Pressure Ulcer

Helpful pointers we’ve learnt

This presentation outlines our new ways of managing pressure ulcers in care home settings. It provides a structured approach to identification, documentation, treatment, and ongoing monitoring of pressure ulcers to ensure optimal resident care and regulatory compliance.

The following slides detail specific responsibilities, timelines, and required actions for all staff members involved in pressure ulcer care, from initial identification through to resolution and prevention of future occurrences.

Response from recent pressure injury and CQC Visit.

Created by Stuart Tyrer 29th November 2025

Initial Identification and Notification

1

Identification

When tissue damage or pressure ulcer is identified, the Registered Nurse (RN) or Senior Care Assistant (SCA) must immediately document the finding and commence appropriate documentation.

2

Notification

Home Manager must be advised of tissue damage within 24 hours. For Grade 3 or above, the Operations Director must be informed. Local Tissue Viability Nurse (TVN) should be contacted for Grade 2 or higher, depending on local policy.

3

Communication

Resident, family members or nominated representatives must be informed and a full care review arranged. Pain levels should be assessed and GP referral made if required.

Why Repositioning Matters

1

Skin dies without movement.

- Tissue can break down in **as little as 2 hours** for high-risk residents.
- Pressure reduces blood flow → oxygen drops → cells die → pressure ulcers start under the skin before you can see them.
- Elderly skin = fragile, tears easily, bruises easily.

2

Risks of poor repositioning:

- Pressure ulcers (painful, can become infected)
- Skin tears during transfers
- Reduced mobility
- Medical complications (infection, hospital admission)
- CQC and safeguarding concerns

“Why do you think sitting positions (Up/A) are more dangerous than lying?”

Correct answer: Pressure is 2× higher on the sacrum when sitting.

Positional Care and Equipment

Implement Positional Change Regime

Establish and document a regular turning schedule tailored to resident needs and ulcer severity. The Home Manager must conduct daily reviews and sign off all positional records.

Equipment Assessment and Provision

Complete an assessment of the resident's current mattress and cushion. If higher specification equipment is required, the RN/SCA will liaise with the Home Manager for consultation and procurement.

Daily Monitoring and Compliance

Conduct daily checks of mattress/cushion settings and record them on the position change log. The Home Manager will perform spot checks during daily walk rounds to ensure full compliance.

Escalate immediately to a nurse or senior if:

- Skin is red and doesn't fade when pressed
- Any blister, purple area, or new wound
- Resident cannot tolerate turning
- Resident is very sleepy or unwell
- Sitting >2 hours for a high-risk resident
- You can't complete a turn safely
- Turn is late (beyond 2 hours)

Documentation Requirements

Comprehensive and accurate documentation is crucial for ensuring continuity of care, maintaining high standards, and complying with regulatory requirements. Proper record-keeping supports informed decision-making and provides a clear audit trail for any potential investigations.

Essential Documentation

- Complete/review Waterlow assessment prior to care plan
- Update body mapping record
- Complete wound care documents including care plan
- Initial wound assessment
- Update skin integrity/prevention plan

Photographic Documentation

- Obtain prior consent for photography
- Ensure photographs are clear with appropriate measurements
- Record weekly to monitor progress

Reporting and Referrals

1

Internal Reporting

- Enter pressure damage as moderate alert on RADAR if grade is greater than 2
- Home Manager to provide weekly updates following wound review
- Implement Tissue Viability Register for home-acquired Grade 3 or 4 pressure ulcers

If the resident refuses Write clearly:

- “Refused – comfort check done – escalated to senior”
- Time and both staff initials
- Go back after 30 mins

2

External Referrals

- Home Manager to confirm grading and refer to TVN as appropriate within 24 hours
- Make Safeguarding referral for Grade 3 or above if appropriate
- Advise Operations Director of Safeguarding referrals
- Consider referrals to other specialists as needed (Dietician, Diabetic foot team, Physiotherapist)

3

Rules:

- Record the exact time (not estimated).
- Use only the approved codes:
- L = Left
- R = Right
- B = Back
- A = Armchair
- Up = Up from bed / in chair
- Bed = Returned to bed
- H = Hoisted
- (Heel) = Heel offloaded

Multidisciplinary Communication

Dietary Support

Ensure chef is aware to provide high protein diet. Update diet notification and encourage fluid intake to support healing and prevent further tissue breakdown.

Maintenance Team

Inform maintenance operative and other colleagues about specialist equipment in use to ensure proper functioning and prevent accidental disruption of therapeutic surfaces.

Training Needs

Consider training requirements for colleagues following investigation, particularly if lack of knowledge has been highlighted as a contributing factor to pressure ulcer development.

Ongoing Monitoring and Investigation

1

24 Hours

Complete initial notifications, documentation and referrals. Enter pressure damage on RADAR if grade is greater than 2. Make Safeguarding referral if appropriate.

2

7 Days

Review all residents' weights, nutritional status and Waterlow assessments. Complete body mapping with consent for all residents. Home Manager to conduct Root Cause Analysis for pressure ulcers greater than Grade 2.

3

Weekly

Home Manager to review wound care documentation and update care plan following review. Provide weekly updates on RADAR. Photograph wound to document progress with appropriate measurements.

Home Manager Review Checklist

Documentation Verification

- Initial Body Map completed, reviewed and in place
- RADAR record and pressure ulcer action plan completed
- Wound assessment documentation and care plan completed
- Verification that wound is redressed as per care plan

Communication Confirmation

- Discussion with Resident and family has taken place
- Appropriate equipment is in place (mattress and cushion)
- Consent for photography is in place where required
- Photos are clear with measurements recorded
- Regular Visits during Walk Arounds Where Operationally Possible

Referral Verification

- All appropriate referrals completed (District Nurses, TVN, Dietician, Diabetic foot team, Physiotherapist, Safeguarding, CQC)
- Wound has been measured on each dressing change
- All documentation signed and dated
- Wound information updated on PCS