

Best Practice Statement ~ *November 2005*

Pressure ulcer prevention

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Introduction

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland.

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHS Scotland with advice, guidance and support on effective clinical practice and service improvements.

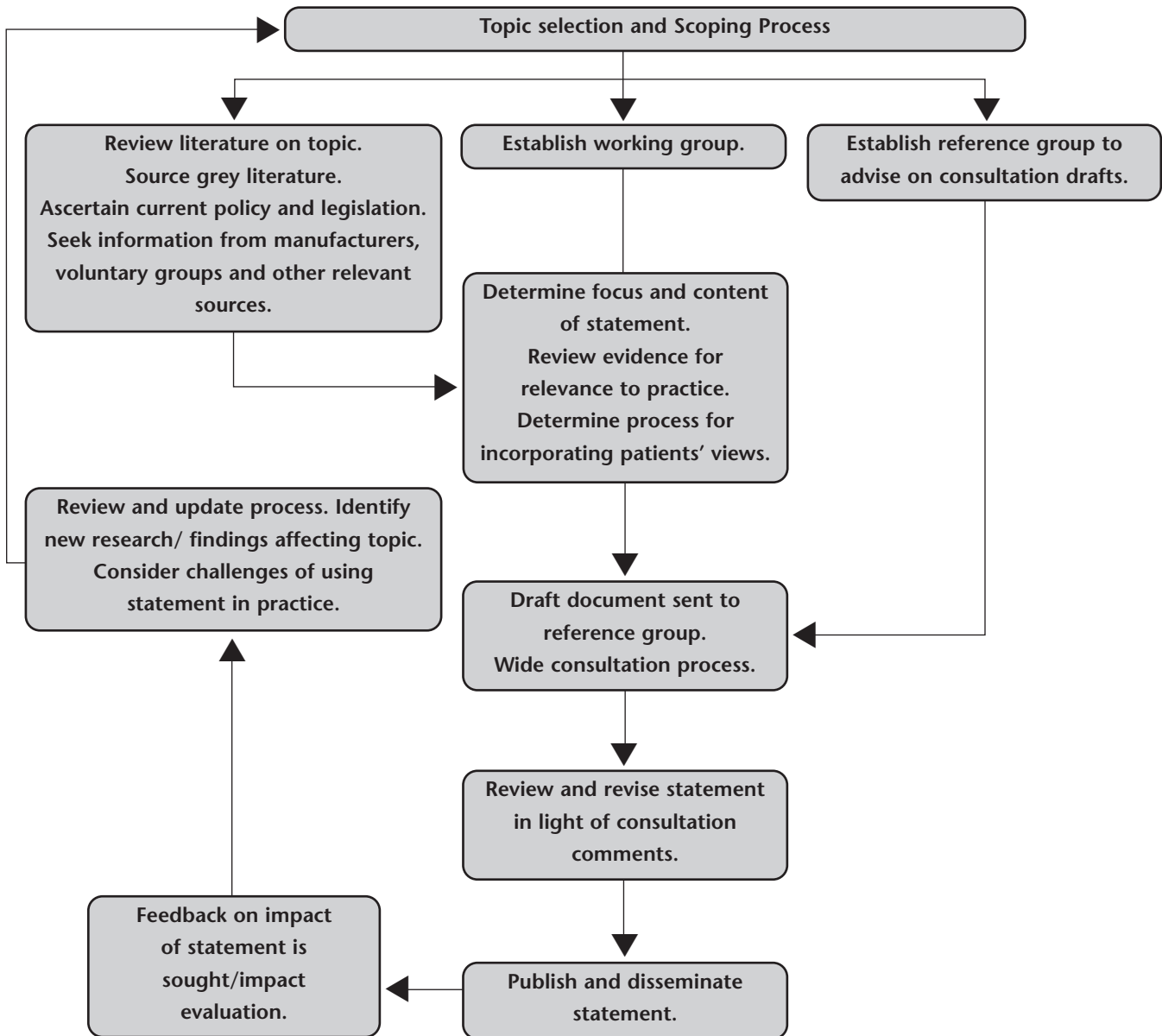
A series of best practice statements has been produced within the Practice Development Unit of NHS QIS, designed to offer guidance on best and achievable practice in a specific area of care. These statements reflect the current emphasis on delivering care that is patient-centred, cost-effective and fair. They reflect the commitment of NHS QIS to sharing local excellence at a national level.

Best practice statements are produced by a systematic process, outlined overleaf, and underpinned by a number of key principles:

- They are intended to guide practice and promote a consistent, cohesive and achievable approach to care. Their aims are realistic but challenging.
- They are primarily intended for use by registered nurses, midwives, allied health professionals, and the staff who support them.
- They are developed where variation in practice exists and seek to establish an agreed approach for practitioners.
- Responsibility for implementation of these statements rests at local level.

Best practice statements are reviewed, and, if necessary, updated after 3 years in order to ensure the statements continue to reflect current thinking with regard to best practice.

Key Stages in the development of best practice statements



Best Practice Statement - Pressure ulcer prevention

This best practice statement was initially produced by NHS Quality Improvement Scotland in May 2002 to offer guidance to health care staff and carers, caring for individuals at risk of developing pressure ulcers in hospital, at home or in care homes. In 2005, the statement was reviewed and updated by the working group in consultation with the Association of Tissue Viability Nurse Specialists (Scotland) (NATVNS) listed in Appendix 6.

Pressure ulcers are areas of tissue death usually located over a bony prominence, caused by external forces of pressure, shear and/or friction. These may be further exacerbated by complications arising from the individual's physical condition, such as altered nutrition and excess moisture.

This document aims to provide staff, patients and carers with a framework which can be utilised when making decisions relating to the early identification of individuals at risk of pressure ulcer development or identification of skin changes. The statement does not give specific details relating to equipment selection as it is intended to be used in conjunction with local policies and guidelines. The statement has been developed to ensure that carers across all care settings, primary, secondary and care homes are provided with relevant and accurate information to assist them in their decision-making when caring for patients at risk of developing pressure ulcers. As part of the review process the working group developed an audit tool which is enclosed (Appendix 5).

The best practice statement for the prevention of pressure ulcers should be used in conjunction with the best practice statement for the treatment/management of pressure ulcers (www.nhshealthquality.org). Utilisation of both documents will ensure best practice is being achieved across all care settings and the statements could be used in this case as a measure for quality in pressure ulcer prevention.

Section 1: Education and audit

Key Points ~

- 1 *Incidence and/or prevalence data should be collected to assist in developing preventative strategies.*
- 2 *Staff and carers caring for patients at risk of pressure ulcer development need appropriate education and training*
- 3 *Information relating to pressure ulcer prevention is made available to the patient.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Staff caring for patients who are at risk of developing pressure ulcers are given education in pressure ulcer prevention. Regular updates are provided for this group of staff.	Whilst all healthcare professionals could come into contact with patients at risk of developing pressure ulcers, education and training resources should be targeted at those who are most likely to do so.	The organisation has a policy on pressure ulcer prevention that includes provision of education and updates to appropriate staff.
Where appropriate, patients and carers are provided with information/education about the prevention of pressure ulcers.		Education materials suitable for use by patients and carers are available and guidance is provided for their use.
Prevalence* and/or incidence** of pressure ulcers is monitored.	<p>Monitoring is an essential component in the prevention and treatment of Pressure Ulcers (Watret 1999, Gray, Cooper & Clark 1999, Clark & Orchard 2004).</p> <p>Monitoring patterns of pressure ulcer development will assist with:</p> <ul style="list-style-type: none"> • the development of preventative strategies, • the identification of patterns of pressure ulcer development in different areas, • the purchasing and allocation of resources, e.g. specialist beds, • targeting of education programmes, and • audit, research and guideline development. 	<p>The organisation and its component clinical areas maintain a record of incidence and/or prevalence.</p> <p>Action is taken to reduce 'hot spots' in incidence/prevalence.</p> <p>Pressure ulcer prevention strategies appropriate to the clinical needs of patient populations are employed.</p> <p>There is a procedure for the purchasing, use and review of specialist resources.</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The method and frequency of prevalence and/or incidence data collection is agreed locally.</p>	<p>There are many types of data collection methods, from daily incidence monitoring to annual point prevalence. All have value.</p>	<p>Incidence and/or prevalence studies are carried out at agreed intervals.</p>

* *Prevalence is defined as the number of individuals with pressure ulcers within a defined population over a defined period of time. This includes pressure ulcers developed before and after admission to the current care setting.*

** *Incidence is defined as the number of individuals developing pressure ulcers over a period of time, within a defined population, having initially been admitted to the care setting with no visible signs of pressure damage.*

Key Challenges ~ Primary Care Settings:

- 1 *With the emphasis in NHSScotland on maintaining people in their own homes whenever possible, there has been an increase in the number of acutely and chronically ill and elderly people being cared for in the community.*
- 2 *Very little data exists on the nature of the problem of pressure ulcers in the community (Moffat and Franks, 1997).*
- 3 *Studies have been conducted in the community setting with the main focus on prevalence data. This can help to determine if available resources are sufficient to meet needs, but does not identify the development of new pressure ulcers (incidence) which would help to identify trends within the local patient population.*

Section 2: Risk assessment

Key Points ~

- 1 *All patients should be assessed using both formal and informal risk assessment to ensure that the correct preventative strategies are initiated and maintained.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All patients are assessed to determine their level of risk of pressure ulcer development. Both formal and informal assessment tools are used (see Appendix 1).</p>	<p>Risk assessment enables correct and suitable preventative measures to be initiated and maintained.</p>	<p>The health records of all patients admitted to, or resident in, a facility include evidence of pressure ulcer risk assessment.</p>
<p>Risk assessment takes place within 6 hours of admission, which should include time in Accident and Emergency or following a change in condition or treatment. If the patient is acutely ill, assessment should happen sooner. If information is not available, assessment should take place as soon as possible.</p>	<p>There is a lack of evidence whether formal or informal risk assessment is more successful at predicting vulnerability. Formal risk assessment involves the use of a recognised tool (see Further reading for examples).</p> <p>Formal combined with informal risk assessment, or clinical judgement it is a useful way of predicting risk (McGough, 1999). Clinical judgement includes understanding the client group and the individual's environment and physical condition.</p>	
<p>Patients are re-assessed at regular intervals, and if their condition or treatment alters.</p>		<p>There is evidence that all patients with existing non-blanching erythema (see Appendix 2) or existing pressure ulcers receive preventative interventions.</p> <p>There is evidence that patients are re-assessed in response to changes in the individual's physical or mental condition.</p> <p>There is evidence that all patients identified as being at risk, receive preventative interventions.</p> <p>The choice of assessment tool reflects the care setting.</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Staff involved in risk assessment receive training and update sessions on risk assessment and the initiation of preventative measures.</p>		<p>There is evidence that staff act on individual components of the risk assessment process, eg poor dietary intake. Records of staff training in assessment and prevention are available.</p>

Key Challenges ~ Care Homes:

- 1 *The majority of individuals in the care home setting will be identified as 'at risk' using a conventional risk assessment tool. Formal assessment combined with clinical judgement will guide staff to identify patients at highest risk of tissue damage.*

Key Challenges ~ Primary Care Setting:

- 1 *Assessment within six hours may not be possible in community settings. Assessment should take place at or as soon as possible after the district nurse's first home visit.*

Section 3: Skin Inspection

Key Points ~

- 1 *All individuals at risk of pressure ulcer development should have their skin assessed for observation of changes. If changes are observed preventative strategies should be initiated.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All patients at risk of pressure ulcer development have their skin assessed.</p>	<p>Most pressure ulcers observed in Scotland are of a superficial nature (Watret 1999, Gray, Cooper & Clark, 1999). Early identification of skin changes followed by appropriate intervention can reduce the progression of superficial ulcers into those with associated tissue loss.</p>	<p>Following an assessment of risk, skin inspection is documented in the patient's health record.</p>
<p>General visual inspection of all areas of skin forms part of the assessment process, with special attention being paid to bony prominences. Inspection of the heels and sacrum is a priority.</p>	<p>The majority of pressure ulcers are located on the sacral and heel areas (Clark, Bours & Defloor, 2004).</p>	<p>Regular skin inspection takes place at opportune times, for example during assistance with personal hygiene.</p> <p>Findings from skin inspection which indicate that further action is required, along with subsequent action taken, are documented in the patient's health record.</p>
<p>Where an area of redness (erythema) is noted, further examination is carried out (see Appendix 2).</p> <p>Factors that increase the likelihood of pressure ulcer development are addressed.</p>	<p>Further examination may help in the identification of the early stages of pressure ulcer development.</p> <p>A range of factors, including altered mobility and incontinence, can increase risk of pressure ulcers developing (Bours et al, 2003).</p>	<p>Erythema and subsequent examination is documented.</p> <p>Non-perfumed moisturisers are used twice daily on individuals with dry skin.</p> <p>Cleansers, as opposed to soap and water, are used to cleanse skin of those patients who are incontinent (Cooper & Gray 2001, Whittingham & May, 1998).</p> <p>The advice of a continence advisor is sought where continence management products are compromised by pressure ulcer prevention strategies.</p> <p>Skin inspection occurs more regularly and is documented when the individual has reduced mobility.</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
		There is documented evidence that patients post-surgery, or undergoing epidural/spinal anaesthesia (including in labour suites) have frequent skin inspection to detect any adverse effects from their reduced mobility/sensation.

Key Challenges ~ Primary Care and Care Homes:

- 1 *The majority of those cared for in primary care and care home settings will have altered skin integrity due to age, for example thinness, bruising and age spots. These individuals require regular skin assessment.*
- 2 *Involving the individual and/or carer in skin management if at all possible, and encouraging the individual to apply non-perfumed moisturisers regularly.*
- 3 *Ensuring individuals involved in the management of skin care receive training and education.*

Section 4: Positioning

Key Points ~

1 *The position of an individual can be altered to minimise risk of pressure ulcer development.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Patients at risk of pressure ulcer development are suitably positioned to minimise pressure, friction and shear.</p>	<p>Pressure is the main factor in the development of pressure ulcers; friction and shear can also play a part in their development.</p> <p>The time period between position changes is dependent on individual assessment.</p> <p>Individuals at risk should not be positioned in a seat for more than two hours without some form of re-positioning (Defloor, 1999).</p> <p>Devices to assist with the re-positioning of patients in bed such as profiling beds, and electric and non-electric bed frames are of benefit.</p>	<p>Health records include an indication of how frequently position changes are to be carried out.</p> <p>Health records indicate that:</p> <ul style="list-style-type: none"> • patients at risk are not seated for more than two hours without being re-positioned, • acutely ill patients are returned to bed for no less than one hour (Gebhardt & Bliss, 1994), • patients who use a wheelchair or static chair on a long-term basis are educated to re-distribute their weight regularly, • for patients in bed, differing positions such as the thirty degree tilt* (Young, 2004) are used, • hoist slings and sliding sheets are not left under individuals after use,** • skin inspection is carried out after each positional change, and • these inspections help to guide decisions on the length of time between positional changes.

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
		Independent movement is encouraged and patient education is documented in the health records. The result of skin inspection and any changes made to the re-positioning regime are documented.

* *When the patient is placed in the laterally inclined position, supported by pillow with the pelvis making a 30 degree angle with the support surface.*

** *Where there are associated manual handling issues concerning the removal of a hoist sling, a joint assessment by tissue viability/manual handling staff should be documented.*

Key challenges ~ Primary Care:

- 1 *Encouraging carers to maintain a record of any positional changes between visits by staff.*
- 2 *Maintaining records of patient/carer education.*

Section 5: Mattresses, chairs and cushions

Key Points ~

- 1 *There is evidence that individuals at risk of pressure ulcers benefit from the provision of different and/or additional products from the standard equipment provided.*
- 2 *There is a clear policy concerning the provision of specialist equipment for individuals at risk of pressure ulcer development.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Patients assessed as being at risk of pressure ulcer development are not cared for on standard NHS mattresses or on basic divan mattresses; at a minimum they are provided with a pressure redistributing foam mattress or overlay.</p>	<p>There is clear evidence that individuals at risk benefit from the provision of different/additional products from the standard NHS provision (McInnes, 2004).</p>	<p>There is a clear organisational policy concerning the provision of specialist equipment for individuals at risk.</p>
<p>The decision to provide any special mattress or overlay is taken as part of a comprehensive assessment and prevention strategy, never as the sole intervention.</p>	<p>Patients who are acutely ill or who have restricted mobility in bed are likely to require an air-filled mattress or overlay.</p>	<p>The policy includes guidance on when to seek advice from a specialist in the field of Tissue Viability.</p> <p>The decision to use any product beyond a basic NHS mattress is documented in the individual's health record.</p> <p>Measures being implemented in addition to the use of special mattresses and overlays are documented in the health record.</p>
<p>Factors taken into account when deciding on which pressure redistributing mattress or overlay to purchase or hire include:</p> <ul style="list-style-type: none"> • efficacy • ease of maintenance • impact on nursing procedures • patient acceptability • cost • ease of use 	<p>There is no clear evidence as to the best products to use (McInnes 2004).</p> <p>Patients identified as requiring pressure reducing equipment (mattresses, seating and cushions) receive it as soon as possible, since delay may result in tissue damage.</p>	<p>The date of first use of specialist equipment is documented in the health record.</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Patients being cared for on specialist equipment have their skin inspected frequently to assess the suitability of the equipment; equipment requirements may change with changes in the patient's condition.</p>	<p>These patients have individual requirements based on their overall condition, skin condition and their previous experience.</p>	<p>Regular skin inspection and any subsequent decisions or actions taken are documented in the health record.</p>
<p>Patients at risk of pressure ulcer development are provided with appropriate pressure redistributing equipment when sitting in a chair or wheelchair in addition to when they are being cared for in bed.</p>	<p>Tissue damage may occur when patients are sitting in chairs. Chairs and/or cushions designed to reduce the risk of pressure ulcer development must be suited to individual needs in relation to the individual's height, weight, postural alignment and foot support.</p>	
<p>Long-term wheelchair or static seat users have their needs assessed by those with relevant specialist skills.</p>	<p>The safety of static seats can be compromised by the use of inappropriate cushions which may change height, balance and lumbar support.</p>	<p>The individual's health record documents the assessment of their needs in relation to their wheelchair/static seat use.</p>

Glossary

erythema	Non-specific redness of the skin that can be localised or general in nature, and may be associated with cellulitis, infection, prolonged pressure or reactive hyperaemia.
reactive hyperaemia	The characteristic bright flush of the skin associated with the release of pressure - a direct response of incoming arterial blood.
blanching hyperaemia	The skin whitening that occurs when pressure is applied, indicating that microcirculation is intact.
non-blanching hyperaemia	There is no skin colour change when light finger pressure is applied.
extrinsic	Factors that are external or outside, for example the surface a person lies on.
incidence	The number of individuals developing pressure ulcers over a period of time within a defined population, having initially been admitted to the care setting with no visible signs of pressure damage.
intrinsic	Factors that are internal, or present within the individual, for example other conditions or illnesses the person may have.
prevalence	The number of individuals with pressure ulcers within a defined population over a defined period of time. This includes pressure ulcers developed before and after admission to the care setting/caseload.
period prevalence	Prevalence data collected over a specific period of time.
point prevalence	Prevalence data collected at a specific point in time.
30 degree tilt	When the patient is placed in the laterally inclined position, supported by pillow with the pelvis making a 30 degree angle with the support surface.

References:

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 - 17 Whittingham, K. and May, S., (1998). Cleansing regimes for continence care. *Professional Nurse*, 14 (3), 167-172.
 - 18 Young, T., (2004). The 30° tilt position vs. the 90° lateral and supine positions in reducing the incidence of non-blanching erythema in a hospital inpatient population: a random controlled trial. *Journal of Tissue Viability*, 14 (93), 86-95.

Further Reading:

National Institute for Clinical Excellence, Pressure ulcer prevention. Pressure ulcer risk assessment and prevention, including the use of pressure-relieving devices (beds, mattresses and overlays) for the prevention of pressure ulcers in primary and secondary care. Clinical Guideline 7, National Institute for Clinical Excellence, London, October 2003.

Royal College of Nursing Clinical Practice Guidelines, Improving practice: improving care. Pressure ulcer risk assessment and prevention. Royal College of Nursing, June 2000.

Appendix 1

Definition and classification of pressure ulcers

Best practice statement for the Prevention of pressure ulcers

Definition of a pressure ulcer

A pressure ulcer is an area of localised damage to the skin and underlying tissue due to occlusion of the blood vessels, which leads to cell death. They are believed to be caused by pressure, shear and friction, Allman (1997); EPUAP Review (1999).

Classification

- Grade 1:** Non-blanchable erythema of intact skin. Discoloration of the skin warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
- Grade 2:** Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.
- Grade 3:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
- Grade 4:** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss. EPUAP Review (1999).

Within the best practice statement Grade 1 and 2 pressure ulcers are described as superficial in nature, while Grade 3 and 4 pressure ulcers are defined as severe.

Appendix 2

Pressure sore classification scores - examples

Guide to Pressure Ulcer Grading	European Pressure Ulcer Advisory Panel, Guide to Pressure Ulcer Grading, EPUAP review, 3 (3) p75, 1999.
Stirling Pressure Sore Severity Scale	Reid J and Morrison M (1994) Towards a consensus: classification of pressure sores. Journal of Wound Care 3 (3) 157-160.
Pressure Ulcer Scale for Healing (PUSH)	Stotts, NA, Rodeheaver, GT, Thomas, DR, Frantz RA. et al. (2001) An instrument to measure healing in pressure ulcers: development and validation of the pressure ulcer scale for healing (PUSH). Journals of Gerontology Series A Biological Sciences and Medical Sciences 56A (Issue 12): p M795.

Appendix 3

Risk assessment tools - examples

Andersen Scale	Andersen KE, Jensen O, Kvorning SA and Bach E. (1982) Prevention of Pressure sores by identifying patients at risk. British Medical Journal. 284: 1370-1.
Braden Scale	Bergstrom N, Braden BJ, Laguzza A and Holman V. (1987) The Braden scale for predicting pressure sore risk. Nursing Research. 36 (4) 205-10.
Knoll scale	Towey AP and Erland SM (1988) Validity and reliability of an assessment tool for pressure ulcer risk 1 (2) 40-48.
Norton Scale	Norton D, McLaren R, Exton-Smith AN (1962) An investigation of geriatric nursing problems in hospital. The National Corporation for the Care of Old People London.
Pressure Sore Prediction Score	Lowthian P (1989) Identifying and protecting patients who may get pressure sores. Nursing Standards 4(4) 26-29.
Waterlow Risk Assessment Score	Waterlow J (2005) The Waterlow card for the prevention and management of pressure sores. www.judy-waterlow.co.uk

Appendix 4

Further examination of erythema should include the following:

- 1 Apply light finger pressure to the area for 10 seconds.
- 2 Release the pressure.
If the area is white and then returns to its original colour, the area probably has an adequate blood supply. Observation should continue and preventative strategies should be employed.
- 3 If on release of pressure the area remains the same colour as before pressure was applied, it is an indication of the beginning of pressure ulcer development and preventative strategies should be employed.
- 4 If there is an alteration in skin colour (redness, purple or black), increased heat or swelling, it may imply underlying tissue breakdown. Frequency of assessment should be increased.
- 5 With dark skin pigmentation, pressure ulcer development will be indicated by areas where there is localised heat, or where there is damage, coolness, purple/black discolouration, localised oedema and induration.

Appendix 5

Best practice statement audit tool Pressure ulcer prevention



This audit tool is also: available at www.nhshealthquality.org

In some sections the audit tool provides lists of data to be recorded. Best practice suggests 100% of information should be recorded. It is for each user to agree what percentage would count as meeting the criteria.

This audit tool is intended to be used as part of the audit cycle. This can be described as the use of audit to identify areas for improvement, drawing up a plan and implementing improvements in these areas, and re-auditing to evaluate and define areas for further improvement. This should raise the standard expected with each cycle of audit.

This tool may be used by individuals to audit their own practice or adapted by organisations to audit their pressure ulcer service.

Best practice statement audit tool

Pressure ulcer prevention

Please ensure that this part of the tool is completed in conjunction with the auditor's checklist, which is retained by the auditor.

Audit Information

Date of audit: _____

Patient Information

Patient's ID no: _____ Patient's D.O.B. _____

Information on auditor

Notes Audited By: _____

Caseload Holder's Name: _____

	Education and Audit	Yes	No	Action
Q1	Are regular updates provided for staff caring for patients at risk of developing pressure ulcers?			
Q2	Are incidence and prevalence of pressure ulcers monitored?			
	Risk assessment			
Q3	Has the patient been assessed, using a recognised risk assessment tool?			
Q4	Is there evidence to demonstrate that a risk score was completed within 6 hours of admission?			
	Patients with pressure ulcers			
Q5	Does the risk assessment indicate that the patient has a pressure ulcer? If 'No,' go to Q7.			
Q6	If the patient has existing pressure ulcers, is there evidence that they are receiving preventative interventions?			
	Patients 'at risk' of pressure ulcer			
Q7	Does the risk assessment indicate that the patient is 'at risk' of getting a pressure ulcer?			
Q8	If the patient is assessed as 'at risk', is there evidence that a care plan has been developed, detailing preventative interventions?			
	Patient's physical and mental well being			
Q9	Is there evidence that the patient is re-assessed in response to changes in their physical and/or mental well-being?			
Q10	Is there evidence that staff act on individual components of the risk assessment, eg poor dietary intake, and develop a care plan accordingly?			

	Skin inspection/skin cleaning regimes			
Q11	Following risk assessment, is skin inspection documented?			
Q12	If 'Yes', is there evidence of action taken (if required) following skin inspection?			
Q13	Is there evidence that the patient receives regular skin inspection, according to the recognised risk assessment tool used in your area?			
Q14	If the patient is identified as having erythema, is there evidence that follow-up skin inspections have been carried out?			
Q15	If the patient is identified as having dry skin, is there evidence that they are being treated with emollients?			
Q16	Is there evidence of skin cleaning regimes?			
Q17	If 'Yes', has the rationale for their use been recorded?			
	Patients with reduced mobility			
Q18	Does the patient have reduced mobility?			
Q19	If 'Yes', is there evidence that more frequent skin inspections are carried out?			
	Independent movement and position changes			
Q20	Is there evidence that independent movement is encouraged as part of patient education?			
Q21	Do care plans give an indication on how frequently position changes are to be carried out?			
	Equipment			
Q22	Is there evidence that the patient has been provided with equipment such as specialist mattress/cushion?			
Q23	If 'Yes', is the rationale for the use of equipment and date of first use recorded in the nursing notes?			
Q24	If 'Yes', has the patient been assessed in relation to their equipment?			

Appendix 6


Who was involved in developing the statement?

Project leaders:

Mrs Pam Cooper and Mr David Gray, Nurse Specialists in Tissue Viability, seconded from NHS Grampian.

Working group:

Joy Bell	Tissue Viability Advisor	NHS Greater Glasgow
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Lynne Campbell	Tissue Viability Nurse	NHS Lanarkshire
Claire Chalmers	Tissue Viability Adviser	NHS Lanarkshire
Lynn Coyne	CNS Plastic Surgery	NHS Fife
Alison Finnie	Lecturer-Practitioner	University of Stirling
Vikki Garrick	Tissue Viability Nurse	NHS Greater Glasgow
Lydia Jack	Clinical Nurse Specialist	NHS Argyll & Clyde
Claire Kilpatrick	Tissue Viability/Infection Control Nurse	HCI Medical Centre
Margaret McDiarmid	Tissue Viability Nurse	NHS Greater Glasgow
Ann McFarlane	Tissue Viability Nurse	NHS Lanarkshire
Mary McHanev	Tissue Viability Nurse	NHS Lanarkshire
Dorothy McIlvenna	Tissue Viability Nurse Advisor	NHS Lanarkshire
Elizabeth McMath	Tissue Viability Nurse	NHS Ayrshire & Arran
Melloney Mitchell	Tissue Viability Nurse	NHS Lothian
Ruth Robins	Plastic Surgery Nurse	NHS Fife



Ruth Ropper	Tissue Viability Nurse	NHS Lothian
Sue Sayer	Tissue Viability Co-ordinator	NHS Lothian
Ailsa Sharp	Tissue Viability Nurse Specialist	NHS Greater Glasgow
Joyce O'Hare	Tissue Viability Nurse	NHS Forth Valley
Sandra Stringfellow	Tissue Viability Nurse	NHS Grampian
Jeannette Timmins	Clinical Nurse Specialist	NHS Lothian
Ria Tocher	Clinical Development Nurse	NHS Lothian
Lynne Watret	Senior Nurse: Tissue Viability	NHS Greater Glasgow
Alice Wilson	Senior Nurse	NHS Dumfries & Galloway
Anne Wilson	Tissue Viability Nurse	NHS Fife
Anne Wilson	Tissue Viability Nurse	NHS Argyll & Clyde
Lorraine Wright	Tissue Viability Nurse	NHS Forth Valley

Statement review 2005

Dr Michael Clark, Senior Research Fellow, Wound Healing Research Unit, Cardiff University, Cardiff Medicentre, Cardiff, acted as clinical advisor to the review process.


The statement was reviewed by reconvening the original working group and by further consultation with members of the National Association of Tissue Viability Nurse Specialists (Scotland) (NATVNS). Members of NATVNS not in the working group but involved in the consultation process are listed overleaf.

Support from NHS QIS

Rhona Hotchkiss Unit Head, Practice Development Unit
Penny Bond Practice Development Professional Officer
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National Association of Tissue Viability Nurse Specialists (NATVNS) Membership List June 2005

Nicola Brow	Tissue Viability Nurse	NHS Lanarkshire
Jane Clark	Tissue Viability Nurse	NHS Greater Glasgow
Pamela Cooper	Clinical Nurse Specialist	NHS Grampian
Valerie Denny	Specialist Nurse - Wound Management	NHS Forth Valley
Margaret Eddington	Tissue Viability Nurse	NHS Forth Valley
Susan Emmerson	Tissue Viability Nurse	Golden Jubilee National Hospital
Pauline Emsley	Tissue Viability Nurse	NHS Lothian
Lesley Fox	Ward Manager/Tissue Viability Nurse	NHS Argyll & Clyde
John Garrity	Lecturer	Bell College Hamilton
Louise Gibson	Lecturer (Post Registration Nursing)	Glasgow Caledonian University
Caroline Harvey	CNS Tissue Viability	NHS Ayrshire & Arran
Senga Hunter	CNS Continence/Tissue Viability	NHS Argyll & Clyde
Alison Johnstone	Tissue Viability Nurse Specialist	NHS Greater Glasgow
Isobel MacIver	Tissue Viability Nurse Specialist	NHS Western Isles
Carrie McCulloch	Tissue Viability Advisor	NHS Lanarkshire
Linda Primmer	Tissue Viability Nurse	NHS Lothian
Fiona Russell	Tissue Viability Nurse	NHS Grampian
Mhairi Stewart	Tissue Viability Nurse	NHS Lanarkshire



Jon Timmons	Lecturer	Glasgow Caledonian University
Elaine Wilson	Tissue Viability Nurse	NHS Forth Valley
Geraldine Young	Nurse Specialist - Wound Management	NHS Forth Valley

