UKMi North West

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A summary of prescribing recommendations from NICE guidance

Pressure ulcers: prevention and management

NICE CG179; 2014

This guideline covers people of all ages at risk of, or who have, a pressure ulcer.

Age categories

- Adults: 18 years or older
- Neonates: under 4 weeks
- Infants: between 4 weeks and 1 year
- Children: 1 year to under 13 years
- Young people: 13 to 17 years

Risk definitions

This guideline uses the terms 'at risk' and 'at high risk' to identify people of all age categories who may develop a pressure ulcer:

- people **'at risk'** are those considered to be at risk of developing a pressure ulcer after assessment using clinical judgement and/or a validated risk assessment tool.
- people at **'high risk'** will usually have multiple risk factors (e.g. significantly limited mobility, nutritional deficiency, inability to reposition themselves, significant cognitive impairment), identified during risk assessment with or without a validated risk assessment tool. Those with a history of pressure ulcers or a current pressure ulcer are also considered to be at high risk.

Prevention

- Be aware that all patients are potentially at risk of developing a pressure ulcer.

Risk assessment

- Carry out and document an assessment of pressure ulcer risk for all ages of patients admitted to secondary or tertiary care **OR** receiving NHS care in other settings (such as primary and community care, care homes and emergency departments) if they have a risk factor, for example:
  - significantly limited mobility,
  - significant loss of sensation,
  - a previous or current pressure ulcer,
  - nutritional deficiency,
  - the inability to reposition themselves,
  - significant cognitive impairment.
- For neonates, infants, children and young people use a validated scale to support clinical judgement e.g. the Braden Q scale for children.
- For adults consider using a validated scale to support clinical judgement e.g. the Braden scale, the Waterlow score or the Norton risk-assessment scale.
- Reassess pressure ulcer risk if there is a change in clinical status e.g. after surgery, on worsening of an underlying condition or with a change in mobility.

Skin assessment

- Offer all people who have been assessed as being at high risk of developing a pressure ulcer a skin assessment by a trained healthcare professional.

Neonates, infants, children and young people

- Take into account:
  - skin changes in the occipital area (back of the head),
  - skin temperature,
  - the presence of blanching erythema or discoloured areas of skin.
- Be aware of specific sites e.g. the occipital area where neonates, infants, children and young people are at risk of developing a pressure ulcer.

Adults

- Take into account any pain or discomfort reported and check the skin for:
  - skin integrity in areas of pressure,
  - colour changes or discoloration (non-blanchable erythema may present as colour changes or discolouration, particularly in darker skin tones/types),
  - variations in heat, firmness and moisture e.g. because of incontinence, oedema, dry or inflamed skin.
- Use finger palpation or diascopy to determine whether erythema or discolouration (identified by skin assessment) is blanchable.
- Start appropriate preventative action in adults who have non-blanching erythema and consider repeating the skin assessment at least every 2 hours until resolved.

Care planning – all ages

- Develop and document an individualised care plan for those assessed at high risk of developing a pressure ulcer, taking into account:
  - the outcome of risk and skin assessment,
  - the need for additional pressure relief at specific at-risk sites,
  - their mobility and ability to reposition themselves,
  - other comorbidities and patient preference.
- Offer timely, tailored information to people and their family/carers, who have been assessed as being at high risk of developing a pressure ulcer. The information should be delivered by a trained or experienced healthcare professional and include:
  - the causes, early signs of, and ways to prevent a pressure ulcer,
  - the implications of having a pressure ulcer.
- Demonstrate techniques and equipment used to prevent a pressure ulcer.
- Take into account individual needs when supplying information to people with: degenerative conditions, impaired mobility, neurological impairment, cognitive impairment, impaired tissue perfusion.

Healthcare professional training and education

- Provide training on pressure ulcer prevention, including:
  - who is most likely to be at risk of developing a pressure ulcer,
  - how to identify pressure damage,
  - steps to take to prevent new or further pressure damage,
  - who to contact for further information and further action.
- Provide further training to healthcare professionals who have contact with anyone who has been assessed as being at high risk of developing a pressure ulcer. Training should include:
  - how to carry out a risk and skin assessment,
  - how to reposition,
  - information on pressure redistributing devices,
  - discussion of pressure ulcer prevention with patients and their carers,
  - details of sources of advice and support.

NHS

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Repositioning – see NICE pathway: neonates, infants, children and young people; adults.

Barrier creams

- Use a barrier preparation to help prevent skin damage in neonates, infants, children and young people who are incontinent and adults at high risk of developing a moisture lesion or incontinence-associated dermatitis.

Pressure redistributing devices

Prevention - see NICE pathway: neonates, infants, children and young people; adults.

Treatment - see NICE pathway: neonates, infants, children and young people; adults.

Treatment and management

- **Do NOT** offer electrotherapy or hyperbaric oxygen therapy to treat a pressure ulcer.

Ulcer measurement and categorisation

- Document the surface area of all pressure ulcers. If possible, use a validated measurement technique e.g. transparency tracing or a photograph.
- Document an estimate of the depth of all pressure ulcers and the presence of undermining, but do not routinely measure the volume of a pressure ulcer.
- Categorise each pressure ulcer using a validated classification tool (such as the International NPUAP-EPUAP [2009] Pressure Ulcer Classification System) to guide ongoing preventative strategies and management. Repeat and document each time the ulcer is assessed.

Nutritional supplements and hydration

Neonates, infants, children and young people

- Offer an age-related nutritional assessment. This should be performed by a paediatric dietitian*.
- Discuss with a paediatric dietitian* whether to offer nutritional supplements to correct nutritional deficiency or to treat a pressure ulcer if nutritional intake is adequate.
- Offer advice on a diet that provides adequate nutrition for growth and healing.
- Assess fluid balance.
- Ensure there is adequate hydration for age, growth and healing. If there is doubt, seek further medical advice.

Adults

- Offer a nutritional assessment by a dietitian*.
- Offer nutritional supplements to adults with nutritional deficiency.
- Provide information and advice to adults and their family or carers, on how to follow a balanced diet to maintain an adequate nutritional status, taking into account energy, protein and micronutrient requirements.
- **Do NOT** offer nutritional supplements if nutritional intake is adequate.
- **Do NOT** offer subcutaneous or intravenous fluids if hydration status is adequate.

*or other healthcare professional with the necessary skills and competencies.

Debridement

Neonates, infants, children and young people

- Consider autolytic debridement with appropriate dressings for dead tissue. If this is unsuccessful; consider sharp and surgical debridement by trained staff.

Adults

- Assess the need to debride a pressure ulcer, taking into consideration:
  - the amount of necrotic tissue,
  - the grade, size and extent of the pressure ulcer,
  - patient tolerance and any comorbidities.
- Offer debridement to adults if identified as needed in the assessment:
  - use autolytic debridement, using an appropriate dressing to support it,
  - consider using sharp debridement if autolytic debridement is likely to take longer and prolong healing time.
- **Do NOT** routinely offer:
  - larval (maggot) therapy,
  - enzymatic debridement.
- Consider larval therapy if debridement is needed but sharp debridement is contraindicated or if there is associated vascular insufficiency.

Negative pressure wound therapy

Adults

- **Do NOT** routinely offer negative pressure wound therapy, unless it is necessary to reduce the number of dressing changes e.g. in a wound with a large amount of exudate.

Neonates, infants, children and young people

- **Do NOT** routinely use negative pressure wound therapy.

Heel pressure ulcers – see NICE pathway: neonates, infants, children and young people; adults.

Pharmacological treatment

Antibiotics and antiseptics

Adults

- Offer systemic antibiotics if there is any of the following:
  - clinical evidence of systemic sepsis,
  - spreading cellulitis,
  - underlying osteomyelitis.
- **Do NOT** offer systemic antibiotics based only on positive wound cultures without clinical evidence of infection.
- **Do NOT** offer systemic antibiotics specifically to heal a pressure ulcer.

Neonates, infants, children and young people

- Consider systemic antibiotics if there is clinical evidence of local or systemic infection.

All ages

- Discuss the choice of antibiotic with a local hospital microbiology department.
- **Do NOT** routinely use topical antiseptics or antimicrobials.

Dressings

Adults

- Discuss with patients and if appropriate, their family or carers, the type of dressing that should be used, taking into account:
  - pain and tolerance,
  - position of the ulcer,
  - amount of exudate,
  - frequency of dressing change.

Neonates, infants, children and young people

- Consider using topical antimicrobial dressings to treat a pressure ulcer where clinically indicated, e.g. spreading cellulitis.
- **Do NOT** use iodine dressings in neonates.

All ages

- To treat grade 2, 3 and 4 pressure ulcers:
  - consider using a dressing that promotes a warm, moist wound healing environment.
- **Do NOT** offer gauze dressings.

See the NICE pathway: Pressure ulcers