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Standard Operating Procedure (SOP): Pressure Area Care in Maternity

Introduction and Aim

A pressure ulcer is localised damage to skin and/or underlying tissue caused by pressure, shear, or friction.

Most pregnant and labouring people are fit and well, yet a number of people have left hospital care with an injury that impacted on their life and the care of their newborn baby.

From 1 April 2000 to 31 March 2018 NHS Resolution received 96 claims relating to pressure ulcers suffered by women in maternity units. (Royal College of Midwives, 2023)

Skin integrity during admission to the Maternity Unit during pregnancy, labour and postnatally should be assessed and monitored.

Objectives

To prevent, identify, and manage pressure damage in maternity patients during antenatal, intrapartum, and postnatal care. This SOP ensures compliance with NICE Guidance and NHS Wales policy.

Scope

Applies to all midwives and maternity support workers in hospital and community settings.
Includes care for:
- Pregnant women with reduced mobility (e.g., epidural, spinal anaesthesia)
- Postnatal women recovering from surgery or prolonged labour
- High-risk patients (BMI >30, diabetes, pre-eclampsia, prolonged bed rest)

Equality Health Impact Assessment	An Equality Health Impact Assessment has not been completed.
Documents to read alongside this Procedure	Acute Tissue Viability Team, Cardiff and Vale Intranet Page
Approved by	Maternity Professional Forum

Accountable Executive or Clinical Board Director	Abigail Holmes (Director of Midwifery)
Author(s)	Sian Jones (Midwife)
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Causes

Pressure Area damage can occur on any area of the body and is caused by 4 factors.

- **Pressure** on a surface for prolonged periods with blood supply being constricted to this area.

- **Friction** – 2 surfaces rubbing against another surface causing a scuff in the skin

- **Shear** - Stretching / rubbing of the skin surface that displaces and distorts blood capillaries.

- **Micro-climate / moisture**

Risk factors specific to maternity care

- Periods of immobility with pressure on skin areas
- Prolonged use of lithotomy position
- Lack of feeling and sensitivity to skin damage
- Vulnerable skin through low or high BMI's
- Friction and shear from blood pressure cuffs, catheter tubing, FSE leads.
- Skin exposure to moisture – lochia, perspiration
- Nutrition – poor fluid and food intake

On admission

Skin safety and prevention to be discussed. Skin Safety Cards (Appendix) are available in Labour Rooms. Routine enquiry around current skin damage or previous pressure area damage should be recorded. Anyone with previous pressure area damage should be seen by the Tissue Viability and Wound Healing Nurse (Available through Switchboard).

A ***Tissue Viability Assessment*** or ***Pressure Ulcer Risk Assessment*** should be completed on Badgernet for all people admitted to Maternity Unit which will determine whether a Pressure Area Care Pathway should be used and which care pathway this should be.

Discussion around pressure area prevention or use of Skin Safety Care (Appendix) should be initiated

A person admitted with no risk factors and mobile will be found on Badgernet as not requiring a Pressure Area care pathway and will not need a further assessment unless the clinical picture changes e.g.

Mobility reduced due to epidural

Current pressure sore evident

Medical devices causing pressure or potential shear of skin e.g. CTG belts, catheter tubing, FSE attachments.

The Tissue Viability Assessment / Pressure Ulcer Risk Assessment is to be completed 4 hourly on Badgernet if the initial risk assessment places them ‘at risk’

The Care Pathways to follow are in all rooms on Delivery Suite to refer to.

A Badger Net Amber Primary Care Pathway (Appendix) advises

- Skin Safety discussion
- 4 hourly position changes
- Applying Derm-S Barrier cream to areas exposed to pressure, moisture, or friction 12 hourly.
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- Perform skin assessments 4 hourly including areas in contact with medical devices e.g. catheter tubing, CTG straps, pulse oximeters, FSE leads.
- If vulnerable / damaged/ broken skin is noted, refer to RED SECONDARY CARE PATHWAY

Secondary, Red Care Pathway (Appendix)

- Highlight Skin Safety
- Use Skin Safety Card
- Encourage and assist in 4 hourly position change is mobility is restricted
- Apply Med-S barrier cream (in drug cupboard) 12 hourly to skin areas that are vulnerable e.g. if immobile and skin areas are exposed to friction or moisture e.g. SROM, lochia, CTG straps.
- Perform skin assessments 4 hourly including areas in contact with medical devices e.g. catheter tubing, CTG straps, pulse oximeters, FSE leads.
- Ensure appropriate analgesia is given.
- Liaise with Tissue Viability Team via switchboard.
- Ensure appropriate pressure relieving mattress.

Classification

Initial signs of pressure area damage

- Localised hard areas
- Localised warm areas
- Pain
- Swollen skin over bony joints
- Red, erythemous, broken skin
- Blanching Erythema (redness) - when lightly pressed - will turn white and then red in a few seconds.

Pressure damage must be categorised using the **European Pressure Ulcer Advisory Grading system (2014**)

- **Category/Stage I** Pressure Ulcer: Non-blanchable erythema – The skin is intact but shows redness (or a change in colour in darker skin). The area may feel painful, warmer, cooler, softer, or firmer than nearby skin. This is the first sign of risk.
- **Category/Stage II** Pressure Ulcer: Partial thickness skin loss – The top layer of skin is damaged, appearing as a shallow open sore or a blister. The wound bed looks red or pink but there is no dead tissue (slough).
- **Category/Stage III** Pressure Ulcer: Full thickness skin loss – The ulcer extends through the skin into the fat underneath. It may look deep, depending on the body area. Dead tissue (slough) may be present, and the wound can have tunnelling or undermining. Bone, tendon, or muscle are not visible.
- **Category/Stage IV** Pressure Ulcer: Full thickness tissue loss – The ulcer extends through skin and fat, exposing bone, tendon, or muscle. Dead tissue may be present, and tunnelling is common. These ulcers can cause serious complications like bone infection.
- **Unstageable Pressure Ulcer** (covered in eschar or slough) – The wound is covered with dead tissue (slough or eschar), making it impossible to see how deep it is. Until this covering is removed, the stage cannot be determined. On the heel, intact dry eschar may serve as the body's natural protection and should not be removed.
- **Suspected Deep Tissue Injury: Depth unknown** – The skin may look purple, maroon, or like a blood-filled blister. This signals damage beneath the surface, which can quickly progress to a more severe ulcer, even if treated. It can be harder to detect in darker skin tones.

Further Actions

- Grade 2 or above pressure damage: Refer to Tissue Viability Nurse within 24 hours. This should ideally via e-referral which requires registering an account on Clinical Portal **through e-Advice and Communications – Secondary Care – e-Advice Training - account request** or Switchboard
- All patients with any level of pressure damage will have details of the damage recorded and an incident form completed on DATIX. This will include an accurate recording of the location where the damage was first noted and when damage occurred.
- If the pressure ulcer deteriorates a new incident form is required.
- All category III /IV and unstageable pressure ulcers will be photographed by Medical Illustration / CNS Wound Healing
- All patients with category III /IV and unstageable pressure ulcers will be referred to the appropriate Clinical Nurse Specialist in Wound Healing /Wound Specialist. Pressure Area wounds to the foot should be referred to Podiatry Team who will liaise with other Healthcare Professionals as require

Pressure Area Care Flowchart

On all admissions complete Pressure Ulcer Risk Assessment on Badgernet and discuss risks and prevention of Pressure Area damage

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Badgernet calculates –

i) **Not at Risk, on no clinical pathway**
ii) **Primary Care Pathway**
iii) **Secondary Care Pathway**

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Refer to Primary Care and Secondary Care Pathways as appropriate including use of Barrier Cream 12 hourly and 4 hourly position changes.

Continue 4 hourly skin and pressure area checks as per Pressure Area Risk Assessment Form

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Secondary Care Pathway is for patients with existing or previous pressure sore.

Refer to Tissue Viability Team via switchboard or phone Tel: 02920 746506
Tel: 02920 745317 or complete E-referral (requires registering account explained on page 5)

Pressure Area Damage on the foot/heel to be reviewed by Podiatry not Tissue Viability

Medical Illustration to be contacted to photograph and Datix to be completed

References

NICE CG179: Pressure ulcers: prevention and management

Cardiff and Vale Health board Tissue Viability and Wound Healing

Royal College of Midwives (2023) Preventing Pressure Ulcers in Maternity Care

European Pressure Ulcer Advisory Panel (2019), National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA:

Appendix

‘Pressure area risk assessment’ on Badgernet to be completed 4 hourly if immobile during labour or postnatally

BADGERNET PRIMARY CARE AMBER PATHWAY FOR VULNERABLE SKIN

Action to be completed
Highlight Skin Safety Use Skin Safety Card and discuss the ASSKING acronym
Encourage and assist in 4 hourly position changes if independent movement in restricted
Apply Med-S barrier cream (in drug cupboard) 12 hourly to skin areas that are vulnerable e.g. if immobile and skin areas are exposed to friction or moisture e.g. SROM, lochia, CTG straps
Perform skin assessments 4 hourly including areas in contact with medical devices e.g. catheter tubing, CTG straps, pulse oximeters, FSE leads
If vulnerable / damaged/ broken skin is noted, refer to RED SECONDARY CARE PATHWAY

BADGERNET SECONDARY CARE PATHWAY FOR DAMAGED SKIN OR PREVIOUS PRESSURE SORE

'Pressure area risk assessment' on Badgernet to be completed 4 hourly if immobile during labour or postnatally

Action to be completed
Highlight Skin Safety Use Skin Safety Card and discuss the ASSKING acronym
Encourage and assist in 4 hourly position changes if independent movement in restricted
Apply Med-S barrier cream (in drug cupboard) 12 hourly to skin areas that are vulnerable e.g. if immobile and skin areas are exposed to friction or moisture e.g. SROM, lochia, CTG straps
Perform skin assessments 4 hourly including areas in contact with medical devices e.g. catheter tubing, CTG straps, pulse oximeters, FSE leads
Ensure appropriate analgesia is given
Liaise with Tissue Viability Team via switchboard Ensure appropriate mattress is in use

Skin Safety Card

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Having a baby in hospital may put you at risk of developing a bed sore from pressure or moisture damage

You may be at higher risk if:

You have a raised BMI

You have had an epidural

You haven been to theatre

These seven tips will help keep you safe: A S S K I N G

Assessment

Your midwife will check if you are at risk.

Surface

A special mattress or device might be used to help protect your skin

Skin inspection

Tell someone if you feel any pain or notice changes in your skin

Keep moving

Into a dry, clean bed

Changing pads every 2-4 hours and getting into a dry, clean bed can help protect your skin

Nutrition & Hydration

Keep hydrated and eat well

Give information

Ask if you would like more information

If you've experienced a pressure ulcer before let us know

v 0.1 2021 Tissue Viability/Podiatry Team