Maternity Pressure Area Care Guideline	
Summary statement: How does the document support patient care?	The purpose of this guideline is to provide clear guidance for all staff caring in regard to pressure area care. To maintain skin integrity and minimise the risk of damage to pressure areas during childbirth and the post natal period.
Staff/stakeholders involved in development: *Job titles only*	Clinical Effectiveness team, patient safety team, senior midwives, Trust Tissue Viability team
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Clinical Effectiveness Support Midwife, Tissue Viability
For use by:	All Obstetric and Midwifery staff
Purpose:	To provide evidence based guidance for staff to protect women having babies from pressure area damage.
This document supports: *Standards and legislation*	Clinical Guideline for the Prevention of Pressure Ulcers in Adults', NICE Pressure Ulcers: Prevention and management CG179, Clinical Guideline for Wound Management See Maternity Pressure Area Care intranet page
Key related documents:	**Maternity Guidelines** Labour Risk Assessment, Antenatal Care and Patient Information, Postnatal Care, Severely ill/High Dependency Care, Wound Management, Prevention of Pressure Ulcers in Adults
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1.0	July 2020	S. Harris, Tissue Viability, A. Clarke	Live	New maternity guideline
2.0				
3.0				

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Maternity Pressure Area Care Guideline

This guideline with appendices can be found on the intranet here

1.0. Aim

- To provide clear guidance for all staff caring for intrapartum and postnatal women with regard to pressure area care.
- To maintain skin integrity and minimise the risk of damage to pressure areas during childbirth and the post natal period.

2.0. Scope

- This guideline provides good evidenced-based practice for all staff to follow with regard to pressure area care for intrapartum and postnatal women.
- This guideline provides clear guidance on identifying those women at risk of pressure ulcers and facilitating the implementation of best practice.

3.0. Responsibilities

Midwives and Obstetricians are expected to:

- Access, read, understand and follow this guidance
- Use their professional judgement in the application of this guideline.

Management are expected to:

- Ensure the guideline is reviewed as required in line with Trust and National recommendations
- Ensure the guideline is accessible to all relevant staff.

4.0. Introduction

Pressure ulcers are damage caused to an area of skin and the tissues below as a result of blood supply impairment due to being placed under pressure. Pressure ulcers can occur in any patient, but they most typically occur in people confined to beds or chairs – either as a result of illness, impaired mobility or nutrition, poor posture or a neurological condition. Equipment not specifically designed to provide pressure relief can also cause pressure area damage. (NICE, 2014.) In maternity care, a woman's mobility can be restricted due to a number of reasons – for example, regional anaesthesia, operative delivery, perineal damage, as well as obstetric conditions such as pre-eclampsia resulting in poor maternal condition.

5.0. Risk assessment

All patients are potentially at risk of developing a pressure ulcer and should be assessed for risk on admission and if there is a change in clinical condition. A modified version of the PURPOSE T risk assessment tool (Appendix 1) to support clinical judgement can be found in the maternity notes.

The pressure ulcer risk category 'Red' (secondary prevention and treatment pathway), 'Amber' (primary prevention pathway), and 'Green' (no risk) must be clearly identified and communicated within the team and on transfer via the SBAR.

Risk must be re-assessed if there is a change in the patient's clinical status, for example:

- After surgery
- On deterioration of an underlying or obstetric condition
- A change in mobility, i.e. an epidural/spinal.

But also at the following times:

- On transfer to another ward
- During each postnatal assessment (daily on the ward)
- On discharge from the postnatal ward and from midwifery care (around Day 10-12).

When the risk category differs from that of previous assessments, the care plan must be reviewed and updated by the midwife.

6.0. Women at Highest Risk of Pressure Ulcers

All patients are potentially at risk of developing pressure ulcers; however, they are more likely to occur in women with the following:

- Limited mobility – for example, with regional analgesia, post-caesarean section, permanent disability, or those that are seriously unwell
- Limited activity – for example, women on continuous fetal monitoring
- A history of past or current pressure ulcers
- Diabetes mellitus
- Other long term conditions such as heart disease or rheumatoid arthritis
- Excessive moisture – for example, those who have ruptured membranes, limited bladder or bowel control, or are sweating heavily
- Poor circulation
- Poor dietary and fluid intake, or being over- or underweight
- Smokers
- Medical devices - in particular urinary catheters and CTG straps.

7.0. Care Planning

On completion of the risk assessment, a preventative care plan must be developed and documented in the notes. This should take into account the following:

- Identified risk factors including their mobility and ability to reposition themselves
- Other comorbidities
- The elements of the SSKIN care bundle:
    - **S**urface - timely provision of an appropriate mattress, and/or cushion
    - **S**kin assessment - consistent monitoring of pressure areas
    - **K**eep moving - a planned repositioning schedule with documented evidence that this has been undertaken

  - **I**ncontinence - a proactive approach to caring for the skin of the patient experiencing incontinence or where the skin is exposed to excessive moisture
  - **N**utritional monitoring and support.
- Patient preference

8.0. Surface: Pressure-reducing equipment

- Patients with grade 3 or 4 pressure ulcers should be provided with an alternating pressure system (see Appendix 2).
- Pressure-reducing equipment is accessed via the equipment libraries. If an alternating pressure mattress is not available from the Equipment Library, the protocol for accessing a rental system should be followed (available on the Equipment Library pages on StaffNet. Code for pressure relieving mattress: M/WM).
- Patients who are unable to move themselves from a seated position must be provided with a pressure-reducing cushion. When a cushion is being used, the patient needs to be able to sit with the feet flat on the floor, buttocks and thighs in parallel contact with the cushion, and back straight with hips, knees and ankles at 90º.
- Patients must continue to be repositioned whilst nursed on an alternating pressure system.
- All equipment used to reduce or redistribute pressure must be documented in the maternity notes.
- For more information on pressure-reducing equipment, please refer to the Trust 'Clinical Guideline for the Prevention of Pressure Ulcers in Adults' .

9.0. Skin Assessment

The frequency of skin assessment is based on the woman's risk category (green/amber/red), clinical condition and tissue tolerance of pressure. The assessment should take into account any pain or discomfort reported by the patient, and the skin should be checked for:

- Skin integrity in areas of pressure
- Colour changes or discoloration
- Variations in heat, firmness and moisture (for example, because of incontinence, oedema, dry or inflamed skin).

To test the tissue tolerance of pressure the **fingertip test** can be used:

- Reddened skin blanches under light fingertip pressure and flushes back on removal of the pressure
- Blanching hyperaemia is the normal tissue response to pressure relief and indicates that the micro-circulation is intact. A non-blanching hyperaemia is category 1 pressure ulcer.

Individuals with alterations to intact skin (changes in colour, temperature, skin texture, or pain over a bony prominence) must be recognised as being at risk of pressure ulcer.

9.1. Clinical indicators of compromised peripheral perfusion:

- Persistent erythema following removal of pressure
- Non-blanching hyperaemia

- Purple/blue discoloration
- Localised heat or coolness over a pressure point as compared to the temperature of adjacent tissue
- Localised oedema
- Localised induration (tissue stiffness)
- Discomfort or pain that may be attributable to incipient pressure ulcer.

In patients with darkly pigmented skin, it may not be possible to detect colour changes, but variations in skin temperature, firmness and moisture may be evident.

9.2. Recommendations for assessing dark pigmented skin

Skin pigmentation can mask the visual indication of erythema, and category 1 pressure ulcers are more likely to go undetected and deteriorate to full thickness pressure ulcers in darkly pigmented skin. Therefore, although erythema has been identified as the main indicator of pressure damage, this is not possible in darkly pigmented skin. Identifying first stages of pressure damage in dark skin are as follows:

- The colour of intact dark pigmented skin may remain unchanged (does not blanch) when pressure is applied over a bony prominence.
- Localised skin colour changes can occur where pressure is applied - these changes may differ from the individual's usual skin colour.
- Local areas of intact skin subject to pressure may feel either warm or cool when touched. This assessment should be performed without gloves to make it easier to distinguish differences in temperature. It is important to clean the skin of any body fluids before this direct contact.
- If a woman has had a previous pressure ulcer, the healed area may be lighter in colour.
- Areas of skin subjected to pressure may be purplish/bluish/violet in colour. This can be compared with the erythema seen in people with lighter skin tones.
- Oedema may occur with an induration (area of skin hardness) more than 15mm in diameter. The skin may be taut and shiny.
- Women may complain of or indicate current or recent pain or discomfort at body sites where pressure has been applied.

10.0. Medical devices

A medical device is defined by NPUAP (2015) as a 'device designed and applied for diagnostic or therapeutic purposes'. In maternity, this could include urinary catheters, oxygen masks, anti-embolism stockings or CTG straps.

When medical devices are in use, the woman's skin must be observed frequently for associated pressure-related changes, and every effort made to offload the pressure.

11.0. Documentation

A modified version of the PURPOSE T risk assessment tool can be found in all maternity care records. This risk assessment should be used for documenting pressure area care (see Appendix 1). Please state clearly if and why the woman has declined any care.

Pressure area care plans should be clearly documented in the maternity notes.

12.0. Nutritional monitoring

Assessment of the nutritional status of the patient is an integral component of the strategy for the prevention and treatment of pressure ulcers. Malnutrition compromises skin integrity and the healing of existing wounds.

In maternity, nutrition is unlikely to be an issue for most women. However, where possible, try to minimise times when nutritional intake is compromised for those at risk e.g. periods of pre-op fasting or nil by mouth.

13.0. Patient Advice and Information

During their pregnancy and whilst an inpatient, women should be directed to look at the information on 'Family Assist'. On admission to maternity wards, women should be informed of routine advice around pressure area care.

14.0. Optimal Intrapartum Pressure Area Care – think SSKIN

14.1. Skin care

- Regular changing of Inco pads to ensure skin is kept clean and dry – particularly if woman is draining liquor or is incontinent
- Use a cleansing foam as first-line product for cleaning women and avoid soap-products
- Use a barrier cream on areas exposed to moisture at least 3-4 times a day
- All cleaning and barrier products should be single-patient use only.

14.2. Women not at risk of pressure area damage – score = "green"

- Skin assessment on admission to maternity ward.
- Skin assessment and application of barrier cream if woman reporting any signs of compromised peripheral perfusion on her pressure areas at any point.
- Keep Moving: Encourage to mobilise independently.
- Keep Moving: Advise to not spend longer than 8-10 hours in bed.
- Incontinence/Moisture: Application of barrier cream if skin exposed to moisture and regular changing of pads.
- Nutrition: Encourage women to eat and drink normally (unless otherwise directed by a Doctor).

14.3. Women at risk of pressure area damage – score = "amber", and those scoring "red" due to a previous pressure ulcer

- Skin assessment on admission to maternity ward and when risk category changed (e.g. prior to epidural/spinal or caesarean section).
- For those scoring "red" for a previous pressure ulcer – document in notes the position and category of the previous pressure ulcer and if there is a visible scar. No Datix required. Consider use of pressure-reducing equipment or mobility aids – discuss with Tissue Viability if unsure.
- Skin assessment 2 hourly.
- Complete Labour PCEA Observation Chart (Appendix 7) colour score at each skin assessment if woman has an epidural.
- Keep Moving: Encourage/assist repositioning 1-2 hourly - if able to stand, they should be assisted to do so for at least 2 minutes.
- Keep Moving: Maximum optimum length of time spent in bed = Up to 12 hours.
- Incontinence/Moisture: Protect the skin from moisture with a barrier cream and cleanse the skin promptly after episodes of incontinence.
- Incontinence/Moisture: A barrier cream should be applied sparingly after every episode of incontinence, and at least 3-4 times per day.
- Nutrition: Monitor and support the maintenance of blood sugars in women with diabetes as per Trust Diabetes in Pregnancy guideline.
- Nutrition: Encourage women to eat and drink normally (unless otherwise directed by a Doctor).
- Use pelvic tilt on delivery beds to prevent woman from sliding and shearing skin.

15.0. Elective Caesarean Section Pressure Area Care – score = "amber"

- Skin assessment and barrier cream application on admission to maternity ward/ prior to LSCS.
- Skin assessment and barrier cream application prior to leaving theatre.
- Follow care for "women at risk of pressure area damage" above and "post-delivery pressure area care" as appropriate below.
- Nutrition: Consider hydration of women that are to be nil by mouth for a prolonged period of time (e.g. IV fluids).

16.0. Optimal Post-delivery Pressure Area Care – think SSKIN

16.1. Care for all women

- Use a cleansing foam as a first-line product when cleaning women.
- Skin assessment prior to transfer to postnatal ward (or earlier if reporting any signs of compromised peripheral perfusion on her pressure areas).
- Diabetic mothers: Monitor blood sugars as per Trust Diabetes in Pregnancy guideline and support the maintenance of stable blood sugars.
- Encourage good hygiene and keeping pressure areas clean and dry.

16.2. Care for women who have had regional analgesia – score = "amber", and those scoring "red" due to a previous pressure ulcer

- Skin assessment and change of Inco pads at birth and then 2-3 hourly until woman is mobilising independently and is scoring "green" on the PURPOSE T risk assessment tool (see Appendix 1).
- If scoring "red" for having a previous pressure ulcer, once mobilising independently (and otherwise scoring "green"), skin assessments should be performed 12 hourly until home. Repositioning should continue 1-2 hourly.
- Keep Moving: Encourage/assist to reposition 1-2 hourly - if able to stand, the woman should be encouraged to do so for at least 2 minutes.
- Keep Moving: Once scoring "green", women should be advised to mobilise/reposition regularly and pressure areas should be assessed at every post-natal check by a midwife (or earlier if reporting any signs of compromised peripheral perfusion on her pressure areas).
- Keep Moving: Optimum maximum length of time spent in bed = Up to 12 hours.
- Incontinence/Moisture: Protect the skin from moisture with a barrier cream when required.
- Incontinence/Moisture: Cleanse the skin promptly after episodes of incontinence.

16.3. Care for women who have not had regional analgesia – score "green"

- Skin assessment and change of Inco pads at birth.
- Keep Moving: Encouraged to mobilise independently.
- Keep Moving: Advised not to spend longer than 8-10 hours in bed.
- Incontinence/Moisture: Advised to change maternity and Inco pads regularly as required, and to keep skin clean and dry.
- Incontinence/Moisture: Consider use of barrier cream if skin exposed to moisture.
- Nutrition: Continue to advise women to eat and drink normally (unless otherwise directed by a Doctor).

16.4. Care for women with medical devices – score = "amber"

- Skin assessment 2 hourly until medical device has been removed.
- Keep Moving: Encouraged/assisted to reposition device 2-3 hourly when in situ.
- Incontinence/Moisture: Consider use of a barrier cream.
- Nutrition: Continue to advise women to eat and drink normally (unless otherwise directed by a Doctor).

17.0. Pressure Ulcer vs Moisture Lesion

Moisture lesions develop when the structural integrity of the skin is compromised by repeated or prolonged exposure to moisture, e.g. from amniotic fluid, excessive sweat or urine. Please see Appendix 3 for a 'Pressure Ulcer Grading Chart' and Appendix 4 for 'Incontinence Dermatitis Treatment Protocol'.

17.1. Symptoms of moisture lesions:

- Wet skin with maceration and/or excoriation
- Diffuse in shape with several closely located areas
- Edges diffuse and irregular
- Often intra-gluteal, but may be over a bony prominence
- Superficial skin loss, without necrosis or slough
- Often symmetrical (copy lesions).

18.0. Diagnosis and Management of Pressure Ulcers

18.1. Categorisation of pressure ulcers

Please refer to Section 6 of the Trust 'Clinical Guideline for the Prevention of pressure Ulcers in Adults' for information on categorisation, and appendix 3 for the classification of pressure ulcers with diagrams/images.
If unsure of the classification of a pressure ulcer, always request a review from a tissue viability nurse.

18.2. Assessment

- When a pressure ulcer is discovered, commence the 'Pressure Ulcer Proforma' and follow the flow-chart (Appendix 6) to determine appropriate care.
- Document on the 'Daily Pressure Ulcer Form' (Appendix 5).
- In addition, all Patients who develop a pressure ulcer must have their wound photographed (with verbal consent) as per Trust Clinical Guideline for Wound Management (see more information below) and added to Datix.

Taking photographs:

- Two photographs should be taken – one close up of the ulcer, one in normal mode to show position on limb/body. This should then be added to the Datix.
- Cameras can be found on both maternity wards. If not available, please ask the patient to use their own mobile phone and to email the photograph to the Tangmere or Labour Ward NHS e-mail account.
- The woman must be identifiable by marking their initials and hospital number on a paper rule used to measure the ulcer in the photograph.
- Please refer to Section 10.4 (page 19) of the Trust 'Clinical Guideline for Wound Management' for further guidance on taking photographs of pressure ulcers.

18.3. Reporting

- When first recognised, all pressure ulcers, including category 1, must be reported as a clinical incident on the Datix system. The reporting mechanism is applicable to pressure ulcers that are present on admission to the Trust hospitals and to those that develop or deteriorate during the inpatient episode.
- Pressure ulcers caused by a medical device must be identified and reported as a 'medical device related pressure ulcer'.

- Skin damage determined to be as the result of incontinence and/or moisture alone should not be recorded as a pressure ulcer, but should be reported via the Datix system as a moisture lesion. A lesion caused by a combination of incontinence, moisture, and pressure should be recorded as a pressure ulcer (EPUAP 2014).
- The Datix ID number should be documented on the 'Pressure Ulcer Proforma' (Appendix 6) and 'Daily Pressure Ulcer Form' (Appendix 5).
- The Datix will automatically alert the Tissue Viability Team, who, if possible, will then review the patient on the ward and review the aSSKINg care plan put in place by a Senior Midwife. The Tissue Viability Nurse (TVN) will then update the Datix and confirm grade of ulcer at time of assessment.

18.4. Care for Women with Pressure Ulcers – "red"

- Complete the 'Pressure Ulcer Proforma' (Appendix 6)
- Document in the 'Daily Pressure Ulcer Form' each day starting with when ulcer first noted (Appendix 5).
- A Senior Midwife must assess the pressure ulcer and create a care plan using the aSSKINg care bundle – see Appendix 12 for the sticker to be placed in the maternity notes.
- Surface: See section 8 for information on the use of pressure-reducing equipment and if required.
- Skin assessment 12 hourly until home.
- Keep Moving: Encourage/assist to reposition 1-2 hourly.
- Incontinence/Moisture: Regular changing of maternity and Inco pads to ensure area is clean and dry (alongside repositioning and skin assessment if not postnatal).
- Incontinence/Moisture: Use a barrier cream on areas exposed to moisture.
- Use a cleansing foam as first-line product if cleaning women.
- Advise women to avoid soap-based products when showering.
- Recommend the use of emollients on dry skin.
- Nutrition: Monitor blood sugars and support the maintenance of stable blood sugars in women with diabetes.
- Nutrition: Continue to advise women to eat and drink normally (unless otherwise directed by a Doctor).
- Consider need for/ impact of analgesia.

18.5. Tissue Viability

All hospital-acquired pressure ulcers (category 2 and above) should be reviewed by the tissue viability team and the circumstances leading to their development assessed against the best practice criteria of the skin bundle. Since maternity patients are often only in hospital for a short period of time, it may be that they are discharged prior to being assessed by a Tissue Viability Nurse. For this reason, a senior midwife must assess the pressure ulcer and create a care plan using the aSSKINg care bundle (see Appendix 12 for sticker) prior to any contact with Tissue Viability.

If unsure of the pressure ulcer category, please contact Tissue Viability for a review.

18.6. Management of pressure ulcers on discharge from hospital

- A Senior Midwife should create a plan for ongoing care using the aSSKINg care bundle.
- Complete the 'Maternity Wound Management Discharge Plan' (Appendix 8) and put in maternal postnatal notes.
- All women with category 2 and above pressure ulcers should have a community nurse referral via One Call:
  Email: SC-TR.OneCallCoastalReferrals@nhs.net
  West Sussex (Worthing & Chichester) One Call: 01903 254789
  North West Sussex (Crawley, Horsham and Mid Sussex) One Call: 01293 228311
- Ensure an alert has been put on the maternity information system prior to discharge.
- All women should have their pressure areas checked prior to discharge from hospital and at each postnatal check when home by a midwife.
- If able to visit prior to discharge, the Tissue Viability Nurse will assist with the plan for ongoing care for those with category 2 and above pressure ulcers – see Pressure Ulcer Proforma (Appendix 6).
- Barrier cream, cleansing foam and dressings should be supplied as a TTO as required.

19.0. Audit/Monitoring

Frequency of Audit:	Annual
Method for data collection:	Approved quality review tool
Standards:	NICE Clinical Guideline CG179. EPUAP et al. (2019)
Reports to:	Women & Children's Division Integrated Governance and Performance Board

See Appendix 13 for audit tool relating to this guideline.

References

Baker M (2016) Detecting Pressure Damage In People with Darkly Pigmented Skin. Wound Essentials: 11; 1.

Clark M (2010) Skin assessment in dark pigmented skin: a challenge in pressure ulcer prevention. Nursing Times; 106: 30, early online publication.

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance (2019) Prevention and treatment of pressure ulcers/injuries: Quick Reference Guide 2019

National Institute for Health and Care Excellence (2014) Pressure Ulcers Prevention and Management: NICE Clinical Guideline (CG179)

National Institute for Health and Care Excellence Quality Standard (QS89) (2015)

NHS Improvement (2018) Stop the Pressure

NHS Midlands and East (2012) Pressure ulcer programme

WSHFT (2018) Clinical guideline for the prevention of pressure ulcers in adults

WSHFT (2018) Clinical guideline for wound management

Click on links for appendices:

Appendix 1 – Pressure Ulcer Risk Assessment – Modified PURPOSE T for Maternity

Appendix 2 – Algorithm for selecting the most appropriate Safeguard pressure redistribution device

Appendix 3 – Pressure Ulcer Grading chart

Appendix 4 – Incontinence Dermatitis Treatment Protocol

Appendix 5 – Daily Pressure Ulcer Form

Appendix 6 – Maternity Pressure Ulcer Proforma (including flow chart)

Appendix 7 – Labour PCEA Observation Chart

Appendix 8: Maternity wound management discharge plan

Appendix 9: Pressure ulcer leaflet

Appendix 10: Reporting and reviewing of pressure ulcers

Please use for information on Datix classification. The flow chart in the Pressure Ulcer Proforma (appendix 6) has been adapted specifically for maternity.

Appendix 11: Correct set up of alternating pressure relieving mattresses

Appendix 12: aSSKINg care bundle sticker

aSSKINg CARE BUNDLE	Actioned	Required
Assess Risk:		
Purpose T Care Plan (RED)		
Skin:		
Observe pressure areas/vulnerable skin every 12 hours		
Surface:		
Continue using static foam mattress		
Provide alternating pressure redistribution mattress		
Provide static pressure redistribution cushion for chair		
Provide safeguard pressure redistribution utility pads/boots		
Off load heels using a pillow or Heel Pro Advance Boot		
Keep Moving:		
1-2 hour position changes		
Slide Sheets to aid position changes		
Incontinence:		
Use Senset foam to cleanse skin after episodes of incontinence		
Use medi-honey barrier cream to protect skin		
Use Proshield barrier cream to protect skin		
Nutrition:		
MUST score		
Monitor and support nutrition		
Refer to dietitians		
Give pressure prevention information leaflet		

Appendix 13: Maternity Pressure Area Care Audit Tool

Name:	**Date of delivery:**
Hospital Number:	**Site:** St. Richard's Worthing
Datix Number:	**Place of birth:**
Name of auditor:	**Date audit tool completed:**
Type of delivery:	**Time of birth:**
BMI:	**Age:**
Date pressure ulcer located:	**Pressure ulcer at discharge to GP care?** Yes / No
Pressure score on admission: Green Amber Red	**Time pressure score became amber (if applicable):**
Any labour/birth complications?	**Period pressure ulcer located:** Antenatal Intrapartum Postnatal

Risks factors for pressure ulcers (tick all those that apply)	
☐ Regional analgesia	☐ Limited bladder or bowel control
☐ General analgesia	☐ Poor circulation
☐ Lack of mobility (for other reasons)	☐ Poor nutrition/hydration
☐ Lack of activity (e.g. on CTG)	☐ Smoker
☐ Diabetes	☐ Medical device in situ (e.g. catheter)
☐ Other long-term medical issue	☐ Previous pressure ulcer
☐ Pressure ulcer on admission	☐ Excessive moisture – e.g. SROM/ARM

Compliance	✓	Non-Compliance	X

Surface	**Prevention**	**Treatment**
1. Is the rationale for the choice of support surface documented (if required)?		
2. Is the prescribed equipment being utilised?		
Compliance	/ 2	/ 2

Skin/Wound Management		
1. Is there evidence of a skin inspection upon admission?		N/A
2. Is there a care plan documented in the notes?		
3. Is the care plan in line with the Trust guideline?		
4. Is there evidence skin assessments were performed in line with Trust guidance?		
5. Is there evidence the care/ treatment plan has been reviewed when necessary?		

6. Is there evidence of recording the size of the wound as per Trust guidance?	N/A	
7. Has the wound(s) been photographed as per Trust guidance?	N/A	
8. If the patient is in pain, is there evidence of a pain scale being utilized?	N/A	
9. Has a TVN been to review (category 2 pressure ulcers and above only)?	N/A	
Compliance	/ 5	/ 8

Keep Moving		
1. Is there a requirement for repositioning identified in the notes?		
2. Is there evidence of repositioning as per Trust guidance?		
3. Has the plan been reviewed as the patient's condition has altered?		
4. Is there evidence of patient information regarding the importance of repositioning?		
5. Does the patient/carer understand the information? (E.g. any language difficulties but no translation used?)		
Compliance	/ 5	/ 5

Incontinence/ Moisture		
1. Is there a clear plan for the care of skin documented?		
2. Is the plan in line with the Trust guideline?		
3. Is there evidence of care as per Trust guidance?		
4. Is there evidence a barrier cream has been used (if required)?		
Compliance	/ 4	/ 4

Nutrition/Hydration		
1. Is there evidence the patient`s nutrition and hydration status has been assessed?		
2. If required, is there a care plan in place?		
3. Is the care plan in line with the Trust guideline?		
4. Is there evidence this care plan was implemented?		
5. Is there evidence of patient/carer education regarding the importance of nutrition/hydration?		
Compliance	/ 5	/ 5

Tissue Viability referral (if required): Yes / No
Type of pressure ulcer:

Moisture Lesion Combined lesion

Category 1 Category 2 Category 3 Category 4

Unstageable Deep Tissue Injury