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Belfast Health and Social Care Trust
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Reference No: SG 17/09

Title:	**Pressure Ulcer Prevention and Management in Adults and Children**			
Policy Author(s)	[redacted]@belfasttrust.hscni.net [redacted]@belfasttrust.hscni.net [redacted]			
Responsible Director:	[redacted] Nursing and User Experience Director			
Policy Type: (tick as appropriate)	*Directorate-specific ☐	Clinical Trustwide ✓	Non-clinical Trustwide ☐	Regional Policy ☐
If ***Directorate-specific** please list the name and date of the local Committee/Group that policy was a**pproved**		Does this policy have Workforce implications? **N** (if *Y please note the date it was approved at Workforce Governance Policy Sub-Committee		
Name: **Date:**		**Date:**		
Approval process:	Policy and External Guidance Assurance Committee Executive Team	**Approval date:**	03/03/2026 24/03/2026	
Operational Date:	March 2026	**Review Date:**	March 2031	
Version No.	4	**Supercedes**	V3 - September 2020-January 2025	
Key Words:	Pressure Ulcer			
Links to other policies	Healthcare Acquired Pressure Ulcers (HAPU): Protocol for carrying out a post pressure ulcer incident review. Guideline for Pressure Injury Prevention and Management in the Regional Neonatal Unit (RNU), Royal Jubilee Maternity Hospital, (RJMH) Wound Management: Principles of Caring for Patients with an Open Wound Promotion of Continence Policy (Adults) Managing risk of non-compliance with care and treatment Nursing roles and responsibilities with regards to patients with Diabetes presenting with foot ulceration.			

Version control for drafts: (box to be removed prior to issue).
Identifies where changes have been made to a document and ensure Policy Authors are using the most recent version.

- The first draft must be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.
- Reviews will then be versioned 1.2, 1.3.
- If major changes are made to the document then it will be reissued through the committee process and renamed as version 2.0.

Date	Version	Policy Author	Comments

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

Pressure ulcers range in severity, from patches of discoloured skin to extensive wounds filled with necrotic tissue and involving fascia, muscle, and bone (EPUAP/NPIAP/PPPIA, 2019). They usually occur over a bony prominence but may also be related to a medical device or other objects. Complications of pressure ulcers include pain, infection, and increased mortality. They are recognised as one of the top three burdensome harms (Slawomirski et al, 2017), and result in the highest number of healthy life years lost (Hauck et al, 2017). In addition, Guest et al (2017) demonstrated that they detract from scarce NHS resources, resulting in the highest number of bed day losses, and high treatment costs (thought to be in excess of £1.4 million every day) (Guest et al 2017).

1.2 Purpose

1.2.1 This policy outlines the responsibilities of staff regarding the prevention and management of pressure damage. It applies to all patient groups including infants, children, young people and adults.

1.2.2 Policies which should be read in conjunction with this policy include:

Healthcare Acquired Pressure Ulcers (HAPU): Protocol for carrying out a post pressure ulcer incident review (SG13/19)

Wound Management: Principles of Caring for Patients with an Open Wound (12/09)

Promotion of Continence Policy (Adults) (22/11)

1.3 Objectives

- To ensure early identification of patients 'at risk' of developing pressure damage
- To guide staff in the provision of safe, standardized, evidence based pressure ulcer preventive care and management

2.0 SCOPE OF THE POLICY

2.1 This policy must be implemented by all staff involved in the care of infants, children young people or adults with existing pressure damage, or who are 'at risk' of pressure damage

3.0 ROLES AND RESPONSIBILITIES

3.1 It is the responsibility of all healthcare practitioners who care for patients with or at risk of pressure damage to adhere to this policy to:

- Be familiar with the policy
- Facilitate an integrated approach to pressure ulcer prevention and management across the hospital/ community interface.
- Be familiar with Encompass pressure ulcer prevention and management documentation, including assessments, preventative care planning and evaluation

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

A pressure ulcer is defined as localized damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear. They usually occur over a bony prominence but may also be related to a medical device or other objects EPUAP/NPIAP/PPPIA (2019).

4.2 Key Policy Statement(s)

The Belfast Trust recognises that pressure ulcers are a threat to patient safety and well-being. It recognises that nurses and midwives play a key role in supporting vulnerable patients by assessing their risk of pressure ulceration and implementing an individualised pressure ulcer prevention plan. However, pressure ulcer prevention requires a multidisciplinary approach and as such, the expert advice of other healthcare practitioners must be provided as and when appropriate.

4.3 Policy Principles

4.3.1 Pressure Ulcer Risk Assessment

Emergency Department (ED) – A RN must assess risk using the PURPOSE-T Screening Tool within 4 hours of arrival to ED if the patient has a functional deficit or there has been a decision to admit

In-patients - A registered nurse/midwife must risk assess patients using PURPOSE-T. This must be completed within 6 hours of admission to hospital, or on transfer from one ward to another. Individuals with overarching medical/surgical needs must be assessed as soon as the situation allows.
The assessment must be updated if the patient's general condition or level of mobility deteriorates. Otherwise, reassess weekly in acute wards and monthly in continuing care facilities e.g. Neurology, Spinal injuries Unit, Amputee Rehabilitation Unit

Community - Community nurses must carry out a risk assessment when a patient/service user is admitted to their caseload.

The risk assessment must be re-evaluated if the patient's general condition or level of mobility deteriorates, otherwise

- 3 monthly for people at risk
- Annually for people who are deemed not to be at risk but remain on the caseload

Recovery – Staff should reassess the patient's pressure ulcer risk within 2 hours of admission to recovery.

Trust Residential Homes – Residents' skin must be checked daily by care workers. If a resident develops non-blanching erythema, blisters, breaks or a discoloured area (blue/purple/black) the Senior Carer must be informed immediately. The Senior Carer must check and document the area of concern, and refer to a District Nurse (DN).

The Senior Carer should contact a DN if they feel a resident is at risk of pressure damage and requires a pressure relieving preventive plan

4.3.2 Patient/Service User/Carer Education - Where appropriate, individuals and carers* must be informed about the potential risk of pressure damage and provided with a relevant information leaflet. Individuals or carers, who are willing and able, should be encouraged to take responsibility for skin inspection and taught how to redistribute weight by their nurse or AHP.

*The term 'carer' refers to unpaid carers as opposed to care workers

4.3.3 Pressure Ulcer Prevention/Management Care Plan - An evidence-based pressure ulcer prevention/management care plan (SSKIN Bundle) must be implemented for individuals with established pressure damage, or 'at risk' of pressure damage. If the skin is broken, this should be detailed on the LDA Avatar on Epic, ensuring a wound assessment is completed.

The wound should be assessed and managed according to the principles outlined in the Trust Wound Care Policy (SG 12/09)

4.3.4. Skin inspection – a registered nurse/midwife must inspect the pressure points of people with:

- Reduced mobility
- Pressure damage/ history of pressure damage
- Reduced sensation or inability to respond appropriately to discomfort from pressure e.g. cognitive impairment, epidural, diabetic neuropathy

The condition of pressure areas should be recorded on admission/ transfer between wards, at least once per shift, and prior to discharge. In Theatre and Interventional Radiology, staff must record the condition of the skin pre-and post-procedure.

In community, this should be completed on admission to caseload, any deterioration in condition and as per individualised care plan/Service Plan.
Pressure damage must be categorised using the International NPUAP/EPUAP Pressure Ulcer Classification System (Appendix 1).

4.3.5 Surfaces: Everyone 'at risk' of pressure ulcers should, as a minimum, be placed on a support surface (mattress, cushion) with pressure-reducing properties.

NB. Patients on ED trolley, who are at risk of pressure damage, should be transferred onto a hospital bed, at the earliest opportunity.

If the patient has pressure damage or their skin deteriorates on these systems (and they are medically fit to be moved), their mattress/cushion may be upgraded (see relevant hospital, community and paediatric mattress flow charts which are available on the Loop Pressure Relieving Equipment Information.

Do not use water filled gloves and donut-shaped devices, as they are ineffective and can cause pressure damage.

Medical Devices, e.g., mattresses, cushions, oxygen masks, collars – Professionals involved in contract adjudication groups should seek to procure devices, which minimise tissue damage. Registered practitioners should:

- Correctly fit and regularly assess the skin under and around medical devices for signs of pressure related injury as part of routine skin assessment.
- Record medical devices & skin checks on Encompass
- Rotate or reposition the medical device as per individualised plan of care.
- Where appropriate, provide physical support for medical devices in order to minimize pressure and shear.
- Remove medical devices as soon as feasible.
- Use a prophylactic dressing to reduce the risk of medical device-related pressure damage if appropriate.
- If safe and appropriate, alternate the oxygen delivery device between correctly fitting mask and nasal prongs to reduce the severity of nasal and facial pressure damage.

Seating -

- Immobile patients should only sit out of bed for **limited periods** in an appropriate chair or wheelchair – the length of time that the patient can sit safely is determined by individual factors, e.g. presence of pressure damage and tissue tolerance. An example of a sitting protocol is provided in Appendix 1.

- People who, despite education, sit/sleep in a chair (most of the day and night), are at a very high risk of pressure damage. Document and escalate concerns. See Managing risk of non-compliance with care and treatment
- Refer patients/service users with specialist seating needs to an Occupational Therapist for a comprehensive assessment of posture and pressure ulcer prevention. People who require specialist static seating or wheelchairs include those with poor posture e.g. contracture and/or marked skeletal deformity, uneven pelvis, tight hamstrings, reduced sitting balance.
- Certain client groups are at particularly high risk of sitting acquired pressure ulcers and require assessment from Occupational Therapy. These include people with a spinal cord injury, amputation, those who are terminally ill and those with severe behavioural needs.

4.3.6 Keep moving/mobile – A registered nurse/midwife must determine how often a patient needs to be repositioned. Consider skin condition as well as the degree to which the patient can move independently without prompting or assistance.

Inpatients, who cannot mobilise independently should, if medically stable, be repositioned

- 2 hourly when seated or as per individualised seating plan
- 4 hourly in bed or an ED trolley as per individualised repositioning plan

Unless contraindicated, position in a 30° lateral tilt when in bed to reduce pressure over bony prominences (Appendix 2). Ensure that the position is changed at each turn, e.g. if they have been lying on their right side, move them onto their left side and record using the positioning codes listed on Encompass. Record Variances. Use manual handling techniques and equipment that reduce friction and shear.

Theatre/Interventional Radiology - during a long procedure, record position changes (if possible) and any pressure relieving devices used.
For individuals at risk of, or with heel pressure ulcers, offload the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon. Consider the use of a heel-offloading boot.

NB. People with renal disease, Diabetes Mellitus, peripheral arterial disease and reduced sensation are at particularly high risk of pressure damage on their feet.

Neonates must be nursed in accordance with the Guideline for Pressure Injury Prevention and Management in the Regional Neonatal Unit (RNU), Royal Jubilee Maternity Hospital, (RJMH).

In the community setting, the repositioning regime should be negotiated with the patient and their main carers. This regime will take into account the patient's level of independence/ mobility, the condition of their skin, their health and well-being, the overall plan of care, the equipment in place and their care-package (as appropriate).

4.3.7 Balancing comfort with repositioning at end of life
Patients receiving palliative and end of life care (who are unable to make significant position changes), should be assisted to change their position at least 4 hourly. This is important as pressure damage can lead to additional pain and discomfort.
Patients who experience significant pain on movement should be given adequate pain relief approximately 15-20 minutes prior to scheduled position changes ; being

mindful of the need to maintain a balance between maintaining adequate pain control whilst avoiding over-sedation.

For individuals who are actively dying (considered to be dying in the next 24 to 48 hours), prevention and treatment of a pressure ulcers, may be superseded by the need to promote comfort by minimising turning and repositioning and allowing the patient to determine the frequency of turning and choice of position.

Additional help and advice can be obtained from the Hospital Supportive & Specialist Palliative Care Team (inpatients), District Nursing or if known to Hospice Services, the Specialist Palliative Care Nurse (Community). Further help and advice regarding skin care, support surfaces and different handling techniques may be obtained from the Tissue Viability Nurse Team or the Ergonomic Advisors.

4.3.8 Increased moisture - Where moisture (urine, faeces, wound fluid, sweat) is identified as a problem, action needs to be taken to limit its damaging effect. This may include the promotion of continence (refer to Continence Team if appropriate), the diligent and appropriate use of skin cleansers, barrier products and containment devices (pads, faecal management system etc.). 'Inco' sheets (procedural sheets) must not be used to manage urinary incontinence.

4.3.9 Nutrition & Hydration - Patients with pressure damage have increased nutritional requirements. All patients with established pressure ulcers or who are identified as being 'at risk' of pressure damage should be nutritionally assessed, using a validated screening tool such as MUST (Adults) or STAMP (Children), where appropriate.

In hospital, refer the following patients to the dietician for a full nutritional assessment:

- Patients with a MUST score of ≥ 2
- Patients with multiple Stage 2 pressure ulcers or deep pressure damage.
- Patients with non-healing or highly exuding pressure ulcers.
- Patients with increased nutritional needs due to disease or injury.
- Patients with diabetes who have poor glycaemic control
- Patients with malabsorption problems e.g. IBD (Irritable Bowel Disease)
- Patients with an unintentional weight loss of 10% or more over the previous 3– 6 months
- Patients who are unable to meet with their nutritional requirements due to
    - Poor appetite
    - Dysphagia
    - Inability to take food and fluids orally

Patients who have a BMI ≤ 20 or a BMI ≥30 are also at risk of nutritional deficiencies and poor wound healing; consider dietetic referral.

In community, discuss the need for dietetic input with the patient's General Practitioner.

4.3.10 Reporting - Report all Trust acquired pressure ulcers (category 2 and above) as a clinical incident and complete a post pressure ulcer incident review. Category 3, 4, Ungraded and Deep Tissue Injuries must be referred to the Tissue Viability Nurse (TVN) Team via a referral (Community) or an Inpatient

Consult (Hospital). The TVN team will assess the wound and determine if a safeguarding referral is required. Guidance in relation to adult pressure ulcer safeguarding concerns is available at Adult Safeguarding concerns in relation to pressure damage

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

5.1.1 This policy is relevant to all Nursing & Midwifery Staff, Medical Staff, Occupational Therapist, Physiotherapists, Podiatrists, Ergonomics Team, and Dieticians

5.1.2 This policy is a review of the previous Pressure Ulcer Prevention and Management Policy. There are no major amendments to the key policy statements. We do not perceive any barriers to implementation. Practitioners should notify the Lead Nurse for Tissue Viability (Dr. Jeannie Donnelly) if significant barriers to implementation are noted.

5.2 Resources

5.2.1 Practitioners can access Pressure Ulcer Prevention training through LearnHSCNI
5.2.2 Loop Page detailing pressure relieving equipment
5.2.3 Guidance in relation to adult pressure ulcer safeguarding concerns

5.3 Exceptions

5.3.1 None

6.0 MONITORING

6.1 KPI in relation to SSKIN BUNDLE care are currently being validated at a regional level. These should be implemented within the next 12 months. If this takes longer than expected, the Tissue Viability Nurse team will audit referrals once a year to determine compliance with this policy. The audit will be registered with the Quality Improvement Team, outcomes reported and an action plan prepared, where appropriate.

7.0 EVIDENCE BASE/REFERENCES

- EPUAP/NPIAP/PPPIA (2019) *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline*. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance. https://www.internationalguideline.com

- Guest, J.F., Ayoub N., McIlwraith T., Uchegbu, I., Gerrish, A., Weidlich, D., Vowden K., Vowden, P. (2017) Health economic burden that different wound types impose on the UK's National Health Service. Int Wound J 14(2): 322–30

- Hauck KD, Wang S, Vincent C, Smith PC. Healthy Life-Years Lost and Excess Bed-Days Due to 6 Patient Safety Incidents: Empirical Evidence From English Hospitals. Med Care. 2017 Feb;55(2):125-130.

- NICE Pressure Ulcers, Quality Standard 89 (2015) https://www.nice.org.uk/guidance/qs89

- Slawomirski, L., Auraaen, A., and Klazinga, N. (2017), "The economics of patient safety: Strengthening a value-based approach to reducing patient harm at national level", OECD Health Working Papers, No. 96, OECD Publishing, Paris, https://doi.org/10.1787/5a9858cd-en.

8.0 CONSULTATION PROCESS

Policy circulated to key stake holders and all Directorates via Senior Nursing and AHP lines (5th of August 2025).

Also circulated to the following teams and managers

- Tissue Viability Nurse Team
- Podiatry – Jennifer Madden and John McCarry
- Physiotherapy – John
- Emergency Department (RVH) – Claire Wilmont
- Specialty doctor in Geriatric Medicine – Moses Mushipe

Comments subsequently received from Band 8A nurse in ED, Band 8C Divisional Nurse Cancer Services, Band 8B Nursing Management, Physiotherapist Team Lead, Meadowlands Frailty Assessment Unit & Tissue Viability Nurse Team. Minor revisions made.

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in understanding principles of pressure ulcer prevention and management in adults and children where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present

and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

10.0 APPENDICES

Appendix 1: Sitting Protocol
Appendix 2: Repositioning Techniques (30-degree Tilt)

11.0 EQUALITY SCREENING

Under Section 75 of the Northern Ireland Act 1998 the Trust has a legal responsibility to undertake an equality screening of all policies. To fulfil this duty an equality screening template must be completed by the policy author.

To complete an equality screening use this template: (LINK)

For support with completion of the template go to: **Equality Screening Toolkit**

For any queries and/or to obtain approval contact the Planning and Equality Team contact: equalityscreenings@belfasttrust.hscni.net or 028 95 048734

Equality Screenings are public documents and previously completed documents can be viewed at Equality and Human Rights Screening | Belfast Health and Social Care Trust (hscni.net)

12.0 STATUTORY RURAL IMPACT ASSESSMENT DUTIES

The Trust has a legal responsibility to have '**due regard'** to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. For more information go to Rural Needs Duties

To satisfy this '**due regard duty'** Trust staff must consider the impact of any policy, proposal or decision on the social and economic needs of people who live in a rural community. For Belfast Trust, this is particularly so when the policy/proposal/decision impacts regional services.

Please tick the box to indicate that you have paid 'due regard' to the social and economic needs of the rural community when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services and that a rural impact assessment is not required. ☒

OR

Please complete a Rural Needs Impact Assessment Template if there is an impact on the social and economic needs of people who live in a rural community.

Please go to the: Rural Impact Assessments Toolkit for HSC NI to find out how to undertake a rural impact assessment.

Contact [redacted]@belfasttrust.hscni.net for further advice

13.0 STATUTORY EQUALITY DUTIES – MAKING REASONABLE ADJUSTMENTS AND INFORMATION ACCESSIBLE

Under the Disability Discrimination Act 1995 (as amended) the Trust has a statutory duty to **make reasonable adjustments** in respect of disabled patients/service users/carers/visitors. This includes making all communication (in person, by phone, via email) *and* any information provided (in writing, verbally) accessible using alternative formats. The aim of the reasonable adjustment duty is to reduce or remove any barrier a person with a disability faces when accessing or using goods, facilities and services. This is a non-delegable duty.

Accessible/ Alternative formats can include, for example, information translated into Easy Read format or into Audio format - when a patient/service user/carer/visitor has a learning disability or is visually impaired.

In addition, if a patient/service user/carer/visitor does not speak English as their first language or has poor English, the Trust has a statutory duty **to provide an interpreter** and to **translate written information**. This facilitates informed consent, better understanding and greater independence.

For information, advice and guidance about these duties contact the Trust Planning and Equality Team equality.team@belfasttrust.hscni.net

Please tick the box to indicate that you have developed the policy in in accordance with the Trust's legal equality duties and that all staff will make reasonable adjustments and information accessible as appropriate. ☒

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

[redacted]

_____ **Date: 11/11/25**

[redacted]

12/11/2025

_____ **Date:** _____

Director

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(Appendix 1)

Sitting Protocol

Early mobilisation is a critical aspect of patient care as it reduces the risk of complications of bedrest (Table 1). Unless there is a specific contraindication, encouraging patients to get out of bed early and often is a key part of modern, evidence-based care.

Table 1: Benefits of Early Mobilisation	
Prevents complications associated with immobility	Staying in bed for prolonged periods increases the risk of several complications: • Pressure ulcers • Deep vein thrombosis and pulmonary embolism • Pneumonia, due to reduced lung expansion and secretion clearance • Muscle atrophy and joint stiffness • Constipation and urinary retention
Improved physical function and strength	Mobilisation helps maintain or improve • Muscle strength and endurance • Joint range of motion • Respiratory function including better coughing and secretion clearance • Cardiovascular function, including blood flow to the extremities • Balance and coordination, reducing fall risk
Enhances mental and emotional well-being	Being mobile can improve mood and cognition by: • Reducing delirium and depression • Improving sleep patterns • Helping patients feel more in control and engaged in their recovery
Supports faster recovery	Early mobilisation: • Shortens hospital stays • Reduces readmission rates • Promotes independence in activities of daily living

Mobilising patients with or 'at risk' of pressure ulcers

When caring for patients with or 'at risk' of pressure damage, mobilisation protocols (including to sitting in a chair) must be carefully designed to minimise pressure, promote healing and prevent further tissue damage. In order to do this the healthcare professional should:

1. Understand the category of pressure damage and identify the location
2. Refer to an appropriate specialist, e.g., OT, if the patient requires specialist seating due to a postural or functional difficulties.
3. Ensure the patient does not sit for long periods, especially for full thickness pressure ulcers on a weight-bearing area, e.g., buttocks or ischium. Timings will vary from person to person and should include support for the feet to

relieve pressure on the heels, remembering that extra pressure exerted on the bottom when feet are raised.

As a general guideline:

a. Patients with intact skin, who are at risk of pressure damage, should be encouraged to change position every 2 hours when up to sit.
b. If a patient with intact skin requires a care-package at home, and is expected to be up sitting for 4 hours, it is important to slowly increase the seating duration in 15 minute intervals, to determine if the patient's skin can safely tolerate this on the support surface provided.
c. Patients with Category 1-2 pressure ulcers can initially sit for up to 1 hour. This can be increased in 15-minute intervals to a maximum of two hours **as long as there is no deterioration** (see point 8). It is critical that pressure areas are checked after each increase to ensure that the there is no deterioration. If the skin shows any sign of deterioration, then the patient will require bed rest until there is good evidence of healing, at which point sitting can be tried again.
d. Patients with full thickness pressure damage may require bed rest, or extremely limited sitting, e.g 30 mins. NPUAP 2014 state that **if sitting in a chair is necessary** (e.g. psychological or medical reasons) for individuals with existing pressure ulcers in the seated region, sitting should be limited to three times a day in periods of 60 minutes or less. The individual's seat, posture and sitting times should be reviewed and modified if pressure damage fails to improve

4. If the patient is alert and mobile teach weight shifting techniques, ideally every 15 minutes, e.g. leaning side-to-side, using arm rests to lift.
5. Use a pressure-relieving cushion (do not use ring/donut cushions as these exacerbate pressure)
6. Do not use a footstool - Using a footstool that is lower than the seat of the chair will not help reduce swelling (oedema) of the leg(s) and the position puts additional pressure on the tailbone and buttocks increasing the risk of pressure ulcers. Footstools may also impede the sit to stand transfer and mobility (Stephens et al, 2025)
7. Check posture when up to sit, slouching can increase sacral pressure. Take action to address poor posture
8. Monitor the skin frequently (before and after each sitting session) for signs of discolouration, warmth or skin breakdown – this is critical. Sitting duration **must** be reviewed if deterioration is observed

NB. Patients with full thickness pressure ulcers on their sacrum, hips, ischial tuberosity or even posterior aspect of their heel, can still get up to stand for at least 2 minutes and/or walk, as this will allow tissues to fully perfuse.
"Standing should be a part of the twenty-four-hour pressure management routine of people with short or long-term mobility problems. Standing not only offers pressure relief but improved functional reach, independence, vital organ capacity, circulation and passive range of motion. Standing reduces the occurrence of water infections, abnormal muscle tone, skeletal deformities and enhances wellbeing" (Stephens et al, 2025, p23)

Postoperative protocols following flap reconstruction

The timing of when to begin a progressive sitting program varies in the literature. Complete rest from 3 to 6 weeks to allow flap healing has been proposed for the surgical site to reach sufficient tensile strength to withstand mobilization. When sitting is initiated, it should be implemented slowly during the first two weeks, eventually allowing the patient to sit up to 4–6 hours/day. Taken together, a complete postoperative flap protocol can range from 5 to 8 1/2 weeks for patients with SCI deemed to be good surgical candidates (Kruger et al, 2013).

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Stephens, M., Bartley, C.A, Chester Bessell, D.S, Greenwood, C., Marshall, A., Neill, S., Rooney, S., Rose, S., Scattergood, S A., Worsley, P.R. (2025). Understanding the association between pressure ulcers and sitting in adults: What does it mean for all of us? Seating guidelines for people, carers, health and social care professionals. Society of Tissue Viability, UK Available at https://societyoftissueviability.org/wp-content/uploads/2025/04/SEATING-GUIDELINES-SINGLE-PAGES.pdf (Accessed 15/07/25)

Appendix 2

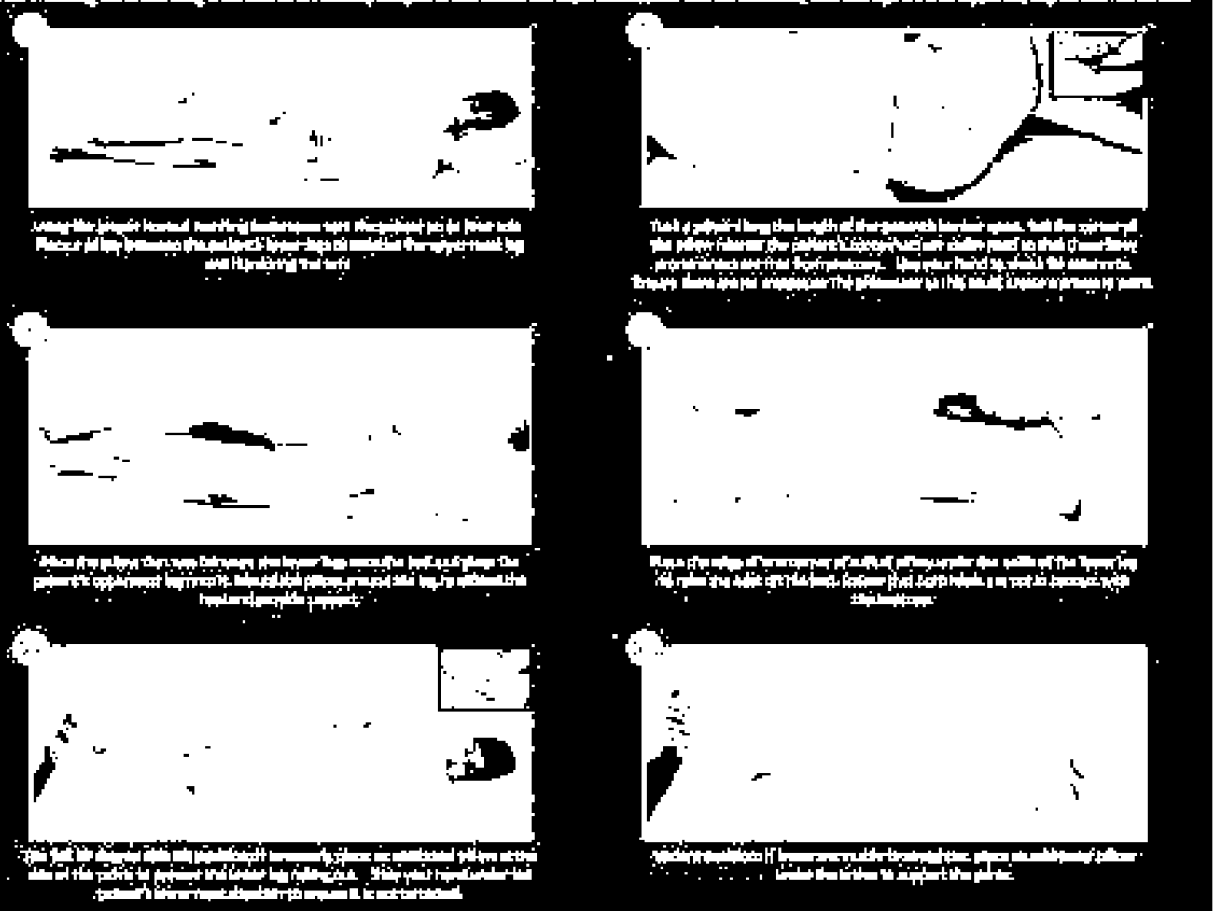
Repositioning Techniques

· Comfort · Pressure Relief · Support ·

Supine Position



30 Degree Side Tilt



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