Prevention & Treatment of Pressure Ulcers

1. Background

A pressure ulcer (sometimes called a bedsore or pressure sore) is 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. (National Pressure Ulcer Advisory Panel (NPUAP) / European Pressure Ulcer Advisory Panel (EPUAP) 2009).

Anyone can develop a pressure ulcer but some people are at greater risk, such as those with significantly limited mobility and older people whose skin becomes thinner and more fragile with age. Pressure ulcers may develop very quickly in some individuals if they are immobile even for a very short period of time, less than an hour in very susceptible people. Without care, pressure ulcers can be very serious. They cause pain and can take a very long time to heal. Severe ulcers can cause deep tissue damage, even destroying muscle and bone. They can become infected, sometimes causing blood poisoning or bone infections, and in extreme cases can be a causative factor in a person's death. However, many are preventable and so it is essential that effective preventative care is in place.

This policy has been developed to reflect best practice in the prevention and treatment of pressure ulcers and reflects the National Institute for Health and Care Excellence (NICE) clinical guideline (CG179) Pressure ulcers: prevention and management; and the NICE Quality Standard (QS89) Pressure ulcers.

2. Objectives

The aims of this policy are to ensure that:

- Staff understand and recognise the causes and signs of pressure damage;
- A consistent and structured approach to pressure ulcer risk management is in place;
- Effective preventative care is provided to minimise the risks of people developing pressure ulcers; and
- People receive the best possible care and treatment in the event that they develop a pressure ulcer.

3. Scope

All established staff, agency staff and volunteers employed in registered care services who provide personal care for residents.

Note: Throughout this policy the term resident is intended to include both people who live in Abbeyfield care homes and those who are living independently and are receiving personal care from an Abbeyfield Care at Home service.

4. Policy

4.1. Prevention of Pressure Ulcers

Effective preventative care relies on a structured approach to risk management involving use of a validated scale to support clinical judgement to assess pressure ulcer risk, and a documented skin assessment to check for signs of tissue damage. Reassessment is required if there is a change in clinical status, for example, if there is a change in mobility.

4.1.1. Risk Factors

The three major extrinsic factors that are identified as being significant contributory factors in the development of pressure ulcers are pressure, shearing and friction. These factors should be removed or diminished to reduce injury.

There are known intrinsic factors which will increase a person's risk of developing a pressure ulcer. Intrinsic risk factors include:

- Reduced mobility or immobility;
- Acute illness;
- Level of consciousness;
- Extremes of age;
- Vascular disease;
- Severe, chronic or terminal illness;
- Previous history of pressure damage;
- Malnutrition and dehydration;
- Neurologically compromised;
- Obesity;
- Poor posture; and/or
- Use of equipment such as seating or beds which do not provide appropriate pressure relief.

The potential of an individual to develop pressure ulcers may be exacerbated by the following factors, which therefore should be considered when performing a risk assessment:

- Sedatives and hypnotics may make the patient excessively sleepy and thus reduce mobility;
- Analgesics may reduce normal stimulus to relieve pressure.
- Inotropes cause peripheral vasoconstriction and tissue hypoxia (inadequate oxygen supply to tissue);
- Non-steroidal anti-inflammatory drugs (NSAIDs) impair inflammatory responses to pressure injury;
- Cytotoxics and high-dose steroids may induce immunosuppression which impairs inflammatory responses to pressure injury and may lead to an increased risk of wound infection; and
- Moisture to the skin (e.g. from incontinence, perspiration or wound exudate.

4.1.2. High risk of developing pressure ulcers

People considered to be at high risk of developing a pressure ulcer will usually have multiple risk factors. People with a history of pressure ulcers or a current pressure ulcer are also considered to be at high risk. People at high risk should be referred for an assessment by a healthcare professional.

4.1.3. Skin Assessment

A skin assessment involves checking all areas of skin that may be vulnerable to damage. How often a skin assessment is needed will depend on the outcome of the pressure ulcer risk assessment and the needs of the individual.

Visible signs of possible or actual damage are:

- Purplish/bluish patches on dark-skinned people;
- Red patches on light-skinned people;
- Swelling;
- Blisters;
- Shiny areas;

- Dry patches; and/or
- Cracks, calluses, wrinkles.

Signs that can be felt are:

- Hard/firm areas;
- Localised heat/coolness; and/or
- Swollen skin over bony points.

People who are willing and able to do so should be advised how to inspect their own skin.

A Skin Assessment and Body Map should be used to document a skin assessment. All pressure areas should be checked so that if a pressure ulcer is developing or has developed, prompt action can be taken to ensure appropriate treatment and care is provided.

If pressure damage is present the District Nurses or GP may request a photograph to be taken of the damaged tissue alongside a ruler to indicate measurements; However, normal practice is for the District Nurses to take the picture. This should be included with the Skin Assessment and Body Map unless this is not possible. This enables the extent of pressure damage and changes to be monitored at each reassessment.

4.1.4. Care Homes (Without Nursing)

All residents will have a full needs assessment completed with them as part of the admission process. This includes completion of an assessment of the risk of developing a pressure ulcer using the **Waterlow Risk Assessment Too**l. People admitted to a care home (without nursing) should have their risk of developing a pressure ulcer assessed by a suitably trained member of staff on the day of admission. Where a risk is identified, actions to minimise the risk will be agreed and recorded in the action plan.

All residents will also have a skin assessment to check their skin for signs of pressure ulcers. This should be carried out on the day of admission and documented using a Skin Assessment and Body Map.

The outcome of the pressure ulcer risk assessment and the skin assessment and the actions to prevent pressure damage must be agreed with the resident and documented in their care plan.

If the resident is at high risk or there are signs of pressure damage, the resident must be referred to community nursing services for assessment by a healthcare professional who will be responsible for the management and treatment of any pressure ulcers.

4.1.4.1. Reassessment

All residents must be reassessed using the **Waterlow Risk Assessment Tool** on a monthly basis, or sooner if there is a change in their clinical status. A Skin Assessment and Body Map should also be used to record the findings of a visual check of all pressure areas in order to monitor changes.

A Skin Assessment and Body Map should be completed when a resident returns from a stay away, for example following a spell in hospital.

4.1.5. Care at Home (Domiciliary Care)

People receiving personal care as part of an assessed package of care from a Care at Home service will have a pressure ulcer risk assessment completed with them

before their care package commences or on their first service visit. This will involve completion of a pressure ulcer risk assessment using the Waterlow Score. (See Appendix 1). People who are at risk of developing a pressure ulcer (a score of 18 or less) should also have a skin assessment completed on their first visit and this should be documented using a Skin Assessment and Body Map.

People who are identified as being at risk (have a score of 18 of less) should be referred to community nursing services to have a pressure ulcer risk assessment to help identify the need for preventative action.

People who have one or more of the following risk factors must be referred to community nursing services:

- Significantly limited mobility (for example, people with a spinal cord injury);
- Significant loss of sensation;
- A previous or current pressure ulcer;
- Nutritional deficiency;
- The inability to reposition themselves; and/or
- Significant cognitive impairment.

The outcome of the pressure ulcer risk assessment and the skin assessment and the actions to treat and prevent any further pressure damage must be agreed with the person and clearly recorded in their care plan.

4.1.5.1. Reassessment

People who are at risk of developing a pressure ulcer (a score of 18 or less) must be reassessed using the Waterlow Score (Appendix 1) on a monthly basis, or sooner if there is a change in their clinical status. A Skin Assessment and Body Map should also be used to record the findings of a visual check of all pressure areas to monitor changes.

People who are not considered to be at risk of developing a pressure ulcer (a score of 19 or more) should be reassessed at least every three months, or sooner if there is a change in their clinical status.

4.2. Repositioning

Changing position to reduce or remove the pressure on a particular area can be key to preventing pressure ulcers. Anyone who has been assessed as being at risk of pressure ulcers should be made aware of:

- The importance of changing their position regularly and how it can help; and
- How frequently to move, depending on the level of risk.

Individuals who are willing and able should be taught how to redistribute weight every 15 minutes. Carers should be aware of the importance of repositioning and taught how to assist in patient weight distribution.

Advice should be given to people in a way that they can understand, taking into account any cognitive impairment.

The frequency of repositioning should be determined by the results of skin inspection and individual needs and wishes, not by a ritualistic schedule.

(NICE QS89) The recommended frequency of repositioning is:

- **every 6 hours for people at risk of developing pressure ulcers**
- **every 4 hours for people at high risk of developing pressure ulcers.**

If the person is unable to reposition themselves, assistance should be provided, using appropriate equipment if needed. Skin injury due to friction and shear forces should be minimized through correct positioning, transferring and repositioning techniques.

Individuals who are considered to be acutely at risk of developing pressure ulcers should restrict chair sitting to less than 2 hours at a time until their general condition improves. Caution should also be exercised once their condition has improved.

The frequency of repositioning required must be documented in the resident's care plan and the Repositioning and Skin Inspection Chart should be used to document all repositioning. **(See Appendix 4).**

4.3. Nutrition & Hydration

People who have experienced weight loss or who have a poor appetite are at increased risk of developing pressure ulcers. Moreover, inadequate nutrient intake and low body weight are associated with slow and non-healing wounds. People who are under nourished will be more susceptible to infection, are more likely to have poor skin condition and to have more prominent bony protrusions. Nutrition and hydration play an important role in preserving skin and tissue viability and in supporting tissue repair for pressure ulcer healing. Ensuring healthy nutrition and hydration therefore can help to reduce the risks of developing pressure ulcers.

Where weight loss is identified as a risk factor, the resident should be referred to their GP. Residents should be encouraged to drink the recommended daily fluid intake for their weight/condition, which should be documented in their care plan.

Do not offer nutritional supplements specifically to prevent a pressure ulcer in adults whose nutritional intake is adequate.

4.4. Support Surfaces

When a person is lying or sitting, pressure is exerted through the skin onto soft tissues. The amount of pressure is related to the person's weight and the size of the contact area between the person and the surface. Using an appropriate support surface is key to preventing and managing pressure ulcers as well as increasing personal comfort. Support surfaces reduce the likelihood of a pressure ulcer developing by preventing build-up of pressure on one area of tissue. This is known as pressure redistribution.

Support surfaces redistribute pressure either by allowing the person's body to sink into them - the weight and therefore pressure is spread over a larger area - or by intermittently removing pressure from certain areas of the body allowing tissues to recover before they bear pressure again.

4.4.1. Pressure Redistribution Devices

Pressure redistribution devices are sometimes referred to as pressure reducing or pressure relieving aids/equipment. Anyone at risk, or suffering with an existing pressure ulcer, should be cared for on a pressure redistribution device, and as a bare minimum on a high-density foam mattress. Pressure redistribution devices should be used in all situations: for example, when a resident is in bed, sitting in a chair or travelling in wheelchairs and vehicles.

Types of pressure redistribution devices include:

- Specialist beds— for people with a high BMI;
- Mattresses:
    - high specification foam – for people at risk of pressure ulcers;

- air filled – for people at low to moderate risk or for very heavy/rigid people who are hard to reposition;
- air fluidised – for people with existing pressure ulcers who cannot be repositioned or who have pressure ulcers on one or more turning surfaces;
- alternating pressure – people at high risk or with an existing pressure ulcer, eg those who are acutely ill/immobile or with a history of pressure ulcer;

- Cushions — for patients at risk of pressure ulcers that sit in chairs or wheelchairs;
- Overlays — useful for adding to one side of a bed to allow partners to continue sharing; or
- Heel protectors — for protecting the heel from shear and friction and preventing foot drop and rotation.

4.4.2. Choosing the Right Pressure Redistribution Devices

It is the responsibility of a healthcare professional to decide which support surfaces are most suitable for each individual.

The type of pressure redistribution device a person needs will depend on their circumstances, for example, their mobility, the results of the skin assessment, their level of risk, the site that is at risk, the person's weight and the person's general health. Using pressure redistribution devices as soon as possible can prevent pressure ulcers developing and help to treat them if they do arise, ensuring people's safety and improving the experience of people at high risk of pressure ulcers.

A resident should not sit in a wheelchair for any length of time without some form of cushioning. The following are recommended according to the resident's Waterlow score:

- Score of 10+ 100mm foam cushion
- Score of 15+ specialist gel and/or foam cushion
- Score of 20+ specialist cushion adjustable to the individual resident.

Special mattresses/beds have an important part to play in reducing pressure. The following are recommended according to the resident's Waterlow score:

- Score of 10+ overlays or specialist foam mattress
- Score of 15+ alternating pressure overlays, mattresses and bed systems
- Score of 20+ bed systems: fluidised beds; low air loss and alternating pressure mattresses.

Standard-specification foam mattresses should not be used for residents who have a pressure ulcer.

4.4.3. Maintenance of Pressure Redistribution Devices

In care and nursing homes the Registered Manager must ensure that suitable arrangements are in place for the servicing, maintaining, cleaning and safe use of pressure redistribution devices. Staff should be trained in the correct use and maintenance of pressure redistribution devices. Devices must be checked when in use to ensure they are safe and effective and these checks should be documented. There should be written instructions detailing what staff are expected to check. For example, where devices which have adjustable settings are being used, the required setting must be recorded in the person's care plan and the setting must be checked and recorded at least daily. Checks should also include ensuring there are no trailing cables from electrically powered devices that might pose a trip hazard.

Visual checks of pressure redistribution devices being used should be documented using **Appendix 4: Repositioning and Skin Inspection Chart.**

Where pressure redistribution devices need to be checked by Care at Home staff, details of what needs to be checked must be clearly documented in the person's care plan.

4.4.4. Who provides pressure redistribution devices?

In most cases, people who live independently and are assessed as needing pressure redistribution devices are supplied these free of charge, often on loan, from their local community health service.

Generally, care and nursing homes are expected to provide all medical equipment, including specialist pressure redistribution devices.

4.4.5. Bedding

The suitability of bed clothing should be considered. Plastic draw sheets should be avoided, and sheets/sheet covers should not be tightly tucked in, especially when using specialist bed and mattress overlay systems. Mattress protectors can reduce the effectiveness of a pressure redistribution mattress which should only be covered with a bed sheet.

Bedding and clothing should be smooth under the person to prevent folds and wrinkles which can cause discomfort and further damage to the skin.

Bed cradles can promote comfort by preventing bedlinen from chafing and rubbing.

4.5. Incontinence

People living with incontinence, especially women, may also develop pressure ulcers, as prolonged exposure to moisture can cause breakdown of skin tissue. Skin should not be left wet as moist skin sticks to material (e.g. bathing, perspiration, incontinence - urine and faeces are acidic), as it can become macerated making it more susceptible to shear and friction.

Residents should be supported as far as possible to use the toilet to improve bladder control and maintain dignity. Where continence aids have been prescribed, staff should ensure these are used and fitted correctly as per instructions or referral notes.

4.5.1. Barrier Creams

Prescribed barrier preparations can help to prevent skin damage in residents who are at high risk of developing a moisture lesion or incontinence-associated dermatitis, as identified by skin assessment (such as those with incontinence, oedema, dry or inflamed skin).

4.6. Treatment & Management of Pressure Ulcers

Care staff must be vigilant in checking for signs of pressure damage. As soon as signs of a pressure ulcer are noted immediate action must be taken. A Skin Assessment and Body Map should be used to document the signs of the pressure ulcer. **The treatment of a pressure ulcer must be referred to and managed by a healthcare professional.**

4.6.1. Nursing Homes

The case must be referred to the nurse on duty who will ensure an initial assessment and reassessments of the pressure ulcer, noting the following:

- Cause;
- Location;

- Dimensions, including the longest length, width to monitor the surface area, and depth (measured using a sterile probe);
- Grade/Stage/Category of pressure ulcer;
- Exudate amount and type;
- Local signs of infection;
- Pain, including cause, level, location and management interventions;
- Wound appearance;
- Surrounding skin;
- Undermining/tracking, sinus or fistula; and/or
- Odour.

The nurse must commence treatment and actions immediately to prevent further damage and to treat the pressure ulcer, and consider repeating skin assessments 2 hourly. The nurse will contact the resident's GP if necessary.

4.6.2. Care Homes (Without Nursing)

The resident's GP and/or the community nursing service should be contacted for advice on how to treat the pressure damage. In some cases, a specialist tissue viability nurse may need to be consulted and this is usually arranged via the GP or community nurse. Preventative actions must be put in place immediately to include the use of pressure redistribution devices and repositioning which must be fully documented. **(See Appendix 4)**

4.6.3. Care at Home (Domiciliary Care)

The person should be advised to contact their GP and/or the community nursing service for advice. Support to do so should be provided in accordance with their agreed care and support plan.

Records should be kept in the resident's care plan of advice sought and received, and of all actions taken and agreed to treat a pressure ulcer and to prevent further damage.

In all cases actions will include:

- Referral to a health care professional
- The use of suitable pressure redistribution devices at all times
- Documented checks on the pressure redistribution devices in use
- Documented repositioning at agreed intervals
- Documented skin inspections at agreed intervals
- Updated actions to be agreed and recorded in the resident's care plan.

4.7. Safeguarding

Where a person has developed a pressure ulcer grade 3 or above by a health professional and it is possible that it has developed as a result of neglect or acts of omission, the Registered Manager must ensure that safeguarding procedures are followed. This will include making a referral to the local safeguarding team, logging the safeguarding incident and the referral, reporting the incident internally using Abbeyfield's safeguarding reporting system, and submitting a Notification to CQC. **(See 4.8 Notifications).**

As soon as the Registered Manager is made aware that a person has developed a pressure ulcer, they must conduct and document a full investigation into the circumstances which resulted in the person developing a pressure ulcer and identify immediate actions to prevent

further tissue damage. The investigation process must consider whether there are any lessons which can be learned which may help to ensure any avoidable circumstances are not repeated.

Some safeguarding teams expect to be notified of all pressure ulcers and it is the responsibility of the Registered Manager to ensure local safeguarding procedures are followed**.**

4.8. Notifications

The Registered Manager must ensure CQC is notified without delay if a resident develops a pressure ulcer of grade 3 or above using the notification of Serious Injury to a Person who uses the Service. **(See 10.1 Pressure Ulcer Classification)**

The Registered Manager must ensure CQC is notified without delay if a resident develops a pressure ulcer which has or may have been caused by neglect or acts of omission using the notification of Abuse or allegations of abuse concerning a person who uses the service. Only one notification is required.

Notification forms should be downloaded directly from the CQC website.

4.9. Training & Resources

All staff involved in the delivery of personal care will receive training in the prevention and treatment of pressure ulcers. Training on preventing a pressure ulcer will include:

- Who is most likely to be at risk of developing a pressure ulcer;
- How to carry out a risk and skin assessment;
- How to identify pressure damage;
- What steps to take to prevent new or further pressure damage;
- Who to contact for further information and for further action;
- How to reposition;
- Information on safe use of pressure redistribution devices;
- What records need to be kept;
- Discussion of pressure ulcer prevention with residents; and
- Details of sources of advice and support.

5. Finance, Value for Money & Social Value

N/A

6. Supported Appendices

APPENDIX 1: Pressure Ulcer Risk Assessment (Waterlow Scale)
APPENDIX 2: Skin Assessment and Body Map
APPENDIX 3: Repositioning & Skin Assessment Chart

7. Linked Policies

Needs Assessment (C017P)
Admission of Residents (C002P)
Statutory Notifications of Events (C028P)
Safeguarding Vulnerable Adults (LG031P)
Duty of Candour (C031P)
Nutrition and Hydration (C018P)

8. Legislation/Regulation

Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

9. Review

Every 3 years, subject to any regulatory or legislative updates.

10. Procedure/Guidance

10.1. Pressure Ulcer Classification

Pressure ulcers have been clinically graded by NPUAP/EPUAP according to the extent of tissue damage involved:

10.1.1. Grade/Stage 1 – Non-blanchable redness of intact skin

Intact skin not affected by light finger pressure (non-blanching erythema), usually over a bony prominence. Discoloration of the skin, warmth, oedema, hardness, or pain may also be present. Darkly pigmented skin may not have visible blanching.

Further description: The area may be more painful, firmer or softer, or warmer or cooler than adjacent tissue. Grade/Stage 1 may be difficult to detect in individuals with dark skin tones. This may indicate an at-risk individual.

10.1.2. Grade/Stage 2 – Partial thickness skin loss or blister

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough present as an intact or open/ruptured blister.

Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.

10.1.3. Grade/Stage 3 – Full thickness skin loss (fat visible)

Full thickness tissue loss. Subcutaneous (beneath al layers of skin) fat may be visible, but bone, tendon, or muscle are not exposed. Some slough may be present.

Further description: The depth of a Grade/Stage 3 pressure ulcer varies by anatomical location. Ulcers on the bridge of the nose, ear or ankle, for example can be shallow but, in contrast, areas of significant adiposity (fatty areas) can develop extremely deep Grade/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable

10.1.4. Grade/Stage 4 – Full thickness tissue loss (muscle/bone visible)

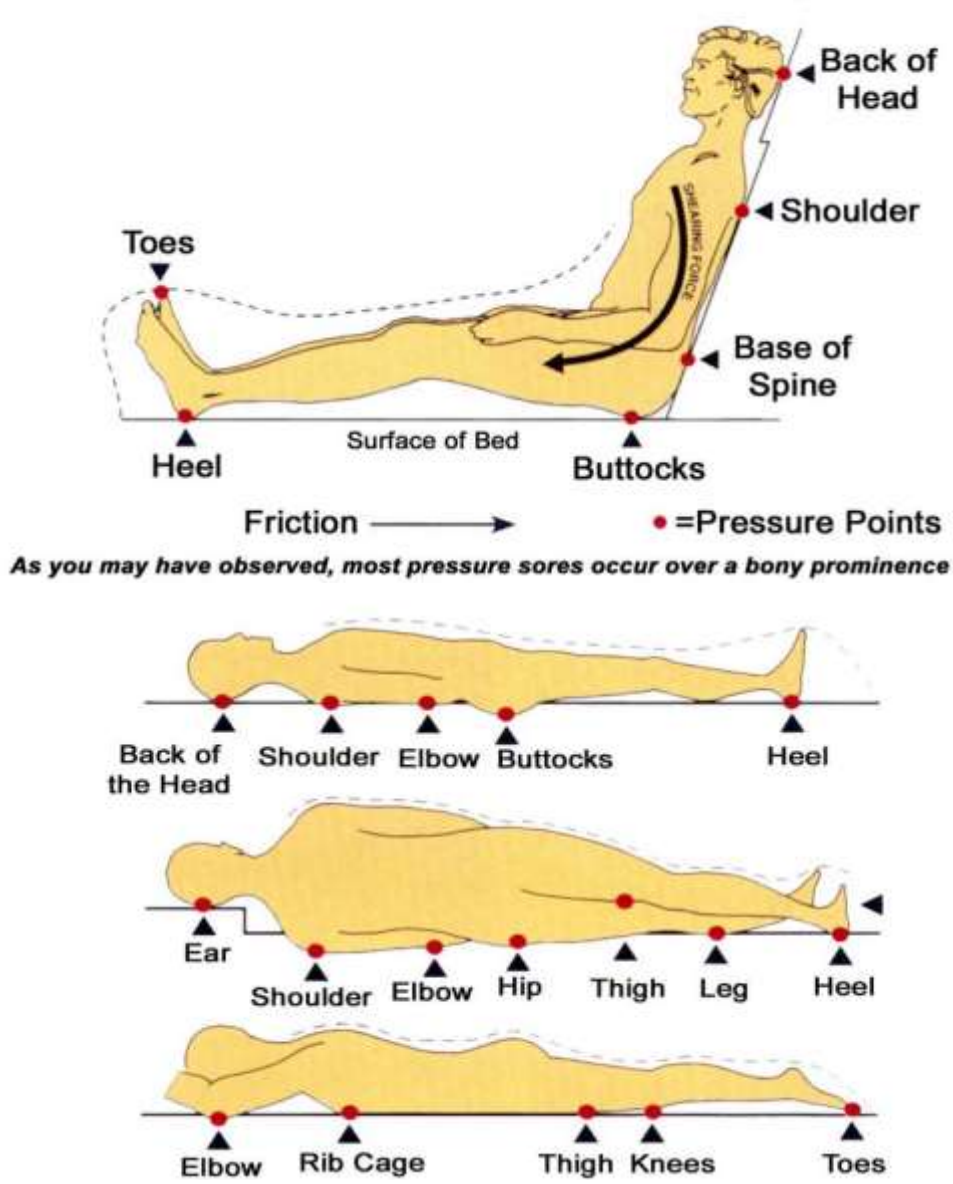
Full thickness skin loss with extensive destruction and necrosis (tissue death) extending to underlying tissue.

Further description: The depth of a Grade/Stage 4 pressure ulcer varies by anatomical location. Ulcers on the bridge of the nose, ear or ankle, for example, can be shallow but, in contrast Grade/Stage 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule). Exposed bone/muscle is visible or directly palpable.

NB Pressure ulcers should not be downgraded. A grade 4 pressure ulcer does not become a grade 3 as it heals, it should be described as a healing grade 4 pressure ulcer.

10.2. Common Sites of Pressure Ulcers (The Tissue Viability Society)

The pressure points on the body depend on whether the person is sitting or lying down, and in what position they are lying.



10.3. Assessment and Treatment (for healthcare professionals)

The use of a pressure ulcer classification system to estimate tissue loss and assess skin by colour, temperature and consistency (i.e. firm/turgid or soft/boggy) is recommended. (NPUAP/EPUAP)

- Stages 1–2 with light exudates: for reddened areas, barrier cream and relief of pressure are recommended, whilst superficial ulcers require dressing with transparent films as they effectively retain moisture and prevent friction.
- Stage 3 ulcers should be dressed with synthetic dressings rather than gauze as these cause less pain and require less frequent changes (NPUAP/EPUAP). These dressings include alginates, hydrocolloids and foams and are often available in site-specific shapes to ease application and removal and minimize leakage.

10.4. Good Practice (Do's & Don'ts)

Do:

- Document support surface decisions, repositioning and skin condition;
- Consider all surfaces used by the person, including wheelchairs and seats in vehicles;
- Consider impact of mattresses on height of bed/chairs and side rails as these may impact on independence and personal safety;
- Regularly re-evaluate suitability of support surface;
- Reposition when using support surfaces (using handling aids where necessary);

- Ensure bedclothes are smooth between the person and the support surface, particularly after repositioning;
- Encourage self-repositioning as often as every 15 minutes;
- Ensure mattress or overlay has not raised the person's height in relation to bedrails;
- Monitor skin condition and the person's hydration status; and
- Encourage mobility and an appropriate level of activity if the person's condition allows.

Do not:

- Use water-filled gloves, sheepskins (synthetic or real), or ring cushions/doughnuts as pressure-relieving aids, as they may be harmful;
- Exceed weight limit of support surface;
- Neglect heels — consider these separately;
- Use fitted sheets with active support surfaces (those that can change pressure distribution without a patient on it and require power supply);
- Use active support surface for anyone with spinal injury or unstable fracture;
- Use a support surface that hinders independent movement by the person;
- Use beds and mattresses of incorrect length/size for the person;
- Use products such as incontinence pads to manage skin moisture when foam support surfaces are in use;
- Use pillows to extend the length of the mattress; or
- Offer skin massage or rubbing over bony prominences, as this does not prevent pressure damage and may actually cause additional damage.

11. Further Guidance

https://www.nice.org.uk/guidance/qs89
https://www.nice.org.uk/guidance/cg179
www.judy-waterlow.co.uk
https://bradenscale.com
www.epuap.org

A guide for registered managers of care homes can be downloaded from the NICE website:
https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/helping-to-prevent-pressure-ulcers

APPENDIX 1: Pressure Ulcer Risk Assessment (Waterlow Scale)

Abbeyfield The Dales Ltd

Pressure Ulcer Risk Assessment

Name: Apt/Suite/Rm No:

		Date:					
Sex	Male	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Female	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
Age	55 – 64	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	65 – 74	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
	75 – 80	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)
	80+	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)
Build / Weight for Height	Below Average (BMI <20)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)
	Average (BMI 20 - 24.9)	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)
	Above Average (BMI 25 - 29.9)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Obese (BMI >30)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
Mobility	Fully Mobile	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)
	Restless / Fidgety	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Apathetic	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
	Restricted	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)
	Bed Bound	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)
	Chair bound e.g. Wheelchair	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)
Skin Type: Visual Risk Areas	Healthy	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)
	Tissue Paper	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Dry	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Oedematous	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Clammy (Temperature)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Discoloured – Grade 1 pressure sore	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
	Broken / Spots – Grade 2-4 pressure sore	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)
Continence	Continent / Catheterised	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)

	Urinary Incontinence	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Faecal Incontinence	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
	Urinary & Faecal Incontinence	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)
Malnutrition	No recent weight loss	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)	☐ (0)
	Eating poorly or lack of appetite/weight loss <5kg	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
	Weight loss >5kg/amount unknown	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
	Weight loss >10kg **REFER TO GP**	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)	☐ (3)
	Weight loss >15kg **REFER TO GP**	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)
Special Risks	Terminal Cachexia	☐ (8)	☐ (8)	☐ (8)	☐ (8)	☐ (8)	☐ (8)
	Multiple organ failure	☐ (8)	☐ (8)	☐ (8)	☐ (8)	☐ (8)	☐ (8)
	Organ failure (Renal, Cardiac)	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)
	Peripheral Vascular disease	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)
	Anaemia	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)	☐ (2)
	Smoking	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)
Neurological Deficit	Diabetes, CVA, MS, Motor/sensory, paraplegia	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)
Major surgery / Trauma	Orthopaedic / Spinal	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)	☐ (5)
Medication	Cytotoxics, High-dose Steriods, anti-inflammatory	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)	☐ (4)
	Score (10+ At Risk, 15+ High risk, 20+ Very High risk)**:**						
	Signed:						

For scores over 10 state the actions to reduce risks below:

Date:	Actions to reduce risks:	Signature:

Reviewed by Head of Care Services 2019
Abbeyfield the Dales Ltd. Registered Charity Number: 1160258, Company No: 9006660, Home England No: 5066

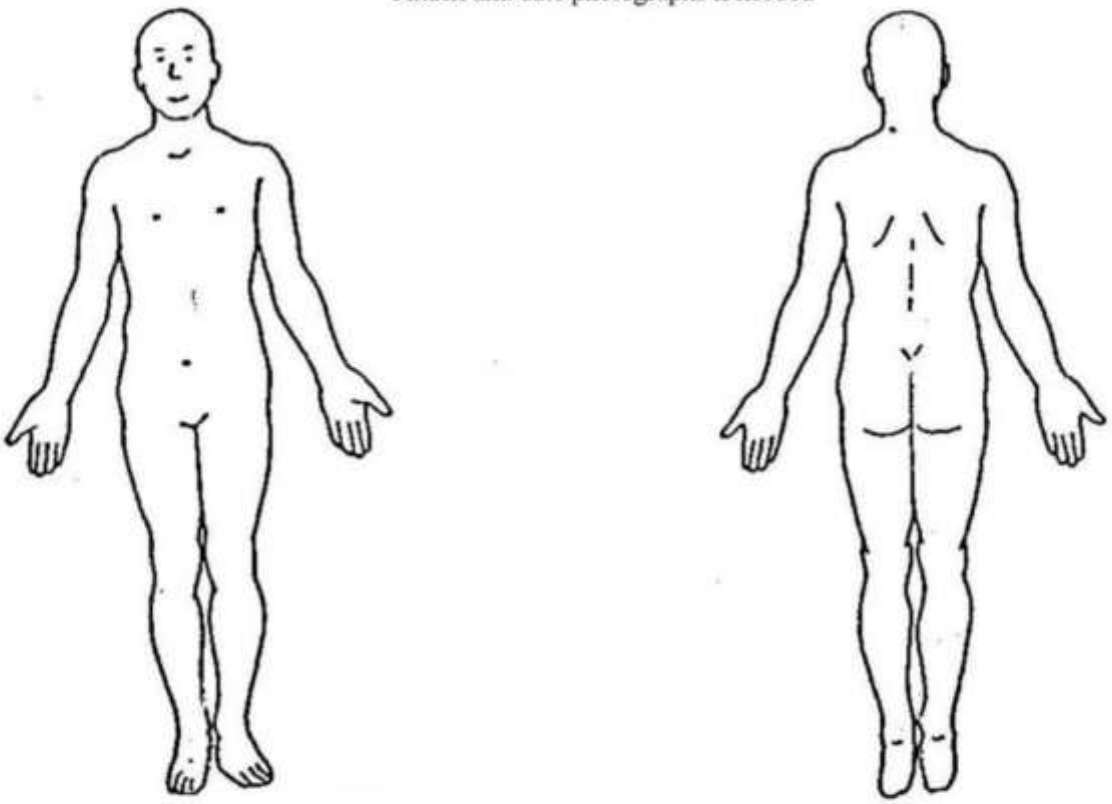
APPENDIX 2: Skin Assessment and Body Map

Abbeyfield The Dales Ltd

Skin Assessment Body Map

Name: Apt/Suite No:

Circle affected area and number each site
Attach and date photographs if needed



Date	No	Description	Signature

APPENDIX 3: Repositioning & Skin Assessment Chart

Abbeyfield The Dales Ltd

Repositioning & Skin Inspection Chart

Name: Apt/Suite/Rm No:

Repositioned every Hours

Date	Time	Repositioning (use code) From	To	Skin inspection and action taken	Support surface check Mattress/Cushion/Heel protectors	Mattress Mode/setting (Record Daily)	Signed

REPOSITIONING CODE: L = Left, R = Right, B = Back, P = Prone (front), T = 30° tilt, M = Mobilised, S = Sitting