East Sussex Healthcare
NHS Trust

FOI REF: 25/102

23rd February 2025

Eastbourne District General Hospital
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East Sussex
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Tel: 0300 131 4500
Website: www.esht.nhs.uk

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

I am writing under the Freedom of Information Act 2000 to request data on bed sore-related death reports and complaints made to this trust.

1. Please provide any trust guidance on pressure care (for the care and prevention of pressure sores, pressure ulcers, or bed sores) issued to administrators and/or hospital staff in the past 24 months.

Please see attached East Sussex Healthcare NHS Trust's 'Pressure Ulcer Prevention and Management Policy'. Please note that this is currently in the process of being updated.

Please note that it is the Trust's FOI policy to only provide the names of staff that are grade 8a or above, therefore staff that are below that grade have been redacted from the attached policy.

We have also redacted the contact details of staff as we consider this information to be exempt from release in accordance with section 44 of the Freedom of Information Act (Prohibition on disclosure) and would refer to the Privacy and Electronic Communications EC Directive Regulations 2003 which provide specific rules on electronic communication services, including marketing (by phone, fax, email or text) and keeping communications services secure. We will not provide any information that could result in the transmission of unsolicited communications which may place an unacceptable risk to our email network and could also have a detrimental impact on patient care and treatment.

The contact number for the Trust are accessible on the Trust website http://www.esht.nhs.uk.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

Cont…/

2. For the following years, please provide the number of patients within the trust treated for bedsores (classified as ICD-10 code L-89), as filed in Datix, Ulysses or other relevant reporting systems:

2022	988
2023	873
2024	1215

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

Pressure Ulcer Prevention and Management Policy

Document ID Number:	1108
Version:	V4
Ratified by:	Clinical Documentation and Policy Group
Date ratified:	10 May 2022
Name of author and title:	[redacted]
Date originally written:	October 2011
Date current version was completed:	April 2022
Name of responsible committee/individual:	Pressure Ulcer Steering Group (PUSG)
Date issued:	17 June 2022
Review date:	April 2025
Target audience:	All clinical staff
Compliance with CQC Fundamental Standards	Person-centred care, Dignity and respect, Consent, Safety, Safeguarding from abuse, Food and drink, Premises and equipment, Duty of candour,
Compliance with any other external requirements (e.g. Information Governance)	NHSI Pressure ulcers: revised definition and measurement framework
Associated Documents:	Duty of Candour

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the policies and can only guarantee that the policy on the Trust website is the most up to date version

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and or/carer. Health care professionals must be prepared to justify any deviation from this guidance.

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2012103	October 2011	[redacted]	Tissue Viability Clinical Nurse Specialists Vascular Nurse Specialist	Previous Community Policy and Acute Trust policy merged
V1.1 2012163	May 2012	As above	Updated document published on 21/4/12 Achieving Consensus in Pressure Ulcer Reporting Amendments To above and consistency in text	Updated reference page 24 Amendment to pages re ungradeable to unstageable page 20 Page 12 Mattress type Page 17, 19, 20, 21 and Appendix 4 & 7
V1.2 2012299	October 2012		Referral and Incident Form changed. Given Chair Approval.	Referral updated to include TVN's alerted to grade 2 Pressure Ulcers. Updated Incident Form
V1.3	May 2013	As above	Up-dated Documentation	
V2	JUNE 2015	As above	Up-dated Documentation	Purpose T SSKIN
V2.1	April 2016	As above	Up-dated reporting process	New appendices and p 13 section 5.6 amendment
V2.2	March 2017	As above, change made by [redacted]	Revised governance process	Proof read and minor amendment to section 5.6.
V3	April 2019	[redacted]	Updated in line with NHSI Definition and Reporting Framework (2018)and locally agreed processes	Complete review in line with NHSI Recommendations and change in local processes.

V4	April 2022	[redacted]	Update in line with revised governance process	Updates to all sections and additional appendices added.

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Tissue Viability Service	Tissue Viability Nurses	January 2022
Pressure Ulcer Review Group	PURG	January 2022
Documentation/Ratification group	ESHT	Oct 2015

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

East Sussex Healthcare NHS Trust (ESHT) ambition is to reduce preventable pressure ulcers. The revised guideline aims to promote an interdisciplinary and patient/carer focused approach to the challenges of preventing pressure ulcers and to ensure a cultural shift towards the prevention and management of pressure ulcers within the Trust. It commits the Trust to ensuring that there are effective arrangements for pressure ulcer prevention and management.

Guidance aims to ensure all individuals from first episode of care, throughout inpatient stay and on transferring to the community, receive consistent risk assessments (Appendix 3 for Maternity and Appendix 4 for Paediatrics), with timely interventions to minimize risks to prevent pressure ulcer incidents or extension of existing pressure injury (EPUAP 2018).

Locally ESHT have been members of the National NHSI Collaborative which aims to use quality improvement methodology to improve the care we provide to prevent pressure ulceration.

In June 2018, NHSI published some recommendations in relation to definition, reporting, defining and measuring pressure ulcers. The majority of these recommendations have been taken up by ESHT and some local amendments have been made to how we code pressure ulcer incidents (Appendix 5). The Tissue viability Team are stakeholders in the National Wound Care Strategy Programme, one of the areas is working on Pressure Ulcer Prevention, and Professional Core Skill competencies Wound-Care-Framework-2021.pdf (skillsforhealth.org.uk)

2. Purpose

2.1 Rationale

To provide information and guidance to ESHT staff to ensure consistent and safe approach to the prevention and management of pressure damage within our care.

Pressure ulcers remain a concern represent harm associated with healthcare delivery. In the NHS in England, 24,674 patients1 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 every day. Finding ways to improve the prevention of pressure damage is therefore a priority for policy-makers, managers and practitioners alike. (NHSI 2018)

2.2 Principles

The wound care strategy focuses on patient safety, patient experience and effectiveness of care. Therefore, the occurrence of pressure ulceration is used to assess the quality of care delivered by a healthcare organisation and the effectiveness of the preventative measures taken.

This emphasizes the importance of health care teams focusing on preventative measures to minimize individual pressure ulcer risks, reduce pain and infection risk, improving safety, quality, dignity and compassion in care (Griffiths et al. 2008; DH 2009c; Care Quality Commission. 2010). Pressure area care, infection prevention and pain were identified as key general nursing care indicators (Hinchliffe. 2009).

Pressure ulcer incidence and prevalence is one key quality care indicator which aims to generate meaningful information to motivate and enable changes in practice leading to improved outcomes for patients (White et al. 2010).

The older person may have one or more chronic diseases on admission to hospital and also in the community setting. These risk factors as well as a growth in the bariatric population impact on nursing dependency and patients' vulnerability to develop pressure ulcers particularly during acute illness and upon recovery.

2.3 Scope

All healthcare ESHT professionals who have direct patient contact and/or make decisions concerning treatment of individuals who may be vulnerable to developing pressure ulcers, including:

- Multidisciplinary Team: Clinical and Business Managers: Clinical Governance and Education Leads

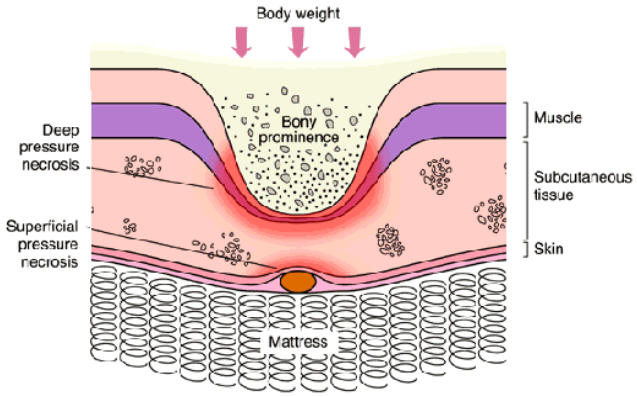
3. Definitions

3.1 Pressure ulcer

A pressure ulcer is defined as a localised injury 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 2018)

A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (European Pressure Ulcer Advisory Panel - EPUAP and National Pressure Ulcer Advisory Panel -NPUAP- 2018).

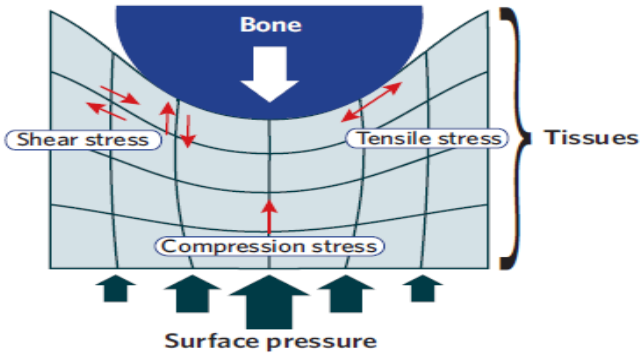
Pressure



Body weight can squash and rupture skin and muscle layers and occlude blood capillaries supplying the area leading to tissue death

- Force applied perpendicular to the skin
- Compression of tissue, and disruption to local blood supply
- Tissue distortion resulting in shear near the bony prominence
- Occur with short durations of high level pressure, and with long durations of low level pressure

3.2 Shear

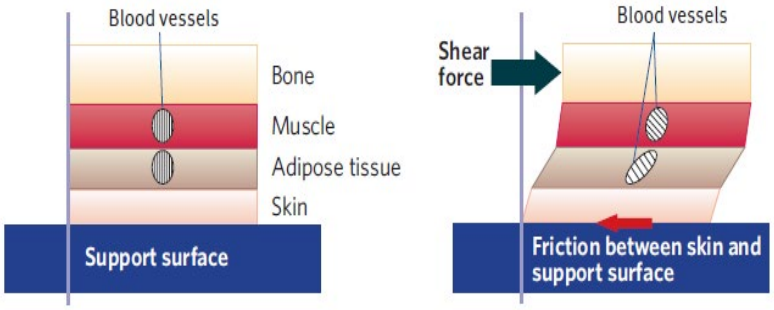


Pressure applied to the skin over a bony prominence causes compression, deformation and distortion of the underlying soft tissues and produces shear within and between tissue layers

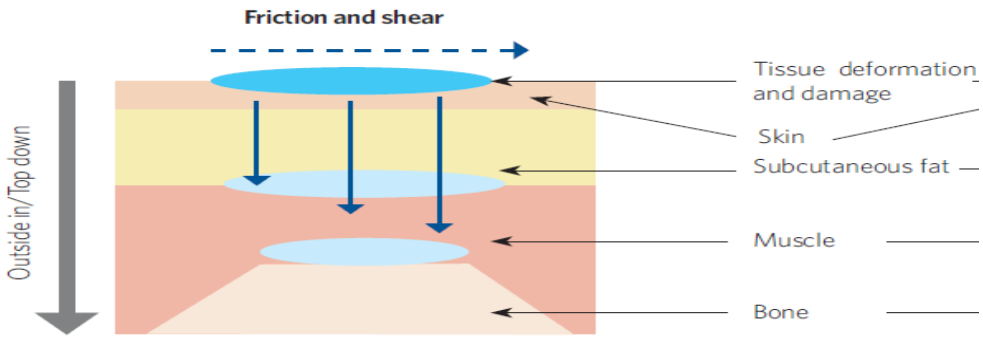
Shear stress caused by exposure of skin to tangential force, resulting in one layer of tissue moving relative to the other, causing the tissues to stretch, rupturing the capillary blood vessels with local tissue loss .Shear stress also caused by pressure related tissue distortion

Commonly occurs in combination with pressure when patients slide down the chair or bed or if the patient is dragged back up the bed. The outer skin fixes against the support surface but shear forces within deeper layers twist and contort tiny capillaries and force inner tissue layers to move against bone causing separation of the skin layers.

When a patient is in contact with a support surface that moves, the friction between the skin and the surface tends to hold the skin in place and a shear force occurs that displaces and deforms the tissues, and may distort and compress blood vessels



Friction and Shear at the surface of the skin contribute to development of superficial pressure ulcers. Develop ‘outside in’, similar to a pothole in the road



3.3 Moisture

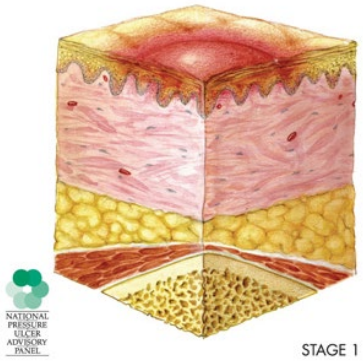
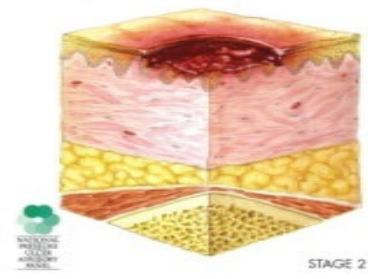
Moisture damage may occur through unmanaged incontinence, sweat, and exudate. Excessive moisture increases friction and shear forces, and causes maceration, making skin more vulnerable to the effect of shear stresses. Also excessive dryness makes the skin more vulnerable to shear stresses

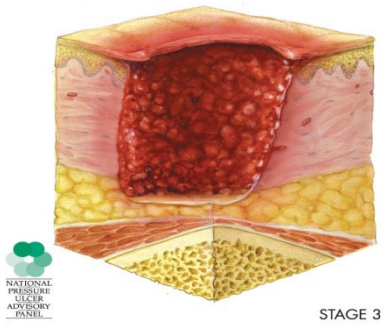
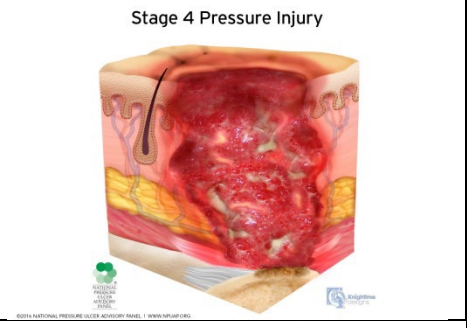
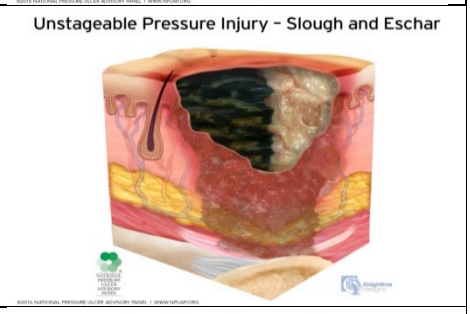
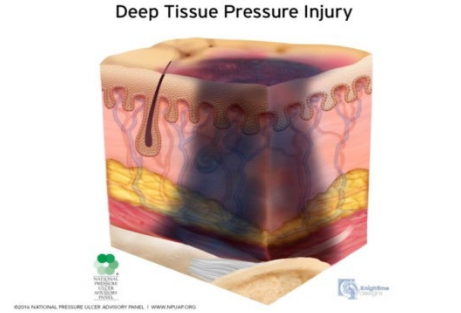
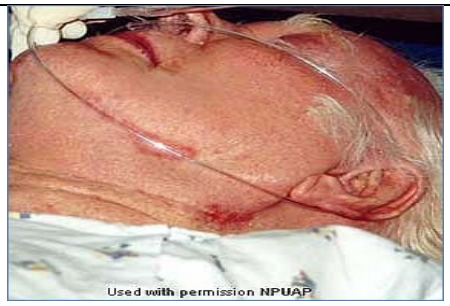
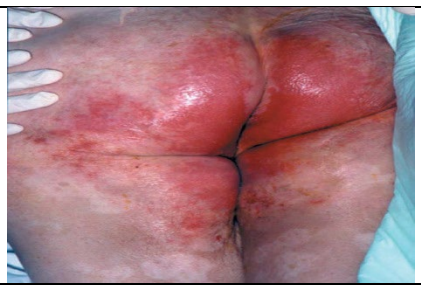
Perspiration with pyrexia or urinary/faecal incontinence in contact with unprotected skin can remove its protective acid microbial barrier leading to excoriation and moisture associated skin damage (MASD). A MASD will be especially vulnerable to develop deeper injury from any friction, shear and/or pressure forces.

3.4 Categories

All pressure ulcers should be categorised 1 - 4 according to European consensus on classification (2018) www.epuap.org. NPUAP/EPUAP 2018 also recognise that patients may present with unstageable pressure ulcers where the depth of damage is unknown or damage that presents as localised purple bruising with potential for deep tissue injury (DTI). Evolution in both cases may be rapid exposing additional layers of tissue even with optimal treatment.

Categorizing pressure ulcers requires a clear understanding of the anatomy of the skin in different locations. Staff must take part in appropriate learning and practice activities that maintain and develop competence and performance (NMC 2018).
Pressure ulcers should not be reverse categorised. For example a category 4 pressure ulcer does not become a category 2. It should be described as a healing category 4 pressure ulcer (EPUAP 2018). ESHT do not report category 1 pressure ulcers

<table>
<tr><td colspan="3">EPAUP Pressure ulcer categorisation chart
Definition
A pressure ulcer is defined as a localised injury 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 (NHSI 2018)</td></tr>
<tr><td>Category 1</td><td>Intact skin with non-blanchable redness, usually over a bony prominence. Not visible in dark skin. Area may be painful, firm, soft, and warmer or cooler compared to adjacent skin. Act promptly to prevent deeper damage</td><td> 
</td></tr>
<tr><td>Category 2</td><td>Partial thickness loss of dermis presenting as a shallow ulcer with a red/pink wound bed, without slough. May also be intact or open/ruptured serum-filled or sero-sanguinous filled blister. Shiny or dry shallow ulcer without slough or bruising. Not skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation</td><td> 
</td></tr>
</table>

Category 3	Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. Can be shallow or very deep, depth varies by anatomical location/ amount of subcutaneous tissue.	
Category 4	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often undermining and tunnelling. Depth varies by anatomical location. Can extend into muscle/ supporting structure making osteomyelitis likely to occur.	
Unstageable	Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined.	
Deep tissue Injury	Purple or maroon localized 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 as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.	
Medical Device Pressure Ulcer	A pressure ulcer that has developed due to the presence of a medical device. Result from use of devices designed and applied for diagnostic or therapeutic purposes. Reportable under the Category of Pressure ulcer with medical device (d) as additional information (NHS I 2018)	
MASD – Moisture associated skin damage	Moisture associated skin damage- Skin damage cause by sustained moisture rather than pressure e.g. incontinence, wound exudate, perspiration. Includes intertriginous dermatitis , peri-wound & peristomal moisture-associated dermatitis	

4. Accountabilities and Responsibilities

All health care professionals should be knowledgeable of current guidelines and reporting procedures and competent with preventative interventions in order to minimize the risks to patients coming into East Sussex Healthcare NHS Trust.

- All ESHT clinical staff should attend Pressure Ulcer Prevention training on induction and as agreed in their PDR.Training accessed online via MYLearn
- All category 2, 3, 4, unstageable, DTI and Medical Related Device pressure ulcers must be reported via DatixWEB (see section 6). Cat 3, 4 pressure ulcers and DTIs will be investigated using the Pressure Ulcer Root Cause Analysis (PU RCA) form (Appendix 7)
- Early identification and on-going pressure ulcer risk assessments are the responsibility of all healthcare professionals using both clinical judgement and PURPOSE T2.

5. Procedures and Actions to Follow

5.1 Identifying Pressure Damage

All healthcare staff should be aware of the following signs, which may indicate pressure ulcer development:

- Persistent erythema (superficial reddening of the skin)
- previously identified as non-blanching erythema (i.e. red skin that does not turn white on light finger pressure applied for 3 – 5 seconds)
- Blisters
- Discoloration
- Localised warmth or coolness, soft or hard tissue usually over bone compared to adjacent skin.
- Purplish/bluish localised areas of skin
- Change in temperature
- Change in texture
- Pain may be a sign of pressure injury for some individuals.

Please be aware that in dark skin tones erythema may not be so evident

Skin Tone in Pressure Ulcers and wounds
It has been acknowledged that skin tone variance may affect presentation of early-stage pressure Ulcers (NPUAP 2018) as many signs and symptoms that clinicians have been educated to look for may present differently depending on the patient's skin type. It is important to note that lack of early identification of skin changes can mean that important signs are missed.

Dark skin tones very rarely show the blanching process we are trained to look for, and erythema may be hard to detect. The term 'redness' itself can be misleading as colour changes run the spectrum of pink, red and purple.

A skin inspection with an awareness of skin tone should be carried out as part of a full holistic assessment. This should incorporate overall health and medical history, their skin, and wound if present. Changes in skin colouration are often the main signs, comparing the affected area with unaffected skin. It is important to note that patients with all skin tones should receive an equitable level of assessment.

It is also important that touch is also used in the skin assessment and factors beyond the appearance/baseline tone of the skin are considered. The different anatomical locations are a

specific challenge as skin tone may vary in different locations. An example on the heel, noting that in patients with dark skin the soles of the feet are much lighter.

Once skin is breached, skin tone no longer affects assessment of the wound tissues due to the location of melanin, but assessment of peri-wound skin remains important.

The language and terminology can be challenging for the clinician if they find skin tone 'difficult' or 'awkward' in fear of causing offence. It is therefore important to remember in wound care the skin tone is separate from race e.g. not all people classified as black have dark skin tone.

The term skin tone should be used, it is also preferable to use terms not centring on 'light skin' as the norm or baseline. An example saying 'dark skin tone' rather than 'darker' or 'non-white'

The Wounds UK Best Practice Statement: Addressing skin tone bias in wound care - Assessing signs and symptoms in people with dark skin tones (Wounds UK 2021) is an excellent resource: Best-Practice-Statement-Addressing-skin-tone-bias-in-wound-care-assessing-signs-and-symptoms-in-people-with-dark-skin-tones.pdf (esht.nhs.uk)

Deep tissue injury is a unique form of Pressure ulcer and not always evident for several days.

The European Pressure Ulcer Advisory Panel defines a deep tissue injury as 'a pressure related injury to subcutaneous tissue under intact skin. Initially these lesions have the appearance of a deep bruise'. Deep tissue injury can result as a consequence of direct pressure and/or internal shearing. It is crucial to take an accurate patient history to determine whether deep tissue injury should be suspected

An example:

- On admission to hospital a patient may present with persistent non-blanching redness/erythema, Category 1 pressure ulceration.
- Several days later the area appears to be deteriorating despite appropriate pressure area care. On review of patient notes the patient had collapsed at home, and found by carers the next day lying on the bathroom floor, length of time on floor unclear.
- The problem with these lesions is that they may not be readily apparent on initial assessment however; these lesions may result in Category 3 or 4 pressure ulcers, even with optimum treatment.

5.2 Groups at Risk

Pressure ulcers are more likely to occur in those who are/have:

- Known or scarring from previous pressure ulcer
- Acutely ill
- Neurologically compromised
- Reduced mobility or increased movement i.e. Parkinson's
- Patient following falls or long lie or at risk of a Deep Tissue Injury
- Incontinence/moisture
- Impaired nutrition
- Patients without fully completed risk assessments, implemented care plans and evaluations
- Conditions affecting central circulation; shock, heart failure, and/or hypotension
- Conditions affecting peripheral circulation; peripheral vascular disease, arterial disease
- Sensory deficits

Example of individual vulnerability factors for pressure ulcer development

Problem	Example	Rationale
Acute Illness	Acute Infection Critically ill Trauma	Associated dehydration / pyrexia Circulatory Fracture
Specific cohorts of patients	Elderly over 70 years Paediatrics	70% of pressure ulcers occur in these age groups due to a combination of age related skin changes and increased co-morbidity factors Pressure/shear (casts/equipment)
Incontinence Pyrexia	Bladder or bowel Sweating	Damp skin from double incontinence strips acid mantle and general dampness increases friction and skin maceration
Poor nutritional status	Emaciated patients or Obesity	High association with acute and chronic illness
Vascular disease	Peripheral Arterial Disease	Decreased blood flow and micro vascular reflexes
Neurological disease	Multiple Sclerosis Stroke	Reduction in sensory perception and mobility. Postural changes and altered muscle tone
Immobility/ hyper mobility Postural changes or deformity	Parkinson's disease Curvature of spine	Reduced ability to relieve pressure Increased pressure to bony prominence
Loss of sensation (acute or chronic)	Diabetes Paraplegia Epidural	Reduced awareness of pressure
Lack of awareness Cognitive impairment	Sedatives Dementia	Reduced mobility, Reduced awareness of pressure and pain. Unable to communicate if in pain.
Debilitating disease	Rheumatoid disease, Terminal illness	Multiple associated factors
Patient and carer lack of awareness of risk	Lack of knowledge	Educate patient and care givers to risk of skin trauma and repositioning

5.3 Common Sites for Pressure Ulcers/Skin Inspection

Skin inspection should occur regularly, and the frequency determined in response to changes in the patients' condition in relation to either deterioration or recovery (NICE 2014).

The following areas of the body are considered most at risk:

- Sacrum
- Heels and toes
- Ischial tuberosity bones (seat bones) in chair bound
- Trochanters (hips)
- Other vulnerable areas include elbows, resting on chair arms
- Protruding bone in curvature of the spine
- Shoulders
- Back of the head (babies) and the frail elderly and terminally ill.

- Ears
- Any bony prominence
- MASD are defined as a redness or partial thickness skin loss involving the epidermis/dermis caused by excessive moisture to the skin they are usually located in the natal cleft and are not over a bony prominence. They are normally superficial without necrotic tissue but can be seen alongside a pressure ulcer

Also, at risk are parts of the body where there are external forces exerted by equipment or clothing, etc. e.g.

- Toes from heavy blankets
- Top of ears/noses from elastic securing Oxygen Masks and NG tubing
- I.V. Lines/catheters
- Bed ends
- Peripheral vascular disease and foot/toe deformities
- Anti-embolism stockings, elastic clothing, casts, infants are particularly vulnerable to pressure exerted by external equipment.
- Footwear in patients with Diabetes, Peripheral Vascular Disease and foot/toe deformities
- Tracheostomy and endotracheal tubes for patients in intensive care
- Skin folds in morbidly obese where pressure and moisture is involved

Heel Ulceration

- Patients with peripheral arterial disease and neuropathy are at higher risk. These are two known complications of diabetes; therefore diabetes is a major risk factor.
- Other risk factors for developing heel pressure ulcers include: immobility of lower limbs due to surgery, paresis, structural deformity, and dementia (Younes et al, 2004; Gefen, 2010) cited by Cook & Fowler 2013)
- In people with diabetes, heel ulcers are very serious and often lead to below-the-knee amputation (Younes et al, 2004)

Contact: in acute the medical equipment librarians to access heel elevation devices. In the community (not including community hospitals) authorised prescribers can access heel elevation devices via the Integrated Community Equipment Service (ICES) (Appendix 6).

- **Heels must be completely off loaded**. The use of air mattresses is **not** sufficient to prevent pressure ulcers to vulnerable heels. For category 1 - 4 heels; all patients identified as vulnerable to pressure injury despite repositioning the heels should be completely elevated off the support surface (“float the heels”).
- Heel protection devices should elevate the heel completely, without pressure to Achilles tendon and the knee should be slightly flexed to avoid popliteal vein obstruction leading to Deep Vein Thrombosis (EPUAP/NPUAP, 2018). In the community Repose foot protectors, Heel Pro Boots and Heel Pro Advance Boots are available.
- Risk assessments must be completed and documented clearly prior to using any off-loading devices.eg risk of falls
- A pillow under the calf elevates the heel from the mattress while at rest but may be unsuited to patients on movement if they have impaired cognition. Additionally, a pillow as a heel offloading device may lack consistent use as it may be removed from offloading the heels and used for other purposes.
- Slide sheets must be used to move all immobile patients so as to prevent skin injuries from shearing on movement. Slide sheets must be positioned under both the heels and sacral area when moving patients.
- Any patients that present with foot drop (dorsiflexion) must be referred to Physiotherapist for appropriate advice.

5.4 Risk Assessment

Risk assessment identifies people who are susceptible to pressure ulcer development, in order to target appropriate preventative interventions.

- Should only be used as an *aide memoire* and not replace clinical judgement (NICE, 2014)
- Provide an assessment framework for the practitioner
- EPUAP recommends every patient in any care setting should be assessed
- ESHT states that a risk assessment should be completed within 2 hours of admission in to an acute setting or on the first visit in the Community.
- Re-assessment should be undertaken if the patient is transferred to a different ward/ unit or another hospital or if the patient's condition deteriorates
- An indication of risk should be followed with an action plan and completion of the Pressure Ulcer Prevention Plan (PUPP).

PURPOSE T – Pressure Ulcer Risk primary or secondary evaluation tool (Appendix 1)

ESHT use **PURPOSE T2** as the only risk assessment tool. It is intended to identify adults at risk of pressure ulcer development. It makes a distinction between primary prevention (i.e. those at risk of pressure ulcer development) and secondary prevention (i.e. those who already have a pressure ulcer)

Alternative risk assessment tools are available for use with mothers during labour (Appendix 3) and for paediatrics (Appendix 4).

PURPOSE T2 consists of two parts:

Screening: **Screening must be completed for all patients.** To identify patient at risk or not at risk. If you tick any yellow or pink boxes this means the patient is at risk and you need to continue to complete full assessment.

Full assessment will include:

- Immobility
- PU Status (existing and previous)
- General skin status (including pain over bony prominences)
- Perfusion
- Diabetes
- Sensory perception
- Moisture
- Nutrition including BMI

6. ESHT Incident Reporting and Governance

Report all category 2, 3, 4, **unstageable**, **medical device related pressure ulcers and deep tissue injury on DatixWEB.**

See Guidelines for reporting Pressure Ulcers via Datix Guidelines-for-reporting-pressure-ulcers-via-Datix.pdf (esht.nhs.uk)

If a pressure ulcer has deteriorated from the original categorisation, please indicate this on the Pressure Ulcer page within the original Datix incident. Please tick the box to indicate the damage has deteriorated and give the date the deterioration was discovered, and the new category.

The Tissue viability team review and action Datix incident reports for all pressure ulcers, both ESHT and Non-ESHT acquired. Staff will be asked to undertake a Pressure Ulcer root cause

analysis (PU RCA) for category 3 and 4 pressure ulcers and deep tissue injury (Appendix 7) and for an 'unstageable' if clinical concerns raised and discussed with TVNs.

Staff will be asked to undertake a Clusters RCA where there are 5 of more category 2 and/or unstageable pressure ulcers reported in any one month in the inpatient areas or 9 or more in community locations (Appendix 8).

Monthly audits are completed locally (Appendix 10). A monthly Pressure Ulcer Review Group (PURG) will be held consisting of TVNs, Governance Lead Nurses, and AHPs, who will review pressure ulcer clusters and RCA, identify themes and trends and facilitate shared learning. If it is found that policy has not been followed it may be necessary to raise an incident under the Serious Incident process and forwarded to WPSS – Weekly Patient Safety Summit (Appendix 5: Pressure Ulcer reporting flow chart)

Identified themes are escalated to the Pressure Ulcer Steering Group (PUSG) and learning is discussed and disseminated by the Division

Sometimes although there are no omissions of care, patients for whatever reason choose to not follow the treatment plan that has been advised. There is guidance on how this can be documented in the *Planning Care Together policy: link*
Planning Care Together Policy

If you feel or suspect 'harm' or 'abuse' has occurred raise a Safeguarding Adults concern with Social Services, regardless of the category. To do this, email hscc@eastsussex.gov.uk – Health and Social Care Direct and copy in ESHT Safeguarding Team on esh-tr.SAAR@nhs.net. ESHT Safeguarding Team will inform the relevant management structure of concerns and initial decision making once they have been informed by ASC.

7. Skin Assessment and Preventative Interventions: aSSKINg

Research carried out on behalf of the NHS Midlands and East NHS Trust, outlines the 7 'essential care' steps to prevent pressure ulcers. We know that most pressure ulcers are avoidable (95%), and the risk of them occurring is increased by poor hydration, nutrition and a lack of individualised care.

7.1 Stop the Pressure – aSSKINg campaign

7.2 Assessing

All patients require completion of a pressure ulcer risk assessment using Purpose T2, completed within 2 hrs of admission or on 1st visit in the community
It provides an assessment framework and should be used alongside clinical judgement to develop the care plan within the pressure ulcer documentation using aSSKINg care bundle (Appendix 1).

7.3 Surface

On all in-patient beds, as a minimum requirement, a pressure redistributing foam mattress must be in place. Patients require close observations of skin changes to pressure areas and an assessment of individual risk documented with appropriate actions.

- All patients at risk and their carers should have information regarding repositioning and recognising early signs of pressure damage

Preventing Pressure Ulcers - A guide for residents, patients, carers and staff

- All patients must be risk assessed within 2 hours of admission and provided with an appropriate mattress as supported by the documented PURPOSE T2 (Appendix 1) and mattress selection flow chart (Appendix 2).

- 30-degree tilts are recommended to offload pressure to the spine for those patients at risk of, or with, pressure injuries to the sacrum or coccyx and avoids side lying onto bony hips.

- Patients should not be routinely positioned onto bone prominences or where there is non-blanching redness/ existing pressure ulcer.

- Hybrid mattress pump boxes and Alternating dynamic mattresses are distributed via the Equipment Librarians on both acute sites. These are also available out of hours at the acute sites via the porters

- District nursing teams and Crisis Response Teams also have 24 hour access to basic pressure relieving equipment via ICES Peripheral Stores that are situated in various community nurse bases. Peripheral stores can only be accessed by authorised ICES PIN holders.

Conquest Hospital
Monday – Friday Equipment Library – [redacted]
Out of Hours - Contact Porters
Eastbourne DGH
Monday – Friday Equipment Library – [redacted]
Out of Hours – Contact Porters

If no Hybrid mattress box is available, commence the Pressure Ulcer Prevention Plan using the repositioning regime. Leave a message with the Equipment Library. Check nearby areas/wards for unused spare equipment that might be available and contact the site manager who may be able to locate an appropriate mattress hybrid box.

Once patients are discharged the mattress hybrid box should be returned to equipment library, and the mattress cleaning in line with infection control policy (Appendix 9)

NB: All patients whether or not they are on a Hybrid or dynamic air mattress or sitting in a chair require repositioning and active monitoring. Frequency of repositioning should be determined for individuals based on skin observations and documented in the prevention plan documentation.

Patients in their homes will have access to pressure relieving equipment via ICES (Integrated Community Equipment Service) following appropriate risk assessment by the District Nursing Team, Occupational Therapists, Physiotherapists or other qualified personnel. Community equipment is prescribed via an online ordering system, which is only available to prescribers with a valid ICES account. Staff who regularly need to access equipment for use in the community should contact their line manager to request that an application is made for an ICES account and PIN.

Following assessment, the District Nursing team do not always provide pressure relief. If the patient is assessed as being at risk of pressure damage, due to sitting for prolonged periods of time, but no other nursing intervention is required, people are encouraged to purchase a pressure relieving cushion or mattress overlay e.g. an visco-elastic foam. These are available in-store and online from a number of stores or chemists that sell a range of mobility equipment/ independent living aids.

- In the community Millbrook Healthcare are currently the contracted service provider for ICES and are responsible for cleaning, maintaining and repairing the mattresses they supply. 24 hour emergency equipment breakdown support is available by contacting them through the local depot phone number [redacted].
- Seating/cushions are available in the Community subject to appropriate risk assessment and confirmation that an ICES eligible need has been identified
- Static mattress overlays and static and dynamic full replacement mattresses are available in the community. Prescribers should consider whether the risk of falls will increase if a mattress is changed, or a mattress overlay is added. If bed rails are also used (with or

  without bumpers) a formal risk assessment covering the risks of head, neck or chest entrapment, entanglement of limbs, and bed falls, MUST be undertaken and approved by an ICES authoriser prior to prescription, The latest version of this risk assessment can be found on Millflow (Millbrook's online ordering system). Please also refer to the MHRA guidance on Safe Use of Bed rails (updated March 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880287/FINAL_Safe_Use_of_Bed_Rails_v3.pdf

- **A fire risk assessment must be completed if dynamic airflow mattresses, overlays or cushions** (including powered hybrid mattresses) **are prescribed and a referral made to East Sussex Fire and Rescue Service for a Home Safety Visit, subject to client consent.**

- Same day or next day orders are available 7 days a week, 364 days a year (Christmas Day is the only day that these are not available). They require authorisation from an ICES Pooled Budget Manager and must be authorised by 2pm. Local procedures are in place for weekends when there are no authorisers on duty. Please note that these arrangements may be subject to change – ICES PIN holders should be informed directly by their Pooled Budget Manager of any changes in service or procedure.

- To ensure support surfaces are prioritised and used appropriately reassessment should be made of all patients on the ward daily, and in the community at each visit, with a view to stepping down patients and utilizing resources in the best interests of all patients. Risk assessment and change of mattress should be clearly documented in patient's pressure ulcer prevention plan. (PUPP).

7.3.1 Seating

European (EPUAP) and US (National Pressure Ulcer Advisory Panel) www.epuap.org and www.npuap.org (2018 combined guidelines on Pressure Ulcer Prevention and Treatment have been developed in recognition of global challenges. Seating guidelines have been launched at UK Tissue Viability Society Conference April 2009 (www.tvs.org.uk). This guidance is in line with NICE Clinical Guidance CG179 2014 which offers comprehensive evidence-based advice on the prevention and management of pressure ulcers.

Taken from: All Wales best practice Guidelines: seating and pressure ulcer 2018 All Wales-Seating and PUs FINAL(1).pdf (wwic.wales)

Factors in pressure ulcer development for the seated patients:

There are three main factors to consider in seated pressure ulcer development and the speed of this tissue damage depends on:

1. The amount of pressure applied to the tissue
2. The length of time the unrelieved pressure is applied
3. An individual's tissue tolerance to injury.

This suggests that the higher the pressure on the tissues, the shorter time it takes for the tissue to become damaged and breakdown. However, lower pressure over longer periods of time also causes ulceration as the tissue is being repeatedly damaged by pressure, and therefore loses its tolerance to injury. The effect of shear forces (which act in a direction parallel to the skin) can exacerbate the effect of pressure on the tissue, resulting in less time and pressure required for tissue breakdown (Wounds International, 2018; NPUAP et al).

Managing risk

The ability for an individual to be seated appropriately and safely has a range of health and social benefits. The potential risks of sitting should be considered alongside the potential benefits to the

individual (e.g. function, health and wellbeing), and managed as part of a multidisciplinary team approach to the individual's care.

The provision of appropriate seating should be used to manage risk and prevent pressure ulcers, however, in circumstances where pressure ulcers occur, conventional advice is that bed rest is often recommended. Despite this, there needs to be a balance with considerations of quality of life, physiological function, and additional objectives of care and further risk of pressure damage in other vulnerable areas.
Skin checks

Visual skin changes are the best indicator for identifying early pressure damage (AWTVNF, 2017). Discomfort and pain are also useful predictors to skin and tissue damage (Hall & Guyton, 2010; NPUAP et al, 2018). However, some individuals are unable to feel discomfort or communicate these symptoms, so pain and discomfort should not be relied upon as indicators or predictors of tissue damage.

Individuals should be encouraged to perform regular changes of their position. Guidance or assistance from carers may also be necessary to perform this safely and effectively.

In care settings where staff is available a full stand is recommended.

Key recommendations for repositioning when using seating equipment:

1. Pressure relief should be performed every 30 minutes lasting 30 seconds (Sonenblum et al, 2014)
2. Individuals should not remain seated for longer than a 2-hour period at any one time during the day (National Institute of Health and Care Excellence [NICE], 2014).
3. If sitting in a chair is necessary for individuals with existing pressure ulcers in the seated region, sitting should be limited to three times a day in periods of 60 minutes or less. The individual's seat, posture and sitting times should be reviewed and modified if the pressure ulcer fails to improve (NPUAP et al, 2018)

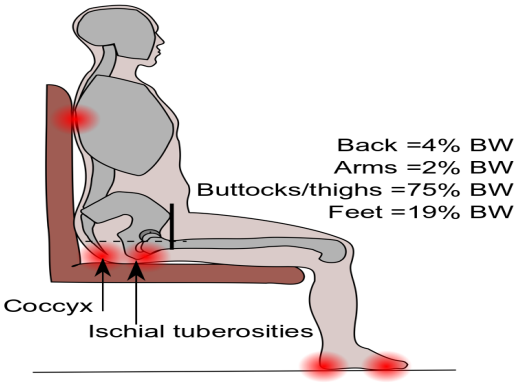
These recommendations may need to be adapted to an individual's level of risk, given that there are a number of influencing factors to consider in relation to reducing and managing the risk of pressure ulcers (such as incontinence, malnutrition and comorbidities).

Seating posture

The seating support surface should provide a safe, stable and comfortable means of supporting the forces exerted by the person. In order to remain upright, a seated person is required to maintain a stable position and counteract the forces of gravity. The ability to do this is compromised for people who are acutely ill, frail, or have a neurological impairment (Collins, 2001).

The most important consideration when seated is the position of the pelvis, as this will directly influence the position of the lower limbs, head and the spine (Ham et al, 1998). It is estimated that typically 75% of the body's weight is taken through the pelvis when an individual is sitting (Collins,

2001). The main contact between the pelvis and the seat surface is via the small, rounded ischial tuberosities (sitting bones of the pelvis).



Estimated proportion of body weight support by a seat (adapted from Collins, 2001). Red spots highlight common locations of pressure ulcers that occurs in the seated individual. BW = Body weight.

Principles of seating

An ideal posture when sitting consists of a stable pelvis where the ischial tuberosities (sitting bones in pelvis) are evenly in contact with the seat and the head is positioned above the hips and both feet are supported.

This posture may not always be possible, however, seating equipment can be provided to help individuals achieve an optimum posture within their limits and functional needs

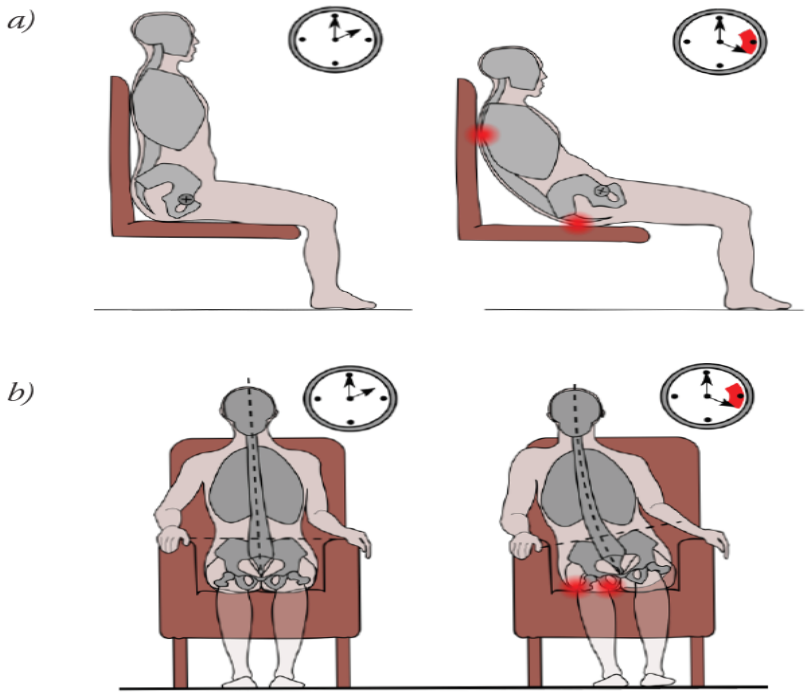


Figure 2. Seated postures that result over time "Sacral sitting" (a) and side-leaning (b) causing uneven loading through the body. The red spots identify areas at risk of developing pressure ulcers.

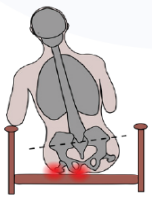
Seating Assessement

Acute in-patient areas

- If correct, the set-up of a seat or chair can have a positive impact on an individuals comfort, function and stability
- The surface of the seat is just as significant as the overall set-up; symmetry is often a goal when considering the principles of seating as this promotes an even pressure distribution.

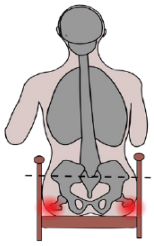
Seat width – too wide

This results in the individual leaning to one side to support themselves on the armrests. This can cause fatigue if the position is held for long periods of time without support. This leads to increased pressures to one buttock (the side they are leaning towards) and increases the risk of pressure damage to that buttock. Elbows are also at greater risk of skin breakdown when leaning to one side. Over time, postural complications such as scoliosis (spine curvature) can develop.



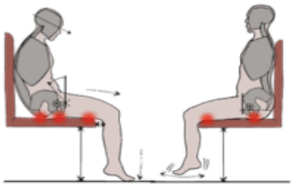
Seat width – too narrow

This can be restricting for an individual leading to a reduction in function and inability to perform pressure relieving exercises. The outer aspects of the hips are at greater risk of pressure damage. *To reduce this risk there should be a 2.5cm gap between the outer aspect of the hip and the inside of the chair's thigh supports/ armrests.*



Seat height – too high

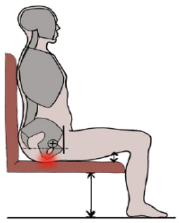
This results in the individual's feet being unsupported and the individual's weight supported only by the seat surface. This position also results in sliding in the chair in order for the individual to feel 'grounded' to provide a more stable sitting position. This increases the shear forces (acting in a direction parallel) to the buttocks increasing the risk of pressure damage, specifically at the sacrum and coccyx.



Seat height – too low

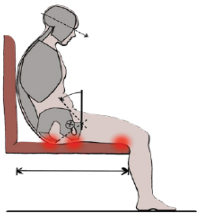
This results in high pressures going through the buttocks, specifically under the ischial tuberosities and feet.

The thighs are a good area of the body to distribute pressure, due to a larger surface area with a lack of bony prominences. The seat height should be adjusted to allow for this.



Seat depth – too deep

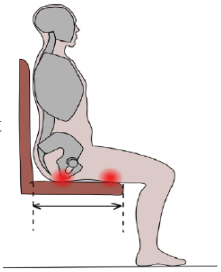
This can have an impact on a person's overall posture and pressure ulcer risk. The individual will not be able to sit all the way back, causing them to lean backwards and resulting in shear forces at the interface of the buttocks. The pressures at the sacrum and coccyx will be higher in this position due to the altered position of the pelvis. To reduce this risk, the set-up of the seat will need adjustment.



Seat depth – too shallow

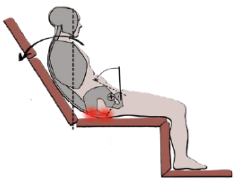
This results in a reduced contact area between the thigh and the seat surface. This will cause poor distribution of pressure throughout the buttocks and upper leg. The ischial tuberosities are at higher risk of pressure damage due to the reduced seat depth.

The set-up of the seat will need to be adjusted to reduce this risk. A distance of 2.5cm is recommended between the back of the knee and the front edge of the seat.



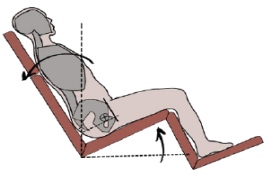
Seat-to-back angle (Recline)

The back section of a chair may be adjustable using recline, this can be beneficial for a change in position for the individual. However, an inappropriate seat-to-back angle may result in excessive pressures, specifically shear forces at the interface of the buttocks as a result of the person sliding forward.



Ground-to-seat angle (Tilt)

Some wheelchairs and specialist armchairs provide an ability to tilt the seat as shown. This assists a person to maintain a good posture and reduces the risk of pressure damage to the buttocks and feet.



Seating assessment – community setting

A seating assessment is recommended for individuals who sit for prolonged periods of time in order to assess posture and appropriately prescribe specialist armchairs or seating for wheelchairs, that will improve and maintain function for the individual

- The assessment should be person-centred.
- The individual needs to understand why specialist equipment is required, the potential impact on their lifestyle and benefits such as the prevention of pressure ulcers (Stephens & Bartley, 2018)

Specialist Seating

- Specialist Postural Seating Service is provided by Wheelchair Services for non-ambulatory clients who have complex postural requirements. Referrals are restricted to specific ICES prescribers and must be approved by ICES Panel. Referrals will not be accepted directly by Wheelchair Services for this purpose... This assessment is often in collaboration with the multidisciplinary team which may include a doctor, tissue viability nurse (NICE, 2014), and community nurses.
- Referral to wheelchair services is necessary if specialist seating is required for wheelchair users. Referrals can be made directly by all Health and Social Care professionals.
- Static air overlays are available for use on riser recliners, particularly on client's own chairs, but these should be used with caution, taking into account the effect it will have on the overall dimensions of the chair, and whether shear forces are still likely to be created due to the recline function.
- In the community ICES do not supply pressure relieving "chairs" as stock items and any requests for such a chair would have to go through the ICES panel after consulting with a Pooled Budget Manager to confirm that there is an ICES-eligible need. Prior to any request for such equipment, seeking advice and guidance via the Tissue Viability Nurse Specialist is essential.
- Specialist seating/pressure relieving cushions are available for community patients via ICES following appropriate risk assessment.

The below checklist may be used to determine if a cushion is suitable:

- ❑ Is the individual comfortable?
- ❑ Is the individual within the quoted weight limit stated by the cushion manufacturer?
- ❑ Is the cushion compatible with chair size? Will it stay in place?
- ❑ Does adding the cushion change the set-up of the chair? E.g. does it change the height of the user in the chair? Can the user still use the armrests? Does it increase the risk of entrapment?
- ❑ Is the cushion prohibiting function or activities for the individual?
- ❑ Are there any unloaded areas (not in contact) of the thighs/ buttocks?
- ❑ Is there risk of it being used incorrectly? E.g. positioned on chair in an incorrect orientation.
- ❑ Does the cushion help support the individual's posture in the chair?
- ❑ Does the cushion provide adequate pressure redistribution under the buttocks? (Check for 'bottoming-out').
- ❑ What training does the individual or their carers require?
- ❑ What maintenance does the cushion require?
- ❑ Who should be contacted if there is concern about the cushion?

7.4 Skin Inspection

The skin should be assessed on every opportunity. A thorough skin assessment should be done at least 3 times a day for in patient settings and at every visit for patients in the community. Look or feel for:

- ✓ Persistent erythema
- ✓ Non-blanching hyperaemia
- ✓ Blisters
- ✓ Localised heat, localised oedema
- ✓ Localised induration
- ✓ Ask about pain

In patients with darkly pigmented skin, observation of erythema is prevented (Bennett, 1995), resulting in the observation of early signs of tissue damage being less visible than lightly pigmented skin (Scanlon, 2004). Close examination of the skin is required to ensure that effective preventative strategies can be implemented.

This information should be recorded in the evaluation of PURPOSE T2 and on the skin assessment chart whenever assessment/checks are carried out. (Appendix 1). It is very important that you discuss patients' at risk pressure areas and what prevention care interventions are in place. This should be actioned at each handover using the SSKIN bundle as guidance.

For dry skin use emollients to moisturise and prevent cracking to optimise the skin's outer protective barrier against infection. Use patient's usual ointment or cream to avoid allergies. This should be prescribed for the individual and where possible use the patient's own prior to ordering through pharmacy or NHS Supply Chain. Refer to Dermatology for specialist skin advice. Avoid massage and rubbing skin to prevent pressure ulcers where blood vessels and fragile skin could easily be damaged (www.epuap.org. 2018)

Where anti-embolism (AES) stockings are in use for venous thromboembolism (VTE) prophylaxis for a number of patients these stockings are not appropriate and increase the risk of pressure ulcers to heels - refer to NICE CG92, (2010). Do not offer anti-embolism stockings to patients with:

- Suspected or proven peripheral arterial disease
- Peripheral arterial bypass grafting
- Peripheral neuropathy or other causes of sensory impairment
- Local condition in which stockings may cause damage, such as fragile 'tissue paper' skin
- Peripheral "pitting" oedema

For further information refer to:
Venous Thromboembolism Diagnosis, Treatment and Prevention Policy and Procedure

7.5 Keep Moving

Repositioning frequency will be determined by the individual' skin tolerance, level of activity and mobility, general medical condition, the support surface they are on and their consent.
Use 30 degree tilts and slide sheets to reduce shearing forces and friction.
Avoid positioning onto areas with pressure damage

- Slide (or glide) sheets **must** be used to assist with movement of all immobile patients and for those who have difficulty transferring to prevent shearing and potentially causing stripping, blisters or grade 2 pressure ulcers, particularly in the older persons skin and/or where oedema is present.
- Slide sheets should be available on all wards via the Equipment Library and in the community via ICES (Integrated Community Equipment Service). In-situ slide sheets are available via

ICES subject to clinical reasoning and risk assessment. Requests for specialist moving and handling equipment or turning equipment can be considered for clients in the community by making a request to ICES Panel. Requests must be clearly presented and supported by a TVN.

- Promote mobility and ensure correct footwear is worn.
- Complete falls risk assessment if indicated.

7.6 Continence/Moisture Management

- Individual assessment of patients' skin and continence needs should be undertaken as per prevention plan.
- For patients who have incontinence it is recommended to use a soap substitute with moisturiser (avoid soap which has a drying effect on skin and strips the skin of its natural protective acid mantle).
- Use absorbent and close fitting continence pads to promote skin dryness as required according to individual assessment (McCoy, 2009).
- For those with double incontinence where skin is vulnerable to excoriation protect with a wash product suitable for intact skin. If the outer layer is damaged use a barrier film. Avoid greasy barrier creams with pad use.
- For Bristol stool 6-7 and immobility refer to: Clinical Guidelines for the use of Faecal Management Systems
- On discharge from hospital, or via community teams Bowel and Bladder service referral should be completed, either via esearcher or community referral system

7.7 Nutrition/Hydration

Patients who are malnourished are highly vulnerable to developing pressure ulcers and wound/ other infections. Therefore, nutritional assessment and support is highly important and this is recognized in the pressure ulcer risk assessment tool (PURPOSE T2). Good nutrition and hydration play an essential role in keeping skin healthy. Nutrition and hydration were identified in an NHS Improvement Project in 2006 involving SSKIN (N being Nutrition), as one of the five key components of care in the prevention and treatment of pressure.

Nutritional support/ supplementation for patients in the prevention and treatment of pressure ulcers should be based on the Malnutrition Universal Screening tool (MUST), general health status, patient's preferences and expert (Dietician) judgement supporting nutritional decisions. Refer to Trust nutrition guidelines and MUST tool www.bapen.org.

Poor nutritional status is a risk factor for the development of pressure ulcers so early identification and treatment of malnutrition is crucial.

- Patient must be referred to dietician to address extra nutritional intake required for category 3 and 4 pressure ulcers, or if MUST score indicates

7.8 Giving information

Patients, their family or carers, should be made aware of their level of risk (NICE, 2014) and provided with information. A patients/carers information leaflet is available on the hospital intranet for patients, families and carers.

Understanding-the-risk-of-pressure-ulcers-when-sitting-in-adults.pdf (esht.nhs.uk)

Preventing Pressure Ulcers - A guide for residents, patients, carers and staff

8. Bariatric Equipment

If the patient's weight exceeds 30 stone (190 kg) or their body shape restricts mobility then bariatric equipment may be required, in the acute via the Equipment Library (office hours Monday to Friday), or the Site Managers (out of hours). Additional support is available from the Moving and Handling advisers.

For community plus-sized users, there is a limited selection of equipment available via ICES. However, due to the complex considerations involved in prescription of bariatric equipment, non-stock solutions may need to be sought, and a swift solution may not be possible. Where stock equipment is suitable, e.g. where the user would be within the weight range and dimensions of the stock bariatric bed, it is not usually possible to deliver on a same day basis, as a pre-delivery visit will need to be undertaken by the service provider to check access and delivery arrangements, suitability of flooring in the property, etc.

9. Care of Devices

These are fundamental to patients' treatment, safety, dignity, comfort and recovery and with constant use have limited functional life.

- Observation of mattresses and seating should determine adequate depth of padding with fist testing of foam mattresses to identify if 'bottoming out' has occurred. Covers should be inspected for any breach where fluids can enter and contaminate the underlying foam. With early inspection between patient episodes and early detection in line with MHRA (2010) a replacement mattress cover may be used rather than condemning a whole mattress, saving on purchasing and disposal costs.
- Mattresses should be cleaned after contamination from incontinence and between all patients using sporicidal wipes.

Refer to Policy for the Decontamination of Reusable Equipment and the Hybrid Mattress Decontamination Form (Appendix 10)

Policy for the Decontamination of Reusable Equipment

10. Discharge Planning

Prior to transfer of care discharging patients at high risk or with existing pressure injuries, consultation must take place between appropriate social and health care professionals, i.e. Social Services, District Nurse Team, Hospice at Home; Joint Community Rehab team; Allied Health Professional; Multi-Disciplinary Team and family/carers.

- For all patients returning home or to a Residential care home a referral via Health & Social Connect to the District Nursing Team must be completed.
- For patients returning to nursing and residential homes, or receiving care at home, ensure ESHT Transfer of Care documentation completed

On discharge of patients with complex wounds that the TVN has been involved with the ward staff should inform the acute TVN

11. Occupational Therapy Pathway

- For most complex discharges the Occupational Therapists (OT) are likely to be involved with the patient's discharge and are therefore well placed to coordinate the ordering of pressure relieving equipment to expedite smooth hospital discharge.
- Discussion between OT and ward nurses is required to assist with the decision-making process.

- If the OT's are **not** involved in the patient's discharge and the patient needs pressure relieving equipment then the ward staff need to contact the patient's District Nurse who will be able to arrange this via ICES, there may be a delay in discharge for safely.

12. Equality and Human Rights Analysis

This policy aims to treat people equally in terms of access to care whilst maintaining an individualised and personalised approach to care. It is ESHT's aim to eliminate unlawful discrimination, harassment and victimisation. People must be treated the same whether they share a protected characteristic or not. Equal opportunity for effective pressure ulcer prevention will be given to all. Patients must be treated with fairness, respect, equality, dignity and autonomy. This policy has considered but not identified any negative impacts or inequalities on any people with a protected characteristic (Appendix 11).

13. Training

Training for pressure ulcer prevention and management is not mandatory but ward matrons / clinical leads should recognise it is essential for that all clinical staff to attend. Training is available to all staff via MYLearn online resources. Ad-Hoc training can be provided by the Tissue Viability Team if requested.

14. Monitoring Compliance with this Document

Monitoring of this policy is through:

Pressure Ulcer Review Group (PURG)
Pressure Ulcer Steering Group (PUSG)
Patient Safety and Quality Group (PSQG)
Quality and Safety Committee (QSC)
Weekly Patient Safety Summit (WPSS) for those incidents deemed to be a Serious Incident

14.1 Document Monitoring Table

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Policy and Procedures	Tina Lloyd	Review of policy	Annually	Reporting quarterly to the PSQG	Please see list of leads at front of document	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Nursing	Divisional Heads of Nursing	The Excellence in Care audit tool is used monthly to assess health records regarding the compliance with Essential Care	On-going monthly basis	Reported in divisional Integrated Performance Reviews (IPR)	Ward Matrons and Community Team Leads	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Immediate escalation of risk management issues	Divisional Heads of Nursing	Spot check audits, learning from incidents	On-going	All category 3 & 4, DTI and unstageable when requested pressure ulcers are reported into PURG	Ward Matrons and Community Team Leads	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

15. References

Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones: Wounds UK 2021. Best-Practice-Statement-Addressing-skin-tone-bias-in-wound-care-assessing-signs-and-symptoms-in-people-with-dark-skin-tones.pdf (esht.nhs.uk)

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Nursing Midwifery Council (NMC) (Updated 2018) *The Code https://www.nmc.org.uk/standards/code/read-the-code-online/*

Tissue Viability Society (2009) Guidelines for Seating www.tvs.org.uk

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White, R., Ousey, K. and Hinchliffe, S. (2010) Implementing the quality accounts agenda in tissue viability *Nursing Standard* **17.** (24): 66-72.

Working together for safer services 2015: Kent Surrey Sussex Academic Health Science Network

16. Associated Documentation

East Sussex Healthcare Trust Safeguarding Adults at Risk Policy, 2019

East Sussex Healthcare Trust Clinical Guidance: *Policy for the Decontamination of Reusable Equipment*

East Sussex Healthcare Trust Clinical Guidance: *Equipment Library Policy*

East Sussex Healthcare Trust Clinical Guidance: *Clinical Guidelines for the use of Faecal Management Systems*

East Sussex Healthcare Trust: *Prevention & Control of Healthcare Associated Infection for all staff working in Primary and Community Care (Non-inpatient areas only)*

East Sussex Healthcare Trust Planning Care Together Policy Respecting Patient Choice with Advised Treatment (Adults)

NHS Improvement Pressure Ulcers: revised definition and measurement framework
https://improvement.nhs.uk/resources/pressure-ulcers-revised-definition-and-measurement-framework/

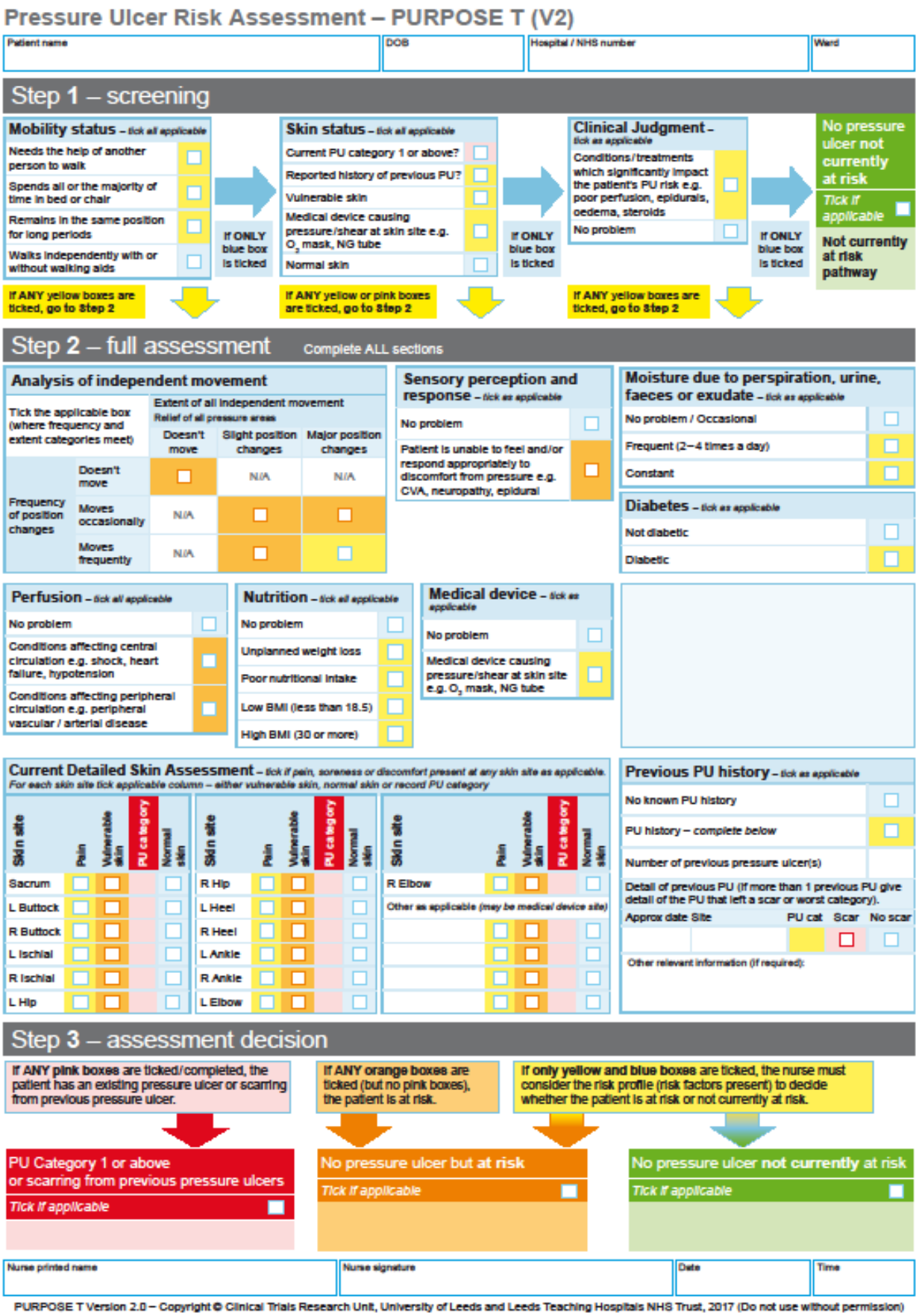
MUST Nutritional Assessment Tool www.bapen.org.uk

National management of pressure ulcers in primary and secondary care guidelines (CG29, NICE, 2005) International Pressure Ulcer Prevention and Treatment guidelines (European Pressure Ulcer Advisory Panel - EPUAP and US (National Pressure Ulcer Advisory Panel) www.epuap.org and www.npuap.org (2018)

SSKIN care bundle
http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability/sskin_care_bundle.aspx

Appendix 1

Pressure Ulcer Primary Prevention Plan Using aSSKINg Care Bundle



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

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
- 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, 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
- 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

Diabetes – tick as applicable
- Not diabetic
- Diabetic

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. O_2 mask, NG tube

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				
R Hip				
L Heel				
R Heel				
L Ankle				
R Ankle				
L Elbow				
R Elbow				
Other as applicable (may be medical device site)				

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

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

No pressure ulcer but at risk
Tick if applicable

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.

No pressure ulcer not currently at risk
Tick if applicable

Nurse printed name | Nurse signature | Date | Time

PURPOSE T Version 2.0 – Copyright © Clinical Trials Research Unit, University of Leeds and Leeds Teaching Hospitals NHS Trust, 2017 (Do not use without permission)

Tick the actions you put in place and write in comments box: **Specify interventions**

Objective	Assessment	Action/Comment
a – Assess	What **colour** is the PURPOSE T risk assessment? Red Orange Green If risk assessment is **RED**, what is the : Category Sites of damage Obtain medical photography with consent Inform Medical team /GP Complete a wound care chart as secondary intervention if pressure ulcer present	Date reassessed …….. ☐ ☐ ☐ ……. ……. Date …… Date …… Date…….
S - Surface	Does your patient require **specialist pressure redistributing equipment**? Select according to individual risk and clinical judgement. Dynamic/air mattress Static foam Hybrid (if on dynamic mode if not record as static) Do heels require offloading?	☐ Talley Plus or ……. ☐ ☐ Yes ☐ No ☐ Device used…….
S - Skin assessment	Document on **SKIN assessment chart** all pressure areas at risk and for daily checks • Assess areas at risk by pressing lightly to determine if red areas are blanching or non-blanching • Darkly pigmented skin observe for signs of discolouration , texture change , hardness or swelling • Complete skin assessment chart x 3 daily if in-patient	Tick all that apply: Heels ☐ Sacrum ☐ Coccyx ☐ Buttock ☐ Hip ☐ Ischial ☐ Other ……

Skin Assessment Chart

Date																						
Pressure Areas at Risk	AM	pm	night	AM	pm	night	AM	pm	night	AM	pm	night	AM	pm	night	AM	pm	r				
Sacrum and buttocks																						
Normal																						
Excoriation																						
Moisture Lesion (s)																						
Red and Blanching *																						
Red non-blanching * / purpleCategory 1																						
Scuff/broken blister																						
Black / discoloured / hard																						
Normal **Left Heel**																						
Red and blanching *																						
Red non-blanching * / purple Category 1																						
Scuff / broken / blister																						
Black / discoloured / hard																						
Normal **Right Heel**																						
Red and blanching *																						
Red non-blanching * / purple Category 1																						
Scuff / broken / blister																						
Black / discoloured / hard																						
Site ……																						
Normal																						
Red and blanching *																						
Red non-blanching * / purple Category 1																						
Scuff / broken / blister																						
Black / discoloured / hard																						
Site ……																						
Normal																						
Red and blanching *																						
Red non-blanching * / purple Category 1																						
Scuff / broken / blister																						
Black / discoloured / hard																						
Observers Signature & status																						

Record with a tick in the corresponding box observing all vulnerable skin sites – Write other sites. *Press lightly to determine if red areas are blanching or non-blanching but for darkly pigmented skin observe for early signs of discoloration or change in temperature, texture, hardness or swelling. Write on chart record “D” if a wound dressing is covering area of injured skin. Pressure ulcer assessment and treatment to be recorded on a wound assessment chart.

PLEASE USE ADDITIONAL SHEET FOR MULTIPLE PRESSURE ULCERS

Pressure Ulcer Prevention Repositioning Chart

K - keep moving	**Can your patient reposition themselves?** If NO, record below position changes at frequencies appropriate to individual assessment If declining repositioning assess for pain and provide verbal prevention education *.	Yes ☐ No ☐ Physiotherapy/JCR required Yes ☐ No ☐ Referral date …….

Can the patient reposition themselves? If NO, record below position changes against time at frequencies appropriate to individual assessment.

	Date Position	Date Position	Date Position	Date Position	Date Position	Date Position	Date Position
01.00							
02.00							
03.00							
04.00							
05.00							
06.00							
07.00							
08.00							
09.00							
10.00							
11.00							
12.00							
13.00							
14.00							
15.00							
16.00							
17.00							
18.00							
19.00							
20.00							
21.00							
22.00							
23.00							
24.00							

Patient's Position

L30	Left side 30 degree tilt
R30	Right side 30 degree tilt
B	Back lying
SB	Sitting up in bed
SC	Sitting in chair (limited to 2 hrly periods)
+H	Offloading heels
OW	Off ward i.e. X-ray , OT & Physio
D	Declined repositioning * assess for pain and provide PU prevention education, if continues please consider 'Planning Care Together' policy.

I - incontinence /moisture management	Is **assistance to go to the toilet required**? Is there a plan in place? Are bowel and bladder devices/pads required and correctly selected? What cleansing and moisturising products are being used If stools are type 6-7 follow infection control guidelines and consider faecal management system (in-patient only).	Yes ☐ No ☐ Plan ……. Pad size ……. Devices …….. Own ☐ Soap substitute ☒ Barrier film ☐ Other …… Is faecal management system in place? ☐
N – Nutrition & Hydration	Refer to dietician if Cat 3, 4 or deep tissue injury Does the person require assistance with eating and drinking or modified diet and fluids?	Date …… Yes ☐ No ☐
g - Giving	Patient Pressure Ulcer Prevention leaflet given and discussed with patient, relatives or/and carers.	Yes ☐ No ☐ If no please explain why……..

Personalised Care Plan to be used to record individual requirements e.g. Person cannot lay
flat due to breathlessness, has to have legs elevated.

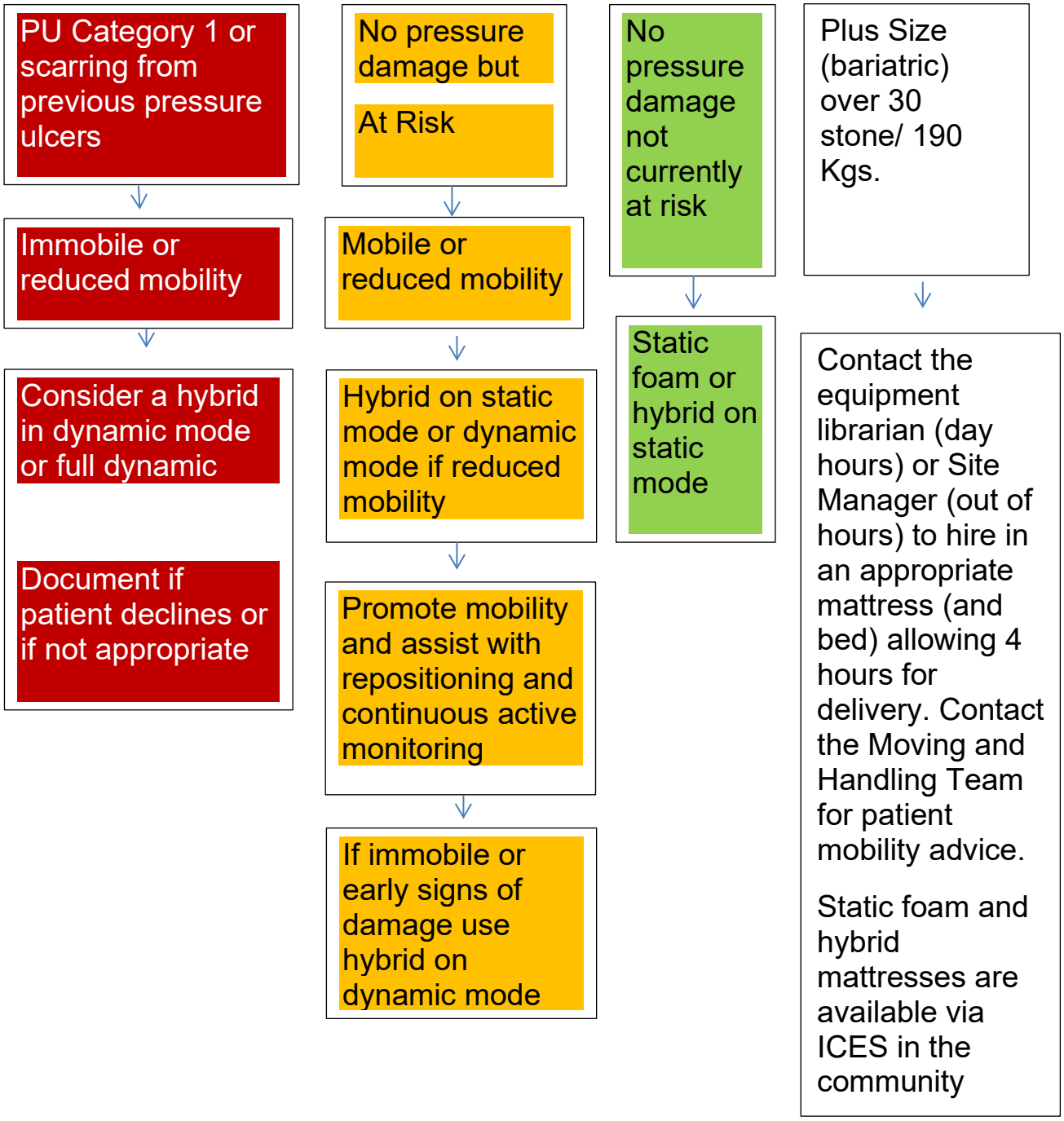
Time and Date	Signature and designation

Appendix 2

East Sussex Healthcare NHS Trust

Mattress selection flowchart for Pressure Ulcer Prevention using **PURPOSE T v2** – in-patients

Primary/Secondary prevention No risk and Plus size guidance



If mobility/nutrition/continence/general condition declines:

- Reassess using PURPOSE T
- Hybrid mattresses can be upgraded to dynamic as appropriate by requesting pump from the equipment library

Step down

- Prior to discharge as patients mobility and condition improves remove pump and place on static mode
- **Return pump to equipment library when not in dynamic mode**

Appendix 3

Maternity Pressure Ulcer Risk Assessment (Plymouth)

PAS LABEL

MATERNITY PRESSURE ULCER RISK ASSESSMENT – Complete during labour							
SKIN Condition parti cularly sacral/buttock areas		MOBILITY		MOISTURE		APPETITE	
Healthy	0	Normally unrestricted	0	Moist, clammy skin	1	Normal	0
Dry	1	Mobility restricted	3	Ruptured membranes	1	Poor during pregnancy or last month	4
Oedema	1	Bedbound by equipment monitoring	3	Neither	0		
Pyrexia (generalised↑temp)	1	Epidural- walking around	2			Poor during last 12 hrs	1
Discoloured/↑temp Grade 1	2	Epidural- sitting lying	1			Fluid only	2
Broken /blister Grade 2	3	Epidural- bedbound	0			Anorexic	3
BMI (booking weight)		NEUROLOGICAL		TISSUE MALNUTRITION		SURGERY	
BMI >19-24.9	0	Motor sensory deficit	4	Normal	0	None	0
BMI 25-29.9	1	Epidural or spinal	4	Smoker	1	Elective LSCS	2
BMI <19	1	Paraplegia	4	Anaemia	2	Emergency LSCS after labour >8 hrs	2
BMI 30-39.9	2	Peripheral neuropathy (MS)	4	Stable diabetes	1		
BMI >41	3	Analgesia (Pethidine)	2	Unstable diabetes	2	Emergency LSCS after 2100hrs	3
Significant change since booking	2	General anaesthesia	4				

Pressure ulcer risk factors= 7+ at risk 12+ High risk 17+ Very High Risk

Date/time		+2hrs	+2hrs	+2hrs	+2hrs	+2hrs	+2hrs	+2hrs	+2hrs
Skin condition									
Mobility									
Moisture									
Appetite									
BMI booking weight									
Neurological									
Tissue Malnutrition									
Surgery									
TOTAL									
Midwife name									
Signature									

Modified from Plymouth Maternity Pressure Sore Risk Assessment Tool 2012

Appendix 4

Paediatric Pressure Ulcer Risk Assessment

Ward:_____

Patient ID Sticker

- The objective of this tool is to link the risk assessment process with a clearly documented clinical decision regarding risk of pressure ulcer development
- This tool is designed to ***support*** (not replace) your clinical judgement in assessing whether the child in your care is at risk of pressure ulcer development.
- Please complete all sections and add comments if necessary.
- Please ensure that the statement of risk is completed fully and signed.

Condition of skin (please circle)						
No problems	Pressure Ulcer	Dry	Eczematous	Inflamed	Oedematous	Other wound/s:
Circle if the following are present:		Cannula	Tubing	Cast	Traction	Other medical device
Please give details: (Location/appearance and size of any areas affected)						

Please indicate level of risk for each category by marking the arrow with an **'x'**. I.E ◄——X——►

Mobility

Typical for age group	Comment:	Completely immobile

Sensation

No problems	Comment:	Cannot perceive sensation over most of body

Pain: Influence on movement

No pain	Comment:	Movement severely limited due to pain

Level of consciousness

Conscious and alert	Comment:	Unconscious. No response to painful stimuli

Continence

Urine: Typical for age group or catheterised	Comment:	Constantly wet
Faeces: Typical for age group	Comment:	Uncontrolled loose stools. Skin in almost constant contact with faeces

Skin perfusion / Oxygenation

No problems. Capillary refill<2seconds	Comment:	Severely compromised

Moving and Handling

No problems	Comment:	Consistently difficult to reposition

Head size

Typical for age group	Comment:	Significant increase in size

Statement of Risk

In my clinical judgement _____ ***is low / moderate / high**** at risk of pressure ulcer development.
(Patients name)
** Please delete as appropriate*

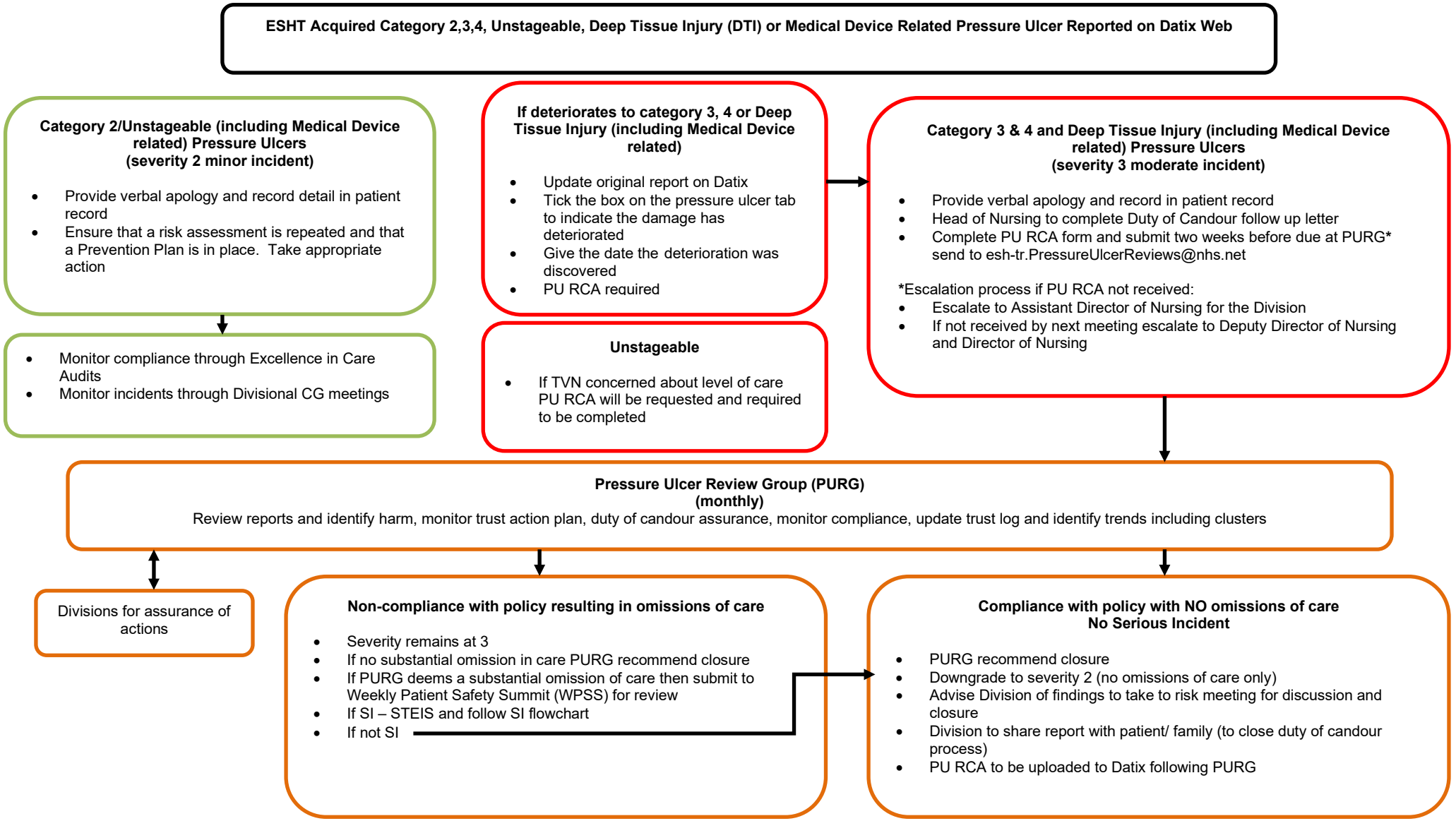
Name of assessor (BLOCK CAPITALS):	Signature:	Date:

Planned interventions: E.g. Protective dressings, turning regime, mattress, referral to CNS-Tissue Viability, etc.

(N.B. If a pressure ulcer has developed since admission please complete a clinical incident report.)

Appendix 5

ESHT Acquired Pressure Ulcer Incident Flowchart



Non ESHT Acquired Pressure Ulcer Incident Flowchart

Non ESHT Acquired Pressure Ulcer Reported on Datix Web that Deteriorates Under ESHT Care

Incidents of non-ESHT acquired PU damage reported on Datix will be reviewed by the TVN team. If appropriate the TVN team will review the patient.

Category 2, 3 or Deep Tissue Injury damage that occurred prior to admission to hospital or community caseload that deteriorates

- Clinical review to establish if deterioration due to nature of damage, ie long lie
- Update original report on Datix, DO NOT re-report
- PU RCA NOT required as damage occurred outside ESHT care
- If omissions in our care identified from clinical review, PU RCA will be required and requested by the TVN – follow *Category 3 & 4 and Deep Tissue Injury (including Medical Devices related) Pressure Ulcers (severity 3 moderate incident)* box overleaf

Appendix 6

Guidelines for the prevention of heel damage (in-patient)

- Is your patient Diabetic?
- Does your patient have PVD? Circulation problems/leg ulcers?
- Is your patient unable to reposition themselves independently?
- Is your patient unable to look after their own feet?
- Oedematous feet/legs?
- Consider whether a safe-guarding concern needs to be raised.
- **Is heel damage present?** If so have you raised a DATIX? Keep heels dry + offload until comprehensive assessment completed

NO **YES**

- Inspect skin, cleanse & hydrate skin daily + document
- Educate patient/carers to report any concerns re: condition of their feet
- Ensure correctly fitting footwear is worn
- Ensure correct positioning of patient feet whilst in bed/chair, use glidesheets to reposition
- Remove anti-embolism stockings daily (if px)
- Complete patients Pressure Ulcer Prevention Plan with your care interventions

Offload Pressure with pillows (length ways) or offloading devices. Risk assess before deciding on appropriate device e.g. risk of falls

Refer for advice

Is there any deterioration in the condition of the heels?

NO **YES**

Continue Care

- Document in pressure ulcer prevention plan

DIABETIC – Vascular nurse/ Podiatry
VASCULAR/PVD – Vascular nurse
OTHERS – TVN referral and undertake ABPI
OTHERS - TVN

On transfer to another ward or in-patient health setting

- Offloading devices go with the patient.

If patient is going home:

Patient to take home offloading device if safe. Repeat risk assessment ensuring equipment is safe to use at home or new environment.

Offloading devices are available from the Equipment Librarians at both acute sites

- Eastbourne [redacted]
- Conquest ex[redacted] or
- Ask for offloading heel device
- HEEL bootees available from TVN/Vascular Nurse

Appendix 7

East Sussex Healthcare NHS Trust

PU RCA for Category 3, 4 and Deep Tissue Pressure Ulcers Acquired within ESHT

DatixWEB No	
Incident description (from DatixWeb)	
Date reported on Datix:	
Division:	
Date of Admission:	
Time of Admission:	
Reason for Admission:	
Patient age:	
Ward:	
Was the patient admitted on the caseload or hospital with the damage?	
Where was the patient admitted from?	
Did Haemodynamic or spinal instability preclude turning or repositioning?	
Was the patient end of life?	
If yes, did this make repositioning intolerable?	
Was the patient non-concordant despite full capacity?	
Was the planning together policy implemented?	
Was patient is known to ESHT but an acute/critical event occurred which affected mobility or the ability to reposition?	

Category and location of each pressure ulcer:	Location:	Category:

BACKGROUND INFORMATION:

Background and Context:

Co-Morbidity (including current / past medical history):

Patient Factors (such as non-concordance after exploring rationale as to why patients do not chose to take advice):

Was the patient assessed for any pressure redistributing equipment?	
If yes, state type and name of equipment if it was required : Mattress Cushion/seating requirements Heel devices	
Where applicable, were the settings monitored regularly to ensure that the equipment was set at an appropriate level of pressure relief?	
Were other options considered if the original equipment was ineffective/not comfortable/not suitable for the client?	
Where applicable, if the equipment was ineffective, were different settings trialled?	

Standards for best practice (please gives dates and add extra lines as required):					
Initial PURPOSE T risk assessment	Initial Skin Inspection	PURPOSE T Care plan in place and completed	Wound assessment care plan	Request for pressure relieving equipment	Incident report form completed

If the above was not achieved within 24 hours, please provide an explanation of any factors / issues / concerns that prevented this from happening:

Comment on the quality of the assessments completed:

Plan of care:	
Is there evidence of implementation of planned care with review?	
Is there evidence of managing risk factors?	
Is there evidence of reassessment of risk status?	

If not completed, please provide an explanation:

Please comment on the quality of the plan of care:

PATIENT CARE:

Patient's Skin Care:	
How was the patient's skin cared for?	
What washing / cleaning products were used?	
Were moisturising products used?	
Was MRSA decontamination in place?	

Continence Management:

Seating and posture:	
Did the patient sit out in a chair?	
If yes, state type of chair / seating cushion and length of time patient spent sitting out of bed	
Were the essentials of seating recorded e.g. can user's feet touch floor, is the seat too deep, etc.	
Is the person in a recliner chair; has shear been considered	

Moving and Handling:

	Yes	No	Partially
Was the M&H assessment completed?			

	Yes	No	If yes, please give details?
Was any M&H equipment required?			

	Yes	No	Please state any unavailable equipment:
Was all the required M&H equipment available?			

	Yes	No	Sometimes
Was the required M&H equipment being used?			

Did the patient spend any period of time on a trolley?	
If yes: length of time, type of trolley, indication patient was at risk?	

Nutrition and Hydration:

Which teams were involved in the patients management:
Other referrals made (i.e. Healogics, podiatry, physio, OT, vascular department):

Duty of Candour - Being Open:	
Date of DoC conversation documented in notes (all categories of PU):	
Date of DoC letter (cat3/4 & DTI only):	
If DoC not completed, please state why not:	

Any Additional Information:

Please state the overall impression of the cause of the pressure ulcers and whether more could have been done to prevent it?

FINDINGS:

Care and Service Delivery Problems:

Contributory Factors:

Root Causes:

Lessons Learned:

CONCLUSIONS:

Recommendations (copy to action plan below):

Arrangements for shared learning:

Job Title:	
Report date completed:	

To be completed following PURG	
Date discussed at PURG:	
Recommendation of group:	

ACTION PLAN

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures:	Evidence of Progress and Completion:	Link to Trust Wide Action Plan (if appropriate):

Appendix 8

East Sussex Healthcare NHS Trust

Concise RCA – Cat 2/Unstageable Pressure Ulcer Clusters

Ward/community team:	Date to return form to Senior CEF:	Date to be presented at PURG:	Name of staff presenting at PURG:

DatixWeb number	Site of damage	Category (2 or US)	Has incident been opened and reviewed by handler?	Was the PURPOSE T and care plan in place?	Is there any learning or area for improvement?	Community Patients: What level of care package is in place?	Summary / comments (please give a short description of the damage)
WEB							
WEB							
WEB							
WEB							
WEB							
WEB							

Causes, themes or trends identified from above:

What actions or changes to practice are to be undertaken? Please include staff member/team responsible.

How will this information be shared with your team?

What assurance can you give to PURG changes to practice will be implemented?

Name of person(s) completing this report:	Signature	Date

Appendix 9

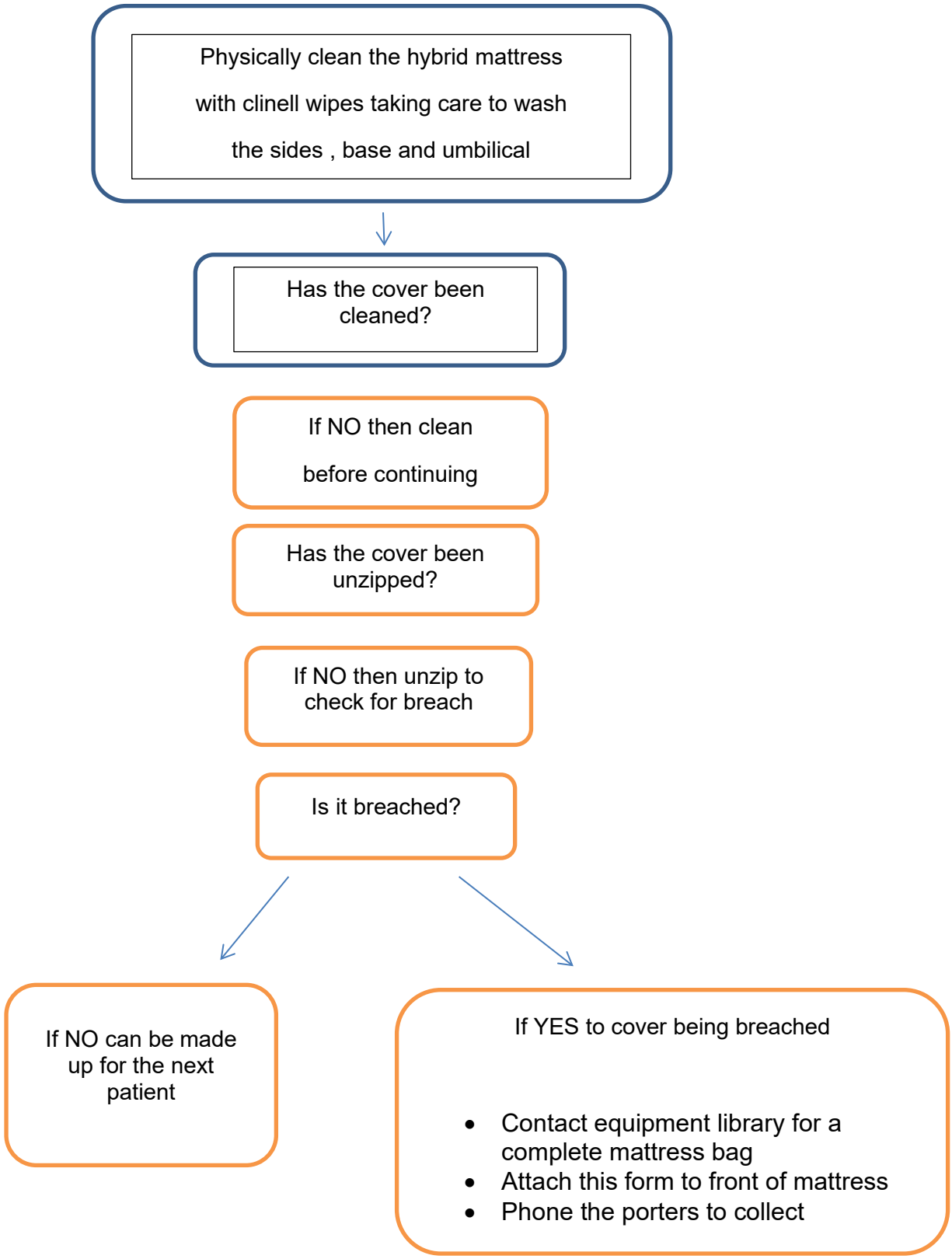
East Sussex Healthcare NHS Trust

Hybrid Mattress Decontamination Form

Date:
Ward:
Form completed by:

	Yes	No
Has the cover been cleaned		
Has the cover been unzipped		
Is the cover breached		
If YES place the mattress (not mains box) in a bag available from the equipment library EDGH: [redacted] Conquest : [redacted]		
Attach this form to front of the mattress		
Phone the porters to collect breached mattress		
Contact equipment library to collect mains box (in hours) EDGH: [redacted] Conquest : [redacted]		

Please note no mattress will be accepted without this form attached and in correct bag available from the equipment library Please contact the porters when ready for collection


Physically clean the hybrid mattress
with clinell wipes taking care to wash
the sides , base and umbilical
Has the cover been cleaned?
If NO then clean
before continuing
Has the cover been unzipped?
If NO then unzip to check for breach
Is it breached?
If NO can be made up for the next patient
If YES to cover being breached
Contact equipment library for a complete mattress bag
Attach this form to front of mattress
Phone the porters to collect

* Primary EIC Measure ** Secondary EIC Measure	**ESSENTIAL CARE STANDARDS (ADULTS) - PRESSURE ULCER PREVENTION AND MANAGEMENT** Evidence base: NICE QS 89, NICE CG 179, ESHT Guidelines for the Prevention of Pressure Ulcers; NHSI Recommendations 2018
	Element: Environment
E1	The electric profiling beds are clean and do not have stickers, sticky tape, surgical tape on the bed frame.
E2	The pressure relieving equipment (including seating) is used appropriately to meet individual patient needs.
E3	Mattress covers are opened up after every patient discharge to check for signs of permeability/damage.
E4	Staff are aware that an investigation (RCA) needs completing for ESHT acquired category 3 & 4 pressure ulcers.
E5	Patients identified at risk will be provided with a glide sheet which must be used when moving patients.
	Element: Care
C1 **	Within 2 hours of admission to your clinical area or 1st visit in the community, an appropriate pressure ulcer risk assessment tool (PURPOSE T2) is completed and updated weekly or if condition has changed.
C2	If the patient has a red or orange PURPOSE T2 risk assessment, there must be a documented care plan evidencing that the patient has been repositioned regularly, what equipment in use and what are the care interventions.
C3	Patients that are deemed at high risk of tissue damage are given the Trust's 'Pressure Ulcer Prevention – A guide for patients and carers' patient information leaflet'.
C4 **	A Wound Chart is completed if a pressure ulcer is present.
C5	Section 6 – Elimination/Continence section of the Nursing Assessment within the Integrated Patient Document (IPD) is complete.
C6	Continence products and barrier creams are available to safely manage patients with incontinence to protect the skin.
	Element: Leadership
L1 *	Staff are aware that all new pressure damage of category 2 and above pressure ulcers are recorded on DatixWEB.
L2	The Nurse in Charge/Team Leader is aware that PURPOSE T2 actions are completed as per assessment need (includes equipment in place where required).
L3	Any new continence issues identified are acted upon and documented in the health record – actions to include correct fitting of Fixpants if continence absorbent products are required.
L4	Staff are aware that all Category 3 and 4 pressure ulcers must be photographed by medical illustration within 24 working hours or by community nursing when discovered.
L5	The clinical area has a proactive Nutrition Link person.
L6	Link person audits practice and generates action plans to ensure improvements in practice.

Excellence in Care Metrics

Standard Title	Standard No	Primary Measure	Primary Responses	Secondary Measure	Secondary Responses
Pressure Ulcers	L1	Number of Category 2 ESHT acquired PUs	Data source DatixWEB		
	L1	Number of Category 3 ESHT acquired PUs	Data source DatixWEB		
	L1	Number of Category 4 ESHT acquired PUs	Data source DatixWEB		
	C1			Purpose T2 initial assessment and care plan completed within 2 hours of admission to your clinical area/first visit	Yes, No, NA
	C1			PURPOSE T2 assessment is reviewed weekly or where their has been a change in condition or location/service	Yes, No, NA
	C4			Wound chart is completed if PU present	Yes, No, NA
	E5			Patients at risk have a slide sheet that is used to move them	Yes, No, NA

Appendix 11
Equality and Diversity

East Sussex Healthcare NHS Trust

Due Regard, Equality & Human Rights Analysis

Title of document: Pressure Ulcer Prevention and Management Policy
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc. All clinical staff and patients under ESHT care
Please include a brief summary of intended outcome: That all staff are aware of the principles of the aSSKINg care bundle in order to prevent pressure ulceration of the skin for patients while in our care. It is also the intended outcome that staff are aware of how to report incidents of pressure ulceration via the DatixWEB system and where required through the Safeguarding Adults Alert process.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of: (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)**		
	• **Age**	No	
	• **Disability (including carers)**	No	
	• **Race**	Yes	Update of Section 5.1 to incorporate new Wounds UK best practice statement which refers to 'Addressing skin tone bias in wound care' Best-Practice-Statement-Addressing-skin-tone-bias-in-wound-care-assessing-signs-and-symptoms-in-people-with-dark-skin-tones.pdf (esht.nhs.uk)
	• **Religion & Belief**	No	
	• **Gender**	No	
	• **Sexual Orientation (LGBT)**	No	
	• **Pregnancy & Maternity**	No	
	• **Marriage & Civil Partnership**	No	
	• **Gender Reassignment**	No	
	• **Other Identified Groups**	No	

2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	Early pressure damage may not be as easily recognised in patients with dark skin tones. Resource document available and included in this Policy Best-Practice-Statement-Addressing-skin-tone-bias-in-wound-care-assessing-signs-and-symptoms-in-people-with-dark-skin-tones.pdf (esht.nhs.uk)
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	Inconsistent approach to pressure ulcer prevention and management and potential for patient harm if policy not implemented	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	Applies to all ESHT patients	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	Applies to all ESHT patients	
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	Applies to all ESHT patients	
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	Applies to all ESHT patients	
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	**(Ensure you comment and link to main policy with page/paragraph number)**	
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	No	