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On Admission:

Assess all patients using Waterlow Scoring Chart (appendix 1)

Assess & document skin condition immediately on admission

Assess existing pressure damage using grading criteria (appendix 1)

Complete Wound Assessment Document

Instigate appropriate wound management according to wound management guidelines folder

Nursing Actions

Specialist Equipment

Waterlow Score ≥ 20
Refer for specialist mattress/cushion (appendix 4)

Waterlow Score 15 - 19
Consider need for specialist mattress/cushion

Plan of Care

- regular repositioning
- 30° tilt
- appropriate manual handling techniques
- skin care
- adjunctive equipment (monkey pole, bed cradle, etc.)
- referral to other members of MDT (i.e. Tissue Viability Nurse, Physio. OT, dietician, etc.)

Vaperm Hospital Mattress (Blue or green)
**On-going Care:**

Regularly reassess pressure damage risk using Waterlow Score:
- upon transfer to a new ward/department
- following surgical or medical procedures
- epidural
- after any change in condition (deterioration or improvement)
- on a weekly basis

Regular skin inspection of pressure areas:
- high risk sites should be assessed each time a patient’s /women’s position is changed
- observe for clinical signs of pressure damage
- any skin changes should be documented and acted upon

**Plan of Care:**
- Regular repositioning - frequency determined by level of risk, existence of ulcers and skin inspection
- Positioning techniques - 30° tilt, where appropriate
- Appropriate manual handling techniques (i.e. sliding sheets, hoists, etc.)
- Minimise the detrimental effects of shear & friction (raise end of bed, use knee-break facility on electric bed frames)
- Consider seating posture and ergonomics of chair (i.e. height, width)
- Maximum sitting time 2 hours for individuals unable to relieve own pressure
- Regular review of appropriateness of tissue viability equipment in place (is the mattress/cushion still required)
- Liaise with other members of multi-disciplinary team (I.e. dietician, OT, physio, nurse specialists)
- Appropriate skin care
Introduction:

These guidelines provide a framework to support decision making with the purpose of promoting best practice in the prevention of pressure ulcers based on current research. The NMC Code of Professional Conduct (June 2002) states that nurses have a responsibility to identify patients at risk. The National Institute for Clinical Excellence published a guideline for “Pressure ulcer risk assessment and prevention” in April 2001, which further endorses this notion.

Assessment and on-going evaluation of patients potential for being at risk of developing pressure ulcers must be viewed as an integral part of patient care which involves all members of the multidisciplinary team.

The content of this guideline draws heavily on the guidelines published by N.I.C.E (April 2001) and the European Pressure Ulcer Advisory Panel Guidelines (1998)

The Cost to the Patient:

For the individual, a pressure ulcer can cause pain, misery, systemic illness, increased length of hospital stay, extended absence from work and normal activities, loss of earnings, low self-esteem and altered body image (Hibbs 1991).

Demographic trends coupled with developments in clinical treatment mean that the patient population is likely to include an ever increasing proportion of people at risk of developing pressure ulcers and slow healing wounds.

The Cost to the Health Service:

The Department of Health in 1993 commissioned a report on the relative financial costs of preventing and treating pressure damage (Touché Ross Report). This quoted a figure of between £180 and £321 million per year for the NHS to treat clients with pressure damage in English hospitals. When measured on a per case basis, the costs to treat pressure damage are usually higher than to prevent it.

In 1998 the net cost of wound dressings dispensed in the community alone was £37m. The actual cost is far higher as this does not include the general care costs or those dressings dispensed by hospitals or obtained directly from the manufacturers (NICE 2001 April)

Collier (1992) estimated the cost of treating one severe pressure ulcer as £40,000.

Further disadvantages include:

- increased length of stay;
- lost opportunity costs;
- increased use of resources; and
- increased use of nursing time.

Increasingly, there is also the real risk of costs incurred by litigation, for failure to prevent or treat pressure damage effectively. Awards in the region of £100,000 (Silver, 1987) have been given for negligent nursing or medical practice which has lead to the development of pressure damage. In today’s litigious society, this trend looks set to increase.
Remember: is has been estimated that 95% of pressure damage is preventable.

Pressure Ulceration: A Definition

A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction or a combination of these (EPUAP 1998).

OR: A pressure sore is an area of localised damage to the skin and may involve underlying structures. Tissue damage can be restricted to superficial epidermal loss or extend to involve muscle and bone (Banks 1992)

Pressure ulcers range from being little more than areas of discoloured skin, to superficial ulcers, to deep purulent cavities extending to muscle and bone (DoH, 1993)

How does it Occur?:

Pressure ulceration occurs when the skin and underlying tissues are compressed for a period of time, between the bone and the surface, on which the patient is sitting or lying. Blood cannot circulate causing a lack of oxygen and nutrients to the tissue cells. Furthermore, the lymphatic system cannot function properly to remove waste products.

If the pressure continues, the cells die and the area of dead tissue that results is called pressure damage. The amount of time this takes will vary, but may develop in as little as two hours in patients at greatest risk.

Primary Causes:

1. Pressure

The blood pressure at the arterial end of the capillaries is approximately 32 mmHg, while at the venous end this drops to 10 mmHg. The average mean capillary pressure equals about 17 mm Hg and any external pressures exceeding this will cause capillary obstruction. Tissues that are dependent on these capillaries are deprived of their blood supply. Eventually the ischaemic tissues will die.

2. Shearing forces

This may occur when the skin rubs against the bed sheets or other surfaces, e.g. when a patient slips down the bed or is dragged up the bed or chair. May also occur when sitting up in bed using the backrest. This gliding of internal tissue layers causes blood vessels to stretch and kink, thus obstructing blood supply to the skin area attached (Blais & Hunt 1991). Fifty percent less pressure is needed to cause damage when shear forces are also present.

3. Friction

This is a component of shearing. Areas caused by friction wounds are more susceptible to damage from pressure and shearing forces. Therefore, to prevent shearing and friction forces, appropriate moving and handling techniques and equipment (e.g. sliding sheets and hoists) should be employed in order to ensure the patient is clear of the support surface.
4. **Moisture**

Skin should not be left wet (e.g. bathing, perspiration, incontinence, amniotic fluid) as it can become macerated making it more susceptible to shear and friction.

Certain areas of the body are more vulnerable to pressure ulcer formation than others. These are areas of tissue found over a bony prominence and are illustrated overleaf.

> **Common Sites of Pressure Damage:**
Seven Point Action Plan:

1. Assess the patient’s risk of developing a pressure ulcer using the Waterlow scale assessment tool immediately on admission to the hospital.

2. Assessment should be ongoing and the frequency of re-assessment should be dependent on change in the patient’s condition, including surgery or transfer to other wards or departments, but a minimum of weekly.

3. In conjunction with the multi-disciplinary team, devise and implement a plan of care to reflect the patients’ individual needs for the prevention and/or treatment of pressure ulcers.

4. Selection of pressure redistributing device/s appropriate to the patients’ risk score on completion of the assessment.

5. Maintain and protect skin integrity.

6. Assess the patients’ nutritional status and plan interventions accordingly.

7. Assess the patient’s moving and handling requirements and plan care accordingly.
1. **Risk Assessment:**

Assess the patient’s risk of developing a pressure sore using a reliable and valid assessment tool immediately on admission.

**Assessment:**

All members of the multi-disciplinary team have a responsibility to assess a patient’s risk of developing a pressure ulcer and to report and document the risk assessment as appropriate.

The primary assessment is the responsibility of the registered nurse delivering care to the patient. All patients should be assessed using the Trust risk assessment tool – see the Pressure Damage Risk Assessment Document (Appendix 1). All patients should be assessed:

- on admission;
- post-operatively;
- post-procedure;
- epidural;
- when their condition changes (deterioration or improvement);
- weekly;
- when patients change ward or department

**Note:** risk assessment tools should be used as an *aide memoire* and should not replace clinical judgement (N.I.C.E, 2001)

**Key Points:**

- Assess patients’ skin condition immediately on admission. Initial skin assessment should take into account the following:
  - Bony prominences (sacrum, heels, hips, ankles, elbows, and occiput) to identify early signs of pressure damage.
  - Identify the condition of the skin – dryness, cracking, erythema (redness), maceration, fragility, heat and induration (hard scaly skin) (EPUAP, 1998).

- Use the *Waterlow scoring chart*, on the back of the Pressure Damage Risk Assessment Document, to assess patients’ risk of developing pressure damage and document on the front of the form (Appendix I).

- Where existing pressure damage is present, a Wound Assessment Document (Appendix 2) should also be completed. A tracing of the wound should be made and, where possible, a photograph of the wound should be taken.

- Assess patients’ nutritional status and hydration requirements.

- Assess any existing pressure damage, skin lesions and condition, the grade and location and any existing nursing interventions should also be recorded.

- Assess patient’s ability to move themselves thereby assisting with their own pressure area care.
• Assess patient’s psychological condition, noting factors which may increase their risk of developing pressure sores.

• Be aware of any external agents such as splints, casts, TED stockings, restrictive clothing or wrinkled bed sheets which may increase the risk.

• Record details of the primary assessment in the patient’s assessment documentation, using the nursing model appropriate to your clinical area.

• Ensure the date and time of the assessment is recorded and the information is signed by the assessing clinician. Name and status should be written in block capitals

2. **On Going Assessment / Reassessment:**

Assessment should be ongoing and the frequency of re-assessment should be dependent on change in the patient’s condition.

• Skin inspection should be based on an assessment of the most vulnerable areas of risk for each patient

• High-risk sites should be assessed each time a patient’s position is changed.

• The clinical signs of pressure damage that should be observed for include:
  - persistent redness which does not disappear after the removal of pressure
  - non-blanching erythema (redness) of intact skin
  - discoloration of the skin
  - warmth, oedema, induration or hardness of the skin over a bony prominence
  - breaks, blisters or abrasions to the skin.

• Any skin changes should be documented immediately and acted upon.

• Care should be evaluated as an on-going process throughout each shift and pressure areas re-assessed as part of this process.

• All care given and evaluated should be documented in the patient’s notes for each episode of care, incorporating progress in the condition of any pressure ulcer(s) present.

Patients should be reassessed in the following circumstances:

• **Upon transfer to a new ward / department**
• **Following surgical or medical procedures**
• **Epidural**
• **After any change in their condition (deterioration and improvement)**
• **weekly**

If the risk assessment score differs from the previous assessment, the plan of care must be amended accordingly.
3. **Care Plan:**

Devise and implement a plan of care to reflect the patient’s individual needs for the prevention and/or treatment of pressure ulcers.

A care plan reflecting the patients individual needs should be formulated within 6 **hours** of admission to the ward/department, incorporating how to position the patient, types of equipment required and set review dates.

**Key Points**

- If pressure ulcers are present, a Wound Assessment Chart (Appendix 2) should be completed for each wound present. The ulcer(s) should be traced and, where possible, photographed.

- The Wound Management Guidelines should be used to assist in choosing the appropriate wound management product for the pressure ulcer.

- Patients who are able and willing should be informed and educated about risk assessment and resulting prevention strategies. This strategy should, where appropriate, include carers (N.I.C.E, 2001)

- Liaise with other members of the multi-disciplinary team, for example, dieticians (where there are nutritional problems), physiotherapists, occupational therapists (where there are problems relating to mobility, function & seating).

- Patients who are ‘at risk’ of pressure damage should be repositioned and the frequency of repositioning determined by the results of skin inspection and individual needs, not by a ritualistic schedule (N.I.C.E 2001).

- Repositioning should take into consideration other relevant matters, including the patient’s medical condition, their comfort, the overall plan of care and the support surface (N.I.C.E, 2001).

- Patients should be positioned in such a way as to minimise the impact on bony prominences (e.g. 30° tilt – see Appendix 3).

- The detrimental effects of shear and friction should be minimised by:
  - raising the end of the bed
  - using the knee-break facility on the electric bed frames
  - using appropriate manual handling techniques and equipment
  - removal of slings, sleeves, sheets or other parts of the handling equipment after moving the patient.

- When planning to sit the patient out of bed consider the following points:
  - The severity of the ulcer
  - The patients’ ability to sit in an armchair
  - Ergonomics of the chair (e.g. height, depth, width)
  - Ease of transfer from the bed to chair and use of appropriate moving equipment
  - Posture, mobility, comfort and support
- Functions required when sitting, e.g. eating/washing
- Appropriate length of time to sit in chair
- Patient choice and psychological considerations

- Patients ‘at risk’ from pressure damage, who cannot relieve their own pressure independently, should **restrict chair sitting to a maximum of 2 hours at any one time.**

- Where there is potential for a moving problem, the identified Manual Handling Risk Assessor should perform a risk assessment. If further advice is required, consult the Manual Handling Advisors at the earliest opportunity.

### 4. **Pressure Relieving Devices:**

Selection of pressure-redistributing device/s, appropriate to the patients risk score, on completion of the assessment.

*(See Appendix 2 for Whittington Guidelines)*

Treatment objectives should be considered when selecting pressure-redistributing devices. These objectives should be integral to the plan of care and should be documented together with base-line assessment details.

**Accessing Pressure – Redistributing Equipment**

The following process is in place for accessing pressure redistributing equipment:

- Specialist mattresses and seating cushions are now held in a central bed store
- Specialist mattresses and seating cushions can be accessed through the Tissue Viability Nurse Specialist bleep 3044 or call 3340.
- Out-of-hours access to the central bed store can be obtained through the Site Manager, bleep 3340.
- For guidance on ordering specialist mattresses and seating cushions, please read “Procedure for ordering specialist mattresses” (Appendix 4).

**Remember:** when re-assessing patients risk, consideration should be given to whether the pressure-redistribution equipment in use is still adequate. Consideration should also be given to whether equipment can be stepped-down or discontinued.

If patient is going to be transferred to another department or hospital, it is the responsibility of the nurse organising the transfer to communicate relevant information regarding risk assessment, pressure ulcers and/or the type of equipment the patient requires.

**Note:** the following items must not be used as pressure relieving aids: water filled gloves; synthetic sheepskins; genuine sheepskins and doughnut-type devices *(N.I.C.E, 2001).*

‘RIK’ mattress and special foam mattresses are shared between wards and must be cleaned before they are moved between patients or wards.
5. **Maintain and Protect Skin Integrity:**

- When handling patients, nurses / midwives / AHPs should take care not to damage a patient’s skin. Neither rings (other than wedding bands) nor watches should be worn when turning or repositioning patients, and nails should be kept short and nail varnish removed.

- The skin should be kept hydrated. Flaky, cracked or dehydrated skin should not be washed with soap. An emollient soap substitute should be used (e.g. aqueous cream, oilatum or emulsifying wax). Moisturising creams should also be applied to the skin topically i.e. E45.

- The patients skin should be thoroughly dried using a patting motion, particularly over vulnerable areas. Do not use a rubbing motion when drying patients as this has shown to cause deeper tissue damage.

- Talcum powder should not be used by patients on areas which are at risk of developing pressure sores because of its tendency to cake, thereby increasing friction.

- Cavilon, Spirlon may be used to protect skin from excoriation caused by incontinence or exudate for wounds/pressure ulcers.

6. **Nutritional Status:**

Assess the patients nutritional status and plan interventions accordingly.

- It is imperative that the patients nutritional status is assessed objectively and regularly and recorded in the patients care plan. It has been cited that protein calorie malnutrition is a major factor in the development of pressure ulcers because it reduces the body’s ability to heal and repair itself (Breslow et al 1991).

- Referral to the dietician should be made as felt necessary and dietary supplements should be available for the patient.

- In order to make an accurate assessment, it may be necessary to calculate the patient’s body mass index, in which case the patient’s height should be measured and a recognised tool for body mass index implemented. (Dieticians can advise on how to measure this correctly).

- Dehydration should be avoided in order to maintain an adequate circulating blood volume and good skin and tissue perfusion.

7. **Moving and Handling Requirements:**

Assess the patients moving and handling requirements and plan care accordingly.

- All patients must have a Patient Handling Risk Assessment completed within 24 hours of admission. (Form available on the Whittington Intranet under “Strategies
and Policies- Manual Handling Policy”) It is also a component of the Integrated Care Plan.

- Patients should be encouraged to move independently where possible. If assistance is required, safer handling techniques should be employed. The Trust Moving and Handling Policy identifies a number of techniques which **must not** be used, these include the Drag and Cradle Lifts.
  
  - The Drag Lift causes shearing and friction which contribute to the development of pressure sores on heels and buttocks.
  - Cradle Lift – sensitive skin may be damaged by carers pushing their arms under patients, heels and buttocks may be subjected to shearing and friction.

- Slide sheets help to eliminate friction and should be used to assist/move patients with mobility needs.

- When hoisting patients who are unable to weight-bear, hoist slings must be the correct size and properly fitted. Hoist slings should not be left under patients for extended periods of time.

- The use of four section electric profiling beds can contribute significantly to reducing pressure on the heels and reducing friction and shearing on the sacrum. Patients weighing in excess of 160kg **must** be provided with an electric profiling bed.
References:


DoH (1993) Pressure Sores – A Key Quality Indicator. *Department of Health*


Trust Moving & Handling Policy. 2001

WOUND STAGING:
STIRLING SCALE

STAGE 0

- No clinical evidence of pressure sore.

STAGE 1

- Discolouration of intact skin, light finger pressure applied to the site will not alter the discoloration.

STAGE 2

- Partial thickness skin loss or damage involving epidermis and / or dermis.

STAGE 3

- Full thickness skin loss involving damage or necrosis of subcutaneous tissue, but not extending to underlying bone, tendon or joint

STAGE 4

- Full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint
# Guidelines for the Selection of Pressure Relieving Aids

<table>
<thead>
<tr>
<th>Waterlow Risk Score</th>
<th>Mattress / Bed Recommended</th>
<th>Cushion Recommended</th>
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<tbody>
<tr>
<td><strong>Up to 9</strong></td>
<td>- Vaperm Mattress</td>
<td>- Own Chair Cushion</td>
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<tr>
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<td>- Permaflex</td>
<td>or</td>
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<td></td>
<td></td>
<td>- Wheelchair Cushion</td>
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<tr>
<td><strong>10 - 15</strong></td>
<td>- Vaperm Mattress</td>
<td>- 4&quot; Foam Cushion</td>
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<td>- Permaflex</td>
<td>- Propad Type</td>
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<td>- Overlay e.g. Propad</td>
<td>- Flo-Tech</td>
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<td>- Spenco</td>
<td>- Permapad</td>
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<td>- Alpha Xcell</td>
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<td>- Tempur (Standard)</td>
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<tr>
<td><strong>16 - 20</strong></td>
<td>- Pegasus Biwave*</td>
<td>- 4&quot; Foam Cushion</td>
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<tr>
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<td>- Nimbus 3*</td>
<td>- Propad Type or</td>
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<td></td>
<td>- AirWorks Success®</td>
<td>- Specialist Cushion</td>
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<tr>
<td></td>
<td>- Tempur (Standard)</td>
<td>Containing Gel / Foam</td>
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<tr>
<td></td>
<td>*8 - 20 stone</td>
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<tr>
<td><strong>21 - 30</strong></td>
<td>- Nimbus 3*</td>
<td>- Specialist Cushion</td>
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<tr>
<td></td>
<td>- RIK*</td>
<td>Containing Gel/ Foam</td>
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<td>20st without base mattress</td>
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<td></td>
<td>- Tempur (Premier)</td>
<td>- CareChair®</td>
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<tr>
<td></td>
<td>*8 - 20 stone</td>
<td>Create a care plan for individual patients needs.</td>
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<td></td>
<td>- AirWorks Success®**</td>
<td>High risk patients may need a turning regime</td>
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<tr>
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<td>*20 - 30 stone</td>
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<tr>
<td><strong>30 +</strong></td>
<td>- Consult TVN’S for advice.</td>
<td>- 20 – 30 stone</td>
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<td>Consult moving and handling &amp; TVN.</td>
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</tbody>
</table>

- Please re-assess patient as their condition changes.
- Consult advice from TVN’S and Moving & Handling.
- Return hired beds promptly.

*Hospital owned
**Hired + please consult TVN
1. Every Patient will be assessed for risk of developing a pressure sore using the Waterlow score within 2 hours of admission.

2. Patients admitted via Accident and Emergency will have their initial assessment undertaken in the department.

3. Re-assessment of risk will take place and be recorded. Any significant change in the patient’s condition or every 2 days.

4. The Care Plan will be devised by the patients’ nurse encompassing the appropriate turning/movement regime. The pressure relieving/reducing support system appropriate to the risk will be identified and obtained within the resource available (see pressure relieving/reducing mattresses and pressure relief cushions). Review equipment as patients condition changes i.e. send back hired mattresses, care chair promptly when not needed.

5. Sites at high risk of pressure sore development i.e. over bony prominences will be inspected whenever patients are re-positioned and 2 hourly if giving cause for concern. Care plans will be evaluated and adjustments made.

6. Existing pressure sores will be assessed on admission and recorded in nursing notes. Grade of pressure ulcers according to the Stirling Classification System (Stage 0-5).

7. Staff in other wards and departments undertaking investigation, surgical intervention or accepting transfer of patient will be informed of the Waterlow score and the status of his/her pressure areas ensuring that the need for pressure relief is maintained.

8. Plans of care will include nursing intervention of other intrinsic factors leading to pressure sore development, e.g. the nutritional assessments completed. Status of patients will be sought from the Dieticians. For special dietary requirements to maintain skin integrity and assist wound healing, if sores are present will be identified.

9. Advice will be sought from the Tissue Viability Nurses Specialist according to referral criteria.
<table>
<thead>
<tr>
<th>Bed No</th>
<th>Hosp No</th>
<th>Waterlow</th>
<th>Mattress type</th>
<th>Pressure sore Y/N</th>
<th>Site of pressure sore</th>
<th>Admitted to hospital with pressure sore Y/N</th>
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Total number of patients: No of beds:

Signature: Print name: Job title:
# TURNING CHART

Plan your patient’s daily turning and movement regime.
- Identify pressure areas, which are at risk
- Ensure patients waterlow assessment is up to date

Date: ___________________    Hospital No.____________________

<table>
<thead>
<tr>
<th>TIME</th>
<th>PATIENTS POSITION</th>
<th>COMMENTS</th>
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**KEY**

**PATIENTS POSITION**
- (M) PATIENT MOBILISING
- (L) LEFT SIDE
- (R) RIGHT SIDE
- (P) PRONE
- (B) BACK
- (C) TO SIT OUT IN ARM CHAIR
- (T) THERAPY (Physio, OT)
- (I) INVESTIGATION (Imaging dept)

**PLAN**
- * change patients position
  ______ Hrly
- * Comment on skin using
  Stirling Grading Scale
- * Patient can sit in arm chair
  For ______ Hour Only
Criteria for Referral to Tissue Viability Nurse

The Tissue Viability Nurse should be contacted when:

1. A patient is admitted with Pressure ulcers of grade 2, 3 or 4 or multiple pressure ulcers.

2. A patient is admitted with a non-healing wound from the community.

3. A patient is admitted with a traumatic wound/fungating tumour or burn and requires specialist advice on dressing/care of the wound.

4. A patient has been admitted with a blistering disorder/abscess and specialist advice is required.

5. A patient has a non healing or deteriorating wound (after assessment and an appropriate dressing regime has been followed for a period of not less than one week.)

6. A patient has developed a grade 3 or 4 pressure ulcer whilst an inpatient.

7. A patient has a non-healing/deteriorating surgical wound.

Before referring a patient please ensure that the patient has been fully assessed and all relevant information has been fully documented.

Tissue Viability Nurses may be contacted Monday - Friday by aircall or bleep 3044.

For urgent advice outside working hours please contact the Modern Matron for your area or appropriate Ward Manager. Contact TVN as soon as possible afterwards.