguarding Procedure

ALERT	A safeguarding adult's alert should be made for all incidents of pressure ulcers. An alert is a concern that an adult at risk is or may be a victim of abuse or neglect. An alert should also be made if there are concerns that the adult at risks carers are refusing assessment, treatment or equipment for the individual. On receipt of the alert the Safeguarding adults team will: o Use the pressure ulcer triggers as detailed in **1.12** and **1.13** to determine if a safeguarding adult's investigation/assessment is required. o Want to know if there are any other concerns. If it is decided that the alert does not meet the threshold for a referral and requires an investigation, advice will be given to the alerter. A decision if the alert is a referral requiring investigation should be made within 24 hours of receipt of the alert.

REFERRAL	If a referral is made, the Multi Agency Safeguarding Adults Procedures will be instigated, and if it relates only to the pressure ulcer(s), the following will be undertaken: Someone must be identified to complete a Safeguarding Adults Pressure Ulcer Investigation Report (see section **1.14**). This person should be independent of the service provider. They could be: • A Tissue Viability Nurse. • Senior District Nurse. • Social Worker – with support/specialist advice from the Tissue Viability Nurse. If the referral identifies other concerns as well as the pressure ulcer(s) then a strategy discussion/meeting should be undertaken to so that information can be shared and agreement on how to proceed with the investigation/ assessment, can be made considering all known facts. It can be face to face or by telephone and should start to bring together the intelligence, held in different agencies, about the adult at risk, the person causing harm and approaches that each agency can take to instigate protective actions.

STRATEGY DISCUSSION / MEETING	The strategy discussion/meeting: • Must involve all agencies that have or had contact with the adult at risk. • Should involve a discussion with the police. • Will identify how a health assessment can contribute to the discussion/meeting. • Can consider if photographic evidence is required • Must identify a lead person and support officer for the investigation and • Will set the scope of the investigation. A record of the strategy discussion/meeting will be made. Strategy discussion/meeting should take place within 5 working days of the referral.

INVESTIGATION / ASSESSMENT	Any investigation/assessment in relation to pressure ulcers should involve the completion of a Safeguarding Adults Pressure Ulcer Investigation Report (see section **1.14**). The investigation/assessment in relation to the pressure ulcer(s) should be sufficient so a decision can be made as to if the: ✓ Pressure ulcer was unavoidable due to the individual's health and the service they were receiving had taken all appropriate measures available to them in a timely manner. **NO FURTHER SAFEGUARDING ACTION REQUIRED** **OR** **X** Pressure ulcer was avoidable and the result of neglect because the service and support they were receiving had NOT taken all appropriate measures available to them in a timely manner. **FURTHER SAFEGUARDING ACTION REQUIRED such as a Protection Plan AND at this stage the police must be involved when willful neglect may be considered.**

CASE CONFERNCE	The case conference is the main forum for sharing information, analysing risk and planning for future protection and risk management. The case conference should decide if: • **No further safeguarding activity is required.** Further care management involvement or referral on to another agency may however be required. • **A protection plan required.** An individual's refusal to accept a protection plan must be recorded and alternative support and advice should be provided if possible. • **A support plan is required for the person causing the harm.** The needs of the person causing the harm must not be forgotten in the safeguarding adult's process. The case conference must agree how, who and when the needs of the person causing harm will be identified and actioned. • **Any action is required in relation to the person causing harm**. Different action will be required depending on who the person causing harm is. • **There are any issues for the services involved.** For example: staff training, staffing levels. • **There are any issues for commissioning and contracting** For example: temporary stop on using the service, increased monitoring etc. • **There are any issues for multi agency working.** For example: multi agency procedures require reviewing, there were concerns about a partner agency participating in the investigation, or a SCR is required.

PROTECTION PLAN	A protection plan is a risk management plan aimed at removing or minimising risk to the person and others who may be affected if it is not possible to remove the risk altogether. It will need to be monitored, reviewed and amended/revised as circumstances arise and develop. A protection plan **MUST** be developed when: • it is believed someone **has** suffered **significant harm** • it is believed someone is **likely** to suffer **significant harm** • when the risk assessment harm is category **Red 9**. • individuals are the victims of repeat safeguarding incidents For further guidance see Solihull Local Practice Guidance 20.

PROTECTION PLAN REVIEW	The case conference will decide when the protection plan will be reviewed. It should be no less than every 6 months. Situations that have been identified as HIGH RISK using the Safeguarding Adults risk matrix should set a review date at no less then 3 months. Stable situations may change from Protection Plan to Care Management after first review.

CLOSURE	Closure is when the Safeguarding Adults investigation is concluded. This includes all corresponding actions being completed and where relevant the development of an effective protection plan for the adult at risk. The purpose of closure is to ensure all actions are completed or are in progress, including that: • all records are completed and contain all relevant information • the adult at risk knows the outcome of the investigation • the adult at risk knows that the process is concluded and who to contact if they have any future concerns about abuse • feedback has been given to all relevant parties including the alerter, the person alleged to have caused harm and any significant others • all those involved with the person know how to re-refer if there are renewed or additional concerns.

1.15 .

The investigation and subsequent report will consider and comment on the following and can be presented in the form of a Chronology or written text report:

The Safeguarding Adults Pressure Ulcer Investigation Report	
1	**The Individuals relevant past history.**
	Significant health history – physical and mental *Has there been rapid onset and deterioration in health* *Individuals compliance, capacity and behaviour*
2	**The Individuals Care Regime**
	Where were they at the time the pressure ulcer was identified? *Where were they prior to this?* *Were they receiving support from a regulated service – what is their quality rating?* *What is Care Contracts view of the quality of care provided by this service? Are there other recent similar incidents?* *Were they assessed? – was the assessment robust?* *Did the individual care plan identify risk and appropriate measures to be taken?* *Was there specialist equipment in place?* *Is there evidence the care plan was implemented?* *Is the service able to give account for staff skills, competences in this area and staff to resident/patient ratio – days and nights?* ***OR*** *Were they living alone?* *Who was providing support?* *What is the relationship?* *Carer's description, age, disability etc.* *Support networks?* *Was support and help sought? When? From whom?* *Was support accepted – all, in part, none?*
3	**The Individuals Mental Capacity**
	Mental Capacity assessment completed?
4	**The Individual mobility**
	History and just prior to pressure ulcer identification *Did the care plan include care needs specific to mobility?*
5	**Hydration and Nutrition**
	Evidence of intake monitoring *Fluid monitoring* *Regular weight records – any cause for concern.* *Care plan includes hydration and nutrition.*

<table>
<tr><td>6</td><td colspan="3">Medication
Note use of sedation – is the individual immobile for extended periods?
Is pain assessed and managed?</td></tr>
<tr><td>7</td><td colspan="3">Individual’s general appearance
At the time of the referral what were the general indicators of care? Clean nails, emaciated, oral care, lucid, generally well presented?</td></tr>
<tr><td>8</td><td colspan="3">Individuals and relatives/significant others views
What is the individual’s view of the care and support they have received?
What are the views and opinions of the individual’s relatives/significant others, of the care and support the individual has received?</td></tr>
<tr><td>9</td><td colspan="3">Conclusion - What does the above suggest/indicate?</td></tr>
<tr><td></td><td>Pressure ulcer was unavoidable</td><td>OR</td><td>Pressure ulcer was avoidable</td></tr>
<tr><td></td><td>“Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had:

- evaluated the person’s clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and
- recognised standards of practice;
- monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or
- the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence”.</td><td></td><td>Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:
- evaluate the person’s clinical condition and pressure ulcer risk factors;
- plan and implement interventions that are consistent with the persons needs and goals, and
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</table>

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Tissue Viability Assessment Tool

(Ref: Waterlow)

			Name:- Date/Time of Assessment & Assessors Initials					
Body Mass Build / weight for height (Choose 1 category)	Average Above Obese average Below average	0 1 2 3						
Continence (Make one selection)	Complete/catheterised Urine Incontinent Faecal incontinence Urine & Faecal	0 1 2 3						
Skin (More than one selection can be made)	Healthy Tissue paper Dry Oedema Clammy/pyrexia Discoloured Grade 1 Pressure ulcer Grade 2-4	0 1 1 1 1 2 3						
Mobility (More than one selection can be made)	Fully mobile Restless & fidgety Apathetic Restricted Bed-bound Chair-bound	0 1 2 3 4 5						
Gender & Age (More than one selection can be made)	Male Female 14-49 years of age 50-64 65-74 75-80 80+	1 2 1 2 3 4 5						
Malnutrition Has person unintentionally lost weight recently – if Yes – by how much (Make one selection)	Up to 5kg 5-10kg 10-15kg >15kg If NO but is eating poorly Unsure or Nil by mouth	1 2 3 4 2 3						
Special Risk Factors (More than one selection can be made)	Smoking Anaemia (Hb<8) PVD Single organ failure Multi organ failure Terminal cachexia	1 2 5 5 8 8						
Neuro Deficit (Score up to a max of 6)	Diabetes, MS, CVA, Paraplegia, confusion, dementia	4-6						
Visits Per Day (Make one selection)	Less than 1 visit per day One visit per day One – 3 visits per day More than 3 visits a day	4 3 2 1						
Medication (Score up to a max of 4)	Cytotoxics, high dose/long term steroids, inotropes	1-4						
TOTAL								
RISK	Below 10 unlikely to be a risk		**10+ At Risk Care Plan Required**		**15+ HIGH Risk Care Plan Required**		**20+ Very High Risk Care Plan Required**	

Working Together to safeguard adults in Solihull

Body Map Guidance

The following Body Maps should be used to document and illustrate visible signs of harm and physical injuries.

Clearly marked on the body map:

- Pressure ulcers
- Red areas
- Bruises
- Cuts, lacerations and wounds
- Scalds and burns
- Swellings.

Provide details such as:

- Size
- Colour
- Grade of pressure ulcer – if known.

Always record:

- The date of the record
- The time the record was made and
- The name and designation of the person making the record.

Use the notes section to add any further comments.

As the wound or mark changes, a new record should be made.

A copy of all body charts must be kept in the individuals records.

Always use a black pen and never use Tipex or an equivalent eraser.

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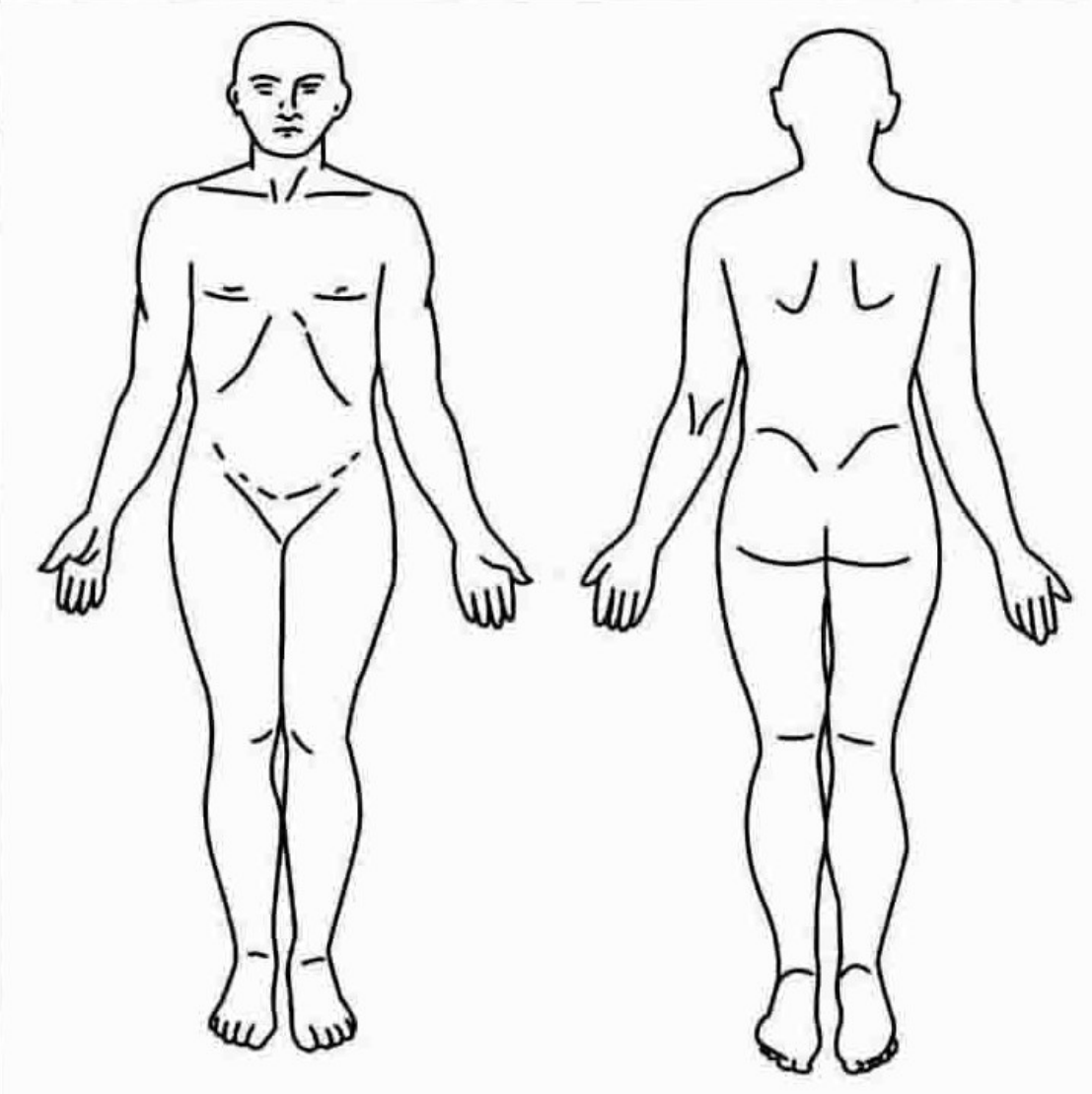
Body Map

Name: ……

Date: ……



Notes:……

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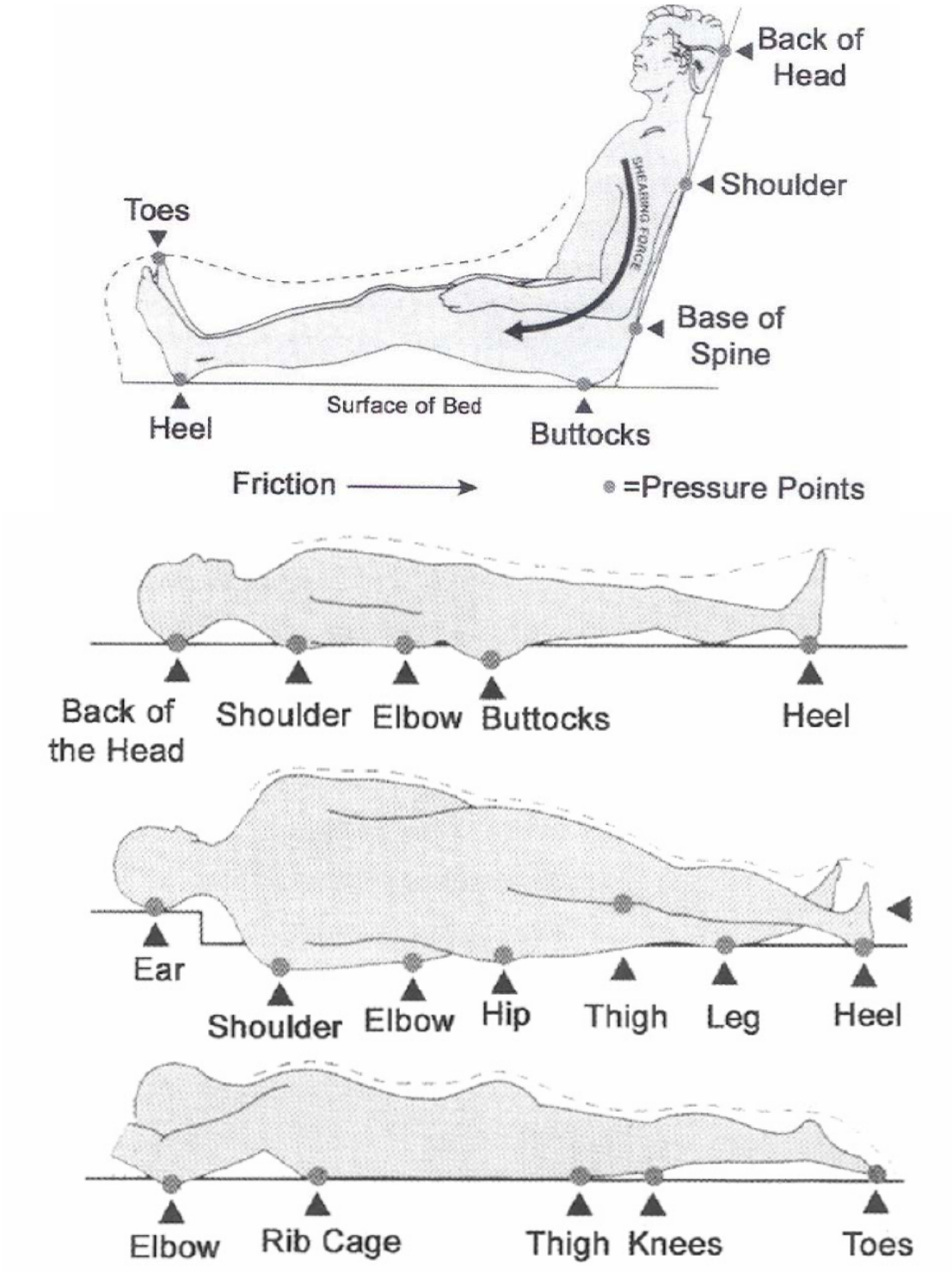
The most common places for pressure ulcers (ref: Your Turn Campaign)



Quick test – How at risk are you?

	✓
Are you over 65?	
Restricted mobility?	
Incontinent?	
Is your skin dry, clammy or reddened?	
Above or below average weight?	
Has you appetite changed or have you lost weight?	
Do you have anaemia?	
Do you have diabetes?	
Have you had major surgery?	
Do you smoke?	
Do you have organ failure?	
Total number of ✓	

If you answer yes to 3 or more, you MAY be at risk. For a complete test refer to- **Tissue Viability Assessment Tool** (Ref: Waterlow) or consult a health care professional.

GLOSSARY

Avoidable Pressure Ulcer	"Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: • evaluate the person's clinical condition and pressure ulcer risk factors; • plan and implement interventions that are consistent with the persons needs and goals, and • recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."
Contracture	Contractures are the chronic loss of joint motion due to structural changes in non-bony tissue. These non-bony tissues include muscles, ligaments, and tendons. They can occur at any joint of the body as a result of immobilization from injury or disease; nerve injury, such as spinal cord damage and stroke; or muscle, tendon, or ligament disease.
CPAP	CPAP, or continuous positive airway pressure, is a treatment that uses mild air pressure to keep the airways open. CPAP typically is used by people who have breathing problems, such as sleep apnea.
Friction	Rubbing the skin
Non Invasive Ventilation (NIV)	Non-invasive ventilation (NIV) refers to the provision of ventilatory support through the patient's upper airway using a mask or similar device.
Pressure	The weight of the body pressing down on the skin
Shear	The layers of the skin are forced to slide over one another or over deeper tissues, for example when you slide down, or are pulled up, a bed or chair or when you are transferring to and from your wheelchair.
Unavoidable Pressure Ulcer	"Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had: • evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and • recognised standards of practice; • monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or • the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence".

No Pressure Ulcers

Nutrition

Observation - skin inspection

Prevention is better than cure

Risk is predictable

Equipment, aid and adaptations

Some people are more vulnerable to pressure ulcers

Skin care

Understand individual's roles and responsibilities

Review – Individual's care & capacity, practices & systems

Education and training

Up and walking, turning, elevation

Lift - don't drag

Continence

Everybody's business

Record keeping

Safeguarding