Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Pressure Ulcer and Moisture Associated Skin Damage Policy

This procedural document supersedes: PAT/T 3 v 4 - Pressure Ulcer Policy - Tissue Viability Top Ten.

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author

Version 5	November 2024	• Major changes have been made throughout, please read in full.
		• Including
		  • Risk assessment
		  • Categorisation
		  • Pathways
			Kelly Phillips (was Moore) – Skin Integrity Nurse Consultant

Version 4	November 2021	• Major changes have been made throughout, please read in full.	Kelly Moore – Skin Integrity Lead Nurse
Version 3	April 2015	• Major changes have been made throughout, please read in full. • Format and style updated. • Updated Appendix • Equality Impact Assessment form included at Appendix 15 • Policy renamed Pressure Ulcer Prevention and Management Policy	Tracy Vernon – Lead Nurse, Tissue Viability

The link to the Skin Integrity Website where all the Doncaster wide wound care formulary and pathway information can be found is:

https://www.dbth.nhs.uk/services/skin-integrity/information-for-healthcare-professionals/doncaster-wound-care-alliance/doncaster-wide-associated-clinical-pathways/

1 INTRODUCTION

Pressure Ulcers

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful[1]. They can affect anyone from new-borns to those at the end of life and can cause significant pain and distress for patients. 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[2].

Pressure ulcers are a key indicator of the quality and experience of patient care and are in the 'top ten harms' in the NHS in England[14]. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem, with over 1,300 new ulcers reported each month[3] with up to 200,000 people developing a new pressure ulcer in 2017/18[4]. Treating pressure ulcers costs the NHS more than £1.4 million every day[4].

We know that many pressure ulcers are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating[5]. Preventing them will improve care for all vulnerable patients. However investigations into the causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers[13].

Despite national[15] and international[16] clinical guidelines, there was currently no up-to-date standardised pathway for implementing these guidelines in England. Consequently, individual health and care organisations develop their own pathways and protocols, which may vary substantially, leading to increased and unnecessary workload and variation in clinical practice. Therefore the National Wound Care Strategy Programme (NWCSP) developed Pressure Ulcer recommendations for England[13].

Moisture-associated skin damage

Moisture-associated skin damage (MASD) represents a significant problem and can have a negative effect on patient wellbeing and quality of life[9]. The wider term of MASD can be subdivided into key areas which are: Incontinence-associated dermatitis (IAD), Peri-stomal dermatitis, Intertriginous dermatitis (intertrigo), Peri-wound maceration. The development of MASD involves more than bodily fluids alone. Rather, skin damage is attributable to multiple factors, including chemical irritants within the moisture source (e.g. proteases and lipases in faeces, drug metabolites), its pH, associated microorganisms on the skin surface (e.g. commensal skin flora), and mechanical factors such as friction[10].

Aim of the Policy

This policy is intended for all clinical staff working within Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and should be used in conjunction with the most recent edition of the Royal Marsden NHS Trust Manual of Clinical Nursing Procedures.

Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust recognises the need to minimise the risks and avoid unnecessary pressure ulcers and MASD within all patients' care

settings. We know that many pressure ulcers and MASD are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating[5]. Preventing them will improve care for all vulnerable patients. As pressure ulcers have a complex and multifactor aetiology and can arise in a number of ways, interventions for prevention and treatment need to be applicable across a wide range of settings[2]. This policy clearly sets out roles and responsibilities with regard to pressure ulcer and MASD prevention for all healthcare professionals.

The Pressure Ulcer aSSKINg care plans (appendix 1, 2, 3 and 4) aim to improve pressure ulcer prevention and management at ward and department level to facilitate the enhancement of quality care in line with NICE 2014[2], European Pressure Ulcer Advisory Panel 2019 (EUPAP[6]) and the National Wound Care Strategy Programme (NWCSP) Pressure Ulcer Recommendations[13]. It also makes the process of preventing pressure ulcers visible to all whilst minimising variation in care practices which is a key recommendation from NHS Improvement.

The Skin Care Pathway for Moisture Associated Skin Damage (MASD) for Secondary Care aims to improve MASD prevention and management at ward and department level to facilitate the enhancement of quality care in line with the 2020 wounds international recommendations[17]. It also makes the process of preventing pressure ulcers visible to all whilst minimising variation in care practices which is a key recommendation from NHS Improvement.

2 PURPOSE

The purpose of this policy is to:

2.1 Provide local and national recommendations for the prevention, assessment, reporting and management of pressure ulcers and MASD to enable standardised approach within the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

2.2 Provide information on how healthcare professionals can identify patients at risk of developing pressure ulcers and MASD.

2.3 Provide information on how to appropriately prevent pressure ulcer development through the use of the aSSKINg interventions. The components of the aSSKINg are:

- a = Assess Risk
- S = Skin Assessment and Skin Care
- S = Surface (Equipment Provision)
- K = Keep Moving (Repositioning)
- I = Incontinence
- N = Nutrition and Hydration
- g = Give Information

2.4 Provide information on how to appropriately prevent MASD development through the use of Skin Care Pathway for Moisture Associated Skin Damage (MASD) for Secondary Care. The components of the Skin Care Pathway are:

- Cleanse
- Protect
- Restore

2.5 Provide information on how to assess a pressure ulcers and MASD.

2.6 Provide information on how to report pressure ulcers and MASD.

2.7 Provide information on how to manage patients with a pressure ulcers and MASD.

2.8 Provide information regarding the investigation process for Hospital Acquired Pressure Ulcers (HAPU).

2.9 Minimise the physical, psychological and financial cost of pressure ulcers and MASD to the patients and the Trust.

2.10 Ensure that the Trust complies with national guidance[2] [11].

3 DUTIES AND RESPONSIBILITIES

- **Chief/Deputy Chief Nurse** ultimately responsible for ensuring that systems are in place which effectively manages the risks associated with pressure ulcer prevention and management. Their role is to support the implementation of a board to ward culture to support a zero tolerance approach to pressure ulcers.
- **Associated Chief Nurse for Patient Safety** will provide assurance to the board that effective systems are in place and is responsible for the development of pressure ulcer prevention and management strategies throughout the Trust to ensure best practice.
- **Skin Integrity Team** are responsible for supporting the Chief/Deputy Chief Nurse/Associate Chief Nurse with implementation of this policy, for supporting staff in its implementation, and assisting with risk assessment where required. The role of the Skin Integrity Lead Nurse is to plan, implement and evaluate a strategic approach for Skin Integrity and to identify and improve the knowledge and practice throughout the Trust.
- **Divisional Nurses/Deputy Divisional Nurses** are responsible for ensuring the policy is adhered to and for ensuring action is taken if staff fails to comply with the policy.
- **Matrons** are responsible for ensuring implementation within their area of best practice by utilising Tendable. Matrons hold the responsibility for leading the HAPU investigation process and implementing learning actions identified.
- **Ward and Department Managers** are responsible for ensuring implementation within their area and staff members adhere at all times and are responsible for ensuring implementation within their area of best practice by utilising Tendable.

- **Skin Integrity Champions** are required on all inpatient areas, wards and departments. There is a requirement for the Skin Integrity Champion to attend and complete the 4 Skin Integrity Education Modules achieving an assessment pass mark of 80%+. The Champion will act as the ward based topic lead and will be available to give educational advice and support in relation to pressure ulcer prevention.
- **Clinical Team** responsible for the patient: are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles at all times.

4 PROCEDURE

Provide local and national recommendations for the prevention, assessment, reporting, investigating and management of pressure ulcers and MASD to enable standardised approach within the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. The Procedure is summarised in the Pressure Ulcer Clinical Pathway (Appendix 14).

4.1 Prevention

Assess the Risk

Assessing the patients' risk of developing pressure ulcers is to be achieved using PURPOSE-T Pressure Ulcer screening and risk assessment (the maternity and paediatric paper version can be seen in Appendix 6 and 7). This is to be completed within 6 hours of arrival to the Trust, change in environment or change of patient condition as a minimum.

PURPOSE-T which is an evidence-based pressure ulcer risk assessment instrument that was developed using robust research methods. PURPOSE-T identifies adults at risk of developing a pressure ulcer and supports nurse decision-making to reduce that risk (primary prevention), but also identifies those with existing and previous pressure ulcers requiring secondary prevention and treatment. It uses colour to indicate the most important risk factors and forms a three-step assessment process which has correlating actions that are required to be undertaken as per the DBTH aSSKINg care plan which are in line with NWCSP recommendation[13] :

- Green: No PU – not currently at risk
- Amber: No PU but at risk, requiring primary prevention
- Red: PU category 1 or above or scarring from previous pressure ulcer, requiring secondary prevention/treatment.

Patient risk factors for developing MASD include: Excessive moisture due to perspiration, excessive moisture due to wound leakage, bariatric patients, medicines e.g. steroids, antibiotics, immunosuppressant's. Patient risk factors for developing IAD include:

Skin Inspections

The DBTH 26 point skin inspection is to be undertaken along with the PURPOSE T assessment (6 hours of arrival to the Trusts, change of environment and change of patient condition) and 3 times a day (every 8 hours/once per shift) as a minimum. The 26 points include: Back of head, sacrum, toes, nose, ribs, spine, natal cleft, devices, left knee, right knee, left foot, right foot, left hip, right hip, left buttock, right buttock, left elbow, right

elbow, left ear, right ear, left scapular, right scapular, left shoulder, right shoulder, left heel, right heel.

Surface

There are several aspects of surface, equipment and devices that clinicians are required to consider for the prevention and management of pressure ulcer:

- Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. There is a Trust wide Pathway in place for the use of mattresses in line with the PUPOSRE T outcome so it is clear what the most appropriate mattress is for the patients' needs and risk factors (Appendix 8). If the clinician feels a further assessment around the mattress provision is required they can contact and refer to the Skin Integrity Team.
- Identify and undertake relevant seating and moving and handling risk assessments, ensure the patients have access to a patient bed side chair where suitable.
- Ensure the patients have access to a foot stool to enable heel offloading 'heels off stool' when sat in a chair and pillows when in bed to enable heel offloading 'heels off bed' when laid in a bed (Appendix 9)
- Ensure 2 slide sheets are available at the bed side and used for all patient repositioning around the bed space as a minimum for patients assessed as requiring assistance or are unable to move themselves (Appendix 10).
- 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 their 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 if equipment, surfaces, devices are used for the prevention or management of pressure ulcer throughout the discharge planning to ensure the require equipment has been arranged at the discharging location.

Keep Moving

There are several aspects for repositioning and keeping the patient moving that clinicians are required to consider for the prevention and management of pressure ulcer:

- Ensure the patient repositions every 2 hours as a minimum if they have a red risk status or 4 hours as a minimum if they have an amber risk status. Where no 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.
- Ensure 2 slide sheets are available at the bed side and used for all patient repositioning around the bed space as a minimum for patients assessed as requiring assistance or are unable to move themselves (Appendix 10).
- 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.

Incontinence

There are several aspects that clinicians are required to consider for the prevention and management of MASD, including incontinence:

- Identify the cause of moisture-related skin damage i.e. Incontinence, sweat, saliva, stoma effluent, wound leakage.
- The skin will be more vulnerable to pressure, shear and friction, Moisture due to urine and/or faeces, with more than 2 episodes of incontinence per day[11]. Moisture Associate Skin Damage (MASD) prevention is to be delivered using the intact skin section of the Skin Care
- Pathway Skin Care Regime for Moisture Associated Skin Damage (MASD) prevention for Secondary Care (Appendix 7) when a patient has been identified as being at risk.
- Where possible, address the cause of the moisture and refer to continence services where necessary.
- Keep the skin clean, dry and maintain hydration.

Nutrition and Hydration

There are several aspects that clinicians are required to consider for Nutrition and Hydration in the role of pressure ulcer prevention and management:

- 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 Fortisips.
- 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.

Giving Information

There are several aspects that clinicians are required to consider for giving information to patients at risk of and living with a pressure ulcer:

- 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 as the source of documentation to ensure information is available to all members of 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.

All patients assessed as being a red or amber pressure ulcer risk should have the patient information preventing pressure ulcer information provided to them. This can be provided to the patient in a hard copy (WPR 50010), via a health care professional observing the patient reading and understanding a laminated version or the patient accessing the document via a QR code (Appendix 14). The method provided is to be document clearly and accordingly in the nursing records.

Heel pressure prevention

For patients assessed as being bed bound or require hoist transfer as part of their manual handing assessment a HeelPro per foot should be provided to be worn at all times when in bed to prevent pressure ulceration to the heels.

Urinary catheter pressure prevention

For patients with a urinary catheter in place a StatLock catheter securing device is to used, adhering to the patient's thigh for the duration that the urinary catheter is in use. If the StatLock requires changing or reapplying for any reasons then it should be adhered to the opposite thigh.

4.2 Assessment and Reporting

Pressure ulcers are to be assessed and reported using the categorisation definitions (Appendix 11) from the guidance produced by the NWCSP Pressure Ulcer Categorisation Tool (2024). MASD is to be assessed and reported as Pathway for Skin Care Regime for Moisture Associated Skin Damage (MASD) (Appendix 7).

When categorising a pressure ulcer, it is important to know about anatomy. For example, understanding what the layers of the skin are, the location of bony prominences, and whether there is muscle or fat over the bony structure. These factors all contribute to our understanding regarding the depth of the tissues, and layers which might be implicated in damage. In particular, a good understanding of the skin is important. A good understanding of anatomy will help to understand what structures should be present beneath the skin e.g. subcutaneous fat, fascia, muscle, bone, cartilage, tendon, and this information should also inform the allocation of the correct category. An example would be: there is no muscle over the calcaneus, there is just subcutaneous fat between the skin and the bone, and therefore it is more likely that a deep pressure ulcer at this site will be a category 4.

When assessing patients with dark skin tones, additional consideration should be given to detecting the early signs of skin damage, which are often overlooked as erythema may not be clearly visible. Where visible signs of damage are diminished, more focus should be placed on temperature and tissue consistency, as well as patient reported pain or itching in relation to surrounding tissue (e.g., induration/hardness).

Medical device-related pressure ulcers should be categorised as per any other pressure ulcer where possible. If the pressure ulcer is on a mucosal membrane, it should not be categorised but recorded as a mucosal pressure ulcer. Details of both the device and cause of the wound, if known, should be recorded (e.g. ties too tight, incorrect securement system, tubing underneath the patient). Device-related pressure ulcers can often be observed over challenging anatomical sites e.g. bridge of the nose (Continuous positive airway pressure mask (CPAP)), top of ear (oxygen tubing), etc. Therefore, careful consideration of tissue depth is needed prior to categorisation.

Mucosal membrane pressure ulcers occur in of the moist membranes that line the respiratory, gastrointestinal, and genitourinary tracts. They do not have the same anatomical structures as the skin; therefore, it is not possible to categorise them.

Category 1 pressure ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss. The patient may report pain or discomfort over the area.

Category 2 pressure ulcer appears with an abrasion, blister, partial-thickness skin loss involving epidermis and or dermis.

Category 3 pressure ulcer with full-thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.

Category 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and/or bone in the ulcer. There is an increased risk of osteomyelitis.

All patients with a pressure ulcer or MASD within the Trust must be recorded and at the point of identification and reported to the Skin Integrity Team via the electronic reporting mechanisms. The Skin Integrity Team will review pressure ulcers categorised as a category 2, 3, 4, or Mucosal Ulcers and confirm the categorisation and status. For pressure ulcer category 1 and MASD relevant pathways (appendix 7, 12 and 13) are to be implemented at ward and department level with any concerns of no improvement or deterioration escalated to the Skin Integrity Team.

The data for Hospital Acquired pressure ulcer categorised as 2, 3, 4, Mucosal Ulcers is verified by the Lead Nurse/Clinical Nurse Specialist for Skin Integrity on a monthly basis. The provisional data is presented to the patient safety team who then share this within the monthly patient safety report. The data is finalised on the 10th working day of the following month 2 once all cases have been reviewed and verified by The Skin Integrity Team.

A systematic approach to holistic wound assessment is essential for the delivery of high quality care. A holistic wound assessment considers the 'whole' patient and should comprise of a generic wound assessment minimum data set[1]. A holistic wound assessment has the potential to:

- Identify factors that require intervention and indicate objectives for management
- Guide appropriate patient and wound management
- Improve healing rates
- Reduce the physical, emotional and socioeconomic impact of wounds on patients
- Benefit practitioners and the NHS by reducing the overall burden of wounds, potentially decreasing workload and the costs associated with wound care
- Raise practitioner and patient morale by improving patient outcomes.

A holistic wound assessment should be performed by a healthcare professional with sufficient knowledge and skills and they should be given sufficient time to perform a holistic wound assessment [3].

Best practice Statement - Holistic wound Assessment

Wounds UK (2018)[1] recommend that a holistic wound assessment includes a generic minimum data set for assessment and documentation. Using a structured approach through a generic holistic wound assessment criteria will underpin the assessment, documentation and practice to facilitate a more consistent approach to wound management and can re-focus services and promote improvements in wound care. Additional assessment parameters may be necessary according to wound type, for example when assessing a wound on the lower limb. This has been compiled using all the criteria from the NHS England Leading Change Adding Value Framework[4] and the assessment criteria from the SIGN Guideline for Venous Leg Ulcers[5].

The wound assessment tool recommended to use as part of a holistic wound assessment is T.I.M.E.S. This tool was developed and published in 2003[6] by an international group of wound healing experts, to provide a framework for a structured approach to wound bed preparation. The T.I.M.E.S acronym facilitates the assessments of:

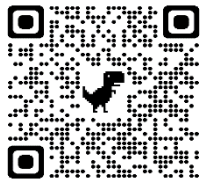
- Tissue
- Infection, inflammation or biofilm
- Moisture
- Edges of the wound
- Surrounding skin.

Generic wound assessment minimum data set	**Criteria of T.I.M.E.S and the assessment of associated barriers to wound healing**	**Wound bed preparation. TIME in practice**

High standard, consistent documentation can guide objective setting, care planning and evaluation/reassessment[1]. Documentation of a holistic wound assessment and a management plan should take place at each dressing change including each parameter in the generic wound assessment minimum data set. The reviews should determine whether the patient and the wound are improving, deteriorating or unchanged; checking the progress against the objectives of management[1]. Any adjustments to the management plan should be fully documented. Drawings and/or photography can illustrate the wound, aiding the assessment. If photography is used, local photography guidance and polices should be adhered to at all times. Only take photographs when consent has been given and according to local guidelines (which may include who is permitted to take photographs and require that camera users are registered)[7]. The National Wound Care Strategy Programme (NWCSP)

provides recommendations on photography, however ensure that local Trust/organisation photography guidance is adhered to:

Top Tips for Photography



NWCSP Photography recommendation

A referral to Skin Integrity will be automated when a new wound assessment is added to Nerve Centre. All areas not using Nerve Centre are required to add the wound information to a DATIX Skin Integrity Form for a referral to be generated.

For all referrals via Nerve Centre clinical photography is required to accompany the wound assessment where the patient provides consent to do so.

All referrals will be triages by a Registered Nurse within the Skin Integrity Team (Monday to Friday excluding Bank Holidays). From this it will be deemed as either:

- No SIT input needed – no support provided
- No SIT input needed – Links to the relevant pathways to follow will be provided
- SIT input virtually is required – a personalised plan will be added to the wound assessment and SIT Update section virtually on Nerve Centre by SIT.
- SIT input face to face is required – a face to face review from SIT will be scheduled. In some case where this cannot be achieved with 24-72 hours a temporary plan from SIT will be provided for the ward to follow in the interim on the wound assessment and SIT Update section on Nerve Centre.

4.3 Investigating

It is essential to monitor the incidence and severity of pressure ulcers within the Trust. Incidence measures the number of pressure ulcers developing in a specific clinical area over a period of time and to determine the most effective care and correct use of resources.

In line with the NHS Improvement document, pressure ulcers revised definition and measurement, summary and recommendations, published in 2018, the Trust are required to ensure the following:

- We should use the term ‘pressure ulcer

- A pressure ulcer should be defined as: "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".
- A pressure ulcer that has developed due to the presence of a device **should** be referred to as a device related pressure ulcer
- A pressure ulcer that has developed at end of life due to 'skin failure' should **not** be referred to as a 'Kennedy ulcer'.
- The term 'category' should be used from October 2018 at a national level (in national reporting/policy documents).
- A pressure ulcer that is identified during the first skin inspection undertaken on admission to that Trust will be referred to as a Present on Admission Pressure Ulcer (POA).
- The '72-hour rule' **should** be abandoned.
- A pressure ulcer that is identified after the first skin inspection within the current episode of care will be referred to as a Hospital Acquired Pressure Ulcer (HAPU).
- The Department of Health and Social Care's definition of avoidable/ unavoidable Hospital Acquired Pressure Ulcer should no longer be used.
- Reporting of all pressure ulcers grade 2 and above (POA and HAPU) should be incorporated into local monitoring systems.
- The number of patients with a pressure ulcer **should** be incorporated into local monitoring systems.
- Moisture-associated skin damage (MASD) should be counted and reported in addition to pressure ulcers.
- Where skin damage is caused by a combination of MASD and pressure, it will be reported based on the category of pressure damage.
- Only pressure ulcers that meet the criteria for a Serious Incident (SI) should be reported to the clinical commissioning group.

The Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) Patient Safety Incident Response Policy and Patient Safety Incident Response Plan set out how we intend to respond to patient safety incidents through the requirements of the Patient Safety Incident Response Framework (PSIRF). The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Response to an event will follow a systems-based approach, recognising that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident. This document relates specifically to applying the above Policy and Plan to a Hospital Acquired Pressure Ulcer (HAPU) through the requirements of the Patient Safety Incident Response Framework (PSIRF).

Hospital Acquired Pressure Ulcers (Appendix 15)

The HAPU patient safety incident profile relates to a patient that has been admitted to DBTH and develops a pressure ulcer categorised as a category 2 or above whist in the care of DBTH (excluding virtual ward):

- Category 2
- Category 3 (including category 3 at least)
- Category 4
- Mucosal Ulcer

The Skin Integrity Team, (SIT) at DBTH accept referrals for potential HAPU's categorised as a category 2 or above. SIT review the patient, pressure ulcer and episode of care to confirm the HAPU status and pressure ulcer category. If SIT confirm a HAPU's categorised as a category 2 or above the HAPU PSIRP is to be commenced. This will be undertaken at the time of the HAPU confirmation using a walkthrough analysis (WTA) and Hot Debrief.

A HAPU Action Outcome Assessment will be completed to confirm if the case requires an improvement repose or Learning response. Following this it may be identified that an After Action Review (AAR) or patient safety incident investigation (PSII) is required to either evaluate an activity or event that have been particularly successful/unsuccessful to capture learning to avoid failure and promote success for the future or to identify potential for new learning and explore decisions or actions that are required for the situation.

Response Types (Appendix 16)

<u>Pressure Ulcer Walkthrough Analysis (WTA)</u>

The Pressure Ulcer Walkthrough analysis (WTA) is a structured approach to collecting and analysing information about a task or process or future development. It is used to help understand how work is performed and aims to close the gap between as imaged and work ad done to be better support performance. The process of care deliver undertaken and documented for 7 day prior to the HAPU developing (or in incidences where the patient has not been in hospital for 7 days, since arrival), in line with the Trusts Pressure Ulcer and Moisture Associated Skin Damage (including Incontinence Associated Dermatitis) Policy.

The WTA divides the process into tasks that are clearer to understand to help identify the areas of contributing factors, safety issues, and areas for improvement/learning.

- Assess Risk - Pressure ulcer risk assessment
- Skin Assessment and skin care – Skin Inspection and preventive products
- Surface Selection and use – Equipment
- Keeping patients moving – Repositioning, including HOB and HOS
- Incontinence assessment and care – IAD/MASD management
- Nutritional and hydration assessment and support - MUST and Dietitian
- Giving Information – where there is non-concordance
- Categorisation and Wound assessment
- Referral and escalation

HAPU Action Outcome Assessment

The HAPU Action Outcome Assessment will conclude if the patient safety event requires an improvement response, learning response or a Patient Response Incident Investigation.

Harm Level

The harm level of the pressure ulcer is assessed in line with the harm level descriptions from Learn from Patient Safety Events (LFPSE), which is a requirement for Patient Safety Incidents.

Hot Debrief

A Hot Debrief is an interactive, structured team dialogues that takes place either immediately or very shortly after a clinical case designed to help the whole team learn from the experience, reflect on what went well, identify team strengths or difficulties and to consider ways to improve future performance.

Safeguarding Performa Assessment

This preform assessment provides a framework for health and care organisations to use to confirm and concern that the hospital acquired pressure ulcer may have arisen as a result of poor practice, neglect or abuse, or an act of omission. If there is a score of 15 or above a referral to Trust safeguarding team for investigation will be triggered.

Action Outcome score

The action outcome combines the WTA, harm level, hot debrief, and the safeguarding Performa outcomes together to identify if an after action review is required, or if escalation to a Patient safety incident investigation is required. There are 4 sections that can all result in a score of 1. The minim outcome is a score of 2 which indicated no further action is required. If there is a score of 3 an After Action Review is required and if there is a score of 4 a Patient safety incident investigation is required.

Q1 = Was the pressure ulcer development unintended or unexpected = Always scores 1

Q2 = Did the pressure ulcer occur during the provision of an activity we regulate = Always scores 1

Q3 = In the reasonable expert opinion of the Skin Integrity Nurse, in combination with the WTA is the overall percentage 49% or less AND/OR In the reasonable expert opinion of the Skin Integrity Nurse, in combination with the WTA is there a single area/subject that has a percentage 49% or less Relating to a new single action that does not already form part of the ward/department HAPU reduction action plan AND/OR Have had more than 2 HAPU's (category 3 or above) in a single month AND/OR Have had more than 6 HAPU's (category 3 or above) in a financial year AND/OR Have they triggered 15 or more on the safeguarding Performa assessment = if yes is answered to 1 or more of these section the score is 1.

Pressure Ulcer After Action Review (AAR)

The Pressure Ulcer After Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

Patient Safety Incident Investigation (PSII)

A Patient safety incident investigation (PSII) is undertaken when an event or near-miss indicates significant patient safety risks and potential for new learning offering an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. This will include the outcome form the Pressure Ulcer Walkthrough Analysis (WTA), Pressure Ulcer Action Outcome Assessment and the four questions from a Pressure Ulcer After Action Review (AAR).

Skin Integrity Monitoring

The Skin Integrity Team will capture all HAPU data using Monday.com. The data will be by ward/department and include information around the category, harm level, harm data, location on of HAPU, WTA outcome, Hot debride outcome, Safeguarding outcome, AAR requirements, PSII requirements, Learning themes. This will form the basis for Skin Integrity Team to update/complete a ward HAPU improvement plan (Appendix D). Which will be emailed to the ward manager and matron on a monthly basis. The ward/department are able to update and add to the improvement plan and send back to Skin Integrity for their records.

Skin Integrity Improvement Meeting 3 monthly Skin Integrity Improvement

Meeting for the HAPU's that require a AAR or PSII following the Learning response will take place. The meeting will be led by the Skin Integrity Team.

The Ward Manger and Matron of the ward will be required to be attendance along with any other nominated members of staff from the ward/department. If the Ward Manger and Matron another nominated member of staff is required to attend in their place. The Deputy Divisional Nurse or Division Nurse from all divisions are required to attend the 3 monthly Skin Integrity Improvement Meeting to enable leadership support and divisional accountability for HAPU improvements across their division.

An open discussion will take place reviewing the wards/departments HAPU improvement plans to discuss the contributing factors and system gaps, whilst undertaking triangulation of the information and insights to enable next steps to be discussed and summarised. This provides Trust wide sharing and learning across multiple areas around HAPU improvements, with both what is going well and what is being worked on. The ward/department HAPU improvement plan will be discussed and agreed at the meeting with the Ward Manager and Matron taking overall accountability for implementing the plan.

Skin Integrity Horizon Scanning

Horizon scanning will be undertaken every 6 months by the Skin Integrity Team using the, WTA, Hot debriefs, AAR and PSII completed over the past 6 months, to develop a scope and purpose for Trust wide quality improvement requirements. Horizon scanning supports health and social care teams to take a forward look at potential or current safety themes and issues.

A workshop will then be planned to include healthcare professionals who care for patients at risk of pressure ulcer development to discuss the scope and purpose and look at what is happening by mapping the process and exploring work as done, whilst taking a forward look to discuss on how risks can be exacerbated or mitigated by future changes/issues. Learning will be summarised and areas of improvement agreed and next steps agreed. This will be undertaken bi-annually and facilitated by the Skin Integrity Team and form part of the quality improvement/ strategy for the reduction in the number of Hospital Acquired Pressure Ulcers.

4.4 Management

The Pathway for Pressure Ulcer Management (Appendix 13) is to be followed for the management of pressure ulcer, unless specified differently by the Skin Integrity Team or Consultant.

The Pathway for Skin Care Regime for Moisture Associated Skin Damage (MASD) Secondary Care (Appendix 7) is to be followed for the management of MASD unless specified differently by the Skin Integrity Team or Consultant.

4.5 Patient Lacking Capacity

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005)[12].

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5 TRAINING/SUPPORT

All healthcare professionals have access to Trust wide study days and a Trust secure social media with material and events relating to the pressure ulcers and MASD prevention. The education programme will be updated on a regular basis based on the local policy and evidence based practice whilst incorporating the national and international agenda. This is to be completed by all patient facing staff every 3 years as a minimum.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Compliance with pressure ulcer pathways and the relevant aSSKINg interventions approach.	Individual Ward/Department Manager or Leads	As per Tendable requirements	The Skin Integrity Quarterly Improvement meetings and reviewed by individual Ward/Department Manager or Leads and Matron.
The Pathway for Skin Care Regime for Moisture Associated Skin Damage (MASD) Secondary Care.	Individual Ward/Department Manager or Leads	As deemed required by Individual Ward/Department Mangers or Leads or the Skin Integrity Team.	The Skin Integrity Quarterly Improvement meetings and reviewed by individual Ward/Department Manager or Leads and Matron.
HAPU figures per patient, per pressure ulcer, by SPC chart, by episodes vs 1000 bed days	Lead Nurse/Clinical Nurse Specialist for Skin Integrity	Monthly as a minimum	Reported to the monthly patient safety report and to the Patient Safety Committee, CGC and CQRG.
Ward attendance to the pressure ulcer prevention training .	Individual Ward/Department Manager or Leads	Quarterly as a minimum	The Skin Integrity Quarterly Improvement meetings and reviewed by individual Ward/Department Manager or Leads and Matron.

7 DEFINITIONS

- **DOC** - Duty of candour.
- **MASD** - Moisture-associated skin damage
- **HAPU** – Hospital acquired pressure ulcer
- **POA** – Present on admission
- **NWCSP** – National Wound Care Strategy Programme

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are

disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified (Appendix 16).

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

DBTH Doncaster Wide Wound Care Formulary and associated policies and pathways PAT/T 77 v 2 - https://www.dbth.nhs.uk/wp-content/uploads/2024/10/Doncaster-Wound-Care-Alliance-Wound-Care-Formulary-and-Associated-Pathways-and-Policies-v2.pdf

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

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8. UK Government (2005) Mental Capacity Act: making decisions

9. Fletcher J, Beeckman D, Boyles A et al (2020) International Best Practice Recommendations: Prevention and management of moisture-associated skin damage (MASD). Wounds International.
10. Gray M, Black JM, Baharestani MM et al (2011) Moistureassociated skin damage: overview and pathophysiology . J Wound Ostomy Continence Nurs 38(3): 233-41
11. Beekman D et al. (2015) Proceedings of the Global IAD Expert Panel. Incontinence Associated Dermatitis: Moving Prevention Forward. Wounds International. Developed by: Skin Integrity Team. January 2017. For review June 2024.
12. Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf
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15. National Institute of Clinical Excellence. Pressure ulcer prevention and management: Clinical Guideline. CG 179. https://www.nice.org.uk/guidance/cg179/resources/pressure-ulcers-preventionand-management-pdf-35109760631749. 2014.
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APPENDIX 1 – DBTH ASSKING RED CARE PLAN

aSSKINg-Red-Care-Plan.pdf (dbth.nhs.uk)

a S S K I N g

Red Care Plan at DBTH

NHS
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.

APPENDIX 2 – DBTH ASSKING AMBER CARE PLAN

aSSKINg-Amber-Care-Plan.pdf (dbth.nhs.uk)

a S S K I N g

Amber Care Plan at DBTH

NHS
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.
		Update the screening tool / risk assessment at each condition and environment change within 6 hours or at least weekly.
s	Skin assessment and skin care	Undertake a PURPOSE T screening tool and where required a risk assessment within 6 hours of arrival to the Trust.
		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 moisture associated skin damage (MASD) or Vulnerable skin (Discoloration/Deep Tissue Injury). Follow the Doncaster Skin Care Pathway for MASD or Pressure Ulcer Management Pathway.
s	Surface (Equipment)	Use a Mercury Advanced Hybrid Mattress with a Pump OR 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 - HOS'.
		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 4 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 assessment.
		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.
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.

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

APPENDIX 3 – DBTH ASSKIN GREEN CARE PLAN

aSSKINg-Green-Care-Plan.pdf (dbth.nhs.uk)

a S S K I N g

Green Care Plan at DBTH

NHS
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.
		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.
		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.
s	Surface (Equipment)	Use a standard Emergency Trolley OR bed frame with a Static Foam Mattress OR bed frame with a Mercury Advanced Hybrid Mattress without a Pump.
		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.
k	Keep moving (Repositioning)	Encourage the patient to reposition throughout the day.
		Undertake a falls risk assessment and moving and handling risk assessments to balance the risk from other harm.
i	Incontinence or increased moisture (Moisture associated skin damage 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.
		Encourage oral intake of diet and fluids where clinically safe to do so.
g	Give information	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.

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

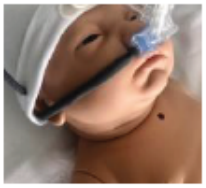
APPENDIX 4 – DBTH NNU ASSKING CARE PLAN

Neonatal Unit
aSSKINg Care Plan at DBTH

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

a. Assess Risk

- All neonatal babies are at risk of pressure ulceration.
- The RGN/RSCN must perform the initial skin inspection within 1 hour of admission/upon transfer from another NNU.
- Reassessment may be required in the event of deterioration as skin integrity could be threatened due to reduced oxygenation. Otherwise reassess weekly as a minimum.



S. Skin assessment and skin care

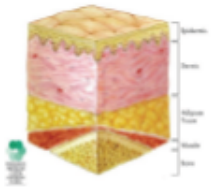
- All babies must have their skin inspected within 1 hour of admission/upon transfer from another NNU and at care times (minimum of 3 hourly) by a RGN/RSCN.
- Babies are at an increased medical device related pressure ulcer (MDRPU), such as CPAP. Refer to the Prevention of Medical Related Pressure Ulcers (MDRPU) guidance for further information.
- Identify and document all pressure ulcers on the Skin Integrity Wound Identification Care Sheet and Skin Integrity Wound Assessment Care Plan
- Assessing wounds using the T.I.M.E.S wound assessment tool allows the principles of wound bed preparation to be understood.
- This focuses on the removal of barriers to healing i.e. debridement, moisture balance and control of bacterial burden enabling wound healing to progress.
- The Skin Integrity Datix/Dashboard should be completed for all pressure ulcers.
- Ward/department staff must perform the initial scoping to determine if there are any potential safeguarding concerns of neglect relating to pressure area care and alert the Safeguarding Team.
- For all children follow the safeguarding children referral processes.
- Staff can contact the Safeguarding Team on 01302 642437 for advice and support.

S. Surface

- Ensure equipment continues to function and there are no issues with humidity for respiratory support devices. High flow and CPAP are to be set on invasive mode with the humidity chamber reading at 37°c and the wire temperature reading at 40°c. Environmental temperature can impact on the humidity levels in the chamber if the readings are out of the normal range for prolonged periods, ensure the equipment is not faulty and seek support from senior staff if required.
- Change SpO2 monitoring probe 3 hourly, frequently.
- Ensure equipment continues to function and there are no issues with humidity for respiratory support devices.
- High flow and CPAP are to be set on invasive mode with the humidity chamber reading at 37°c and the wire temperature reading at 40°c. Environmental temperature can impact on the humidity levels in the chamber if the readings are out of the normal range for prolonged periods, ensure the equipment is not faulty and seek support from senior staff if required.
- Change SpO2 monitoring probe 3 hourly, frequently.

K. Keep moving (repositioning)

- Relieving the pressure is the key to healing areas but can also prevent damage from occurring.
- Medical devices must be repositioned frequently to minimise the pressure and friction to vulnerable skin areas and can reduce the severity of nasal injury if there is damaged tissue.
- If the baby does not tolerate frequent pressure relief from respiratory support or for long periods this must be documented.
- Ensure that prong pressure is relieved 3 hourly.
- Babies requiring CPAP will require their mask and prongs alternating at least every 6 hours if tolerated.
- All pressure relief interventions and repositioning must be charted. If there are any exceptions e.g. babies are too unstable for pressure relief, this must be documented.



I. Incontinence

- Identify the cause of moisture-related skin damage i.e. Incontinence, sweat, saliva, stoma, wound leakage.
- Implement appropriate prevention strategies as per the Pathway for Skin Care Regime for Moisture Associated Skin Damage (MASD) where there are signs of MASD.
- Keep the skin clean and dry using a pH balanced soap substitute.

N. Nutrition and Hydration

- Electrolyte imbalance can be a significant problem during the neonatal period.
- Good nutrition improves neurological outcome and reduces incidence and severity of chronic lung disease in preterm infants.
- Maternal breast milk provides optimal nutrition for preterm infants and reduces the incidence of necrotising enterocolitis.
- Enteral nutrition should be initiated as early as possible – usually within first 48 hours of birth unless significant medical/surgical contraindications.

g. Giving Information

- Select and implement the most appropriate communication approach to parents and carers to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies.
  Use the clinical record to documentation to ensure information is available to the inter-professional team.
- Identify and document all pressure ulcers using the European Pressure Ulcer Advisory Panel guidelines, on the Skin Integrity Wound Identification Care Sheet and Skin Integrity Wound Assessment Care Plan.

Safeguarding
Children & Adults

Developed by the Neonatal Team and Skin Integrity Team April 2024. For review April 2027

WPR48662 August 2024

APPENDIX 5 – PURPOSE T - MATERNITY

(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Maternity PURPOSE T (V2)
Pressure Ulcer Risk Assessment

Step 1 – screening

Mobility status – tick all applicable
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods (2-3 hours)
- Walks independently with or without walking aids

If ONLY blue box is ticked

Skin status – tick all applicable
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, CTG belts, TEDS
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – tick as applicable
- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If ONLY blue box is ticked

No pressure ulcer not currently at risk
Tick if applicable ☐
Not currently at risk pathway

If ANY yellow boxes are ticked, **go to Step 2**

If ANY yellow or pink boxes are ticked, **go to Step 2**

If ANY yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)		Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Frequency of position changes	Doesn't move	☐	N/A	N/A
	Moves occasionally	N/A	☐	☐
	Moves frequently	N/A	☐	☐

Sensory perception and response – tick as applicable
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – tick as applicable
- No problem / Occasional
- Frequent (2 – 4 times a day)
- Constant / SROM

Diabetes – tick as applicable
- Not diabetic
- Diabetic (Not gestational)

Perfusion – tick all applicable
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – tick all applicable
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – tick as applicable
- No problem
- Medical device causing pressure/shear at skin site e.g. CTG belts, TEDS, O_2 tubing

Vulnerable skin (precursor to PU) e.g. discoloration previously known as DTI, blanchable redness that persists, dryness, paper thin, moist including MASD.
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Also Pressure Ulcers where the Category and/or depth is unknown.

Current Detailed Skin Assessment – tick if pain, soreness or discomfort present at any skin site as applicable.
For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable (may be medical device site)				
CTG belts	☐	☐		☐
	☐	☐		☐
TEDS	☐	☐		☐
	☐	☐		☐

Previous PU history – tick as applicable
- No known PU history
- PU history – complete below
- Number of previous pressure ulcer(s)

Detail of previous PU (If more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable ☐
aSSKING Red Care Plan at DBTH

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk
Tick if applicable ☐
aSSKING Amber Care Plan at DBTH

If **only yellow and blue boxes** are ticked, the nurse must consider the risk pro file (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk
Tick if applicable ☐
aSSKING Green Care Plan at DBTH

Nurse printed name	Nurse signature	Date	Time

APPENDIX 6 – PURPOSE T - PAEDIATRICS

Pressure Ulcer Risk Assessment – Paediatric assessment adapted from PURPOSE T (V2)

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patient name	DOB	Hospital / NHS number	Ward

Step 1 – screening

Mobility status – *tick all applicable*
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Moves independently with or without aids

If ONLY blue box is ticked

Skin status – *tick all applicable*
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – *tick as applicable*
- Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids, poor nutrition
- No problem

If ONLY blue box is ticked

- No pressure ulcer not currently at risk – *Tick if applicable*
- Not currently at risk pathway

If ANY yellow boxes are ticked, go to Step 2

If ANY yellow or pink boxes are ticked, go to Step 2

If ANY yellow boxes are ticked, go to Step 2

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)		Extent of all independent movement. Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Frequency of position changes	Doesn't move	☐	N/A	N/A
	Moves occasionally	N/A	☐	☐
	Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. paralysis, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*
- No problem / Occasional
- Frequent (2–4 times a day)
- Constant/nappies

Diabetes – *tick as applicable*
- Not diabetic
- Diabetic

Perfusion – *tick all applicable*
- No problem – Capillary refill <2 secs
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. meningitis, medication, inotropes

Nutrition – *tick all applicable*
- No problem
- Unplanned weight loss
- Poor nutritional intake
- <2 centiles below weight
- >2 centiles over weight

Medical device – *tick as applicable*
- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. discoloration previously known as DTI, blanchable redness that persists, dryness, paper thin, moist including MASD.

Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Also Pressure Ulcers where the Category and/or depth is unknown.

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category*

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Occipital	☐	☐		☐
L ear	☐	☐		☐
R ear	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Medical device skin site				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Step 3 – assessment decision

If ANY pink boxes are ticked/completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If ANY orange boxes are ticked (but no pink boxes), the patient is at risk.

If only yellow and blue boxes are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

- PU Category 1 or above or scarring from previous pressure ulcers – *Tick if applicable* ☐ – aSSKINg Red Care Plan at DBTH
- No pressure ulcer but at risk – *Tick if applicable* ☐ – aSSKINg Amber Care Plan at DBTH
- No pressure ulcer not currently at risk – *Tick if applicable* ☐ – aSSKINg Green Care Plan at DBTH

Nurse printed name	Nurse signature	Date	Time

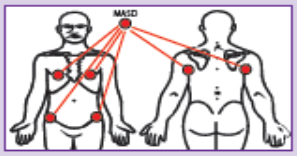
APPENDIX 7 – PATHWAY FOR SKIN CARE REGIME - MASD

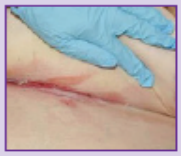
Pathway for Skin Care Regime for Moisture Associated Skin Damage (MASD)

Moisture Associated Skin Damage (MASD) is damage to the skin caused by prolonged contact of moisture such as urine, stool (Incontinence associated dermatitis - IAD) perspiration, saliva, intestinal liquids from stomas and exudate from wounds.

Risk factors

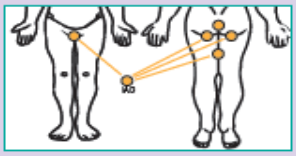
- The skin will be more vulnerable to pressure, shear and friction
- Moisture due to urine and/or stool, with more than 2 episodes of incontinence per day
- Excessive moisture due to perspiration
- Excessive moisture due to wound leakage
- Bariatric patients
- Medicines e.g. steroids, antibiotics, immunosuppressants.

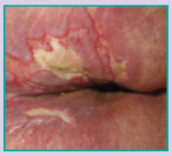




Management Plan

- Assess and treat reversible causes of incontinence
- Implement the Pressure Ulcer Prevention and Management Care Plan
- Assess and treat pyrexia
- Assess and treat wound exudate
- Implement Skin Care Regime as below
- DBTH - Complete a wound assessment on Nervecentre or if your area does no have nerve centre complete a Datix form
- RDaSH - Report using IR1and document the areas within SystmOne/EMIS Web.





Step 1 Undertake a full patient assessment to establish a diagnosis of Incontinence Associated Dermatitis (IAD) or Moisture Associated Skin Damage (MASD).

Step 2
Cleanse
https://www.youtube.com/watch?v=XdkS-G0UIUk

PROSHIELD FOAM and SPRAY Incontinence Cleanser
- Cleanse areas of skin at risk after every episode of incontinence
- Remove faeces/urine where applicable • Do not rinse off, pat dry with dry wipe.

Type 7 Stool (Bristol Stool Chart)	Intact skin	Broken skin

Step 3
Protect and Restore
https://www.youtube.com/watch?v=ylffmoc4WhY

PROSHIELD PLUS Skin protectant	PROSHIELD PLUS Skin protectant	PROSHIELD PLUS Skin protectant
Apply a thick layer to affected areas after each episode of incontinence.	Apply a thin layer once per day as a minimum, to protect and restore the skin and reduce risk of skin breakdown.	Apply a thick layer to affected areas after each episode of incontinence.

Secondary Care:
If there is no improvement after 7 days, or if advice is required refer to the Skin Integrity Team (SIT).
Primary Care:
Refer to TVALS if deterioration noted or no improvement after 7 - 10 days.

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document.

Reference: Fletcher J, Beeckman D, Boyles A et al (2020) International Best Practice Recommendations: Prevention and management of moisture-associated skin damage (MASD). Wounds International. Available online at www.woundsinternational.com
Woo KY, Beeckman D, Chakravarthy D (2017) Management of moisture-associated skin damage: A scoping review. Adv Skin Wound Care 30(11): 494-501
Gray M, Black JM, Baharestani MM et al (2011) Moisture-associated skin damage: overview and pathophysiology. J Wound Ostomy Continence Nurs 38(3): 233-41
Developed by: Skin Integrity Team. January 2017. Update June 2024, V4 For review June 2027.

APPENDIX 8 – DBTH PRESSURE ULCER PREVENTION MATTRESS SELECTION GUIDE

DBTH-Pressure-Ulcer-Prevention-Mattress-Selection-Guide-2024-1.pdf

PURPOSE T Pressure Ulcer Risk Assessment

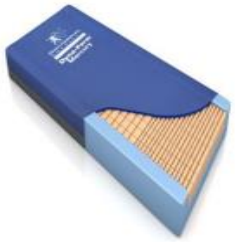
Mattress Selection Guide at DBTH

Skin Integrity Team

Green
Low Risk

1st choice

Foam Mattress
(Soft-foam/Static)



OR

2nd choice *(if 1st choice not available)*

Hybrid Mercury Advance
Pump Turned OFF

Amber
At Risk

1st choice

Hybrid Mercury Advance
Pump Turned ON

OR

2nd choice *(if 1st choice not available)*

Quattro Plus Dynamic Mattress

Red
High Risk

1st choice

Quattro Plus
Dynamic Mattress

The Mercury Advance Hybrid Mattress provides a solution to 'step up' to that of an air mattress when clinically required and 'stepped down' to a foam mattress as the patient's condition improves, whilst using the same mattress.
Here is a user video:
https://www.youtube.com/watch?v=hIaI9Ufoxds

The Quattro Plus Dynamic mattress is a high specification air mattress to aid with the management of up to a category 4 pressure ulcer. Here are some user video for the Quattro Plus Dynamic:
https://www.youtube.com/watch?v=hIaI9Ufoxds
https://www.youtube.com/watch?v=tOb4NJcWfFI
https://www.youtube.com/watch?v=BHr1ZJ2OHSU

APPENDIX 9 – HEEL OFFLOADING

Heel-Pressure-ulcer-Management-poster.pdf (dbth.nhs.uk)

Prevention and Management of Heel Pressure Ulcers

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

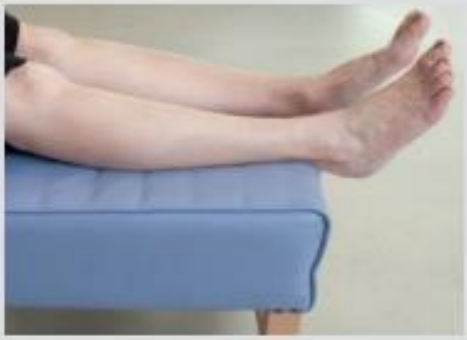
Patients with a red or amber pressure ulcer risk status require heel prevention/management.

This can be achieved by offloading the heels in line with the repositioning schedule time frame: 'heels off bed' (HOB) or 'heels off stool' (HOS).

Whilst in bed, pillows should be used to elevate the heels so they are free of the bed surface.

Place a pillow vertically under each lower leg between the knees and the ankle so that the heels are offloaded, so to distribute the weight of the leg along the calf without causing pressure to the popliteal space or Achilles tendon (National Pressure Injury Advisory Panel 2014).

When a patient is positioned in a chair, offloading can be achieved by elevating the heels over a footstool .



Patients with a pressure ulcer to their heel should be referred to Orthotics for an offloading device to be provided.

Skin Integrity Team

We care

APPENDIX 10 – USE OF SLIDE SHEETS

How-slide-sheets-help-prevent-pressure-ulcers-to-the-heels-poster.pdf (dbth.nhs.uk)

How slidesheets help prevent pressure ulcers (youtube.com)

How Slide Sheets Prevent Pressure Ulcers to the Heels

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

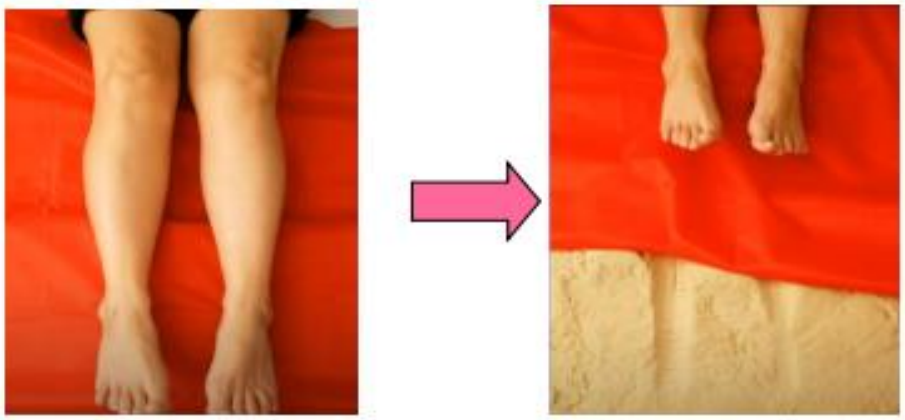
The risk of a pressure ulcer developing on a heel is higher than other bony prominences due to the anatomical location (no muscle or fascia and little subcutaneous tissue). The risk increases further if the patient is immobile, has the presence of previous pressure ulcers and/or scar tissue, there is suboptimal tissue perfusion, the patient has diabetes mellitus or has a raised BMI due to the weight of the foot and lower leg when lying down.

When slide sheets are used underneath the heels when undertaking repositioning and movement techniques in bed the shear force to the heels are reduced by approximately 66% (Kohta el al 2021) when compared to no slide sheets being used.
Therefore using 2 slide sheets as a minimum, to cover the whole mattress surface can significantly reduce the interface friction and internal shear forces in the whole skin surface that is in contact with the mattress.

Please ensure a minimum of 2 slide sheets per patient are used to cover the whole bed surface when a patient is assessed as requiring assistance or is unable to achieve a position change, to cover the whole body surface.
Consider using at least 4 when assisting with patients using bariatric equipment.
Please view this video showcasing the importance of slide sheets: https://youtu.be/1cTRpauNsXQ

Example of the focus on the heels when slide sheets are not used

Example of the focus on the heels when slide sheets are not used



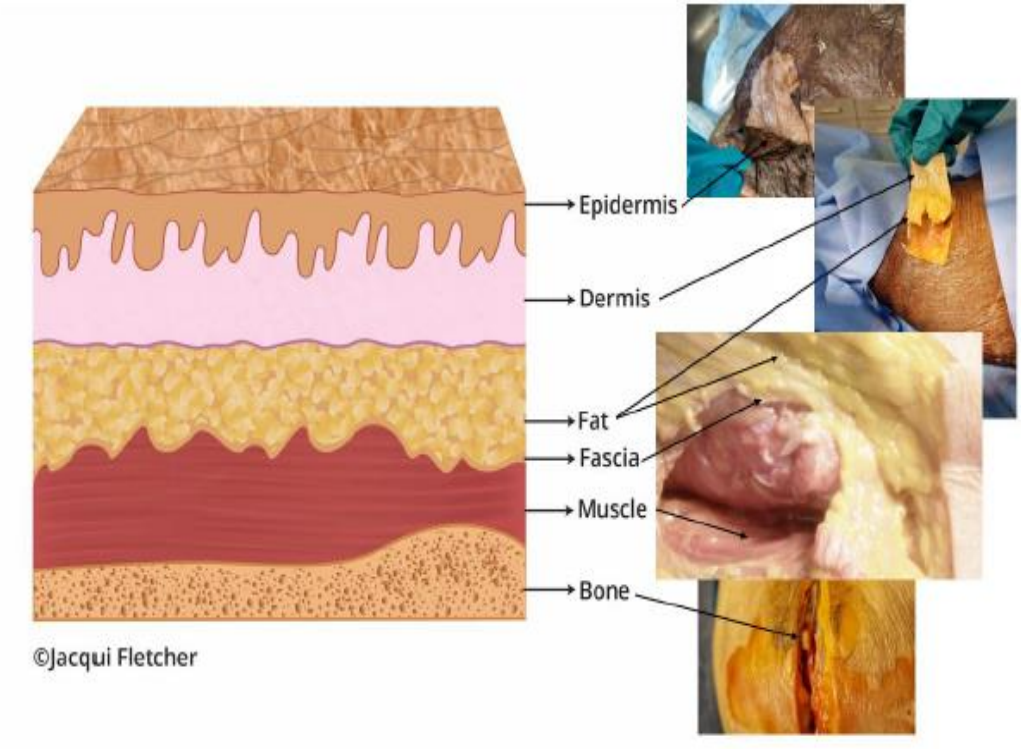
Skin Integrity Team

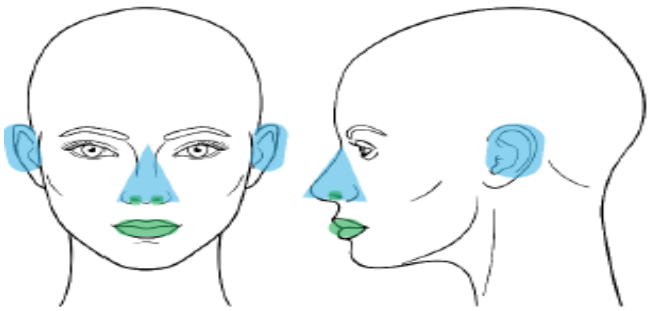
We care

Pressure Ulcer Categorisation Tool

When categorising a pressure ulcer, it is important to know about anatomy. For example, understanding what the layers of the skin are, the location of bony prominences, and whether there is muscle or fat over the bony structure. These factors all contribute to our understanding regarding the depth of the tissues, and layers which might be implicated in damage. In particular, a good understanding of the skin is important. A good understanding of anatomy will help to understand what structures should be present beneath the skin e.g. subcutaneous fat, fascia, muscle, bone, cartilage, tendon, and this information should also inform the allocation of the correct category. An example would be: there is no muscle over the calcaneus, there is just subcutaneous fat between the skin and the bone, and therefore it is more likely that a deep pressure ulcer at this site will be a category 4.

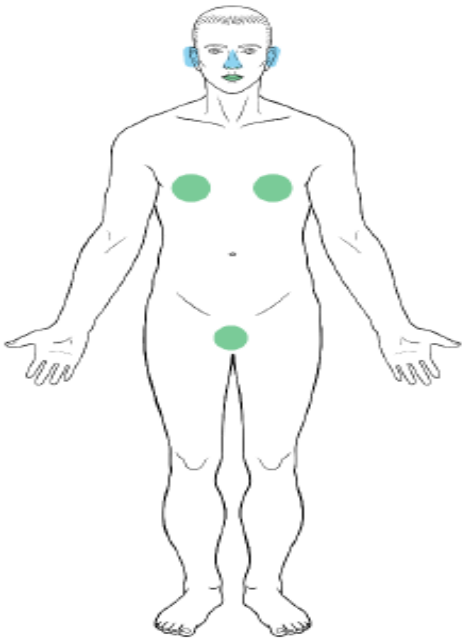
When assessing patients with dark skin tones, additional consideration should be given to detecting the early signs of skin damage, which are often overlooked as erythema may not be clearly visible. Where visible signs of damage are diminished, more focus should be placed on temperature and tissue consistency, as well as patient reported pain or itching in relation to surrounding tissue (e.g., induration/hardness).

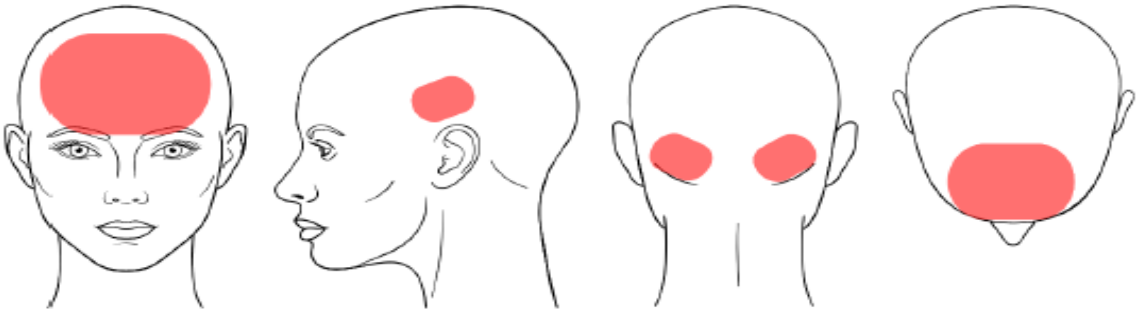




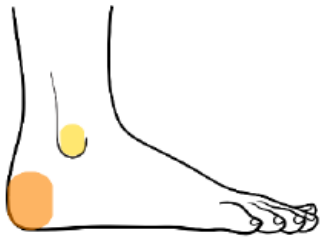
Ears and nose have no muscle or bone. The underlining structure is cartilage *(in blue)*.

Lips, nostrils, nipples and genitalia are formed of mucosal membranes cannot be allocated a numerical category *(in green)*.





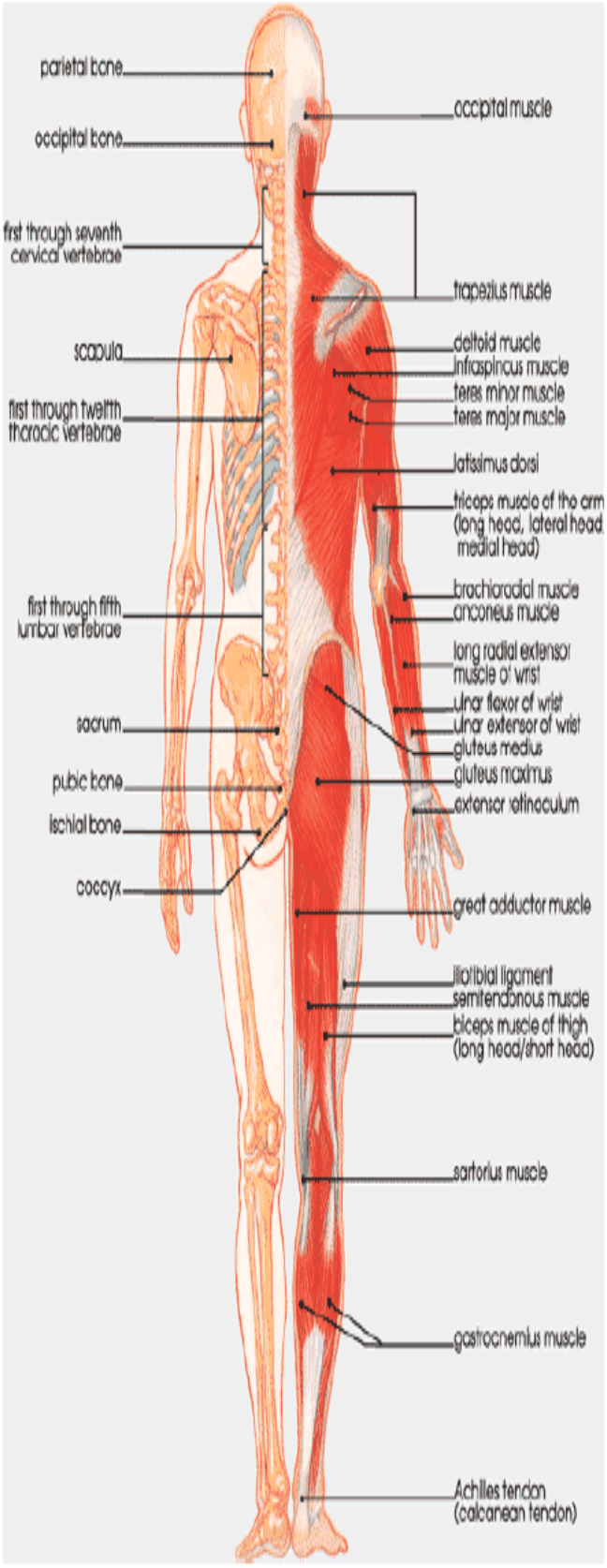
Occiput, skin closely overlayed onto the bone. There are small muscles located at some areas over the skull (*in red*).

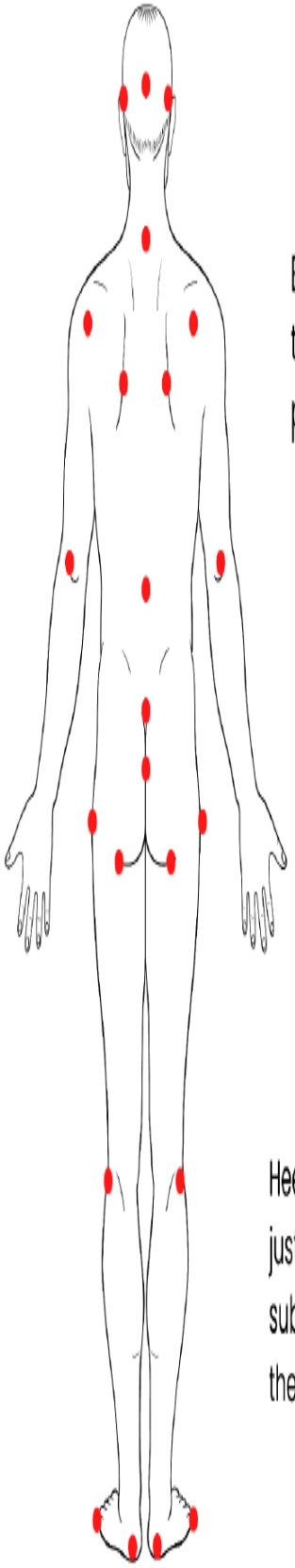


The lateral malleolus is covered in a thin layer of ligament, with a thin layer of muscle over the top of the ligament *(in yellow)*.
There is no subcutaneous tissue at this location.

In contrast the posterior element of the calcaneus bone is covered only by subcutaneous tissue and skin *(in orange)*.

Posterior view of muscles & bones:





Elbows, the bone is very close to the skin surface no muscle present beneath the skin.

Sacrum, Very close to the skin surface, no muscle coverage on some areas.

Heel area, the achilles tendon is just beneath a thin layer of subcutaneous fat superior to the heel.

Medical device-related pressure ulcers

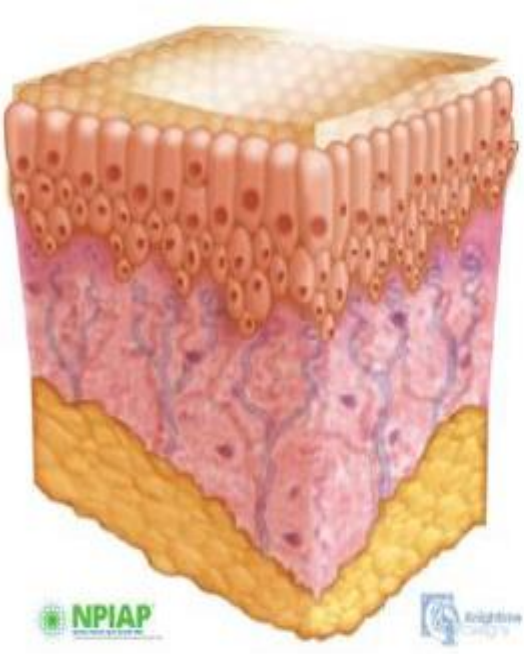
Device-related pressure ulcers should be categorised as per any other pressure ulcer where possible. If the pressure ulcer is on a mucosal membrane, it should not be categorised but recorded as a mucosal pressure ulcer. Details of both the device and cause of the wound, if known, should be recorded (e.g. ties too tight, incorrect securement system, tubing underneath the patient). Device-related pressure ulcers can often be observed over challenging anatomical sites e.g. bridge of the nose (Continuous positive airway pressure mask (CPAP)), top of ear (oxygen tubing), etc. Therefore, careful consideration of tissue depth is needed prior to categorisation.

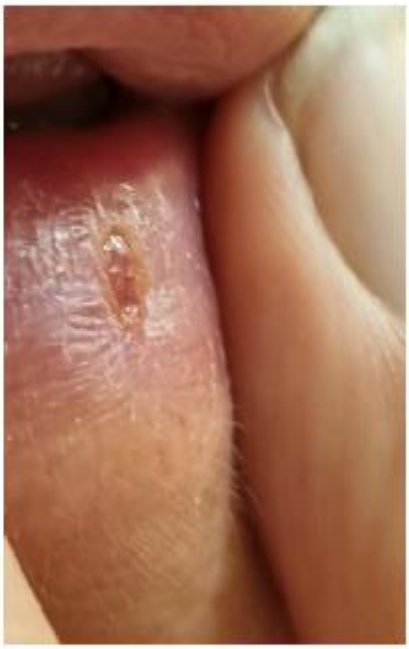
Pressure ulcer categories

The following categories are taken directly from the International Pressure Ulcer Guidelines ((EPUAP, NPIAP, PPPIA 2019 pp 203 – 205) and reflect the National Wound Care Strategy Programme Pressure Ulcer Recommendations and Clinical Pathway 2024. Minor amendments have been made to the language to reflect new understanding of assessing patients with dark skin tones.

Mucosal membrane pressure ulcers

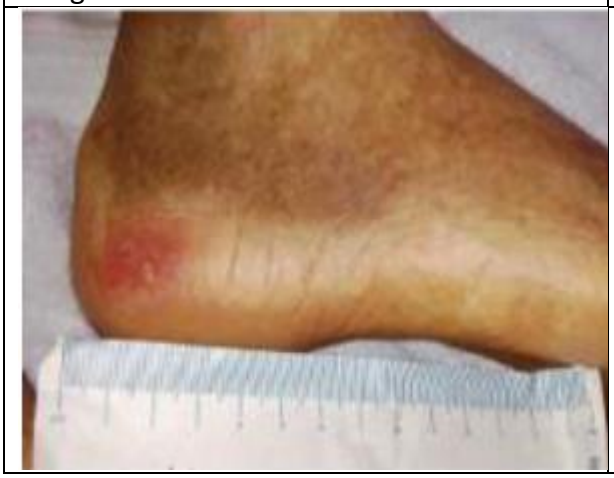
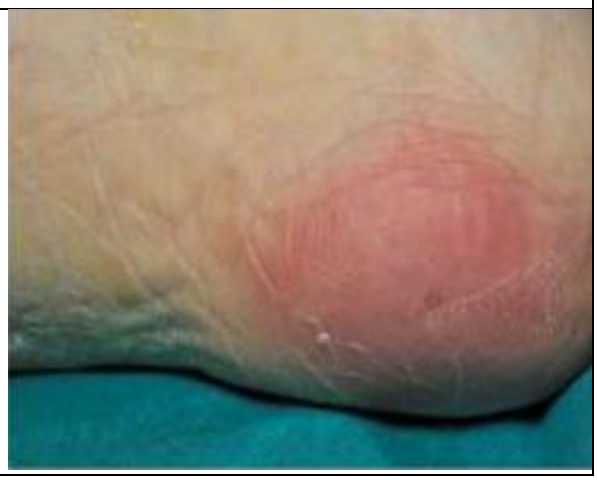
Mucosal membrane pressure ulcers occur in of the moist membranes that line the respiratory, gastrointestinal, and genitourinary tracts. They do not have the same anatomical structures as the skin; therefore, it is not possible to categorise them.





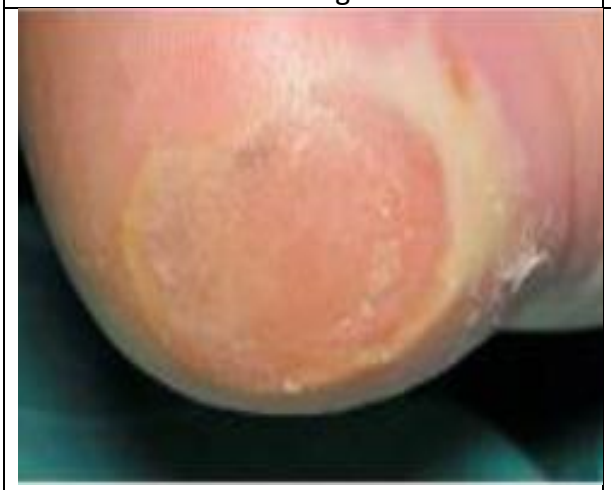
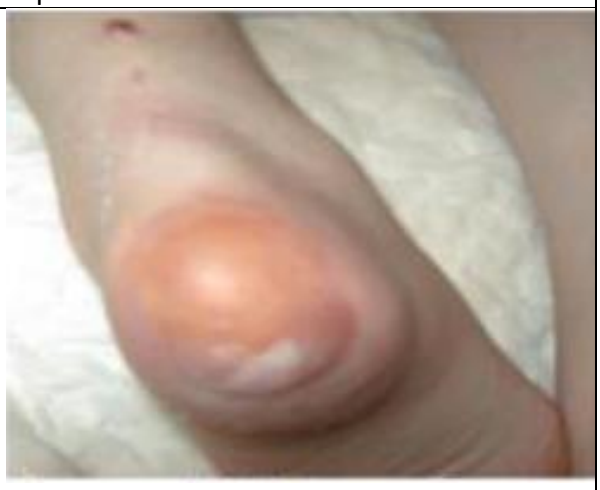
Category 1 Pressure Ulcer / Non blanchable erythema

The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss. The patient may report pain or discomfort over the area.

This is a category 1 pressure ulcer in brown skin. Note that the erythema (redness) is still visible as the skin is much lighter on the margin of the foot:	This image shows non-blanching erythema in white skin:
	

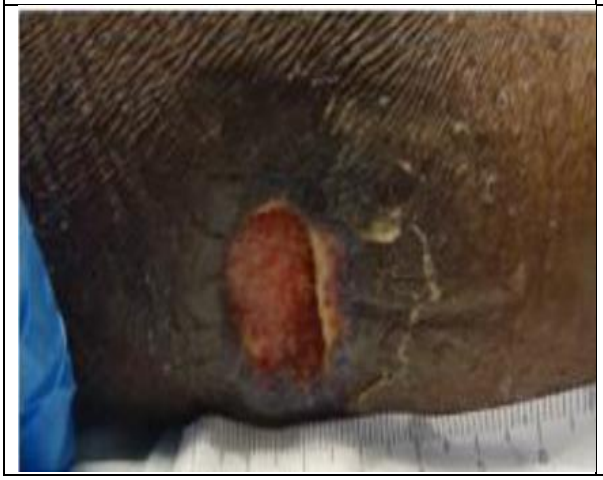
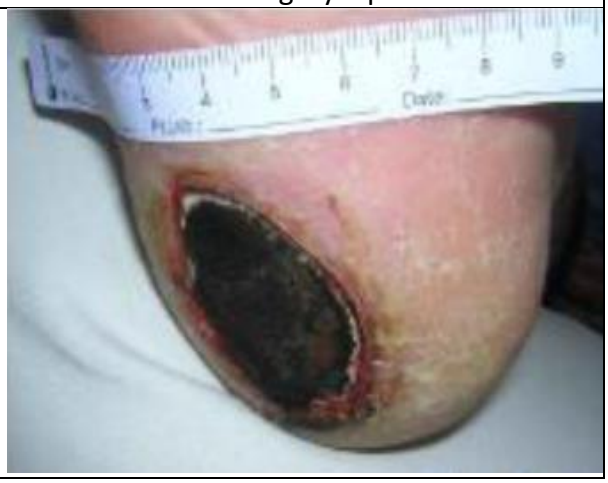
Category 2 Pressure Ulcer

Pressure ulcer with abrasion, blister, partial-thickness skin loss involving epidermis and or dermis.

A shallow open ulcer with red/pink wound bed without slough	A intact blister or a collapsed blister with a superficial ulcer beneath
	

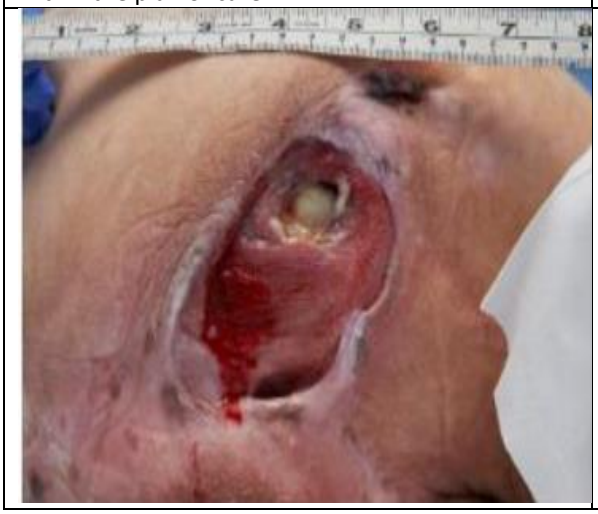
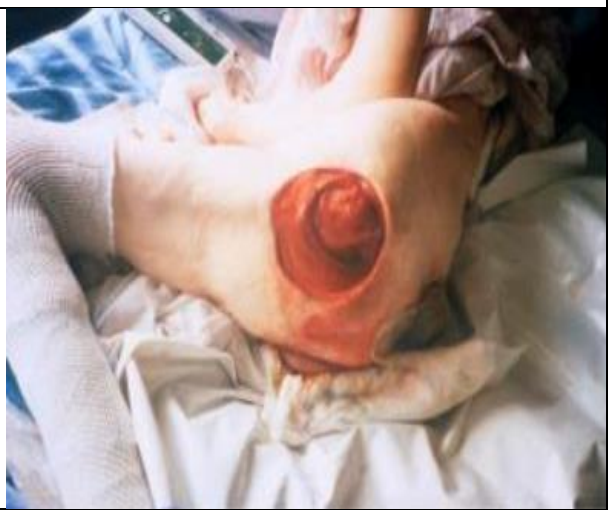
Category 3 Pressure Ulcer

Pressure ulcer with full-thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.

A category 3 pressure ulcer, subcutaneous fat is visible but no underlying structures.	A dry necrotic wound over the heel, the skin surrounding the wound should be carefully palpated and consideration given to the location to help determine the category. It is as a minimum a Category 3 pressure ulcer.
	

Category 4 Pressure Ulcer

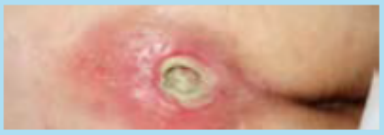
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and/or bone in the ulcer. There is an increased risk of osteomyelitis.

The bone is clearly visible. There is an increased risk of osteomyelitis and this should be addressed within the plan of care.	Underlying structures Muscle is exposed muscle.
	

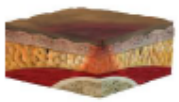
APPENDIX 12 – PATHWAY FOR PRESSURE ULCER MANAGEMENT

Pathway for Pressure Ulcer Management

A pressure ulcer is defined as localised damage to the skin and/or underlying tissue, as a result on pressure or pressure in combination with shear. They usually occur over a bony prominence but may also be related to a medical device or other object (NICE 2023). Pressure ulcers are in the 'top ten harms' in the NHS in England *(Fletcher 2022)*.



RED FLAG:
If the pressure ulcer is on the foot and the patient has diabetes, neuropathy or ischemia please refer to the Foot Ulcer Pathway rather than the below.

Category		Moisture Levels		
		Nil	Minimal or Moderate	Heavy
Potential tissue damage Skin that is slow to blanche.		• For sacral/buttock area(s) with incontinence: Proshield Plus Skin Protectant. *At every wash or 3 times daily.* • For all other areas: **ClearFilm Semi-Permeable Film Dressing.** *Maximum wear time 7 days. OR* **Barrier Protection Film** *Daily application as a minimum.*		
Category 1 The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss.				
Category 2 Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and or dermis.		• For sacral area with incontinence: Proshield Plus Skin Protectant *At every wash or 3 times daily.* • For all other areas: Urgo Start Plus Border or Comfeel Plus *Maximum wear time 7 days.*		Biatain Silicone 3DFIT Foam *Maximum wear time 7 days. (dependent on exudate levels).*
Category 3 Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.		• Less than 0.5cm depth: Urgo Start Plus Border or Comfeel Plus • 0.5cm or more depth: Cutimed Sorbact Ribbon and Comfeel Plus *Maximum wear time 7 days. (dependent on exudate levels)*		• Less than 2cm depth: Biatain Silicon 3DFIT Foam • More that 2cm depth: Cutimed Sorbact Ribbon and Biatain Silicon 3DFIT Foam *Maximum wear time 7 days. (dependent on exudate levels).*
Category 4 Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and or bone in the ulcer. There is an increased risk of osteomyelitis.		Cutimed sorbact Ribbon and Comfeel Plus *Maximum wear time 7 days. (dependent on exudate levels).*		**Cutimed Sorbact Ribbon and Biatain Silicon 3DFIT Foam** *Adhesive Foam Maximum wear time 7 days.(dependent on exudate levels).*
Mucosal Pressure Ulcer Mucosal Pressure Ulcers occur when the mucous membrane is damaged as a result of pressure (usually a device): oral, nasal, anal, genital, eyelids and round trachy tubes.		• Secondary care: **Intrasite Gel** Apply 3 x daily (every 8 hours) • Primary care/Community care with carers,support or able to self care: **Intrasite Gel** Apply 3 x daily (every 8 hours) • Primary care/Community care with no carers, support or are unable to self care: in bold - **Refer to TVALS who can provide a personalised plan.**		**A bespoke plan is required from a Tier 4 service:** • **Skin Integrity Team** • **Tissue Viability and Lymphoedema Service** • **Tracheotomy Specialist Nurses**

If the named product on this pathway is not available a temporary second line product is available to use. This can be found within the main text of the Doncaster Wide Wound Care Formulary Document.

Reference: National Wound Care Strategy Program (2023) Pressure Ulcer Recommendations.

Developed by the Skin Integrity Team September 2020. Updated July 2024 from the Pressure ulcer product selection guide. V3. For review July 2027.

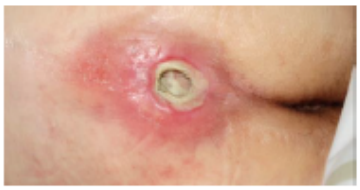
APPENDIX 13 – PRESSURE ULCER CLINICAL PATHWAY

Pressure Ulcer Clinical Pathway

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

A pressure ulcer is defined as localised damage to the skin and/or underlying tissue, as a result on pressure or pressure in combination with shear. They usually occur over a bony prominence but may also be related to a medical device or other object (NICE 2023).

Pressure ulcers are in the 'top ten harms' in the NHS in England (Fletcher 2022).



Risk Assessment

Complete PURPOSE T pressure ulcer risk assessment at 1st contact with a healthcare professional.

GREEN
No pressure ulcer and currently not at risk.

AMBER
No pressure ulcer but at risk, with or without vulnerable skin (Discolouration previously known as DTI, blanchable redness that persists, dryness, paper thin, moist including MASD).

RED
A pressure ulcer present OR scarring from a previous pressure ulcer.

Diagnosis

Categorise the pressure ulcer/s.
Click here for guidance on categorisation:

- Category 1
- Category 2
- Category 3
- Unknown depth / Category 3 at least
- Category 4

Ongoing care

Follow the **aSSKINg Green Care Plan.** Click on the relevant link below for the appropriate care plan: https://gbr01.safelinks.protection.outlook.
https://www.dbth.nhs.uk/wp-content/uploads/2024/04/aSSKINg-Green-Care-Plan.pdf

Follow the **aSSKINg Amber Care Plan** to commence preventive care. Click on the relevant link below for the appropriate care plan:
https://www.dbth.nhs.uk/wp-content/uploads/2024/04/aSSKINg-Amber-Care-Plan.pdf

Follow the **aSSKINg Red Care Plan** to commence preventive care the **Pressure Ulcer Management Care Plan.** Click on the relevant link for the appropriate care plan:
https://www.dbth.nhs.uk/wp-content/uploads/2024/04/aSSKINg-Red-Care-Plan.pdf

Review of risk, care delivered, status and healing

Formal review of risk status and interventions

Formal review of healing

- Undertake and document a wound assessment at each dressing change/ intervention.
- Undertake a regular review and monitoring of healing, at least 4 weekly.
- If unhealed at 12 weeks undertake a detailed reassessment.
- Onward referrals to specialist services, as required.

Care following healing status

Healing or no concerns

- Ongoing preventative care
- Ongoing review of risk

Static or Deteriorating

- Specialist review
- Consider surgical revision
- Re-review preventative care

Developed from the National Wound Care Strategy Programme (NWCSP) Pressure Ulcer Recommendations and Clinical Pathway.
Fletcher, J. National Wound Care Strategy update: Pressure ulcer prevention and the PSIRF exemplar. 2022, Vol. 18, 4.
National Institute for Health and Care Excellence (NICE) 2023 pressure-ulcers.

Developed by The Skin Integrity Team DBTH April 2024. For review by July 2027

APPENDIX 14 – PATIENT INFORMATION PREVENTING PRESSURE ULCERS

Preventing Pressure Ulcers

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

This information leaflet is provided by Doncaster and Bassetlaw Teaching Hospitals to explain what a pressure ulcer is (sometimes known as a bedsore or pressure sore) and describe the common causes and steps that can be taken to reduce them.

A pressure ulcer can seriously impact the quality of your life and it's important to understand whether you may be at risk, so you can help prevent a pressure ulcer from developing.

What is a pressure ulcer?

A pressure ulcer is an area of skin that is damaged. The most common places for pressure ulcers to occur is where bones are close to the surface of the skin or underneath a medical device such as an oxygen mask.

What causes a pressure ulcer?

Pressure ulcers can develop when the blood supply to an area of skin is reduced, causing the skin to become sore and broken. They can develop in as little as twenty minutes.

They can occur when:

- An area of skin is placed under pressure for any length of time
- A person has to stay in bed, in a chair/wheelchair for long periods of time
- A person is unable to move around or change position easily
- You are moving up and down in a bed or chair without support, causing friction to the skin
- An area of skin is exposed to moisture such as urine, faeces and sweat.

Who is at risk of developing a pressure ulcer?

Anyone can develop a pressure ulcer, but some people may be at greater risk than others.

They are more likely to occur if you:

We care

WPR50010 July 2024

- have challenges moving
- have had a pressure ulcer before
- have swollen, sweaty or broken skin
- have challenges feeling sensation or pain
- are seriously ill or undergoing surgery
- have a device on your skin such as a plaster cast or an oxygen mask.

What are the early signs of a pressure ulcer?

You may notice one of the following:

- Discoloured patches of the skin that do not change colour when pressing down. The patches are usually red on white skin, or purple or blue on black or brown skin.
- A patch of skin that feels warm, spongy or hard
- A patch of skin that is swollen, itchy or causing pain
- A blister.

The NHS website shows some examples of what pressure ulcers may look like. Search 'NHS Pressure Ulcers' or follow this link: https://www.nhs.uk/conditions/pressure-sores/

What should I expect when I am in hospital?

Ward staff will encourage you to follow steps try and stop a pressure ulcer developing. For example, they will:

- Examine you to determine how likely you are to develop a pressure ulcer
- Check your skin for symptoms of a pressure ulcer
- Decide if you will need a specially designed mattress
- Make sure you don't stay in the same position for too long and encourage you to stay active
- Ensure moisture such as urine, faeces and sweat is not left on your skin
- Promote eating a healthy balanced diet and having enough to drink.

A nurse or midwife will also ask you some questions to help them determine the likelihood of a pressure ulcer developing and create a plan to help prevent this from happening.

Skin Integrity Team

How will you check for symptoms of a pressure ulcer?

A nurse or midwife will look at your skin three times a day for early signs of a pressure ulcer. This is important as the start of a pressure ulcer can often be seen before it is felt. Staff will offer you a daily moisturising of the skin. If you have a moisturiser you prefer, please arrange for this to be brought into hospital with you. If a pressure ulcer is found, a Skin Integrity Nurse who specialises in wounds may come and see you.

Will I need a special mattress?

If the nurse or midwife thinks you are at risk of getting a pressure ulcer you will be provided a specially designed mattress. This mattress will pump air through the bed automatically to reduce any pressure over your bones close to the skin.

What can I do?

Keep moving (where possible)

The key action you can take to prevent a pressure ulcer is to keep moving.

Making sure you don't stay in the same position for too long, where possible, will help reduce the pressure over your bones close to the skin. A member of staff will assist you with moving if needed every few hours. If you require support moving into a bed, staff will use slide sheets underneath you to stop your skin rubbing on the mattress.

Keep your skin moisture-free

Ensure moisture such as urine, faeces and sweat is not left on your skin. If you have episodes of moisture being on your skin, staff will make plans to help you to go to the toilet and keep your skin clean and dry. They will also apply products and creams to the skin several times a day to keep your skin clean and protected.

Eat healthily and stay hydrated

Eating healthily and drinking well is important for everyone, but especially if you are at risk of a pressure ulcer. Sometimes staff may recommend extra protein in your diet such as meat, fish, eggs and beans.

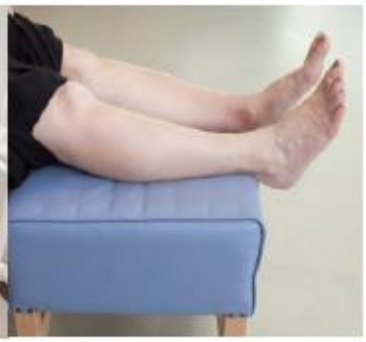
If you have an existing pressure ulcer, you may be recommended some supplements such as a specialised drink to help with healing the ulcer.

If you're concerned about your nutrition, please talk to a member of the nursing team. You may be referred to a dietitian for assessment and advice.

Some simple additional action staff may recommend include:

- Putting pillows under your legs or put a padded boot around your foot to raise your heels
- Putting your legs up on a stool with your heels and feet floating over the edge to reduce swelling
- Putting pillows around you to help you remain in a position in bed.





These recommendations were developed using an evidence-informed approach, including consideration of research studies, healthcare resources, clinical settings, and individuals' preferences.

Patient Advice and Liaison Service (PALS)

The team are available to help with any concerns/complaints you may have about your experience at the Trust. Their office is in the Main Foyer (Gate 4) of Doncaster Royal Infirmary. Contact can be made either in person, by telephone or email.

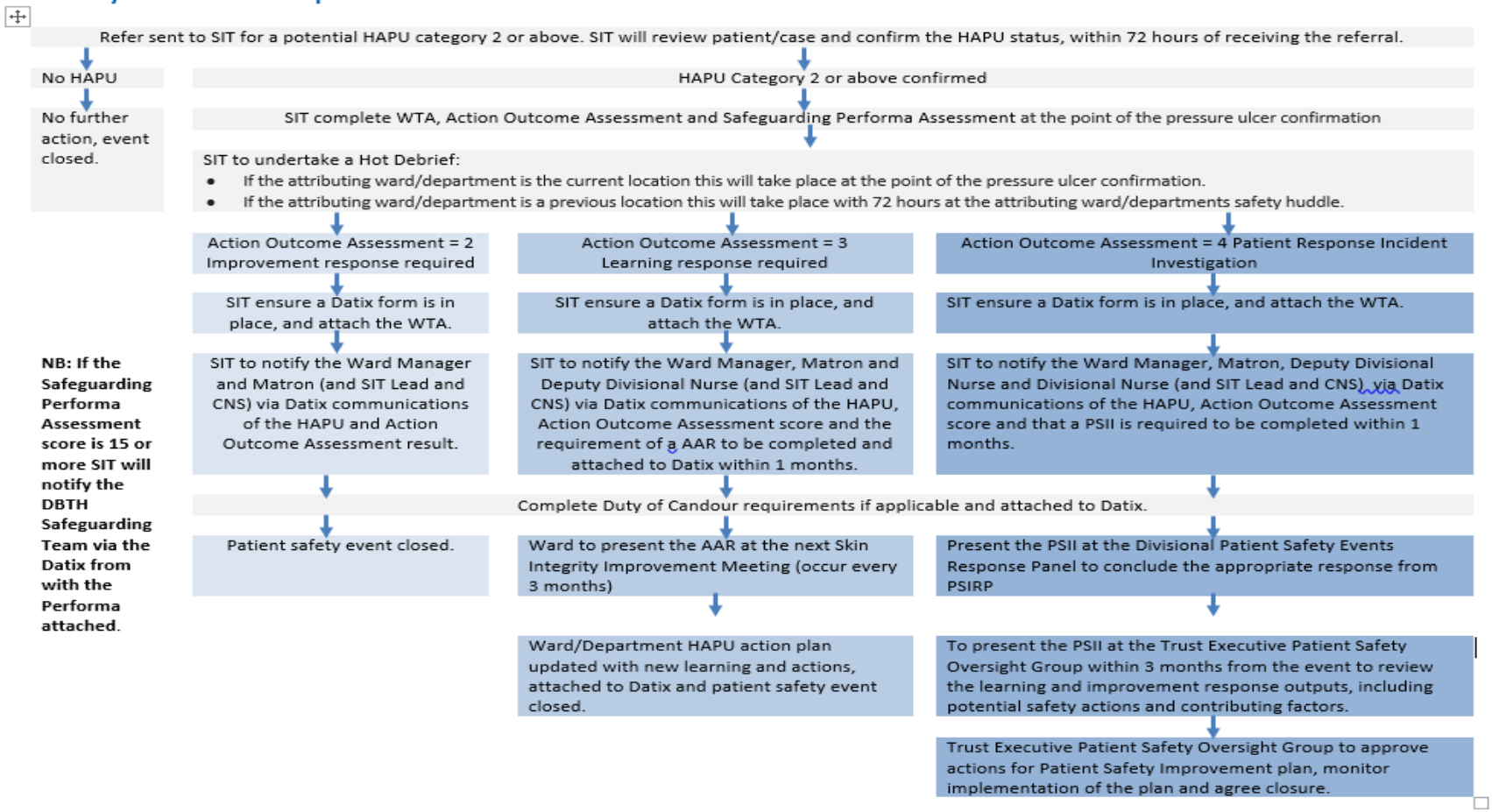
The contact details are:

Telephone: 01302 642764 or 0800 028 8059
Email: dbth.pals.dbh@nhs.net

Skin Integrity Team

APPENDIX 15 – HOSPITAL AQUIRED PRESSURE ULCER PSIRF PROCESS

Safety Incident Response Process



Developed by: Kelly Phillips Skin Integrity Lead Nurse October 2023. Approved by: Marie Hardacre Associate Chief Nurse for Patient Safety and Quality November 2024. Implemented April 2024. For review by: April 2026

APPENDIX 16 – HOSPITAL AQUIRED PRESSURE ULCER - WTA, HOT DEBRIEF, HARM LEVEL, OUTCOME, SAFEGUADING, AAR, PSII, WARD ACTION PLAN

Pressure Ulcer Walkthrough Analysis

Hospital number		Patient Initials		Date of Incident		Category of pressure ulcer		Location of pressure ulcer	
Ward acquired		Date of referral		Date of review		SIT Nurse completing WTA		Date WTA completed	
Datix ID		Datix REF		Photographs?		Date Datix comms sent		Harm level	

Walkthrough Assessment

Complete all tasks with a Y for yes, N for no or N/A for not applicable. A score will be automatically generated

		Tasks								
Location Details		Assess risk	Skin inspection	Surface	Keep moving	Incontinence and increased moisture	Nutrition	Giving information	PU Categories and Assessment	Reporting and escalation
Ward Area	Date	Pressure ulcer risk assessment completed timely and accurately	26 point skin inspection completed 3 x daily	Appropriate equipment in use timely	Repositioning schedule appropriate and completed	Skin Care Pathway for IAD/MASD in use as required	MUST completed timely. MUST score of 1+ - nutrition support action plan commenced. MUST score 4+/ PU 3+ - Dietitian referral	If there is any evidence of non concordance has information been provided to the patient (documented evidence)	Completed and updated timely and appropriately	Referral on identification/ deterioration timely and appropriately
VTA single action score		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

VTA Total Score: #DIV/0!

Additional information and colour code

Add in any relevant additional information e.g. W3 inspections. Colour code the sections green for Y and red for N

		Tasks								
Location Details		Assess risk	Skin inspection	Surface	Keep moving	Incontinence and increased moisture	Nutrition	Giving information	PU Categories and Assessment	Reporting and escalation
Ward Area	Date	Pressure ulcer risk assessment	26 point skin inspection	Appropriate equipment	Repositioning schedule	Skin Care Pathway for IAD/MASD	MUST and Dietitian	Non concordance	Completed	Referral

Guidance on recording patient safety events and levels of harm

			next to the appropriate criteria below
No harm	No harm is when all of the following apply:	No physical harm	
		You are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.	
Low physical harm	Low physical harm is when **all of the** following apply:	minimal harm occurred – patient(s) required extra observation or minor treatment	
		did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit	
		did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication	
		did not or is unlikely to affect that patient's independence	
		did not or is unlikely to affect the success of treatment for existing health conditions.	
	Low psychological harm is when **at least one** of the following apply:	distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit	
		distress that did not or is unlikely to affect the patient's normal activities for more than a few days	
		distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition	
Moderate physical harm	Moderate harm is when **at least one** of the following apply:	has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention	
		has limited or is likely to limit the patient's independence, but for less than 6 months	
		has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.	
	Moderate psychological harm is when **at least one** of the following apply:	distress that did or is likely to need a course of treatment that extends for less than six months	
		distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six	
		distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six	
Severe physical harm	Severe harm is when at least one of the following apply:	permanent harm/permanent alteration of the physiology	
		needed immediate life-saving clinical intervention	
		is likely to have reduced the patient's life expectancy	
		needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment	
		has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions	
		has limited or is likely to limit the patient's independence for 6 months or more.	
	Severe psychological harm is when **at least one** of the following apply:	distress that did or is likely to need a course of treatment that continues for more than six months	
		distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months	
		distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months	
Fatal (previously documented as 'Death' in NRLS)		You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.	
		Harm Level outcome: (no harm, low, moderate, severe, fatal)	

Hot Debrief			
Date completed		Attendees	
Tme located			
Location completed			

S	Summairse the event	
T	Things that went well	
O	Opportunities to improve	
P	Points to action and resposnibilites	

HAPU Action Outcome Assessment

Answer the following 3 questions. If answered with a yes they gain a score of 1.

Question	Answer	Score
1. Was the pressure ulcer development unintended or unexpected		1
2. Did the pressure ulcer occur during the provision of an activity we regulate		1
3A In the reasonable expert opinion of the Skin Integrity Nurse, in combination with the WTA is the overall percentage 49% or less AND/OR		
3B In the reasonable expert opinion of the Skin Integrity Nurse, in combination with the WTA is there a single area/subject that has a percentage 49% or less Relating to a new single action that does not already form part of the ward/department HAPU reduction action plan AND/OR		
3C Have had more than 2 HAPU's (category 3 or above) in a single month AND/OR		
3D Have had more than 6 HAPU's (category 3 or above) in a financial year AND/OR		
3E Have they triggered 15 or more on the safeguarding performa assessme		
4. Is the event resulted in serious harm or death		
A score of 2 or less indicates the no further action is required.	Total score	2
A score of 3 indicates the need for a AAR to be completed at presented at the next Skin Integrity Improvement Meeting to update		
A score of 4indicates the need for the PSII process to be commenced.		

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NHS Foundation Trust

Adult Safeguarding Decision guide for management of pressure ulcers

Patient Name	
Patient D number	
Assessing Skin Integrity Nurse Name	
Assessing Skin Integrity Nurse Job Title	
Date Completed	

Question 1

Has the person's skin deteriorated to either category 3 or 4 or multiple sites of category 2 ulceration from healthy unbroken skin since the last opportunity to assess or visit?

Level of concern	Score	Evidence	Outcome
Yes	5		
No	0		

Question 2

Has there been a recent change that is within days or hours, in their clinical condition that could have contributed to skin damage? (For example, infection, pyrexia, anaemia, end of life care or critical illness)

Level of concern	Score	Evidence	Outcome
Change in condition contributing to skin damage	0		
No change in condition that could contribute to skin damage	5		

Question 3

Was there a pressure ulcer risk assessment or reassessment with an appropriate pressure ulcer care plan in place, and was this documented in line with the organisation's policy and guidance

Level of concern	Score	Evidence	Outcome
Yes, current risk assessment and care plan carried out by a healthcare professional and documented appropriate to patient's needs	0	*State date of assessment, risk tool used and score or risk level*	
Yes, risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	*State the elements of care plan that are in place*	
No or incomplete risk assessment and/or care plan carried out	15	*State the elements that would have been expected to be in place but were not*	

Question 4

Is there a concern that the pressure ulcer developed as a result of the informal carer wilfully ignoring or preventing access to care or services?

Level of concern	Score	Evidence	Outcome
No, or not applicable	0		
Yes	15		

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Adult Safeguarding Decision guide for management of pressure ulcers

Question 5

Is the level of damage to skin inconsistent with the or service user's risk status for pressure ulcer development? (For example, low risk, category (or grade) 3 or 4 pressure ulcer).

Level of concern	Score	Evidence	Outcome
Skin damage less severe than patient's risk assessment suggests is proportional	0		
Skin damage more severe than patient's risk assessment suggests is proportional	10		

Question 6

Question 6 has 2 parts depending on the patient or service user:

- if the patient or service user **has capacity** to consent to every element of the care plan, answer question 6a
- if the patient or service user has been assessed as **not having mental capacity** to consent to any of the care plan or some capacity to consent to some but not the entire care plan, answer 6b

Question 6a

Was the patient or service user able to follow the care plan having received clear information regarding the risks of not doing so?

Level of concern	Score	Evidence	Outcome
Patient has not followed care plan and local non concordance policies have been followed	0		
Patient followed some aspects of care plan but not all	3		
Patient has not followed care plan or not given information to enable them to make an informed choice	5		

Question 6b

Was appropriate care undertaken in the patient's best interests, following the best interests checklist in the Mental Capacity Act Code of Practice?

This should be supported by documentation, for example, capacity and best interest statements and record of care delivered.

Level of concern	Score	Evidence	Outcome
Documentation of care being undertaken in patient's best interests	0		
No documentation of care being undertaken in patient's best interests	10		

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Adult Safeguarding Decision guide for management of pressure ulcers

Score outcome:

Score conclusion

1. Save this completed form the HAPU Datix forms for all cases
2. If the **total** score is **15 or over**, add Denis Phillip and Amanda Tanner from safeguarding to the datix form
3. Send copies via DATIX to dbth.safeguardingadultsreferral@nhs.net making them aware that the patient has a HAPU safeguarding score of 15 or more and to please see the attached decision tool
4. Place a copy/snip of the nerve centre body map locating the pressure ulcer onto the DATIX attached documents
5. Place a copy/snip of the nerve centre clinical photography locating the pressure ulcer onto the DATIX attached documents
6. Arrange clinical photography through our medical clinical photography service due to safeguarding concerns.

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NHS Foundation Trust

Hospital Acquired Pressure Ulcer After Action Review (HAPU AAR)

To be completed following the completion of the WTA and HAPU Action Outcome Assessment, resulting in a score of 3. To be completed within 1 month by the ward manager/matron and upload to relevant Datix form and presented at the next Skin Integrity Improvement Meeting to enable the ward/department HAPU reduction action plan to be reviewed and updated.

Hospital Number :		**Date of Incident:**	
Patient Initials:		**Datix ID:**	
Category of pressure ulcer:		**Datix REF:**	
Location of pressure ulcer:		**Date WTA completed:**	
Ward acquired:		**SIT Nurse completed WTA:**	
Photography: **(attached document)**		**WTA Total Score:** **(attached document)**	
Date communications sent:		**Actions with 49% or less:**	
Date of the Skin Integrity Improvement Meeting:		**Date AAR commenced:**	
Harm Level:		**Date AAR completed:**	

Duty of Candour if the harm level is moderate			
Has the patient/family been informed of the pressure ulcer development, and investigation?		**Date Letter 1 DoC sent :**	
Who informed the patient/family and when:		**Date Letter 2 DoC sent**	

After Action Review			
Points to consider:			
Safeguarding considered	Mental capacity assessment	Facility score	EOL status
WTA total score	WTA single task scores	Previous pressure ulcer	Previous MASD/IAD
Expected: (What was the expected outcome)			
Outcome: (What was the actual event/outcome)			
Analysis: (the difference between the expected and the outcome)			
Learning: (Contributory factors. Why was there a difference)			
Areas for improvement: (Wider themes)			
Safety Actions: (immediate actions taken)			
Ward Manager Sign off: (name and date)		Matron Sign off : (name and date)	

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NHS Foundation Trust

Scoping Document Case Review for Patient Safety Incident Investigation (PSII) panel		
Patient Name:	Hospital Number:	Datix ID Number:
Date and time of Incident:	Date of case review:	Case review completed by:
Level of Harm *(as graded on Datix)* *Please highlight / circle below:*	Division/ Speciality involved:	Investigation team involved: *List all those that have supported/ had input into these preliminary investigations.*
No harm Low Moderate Severe Death		

Duty of Candour:

All incidents graded moderate harm and above will require duty of candour. Both Verbal & Written.

Duty of candour must be applied within 10 days and include written correspondence to the patient and/or family.

YES Please complete below		NO Why Not ?	
Who has contacted the patient/family?			
Date of initial conversation			
Date of Letter 1 sent			
Has DOC been recorded/ uploaded to the Datix record? (Date)		Yes /No DATE	

SITUATION:

Provide a brief overview of the situation and why this review is taking place

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BACKGROUND: Provide a background of the patient, including age, reason for admission, past medical history, summarise social history if applicable, and including any vulnerabilities, known dementia etc.

ASSESSMENT:	
What was expected to happen?	
What actually occurred?	

What was the difference?	
Why was there a difference?	
What can be learned?	

Safety Actions identified Mandatory to explain what measures have been implemented to prevent this incident scenario occurring today	
Issue /Risk	
Immediate action required	
Person/s responsible	
Timeframe	

RECOMMENDATION			
Does this incident meet any of the criteria for a Serious Incident?			
Yes (Please put an 'X' next to the appropriate criteria below). Criteria used as reported on STEIS.		No	
A Never Event			

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Unexpected or avoidable death	
Unexpected or avoidable injury that has resulted in serious harm	
Unexpected or avoidable injury that requires further treatment in order to prevent death or serious harm	
Actual or alleged abuse where healthcare did not take appropriate action / intervention to safeguard against such abuse occurring or where abuse occurred during the provision of NHS-funded care	
An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services	
Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation	

Was a learner involved?	
Has a learner (student, trainee, apprentice, or work experience) been directly involved?	
Name & role of learner/s:	
Support provided?	
Mentor/supervisor informed?	
Education team informed by email?- state date & name	

WARD/DEPARTMENT (2024.2025)		
HAPU Improvement Plan		
Initial Goal	Reduce the number of Hospital Acquired Pressure Ulcers (HAPU) occurring on the ward/department	
S Specific	What do you want to accomplish	Who needs to be included
M Measurable	How can you measure progress	How will you know if you've successfully met your goal
A Achievable	Does the ward have the skills required to achieve the goal	If not, can you obtain them
R Relevant	Why am I setting this goal now	Is it aligned with overall objectives
T Time-bound	What's the deadline	Is it realistic
Last Review and Update Date		
Review Outcome		

APPENDIX 1- EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Pressure Ulcer and Moisture Associated Skin Damage (including Incontinence Associated Dermatitis) Policy	Corporate Nursing – Skin Integrity	Kelly Phillips	Existing Policy	17 October 2024

1) Who is responsible for this policy? Corporate Nursing – Skin Integrity

2) Describe the purpose of the service / function / policy / project/ strategy? For the use of healthcare professionals to benefit patients in the prevention, assessing, reporting, investigating and managing pressure ulcers, MASD and IAD.

3) Are there any associated objectives? Reduction of hospital acquired pressure ulcers

4) What factors contribute or detract from achieving intended outcomes? – Nil

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** – N/A

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: November 2027

Checked by: Marie Hardacre **Date: 1/11/24**