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Abertawe Bro Morgannwg
University Health Board

Policy for the Prevention and Management of Pressure Ulcers

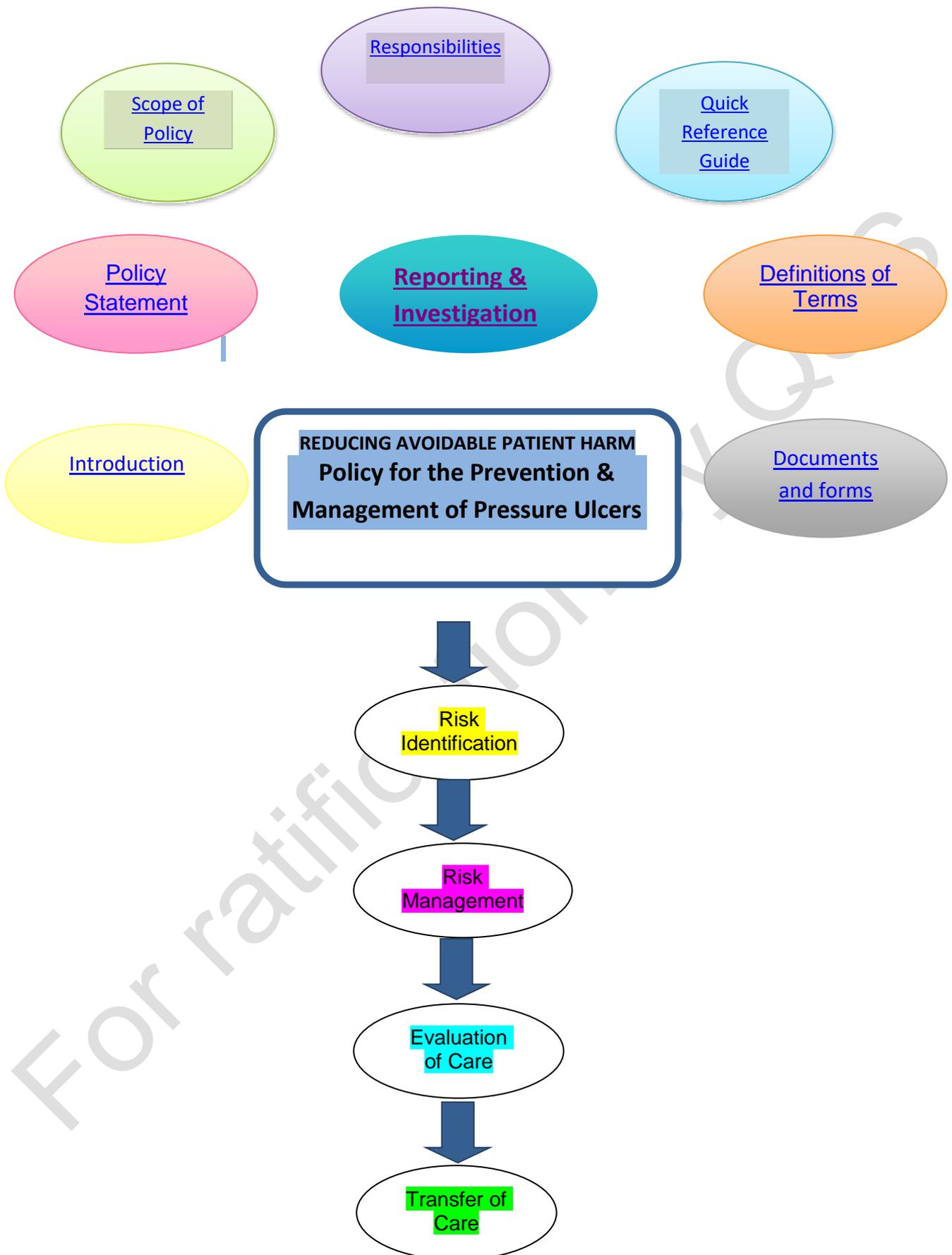
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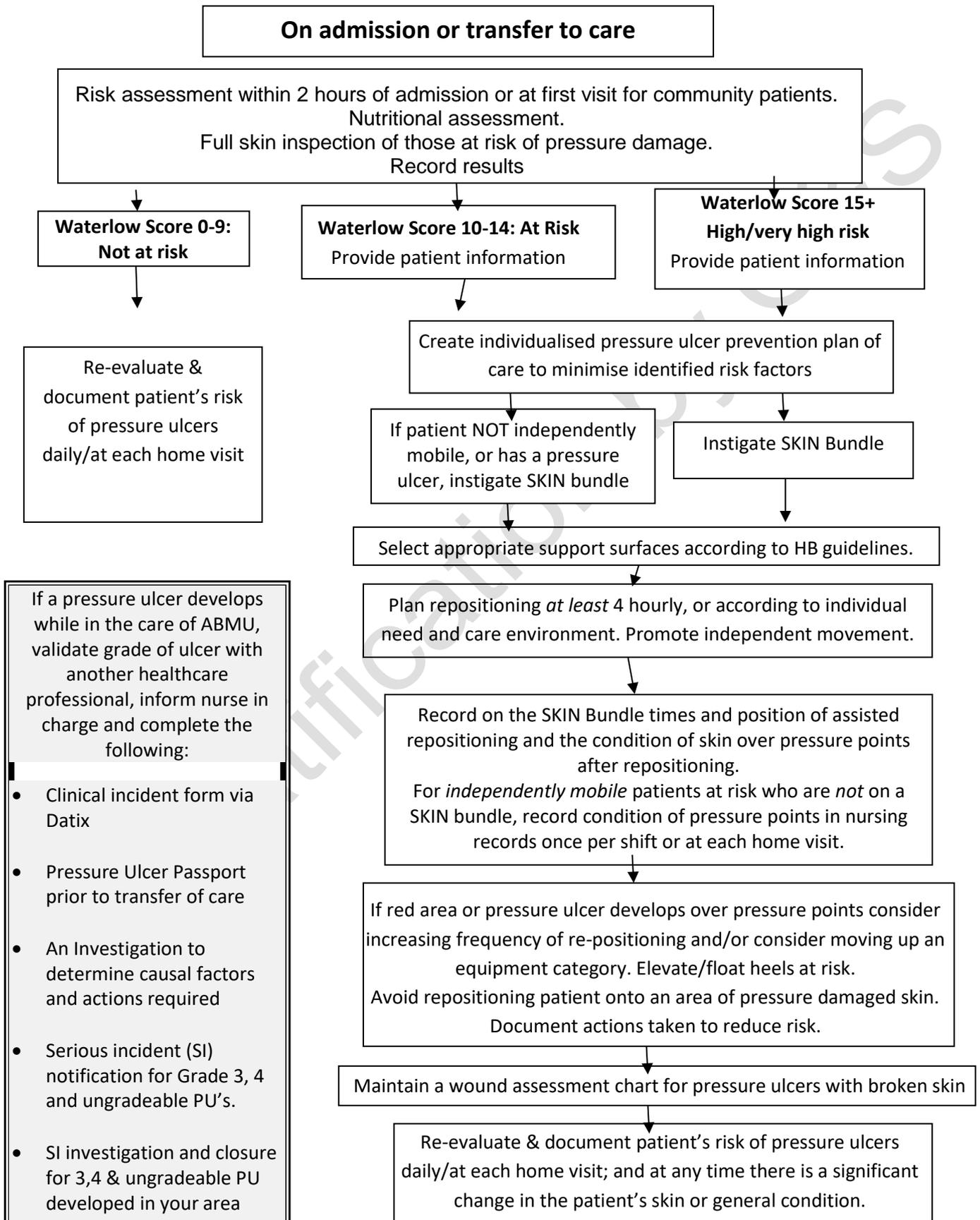
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Further guidance and specific advice and on preventing and managing pressure ulcers can be found in [Essential Elements of Pressure Ulcer Prevention and Management. All Wales Guidance](#)

PRESSURE ULCER PREVENTION

Quick Reference Guide



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1. INTRODUCTION

Abertawe Bro Morgannwg University (ABMU) Health Board is committed to a culture of delivering high level care and this includes a zero tolerance to the development of avoidable pressure ulcers and to the avoidable deterioration of existing pressure ulcers.

Preventing pressure ulcers remains one of the greatest healthcare challenges today in terms of reducing patient harm. Despite progress being made in the prevention and management of pressure ulcers they remain a significant healthcare problem. They are associated with reduced quality of life affecting the individual's physical, social and emotional wellbeing. Not all pressure ulcers can be prevented, but the number and severity of pressure ulcers can be reduced by effective prevention and management (Beldon 2014, NICE 2014).

2. POLICY STATEMENT

ABMU Health Board will ensure appropriate care and management is provided for individuals at risk of, or with pressure ulcers. Pressure ulcer prevention practices will be implemented across ABMU Health Board that are consistent with best practice and research evidence (National Institute of Clinical Excellence (NICE) 2015; European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel/Pan Pacific Pressure Injury Alliance (EPUAP /NPUAP/ PPIA) 2014; All Wales Tissue Viability Nurse Forum (AWTVNF) 2017; Welsh Government 2015)

This policy will replace the existing policy for the Prevention and Management of Pressure Ulcers (CID2456).

3. PURPOSE & SCOPE

The purpose of this policy is to ensure best practice following national and international guidance and to minimise the potential for inconsistency in care through standardising approaches to pressure ulcer prevention and management.

This document is relevant to all clinical staff employed or contracted within ABMU Health Board including medical staff, nurses and allied health professionals and is designed to:

- inform staff of their roles and responsibilities in relation to pressure ulcers
- provide direction regarding risk assessment and mitigation of risk
- act as a resource for staff caring for individuals with or at risk of pressure ulcers
- ensure effective monitoring, reporting and investigation of pressure ulcers

4. RESPONSIBILITIES

4.1 Pressure Ulcer Prevention Strategic Group (PUPSG)

The PUPSG has been nominated by the Assurance and Learning Group to support its role and function in its responsibility for ensuring the quality and safety of healthcare in relation to the prevention, assessment and management of pressure ulcers in line with Health and Care Standard 2.2 (2015).

The PUPSG provides a means for the six ABMU Health Board Service Delivery Units to work collaboratively to develop a quality improvement programme which is a vehicle for reducing the incidence of avoidable harm from health acquired pressure damage. It will assist the Assurance and Learning Group in measuring the success of quality improvement goals by sharing learning and best practice and identifying trends that should be taken into account in improving care and escalating risks.

4.2 Service Delivery Units (SDU)

The Service Delivery Unit's Nurse Director and Medical Director are responsible for ensuring the provision of adequate resources in relation to pressure ulcer prevention and management. This includes: staffing levels, equipment, wound management materials and access to on-going education and training for staff.

The Service Delivery Unit's Nurse Director and Medical Director are responsible for ensuring systems are in place to audit pressure ulcer prevention documentation and for peer review scrutiny of ABMU Health Board acquired pressure ulcers.

4.3 Risk Management Team

The Risk Management team will collate Datix-Web reported incidents of pressure ulcers. The incident data will be presented in the monthly ABMU Health Board Performance Score Card.

4.4 Medical Staff

Medical staff are responsible for:

- keeping their knowledge and skills in pressure ulcer prevention and management care up to date
- assessment, management and review of patient's general medical condition
- liaison and referral to other healthcare professionals

4.5 Registered Nurse in Charge of Clinical area/team

The practitioner in charge of clinical area/clinical team is responsible for:

- Ensuring that appropriate resources are available locally to meet identified needs and reporting any deficit in resources to their line manager, including the need for training.
- Supporting the use of pressure ulcer prevention and management documentation, to include: risk assessment tools, individualised care plans, SKIN Bundles, wound assessment charts and wound management care plans; and for monitoring local compliance.
- Ensuring Datix incident reporting forms are completed for pressure ulcers and for any deterioration of existing pressure damage. Validation of correct grading of each ABMU Health Board acquired pressure ulcer.
- Review and investigation of pressure ulceration incidents to determine whether the pressure ulcer is avoidable or unavoidable. Identify causal factors, develop local action plans and instigate any local remedial action required.

4.6 Registered Nurse

The registrant is responsible for:

- Keeping their knowledge and skills in pressure ulcer prevention and management up to date.
- Undertaking a comprehensive assessment of the patient, identifying any pressure ulcer risks, creating an individualised management plan and where appropriate:
- Ensuring the patient is nursed on a pressure relieving surface which minimises

direct pressure, shear and friction.

- Ensuring a repositioning schedule is agreed and implemented according to individual patient needs.
- Ensuring that a clear record of advice given and discussed with the patient (and carers when appropriate) and interventions provided are documented in the patient's notes (information leaflet: [English](#) or [Welsh](#)).

Reporting any ABMU Health Board acquired pressure ulcer to the practitioner in charge; entering the incident onto the Datix system; and completing a [Pressure Ulcer Passport](#).

The registrant must highlight any inadequate provision of interventions or resources to the practitioner in charge.

4.7 Tissue Viability Nurse (TVN)

The [Tissue Viability Nurse](#) is responsible for:

- Maintaining specialist knowledge and skills to expertly guide healthcare professionals, patients and carers, in the prevention and management of a range of skin integrity issues including pressure ulcers
- Assisting in the investigation and scrutiny of ABMU Health Board acquired pressure ulcers and sharing the learning to minimise future risk
- Improving the evidence based knowledge and skills of staff involved in the care of patients at risk of and with pressure ulcers through education and training
- Working in partnership with Service Delivery Units to support improvements in the prevention and management of pressure ulcers
- Validating Grade 3, 4 and ungradeable pressure ulcer

4.8 Pressure Ulcer Prevention and Intervention Service (PUPIS)

The Pressure Ulcer Prevention and Intervention Service (PUPIS) are responsible for:

- Providing a specialist service to community referrals for complex pressure ulcers that have not responded to a period of appropriate local management ([PUPIS](#))
- Provide access to a multi-disciplinary team including clinical scientists and rehabilitation engineers when appropriate
- Provide expert advice to help prevent the worsening of pressure ulcers and to promote healing, and where applicable recommend and/or provide

interventions

- Support Health Board professionals in increasing their knowledge and skills through information, education and training

4.9 Other Health Care Professionals

Health and care professionals are responsible for:

- maintaining an awareness of patients who may be at risk of pressure ulcers
- where appropriate, raising patient awareness using the public awareness leaflet ([English](#) / [Welsh](#))
- liaising with multidisciplinary team to ensure effective management of patients at risk of or with pressure ulcers
- liaison and referral to other healthcare professionals

5. RISK IDENTIFICATION

The prevention of pressure ulceration depends upon early identification of patients at risk, prompt recognition of skin changes and implementation of an appropriate management plan.

Every patient's risk of developing pressure ulcers must be assessed by a registered nurse on admission to hospital, referral to a service/case-load or when transferred to another clinical area, using the [Waterlow Risk Assessment](#) tool for adults and the [Glamorgan Tool](#) for paediatrics.

Pressure ulcer risk assessment, including a comprehensive skin assessment, must be completed and documented within 2 hours of admission to hospital/unit and on the first visit for patients in their own home.

An ABMU Health Board nutritional risk assessment must be completed on admission to hospital/caseload and the results acted upon.

For in-patients, Waterlow pressure ulcer risk assessment must be re-calculated every day and whenever there is a significant change in condition. For community patients, pressure ulcer risk must be re-assessed and recorded at each visit to the patient's home (recorded once daily if multiple visits made in 24 hours).

Patients must have a SKIN Bundle for Pressure Ulcer Prevention ([hospital](#), [community](#)) implemented if they are:

- at high risk of developing pressure ulcers (Waterlow 15+) *or*
- not independently mobile *or*
- have a pressure ulcer *or*
- based on clinical judgement

6. RISK MANAGEMENT

6.1 INDIVIDUALISED PLAN OF CARE

A registered nurse will develop and implement an individualised plan of care to minimise the impact of identified risk factors, where possible, in conjunction with the patient. The plan must incorporate the principles of SKIN: Surface, Keep moving, Incontinence and Nutrition.

- Provide the patient and/or carers with an explanation and information (information leaflet: [English](#) or [Welsh](#)) on how to:
 - reduce their risk of pressure ulcers
 - identify early changes in skin over pressure points
 - who to contact for advice

Surface

Follow the ABMU Health Board equipment selection guide ([in-patient](#), [community](#)) to select appropriate pressure reducing equipment according to the patient's level of risk, condition and location of pressure ulcers and acceptability to the patient. The equipment selection must consider the size of the patient and all support surfaces used by the patient. Document the equipment selected, when it was ordered and when it became available for the patient to use. If there is a delay in providing the selected equipment, document the remedial action taken to reduce risk and escalate supply issue.

The correct functioning and suitability of the equipment must be checked, to ensure the equipment is working as intended, each time the patient is repositioned, or at each

visit in the patient's home ([equipment leaflet](#)). Any equipment failure and the actions taken to reduce the immediate risk must be recorded in the patient's records.

Keep Moving

Patients should be encouraged to keep moving or be repositioned with assistance. The frequency of repositioning should be appropriate for the individual, their wishes and needs; and the care environment. Repositioning is recommended *at least* every 4 hours for adults at high risk (NICE, 2015). The recommended repositioning frequency must be documented in the plan of care/nursing records.

Reduce the risk of skin damage caused by friction and shear by using appropriate manual handling techniques. Patients at high/very high risk of developing heel pressure ulcers and those with existing heel damage must have their heels kept elevated from the support surface. Ensure foot wear is appropriate and correctly fitting and any device used is fitted correctly.

Patients with pressure ulceration to the sacrum or buttocks should avoid sitting until the pressure ulcer/s show signs of healing. When healing is evident, sitting out in an appropriate chair with a pressure reducing cushion may be appropriate for 1 -2 hour periods. If deterioration in the ulcer/s is noted, nurse in bed and re-evaluate the sitting plan. The risks and benefits of supported sitting must be weighed against the benefits to physical and emotional health.

Incontinence

Moist skin increases the risk of pressure damage and any patient experiencing incontinence should have their skin kept clean and free from excess moisture.

If incontinence is an issue the healthcare professional should complete the [All Wales Bladder and Bowel Assessment](#) in order to identify and treat any underlying bladder or bowel incontinence. If the incontinence does not improve by following the recommendations at assessment then a referral to the [Continence Team](#) would be the next step.

For patients with intractable incontinence use well-fitting continence products and a

soap substitute to cleanse the skin. If barrier cream is used it should be compatible with incontinence pads, do not use oil-based barrier creams ([Moisture/skin care guidance](#)).

Nutrition

Complete a [Nutritional Risk Assessment](#) and document the results. Follow nutritional recommendations according to risk score to ensure optimal nutritional intake and keep the patient well hydrated.

6.2 DEVICE RELATED PRESSURE ULCER RISK

Medical devices must be applied by a healthcare practitioner who has received training to apply the device. In the case of casts, splints, braces and collars the practitioner must be competent. Staff looking after a patient fitted with a device that they are unfamiliar with must seek management advice from the practitioner or specialty that applied the device.

Pressure ulcers can develop as a result of medical devices used for monitoring or treatment, even though the patient may not be considered at risk of pressure ulcers when using a traditional risk assessment tool. Some devices may be able to be removed or repositioned, although others are non-removable. Pressure ulcers caused by medical devices must be reported as a clinical incident on Datix.

Staff must be vigilant for signs that a pressure ulcer may be occurring as a result of using a device by observing the skin for changes (for removable devices) and for any concerns from the patient about the device hurting or feeling tight. Skin changes under a device must be recorded in the nursing records. If pressure damage is noted consider if the device can be repositioned, removed or altered to relieve pressure. If it is non-removable contact the practitioner or department responsible for applying the device to review the patient. Record management to reduce further risk of pressure damage under the device.

6.3 CHALLENGES IN RISK MANAGEMENT

A patient with mental capacity may disagree with the management plan suggested by

a healthcare professional and this decision must be respected. The healthcare professional will retain on-going responsibility for trying to discover the basis for the patient's refusal; presenting a rationale and information on why the intervention is important; and offering and designing an alternative, acceptable plan where appropriate. Details of discussions with the patient must be recorded in the nursing notes.

7. MANAGEMENT OF PRESSURE ULCERS

Pressure ulcers will be graded using the [EPUAP classification system](#). The grade of an ABMU acquired pressure ulcer should be validated by two healthcare professionals who have up to date knowledge and skills in pressure ulcer grading.

Pressure ulcers where the skin is broken (open wound) must be recorded using the ABMU [Wound Assessment chart](#) and a [wound management care plan](#) designed to identify goals of management and monitor progress towards healing. Wound dressings must be selected from the [ABMU wound dressing selection guide](#) to meet the goals of management.

Pressure ulcers with dry, stable necrosis on the lower limb do not require a dressing until the necrosis starts to soften (autolytic debridement).

Grade 3, 4 and ungradeable pressure ulcers are considered Serious Incidents (SI) and should be referred to the [Tissue Viability Nurse](#) for further assessment and management advice. This may not be necessary if the Pressure Ulcer Prevention Service ([PUPIS](#)) are involved.

8. EVALUATION OF CARE

Evaluation of the care delivered to reduce the risk of, or to manage pressure ulcers will determine whether the patient's condition is stable; has deteriorated or improved; and if planned interventions need to be adjusted. The evaluation of care record, for each shift or home visit, must include the condition of skin over pressure points for patients at risk pressure ulcers.

The plan of care and prevention strategies must be revised by a registered nurse whenever there is a change in skin condition over pressure points, a change in the patient's condition and/or risk factors. If there is a deterioration in the skin over a pressure point/s, act immediately to reduce the pressure or shear on the affected area and record the action taken.

9. TRANSFER OF CARE

Continuity of care needs to be maintained when patients move between care settings. There must be an accurate exchange of information between healthcare professionals regarding the patient's pressure ulcer prevention/management care requirements to ensure safe transfer of care and/or discharge.

For planned transfers of care the transferring area must communicate the patient's risk score, management plan and the condition of skin over pressure points to the receiving health care professional. There must be confirmation that pressure reducing equipment required by the patient is available in the receiving area prior to the patient being transferred.

If the patient has a pressure ulcer a completed [Pressure Ulcer Passport](#) must accompany the patient on transfer/discharge.

10. REPORTING AND INVESTIGATION OF PRESSURE ULCER

10.1 Reporting Pressure Ulcers

Pressure ulcers, [Grade 1, 2, 3, 4, suspected deep tissue injury \(SDTI\) and ungradeable](#); including pressure ulcers that are determined to be as a result of pressure from a medical device; must be reported as a clinical incident using Datix within 48 hours of discovery. Following reporting on Datix, a [Pressure Ulcer Passport](#) must be completed for the patient to be sent with the patient on planned transfer or discharge.

Patients admitted to hospital or caseload with an existing pressure ulcer who do not have a [Pressure Ulcer Passport](#) or have a passport containing incorrect details/grading

of the pressure ulcer/s must have the pressure ulcer reported on Datix as *developing prior to admission* and a new pressure ulcer passport completed for transfer of care.

It is the responsibility of the Unit that identifies the pressure ulcer to report the pressure ulcer. If the pressure ulcer is believed to have developed prior to admission to the Service, the incident must be transferred to the Service where it is believed the pressure ulcer has developed to lead on the investigation process. The Unit must notify the relevant service prior to transferring the incident and obtain agreement that the Unit accept the incident on Datix and take necessary action.

Pressure ulcers that have been reported as clinical incidents via Datix that then deteriorate must have the original Datix entry amended to reflect this.

When pressure ulcers (grade 3, 4 and unstageable) has occurred Health Boards are required to formally report to Welsh Government via the serious incident reporting mechanisms. During the investigation stage via Datix for Wards that fall under the Nurse Staffing Levels (Wales) Act, it will be established as to whether the agreed Planned Roster for that area was met. If the Planned Roster was **not** maintained during which time the pressure damaged occurred, an investigation must be completed on the actions taken in an attempt to provide the correct number of nurses to meet the roster. This is reported to the Executive Board bi-annually and Welsh Government 3 yearly.

10.2 Investigation of Pressure Ulcers

A two-stage investigation process must be followed for pressure ulcers [Grade 2, 3, 4, ungradeable and SDTI](#) that **develop or deteriorate** in ABMU Health Board care or in ABMU Health Board commissioned care in order to:

- establish the cause of the pressure ulcer or its deterioration
- identify any contributing factors
- determine if the pressure ulcer was [AVOIDABLE](#) or [UNAVOIDABLE](#)
- develop and complete actions which address the issues identified

- share learning from the incident across the Health Board

Each Service Delivery Unit Nurse Director will determine the process for reporting the

investigation of pressure ulcers to their Quality and Safety Forum.

STAGE ONE

ABMU Health Board acquired pressure ulcers Grade 2, 3, 4, ungradeable and suspected deep tissue injury must be investigated using the Pressure Ulcer Investigation tool (located in Datix) by a healthcare professional of Band 6 or higher. The investigation must be completed in full and determine the causal and contributory factors for the pressure ulcer development.

The stage one investigation will be subject to a scrutiny process to determine if the pressure ulcer was [AVOIDABLE](#) or [UNAVOIDABLE](#), identify actions required and learning to be shared that address any issues identified.

If the pressure ulcer has been identified as AVOIDABLE, please refer the matter to the Service Delivery Unit to consider the need for Redress- please see 10.6 below.

STAGE TWO

Community Acquired Pressure Ulcers:

The stage two scrutiny of avoidable Grade 2 pressure ulcers that develop in the community setting can be conducted by a healthcare professional senior to the stage one investigator. The stage two scrutiny process and outcome will be recorded on the governance/scrutiny form (located in Datix).

A Community [Peer Review Scrutiny Panel](#) must as a minimum requirement, scrutinise unavoidable Grade 2 pressure ulcers and all Grade 3, 4, SDTI and ungradeable pressure ulcers (avoidable and unavoidable). The stage two scrutiny process and outcome will be recorded on the governance/scrutiny form (located in Datix).

Hospital Acquired Pressure Ulcers:

Hospital acquired pressure ulcers must be scrutinised by a [Peer Review Scrutiny Panel](#). The stage two scrutiny process and outcome will be recorded on the governance/scrutiny form (located in Datix).

10.3 Pressure Ulcer Prevention Strategy Group (PUPSG)

A summary of actions required and learning identified from pressure ulcer investigations undertaken in the individual Service Delivery Unit's will be reported to the PUPSG for discussion at the quarterly meetings.

10.4 Safeguarding

All instances of Grade 3, Grade 4 or Ungradable pressure ulcers that develop when the patient is under Health Board care must be forwarded to Safeguarding for review by the **incident approver**. Approvers may also forward for review, other pressure ulcer incidents where there is a reasonable suspicion that neglect may have contributed to the ulcer development.

If evidence suggests that there is a trend or pattern of pressure ulcer development in a clinical area, a discussion must take place with the Safeguarding team.

The ABMU Health Board Safeguarding Team will review all incidents of pressure ulcers that are forwarded to them by the incident approver. Forwarding will be triggered by selecting '**YES**' in the box '**Is this a Safeguarding Adult Incident**' within the DATIX record.

NOTE – it will not be necessary to automatically generate an Adult at Risk (VA1) referral at this stage. If such referral is assessed as required, the Safeguarding Team will advise the approver accordingly.

10.5 Serious Incident Reporting for Pressure Ulcers

A Serious Incident (SI) must be submitted to Welsh Government (WG) for all individuals with Grade 3, 4 and ungradeable pressure ulcers who are in receipt of commissioned health care. An SI will consist of a notification of the pressure ulcer submitted to WG, investigation of the incident and a closure form that is submitted to WG.

Notification of a Serious Incident

An SI notification form should be submitted by the first area to identify the Grade 3, 4 or ungradeable pressure ulcers – this may not necessarily be the area of origin. This SI notification should be submitted to Serious Incident team within 24 hrs of the

pressure ulcer discovery.

Serious Incident investigation

An SI investigation should be undertaken for all Category/Grade 3, 4 and ungradeable pressure ulcers by the relevant team in the Health Board responsible for the care setting where the pressure ulcer occurred. The ABMU Health Board pressure ulcer investigation process should be used for this investigation.

Submission of a Serious Incident Closure Form

The SI closure form should be submitted within 60 days of the initial notification. The closure form must include whether the pressure ulcer was determined as avoidable or unavoidable and incorporate evidence of the investigation and learning from the pressure ulcer investigation and scrutiny (include the investigation tool and panel scrutiny forms from Datix).

10.6 Redress

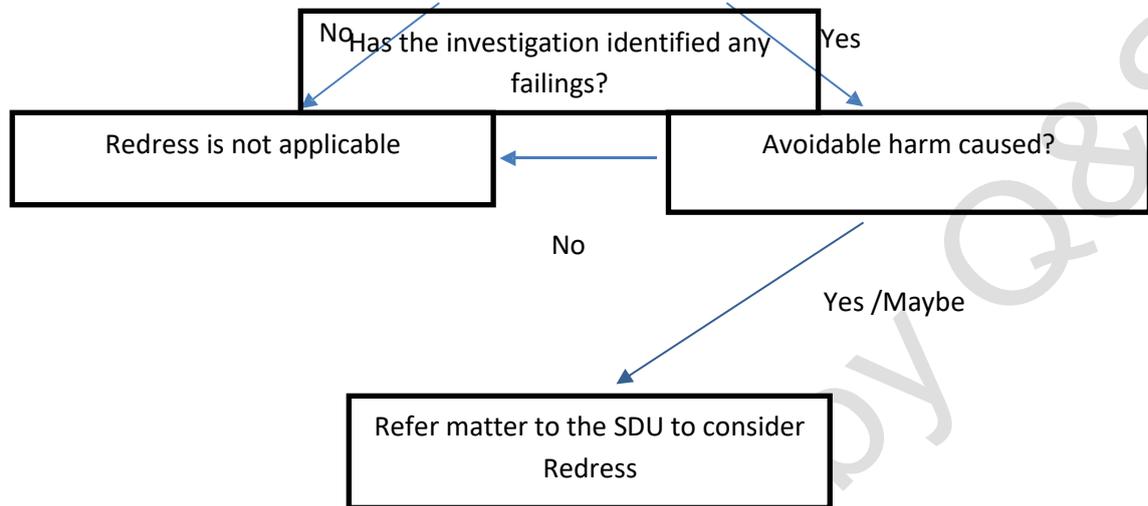
Once a pressure ulcer is determined to be **AVOIDABLE** and failings have been identified, refer the matter to the Service Delivery Unit to consider whether any of the failings constitute a breach of duty of care and whether redress is appropriate.

Breach of duty is established where the standard of treatment/care given falls below the standard of a reasonably competent medical practitioner in the relevant field at the relevant time.

If any avoidable harm has been caused to the patient, ABMU Health Board must consider the need for redress. Redress can take the form of an apology, explanation, action plan, remedial treatment (where appropriate) and/or financial compensation.

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance places an obligation on the Health Board to consider Redress in situations where harm has/may have been caused as a result of the Health Board's breach of duty. For further details, please go to: <http://howis.wales.nhs.uk/sites3/Documents/743/83.%20Putting%20Things%20Right%20Policy.pdf>

It is the responsibility of the Service Delivery Unit to refer any matter where breach of duty has been established to the Redress Team- abm.claims@wales.nhs.uk.



11. LINKING POLICIES AND GUIDANCE

This policy should be read in conjunction with:

- Essential Elements of Pressure Ulcer Prevention and Management Guidance CID
- Wound Management Policy CID1392
- **Pressure Ulcer Reporting and Investigation All Wales Guidance (2018)**
- Tissue Viability Nurse Referral Procedure CID1394
- Safeguarding Vulnerable Adults CID722
- Consent In Healthcare CID1814
- Discharge Policy CID1308
- End of Life Policy CID1276b
- Manual Handling Policy CID510
- Standard Infection Control Precautions CID892
- Mental Capacity Act 2005
- Putting Things Right Policy 2015

12. DOCUMENTS AND FORMS

[Pressure Reducing Equipment Selection chart – Hospital](#)

[Pressure Reducing Equipment Selection Chart – Community](#)

[Pressure Ulcer Classification Guide EPUAP](#)

[Pressure Ulcer Grade Identification Flow Chart](#)

[Open Wound Care Plan](#)

[Pressure Ulcer Prevention Care Plan](#)

[Glamorgan Paediatric Risk Assessment Chart](#)

[Serious Incident Reporting Flow Chart](#)

[Waterlow Risk Assessment Tool](#)

[Pressure Ulcer Passport](#)

[Wound Assessment chart](#)

[ABMU wound dressing selection guide](#)

SKIN Bundle: [Hospital](#)

SKIN Bundle: [Community](#)

13. DEFINITION OF TERMS

Pressure Ulcer

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers (European Pressure Ulcer Advisory Panel EPUAP 2009). The aetiology of pressure ulceration can be complex and is affected by intrinsic and extrinsic factors.

Pressure ulcers are classified as Grade 1, 2, 3 and 4 according to the **severity of skin and tissue damage** using the [Pressure Ulcer Classification Guide EPUAP](#). There are two additional categories used when the full depth of the damage is obscured by devitalised tissue: suspected deep tissue damage (SDTI) and ungradeable.

A Moisture Lesion is defined as:

“Moisture lesions, moisture ulcers, perineal dermatitis, diaper dermatitis and incontinence associated dermatitis (IAD) all refer to skin damage caused by excessive moisture by urine and/or faeces being in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft.”

(Ousey et al, 2012) “Moisture lesions may develop slough if infection present.”
(www.pressureulcer.scot)

Avoidable Pressure Ulcers

‘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 were consistent with the person’s needs and goals, and the recognised standards of practice
- Monitor and evaluate the impact of interventions
- 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 were consistent with the persons needs and goals;
- recognised standards of practice;
- monitored and evaluated the impact of the interventions
- revised the approaches as appropriate

OR

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

Risk Assessment Tools

The pressure ulcer risk assessment tool used in ABMU Health Board for adults is the [Waterlow Risk Assessment](#) and for paediatrics is the [Glamorgan Paediatric Risk Assessment Chart](#).

Peer Review Scrutiny Panel

The purpose of the peer review panel meetings is to drive accountability and quality improvement relating to pressure ulcer prevention at a local level and to provide assurance to Service Delivery Unit Directors. Peer review scrutiny panel meetings will be convened to scrutinise pressure ulcer incidents that develop in ABMU care and will form stage two of the two-part pressure ulcer investigation. The frequency of the meetings will be determined by the volume of incidents to ensure risk is managed in a timely manner.

The panel will determine if the pressure ulcer is avoidable or unavoidable and identify issues that require action. The panel will feedback and share lessons learnt relating to pressure ulcer incidents to staff in their Service Delivery Unit and quarterly to the Pressure Ulcer Prevention Strategy Group.

The panel Chair will be a senior member of the nursing management team and membership will include relevant Service Delivery Unit nursing staff and a Tissue Viability Nurse. Members of the multidisciplinary team may be invited to attend

meetings as required as determined by the Chair e.g. physiotherapy, occupational therapy, doctor, governance team member.

The panel chair is responsible for developing Terms of Reference for the meetings and ensuring the meeting proceedings and outcomes are recorded.

14. REFERENCES AND BIBLIOGRAPHY

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