Government of JERSEY

Health and Community Services

Pressure Ulcer Prevention and Management Policy (Adults)

March 2023

DOCUMENT PROFILE

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Document Purpose	Policy
Short Title	Pressure Ulcer Policy
Author	Gillian Mallet Tissue Viability Nurse
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Circulation List	HCS All users
Description	Policy for the prevention and management of pressure ulcers (Adults)
Linked Policies	Infection Control, Health and Safety, Incident Reporting, Safeguarding Adults, Sepsis, Consent, Mental Capacity, Care Records, Nutritional Screening and First Line Nutritional Care, Fluid Balance Monitoring Policy for Adult Inpatients
Approval Route	Hospital Care Quality Group / Community Care Quality Group / Integrated Governance Committee
Review Date	1 year from approval
Contact Details	Clinical Specialist – Tissue Viability TVNacute@health.gov.je

CONTENTS LIST:

1. INTRODUCTION

1.1 Rationale

Pressure ulcers represent a major burden of sickness and reduced quality of life for individuals, their carers, and families. New pressure ulcers are estimated to occur in approximately 4% of individuals admitted to acute hospitals (DHSS, 2018).

In the NHS (National Health Service) in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016 and treating pressure damage costs the NHS more than £3.8 million each day. (NHS Improvement, 2018).

The Quality, Innovation, Productivity and Prevention (QIPP) initiative, designed to improve health outcomes and the quality of patient care, has identified pressure ulcers as one of the four main avoidable harms in healthcare, clearly stating that health authorities are responsible for establishing local programmes and strategies for avoiding these harms (McIntyre et al, 2012).

The effective management of pressure ulcers and pressure ulcer prevention is dependent on initial nursing, Allied Health Professionals (AHPs) and physician assessment to identify those patients at risk and to ensure appropriate measures are put in place to prevent harm or deterioration.

1.2 Scope

The prevention and management of pressure ulcers is an organisational priority and a Health and Community Services (HCS) wide responsibility; therefore, this policy applies to all staff employed within HCS.

2. DEFINITION

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. (NHS Improvement, 2019).

3. POLICY

The aims of this policy are;

- to ensure a cultural shift towards the prevention rather than the management of pressure ulcers throughout HCS and commit the organisation to ensuring that there are effective arrangements for pressure ulcer prevention and management
- to ensure that all adult patients at risk of developing pressure ulcers and any adult patients who have developed pressure ulcers are appropriately assessed and have a plan of care to minimise further risk to healthy tissue

- to minimise the physical, psychological, and financial cost of pressure ulcers to the patient and to HCS
- to ensure that HCS complies with national guidance and evidence based high quality care

4. ROLES AND RESPONSIBILITES

4.1 Medical personnel will:

- ensure they are aware of and adhere to the HCS Pressure Ulcer Prevention and Management Policy
- actively promote pressure ulcer prevention care strategies for all patients
- identify and manage any training needs and ensure they are trained in pressure ulcer prevention and management principles
- ensure that any pressure ulcer, warranting reporting, is done so as outlined in this policy
- observe, evaluate, and plan the care necessary for the management of the patient's pressure ulcer
- communicate the management plan to the primary nurse or the Nurse in Charge (NIC) and all plans of care will be documented in the patient's case notes

4.2 Nursing personnel will:

- ensure they are aware of and adhere to the HCS Pressure Ulcer Prevention and Management Policy
- ensure pressure ulcer prevention strategies are utilised for all patients
- identify and manage any training needs and ensure they are trained in pressure ulcer prevention and management principles
- ensure that any pressure ulcer, warranting reporting, is done so as outlined in this policy
- observe, evaluate, and plan the care necessary for the prevention and management of the patient's pressure ulcer utilising the HCS SSKIN Care Plan
- ensure that any pressure redistribution equipment is used in concordance with manufacturer's instructions
- ensure pressure ulcer prevention and management strategies and treatment options / decisions are communicated effectively to patients and their relatives / families (where appropriate)
- be responsible for the timely and accurate documentation of all prevention and management strategies employed and ensure communication between patients / families and carers has been conducted

4.3 Management personnel will:

- ensure the Pressure Ulcer Prevention and Management Policy is distributed and promoted within all clinical areas and to all health care professionals
- ensure that pressure redistribution equipment is available for all patients as required and take into account its clinical effectiveness, educational requirements of staff and financial factors
- ensure that clinical staff are working in concordance with this policy and with the philosophy of pressure ulcer prevention
- investigate any failure to comply with this policy
- take action to prevent recurrence of reported incidences
- ensure the provision and management of a Tissue Viability Nurse Specialist for all clinical areas

4.4 Tissue Viability Nurse Specialist will:

- ensure a comprehensive Policy and evidence-based risk assessment and care plan for pressure ulcer prevention and management is developed, agreed, and implemented throughout HCS
- ensure that the Pressure Ulcer Care documentation and associated policy is reviewed as regularly as necessitated by the contemporary evidence base
- support all clinical areas in the dissemination of this policy and supporting care documentation
- liaise with other members of the organisation to ensure that practice is developed in light of contemporary evidence and best practice guidance
- lead on pressure ulcer training in liaison with and through collaborative working with allied health care professionals and the education department

4.5 Allied Health Professionals

4.5.1 Dietitians will:

- be responsible for making detailed nutritional assessments of patients referred to them and identifying which particular nutrients may be insufficient in the patient's diet to provide the necessary conditions for maintaining skin integrity

4.5.2 Podiatrists will:

- provide a specialist clinical review of pressure ulcers pertaining to ankle and foot when required
- provide education and training for clinical staff in pressure ulcer prevention and management in a variety of formats

4.5.3 Occupational Therapists will:

- advise on the suitability and correct use of specialist equipment, such as cushions, seating, and wheelchairs to alleviate the risk of pressure ulcer formation

4.5.4 Physiotherapists will:

- teach the patient, and other professionals to handle and position patients to minimise trauma to the skin and promote recovery and early mobilisation

5. PREVENTION OF PRESSURE ULCERS

5.1 Pressure ulcer risk assessment

All adult patients, admitted with an expected stay of >24 hours will have a Waterlow Pressure Ulcer Risk Assessment (Appendix 1) completed on admission by a registered practitioner, within 6 hours of the start of the episode of care (NPUAP / EPUAP 2009a).

Patients with a stay of <24hours, in any clinical setting, will have an assessment of their individual needs in relation to tissue viability risk management. This can be undertaken as part of an informal risk assessment (Appendix 2). For example, the Modified Andersen Pressure Ulcer Screening Tool (Appendix 3) is utilised in the Emergency Department to perform a rapid assessment of patient risk.

The outcome of any informal risk assessment should be documented in the patient's medical notes alongside any management strategies implemented. The Pressure Ulcer Risk Assessment and the SSKIN Care Plan (Appendix 4) is available should the practitioner require a formal risk assessment and care plan for any adult with evidence of pressure damage or at high risk, regardless of length of hospital stay.

The Pressure Ulcer Risk Assessment document is evidence based to aid decision making and standardise care delivery. As part of the assessment process practitioners will utilise the Waterlow Risk Assessment Tool to stratify the patient into one of two bands of increasing risk; high, or elevated. The outcome of the Waterlow score should not be considered in isolation but should facilitate clinical decision making enabling appropriate cost-effective preventative aids and nursing resources to be allocated (Waterlow 2005). It is important that those at risk of pressure ulcers are identified early, and appropriate prevention measures are implemented without delay.

As a minimum requirement individual risk assessment should be repeated weekly for adults in hospital (Essence of Care 2010) however if there is a change in the clinical status of the individual such as post-surgery or worsening of an underlying condition or a change in mobility, then a reassessment of risk will need to be undertaken (NICE, 2014). In addition, reassessment of risk should be undertaken following transfer to other in-patient areas.

All adult patients identified as being at risk of developing pressure ulcers will be offered a patient information leaflet relating to pressure ulcers (Appendix 5). An adult at risk status must be communicated during the handover process whether it occurs between nursing shifts, between teams or following transfer to other areas. It is the responsibility of the individual nurse to ensure that records are maintained, are legible, clear and are entered in a timely manner (Nursing and Midwifery Council, 2018).

Any identified tissue damage must be documented on the Pressure Ulcer Risk Assessment and any Category 2 pressure ulcer (or above) must be communicated to the responsible medical team whose responsibility it is to accurately document the assessment in the patient's medical notes.

5.2 Body mapping

The Pressure Ulcer Risk Assessment utilises a body mapping concept, which ensures that all adult patients are fully assessed in terms of skin integrity and allows for the early identification of tissue compromise. Documentation of skin damage must be identified, dated, and signed on the patient diagram to include any bruising, abrasions, lacerations, rashes, moisture lesions, pressure ulcers or free text descriptions of additional damage. This will be communicated to the responsible medical team as part of the holistic assessment and care provision for patients.

All adult patients with an expected stay of >24 hours should have a skin assessment undertaken by a qualified practitioner. Health Care Assistants (HCAs) are permitted to undertake skin assessments if they are deemed competent to do so. However, the qualified practitioner, responsible for the care of the patient, will remain professionally accountable.

Prior to undertaking any skin inspection, the qualified practitioner must ensure that the rationale for skin inspection is communicated to the individual and consent is obtained as dictated by professional and organisational guidelines and policy. For those patients who decline a skin assessment or are deemed to be low risk, a verbal confirmation that they have no sore, painful or broken areas may be recorded. This must be documented as self-reported on the body map.

5.3 Clinical photography

Any photographic records made for clinical purposes form part of a patient's record and must adhere to local organisational guidelines for clinical photography. Photographs taken, must not be used for any other purpose other than the patient's care or the audit of that care, without the express consent of the patient.

5.4 Classification of pressure ulcers

Categorisation of the pressure damage will be conducted in accordance with the NHS Improvement Pressure Ulcer Categorisation Group (2019) (Appendix 6). Pressure ulcer grading dictates that pressure ulcers should not be reverse graded, i.e., a category 3 ulcer that is healing should be described as a "category 3 healing ulcer" and not as a category 2 (NPUAP / EPUAP 2009). A deteriorating pressure ulcer, i.e., from a category 2 to a category 3, will require the completion of an additional Datix incident report.

For those adults who have been assessed as having non-blanching erythema (Category 1 pressure damage) (Appendix 6), appropriate prevention actions should be implemented with subsequent skin assessment considered at least every two hours (NICE 2014).

Any pressure ulcer identified as a Category 3 or Category 4, should have the grading confirmed by the Tissue Viability Nurse and communicated to the medical team

responsible for the patient's care. The Tissue Viability Nurse, in collaboration with the medical team will be responsible for devising and communicating a management plan to the relevant practitioners responsible for delivering care.

5.5 Moisture lesions

There is often confusion in recognising a superficial pressure ulcer and a lesion caused by moisture, which is usually associated with incontinence (Voegeli 2011). The differentiation is important (Appendix 7), as patient outcomes may be adversely affected since prevention and treatment strategies may differ.

5.6 Patient information leaflet

All at risk patients should be given timely, tailored information about managing the risks of pressure damage from practitioners delivering their care (NICE 2014). A pressure ulcer prevention and management leaflet (Appendix 5) should be given to all patients and / or relatives (where appropriate).

6. MANAGEMENT OF PRESSURE ULCER RISK

6.1 SSKIN care plan

The SSKIN (Surface, Skin, Keep Moving, Incontinence and Nutrition) Care Plan is a five-step model for pressure ulcer prevention (www.nhs.stopthepressure.co.uk) (Appendix 4). All adult patients identified as being at risk of pressure damage, having had a pressure ulcer in the past or with an existing pressure ulcer must have the SSKIN Care Plan implemented. An individual's risk may be identified through an informal or formal risk assessment process, which must be documented in the patient's medical notes.

The interventions identified on the care plan should be individually signed and dated as applicable. All interventions should be considered to ensure key elements of care are implemented however in some instances; certain interventions may not be applicable. Any interventions not dated and signed will be regarded as not appropriate to the individual and therefore considered as not implemented.

When possible, the plan of care will be developed in collaboration with the patient, family and carers and include the multi-disciplinary team. Effective communication between the patient, family and carers is essential to ensure co-operation and allow the patient to become an active participant in their care.

6.2 Surface

All adults admitted to secondary care should have a high specification, Dyna-form Mercury Advance Hybrid mattress, which may be used with or without a pump, dependent upon the patient's risk assessment.

The implementation of a pressure redistributing surface does not negate the need for repositioning (Waterlow 2005) and patients nursed on dynamic support surfaces must still have a repositioning schedule documented and communicated.

Practitioners should consider the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time. A high specification Dyna-form cushion, which may be connected to the pump, or equivalent pressure redistributing cushion should be considered for adults who use a wheelchair or who sit for prolonged periods (NICE 2014).

The use of water-filled gloves; synthetic sheepskins or doughnut type devices must not be used as pressure redistribution devices (NPUAP / EPUAP 2009).

6.3 Skin inspection

Observation and management of an individual's skin integrity will reduce the incidence of skin deterioration and breakdown. Therefore, a regular skin inspection regimen must be undertaken and documented for those who are at risk of pressure ulcers, have had a previous pressure ulcer or have an existing pressure ulcer. Particular attention should be paid to high-risk areas and include inspection for localised heat, oedema, or induration (hardness) (NPUAP / EPUAP 2014).

6.4 Keep moving

All individuals at risk and their carers, should be advised regarding the importance of repositioning as frequently as clinically indicated. Individuals should be encouraged to actively participate in mobilising and repositioning as their condition dictates and referral to the physiotherapist and occupational therapist should be considered where there is a need for assessment and support.

6.5 Incontinence / moisture

Moisture next to the skin puts the skin at greater risk from maceration, friction, and shearing forces (NPUAP / EPUAP 2014, Waterlow 2005), therefore effective management of incontinence is an essential part of skin care and fundamental to maintaining a person's dignity and comfort. Continence aids must be utilised as appropriate for the patient and practitioners should use opportunities during the turning schedule to cleanse and dry the skin of individuals who have been incontinent.

Skin cleansing regimens must be selected that optimise skin integrity ensuring gentle cleansing and the application of a suitable skin barrier product if indicated (Beeckman et al 2009) (NPUAP / EPUAP 2014).

6.6 Nutrition and hydration

Malnutrition is frequently cited as a risk factor for the development and non-healing of pressure ulcers. Malnutrition and specific nutrient deficiencies compromise the body's ability to heal wounds and make the individual more susceptible to pressure damage. Nutrition plays a vital role in the prevention and treatment of wounds and pressure ulcers.

Nutritional status has a direct influence on the health of the body's tissue and its repair in the event of damage. Wound healing is a complex process which can be further complicated by chronic illness. The nutrition of the patient with a pressure ulcer requires a

multidisciplinary approach and effective communication between all health care professionals. Improving nutrition can improve the quality of life by reducing the risk of infection, increasing the strength of the skin, and improving the appearance of the patient's pressure ulcer.

Many people admitted to hospital have an impaired nutritional intake due to functional or psychological issues, for example, arthritic fingers and self-neglect. Research has shown that nutritional status deteriorates in hospital, particularly in older people. Malnutrition has direct influence on the development and severity of pressure ulcers (NICE 2015). Skin tolerance is also reduced by dehydration, decreased calorie intake and a fall in serum albumin; this increases the risk of skin breakdown and delays wound healing (NICE 2015). Emaciated patients have no subcutaneous fat, particularly over the bony prominences, and so have less protection against pressure ulcers. However, obese patients are also at high risk of pressure damage due to immobility and excess moisture in skin folds causing maceration. Both extremes of patient bodyweight may have poor nutritional status.

All patients admitted to hospital must be screened for malnutrition using the Government of Jersey Nutritional Care Bundle for Inpatients within 24 hours of admission, and weekly thereafter or if change in clinical condition, as indicated by the Risk Assessment. It is important to assess weight status to determine their weight history and note any significant weight loss from their usual body weight; also assess their ability to eat independently and if their total nutrient intake is adequate (EPUAP 2014).

Relevant and evidence-based guidelines on nutrition and hydration for individuals who exhibit nutritional risk, and who are at risk of pressure ulcers or have an existing pressure ulcer should be used and an individual nutritional plan be made (EPUAP 2014).

Patients with nutritional risk identified should be referred to the dietitian for a more comprehensive nutritional assessment (EPUAP 2014). Patients with category 3 or 4 pressure ulcers of moderate or severe harm should be referred to the dietitian regardless of nutritional score.

Offer high calorie, high protein nutritional supplements, vitamins, and minerals in addition to the usual diet to adults with nutritional risk and pressure ulcer risk, if nutritional requirements cannot be achieved by dietary intake alone. Do not offer nutritional supplements specifically to prevent a pressure ulcer in adults whose nutritional intake is adequate. Provide information and advice to adults with a pressure ulcer and, where appropriate, their family or carers, on how to follow a balanced diet (NICE 2014). ("1 Recommendations | Pressure ulcers: prevention and management ...")

Monitor individuals for signs and symptoms of dehydration. Provide and encourage adequate daily fluid intake for hydration for an individual assessed to be at risk of or with a pressure ulcer. This must be consistent with the individual's co-morbid conditions and goals.

Provide additional fluid for individuals with dehydration, elevated temperature, vomiting, profuse sweating, diarrhoea, or heavily exuding wounds. Do not offer subcutaneous or intravenous fluids to treat a pressure ulcer in adults whose hydration status is adequate. (NICE 2014).

7. REPOSITIONING

7.1 Repositioning chart

The use of repositioning will be used in all at risk patients to reduce the duration and magnitude of pressure over vulnerable areas of the body with consideration given to the individual's comfort, dignity, functional ability, and the properties of the support surfaces they are being nursed on (NPUAP / EPUAP 2014).

The Repositioning Chart (Appendix 8) allows for the documentation of a schedule of care including repositioning, pain (NPUAP / EPUAP 2014), tissue tolerance and turning schedule, skin observations and other personal care interventions appropriate to the individual patient, e.g., mouth care, traction observations and eye care etc.

Those adults at risk of developing a pressure ulcer should be encouraged to change their position frequently and at least every six hours. Those adults who are assessed as high risk should be encouraged to change their position at least every four hours (NICE 2014). The patient's skin condition must be recorded as an indicator of tolerance of a particular position with timings for a repositioning schedule adjusted to meet the individual's requirements.

It is the responsibility of the qualified practitioner to ensure that the individual's need for repositioning is communicated appropriately between the Multidisciplinary Team and that there is clear communication when a patient declines repositioning or appropriate support surfaces. The consequences of these actions must be communicated to the patient.

8. WOUND MANAGEMENT

8.1 Wound chart

A Wound Chart (Appendix 9) must be completed for any patient with an identified pressure ulcer (Category 2 and above). This should be updated regularly and communicated to the patient's medical / surgical team. The effectiveness of a wound management plan must be evaluated at each dressing change. It may also be necessary to inform the Tissue Viability Nurse Specialist (TVNS) in the event of complex pressure ulcer management or if dressing advice is needed.

The surface area of all pressure ulcers should be documented and if possible, a validated measurement technique should be used e.g., transparency tracing or a photograph (NICE 2014). The use of photography must comply with organisational guidelines and will form part of the patient's medical notes. Adherence to organisational consent and confidentiality policies must be adhered to.

8.2 Formulary

Pressure ulcers will be treated and dressed in concordance with the HCS and Family Nursing & Home Care (FNHC) Dressing and Wound Formulary. All pressure ulcers requiring dressing / treatment advice should be referred, in the first instance, to the TVNS.

An individual plan of care will then be formulated which should be communicated to all healthcare professionals involved in the care of the patient's pressure ulcer.

The HCS Dressing Formulary will be managed by the TVNS to ensure dressing usage is based on contemporary evidence base, best practice guidance and standardised across HCS and the community.

8.3 Dressings

The type of dressing selected to promote healing of a pressure ulcer should be discussed with the individual and their family or carers if appropriate. In particular, dressings that promote a warm and moist wound healing environment to treat category 2, 3 and 4 pressure ulcers should be considered (NICE 2014).

8.4 Debridement

If autolytic debridement is likely to take longer and prolong healing time, then the utilisation of sharp debridement may be considered (NICE 2014). A qualified practitioner, such as TVNS, or a medical professional, competent to undertake the procedure, should undertake sharp debridement.

9. DISCHARGE

All incidences of damage to skin integrity must be communicated to receiving providers of care on discharge and supported with documentation including photographs to ensure continuity between care settings and agencies. When possible, communication should take place prior to discharge and include any need for specialist services, equipment, or dressings.

10. EQUIPMENT

10.1 Repositioning equipment

All staff must undertake the mandatory organisational training for Safe Handling prior to using any of the moving and handling hoists or any other repositioning equipment. It is the responsibility of the individual practitioner to ensure that they are familiar and competent to undertake any safe handling procedure.

11. INCIDENT REPORTING

11.1 Datix

All identified pressure ulcers, of category 2 and above, including Suspected Deep Tissue Injury (SDTI) and unstageable pressure ulcers, Medical Device Related Pressure Ulcers (MDRPU) (Appendix 6) and Moisture Associated Skin Damage (MASD) (Appendix 7) will be reported utilising the Datix incident reporting system. Where skin damage is caused by

a combination of moisture and pressure, the damage will be recorded as the category of pressure ulcer. Identification of the area, size and category should be detailed on the Datix report.

Additional information, such as whether the pressure ulcer existed prior to admission, was identified following transfer between clinical areas or occurred whilst in care, must be recorded. Other mitigating factors such as patient acuity or issues with compliance must also be documented, if known.

Photographs of the pressure injury should be taken at the earliest opportunity following detection and uploaded onto the submitted Datix. (5.3 Clinical Photography)

11.2 Root Cause Analysis (RCA)

All incidences of significant pressure damage will be analysed to establish the root cause.

Pressure ulcers, multiple category 2 or above, thought to have been sustained in care will have a Pressure Ulcer Specific Root Cause Analysis (RCA) tool completed by the ward /registered manager and reported within the organisations quality assurance process to support individual and organisational learning. The RCA will be completed as part of the datix investigation process. In the event of electronic system failure, a paper version is available. (See Appendix 13 for example Hospital RCA).

Pressure ulcers, category 2 or above, thought to have been sustained prior to admission to hospital and the patient is in receipt of nursing or social care, should be reported utilising the Datix incident reporting system and categorised as ‘Present before admission’. Contact should be made with the relevant care provider as it is then their responsibility to complete a Pressure Ulcer Specific Root Cause Analysis (RCA) and report in the organisations quality assurance process to support individual and organisational learning.
Pressure ulcers, category 2 or above, that are thought to have been sustained in the person’s home prior to admission where there is no nursing or social care input should be reported utilising the Datix incident reporting system and categorised as ‘Present before admission’. Clinical judgement should be utilised to determine if a Safeguarding referral is to be considered. The Adult Safeguarding Lead may be contacted for further discussion to determine if a Safeguarding referral is appropriate.

11.3 Safeguarding

All health and social care providers are required to raise concerns around Safeguarding. A Reporting and Referral Process for Pressure Ulcers (Appendix 10) must be adhered to when concerns have been raised regarding an incidence of significant pressure damage. Incidences of significant damage are indicated by multiple pressure ulcers of category 2 or a category 3 or 4, Unstageable or sDTI classified in accordance with NHS Improvement Pressure Ulcer Classification System (Appendix 6).

In the event that multiple category 2 pressure ulcers are identified or a category 3 or 4, Unstageable or sDTI, the Tissue Viability Nurse must be contacted to confirm classification and assist in the development of a management plan. Photographic evidence to support classification and reporting should be provided and consent for

clinical photography should be sought in line with organisational consent and clinical photography guidelines.

A Datix incident report must be completed following an incidence of significant pressure damage and information gathered to determine whether a safeguarding concern should be raised. The Ward Manager, Lead Nurse and Tissue Viability Nurse will have collective responsibility for gathering the information required and will utilise the Reporting and Referral Tool (Appendix 10) to establish if any further action is required.

In a minority of cases, it may warrant raising a safeguarding concern. For additional information and advice for referral please see Adult Safeguarding Referral information. The individual should be made aware they are being referred unless there is an identified reason not to share this with them such as lack of capacity in this area. Prior to making a referral, the Safeguarding Team can be contacted to provide support and discuss concerns.

The Adult Safeguarding Trigger Tool provides a focus on the thresholds for referral through the Adult Safeguarding Process. However, this does not negate the need to utilise clinical judgement to consider a safeguarding concern outside these thresholds.

11.4 Auditing

Audits will be conducted and reviewed to ascertain the compliance with the recommendations of this policy as well as establishing the prevalence rates. The TVNS will be responsible for undertaking and disseminating the results of the audits conducted across the organisation. Jersey Nursing Assessment Accreditation System (JNASS) will ensure that compliance is met with relation to the pressure ulcer standards of care.

12. TRAINING

12.1 Educational strategy for pressure ulcer prevention and management

The education of staff in the prevention and management of pressure ulcers is an organisational priority. This will be led by the Tissue Viability Nurse Specialist in collaboration with the Practice Development Team (PDT), Allied Health Care Professionals, the Education Department, and the Vocational Training Centre.

It is the responsibility of each individual health professional to identify any deficits in their knowledge and take action to ensure their practice complies with local policy and procedures.

13. REFERENCES

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14. CONSULTATION SCHEDULE

Name and Title of Individual	Date Consulted
Mr Patrick Armstrong Medical Director	31/10/22
Mr Mark Whyman Consultant General Surgery	31/10/22
Rose Naylor Chief Nurse	31/10/22
Jessie Marshall Associate Chief Nurse	31/10/22
Claire Thompson Director of Clinical Services	31/10/22
Abbie Mcloughlin Tissue Viability Nurse Specialist Inpatient Services	31/10/22
Claire Ash Lead Nurse Surgical Services	31/10/22
Valter Fernandes Lead Nurse Medical Services	31/10/22
Jenna MacKay Acting Lead Nurse Medical Services	31/10/22
Robert Gardner Head of Nursing Special Needs Services	31/10/22
Lindsey Le Masurier Governance Lead Surgical Services	31/10/22
Claire White	31/10/22

Client / Patient Safety Officer	
Olivia Card Acting Lead Nurse inpatient Mental Health	31/10/22
Tim Hill Practice Development Sister	31/10/22
Emma Bish Practice Development Sister- Theatres	31/10/22
Sandra Keogh-Bootland Senior Clinical Audit and Effectiveness Officer	31/10/22
Sarah Whitmarsh Named Nurse for Adult Safeguarding	31/10/22
Gilly Glendewar Tissue Viability Community Sister	31/10/22
Emma Papworth Nutrition Nurse Specialist	31/10/22
Laura Foster Head of Nutrition & Dietetics	31/10/22

Name of Committee/Group	**Date of Committee Group meeting**
Pressure Ulcer Task Force Group	Nov 2023
Care Quality Committee	
PPRG	07/03/2023

15. IMPLEMENTATION PLAN

Action	**Responsible Officer**	**Timeframe**
Policy to be ratified and adjustments made ready for distribution	GM	
Policy to be uploaded onto HSS Net on Policy and Procedure Website	NK	
Disseminate policy availability on the HSS e-mail-all users notification	NK	
Present policy and changes at Pressure Ulcer Task Force Group Meeting	GM	
Disseminate change in RCA investigation to a senior clinical manager via email	GM	Once policy is live
Print off policy give to ward / registered managers to distribute to all relevant ward staff.	GM	Within 1 month of going live

16. GLOSSARY OF KEYWORDS

Adult	For the purpose of this policy an adult is defined as an individual aged 18 and over.
Autolytic debridement	The removal of devitalised tissue using moisture-retentive dressings.
Dynamic support surface	Dynamic devices usually use electricity or a battery pack to alter the level of support provided in the different chambers within the support devices. The types of support surface devices include overlays, replacement mattresses and speciality beds. The purpose of dynamic devices is to constantly change the pressure of the support surface against the skin, particularly at the body's pressure points.
Erythema	Redness that persists following the application of fingertip pressure, usually over a bony prominence. Darkly pigmented skin may not have visible blanching. This is a symptom of a Grade 1 pressure ulcer.
Sharp debridement	The removal of devitalised tissue by a sharp instrument e.g., scalpel or scissors.

17. Appendices

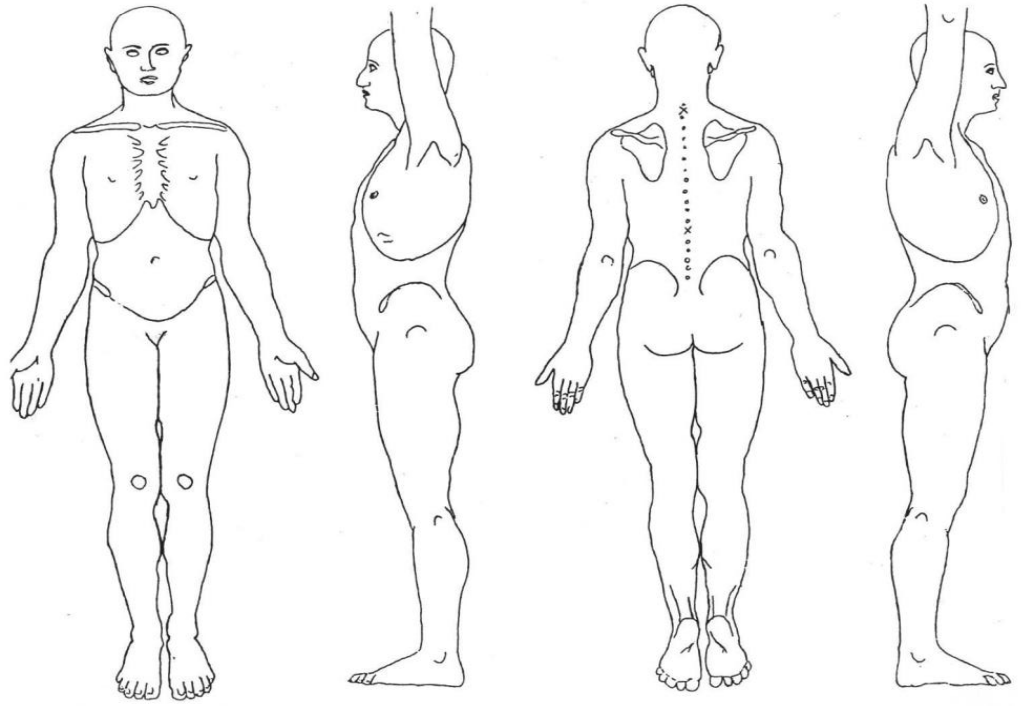
Appendix 1: Pressure Ulcer Risk Assessment (Front)

Please complete or affix addressograph Surname Forename Address Date of birth URN No: **SHEET NO:**	States of Jersey Ward Date/Time Signature Transfer Ward Transfer Date/Time Signature

PRESSURE ULCER RISK ASSESSMENT

For use on all adult patients with an expected stay of > 24hours (complete within 6 hours)

Skin mapping MUST occur on admission and any areas of skin damage MUST be identified on a wound chart. All skin damage must be identified, dated and signed individually



All pressure ulcers MUST be graded utilising the EPUAP Pressure Ulcer Grading Scale

EPUAP	Category/Grade 1	Category/Grade 2	Category/Grade 3	Category/Grade 4
	Non-blanchable erythema of intact skin. Discolouration of the skin. Observe for warmth, hardness and oedema	Partial thickness skin loss involving epidermis, dermis or both. Presents clincially as an abrasion or clear blister. Ulcer is superficial without bruising	Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed. May include undermining and tunnelling	Full thickness tissue loss with exposed bone (or directly palpable) tendon. Grade 4 ulcers can extend into the muscle and/or supporting structures

Action Checklist		Signature/Date
Wound Chart has been commenced	YES/NO	
Pressure ulcer prevention and management leaflet given	YES/NO	

A Datix Incident report must be completed for all grade 2 pressure ulcers and above
An additional Datix report must be completed for any deterioration in the pressure ulcer

Datix date	PU Grade and site	Datix Reference Number	Signature

FH&GB Review date - August 2017 WPD????

Pressure Ulcer Risk Assessment (Back)

WATERLOW PRESSURE ULCER RISK ASSESSMENT For use on all adult patients with an expected stay of > 24hours The Waterlow risk assessment must be performed on admission, on transfer or post surgery. Minimum weekly.						
More than 1 score per category can be used. Add total score to determine risk.		Date Time				
Risk Category	**Risk Factors**	**Score**				
BMI	20 - 24.9 (Average)	0				
	25-29.9 (Above average)	1				
	>30 (Obese)	2				
	<20 (Below average)	3				
Continence	Complete/catheter	0				
	Urine / incont	1				
	Faecal incont	2				
	Urine and faecal inc.	3				
Skin Type	Healthy	0				
	Tissue paper	1				
	Dry	1				
	Oedematous	1				
	Clammy, pyrexia	1				
	Grade 1	2				
	Grade 2-4	3				
Gender	Male	1				
	Female	2				
Age	14-49	1				
	50-64	2				
	65-74	3				
	75-80	4				
	81+	5				
Lack of appetite	Yes	1				
	No	0				
Weight loss	None	0				
	Unsure	2				
	0.5-5kg	1				
	5-10kg	2				
	10-15kg	3				
	>15kg	4				
Mobility	Fully	0				
	Restless/ Fidgety	1				
	Apathetic	2				
	Restricted	3				
	Bedbound	4				
	Wheel/chair bound	5				
Tissue Malnutrition	Terminal Cachexia	8				
	Multiple organ failure	8				
	Single organ failure	5				
	PVD	5				
	Anaemia HB <8	2				
	Smoking	1				
Neurological Deficit	Diabetes, MS, CVA	4-6				
	Motor/ Sensory	4-6				
	Paraplegia (max of 6)	4-6				
Medication	Cytotoxics,Long term/					
	High dose steroids,					
	Anti-inflammatory	Max of 4				
Major surgery/trauma	Orthopaedic spinal	5				
	On table >2 hrs*	5				
	On table >6hrs*	8				
*** Scores can be discounted after 48hours provided patient is recovering normally**						
Waterlow Score to be used together with clinical judgement	Total Score					
	Signature					
			15+ High Risk		**20+ Elevated Risk**	

Appendix 2: Informal Risk Assessment

Adult patients not expected to have a stay that exceeds 24 hours should have an informal risk assessment undertaken upon admission or at the start of the care episode.

Circumstances where this may be applicable:

- Emergency Department
- Day Surgery
- Outpatient Clinics
- Day case admission
- Medical Day Case

(The above list is not intended to be an exhaustive list of circumstances)

An informal risk assessment should form part of the patient's holistic assessment and be guided by the nurse's clinical knowledge and expertise.

Risk factors to be considered include:

- Those with significantly limited mobility (for example, those with a spinal cord injury)
- Those with significant loss of sensation
- A previous or current pressure ulcer
- A nutritional deficiency
- The inability to reposition themselves
- Those with significant cognitive impairment (NICE 2014)

The assessment and outcomes should be documented in the patient's medical or nursing notes.

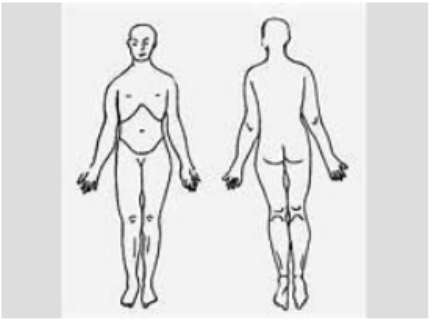
Appendix 3: Modified Andersen Screening tool

Modified Andersen Pressure Ulcer Screening Tool

Guidance: Tick all relevant criteria			
Hx of or existing pressure damage		Incontinent/Oedema/Excess Moisture	
Unable/unlikely to reposition independently		Visually obese/underweight/ reduced oral intake	
PVD or Diabetes		Terminal illness/acutely unwell NEWS>5	
Long lie (more than 4 hours)		Cognitive impairment	
Patient at risk? 2 or more or any red criteria Y N (circle response)			

Complete actions below if total risk score 2 or more: (circle response)

Skin Inspection: Pressure areas intact: Y N



Document skin assessment and category of pressure ulcer location:

Leg dressings removed heels checked and documented: **Y N**

Photograph: **Y N** Datix: **Y N**

Pressure relieving mattress required: **Y N**

Additional comments:

Date……Time……..

Signature……Print Name…….....

Appendix 4: SSKIN (front)

Please complete or affix addressograph Surname Forename Address Date of birth URN No. **SHEET NO.**	States of Jersey Ward / Area: Date / Time: Transfer Ward : Transfer Date: Name / Designation : Signature :

Pressure Ulcer Prevention SSKIN Care Plan

SSKIN Care Plan to be commenced for all patients	Please tick
~ at risk of pressure damage (Waterlow >10) or as a result of an informal assessment	☐
~ with existing pressure damage	☐
~ who have had pressure damage previously	☐

Problem:	The patient is at risk of pressure damage as a result of risk assessment, has existing pressure damage and/or has had previous skin pressure damage

Goal:	To minimise the risk of pressure damage and/or prevent further deterioration of existing pressure damage

SSKIN	INTERVENTIONS	Date	Signature
S **Surface**	An appropriate support surface has been selected based on assessment of patient risk.		
	Individual is bedbound/ wheel chair bound		
	Mattress type		
	Cushion type		
S **Skin**	Regular skin inspection is undertaken and documented		
	Vulnerable areas have been identified as:		
	A referral to the Tissue Viability Nurse has been made		
	A Wound Chart has been implemented a a result of identified pressure damage		
K **Keep Moving**	A Repositioning Chart has been commenced		
	A turning schedule is identified and reviewed		
	Mobility will be encouraged as patient condition allows		
	A referral to the Physiotherapist has been made		
	A referral to an Occupational therapist has been made		
	A Manual Handling assessment has been completed		
I **Incontinence**	A Catheter Care Bundle is needed and commenced		
	Toileting assistance is needed and is regularly offered		
	Incontinence pads are indicated		
	Skin cleansing regime(including barrier) identifed as:		
	A referral to the continence service has been made		
N **Nutrition**	A nutritional assessment has been completed		
	A referral to the Dietician has been made		
	The dietary regime has been identifed as		
	Nutritional intake is monitored (dietary intake chart)		
	Fluid intake is monitored (fluid balance chart)		

Additional Referrals	**Date**	**Signature**
Speech And Language Therapist (SALT)		
Other (Specify) -		
Other (Specify) -		

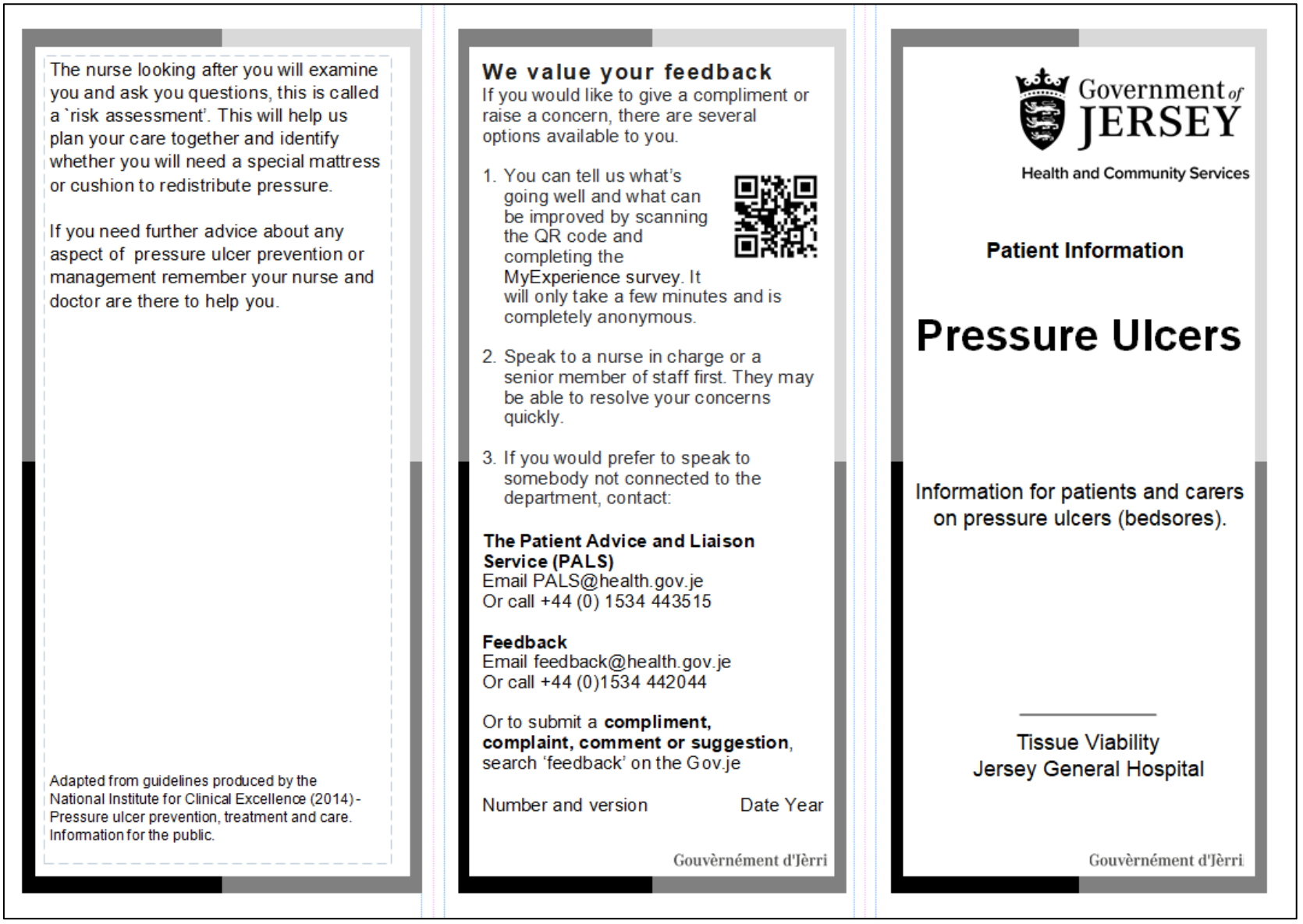
All practitioners will have a responsibility to implement, evaluate and review the SSKIN care plan.
Any interventions not dated and signed will be noted as not applicable to the patient.

© Initials of staff member Review date - Evidence Base WPD????

SSKIN (back)

Patient Name :		URN NO.
Pressure Ulcer Prevention SSKIN Bundle Care Plan Multidiscipliany enteries		
Date/ Time	**Evaluation**	**Signature**

Appendix 5: Patient Information leaflet available at: [Pressure Ulcers Leaflet]



The nurse looking after you will examine you and ask you questions, this is called a `risk assessment'. This will help us plan your care together and identify whether you will need a special mattress or cushion to redistribute pressure.

If you need further advice about any aspect of pressure ulcer prevention or management remember your nurse and doctor are there to help you.

Adapted from guidelines produced by the National Institute for Clinical Excellence (2014) - Pressure ulcer prevention, treatment and care. Information for the public.

We value your feedback

If you would like to give a compliment or raise a concern, there are several options available to you.

1. You can tell us what's going well and what can be improved by scanning the QR code and completing the MyExperience survey. It will only take a few minutes and is completely anonymous.
2. Speak to a nurse in charge or a senior member of staff first. They may be able to resolve your concerns quickly.
3. If you would prefer to speak to somebody not connected to the department, contact:

The Patient Advice and Liaison Service (PALS)
Email PALS@health.gov.je
Or call +44 (0) 1534 443515

Feedback
Email feedback@health.gov.je
Or call +44 (0)1534 442044

Or to submit a **compliment, complaint, comment or suggestion**, search 'feedback' on the Gov.je

Number and version Date Year

Gouvèrnément d'Jèrri

Government of JERSEY

Health and Community Services

Patient Information

Pressure Ulcers

Information for patients and carers on pressure ulcers (bedsores).

Tissue Viability
Jersey General Hospital

Gouvèrnément d'Jèrri

About pressure ulcers

A pressure ulcer is a sore, an area of skin that has been damaged due to unrelieved and prolonged pressure. They are also known as pressure sores or bed sores.

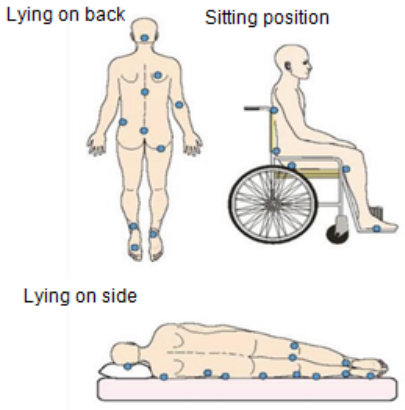
They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

Where do pressure ulcers form

Pressure ulcers can affect any part of the body that's put under pressure. They're most common on bony parts of the body, such as the:

- heels
- elbows
- hips
- base of the spine

Common locations of pressure ulcers



Risk factors

You may be at risk if you have:

- problems with movement which causes you to lie or sit in the same position for long periods
- poor circulation: vascular disease or heavy smoking may affect your circulation
- moist skin, due to incontinence, sweat or a weeping wound - it is important your skin is kept clean and dry
- had a pressure ulcer before
- A poor diet or do not drink enough
- problems with your memory and understanding (such as dementia)
- had an operation
- problems with sensitivity to pain or discomfort

How to prevent pressure ulcers

- keep moving: changing position often helps prevent the build up of pressure If you are unable to move yourself then you will be offered help to do so.
- keep skin clean and dry wash every day with a mild soap or cleansers. Avoid talcum powder or perfumed soaps as these can cause dry skin which is more vulnerable to damage
- drink little and often
- eat a healthy well-balanced diet
- check your skin regularly for signs of damage

Report any areas of soreness or redness over a bony area to the nurse or medical professional looking after you.

Do not continue to lie on skin that is red or darker than usual. Watch out for dry patches or cracks in the skin.

Symptoms to look for

- purple / blue patches on dark skin
- red patches on light skin
- swelling over a bony area
- blisters or broken skin
- dry patches of skin
- cracks in the skin

The skin may feel unusually:

- hard
- warm or hot
- swollen
- dry
- tender

Appendix 6: Pressure ulcer categorisation

Available at: https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/Pressure-ulcer-categorisation-poster.pdf

Pressure ulcer categorisation

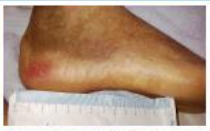
NHS

Blanching erythema

Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is not a pressure ulcer.

Example of skin blanch

Blanch in darker skin



This redness is persistent and does not blanch

This redness will not blanch when pressure is applied

Category 1: Non-blanchable erythema

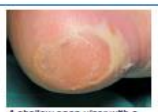
Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

Category 2: Partial thickness skin loss

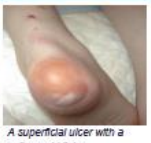
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury.*

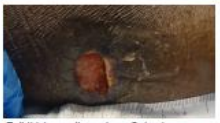
An intact serum-filled blister



A shallow open ulcer with a red pink wound bed without slough



A superficial ulcer with a collapsed blister



Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

Category 3: Full thickness skin loss

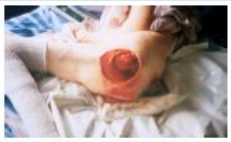
Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full thickness tissue loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

In this wound, the bone is clearly visible



This wound shows exposed muscle

This occipital ulcer is covered by softening necrosis

This heel ulcer is covered by hard dry eschar

The necrotic cap on this heel has softened and started to separate

Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

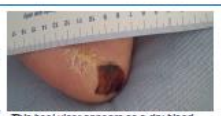
Unstageable: depth unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.

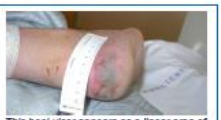
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected deep tissue injury: depth unknown

Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



This heel ulcer appears as a dry blood blister



This heel ulcer appears as a linear area of deep purple black discolouration

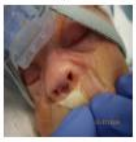
Pressure ulcer categorisation

Device-related pressure ulcers (DRPU)

'Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.'

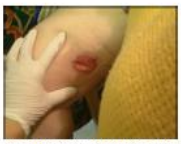
While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition of a (d) after the category.

This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear



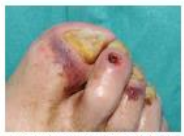
This neonate has damage to the nares that cannot be categorised

The damage caused by this urinary catheter could be categorised as a DTI (d)



Although difficult to identify, this PU was caused by the leather ring at the top of an old-fashioned calliper

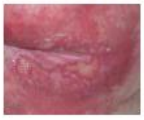
Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



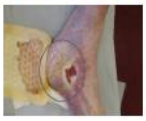
Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

Moisture-associated skin damage

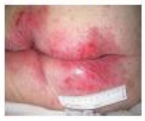
This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat



These multiple superficial lesions with diverse edges are typical of Incontinence Associated Dermatitis



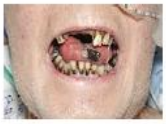
The white cobblestone appearance of the tissue around this wound show evidence of significant maceration due to wound exudate remaining on the skin



Wounds related to IAD such as these are often extremely painful

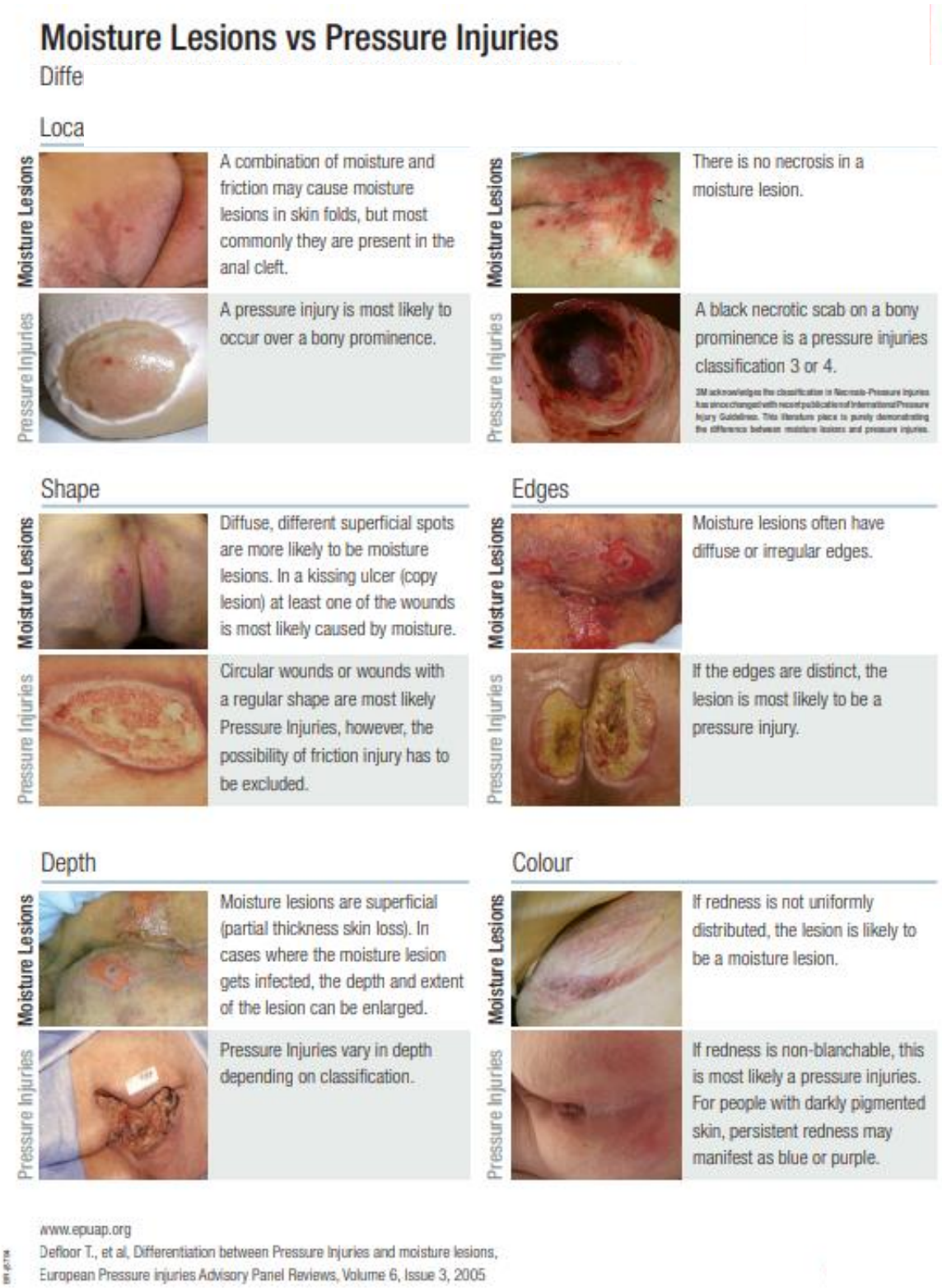
This wound demonstrates how the epidermis can easily be stripped away by incontinence

Mucosal pressure ulcers



Mucosal pressure ulcers can not be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These PU are therefore uncategorisable (NOT unstageable) . They are usually caused by devices and therefore should be recorded as PU (d), locally you may wish to denote them as "Mucosal" or "Uncategorisable".

Appendix 7: Moisture Lesion v Pressure Ulcers



Appendix 8: Repositioning chart

Please Complete or Affix Addressograph Surname: Forename: Date of Birth: URN No: **Sheet No:**	States of Jersey Ward / Area: Sheet No: Name / Designation Signature

Repositioning Chart for all those identified at risk of pressure damage, with existing pressure damage or recently had pressure damage

* Encourage all those identified as being **at risk** of pressure damage to change their position frequently and at least six hourly.
* Encourage all those identified as being **at high risk** of pressure damage to change their position frequently and at least four hourly.
* Individual tissue tolerance time should be taken into consideration when determining repositioning schedules.The above are available as a guide only.

Inspect the patients skin regularly. Patients on pressure redistribution equipment still require skin inspection and regular repositioning

		Repositioning (using legend)		Skin Inspection	Identified repositioning	Other comments- include Pain	Signature /
Date	Time	From	To	Comments	schedule (hrs)	e.g. Mouth care, eye care, traction obs etc	Designation

Legend - Left (L), Right (R), Back (B), Prone (P), Sitting Up (SU), Chair (C), Mobilising (M)

Appendix 9: Wound Assessment Chart (front)

WOUND ASSESSMENT CHART

Please Complete or Affix Addressograph Surname: Forename: Address: Date of Birth: HSS No: General Practitioner:	Area: Allergies & Alerts: Sheet No: Date:

ASSESSMENT

Wound Aetiology: State									
Location:									
Type:									
Wound Description:									
State Dates									
Wound Size: Measure monthly Length x Width x Depth in cm									
Photographed / Traced: Y / N									
Wound Bed:									
1. Epithelialising (Pink)									
2. Granulating (Red)									
3. Over-Granulating (Friable/Red)									
4. Sloughy (Yellow)									
5. Necrotic (Black)									
Surrounding Skin:									
1. Healthy / Normal									
2. Scaly / Dry **3.** Cellulitis									
4. Oedematous **5.** Macerated									
6. Eczema **7.** Fragile									
8. Callus									
Exudate (Amount):									
1. None									
2. Light - on primary dressing									
3. Moderate - on primary dressing									
4. High - saturated secondary dressing									
Exudate (Colour):									
1. Clear / Serous **2.** Opaque									
3. Blood **4.** Brown									
5. Yellow **6.** Green									
Odour Present State:									
Clinician's Opinion: Y / N									
None / Slight / Offensive									
Clinical Infection Evident									
Yes / No - If yes									
Swab Taken Y / N									
Started Antibiotics: Y / N									
Ceased Antibiotics:									
Comments:									
Nurse Initials:									

Appendix 9: (back)

TREATMENT / MANAGEMENT

Objective Dressing Product:		State Dates									
1. Debridement	2. Absorption										
3. Hydration	4. Medication										
5. Closure	6. Protection										

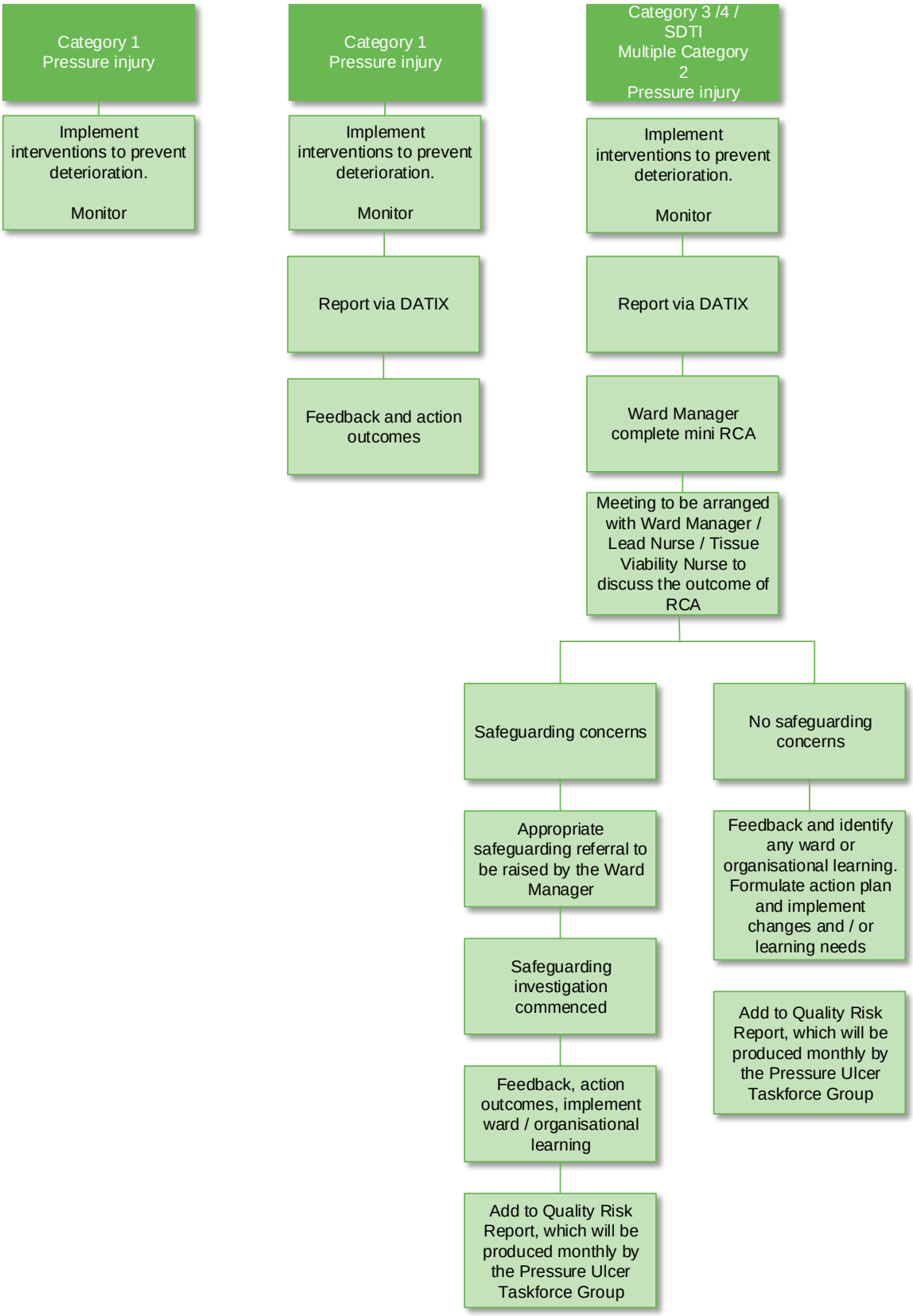
A) Cleansing

B) Primary Dressing	Date Started	Date Stopped	Rationale	Signature
C) Secondary Dressing				
D) Secure with				

Special Requirements:

Community Referrals:
State Name and Dates:

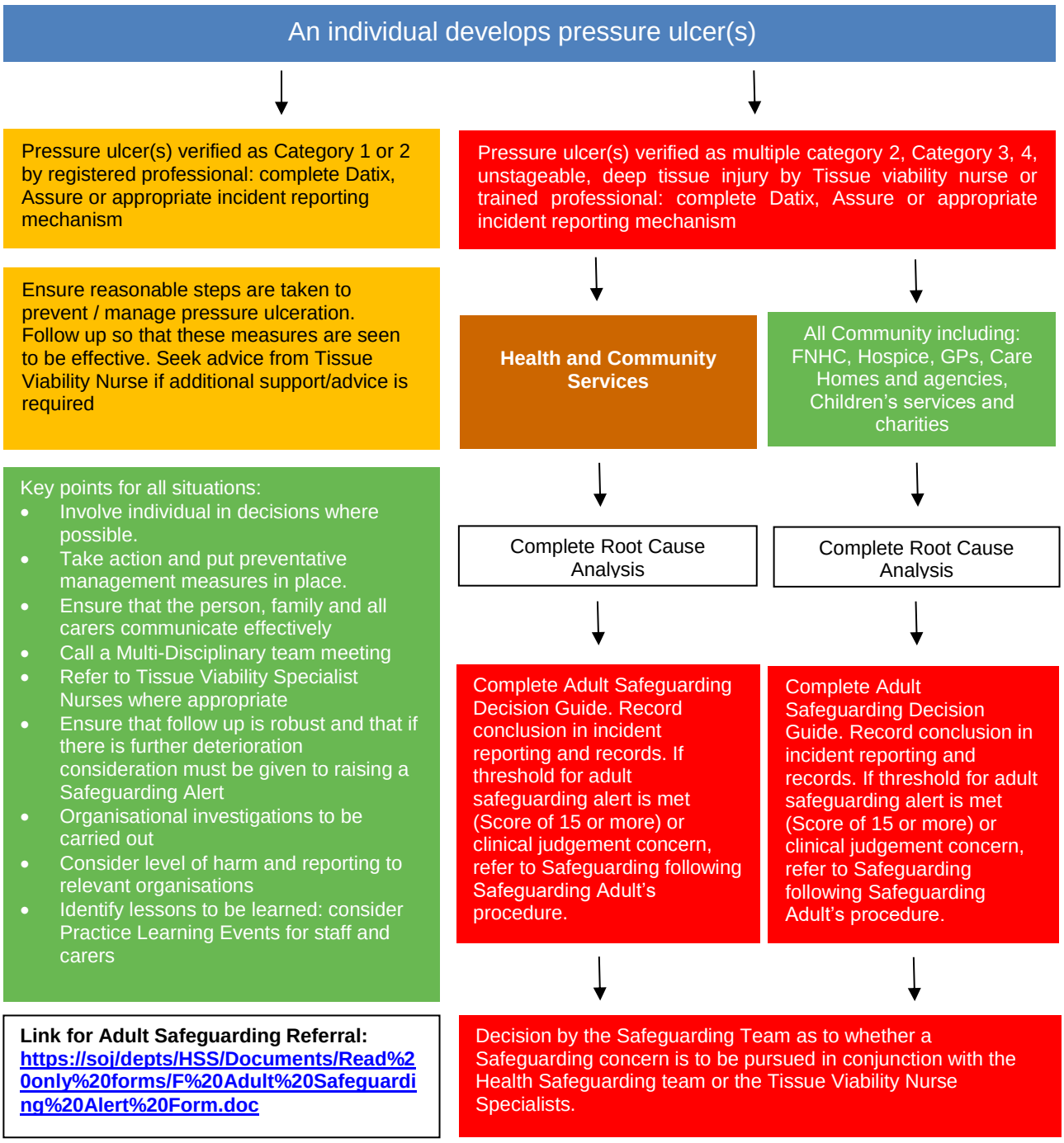
Appendix10: Reporting and referral process



Appendix 11: Safeguarding trigger tool

Pressure Ulcers: When to raise a Safeguarding Concern
Flow chart to be used for inpatient services (HCS) and all community providers

An individual who develops Pressure ulceration is considered at risk and therefore consideration must be given to the safeguarding process. This process is inclusive of all ages: children through to adult. All agencies must be aware of indicators in determining when safeguarding issues may arise.



Appendix 12: Adult Decision Guide – Safeguarding

Adult decision guide – Safeguarding Risk category		Level of concern		Evidence
1	Has the patient's skin deteriorated to either grade 3 /4 /unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess / visit?	Yes. E.g., record of blanching / non-blanching erythema	5	E.g., evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided
		No e.g., no previous skin integrity issues or no previous contact with Health or Social Care Services	0	
2	Has there been a recent change, i.e., within days or hours, in their / clinical condition that could have contributed to skin damage? E.g., infection, pyrexia, anaemia, end of life care, critical illness	Change in condition contributing to skin damage	0	
		No change in condition that could contribute to skin damage	5	
3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patient's needs	0	Sate date of assessment risk tool used Score / Risk level
		Risk assessment carried out and care plan in place. Documented but not reviewed as person's needs have changed	5	What elements of care plan are in place?
		No, or incomplete risk assessment and / or care plan	15	What elements would have been expected to be in place but were not?
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	No / Not applicable	0	
		Yes	15	
5	Is the level of damage to the skin inconsistent with the patient's risk status for pressure ulcer development? e.g., low risk – Category / grade 3 or 4 pressure ulcer	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	
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan			
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	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 followed care plan or not given information to enable them to make an informed choice	5	
b	Was appropriate care undertaken in the patient's best interests, following the best interest's checklist in the Mental Capacity Act Code of Practice? (Supported by documentation, e.g., capacity, and best interest statements and record of care delivered)	Documentation of care being undertaken in the patient's best interests	0	
		No Documentation of care being undertaken in patient's best interests	10	

If the score is 15 or over, discuss with the HCS (safeguarding) as determined by local procedures and reflecting the urgency of the situation. Please send this decision guide along with the referral through to Adult Safeguarding Team. When the decision guide has been completed even when there is no indication that the safeguarding alert needs to be raised, the tool should be stored in the DATIX record. The individual should be made aware they are being referred unless there is an identified reason not to share this with them such as lack of mental capacity in this area.

Appendix 13: Mini RCA

Mini RCA – Pressure ulcers				
Patient's name			Age	
Datix no			Date of completion	
Completed by:			DOB	
URN				
Ward				
Assessment and findings				
1	Date pressure ulcer detected /date deterioration of ulcer detected		Date	
2	Where was the person resident when the pressure ulcer was acquired		Date	
3	Current Waterlow score	Score	Date	
4	Previous Waterlow score	Score	Date	
5	Location and size of pressure ulcer(s)			
6	Category of pressure ulcer(s)			
7	Reason for admission / transfer?			
8	Outline any relevant past medical history			
9	Has a movement and handling assessment been carried out? (Delete as appropriate)		Yes	No
10	Were there delays in:			
	• using appropriate preventative equipment		Yes	No
	• providing nursing care		Yes	No
	If yes – please state reason			
11	Comments / additional information:			
12	Has there been a rapid onset / deterioration of skin integrity? (Delete as appropriate)		Yes	No
13	Has there been a change in medical condition? (Delete as appropriate)		Yes	No
	If yes, explain briefly:			

14	Were reasonable steps taken to prevent skin damage?	Yes	No
	Appropriate pressure relieving mattress (delete as appropriate)	Yes	No
	Regular turning (delete as appropriate)	Yes	No
	Heel protectors (delete as appropriate)	Yes	No
	Pressure relieving cushion (delete as appropriate)	Yes	No
	Regular skin checks (delete as appropriate)	Yes	No
	Other (please specify)		
15	Were the pressure areas and any skin breaks monitored regularly	Yes	No
16	Were treatments and care plans altered as necessary and recorded	Yes	No
17	Was there concordance with the care plan?	Yes	No
18	If no – please explain what the issues were:		
19	Did the patient have capacity to make informed decisions?	Yes	No
20	Was the capacity assessment recorded	Yes	No
21	Are / were there concerns regarding family / carers?	Yes	No
	Is a safeguarding referral needed?	Yes	No
20	Were agreed protocols followed? (Delete as appropriate)	Yes	No
21	Summary of findings		
22	Root causes – what caused the pressure ulcer to develop / deteriorate?		
23	Is there any concern about nursing care? (Delete as appropriate)	Yes	No
	If yes, please provide detail		

24	What are the lessons learned (if any)?			
25	Actions to be taken to address any lessons learned	By when	Action plan	To be added (Y/N)
	•			
	•			
	•			
	•			
26	If any actions are not being added to the action plan, please specify monitoring arrangements			
27	Being open (duty of candour) for PUs grade 3 / 4 please detail discussion / s with the patient (family / carers if the patient consents / does not have capacity) about the pressure ulcers			
			Date	

Name		Designation		Date	
Name		Designation		Date	

Formal approval by pressure ulcer assurance group	
Signed _____ Tissue viability lead	Date
Signed _____ Safeguarding lead	Date
Signed _____ Patient safety lead	Date
Comments / actions (if any)	