INHERITED Clinical Guideline B

NHS

National Institute for Clinical Excellence

Pressure ulcer risk assessment and prevention

April 2001

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Issue date: April 2001
Review date: 2005

Ordering Information
Copies of this Guideline can be obtained from the NHS Response Line by telephoning 0870 1555 455 and quoting ref.23643. A patient version of this document, Working Together to Prevent Pressure Ulcers, can be obtained by quoting ref: 23644. A bi-lingual patient leaflet is also available ref:23651.

Distribution of Guidelines

This document has been circulated to the following:
- Health Authority Chief Executives in England and Wales
- NHS Trust Chief Executives in England and Wales
- PCG Chief Executives
- Local Health Group General Managers
- Medical and Nursing Directors
- GP partners in England and Wales
- Practice Nurses in England and Wales
- Consultants in the care of the elderly in England and Wales
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- Tissue Viability Society Members
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- Medical Director & Head of NHS Quality – National Assembly for Wales
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- Representative bodies for health services, professional organisations and statutory bodies, Royal Colleges

This Guidance is written in the following context:
This guidance represents the view of the Institute which was arrived at after careful consideration of the available evidence. Health professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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Web: www.nice.org.uk

ISBN: 1-84257 083-8
Published by the National Institute for Clinical Excellence
April 2001

Contents

This guideline is a part of the Inherited Clinical Guidelines work programme. It was commissioned by the Department of Health before the Institute was formed in April 1999. It has followed closely the development brief that was agreed at the time of commissioning. The developers have worked with the Institute to ensure, in the time available, that the guideline has been subjected to validation and to consultation with stakeholders. However it has not been possible to subject it to the full guideline development process that the Institute has now adopted.

1. Evidence

1.1 The recommendations in this guideline are graded according to the system set out below.

❶ Generally consistent finding in a majority of multiple acceptable studies

❷ Either based on a single acceptable study, or a weak or inconsistent finding in multiple acceptable studies

❸ Limited scientific evidence which does not meet all the criteria of acceptable studies or absence of directly applicable studies of good quality. This includes expert opinion.

(adapted from Waddell G., Feder G., McIntosh A., Lewis M., Hutchinson A. (1996) Low back pain evidence review. London: Royal College of General Practitioners)

('acceptable' for this guideline refers to those that have been subjected and approved by a process of critical appraisal, see Technical Report for more details).

2. Guidance

2.1 Identifying individuals 'at risk'

2.1.1 Assessing an individual's risk of developing pressure ulcers should involve both informal and formal assessment procedures. ❸

2.1.2 Risk assessment should be carried out by personnel who have undergone appropriate training to recognise the risk factors that contribute to the development of pressure ulcers and know how to initiate and maintain correct and suitable preventative measures. ❸

2.1.3 The timing of risk assessment should be based on each individual case. However, it should take place within six hours of the start of admission to the episode of care. ❸

2.1.4 If considered not at risk on initial assessment, reassessment should occur if there is a change in an individual's condition which increases risk (see section 2.3). ❸

2.1.5 All formal assessments of risk should be documented/recorded and made accessible to all members of the inter-disciplinary team. ❸

2.2 Use of risk assessment scales

2.2.1 Risk assessment tools should only be used as an *aide memoire* and should not replace clinical judgement. ❶

2.3 Risk factors

2.3.1 An individual's potential to develop pressure ulcers may be influenced by the following intrinsic risk factors which therefore should be considered when performing a risk assessment: ❷

- reduced mobility or immobility;
- sensory impairment;
- acute illness;
- level of consciousness;
- extremes of age;

- vascular disease;
- severe chronic or terminal illness;
- previous history of pressure damage;
- malnutrition and dehydration.

2.3.2 The following extrinsic risk factors are involved in tissue damage and should be removed or diminished to prevent injury: pressure, shearing and friction. 2

2.3.3 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: medication and moisture to the skin. 2

2.4 Skin inspection

2.4.1 Skin inspection should occur regularly and the frequency determined in response to changes in the individual's condition in relation to either deterioration or recovery. 3

2.4.2 Skin inspection should be based on an assessment of the most vulnerable areas of risk for each patient. These are typically heels; sacrum; ischial tuberosities; parts of the body affected by anti-embolic stockings; femoral trochanters; parts of the body where pressure, friction and shear is exerted in the course of an individual's daily living activities; parts of the body where there are external forces exerted by equipment and clothing; elbows; temporal region of skull; shoulders; back of head and toes. 3 Other areas should be inspected as necessitated by the patient's condition.

2.4.3 Individuals who are willing and able should be encouraged, following education, to inspect their own skin. 3

2.4.4 Individuals who are wheelchair users should use a mirror to inspect the areas that they cannot see easily or get others to inspect them. 3

2.4.5 Health care professionals should be aware of the following signs which may indicate incipient pressure ulcer development: persistent erythema; non blanching hyperaemia previously identified as non-blanching erythema; blisters; discolouration; localised heat; localised oedema and localised induration. In those with darkly pigmented skin: purplish/bluish localised areas of skin; localised heat which, if tissue becomes damaged, is replaced by coolness; localised oedema and localised induration. 3

2.4.6 Skin changes should be documented/recorded immediately. 3

2.5 Pressure relieving devices

See Section 3.4

2.6. Use of aids

2.6.1 The following should not be used as pressure relieving aids: water filled gloves; synthetic sheepskins; genuine sheepskins and doughnut-type devices. 3

2.7 Positioning

2.7.1 Individuals who are 'at risk' of pressure ulcer development should be repositioned and the frequency of repositioning determined by the results of skin inspection and individual needs not by a ritualistic schedule. 3

2.7.2 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. 3

2.7.3 Individuals who are considered to be acutely at risk of developing pressure ulcers should restrict chair sitting to less than 2 hours until their general condition improves. 3

2.7.4 Positioning of patients should ensure that: prolonged pressure on bony prominences is minimised, that bony prominences are kept from direct contact with one another and friction and shear damage is minimised. 3

2.7.5 A re-positioning schedule, agreed with the individual, should be recorded and established for each person 'at risk'. 3

2.7.6 Individuals or carers, who are willing and able, should be taught how to redistribute weight. 3

2.7.7 Manual handling devices should be used correctly in order to minimise shear and friction damage. After manoeuvring, slings, sleeves or other parts of the handling equipment should not be left underneath individuals. 3

2.8 Seating

2.8.1 Seating assessments for aids and equipment should be carried out by trained assessors who have the acquired specific knowledge and expertise (for example, physiotherapists / occupational therapists). 3

2.8.2 Advice from trained assessors with acquired specific knowledge and expertise should be sought about correct seating positions. 3

2.8.3 Positioning of individuals who spend substantial periods of time in a chair or wheelchair should take into account: distribution of weight; postural alignment and support of feet. 3

2.8.4 No seat cushion has been shown to perform better than another, so this guideline makes no recommendation about which type to use for pressure redistribution purposes. 3

2.9. Education and training

2.9.1 All health care professionals should receive relevant training or education in pressure ulcer risk assessment and prevention. 2

2.9.2 Health care professionals with recognised training in pressure ulcer management should cascade their knowledge and skills to their local health care teams. 3

2.9.3 An inter-disciplinary approach to the training and education of health care professionals should be adopted. 3

2.9.4. Training and education programmes should include: ❸

- risk factors for pressure ulcer development;
- pathophysiology of pressure ulcer development;
- the limitations and potential applications of risk assessment tools;
- skin assessment;
- skin care;
- selection of pressure redistributing equipment;
- use of pressure redistributing equipment;
- maintenance of pressure redistributing equipment;
- methods of documenting risk assessments and prevention activities;
- positioning to minimise pressure;
- shear and friction damage including the correct use of manual handling devices;
- roles and responsibilities of inter-disciplinary team members in pressure ulcer management;
- policies and procedures regarding transferring individuals between care settings; and patient education and information giving

2.9.5 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. ❸

2.9.6 Patient/carer education should include providing information on the following: ❸

- the risk factors associated with them developing pressure ulcers;
- the sites that are of the greatest risk to them of pressure damage;
- how to inspect skin and recognise skin changes;
- how to care for skin; methods for pressure relief/reduction;
- where they can seek further advice and assistance should they need it;
- emphasise the need for immediate visits to a health care professional should signs of damage be noticed

Note: Information for Patients and Carers is appended to this guideline. (Appendix C)

3. Detailed Guideline

3.1 These recommendations are derived from a guideline entitled "Pressure Ulcer Risk Assessment and Prevention" which was commissioned by the Department of Health from the Royal College of Nursing (RCN). It is available on the Institute's website (www.nice.org.uk), the National Electronic Library for Health's website (www.nelh.nhs.uk), and the RCN's website (www.rcn.org.uk) . The contributors to the Guideline are listed in Appendix A.

3.2. This guideline was commissioned before the Institute was formed in April 1999. It followed closely the development brief which was agreed at the time of commissioning. It has not been possible to subject it to the full guideline development process that the Institute has now adopted. The guideline has been reviewed by the Institute's Guidelines Advisory Committee (Appendix B).

3.3. The guideline developers were not in a position to undertake a full assessment of the cost effectiveness of pressure relieving devices and there are, therefore, no recommendations on their use in this document.

3.4. In view of the importance of assessing the cost-effectiveness of pressure redistributing devices, the Institute will commission the Nursing and Supportive Care Collaborating Centre to update this aspect of the guideline using the Institute's methodology.

4. Scope

4.1 The guideline aims to reduce the occurrence of pressure ulcers by providing health care professionals with guidance on the early identification of patients at risk of developing pressure ulcers, the provision of preventative interventions, and by identifying practice that may be harmful or ineffective. The guideline does not cover the epidemiology of pressure ulcers or make recommendations for wound care and/or the surgical management of pressure damage.

4.2 This guideline does not include treatment of existing pressure ulcers. However in cases where a patient has a pressure ulcer, it will be useful in preventing pressure ulcers on other areas of the body.

5. Implementation

5.1 Clinicians and relevant managers should review their current clinical practice against the recommendations laid out in section 2.

5.2 Relevant local clinical guidelines and protocols should be reviewed in the light of this guidance and revised if necessary.

5.3 To enable clinicians to audit their own adherence to this guideline it is recommended that, if not already in place, management plans are recorded for each patient.

5.4 Evaluative statements derived from the recommendations are included in the full text guideline. These should be considered when developing review criteria as part of a clinical audit programme.

5.5 This information should be incorporated into local clinical audit data recording systems and consideration given (if not already in place) to the establishment of appropriate categories in electronic record systems.

5.6 Prospective clinical audit programmes should record the extent to which care adheres to the guideline. Such programmes are likely to be more effective in improving patient care when they form part of the organisation's formal clinical governance arrangements and where they are linked to specific post-graduate activities.

6. Further Research

6.1 As the evidence base for pressure ulcer risk assessment and prevention is poor, the potential research agenda is large.

6.2 Future primary research studies should adhere more closely to current methodological standards for the conduct and reporting of research. There is also a need for the researchers to adopt a structured approach to abstracts which would help reviewers to focus on the essential detail.

6.3 On risk assessment, more epidemiological research needs to be conducted to better understand risk factors. It is recommended that the data, gathered by prospective cohort studies conducted in different health care settings, could generate an 'item pool' which might then be used to develop a new risk assessment scale. The effectiveness of such a scale would need to be evaluated.

6.4 Further research about the effectiveness of other interventions such as re-positioning is required. The practice of routine two- and four-hour turnings is largely a historical artefact with very little quality research support . Studies on the effect of different turning intervals on the development of pressure ulcers may contribute to understanding this practice.

6.5 Similarly, further research which systematically compares the 30 degree/lateral tilt with other positions, in differing patient groups and clinical contexts, including the collection of data on patient comfort as well as physiological measures, would be of value.

6.6 Further research, evaluating the effect of educational programmes, is required. Limited research suggests that educational programmes may have an effect in reducing pressure ulcer incidence. Clinicians' reported experiences indicate that education is key to effective pressure area management. However more conclusive research evidence is required on what should be included in training, at what level, how training and education should be delivered, and how competency is assessed and updated.

6.7 There is also a paucity of research exploring patients' and carers' perceptions and experiences of pressure ulcers, their involvement in pressure area care and their educational requirements. This information might be uncovered by well-designed studies using a mixture of qualitative and quantitative approaches to data collection through, for example, semi-structured interviews and focus groups, and pre-validated quality of life measures.

7. Related NICE Guidance

7.1 Pressure Relieving Devices Guideline (Anticipated publication: 2002)

8. Review Date

8.1 The Institute will review the evidence for pressure ulcer risk assessment and prevention in 2005.

Appendix A

Guideline Development Group

The Guideline Development Group is a multiprofessional team brought together on a project basis, to consider the evidence of clinical and cost effectiveness and develop the guideline.

Guideline developers

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Appendix B

Guideline Advisory Committee

The Guidelines Advisory Committee (GAC) is a standing committee of the Institute. It has responsibility for agreeing the scope and commissioning brief for clinical guidelines and for monitoring progress and methodological soundness. The GAC considers responses from stakeholders and advises the Institute on the acceptability of the guidelines it has commissioned. The members of the GAC are:

Chairman: Professor Martin Eccles
Professor of Clinical Effectiveness,
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Vice Chair: Professor Gene Feder
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MSD

Appendix C

Working Together to Prevent Pressure Ulcers

A Guide for Patients and their Carers

The patient information in this appendix has been designed to support the production of your own information leaflets. You can download it from our website at **www.nice.org.uk** where it is available in English and Welsh. If you would like printed copies of the leaflets please ring the NHS Response Line on 0870 1555 455 and quote reference number 23644 for the English patient leaflet and 23651 for the bi-lingual patient leaflet.

About clinical guidelines

The National Institute for Clinical Excellence (NICE) is a part of the NHS. It produces guidance for both the NHS and patients on medicines, medical equipment and clinical procedures and where they should be used. This guidance exists to help patients and their healthcare team make the right decisions about health care. The recommendations in this booklet are adapted from a guideline produced by the National Institute of Clinical Excellence based on the work of the Royal College of Nursing. The advice is based on the results of scientific studies and expert knowledge of the best ways to prevent pressure ulcers.

This booklet contains the best advice currently available to help people avoid getting a pressure ulcer. It is for people who are at risk of developing a pressure ulcer (also known as pressure sores or bed sores). If you have a relative or carer who helps to look after you, they may also find this booklet useful. It has been written to help you be involved in your care and to know what to expect from healthcare staff who look after you.

What are pressure ulcers?

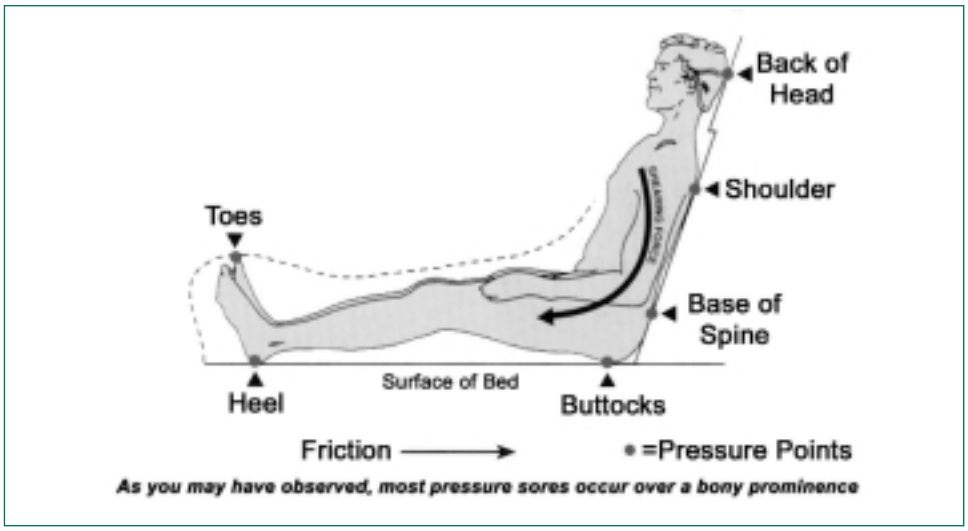
Clinical guidelines are recommendations for good practice. They are not regarded as a substitute for a health professional's clinical judgement. Therefore there may be good reasons for the treatment you are offered to differ from the recommendations in this booklet. If the care you receive is very different, then you (and / or your carer) should discuss the reasons with your doctor or nurse.

Pressure ulcers are areas of damage to the skin and underlying tissue. They are also known as pressure sores or bed sores.

If care is not taken, pressure ulcers can be serious. They can damage not just the skin but also the fatty tissue beneath the skin. Pressure ulcers may cause pain, or lead to a longer stay in hospital. They can become infected, sometimes causing blood poisoning or bone infections. In severe cases, the underlying muscle or bone may be destroyed. In extreme cases pressure ulcers can become life threatening.

Pressure ulcers are caused by a combination of:

- **Pressure** – normal body weight can squash the skin in people at risk and damage blood supply to the area which can lead to tissue damage;
- **Shearing** – strain forces the skin and upper layers away from deeper layers of skin. This can happen when you slide down, or are dragged up, a bed or chair;
- **Friction** – poor lifting and moving techniques can remove the top layers of skin. Repeated friction can increase the risk of pressure ulcers.



(Diagram courtesy of the Tissue Viability Society)

Usually, people can relieve the effects of pressure, friction or shearing, by moving around, changing position and adjusting clothing and bedding. If you are unable to do this, you may be at increased risk of developing pressure ulcers.

You may be at risk of developing pressure ulcers for a number of reasons, including:

- **Problems with movement**
  Your ability to move may be limited or you may be unable to move. This may be due to a variety of causes, for example, a spinal cord injury, old age, very young age, a long-term illness such as osteoarthritis, a sudden event or condition such as being unconscious or during an operation.

- **Problems with sensitivity to pain or discomfort**
  Some conditions (for example diabetes, stroke) and some treatments (eg epidural pain relief) may reduce your sensitivity to pain or discomfort so that you are not aware of the need to move.

- **Poor circulation**
  Poor circulation caused, for example, by vascular disease or heavy smoking, may increase your risk of pressure ulcers.

- **Moist skin**
  You may be at increased risk if damp skin caused, for example, by incontinence, sweat, or a weeping wound, is not kept clean and dry.

- **Pressure ulcers in the past**
  Scar tissue from a previous pressure ulcer is weaker and more prone to further damage.

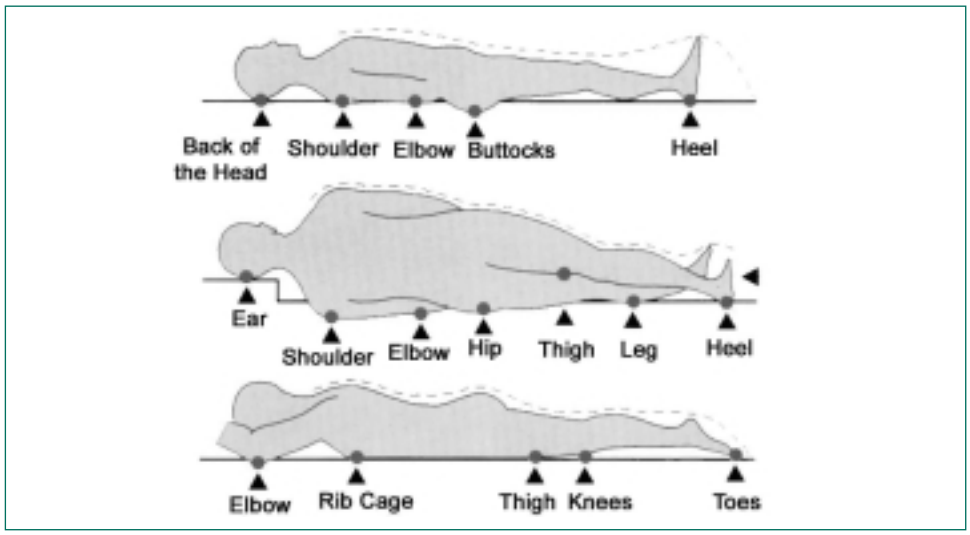
- **Inadequate diet or fluid intake**
  Poor diet may cause you to be malnourished. Lack of fluid intake may lead to dehydration. Losing too much weight can lead to loss of padding over bony points.

Assessing your risk

To assess your risk of developing pressure ulcers, a member of the health care team looking after you will examine you and ask you certain questions. This is called a 'risk assessment'.

Your risk assessment should be carried out by someone who has had special training in identifying people at risk of developing pressure ulcers. The timing of the risk assessment will depend on your individual circumstances and condition but should take place within six hours of any admission to hospital. If you (or your carer) are aware of a risk, you should inform the health care staff looking after you as soon as possible. The results of the risk assessment should be noted in your medical records.

Common sites for pressure ulcers



(Diagram courtesy of the Tissue Viability Society)

If the assessment reveals that you are at risk, your health care team should draw up a plan of action (a prevention plan) to help prevent the development of a pressure ulcer. The prevention plan should be discussed with you (and/or your carer if appropriate), written into your medical records and put into action shortly after the examination.

If your condition or circumstances change over time, your risk of developing pressure ulcers should be reassessed.

Care from your health care staff – what you can expect

You (and your carer if appropriate) should be fully informed about your care and be involved in decisions about your care. The health care staff who look after you should respect and take into account your knowledge and experience, especially if you have been at risk of pressure ulcers for a long time.

The care and advice you should expect to receive from health care staff to prevent pressure ulcers should include:

Skin inspection

Your skin will be inspected regularly. How often will depend on how quickly your condition is changing. The areas of skin that your health care staff inspect will depend on the areas identified as vulnerable in your risk assessment.

Position

If you are able to do so, you will be encouraged to change your position at frequent intervals and advised about correct seating positions, supporting your feet and posture.

If you need help to move, staff looking after you will move you at regular intervals. How often you are moved and to what position will depend on your level of risk. This should be agreed with you and recorded in your notes. If you are uncomfortable at any time, tell the staff who are looking after you.

Staff may use special lifting equipment and should not leave you on the equipment once it has been used to move you.

Equipment

You should not use the following as pressure relieving aids: water filled gloves; synthetic sheepskins; genuine sheepskins and doughnut-type devices.

No seat cushion has been shown to out-perform another. It is not possible to recommend any particular type to use for pressure redistribution purposes.

Information and training

If you (or your carer) want information or training on how to prevent pressure ulcers yourselves, health care staff can offer this. They can provide information and advice on:

- the risk factors associated with developing pressure ulcers
- areas of your skin that are of the greatest risk of pressure damage
- how to inspect your skin and recognise skin changes
- how to care for your skin
- methods for relieving or reducing pressure
- the need to seek professional advice as soon as you notice signs of pressure
- where to seek further advice and assistance if you need it

Things you can do for yourself to avoid pressure ulcers are described in more detail below.

Self care - what you and your carer can do

Skin inspection

If you are willing and able to do so, staff can teach you how to inspect your own skin. Training can also be given to your carer (if you have one). You or your carer should inspect your skin regularly, looking for signs of possible or actual damage.

The signs to look for are:

- Purplish/bluish patches on dark-skinned people
- Red patches on light-skinned people
- Swelling
- Blisters
- Shiny areas
- Dry patches
- Cracks, calluses, wrinkles

The signs to feel for are:

- Hard areas
- Warm areas
- Swollen skin over bony points

If you or your carer notice possible or actual signs of damage, you should inform your health care staff immediately. Contact the nursing staff if you are in hospital or your district nurse or GP if you are at home.

Relieving pressure

You (and your carer if you have one) should be given advice on how best to relieve or reduce pressure on areas of your skin that are susceptible to pressure damage. You should be given advice about:

- What are the correct seating and lying positions
- How to adjust your lying or sitting position.
- How often you need to move or be moved.
- Which equipment you should use and how.
- How to avoid pressure (e.g. by making sure bedding is free of creases, clothing does not have thick seams, zips, studs and buttons, and shoes and socks are not too tight).

Further information

For further information about pressure sores talk to your Doctor or Nurse. Tissue Viability Nurses are specially trained in pressure ulcer care. Advice on and assessment of your need for seating aids and equipment may be available from your local physiotherapy or occupational therapy department.

For confidential healthcare advice and information contact

NHS Direct	Phone 08 45 46 47
NHS Direct online	web www.nhsdirect.nhs.uk

For specialist information on pressure ulcers and how to prevent them contact:

The Tissue Viability Society	Phone:	01722 429057
The Glanville Centre		Mon to Fri 9.00am till 5.00pm
Salisbury District Hospital	e-mail:	tvs@dial.pipex.com
Wiltshire SP2 8BJ	web:	www.tvs.org.uk

For further information about NICE, the Clinical Guidelines Programme or other versions of this guideline (including the sources of evidence) you can visit the NICE website at www.nice.org.uk. Full copies of the guideline can be requested from 0870 1555 455, quoting the reference number 23643.

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