

# Pressure ulcers: prevention and management

Clinical guideline

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[www.nice.org.uk/guidance/cg179](https://www.nice.org.uk/guidance/cg179)

## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guideline replaces CG29 and CG7.

This guideline is the basis of QS89.

## Introduction

This guideline updates and replaces 'Pressure ulcers' (NICE guideline CG29) and 'Pressure ulcer prevention' (NICE guideline CG7). See [update information](#) for details.

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply. Typically they occur in a person confined to bed or a chair by an illness and as a result they are sometimes referred to as 'bedsores', or 'pressure sores'.

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Also, the use of equipment such as seating or beds which are not specifically designed to provide pressure relief, can cause pressure ulcers. As pressure ulcers can arise in a number of ways, interventions for prevention and treatment need to be applicable across a wide range of settings including community and secondary care. This may require organisational and individual change and a commitment to effective delivery.

Pressure ulcers are often preventable and their prevention is included in domain 5 of the [Department of Health's NHS outcomes framework 2014/15](#). The current guideline rationalises the approaches used for the prevention and management of pressure ulcers. Its implementation will ensure practice is based on the best available evidence. It covers prevention and treatment and applies to all people in NHS care and in care funded by the NHS.

Recommendations for prevention include methods for identification and risk assessment and the preventive measures that should be applied. Treatment of pressure ulcers includes recommendations on wound care, adjunctive therapies and support surfaces. While there is much clinical expertise and good practice focused on preventing and treating pressure ulcers, it is hoped that this evidence-based guidance will contribute to reducing the

number of pressure ulcers nationally through its implementation throughout the NHS.

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

See also [the NHS Improvement revised definition and measurement framework for pressure ulcers](#). This will help deliver a consistent approach to defining and measuring pressure ulcers, and help to understand the level of pressure damage harm in England.

## **Safeguarding children**

Remember that child maltreatment:

- is common
- can present anywhere, including primary and secondary care and community settings (such as the child's home)

Consider or suspect abuse (particularly malnourishment) as a contributory factor to or cause of pressure ulcers in children. Abuse may also coexist with pressure ulcers. See the [NICE guideline on child maltreatment](#) for clinical features that may be associated with maltreatment.

This section has been agreed with the Royal College of Paediatrics and Child Health.

## **Safeguarding adults**

[The Department of Health and Social Care has issued a protocol for safeguarding adults at risk of pressure ulcers](#). It aims to help practitioners and managers across health and care organisations to provide caring and quick responses to people at risk of developing pressure ulcers.

It includes a process for deciding whether an adult safeguarding response is needed.

## Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

### Adults: risk assessment

- Carry out and document an assessment of pressure ulcer risk for adults:
  - being admitted to secondary care or care homes in which NHS care is provided or
  - receiving NHS care in other settings (such as primary and community care and emergency departments) if they have a risk factor, for example:
    - ◇ significantly limited mobility (for example, people with a spinal cord injury)
    - ◇ significant loss of sensation
    - ◇ a previous or current pressure ulcer
    - ◇ nutritional deficiency
    - ◇ the inability to reposition themselves
    - ◇ significant cognitive impairment.

### Adults: skin assessment

- Offer adults who have been assessed as being at high risk of developing a pressure ulcer a skin assessment by a trained healthcare professional (see [recommendation 1.3.4](#)). The assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for:
  - skin integrity in areas of pressure
  - colour changes or discoloration

Healthcare professionals should be aware that non-blanchable erythema may present as colour changes or discoloration, particularly in darker skin tones or types.

- variations in heat, firmness and moisture (for example, because of incontinence, oedema, dry or inflamed skin).

## All ages: care planning

- Develop and document an individualised care plan for neonates, infants, children, young people and adults who have been assessed as being at high risk of developing a pressure ulcer, taking into account:
  - the outcome of risk and skin assessment
  - the need for additional pressure relief at specific at-risk sites
  - their mobility and ability to reposition themselves
  - other comorbidities
  - patient preference.

## Adults: repositioning

- Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every 6 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required.

## Adults: devices for prevention of pressure ulcers

- Use a high-specification foam mattress for adults who are:
  - admitted to secondary care
  - assessed as being at high risk of developing a pressure ulcer in primary and community care settings.

## Neonates, infants, children and young people: risk assessment

- Carry out and document an assessment of pressure ulcer risk for neonates, infants, children and young people:
  - being admitted to secondary care or tertiary care or
  - receiving NHS care in other settings (such as primary and community care and emergency departments) if they have a risk factor, for example:
    - ◇ significantly limited mobility (for example, people with a spinal cord injury)
    - ◇ significant loss of sensation
    - ◇ a previous or current pressure ulcer
    - ◇ nutritional deficiency
    - ◇ the inability to reposition themselves
    - ◇ significant cognitive impairment.

## All ages: healthcare professional training and education

- Provide training to healthcare professionals on preventing a pressure ulcer, including:
  - who is most likely to be at risk of developing a pressure ulcer
  - how to identify pressure damage
  - what steps to take to prevent new or further pressure damage
  - who to contact for further information and for further action.
- Provide further training to healthcare professionals who have contact with anyone who has been assessed as being at high risk of developing a pressure ulcer. Training should include:
  - how to carry out a risk and skin assessment



- how to reposition
- information on pressure redistributing devices
- discussion of pressure ulcer prevention with patients and their carers
- details of sources of advice and support.

## **Adults: management of heel pressure ulcers**

- Discuss with adults with a heel pressure ulcer and if appropriate, their carers, a strategy to offload heel pressure as part of their individualised care plan. (See also [the NICE guideline on diabetic foot problems](#) for advice on heel pressure offloading.)

## Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## Terms used in this guideline

### Adults, neonates, infants, children and young people

This guideline covers people of all ages at risk of, or who have, a pressure ulcer. These terms are defined as follows:

- adults: 18 years or older
- neonates: under 4 weeks
- infants: between 4 weeks and 1 year
- children: 1 year to under 13 years
- young people: 13 to 17 years.

### Risk assessment

This guideline uses the terms 'at risk' and 'at high risk' to identify people who may develop a pressure ulcer. For the purposes of this guideline:

- Adults considered to be **at risk** of developing a pressure ulcer are those who, after assessment using clinical judgement and/or a validated risk assessment tool, are considered to be at risk of developing a pressure ulcer.

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

Please note that the examples given are not exhaustive.

## 1.1 Prevention: adults

### Risk assessment

- 1.1.1 Be aware that all patients are potentially at risk of developing a pressure ulcer.
- 1.1.2 Carry out and document an assessment of pressure ulcer risk for adults:
- being admitted to secondary care or care homes in which NHS care is provided or
  - receiving NHS care in other settings (such as primary and community care and emergency departments) if they have a risk factor, for example:
    - significantly limited mobility (for example, people with a spinal cord injury)
    - significant loss of sensation
    - a previous or current pressure ulcer

- nutritional deficiency
  - the inability to reposition themselves
  - significant cognitive impairment.
- 1.1.3 Consider using a validated scale to support clinical judgement (for example, the Braden scale, the Waterlow score or the Norton risk-assessment scale) when assessing pressure ulcer risk.
- 1.1.4 Reassess pressure ulcer risk if there is a change in clinical status (for example, after surgery, on worsening of an underlying condition or with a change in mobility).

## Skin assessment

- 1.1.5 Offer adults who have been assessed as being at high risk of developing a pressure ulcer a skin assessment by a trained healthcare professional (see [recommendation 1.3.4](#)). The assessment should take into account any pain or discomfort reported by the patient and the skin should be checked for:
- skin integrity in areas of pressure
  - colour changes or discoloration
- Healthcare professionals should be aware that non-blanchable erythema may present as colour changes or discolouration, particularly in darker skin tones or types.
- variations in heat, firmness and moisture (for example, because of incontinence, oedema, dry or inflamed skin).
- 1.1.6 Use finger palpation or diascopy to determine whether erythema or discolouration (identified by skin assessment) is blanchable.
- 1.1.7 Start appropriate preventative action (see recommendations 1.1.1–1.1.17) in adults who have non-blanching erythema and consider repeating the skin assessment

at least every 2 hours until resolved.

## Repositioning

- 1.1.8 Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every 6 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required.
- 1.1.9 Encourage adults who have been assessed as being at high risk of developing a pressure ulcer to change their position frequently and at least every 4 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required.

## Skin massage

- 1.1.10 Do not offer skin massage or rubbing to adults to prevent a pressure ulcer.

## Nutritional supplements and hydration

- 1.1.11 Do not offer nutritional supplements specifically to prevent a pressure ulcer in adults whose nutritional intake is adequate.
- 1.1.12 Do not offer subcutaneous or intravenous fluids specifically to prevent a pressure ulcer in adults whose hydration status is adequate.

## Pressure redistributing devices

- 1.1.13 Use a high-specification foam mattress for adults who are:
- admitted to secondary care
  - assessed as being at high risk of developing a pressure ulcer in primary and

community care settings.

- 1.1.14 Consider a high-specification foam theatre mattress or an equivalent pressure redistributing surface for all adults who are undergoing surgery.
- 1.1.15 Discuss with adults at high risk of developing a heel pressure ulcer and, where appropriate, their family or carers, a strategy to offload heel pressure, as part of their individualised care plan.
- 1.1.16 Consider the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods.
- 1.1.17 Consider a high-specification foam or equivalent pressure redistributing cushion for adults who use a wheelchair or who sit for prolonged periods.

## **Barrier creams**

- 1.1.18 Consider using a barrier preparation to prevent skin damage in adults who are at high risk of developing a moisture lesion or incontinence-associated dermatitis, as identified by skin assessment (such as those with incontinence, oedema, dry or inflamed skin).

## **1.2 Prevention: neonates, infants, children and young people**

### **Risk assessment**

- 1.2.1 Carry out and document an assessment of pressure ulcer risk for neonates, infants, children and young people:
- being admitted to secondary or tertiary care or
  - receiving NHS care in other settings (such as primary and community care and emergency departments) if they have a risk factor, for example:

- significantly limited mobility
- significant loss of sensation
- a previous or current pressure ulcer
- nutritional deficiency
- the inability to reposition themselves
- significant cognitive impairment.

1.2.2 Use a scale validated for this population (for example, the Braden Q scale for children), to support clinical judgement.

## Skin assessment

1.2.3 Offer neonates, infants, children and young people who are assessed as being at high risk of developing a pressure ulcer a skin assessment by a trained healthcare professional. Take into account:

- skin changes in the occipital area
- skin temperature
- the presence of blanching erythema or discoloured areas of skin.

1.2.4 Be aware of specific sites (for example, the occipital area) where neonates, infants, children and young people are at risk of developing a pressure ulcer.

## Repositioning

1.2.5 Ensure that neonates and infants who are at risk of developing a pressure ulcer are repositioned at least every 4 hours.

1.2.6 Encourage children and young people who are at risk of developing a pressure ulcer to change their position at least every 4 hours. If they are unable to

- reposition themselves, offer help to do so, using appropriate equipment if needed.
- 1.2.7 Consider more frequent repositioning than every 4 hours for neonates and infants who have been assessed as being at high risk of developing a pressure ulcer. Document the frequency of repositioning required.
- 1.2.8 Encourage children and young people who have been assessed as being at high risk of developing a pressure ulcer to change their position more frequently than every 4 hours. If they are unable to reposition themselves, offer help to do so, using equipment if needed. Document the frequency of repositioning required.
- 1.2.9 Ensure that repositioning equipment is available to aid the repositioning of children and young people, if needed.
- 1.2.10 Ensure that healthcare professionals are trained in the use of repositioning equipment.
- 1.2.11 Ensure that patients, parents and carers understand the reasons for repositioning. If children and young people decline repositioning, document and discuss their reasons for declining.
- 1.2.12 Consider involving a play expert to encourage children who have difficulty with, or who have declined repositioning.
- 1.2.13 Relieve pressure on the scalp and head when repositioning neonates, infants, children and young people at risk of developing a pressure ulcer.

## **Skin massage**

- 1.2.14 Do not offer skin massage or rubbing to neonates, infants, children and young people to prevent a pressure ulcer.



## Nutritional supplements and hydration

- 1.2.15 Do not offer nutritional supplements specifically to prevent a pressure ulcer in neonates, infants, children and young people with adequate nutritional status for their developmental stage and clinical condition.
- 1.2.16 Do not offer subcutaneous or intravenous fluids specifically to prevent a pressure ulcer in neonates, infants, children and young people with adequate hydration status for their development stage and clinical condition.

## Pressure redistributing devices

- 1.2.17 Use a high-specification foam cot mattress or overlay for all neonates and infants who have been assessed as being at high risk of developing a pressure ulcer as part of their individualised care plan.
- 1.2.18 Use a high-specification foam mattress or overlay for all children and young people who have been assessed as being at high risk of developing a pressure ulcer as part of their individualised care plan.
- 1.2.19 Discuss with children and young people at high risk of developing a heel pressure ulcer and their parents and carers, where appropriate, a strategy to offload heel pressure as part of their individualised care plan.
- 1.2.20 Offer infants, children and young people who are long-term wheelchair users, regular wheelchair assessments and provide pressure relief or redistribution.
- 1.2.21 Offer neonates, infants, children and young people at risk of developing an occipital pressure ulcer an appropriate pressure redistributing surface (for example, a suitable pillow or pressure redistributing pad).

## Barrier creams

- 1.2.22 Use barrier preparations to help prevent skin damage, such as moisture lesions, for neonates, infants, children and young people who are incontinent.

## 1.3 Prevention: all ages

### Care planning

- 1.3.1 Develop and document an individualised care plan for neonates, infants, children, young people and adults who have been assessed as being at high risk of developing a pressure ulcer, taking into account:
- the outcome of risk and skin assessment
  - the need for additional pressure relief at specific at-risk sites
  - their mobility and ability to reposition themselves
  - other comorbidities
  - patient preference.

### Patient and carer information

- 1.3.2 Offer timely, tailored information to people who have been assessed as being at high risk of developing a pressure ulcer, and their family or carers. The information should be delivered by a trained or experienced healthcare professional and include:
- the causes of a pressure ulcer
  - the early signs of a pressure ulcer
  - ways to prevent a pressure ulcer
  - the implications of having a pressure ulcer (for example, for general health, treatment options and the risk of developing pressure ulcers in the future).

Demonstrate techniques and equipment used to prevent a pressure ulcer.

- 1.3.3 Take into account individual needs when supplying information to people with:
- degenerative conditions

- impaired mobility
- neurological impairment
- cognitive impairment
- impaired tissue perfusion (for example, caused by peripheral arterial disease).

## Healthcare professional training and education

1.3.4 Provide training to healthcare professionals on preventing a pressure ulcer, including:

- who is most likely to be at risk of developing a pressure ulcer
- how to identify pressure damage
- what steps to take to prevent new or further pressure damage
- who to contact for further information and for further action.

1.3.5 Provide further training to healthcare professionals who have contact with anyone who has been assessed as being at high risk of developing a pressure ulcer. Training should include:

- how to carry out a risk and skin assessment
- how to reposition
- information on pressure redistributing devices
- discussion of pressure ulcer prevention with patients and their carers
- details of sources of advice and support.

## 1.4 Management: adults

### Ulcer measurement

- 1.4.1 Document the surface area of all pressure ulcers in adults. If possible, use a validated measurement technique (for example, transparency tracing or a photograph).
- 1.4.2 Document an estimate of the depth of all pressure ulcers and the presence of undermining, but do not routinely measure the volume of a pressure ulcer.

### Categorisation

- 1.4.3 Categorise each pressure ulcer in adults using a validated classification tool (such as the International NPUAP-EPUAP Pressure Ulcer Classification System). Use this to guide ongoing preventative strategies and management. Repeat and document each time the ulcer is assessed.

### Nutritional supplements and hydration

See also [the NICE guideline on nutrition support](#) for details of nutrition support other than supplements, and advice on energy and protein intake levels.

- 1.4.4 Offer adults with a pressure ulcer a nutritional assessment by a dietitian or other healthcare professional with the necessary skills and competencies.
- 1.4.5 Offer nutritional supplements to adults with a pressure ulcer who have a nutritional deficiency.
- 1.4.6 Provide information and advice to adults with a pressure ulcer and, where appropriate, their family or carers, on how to follow a balanced diet to maintain an adequate nutritional status, taking into account energy, protein and micronutrient requirements.

- 1.4.7 Do not offer nutritional supplements to treat a pressure ulcer in adults whose nutritional intake is adequate.
- 1.4.8 Do not offer subcutaneous or intravenous fluids to treat a pressure ulcer in adults whose hydration status is adequate.

## Pressure redistributing devices

- 1.4.9 Use high-specification foam mattresses for adults with a pressure ulcer. If this is not sufficient to redistribute pressure, consider the use of a dynamic support surface.
- 1.4.10 Do not use standard-specification foam mattresses for adults with a pressure ulcer.
- 1.4.11 Consider the seating needs of adults who have a pressure ulcer who are sitting for prolonged periods.
- 1.4.12 Consider a high-specification foam or equivalent pressure redistributing cushion for adults who use a wheelchair or sit for prolonged periods and who have a pressure ulcer.

## Negative pressure wound therapy

- 1.4.13 Do not routinely offer adults negative pressure wound therapy to treat a pressure ulcer, unless it is necessary to reduce the number of dressing changes (for example, in a wound with a large amount of exudate).

## Hyperbaric oxygen therapy and electrotherapy

- 1.4.14 Do not offer the following to adults to treat a pressure ulcer:
- electrotherapy

- hyperbaric oxygen therapy.

## Debridement

1.4.15 Assess the need to debride a pressure ulcer in adults, taking into consideration:

- the amount of necrotic tissue
- the category, size and extent of the pressure ulcer
- patient tolerance
- any comorbidities.

1.4.16 Offer debridement to adults if identified as needed in the assessment:

- use autolytic debridement, using an appropriate dressing to support it
- consider using sharp debridement if autolytic debridement is likely to take longer and prolong healing time.

1.4.17 Do not routinely offer adults with a pressure ulcer:

- larval (maggot) therapy
- enzymatic debridement.

Consider larval therapy if debridement is needed but sharp debridement is contraindicated or if there is associated vascular insufficiency.

## Systemic antibiotics and antiseptics

See also [the NICE guideline on antimicrobial stewardship](#).

1.4.18 After a skin assessment, offer systemic antibiotics to adults with a pressure ulcer if there are any of the following:

- clinical evidence of systemic sepsis (see also [the NICE guideline on sepsis](#))
  - spreading cellulitis
  - underlying osteomyelitis
- 1.4.19 Discuss with a local hospital microbiology department which antibiotic to offer adults with infection to ensure that the chosen systemic antibiotic is effective against local strains of infection.
- 1.4.20 Do not offer systemic antibiotics specifically to heal a pressure ulcer in adults.
- 1.4.21 Do not offer systemic antibiotics to adults based only on positive wound cultures without clinical evidence of infection.

## Topical antimicrobials and antiseptics

See also [the NICE guideline on antimicrobial stewardship](#).

- 1.4.22 Do not routinely use topical antiseptics or antimicrobials to treat a pressure ulcer in adults.

## Dressings

- 1.4.23 Discuss with adults with a pressure ulcer and, if appropriate, their family or carers, what type of dressing should be used, taking into account:
- pain and tolerance
  - position of the ulcer
  - amount of exudate
  - frequency of dressing change.
- 1.4.24 Consider using a dressing for adults that promotes a warm, moist wound healing

environment to treat category 2, 3 and 4 pressure ulcers.

1.4.25 Do not offer gauze dressings to treat a pressure ulcer in adults.

## Heel pressure ulcers

1.4.26 Discuss with adults with a heel pressure ulcer and, if appropriate, their family or carers, a strategy to offload heel pressure as part of their individualised care plan. (See also [the NICE guideline on diabetic foot problems](#) for advice on heel pressure offloading.)

# 1.5 Management: neonates, infants, children and young people

## Ulcer measurement

1.5.1 Document the surface area of all pressure ulcers in neonates, infants, children and young people, preferably using a validated measurement technique (for example, transparency tracing or a photograph).

1.5.2 Document an estimate of the depth of a pressure ulcer and the presence of undermining, but do not routinely measure the volume of a pressure ulcer in neonates, infants, children and young people.

## Categorisation

1.5.3 Categorise each pressure ulcer in neonates, infants, children and young people at onset using a validated classification tool (such as the International NPUAP-EPUAP) Pressure Ulcer Classification System) to guide ongoing preventative and management options. Repeat and document each time the ulcer is assessed.



## Nutritional supplements and hydration

- 1.5.4 Offer an age-related nutritional assessment to neonates, infants, children and young people with a pressure ulcer. This should be performed by a paediatric dietitian or other healthcare professional with the necessary skills and competencies.
- 1.5.5 Discuss with a paediatric dietitian (or other healthcare professional with the necessary skills and competencies) whether to offer nutritional supplements specifically to treat a pressure ulcer in neonates, infants, children and young people whose nutritional intake is adequate.
- 1.5.6 Offer advice on a diet that provides adequate nutrition for growth and healing in neonates, infants, children and young people with a pressure ulcer.
- 1.5.7 Discuss with a paediatric dietitian whether to offer nutritional supplements to correct nutritional deficiency in neonates, infants, children and young people with a pressure ulcer.
- 1.5.8 Assess fluid balance in neonates, infants, children and young people with a pressure ulcer.
- 1.5.9 Ensure there is adequate hydration for age, growth and healing in neonates, infants, children and young people. If there is any doubt, seek further medical advice.

## Pressure redistributing devices

- 1.5.10 Consider using specialist support surfaces (including dynamic support surfaces where appropriate) for neonates, infants, children and young people with a pressure ulcer, taking into account their current pressure ulcer risk and mobility.
- 1.5.11 Use a high-specification cot or bed mattress or overlay for all neonates, infants, children and young people with a pressure ulcer.
- 1.5.12 If pressure on the affected area cannot be adequately relieved by other means

(such as repositioning), consider a dynamic support surface, appropriate to the size and weight of the child or young person with a pressure ulcer, if this can be tolerated.

- 1.5.13 Tailor the support surface to the location and cause of the pressure ulcer for neonates, infants, children and young people.

## Negative pressure wound therapy

- 1.5.14 Do not routinely use negative pressure wound therapy to treat a pressure ulcer in neonates, infants, children and young people.

## Hyperbaric oxygen therapy and electrotherapy

- 1.5.15 Do not use the following to treat a pressure ulcer in neonates, infants, children and young people:
- electrotherapy
  - hyperbaric oxygen therapy.

## Debridement

- 1.5.16 Consider autolytic debridement with appropriate dressings for dead tissue in neonates, infants, children and young people. Consider sharp and surgical debridement by trained staff if autolytic debridement is unsuccessful.

## Systemic antibiotics and antiseptics

See also [the NICE guideline on antimicrobial stewardship](#).

- 1.5.17 Consider systemic antibiotics for neonates, infants, children and young people with a pressure ulcer with clinical evidence of local or systemic infection.

- 1.5.18 Discuss with a local hospital microbiology department which antibiotic to offer neonates, infants, children and young people with infection to ensure that the chosen systemic antibiotic is effective against local strains of bacteria.

## Topical antimicrobials and antiseptics

See also [the NICE guideline on antimicrobial stewardship](#).

- 1.5.19 Do not routinely use topical antiseptics or antimicrobials to treat a pressure ulcer in neonates, infants, children and young people.

## Dressings

- 1.5.20 Consider using a dressing that promotes a warm, moist healing environment to treat category 2, 3 and 4 pressure ulcers in neonates, infants, children and young people.
- 1.5.21 Consider using topical antimicrobial dressings to treat a pressure ulcer where clinically indicated in neonates, infants, children and young people, for example, where there is spreading cellulitis.
- 1.5.22 Do not use iodine dressings to treat a pressure ulcer in neonates.
- 1.5.23 Do not offer gauze dressings to treat a pressure ulcer in neonates, infants, children and young people.

## Heel pressure ulcers

- 1.5.24 Discuss with the parents or carers of neonates and infants and with children and young people (and their parents or carers if appropriate), a strategy to offload heel pressure as part of their individualised care plan to manage their heel pressure ulcer, taking into account differences in size, mobility, pain and tolerance. (See also [the NICE guideline on diabetic foot problems](#) for advice on heel pressure offloading.)

# Recommendations for research

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

## 1 Debridement

What is the effect of enzymatic debridement of non-viable tissue compared with sharp debridement on the rate of healing of pressure ulcers in adults?

### Why this is important

Debridement of dead tissue is vital as its presence can delay healing and encourage infection. Although autolytic debridement via natural processes (supported by use of an appropriate dressing) is considered to be adequate for the majority of pressure ulcers, other methods, including mechanical, enzymatic, sharp debridement and larval therapy are available.

There is limited high quality evidence on whether removal of dead tissue via sharp (carried out at the bedside) or enzymatic debridement produces the best outcomes. Use of enzymatic debridement in the UK is limited and the availability of these agents is variable, however, it is used in other countries. Additionally, there is some evidence that it may be slower than sharp debridement and result in the removal of viable tissue.

Identifying the best method of debridement may have significant benefits, including reducing the length of time people with pressure ulcers need to stay in hospital.

## 2 Negative pressure wound therapy

Does negative pressure wound therapy (with appropriate dressing) improve the healing of pressure ulcers, compared with the use of dressing alone in adults with pressure ulcers?

### Why this is important

Negative pressure wound therapy is used for a variety of wounds, including pressure ulcers. It aims to assist healing, reduce the surface area of a wound and remove wound

exudate. Negative pressure wound therapy creates a suction force which helps drain the wound and promote wound healing. There is evidence to suggest some benefit in the use of negative pressure wound therapy in other wound areas (for example, surgical wounds) but there is limited evidence to support its use for pressure ulcers.

Negative pressure wound therapy is used variably across the NHS and many trusts have purchased or hired negative pressure wound therapy pumps. There would be benefits to patients and the NHS in establishing whether negative pressure wound therapy improves the healing of pressure ulcers.

### **3 Risk assessment in neonates, infants, children and young people**

Which pressure ulcer tools are most effective for predicting pressure ulcer risk in children?

#### **Why this is important**

There are a few published pressure ulcer risk assessment tools for children, but most of these have no evidence of validity and over half have been developed from adult pressure ulcer risk assessment tools. Of the tools which have validation data, the evidence is mainly poor quality. When healthcare professionals are choosing a risk assessment tool to use in clinical practice, they should be looking for a tool that has evidence to demonstrate that it is good at predicting risk in the population of interest.

### **4 Pressure redistributing devices**

Do pressure redistributing devices reduce the development of pressure ulcers for those who are at risk of developing a pressure ulcer?

#### **Why this is important**

Pressure redistributing devices are widely accepted methods of trying to prevent the development of pressure areas for people assessed as being at risk. These devices include different types of mattresses, overlays, cushions and seating. They may work by reducing or redistributing pressure, friction or shearing forces. There is limited evidence on the effectiveness of these devices and much of the evidence has been funded by industry. The cost of pressure redistributing devices can vary significantly and there is limited

evidence on whether more sophisticated devices (for example, alternating pressure devices) provide any additional benefit compared to more basic devices such as high-specification foam mattresses.

There is also limited evidence on whether different at-risk sites benefit from using different pressure redistributing devices. For example, a pressure redistributing device used for pressure relief on one site could cause pressure on another site. Further research is needed to identify what devices are beneficial for specific at-risk sites for all age groups.

## 5 Repositioning

When repositioning a person who is at risk of developing a pressure ulcer, what is the most effective position – and optimum frequency of repositioning – to prevent a pressure ulcer developing?

### **Why this is important**

It is generally accepted that repositioning people who are at risk of developing a pressure ulcer can prevent one developing by removing pressure from the at-risk site. Identifying the most effective position – and the optimum frequency of repositioning – will minimise discomfort and maximise pressure ulcer prevention.

There is limited evidence on the most efficient position and frequency of repositioning for all age groups. Many studies include people who are on pressure redistributing surfaces, so it is unclear whether prevention is because of the support surface or the repositioning. A randomised study of different frequencies and positions on a standard support surface (for example, a high-specification foam mattress) is needed.

## Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the, see the [NICE topic page on skin conditions](#).

For full details of the evidence and the guideline committee's discussions, see [the full guideline](#). You can also find information about [how the guideline was developed](#), including details of the committee.

NICE has produced [tools and resources](#) to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see [resources to help you put guidance into practice](#).

# Update information

## Minor changes since publication

**February 2019:** After a surveillance review, links were added throughout to other NICE guidance that has been produced since this guideline was originally published. Some terms used in some recommendations were updated to reflect current practice.

This guideline updates and replaces NICE clinical guideline 29 (published September 2005) and NICE clinical guideline 7 (published October 2003).

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