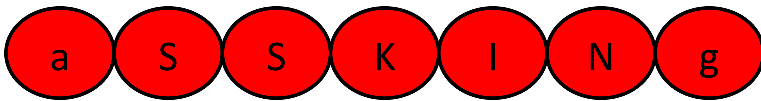

Red Care Plan at DBTH

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

For pressure ulcer prevention 7 key principles are required, commonly referred to as 'aSSKINg'. The framework is a tool which brings together best practice with the aim of minimising variation in care, recommended by the National Wound Care Strategy Programme (2023). Click on the hyperlinks for more information.

	Principle	Action
a	Assess risk (Risk Assessment)	Undertake a PURPOSE T screening tool and where required a risk assessment within 6 hours of arrival to the Trust.
		Refer all pressure ulcer to the Skin Integrity Team via NerveCentre or Datix Web.
		Be aware of the Trust safeguarding policies and take appropriate action when necessary.
		Update the PURPOSE T screening and where required a risk assessment at each condition and environment change within 6 hours or at least weekly.
s	Skin assessment and skin care	Undertake a 26 point skin inspection, including skin under devices where it is safe to do so, alongside the risk assessment and then 3 times within a 24 hour period whilst the risk remains red.
		Consider colour, texture and temperature of the skin.
		Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb.
		Apply emollient daily to keep the skin well hydrated and promote skin integrity.
		Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
		Undertake and document a wound assessment and treatment plan for any pressure ulcers or moisture associated skin damage. Follow the Doncaster Pressure Ulcer Management Care Plan.
s	Surface (Equipment)	Use a Quattro Plus Dynamic air Mattress
		Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. If you feel a further assessment around the mattress provision is required refer to the Skin Integrity Team.
		Identify and undertake relevant seating and moving and handling risk assessments. Ensure the patient has access to a patient bed side chair where suitable.
		Ensure the patient has access to a foot stool to enable heel offloading 'heels off stool' when sat in a chair.
		If the patient has a pressure ulcer or wound to the heel refer to Orthotics for an offloading boot/device.
		Consider the impact of medical devices and there contact with the skin and use preventive techniques where required as per the Medical Device Pressure Ulcer Prevention Guidance.
		Refer to the Integrated Discharge Team throughout the discharge planning to ensure the require equipment has been arranged at the discharging location.
k	Keep moving (Repositioning)	Ensure the patient repositions every 2 hours at least. Where non concordance or instability occurred ensure this is documented on the repositioning schedule.
		Identify and understand and, where possible, address the cause of any change in mobility level.
		Undertake a falls risk assessment and moving and handling risk assessments to balance the risk from other harm.
		Where assistance is required use 2 slide sheets as a minimum for positon changes in bed.
		Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks.
		Safely use a range of appropriate equipment to promote self-mobilisation and good posture. For example: hoists and slings, standing hoists, frames etc.
i	Incontinence or increased moisture (Moisture associated skin damage MASD)	Identify the cause of moisture-related skin damage i.e. Incontinence, sweat, saliva, stoma, wound leakage.
		Where possible, address the cause of the moisture and refer to continence services where necessary.
		Implement appropriate prevention and management strategies using the Doncaster Skin Care Pathway for MASD.
		Keep the skin clean, dry and maintain hydration.

n	Nutrition (Nutrition and Hydration)	Undertake a MUST assessment with 24 hours of arrival to the Trust. Utilising relevant tools such as BMI and MUAC.
		Commence a food and/or fluid balance chart where required as per MUST guidance or if the patient has a category 3 or 4 pressure ulcer.
		Provide fortification and nutritional supplementation through Fotisips.
		For patients with a category 3 or 4 pressure ulcer refer to the dietitian service for a review of enhanced protein and/or moderation of dietary restrictions.

g	Give information	Provide the patient with a **Pressure Ulcer patient information leaflet**.
		Select and implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
		Consider the patient's level of capacity and perform the necessary checks.
		Use the clinical record to documentation to ensure information is available to the inter-professional team.
		Use appropriate language to ensure the clinical record can be appropriately used for coding/analytic purposes.
		When capturing/using digital images, ensure appropriate consent has been obtained.

Developed by The Skin Integrity Team April 2024. For review July 2027.
Bases on the National Would Care Strategy Programme Pressure Ulcer Recommendations.