East Sussex Healthcare
NHS Trust

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FOI REF: 25/575

24th October 2025

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 requesting information regarding pressure ulcer prevention held by the trust:

1. A copy of the current guidelines and protocols for pressure ulcer prevention (please include policy dates and version numbers)

Please see attached Pressure Ulcer Prevention and Management Policy.

Please note that it is East Sussex Healthcare NHS Trust's FOI policy to only provided the names of staff that are grade 8a or above. Therefore, names below this criterion have been redacted from the attached document.

We have also redacted the names of the Trust's IT Systems and in doing so we are applying a Section 31(1)(a).

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- *NHS England — London » Synnovis Ransomware Cyber-Attack*
- *NHS England confirm patient data stolen in cyber attack - BBC News*

- *Merseyside: Three more hospitals hit by cyber attack - BBC News*

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term ‘’public interest’’ does not refer to the private or commercial interests of a requestor; its meaning is for the “public good”. The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the FOI portal whatdotheyknow.com who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can be heavily fined should it be found to have acted in a negligent way which results in a personal data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the Network and Information Systems (NIS) Regulations Act 2018 can be found here – The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK

Your request asks for a specific guideline which details the names of our IT Systems which, for the reasons explained above, would be inappropriate to release

into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust's IT systems and infrastructure. The Trust's capacity to defend itself from such acts relates to the purposes of crime prevention and therefore section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the names of the Trust's IT Systems to be exempt under section 31(1)(a) [*law enforcement*] of the FOIA and this information is therefore being withheld. The full wording of section 31 can be found here: Freedom of Information Act 2000

Section 31 is a *qualified* exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- Organisations must do more to combat the growing threat of cyber attacks | ICO

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:

> *"Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.*
>
> *Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August 2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating."*

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is 'of interest' to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust's transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust's IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services
- Public interest in maintaining the integrity and security of the Trust's systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take

a cautious approach to requests of this nature and appreciate your understanding in this matter.

It is important to note that the Trust and its commissioning partners are required to follow very specific rules when procuring equipment or services. Information about procurement and tendering can be found on our website – Governing documents, incorporating: Standing Orders, Standing Financial Instructions, Scheme of Delegation.

To contact the Procurement Service, please email - esht.procurement@nhs.net.

2. Hospital-acquired pressure ulcer statistics from 2015-2024, including the following where available:

Clarification was sought with regard to what definition is to be applied for hospital acquired pressure ulcers, is this for acute hospitals only or for community beds only? Confirmation was received as follows:

For hospital-acquired pressure ulcers, we would like to use the definition applied by your organization, and we are interested in data from all settings where pressure ulcers are recorded, including both acute hospitals and community beds, if available.

a. Annual numbers by severity grade (Category/Stage 1-4)

b. Anonymized aggregate data by ward type/specialty

c. Any trend analysis or benchmarking data

East Sussex Healthcare NHS Trust does not centrally record the information requested as above. To enable the Trust to provide this information would require us to extract and analyse the requested information which we estimate would take in excess of 5 working days. We are therefore applying Section 12(1) to this part of your request.

Section 12(1) of the Act allows a public authority to refuse to comply with a request for information if the authority estimates that the cost of compliance would exceed the 'appropriate limit', as defined by the Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations 2004 (the Regulations). These state that this cost limit is £450 for public authorities which are not part of central government or the armed forces. The costs are calculated at £25 per hour per person regardless of the rate of pay, which means that the limit will be exceeded if the work involved would exceed 18 hours. The Trust estimates that the cost of complying with this request would significantly exceed the above limit.

3. Legal costs and compensation payments related to pressure ulcer incidents from 2015-2024:

a. Total annual legal fees paid to external solicitors

b. Settlement/compensation amounts (aggregated figures)

c. Number of claims by year

The information requested above is collated by NHS Resolution and is available via their website which can be accessed using the link below:

Annual statistics - NHS Resolution

For further information, Freedom of Information requests to NHS Resolution can be made via the link below:

https://resolution.nhs.uk/freedom-of-information/

4. Effectiveness metrics including:

a. Audit results for pressure ulcer prevention initiatives

Not applicable.

b. Staff training completion rates for pressure ulcer prevention

Pressure Ulcer Prevention Training/Wound Care Training requirements have been changed in the last two months and now include additional modules which is reflected in the compliance rates below.

Pressure Ulcer Prevention	52.5%
Wound Care Tier 1	32.4%

c. Equipment expenditure (pressure-relieving mattresses, cushions)

Clarification was sought with regard to the time period and confirmation was received that you require the following:

The period for this request is 2015–2024.

£1,377,207

Note: part of this spend is from 2016-2025 and some is from 2018-2025

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:	253
Legacy ID Number	1108
Version:	V5
Ratified by:	Clinical Documentation and Policy Group/ IGM
Date ratified:	01 July 2025
Name of author and title:	[redacted] Tissue Viability Team Lead [redacted] Tissue Viability Nurse
Date originally written:	October 2011
Date current version was completed:	December 2024
Name of responsible committee/individual:	Pressure Ulcer Steering Group (PUSG)
Date issued:	28TH July 2025
Review date:	01st December 2027
Target audience:	All ESHT 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)	National Wound Care Strategy Programme, NHS England NWCSP – Pressure Ulcer Recommendations and Clinical Pathway October 2023 NICE Quality Standards 89, Pressure Ulcers 2015 NICE Clinical Guidelines 179, Pressure Ulcers prevention and management 2014 Patient Safety incident Response Framework (PSIRF) NHS England Updated July 2024
Associated Documents:	Duty of Candour Planning care together policy

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

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V4	April 2022	[redacted] Nicola James, [redacted]	Update in line with revised governance process	Updates to all sections and additional appendices added.
V5	2024	[redacted]	Updated in line with National wound care strategy programme (NWCSP) recommendations and PSIRF	Full review and rewriting of guidance

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	Sept 2024
Pressure Ulcer Steering Group	Multidisciplinary	Nov 2024
[redacted]	Senior Clinical Effectiveness Facilitator	Oct 2024
Tina Lloyd	Assistant Director of nursing	Oct 2024
Alison Newby	Head of Midwifery	Oct 2024
Documentation/Ratification group	ESHT	TBC

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

Purpose of these guidelines
The purpose of these guidelines is to provide clear advice to ESHT health and care practitioners, departmental leads, and service managers about the fundamentals of evidence-informed care for people who have or are at risk of developing pressure ulcers. Implementing these recommendations will achieve better individual outcomes and more effective use of health and social care resources. The guidelines outline a pathway of care that promotes early risk identification and preventative care, enabling fast access to evidence-informed therapeutic interventions, with escalation of treatment or service provision for people requiring more complex care.

Background

The national wound care strategy programme (NWCSP) seeks to prevent pressure damage and improve healing of pressure ulcers.

Pressure ulcers are in the top ten harms in the NHS in England. Analysis of causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers (NWCSP, May 2024)

2. Rationale

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

3. Scope

All healthcare professionals who have direct patient contact and/or make decisions concerning treatment of individuals who are in ESHT care.

4. Accountabilities and Responsibilities

All health care professionals should have access to current guidelines and reporting procedures and put in place advised preventative interventions in order to minimize the risks to patients receiving care within ESHT.

- All ESHT patient facing clinical staff to complete pressure ulcer prevention, Purpose T and skin care modules via MyLearn Home - elearning for healthcare (e-lfh.org.uk)

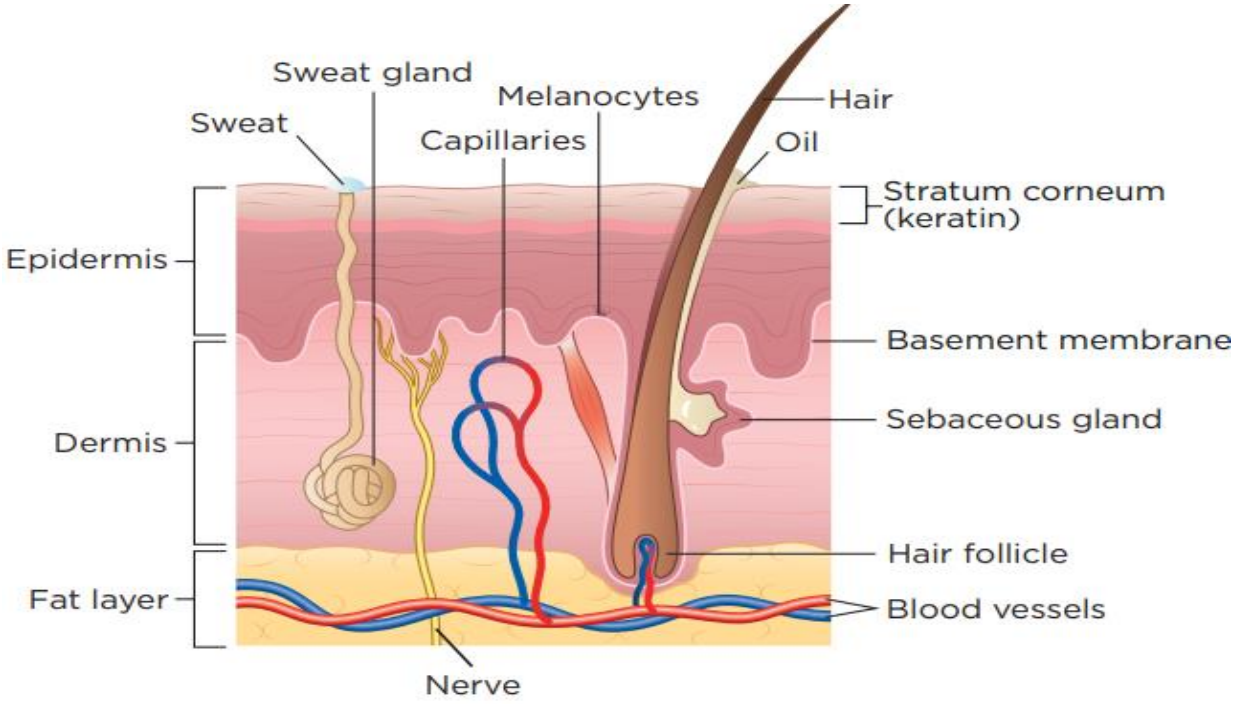
- Early identification and on-going pressure ulcer risk assessments are the responsibility of all healthcare professionals using both clinical judgement and using the pressure ulcer risk assessment tool Purpose T V2.

5. Understanding healthy skin

Skin is a complex organ. An average square inch of skin contains 650 sweat glands, 20 blood vessels, and more than 1000 nerve endings. Despite being just a few millimetres thick, the skin makes up around one-seventh of a person's body weight.

Approximately half of the UK population will experience a skin condition in any given year, so it is important for health professionals to understand the skin structure in order to identify problems as they arise.

Key functions of the skin include protection, regulation of body temperature, excretion, sensation, and vitamin D synthesis. The skin has three basic layers – the epidermis, the dermis and subcutaneous tissue.



Epidermis
The epidermis is the outermost layer. It is a waterproof barrier that gives skin its tone. Its main roles are:

- to make new skin cells
- to give the skin its colour
- to protect the body from the external environment

Humans shed around 50 million skin cells each day. The outermost parts of the epidermis consist of 20-30 layers of dead cells.

The epidermis constantly makes new cells in its lower layers. Over the course of around four weeks, these cells make their way to the surface, become hard, and replace the shedding, dead cells.

Keratinocytes are the most common type of cells within the epidermis. Their job is to act as a barrier against bacteria, parasites, fungi, viruses, heat, ultraviolet (UV) rays, and water loss.

The epidermis contains no blood vessels. The colour of the skin comes from a pigment called melanin, which is produced by melanocytes. These are found in the epidermis and protect the skin from UV rays. A thin sheet of fibres known as the basement membrane divides the epidermis and the dermis.

Dermis
The dermis serves as connective tissue and protects the body from stress and strain. It also gives the skin strength and elasticity. In addition, its main roles are:

- to make sweat and oil
- to provide sensation and blood to the skin
- to grow hair

The reason the dermis can perform these functions is that it houses the hair follicles, blood vessels, and lymphatic vessels. It is home to a number of glands, including sweat glands and sebaceous glands, which produce sebum, an oil that lubricates and waterproofs hair.

The dermis also contains the receptors that detect pressure (mechanoreceptors), pain (nociceptors), and heat (thermoreceptors).

If the dermis stretches a lot, such as during pregnancy, then it can tear. This will show up later as stretch marks.

Subcutaneous tissue
The deepest layer of the skin is the subcutaneous tissue, the hypodermis, or the subcutis. It is not technically part of the skin, but it helps attach the skin to the bones and muscles. Subcutaneous tissue also provides the skin with nerves and blood supply.

The hypodermis contains mostly fat, connective tissue, and elastin, which is an elastic protein that helps tissues return to their normal shape after stretching. The high levels of fat help insulate the body and prevent a person from losing too much heat. The fat layer also acts as protection, padding the bones and muscles.

Skin colour
Skin colour is a phenotype, which is an observable trait like eye colour or height. The colour results from different types of a pigment called melanin.

Melanin's primary role is to protect the skin from damaging UV light from the sun, which can cause skin cancer. When skin is exposed to UV light, melanocytes start producing melanin, creating a suntan.

People who have more pheomelanin will have paler skin. People who have more eumelanin will have darker skin. Research on evolution shows that historically, populations closer to the equator evolved to have darker skin for better protection again the sun's UV rays. On the other hand, people in colder climates evolved lighter skin to better maintain Vitamin D.

6. Patient Assessment

The NWCSP (2024) recommends red flag risk factors to consider:

‘Red Flag’ risk factors are:

- Skin over bony prominence that is hot, discoloured and swollen or the patient complains of new onset or change/increase in pain or numbness, and this does not resolve when the patient is repositioned.
- An existing pressure ulcer or scar from a pressure ulcer or other wound in an at-risk area,
- The individual has had a long lie (fall and being on the floor) of more than 1 hour.
- Rapid deterioration in the clinical condition of the patient.
- There is a medical device in prolonged contact with the skin

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

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

Purpose T is the nationally recommended pressure ulcer risk assessment tool. It is intended to identify adults at risk of pressure ulcer development. ESHT community paediatric team also use this tool. 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 2).

All children should be assessed within 2 hours of arrival in the acute setting and a body map is completed with individual care plan. If risks are identified during assessment this signposts to completion of a risk assessment.

PURPOSE T2 consists of two parts:

Screening: **Initial screening must be completed for all patients.**

- Community this should be during the first face to face visit.
- Inpatient settings this should take place within 6 hours of decision to admit.
- Mothers during labour

To identify patient at risk or not at risk.

Within ESHT Purpose T is an adapted version of Purpose T completed via the electronic patient record system in the acute and in-patient bedded areas. Community teams complete an adapted version via [redacted]

Full assessment will include:

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

Screening and skin assessment should be based on a combination of skin temperature, skin texture, patient reports of pain and discomfort as well as visual skin assessment. This is particularly important when considering skin of dark colour and tone.

Outcome of Risk Assessment
The outcome of the risk assessment and diagnosis will aid in identifying which of the following pathways should be followed:

- No pressure ulcer, not currently at risk, or
- No pressure ulcer but at risk, or
- PU category 1 or above or scarring from previous pressure ulcers.

Reassessment
- Reassess if there is a change in the patients' condition, circumstances or environment.
- This indicate that reassessment should take place on ward transfer as new environment
- For those whose condition is stable, review at regular intervals. Every 7 days for inpatients. Every 4 weeks for community patients.
- If the person identifying someone in need of a full pressure risk assessment does not have the appropriate knowledge / skills to carry out that risk assessment, they should provide immediate preventative care that reduces any identified risk and refer to a suitably trained professional.

6.1 Skin assessment and preventative intervention

Use the aSSKINg Framework to plan and deliver individualised care that addresses the individual's presenting risk factors for anyone identified at risk of pressure ulceration.

	Action	Best Practice
	Assess Risk	• Undertake screening and risk assessment using Purpose T screening and risk assessment tool • Consider 'red flags' • Raise any safeguarding concerns • Complete clinical incident report if damage present and not known to be previously reported • Document risk status • Further actions in the framework need to be followed if: No pressure ulcer but at risk *or* PU category 1 or above or scarring from previous pressure ulcer.
S	**Skin assessment**	• Carry out a comprehensive skin assessment including skin under devices • Consider colour, temperature and texture of skin • Ask the patient to identify any areas that are painful, itchy, uncomfortable or numb • Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation • Consider patient risk factors and comorbidities that might contribute to impaired skin integrity
S	**Surface**	• Consider the use of pressure redistributing devices in conjunction with regular patient repositioning in supporting patient with or at risk of pressure damage,

		including mattresses, heel devices, chair cushion, specialist seating • Utilise repositioning devices such as removable slide sheets, in situ slide sheets, tilting systems • Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development • Remember the use of a pressure redistributing mattress (Appendix 3) is not sufficient for vulnerable heels • Identify moving and handling risks, and consider whether specialist assessment required i.e., seating • Check placement and positioning of medical devices in contact with skin • Refer to Allied health professionals (AHPs) to support discharge planning for patients at risk • Bariatric equipment needs to be considered • Request equipment from relevant supplier*
K	**Keep Moving**	• Complete moving and handling assessment and falls risk • Consider level of mobility and risk factors associated with reduced mobility or hyper mobility • Identify and manage the cause, where possible, of any change in mobility level • Reposition using 30-degree tilt • Refer to AHP to support optimising mobility • Support patient with engaging with AHPs where appropriate • Individuals should not remain seated for longer than a 2-hour period at any one time during the day (NICE, 2014) • If patient has existing pressure damage and sitting in a chair is necessary, sitting should be limited to 60 minutes or less, 3 times per day (EPUAP, 2019)
I	**Incontinence and moisture management**	• Identify the cause of moisture associated skin damage (MASD) i.e., incontinence, sweat, saliva, stoma effluent, wound leakage • Address the cause of MASD • Acknowledge how increased moisture increases the risk of skin damage caused by shear and friction • Implement appropriate prevention and management strategies • Refer to bowel and bladder service (community only) • Support skin cleansing and application of barrier products if necessary • Use continence pads to promote skin dryness as required according to individual assessment, and as per manufacturer guidelines • For Bristol stool 6-7 and immobility refer to: Clinical Guidelines for the use of Faecal Management Systems (Acute only)

N	**Nutrition**	• Utilise relevant tools and documentation which may include MUST, MUAC, BMI, food charts, fluid charts, food diaries • Collaborate to deliver appropriate care with relevant members of the multidisciplinary team (MDT): Dietician, Speech and language therapist, AHP • Consider practical elements of maintaining nutrition and hydration including portion sizing, food texture, access and ease of use of implements and good dentition • Refer patients with confirmed category 3 or 4 pressure ulcer to dietician, or if MUST score indicates
g	**Give information**	• Communicate proposed interventions with patient, family, carers and within the MDT, and document • Implement the most appropriate communication approach to increase awareness and facilitate concordance and engagement with pressure ulcer prevention strategies • Consider patient capacity, concordance and engagement and use of associated policies to be applied: Planning Care Together Policy • Gain appropriate consent when capturing and sharing clinical images • Patient/carer 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

* Conquest Hospital
Monday – Friday Equipment Library – Ext 772000
Out of Hours - Contact Porters

* Eastbourne DGH
Monday – Friday Equipment Library – Ext 733573
Out of Hours – Contact Porters

Community equipment supply guidance – See Appendix 8

6.2 Diagnosis

Primary diagnosis of pressure damage:

Document pressure ulceration accurately, avoiding confusion with similar but different aetiologies (e.g., moisture associated skin damage (MASD), skin tears, tapes burns.

Differential diagnosis of pressure ulceration should consider:

- Is there evidence of pressure or shear?

- Is the wound or skin damage over a bony prominence or under a device?
- Are the edges distinct?

Categorisation of pressure damage

Healthy Skin
Healthy skin may demonstrate reactive hyperaemia i.e. transient redness (or alterations in skin tone in darker skin) for example, where the arms or legs have been crossed. This should resolve after a short period of time (20 to 30 minutes). To distinguish between reactive hyperaemia and a category 1 pressure ulcer (also known as non-blanching erythema) the blanche test should be used.

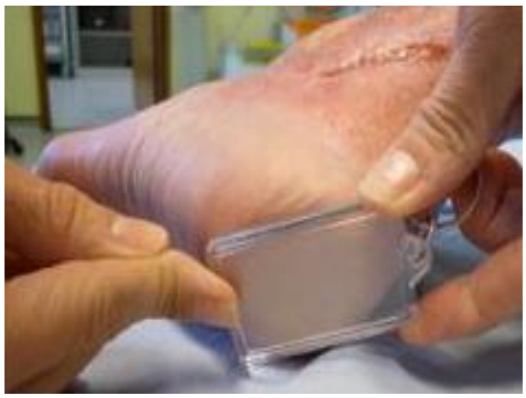
To test for non-blanching erythema (remember this may not be helpful in some skin tones):

- Using the finger pressure method, a finger is pressed on the erythema for three seconds and blanching is assessed following removal of the finger on intact skin.
- Using the transparent disk method, a transparent disk is used to apply pressure equally over an area of erythema and blanching can be observed underneath the disk during its application.

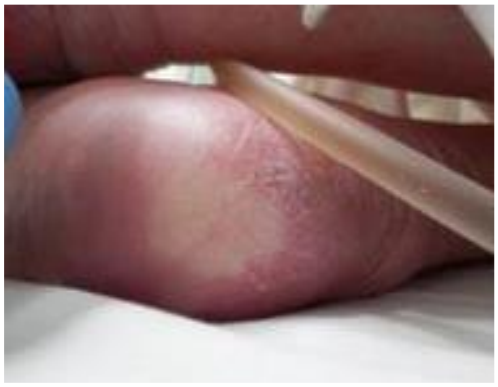
If there is difficulty in differentiating between a Category 1 pressure ulcer and reactive hyperaemia, relieve the pressure area for 30 minutes, then repeat the skin inspection.

Large skin areas require several measurement points.

(EPUAP, 2019)



Healthy skin showing reactive hyperaemia tone, note (normal redness) in white skin. the catheter tube.



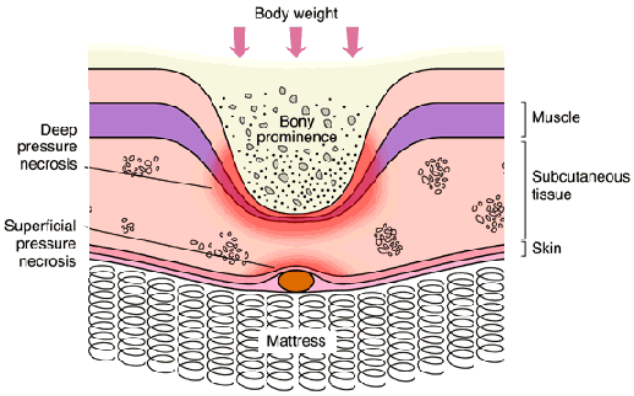
Healthy skin showing blanching in a dark skin risk of a Medical Device Related PU from

Further discussion about skin tone : [Best-Practice-Statement-Addressing-skin-tone-bias-in-wound-care-assessing-signs-and-symptoms-in-people-with-dark-skin-tones.pdf (esht.nhs.uk)]

Definition of a 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

A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (EPUAP, 2019).

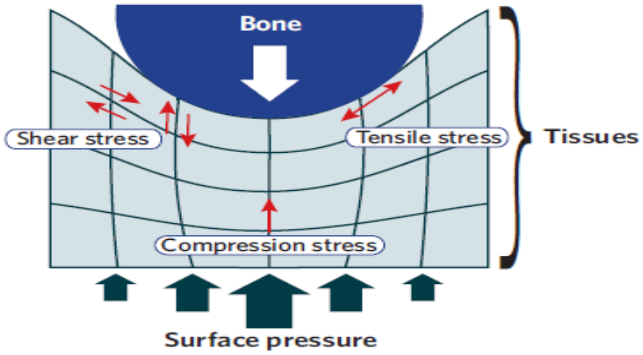
Pressure



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

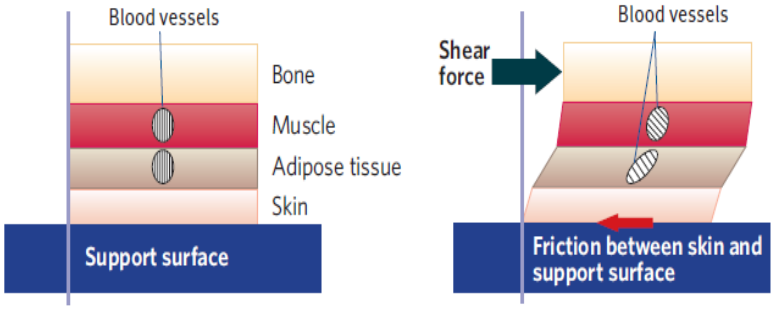
Shear



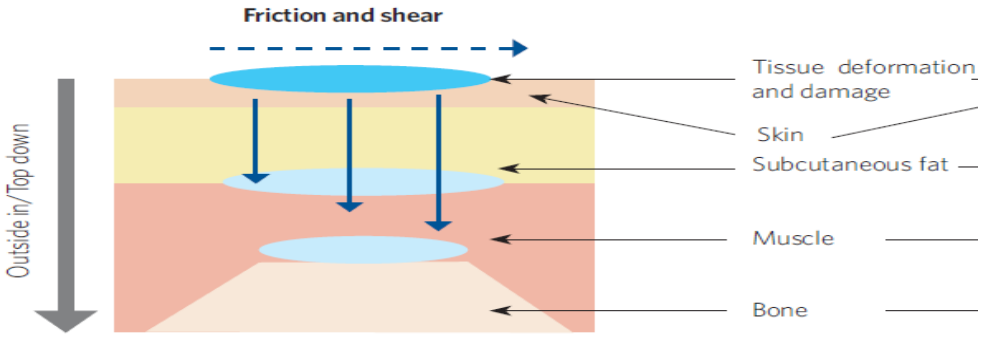
Pressure applied to the skin over a bony prominence causes compression, deformation and distortion of the underlying soft tissues and produces shear within and between tissue layers

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



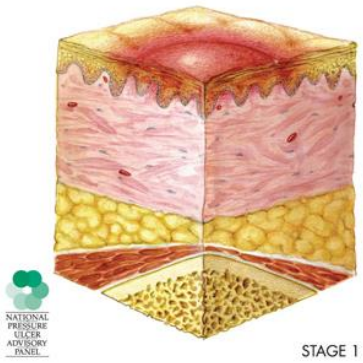
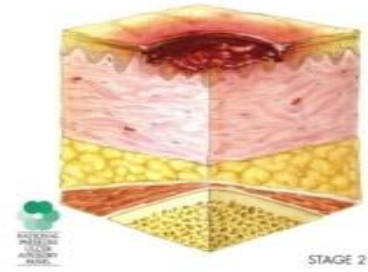
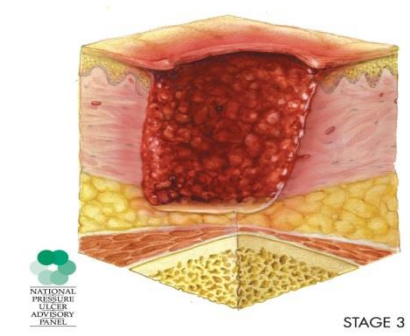
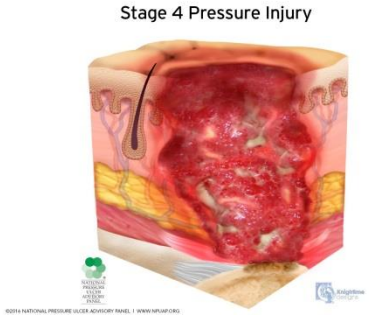
6.3 Categories

All pressure ulcers should be categorised 1 - 4 according to European consensus on classification (2019) www.epuap.org. The following categories are taken directly from the International Pressure Ulcer Guidelines ((EPUAP 2019) and reflect the National Wound Care Strategy Programme Pressure Ulcer Recommendations and Clinical Pathway 2024 NWCSP-Pressure-Ulcer-Categorisation-Tool-2024.pdf (nationalwoundcarestrategy.net)

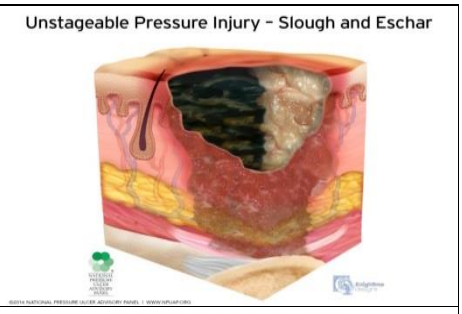
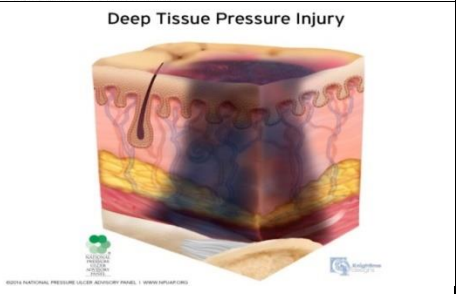
Minor amendments have been made to the language to reflect new understanding of assessing patients with dark skin tones – NWCSP amendments are described below in italics.

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 2019). ESHT do not report category 1 pressure ulcers

Category 1	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 *The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin tones, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss. The patient may report pain or discomfort over the area.*	
Category 2	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. *Pressure ulcer with abrasion, blister, partial-thickness skin loss involving epidermis and or dermis.*	
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. *Pressure ulcer with full-thickness skin loss involving damage or necrosis of subcutaneous tissue. Undermining and tunnelling may occur, fascia, muscle, tendon, ligament, cartilage and or bone are not exposed.*	
Category 4	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. *Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage and/or bone in the ulcer. There is an increased risk of osteomyelitis.*	

Current ESHT guidance maintains the use of ‘unstageable’ as pressure ulcers, so should still be used within our reporting and documentation systems.
Deep tissue injury DTI is reported as an injury and may resolve or evolve. If this evolves then a new incident is raised for the category of the damage.

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.	

Deep tissue injury is a unique form of skin damage 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 discolouration. 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 injuries is that they may not be readily apparent on initial assessment; however, these injuries may result in a Category 3 or 4 pressure ulcer, even with optimum treatment.

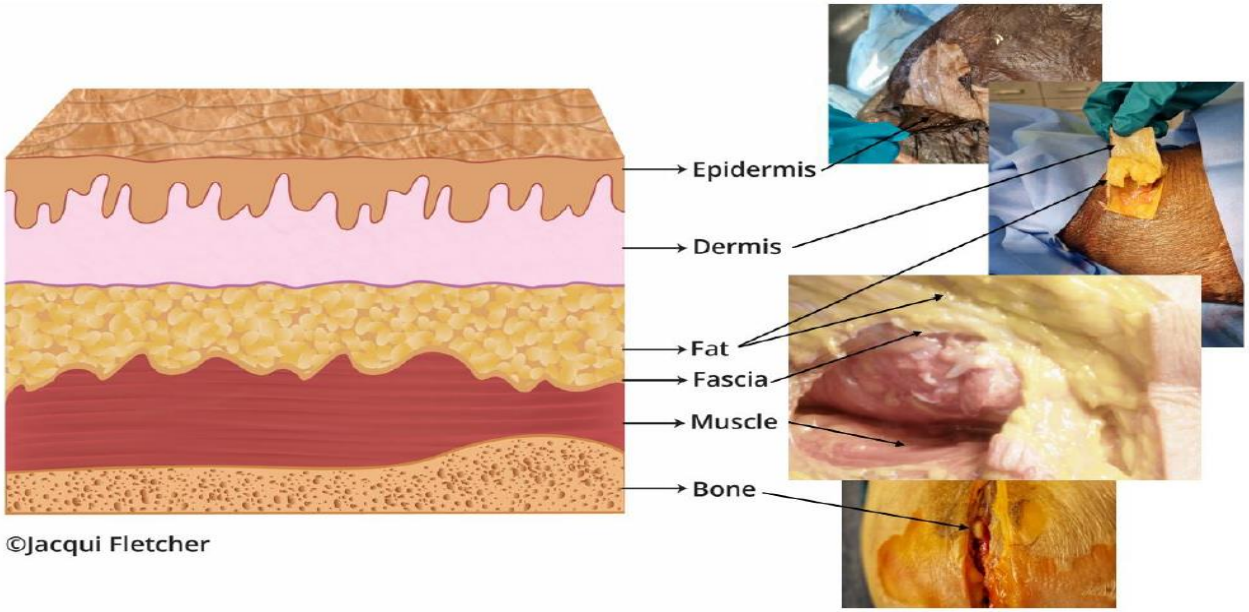
Medical Device Pressure Ulcer	A pressure ulcer that has developed due to the presence of a medical device. Result from use of devices designed and applied for diagnostic or therapeutic purposes. Reportable under the Category of Pressure ulcer with medical device (d) as additional information (NHS I 2018) If the pressure ulcer is on a mucosal membrane, it should not be categorised but recorded as soft tissue damage	

Identifying Pressure Damage
When categorising a pressure ulcer, it is important to consider not just what you see but also what you feel, and what you know about anatomy. For example, understanding what the layers of the skin are, the location of bony prominences, and whether there is muscle or fat over the bony structure. These factors all contribute to our understanding regarding the depth of the

tissues, and layers which might be implicated in damage. In particular, a good understanding of the skin is important.

A good understanding of anatomy will help to understand what structures should be present beneath the skin e.g. subcutaneous fat, fascia, muscle, bone, cartilage, tendon, and this information should also inform the allocation of the correct category. An example would be there is no muscle over the calcaneus, there is just subcutaneous fat between the skin and the bone, therefore it is more likely that a deep pressure ulcer at this site will be a category 4.

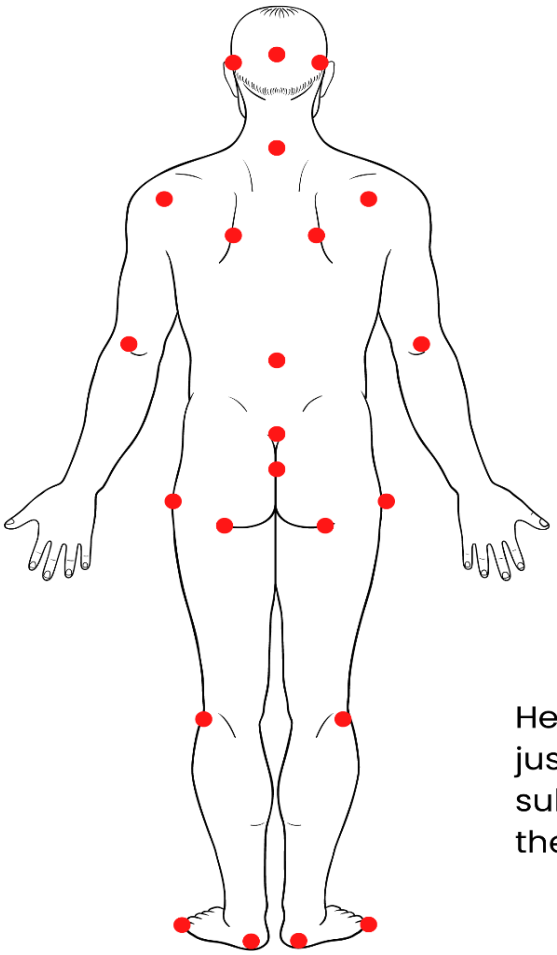
Dark Skin Tones
When assessing patients with dark skin tones, additional consideration should be given to detecting the early signs of skin damage, which are often overlooked as erythema may not be clearly visible. Where visible signs of damage are diminished, more focus should be placed on temperature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



6.4 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:



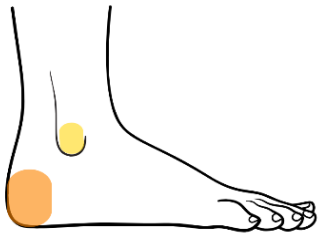
Elbows, the bone is very close to the skin surface no muscle present beneath the skin.

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

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

Red dots indicate common sites for pressure damage to occur

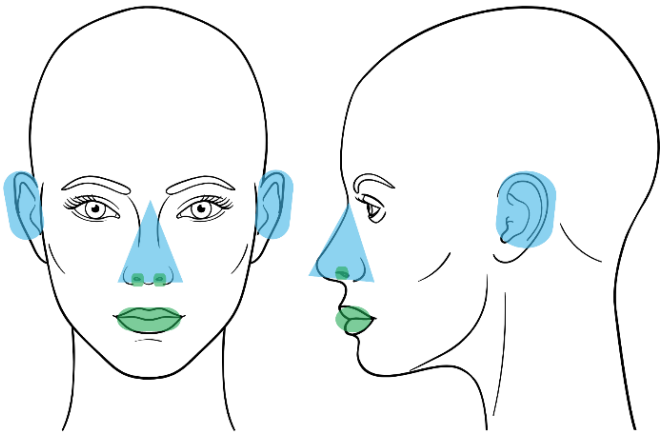
Patients with arterial disease and diabetes are at greater risk of complications from heel pressure ulcers, therefore should be referred to podiatry and/or vascular team (Appendix 6)



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

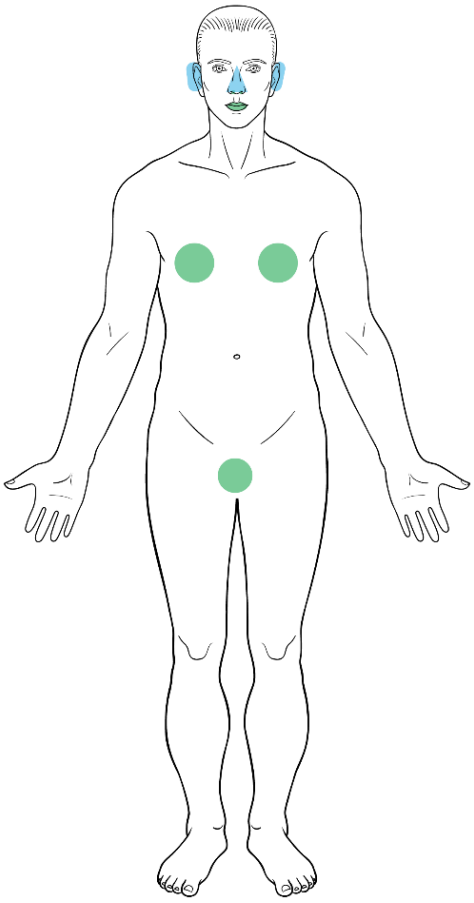
In contrast the posterior element of the calcaneus bone is covered only by subcutaneous tissue and skin *(in orange)*.

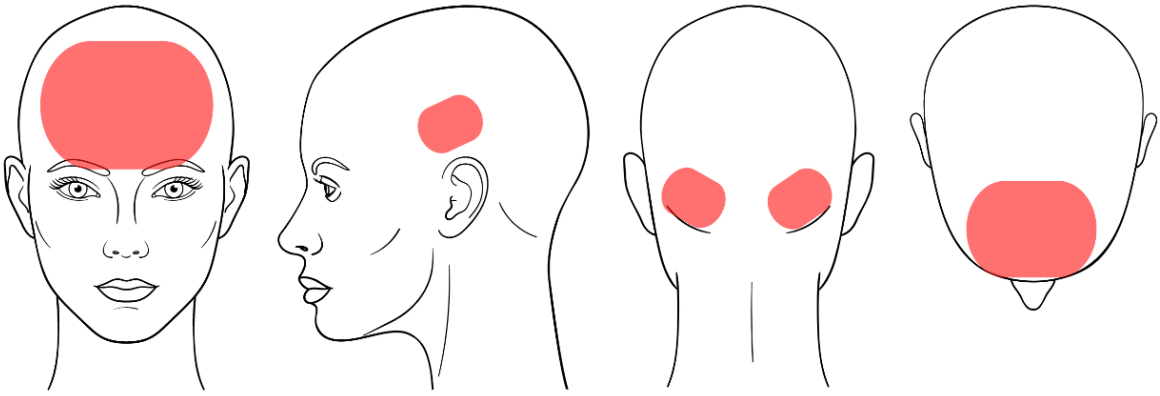
Other sites of pressure injury to consider:



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

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





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

7. ESHT Incident Reporting and Governance (Appendix 4)

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

See Guidelines for reporting Pressure Ulcers via [redacted] Guidelines-for-reporting-pressure-ulcers-via-[redacted].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 [redacted] incident. Please tick the box to indicate the damage has deteriorated and give the date the deterioration was discovered, and the new category.

A Pressure Ulcer After Action Review (AAR) (Appendix 5) will be required for ESHT acquired category 3 and 4 pressure ulcers and for an 'unstageable' if clinical concerns raised and discussed with TVNs.

Where there are 5 of more category 2 and/or unstageable pressure ulcers reported in any one month in an inpatient area, or 9 or more in a community location, a cluster AAR report (Appendix 6) will be required.

These AAR's are to be presented at the Pressure Ulcer Review Group (PURG) meeting, which is held the fourth Tuesday of every month. The PURG consists of TVNs, Governance, Lead Nurses, and AHPs who review the presented pressure ulcer clusters and AARs to identify themes and trends and facilitate shared learning. A monthly report is sent to the Weekly Patient Safety Summit detailing outstanding AARs.

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

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: 01540_P.pdf

If you feel or suspect 'harm' or 'abuse' has occurred raise a Safeguarding Adults Concern with Adult Social Care (ASC), 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.

8. 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 Pressure ulcer passport and Transfer of Care documentation completed via esearcher, printed, copied and sent with patient.

- Medical photographer images should be requested pre discharge for accuracy and ability to share

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

- 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.

- If the OTs are not involved in the patient's discharge and the patient needs pressure relieving equipment, then the ward staff need to complete a HSCC referral to the community nursing team to arrange appropriate equipment prior to discharge. There may be a delay in discharge to enusre all equipment in place to facilitator safe discharge.

9. 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 9).

10. Training

Training is available to all staff via MYLearn online resources

All ESHT patient facing clinical staff to complete pressure ulcer prevention and skin care modules via MyLearn: Home - elearning for healthcare (e-lfh.org.uk)

ESHT Community and ward based nursing staff will complete wound care tier 1 training as set out by the NWCSP and consist of 8 short modules. Further details on the ESHT MYlLearn

11. 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)

12. 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
Nursing	Divisional Heads of Nursing	The Excellence in Care audit tool is used monthly to assess health records Appendix 7	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, and unstageable when requested pressure ulcers are reported into Pressure Ulcer Review Group	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.

13. 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)

European Pressure Ulcer Advisory Panel *Classification of Grading* www.epuap.org

European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) (2014) International Guidelines on Pressure Ulcer Prevention www.epuap.orgwww.npuap.org – 2018

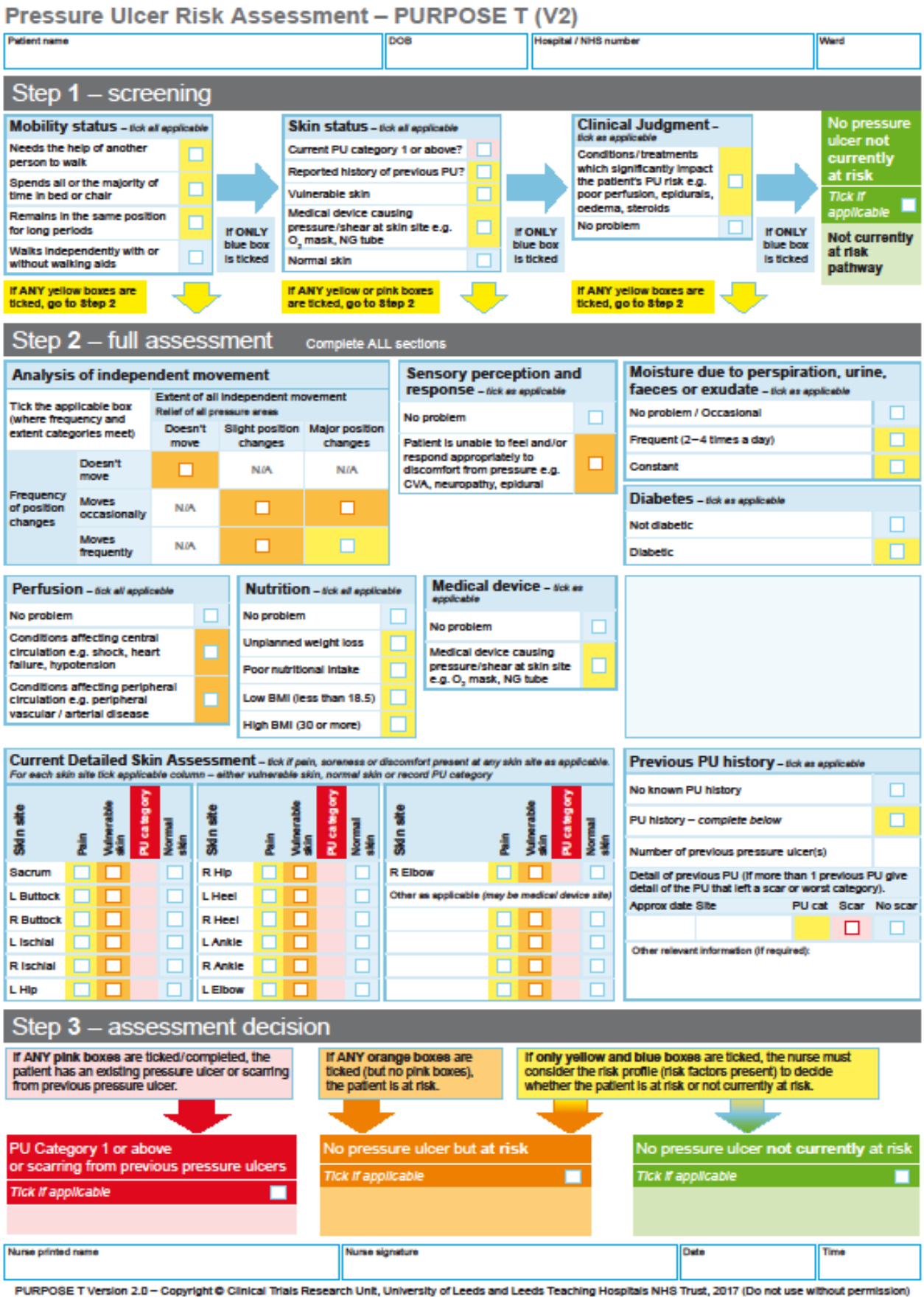
National Wound Care Strategy Programme: Pressure Ulcer Categorisation Tool. June 2024

National Wound Care Strategy Programme: Pressure Ulcer Recommendations and Clinical Pathway. October 2023

NHS England Patient Safety Incident Response Framework (PSIRF) , updated July 2024

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

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	☐	☐		☐

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

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

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.

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

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

- PU Category 1 or above or scarring from previous pressure ulcers — Tick if applicable ☐
- No pressure ulcer but at risk — Tick if applicable ☐
- No pressure ulcer not currently at risk — Tick if applicable ☐

Nurse printed name	Nurse signature	Date	Time

Appendix 2 – 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									

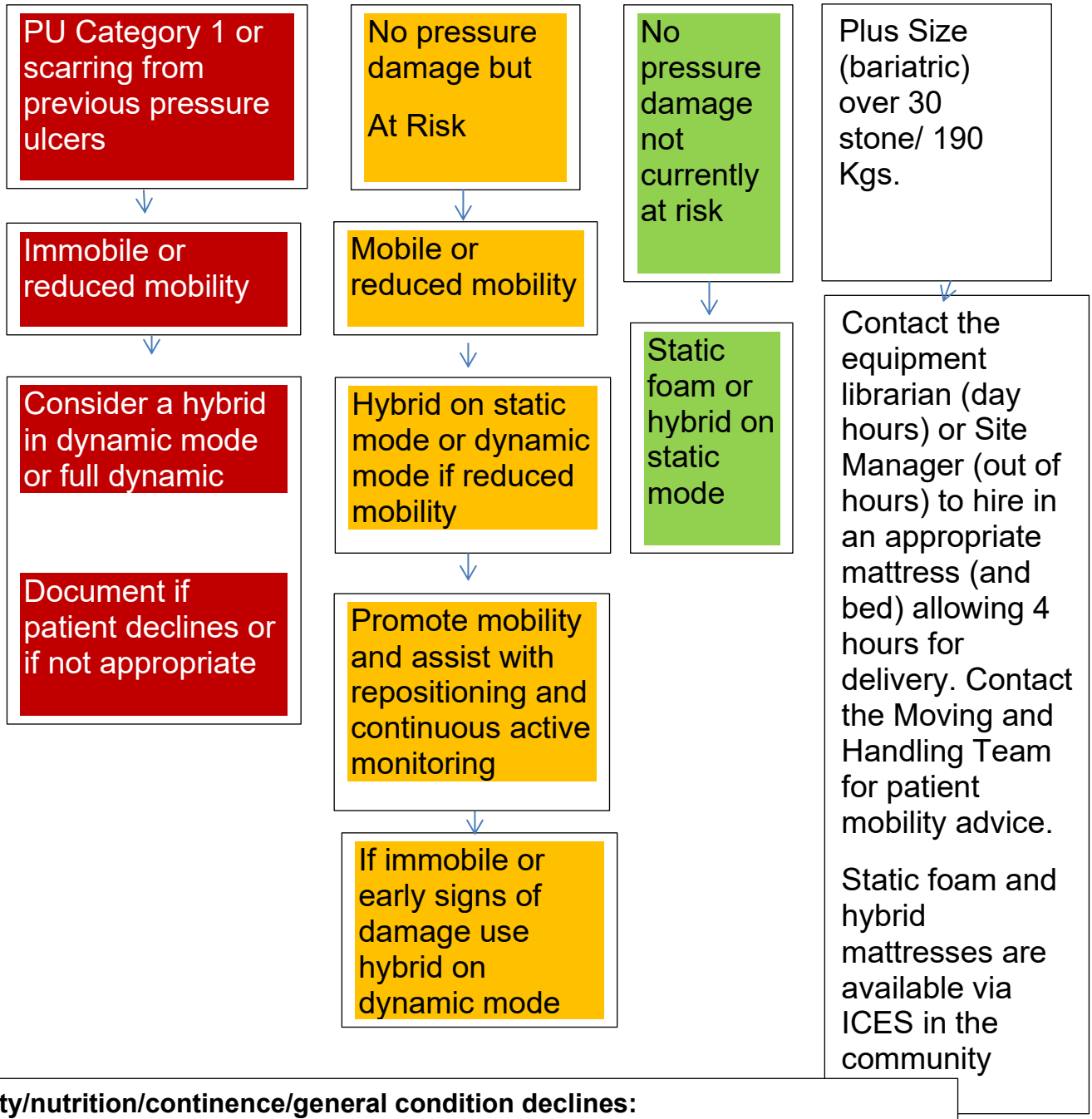
Modified from Plymouth Maternity Pressure Sore Risk Assessment Tool 2012

East Sussex Healthcare NHS Trust

Appendix 3

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:

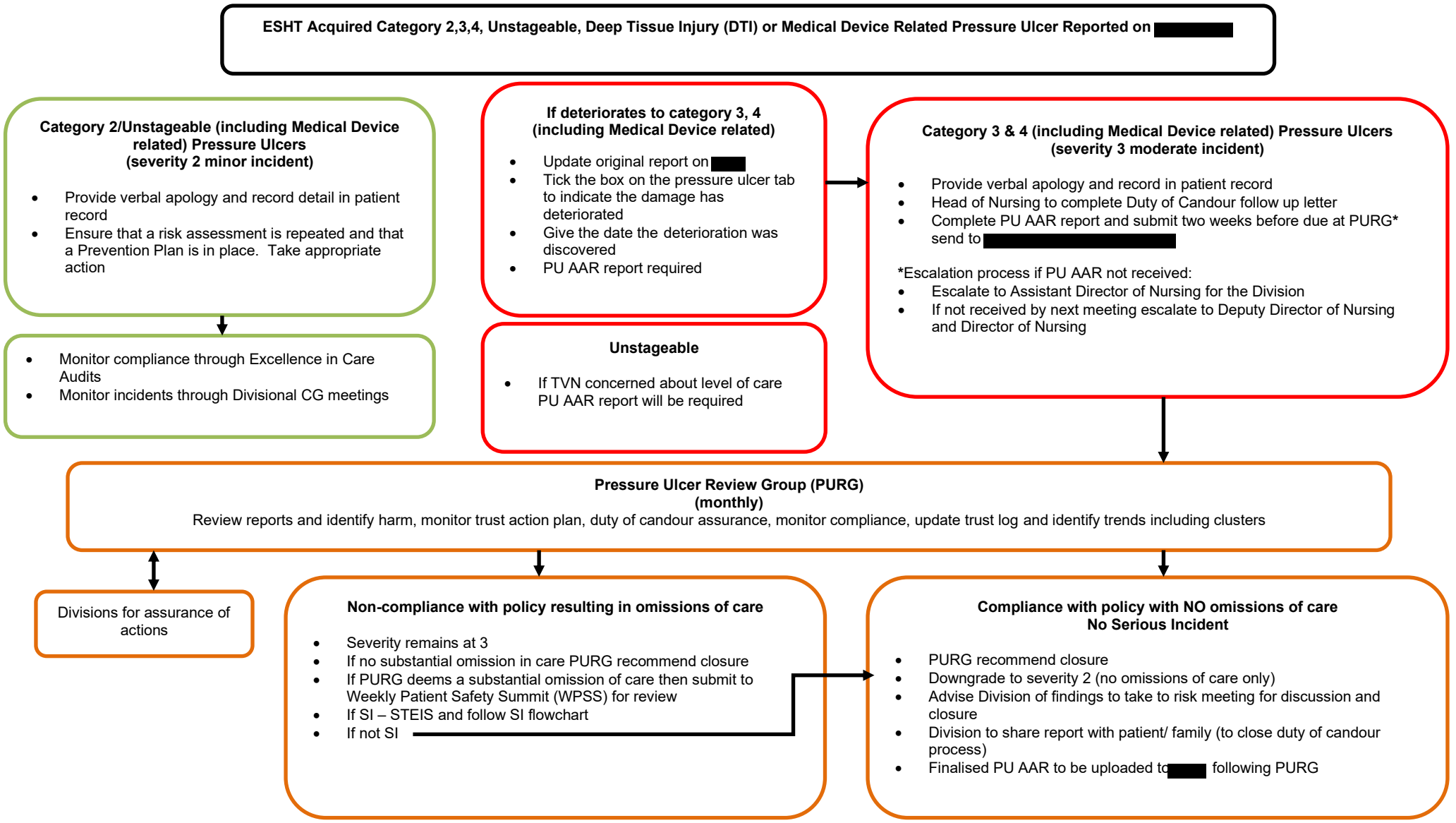
- Reassess using PURPOSE T
- Hybrid mattresses can be upgraded to dynamic as appropriate by requesting pump from the equipment library

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 4

ESHT Acquired Pressure Ulcer Incident Flowchart



Non ESHT Acquired Pressure Ulcer Incident Flowchart

Non ESHT Acquired Pressure Ulcer Reported on [redacted] that Deteriorates Under ESHT Care

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

Category 2, 3 and 4 that occurred prior to admission to hospital or community caseload that deteriorates

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

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Appendix 5

Pressure Ulcer After Action Review (AAR)

The Event: ESHT acquired pressure ulcer		
[redacted] **WEB Number:**		**Details and Date of pressure Ulcer Incident:** *(As per description on [redacted])*
Division & Specialty:		
Ward Name:		**Confirmed PU category and site(s):**
Incident Date & Time:		

Points to consider:

- Planning Care Together / Safeguarding considered
- Mental capacity assessment completed
- MUST / Purpose T assessments completed in a timely manner
- Ensure the investigation page on the [redacted] form has been completed before the AAR meeting
- Note frailty score / EoL
- Has there been a reported previous pressure damage or moisture associated skin damage?
- Other care provider involved?

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Expected Outcome: *(what was expected)*	**The Event/Outcome:** *(what happened)*
• ESHT staff undertake a pressure risk assessment as per ESHT pressure ulcer prevention and management policy, and to provide care and interventions in line with recommendations within the policy. • To minimise risk of harm to ESHT patients	
Analysis: *(What was the difference in the expectation and event)*	**Any other contributory factors to note:**
Safety Actions: *(Immediate actions taken)*	**Learning and Areas for improvement:** *(Wider themes/areas for improvement)*

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Quality Improvement Action Plan:					
	Learning and Areas for improvement	**Specific actions** (SMART- specific, measurable, achievable/action-related, relevant, time-specific)	**Responsible person** (Include job titles)	**By when**	**Measuring effectiveness** (What will be measured? How will it be measured? How often will it be measured? How will we know if the change represents an improvement?)
1.					
2.					
3.					
4.					

PU AAR Date:	
Facilitated by:	
Verbal Duty Of Candour (DOC) Completion Date:	
Written DOC Completion Date: (If not completed, why?)	
Outcome of AAR discussion at PURG:	

Divisional approval for incidents severity 3 or above:	
Date signed off:	
By whom – *state name & title:*	

Executive sign-off:	
Date:	
Title:	
Signature:	

Appendix 6

Cluster AAR– Cat 2 / Unstageable Pressure Ulcers

Ward/community team:	Name of Person completing Cluster investigation:
Date to return form to Senior CEF:	Date to be presented at PURG:
Month incidents reported:	Name of staff presenting at PURG:

Incident Record ID	Category (2 or US) and site of damage	Confirmed type of skin damage (PU/Moisture/ Trauma)	Event/Outcome What happened?
INC			
INC			
INC			
INC			
INC			
INC			
INC			
INC			
INC			
INC			

Causes, themes or trends identified:
Barriers to Care:
Safety Actions: (*immediate actions taken*)
Learning and Areas for Improvement: (*Wider themes/areas for improvement*)

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Quality Improvement Action Plan:					
Learning and Areas for improvement		**Specific actions** (SMART- specific, measurable, achievable/action-related, relevant, time-specific)	**Responsible person** (Include job titles)	**By when**	**Measuring effectiveness** (What will be measured? How will it be measured? How often will it be measured? How will we know if the change represents an improvement?)
1.					
2.					
3.					
4.					

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

Appendix 7

* 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 after every patient discharge to check for signs of permeability/damage.
E4	Staff are aware that an investigation (AAR) need 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 6 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 [redacted]
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 Fix pants 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 [redacted]		
	L1	Number of Category 3 ESHT acquired PUs	Data source [redacted]		
	L1	Number of Category 4 ESHT acquired PUs	Data source [redacted]		
	C1			Purpose T2 initial assessment and care plan completed within 6 hours of admission to your clinical area/first visit	Yes, No, NA
	C1			PURPOSE T2 assessment is reviewed weekly or where there 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 8 - Community equipment

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 03332 400599.
- 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, hybrid 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).

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

Appendix 9

Equality and Health Inequalities Impact Assessment (EHIA) template

Undertaking EHIA helps us to make sure that our services and polices do not inadvertently benefit some groups more than others, ensuring that we meet everyone's needs, and our legal and professional duties.

This is important because:

- Assessing the potential for services and policies to impact differently on some groups compared with others is a legal requirement.
- People who find it harder to access healthcare services are more likely to present later when their disease may be more progressed, have poorer outcomes from treatment, and need more services than other groups who have better access.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

These are called 'protected characteristics'. The Act requires that public sector organisations meet specific equality duties in respect of these protected characteristics. This is known as the public sector equality duty.

Public Sector Equality Duty

Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

Public bodies must have due regard to the need to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations.

Armed Forces Covenant Duty

The new Covenant Duty raises awareness of how Service life can impact on the Armed Forces community, and how disadvantages can arise due to Service when members of that community seek to access key local services. The Duty requires organisations to pay due regard to the Covenant principles when exercising functions in healthcare. "Due regard" means that we need to consciously consider the unique obligations and sacrifices made by the Armed Forces; that it is desirable to remove disadvantages faced by the Armed Forces community; and that special provision may be justified in some circumstances.

Health Inequalities Duties- Equity for all

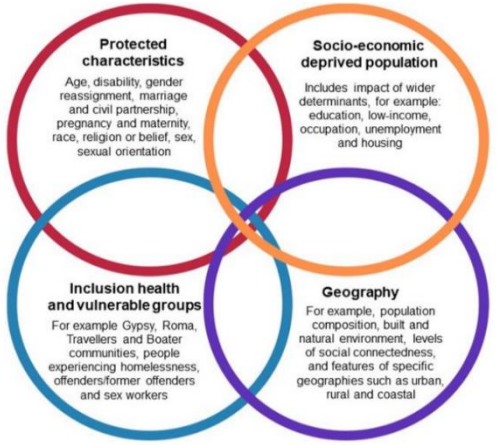
In addition to our legal duties in relation to Protected Characteristics, the Health and Social Care Act and other legislation, NHS Planning Guidance and sector specific recommendations require the NHS to have regard to the need to address health inequalities (or differences in access to or outcomes from healthcare) and take specific action to address them.

Figure 1 shows the different population groups, factors associated with where we live, or our individual circumstances, which separately, or when combined, influence access to and outcomes from health care.

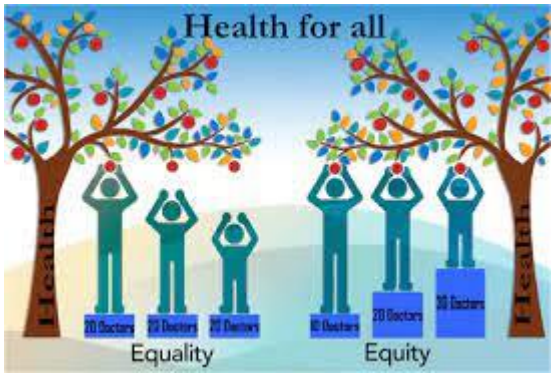
Getting equal outcomes may require different inputs (or services). In completing an EHIA its important to think about whether a one size fits all approach will generate the same

Factors associated with poorer health outcomes

(PHE 2021)[1]



The Health Tree[1]



The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the Trust must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the Trust is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy/process is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EHIA in itself does not meet the requirements of the equality and health inequalities duties. All the requirements above must be fulfilled or the EHIA (and any decision based on it) may be open to challenge. Properly used, an EHIA can be a tool to help us comply with our equality and health inequalities duty and as a record that to demonstrate that we have done so. It is advised that you complete the short EHIA training session on MyLearn before completing this EHIA.

[1] https://www.researchgate.net/figure/Equality-and-equity-of-medical-resources-distribution_fig2_323266914

East Sussex Healthcare NHS Trust

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. Function/policy/service name and number:	Pressure Ulcer Prevention and Management Policy		
Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):	The purpose of these guidelines is to provide clear advice to ESHT health and care practitioners, departmental leads, and service managers about the fundamentals of evidence-informed care for people who have or are at risk of developing pressure ulcers. Implementing these recommendations will achieve better individual outcomes and more effective use of health and social care resources. Recognising that pressure ulcers are in the top ten harms in the NHS in England. The National wound care strategy programme (NWCSP) seeks to prevent pressure damage and improve healing of pressure ulcers with evidence-based practice guideline to remove unwarranted variation (NWCSP, May 2024)		
How will the function/policy/service change be put into practice?	These are just updated guidelines on practice that is currently in place with ESHT. The updated policy will be presented at the ESHT pressure ulcer steering group		
Who will be affected/benefit from the policy?	All healthcare professionals who have direct patient contact and/or make decisions concerning treatment of individuals who are in ESHT care.		
State type of policy/service	Policy x	Service	
	Business Case	Function	Existing

Is an EHIA required? NB :Most policies/functions will require an EA with few exceptions such as routine procedures	Yes X
	No (If no state reasons)
Accountable Director: (Job Title)	Tissue Viability Team Lead
Assessment Carried out by:	[redacted]
Contact Details:	[redacted]
Date Completed:	2/9/24

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties

For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised

Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.**

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Age: older people; middle years; early years; children and young people.	There are no restrictions on age for any provisions in these policies	The policy identifies individual risk assessment for both adults , paediatrics and maternity patients	
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	The policy covers all the population		
Gender Reassignment and/or people who	The policy covers all the population	This policy is applicable to all irrespective of gender reassignment or identifying as	

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
identify as Transgender		transgender	
Marriage & Civil Partnership: people married or in a civil partnership.	The policy covers all the population	This policy is applicable to all irrespective of marriage or civil partnership status	
Pregnancy and Maternity: before and after childbirth and who are breastfeeding.	The policy identifies a specialist risk assessment required for maternity patients	Risk assessment within the policy	
Race:	The policy covers all the population	This policy is applicable to all irrespective of race but does explain different skin tones than can relate to race	National wound care strategy programme and these guidelines address skin tone bias
Religion and belief: people with different religions/faiths or beliefs, or none.	The policy covers all the population	This policy is applicable to all irrespective of religion or belief.	
Sex:	The policy covers all the population	This policy is applicable to all irrespective of sexual orientation	
Continued on next page			

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Sexual orientation	The policy covers all the population		
Veterans/Armed Forces Communities	The policy covers all the population		

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this sections does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the 'how do you know this' column to demonstrate that you have considered the potential for impact**. If you identify the potential for impact for one or more of these groups please complete the full assessment in Appendix A**

Groups who face health inequalities[2]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.	The policy has been updated with the latest national wound care strategy programme information. Addresses all patients group when they have accessed ESHT care - Updated skin assessment to discuss skin tones Risk assessment for assessment adults , paediatrics and maternity patients	National Wound Care Strategy Programme | NWCSP	

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies your may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally

Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	**No X**

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please **add an x** to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?	x	x	x
The proposal may support?			

Uncertain whether the proposal will support?			

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?	x	x
Uncertain if the proposal will support?		

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1		
2		
3		

9. EHIA sign-off: (this section must be signed)

Person completing the EHIA:	[redacted]	**Date: 2/9/25**
Line Manager of person completing:		**Date:**

Appendix A

Breakdown of Groups who are more likely to experience health inequalities:

Groups who face health inequalities[3]	**Summary explanation of the potential positive or adverse impact of your proposal**	**How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback**	**Action that will be taken to address the potential for negative impact.**
Looked after children and young people			
Carers of patients			

Groups who face health inequalities[3]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.			
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.			
People with addictions and/or substance misuse issues			
People or families on a **low income**			
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).			
People living in deprived areas			

Groups who face health inequalities[3]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
People living in remote, rural and island locations			
Refugees, asylum seekers or those experiencing modern slavery			
People who have served in the Armed Forces			
Other groups experiencing health inequalities (please describe)			

Appendix B – EHIA Resources

Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data

State of the County 2021 Focus on East Sussex

East Sussex JSNA

Community Insight

Further Reading on Equality and Health Inequalities

Training