OP96
Pressure Ulcer and Moisture Associated Skin Damage Prevention and Management for Adult & Paediatric Patients in Hospital and Community Services

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1.0 Policy Statement (Purpose / Objectives of the policy)

1.1 The policy defines the Trust's approach to prevention of pressure ulcers (PU) and moisture associated skin damage (MASD) within hospital and community services care. The policy applies to all patients and multidisciplinary healthcare professionals involved in the prevention and management of patients at risk and/or with existing pressure ulcers.

1.2 Pressure ulcer prevention is a key element of preventing avoidable harm

1.3 The policy places emphasis on the nurse, midwife and allied health care professional risk assessment, multidisciplinary identification of risk factors and preventative measures encouraging holistic assessment and management of the patient.

1.4 The Trust monitors PU and MASD incidence as the most accurate measure, but coding information will link to benchmarking dashboards on Model Health.

1.5 In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

1.6 If there is failure to adhere to the policy, staff must be supported following Human Resources Capability Policy (HR19), to enhance staff development and prevent avoidable harm.

Note: The most recent versions of the Mi documents included in this policy are controlled via the Clinical Illustrations department and copies can be requested from Clinical Illustration upon request.

2.0 Definitions

aSSKINg	Is NHSEI (2018) recommended prevention model pressure ulcer prevention. a- Assessment, S- Skin Inspection, s- Surface, K- Keep moving, I- Incontinence and moisture, N- Nutrition and hydration, G- Giving information. The model will aid the format of this policy.
Badgernet	Is a digital toll used by Maternity and Neonatal departments to record assessments and care. These departments will use this system to record all pressure ulcer risk assessments, skin assessment and care.
Device related pressure ulcer	Is a pressure ulcer caused by a medical device such as oxygen device, bandages, compression garment, bed pan, tubing and must be reported as an incident
Incidence	Is an adverse event which is recorded on Datix.
Pressure Ulcer	A pressure ulcer is localised damage to the skin and/ or underlying tissue, usually over a bony prominence (or related to a medical or other device) resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and maybe painful (NHSI 2018)

PURPOSE T	Pressure Ulcer Risk Primary or Secondary Evaluation tool. This tool enables screening, risk assessment and care planning for patients at risk or pressure ulcer (Paediatrics and Adults)
Safeguarding	Safeguarding is about protecting an individual's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risk and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, wishes, feelings and beliefs in deciding on any action (DOH and SC 2018)
Serious incidents	Acts and/ or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: • Unexpected or avoidable death of one or more people • Unexpected or avoidable injury to one or more people that has resulted in serious harm • Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent o the death of the service user; or o serious harm The serious harm definition • Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care). • Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred as a result of the harm). • Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted or is likely to last for a continuous period of at least 28 days) (NHSI 2015).

3.0 Accountabilities

3.1 Chief Executive Officer

The Chief Executive Officer is accountable to the Trust Board for ensuring that the Executive Management Team meets all of its NHS obligations and legal requirements, including those relating to Patient Safety, Financial Governance, and Health and Safety legislation.

3.2 Group Chief Nurse and site Director of Nursing/ Director of Allied Health Care Professionals

The Group Chief Nurse, Director of Nursing and Director of Allied Health Care Professional has designated executive responsibility for Governance and risk management (including Health and Safety, serious incident Management and Safeguarding) and is required to report via Trust committees to the Management Team and Trust Board.

3.3 Finance Director

The Financial Director has designated responsibility for Financial Risk and report on areas of financial risk to the Management Team and Trust Board. The Finance Director also fulfils the role of Senior Information Risk Owner (SIRO) ensuring that identified information security risks are followed up and incidents managed.

3.4 Executive Directors

All Directors have responsibility to ensure all aspects of clinical, corporate and financial risk within their portfolios are assessed and managed and are reported to the Trust Board through the Trust Assurance Framework.

3.5 Non-Executive Board Members (NEDs)

The Non-Executive Board Members are accountable for ensuring Board Assurance is delivered by reviewing the Trusts risk management activity through specific Non-Executive review committees, i.e. Audit Committee, Risk Assurance Committee, Finance and Performance forums. NED responsibilities will be reflected in the membership of appropriate committees.

3.6 Deputy Director of Assurance

The Deputy Director of Assurance is responsible for the development of the Trust risk management reporting systems which support the Trust Board, managers and staff in their risk management activity relating to Clinical and Corporate risks. The Head of Governance and Legal Services, Divisional Healthcare Governance Managers and identified senior management leads (for specialist organisations e.g. MHRA, HPA, SHOT, HSE) will have delegated responsibility for reporting serious or externally reportable incidents to the appropriate bodies e.g. CQC, NPSA, NHS England, CCG, ICO and external specialist bodies. To ensure accountabilities and responsibilities of the Governance and Legal are followed as listed in OP10.

3.7 **Heads of Nursing & Midwifery& Allied Healthcare Professionals**

Heads of Nursing & Midwifery& Allied Healthcare Professionals are responsible for ensuring the policy is implemented in a consistent manner across all areas and will lead the root cause analysis outcome decision and action plan process.

3.8 **Matrons**

Matrons will ensure sustained concordance with the policy and accurate monitoring of incidence, escalation and prevalence is in place.

3.9 **Senior Ward Sisters and Charge Nurses**

Senior Ward Sisters and Charge Nurses are responsible and accountable for ensuring all staff are aware of the policy, adequately trained and supported to sustain pressure ulcer and MASD prevention. Audit or investigate clinical practice or adverse events and share lessons from any investigation process.

3.10 **Clinical staff** are responsible for:

- Ensuring safe patient care and experience
- Reporting incidents
- Support the investigation of clinical practice or adverse events (includes leading, attending meetings/interviews, provision of information and taking improvement actions.)
- Complying with Trust policy (including training attendance).

3.11 **Tissue Viability Link Nurses**

Tissue Viability Link Nurses will disseminate pressure ulcer and wound care information within their clinical area. They will have an active role in the implementation of the policy and will assist with monitoring practice.

3.12 **Practice Educator Facilitators**

The Practice Educator Facilitators will assist the development of nursing colleagues based on lessons learnt to optimise staff development and safe care.

3.13 **Tissue Viability Team**

The Tissue Viability Team are responsible for providing blended education to all levels of Trust staff, for implementing the link nurse system appropriately, overseeing prevalence and incidence data and providing expert advice for all complex wounds.

Note: all current document examples are available via Medical Illustration using the relevant (MI) numbers listed within this policy.

4.0 Policy Detail

4.0.1 Trust employees managing care of patients must comply with all the minimum expected standards required to minimise risks to prevent pressure ulcers using fundamental elements of care outlined in the aSSKINg model.

4.0.2 The policy will refer to relevant standard operational procedures for specific divisional or service guidance as the trust manages a cross section of ages and access to care.

4.1 Assessment

Inpatient pressure ulcer risk assessment

4.1.1 The Emergency Department must complete the Anderson tool ***(MI_7535914)***, when the patient is safe to be examined in a clinical area (within 4 hours) to recognise who is at risk of pressure ulcers during their attendance within the department.

4.1.2 Hospital- All patients must be risk assessed using the locally agreed pressure ulcer risk assessment tool available for their division within 6 hours of hospital admission once there is a decision to admit, Maternity and neonates service must assess and record the risk assessment on Badgernet, Paediatric services must record the risk assessment in ***Mi_17827614*** and adult services must record the risk assessment in ***Mi_I8231914***.

4.1.3 Theatres must assess pressure ulcer risk pre and post operatively and record in the theatre documentation ***(Mi_5307614)***

4.1.4 A hospital pressure ulcer risk assessment must be repeated after each ward move, transfer from theatres and at least every 7 days or if clinical needs change.

4.1.5 The risk pathway care plan must be completed and evaluated weekly or if risk pathway is amended. Include the risk pathway on all handovers.

Community pressure ulcer risk assessment

4.1.6 Community services must record the pressure ulcer risk assessment in ***Mi_854914*** and reassessed as per ***Mi_9224514*** excluding Urgent Care Centres. Allied health care professionals must screen risk and escalate to a nursing service as per local standard operational procedure.

4.1.7 Orthotics and foot health must screen patients using their locally agreed assessment document and plan suitable prevention if related to device or treatment planned or escalate to a nurse for further assessment.

4.1.8 If a patient is deemed at risk of pressure ulcers due to their clinical condition or application of medical device, a care plan must be completed and evaluated monthly or if needs change.

4.2 Skin Inspection

4.2.1 All patients admitted to hospital must have their skin assessed if the patient consents to the examination as part of the initial risk assessment to plan preventative care. If the patient is unable to consent, decide on their best interests and risks. The skin assessments must be completed twice a day if the patient is on the primary (amber) or secondary (red) pressure ulcer prevention care plan and recorded on the skin assessment page of the Intervention chart or Badgernet. If the patient is not at risk (green), the skin assessment is included in the weekly Purpose T assessment.

4.2.2 All dressings must be removed and wound swabbed as per IP03 for MRSA, to also assess all pressure points within 6 hours of hospital admission.

4.2.3 Trust staff will use Pressure Ulcer Confirmation Process and categorisation poster (***Mi3885514***) to assist with communicating the correct category of pressure ulceration to the patient, on handover/ service or ward transfer, discharge.

4.2.4 Hospital staff must record all new to trust pressure ulcers on Purpose T and state the wound is trust acquired to ensure the wound is coded correctly for benchmarking information on Model Health.

4.2.5 In hospital a patient and their wound must be reassessed at least every 7 days or if the wound has changed e.g. new slough, necrosis or change to exudate or size, to monitor progression of the wound and evaluate the plan of care.

4.2.6 In the community a patient must have their skin assessed on initial assessment if they consent and repeated as per recommended plan in ***Mi_9224514*** if the patient is on the primary (amber) or secondary (red) pressure ulcer prevention care plan. If the patient is not at risk (green), the skin assessment should be repeated if their health deteriorates.

4.2.7 Community services must triage and assess a patient reported to have a pressure ulcer or moisture associated skin damage within 48 hours of referral to ensure the appropriate preventative measures are in place at the patient's home.

4.2.8 In a community setting a wound assessment must be completed every 7 to 28 days depending on clinical risks to prevent and manage a chronic wound or identify early signs of deterioration.

4.2.9 Manage the patient with a wound with the relevant dressing listed on the first line option for wound care guide using current formulary items or tissue viability recommendations if it is a complex wound and offload pressure to aid healing. Attachment 1

4.2.10 Clinical images must be completed with consent in accordance with CP18- Hospital must follow ***Mi_4506514***.

4.2.11 Prior to reporting the pressure ulcer as an incident, two registered nurses must check the wound either during care or view an image.

4.2.12 Refer all complex (large or high exudate or deep cavity), non-healing (failed to reduce in size or increased in size within 28 days) or rapidly deteriorating wound to tissue viability. Tissue viability will follow the tissue viability referral standard operational procedure-. The referral or incident will be triage and face to face, telemedicine or video consultation must be planned and documented.

4.2.13 All patients living with diabetes and foot wound(s) must be referred to the foot health team in addition to tissue viability to agree specialist lead or joint assessment.

4.3 Surface

4.3.1 Surfaces for acute and community must be provided to reduce risk and selected based on clinical presentation following the procedure for selecting and monitoring pressure ulcer prevention equipment attachment 2

4.3.2 If a patient is nursed in a hospital bed, the bed must be profiled to reduce heel pressure and documented.

4.3.3 Patients heels can be offloaded with pillows or trust approved heel offloading devices if safe to use on the patients' legs. Do not use a heel offloading device if the patient has leg ulcers or skin changes to the lower leg region and document.

4.3.2 If an acute inpatient is deemed complex for example multiple deep pressure ulcers/ unable to move due acute severe pain difficult to control, for example septic arthritis or skin is breaking down quickly despite using the hybrid mattress and optimising prevention strategies; refer to the tissue viability team to assess for a low air loss mattress following the standard operational procedure for selecting and monitoring pressure ulcer prevention equipment attachment 2

4.3.3 If a complex patients require bespoke specialist equipment deemed appropriate by a tissue viability nurse and approved via the Clinical procurement team, approval must be

obtained from the relevant directorate and purchased following HS11 process. Training must be arranged to use the medical device safely and recorded as per HS11.

4.3.6 All medical devices must be fitted and used as per manufacturer's instructions. Move the device to redistribute pressure at a planned frequency and recorded. Skin must be monitored to identify early signs of skin changes. Skin must be protected by skin protectant or approved pressure redistribution device listed on the wound formulary e.g. silicone gel products, foam or hydrocolloid dressings to protect the skin if suitable to use with the medical device. Medical device incident themes must be reported via the Clinical Procurement Group to agree actions.

4.3.7 In hospital, when bandages are removed at the planned dressing change and prophylactic anti-embolic stockings are removed for skin care, all pressure points must be assessed and recorded on the skin assessment.

4.4 Keep Moving

4.4.1 Patients at risk must be advised to keep changing their position to offload sustained pressure from at risk areas or informed they will have assistance to reposition. If a patient cannot reposition themselves, appropriate moving and handling aids must be used to prevent shear and friction**.** Check the position of the patient first with the last recorded position on the intervention chart or care home chart. If they have repositioned independently, record the new position. If their position has not changed, assist the patient to change to a new position, unless there is a special clinical rationale for the patient to remain in a position. If log rolling or assisting with standing to relieve pressure, offload pressure for 10-15 minutes depending on skin tolerance, unless clinically unsafe.

4.4.2 Patients and carers must be taught arm, hand and leg exercises and positioning to prevent contractures. Staff must assist with these if the patient requires assistance with all needs. If a patient has contractures, they must be positioned safely to prevent sustained pressure.

4.4.3 Hospital/ 24-hour care environment- repositioning must be recorded on the Intervention Chart ***Mi_8881414*** or care home approved chart. A starting point is 2 hourly, to check tissue tolerance for high to very high risk patients. Amber risk patients can have a reduced frequency of up to 4 hours if deemed safe and tissue tolerance is good.

4.4.4 Patients awaiting an operation who are either at risk of pressure ulcers or have the potential to be on the theatre table for 2 hours or more, must be positioned or advised to lie in an alternative position to the supine position pre operation on the ward, unless it is unsafe to do so due to a clinical rationale such as spinal injury or fractured neck of femur.

4.4.5 Community primary or secondary pathway risk patients must be advised to move every 2 hours if possible, depending on their mobility and care provision. Simple tips must be advised to try to relieve pressure between care visits. This may not be possible if care access is limited. Refer to Social Services if the care package requires a reassessment of needs. Some circumstances will require a continuing health care assessment to support additional care. In complex cases a tilting device might be suitable set at 15 minutes to hourly repositioning if an individual funding request is approved for the device.

4.4.6 Repositioning frequency can be reduced for comfort only, to every 6 hours for patients on the SWAN pathway.

4.5 Incontinence and Moisture

4.5.1 If a patient is incontinent, staff must complete a continence assessment. Staff must promote continence with a toilet first approach and encourage regular exercises to improve

continence. If a patient requires a containment product, the suitable products for prescription the can be located: Process for Ordering Continence/Containment Products (xrwh.nhs.uk)

4.5.2 Sweat and other types of moisture can affect the skin. Staff must ensure they manage the microclimate of patients, sweat and other causes of excess moisture to prevent moisture associated skin damage.

4.5.3 Follow the moisture associated skin damage prevention guide to prevent moisture associated skin damage, as these wound types with increase the risk of pressure ulcer forming.

4.5.4 Patients with complex (large area)/ non healing (not reduced in size or healed within 14 days) refer to the tissue viability team.

4.5.5 Trust approved skin protection must be used as per manufacturer's instructions and documented.

4.6 **Nutrition and Hydration**

4.6.1 Patients nutrition must be assessed and managed according to CP17.

4.6.2 Hospital-Record nutrition and hydration intake for patients at risk of pressure ulcers on the Food and Fluid chart (***Mi_2587914)*** and escalate poor intake to a Senior Nurse or Doctor.

4.6.3 Community services must view the care home charts if the patient is at risk of pressure ulcers or if skin shows signs of pressure ulceration or MASD.

4.6.4 Community Services must advise and monitor nutrition & hydration, ensuring extra fluids are readily available in hot weather. If the patient shows signs of poor nutrition or hydration follow Nutrition and Dietetics guidance accessed Nutrition Guidance and Documents (xrwh.nhs.uk)

4.6.5 Patients at high risk of Malnutrition i.e., MUST score 2-6 must be referred to the dietitian. Patients at high risk of Malnutrition. Likewise, patients with non-healing category 3 or 4 pressure ulcers should be referred to the dietitian for nutrition support/dietary education.

4.7 **Giving Information**

4. 7.1 Patients at risk of pressure ulcers must have pressure ulcer prevention explained ***(Mi_317611***) and issued. In the event the patient cannot understand, issue the leaflet to a relevant family member or carer. All additional advice must be documented as clinical needs or circumstances change. If a patient has a wound, issue a General Wound Information leaflet ***(Mi_3379714)***.

4.7.2 Community, a letter must be sent to the care agency, care home for adults, or special school and or parents for paediatrics, if the patient is at risk of pressure ulcers, including the individual advice to prevent pressure ulcers for the patient.

4.7.3 If the patient has mental capacity and has a history of non-concordance, complete and monitor a Trust approved patient autonomy risk assessment (***Mi_4318314***) and action plan (***Mi_43762114***).

4.7.4 All "pressure ulcers on assessment" and "New" category 2, 3, 4, unstageable and deep tissue injuries, plus new moisture associated skin damage, including incontinence associated dermatitis, intertrigo dermatitis, peristomal dermatitis and periwound dermatitis must be recorded on Datix. Inform the patient or relevant other, following the Duty of

Candour process and document (OP10 Risk Management and Patient Safety Reporting Policy (xrwh.nhs.uk))

Follow the procedure for managing pressure ulcer and moisture associated skin damage incidents – attachment 3

4.7.5 Safeguarding referrals must be made in line with CP41, Safeguarding Children or OP05, Adult Safeguarding Supervision Policy, CP53, Safeguarding Adults at Risk if the patient develops multiple wounds or category 3 or Category 4 pressure ulcers.

4.7.6 Discharge from hospital- the risks, pressure ulcer category and site, equipment ordered and wound management plan for the patient must be recorded in the wound section of the e-Discharge section if the patient has a pressure ulcer and complex discharge document (***Mi_7499314)*** A copy must be issued with the patent if discharged to a care home. Patients must be referred to the relevant Community service if nursing care is required.

Note: If the patient has a wound deeper than 2 cm and is packed with a dressing, ensure a cavity care log (*Mi_4148114*) copy is sent with the patient when discharged to prevent retained dressings.

4.7.7 All patient related documents must be obtained via the Clinical Illustration team referring to the list in ***Mi 4506514***

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
√	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

The policy will be reviewed by the Tissue viability Steering Group.

8.0 Communication and Training

8.1 Training is mandatory specific and all nurses, health care assistants, allied health care professionals which manage patients at risk or pressure ulcers must update every other year.

8.2 The tissue viability team will provide blended training programmes that underpin the implementation of the policy in line with the recommended national core curriculum.

8.3 The policy will be available via the Trust intranet and awareness made at Trust and Nurse Induction.

8.4 The pressure ulcer prevention competency document (attachment 4a and 4b) and other relevant wound competencies must be completed for all staff involved with care in high-risk areas such as all inpatient areas, community and rehabilitation nursing services as part of their training programme

9.0 Audit Process

The audit of the process and measures are outlined in the table below to demonstrate the policy supports the Trusts Professional Values and Standards Professional Values and Standards (xrwh.nhs.uk)

Criterion	Lead	Monitoring method	Frequency	Committee
Pressure ulcer documents	Ward sisters	Audit tool	Monthly Quality Audits	Quality & Safety Advisory Group Meeting (QSAG)
Training Compliance	TV Lead & Ward Sisters through monthly KPIs	Training database	Monthly	QSAG
Incidence	TV Lead	Datix/ Inphase	Monthly	Tissue Viability Steering group- Report to Chief Nursing officer report

10.0 References - Legal, professional or national guidelines

Coleman, S.et al (2014). Developing a pressure ulcer risk factor minimum data set and risk assessment framework. *Journal of Advanced Nursing*, *70*(10), 2339-2352

European pressure ulcer advisory panel (2014)- digital http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf

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Fletcher J, Gefen A, Irvine M and Jones L (2015) Hybrid Support surfaces made easy, http://www.woundsinternational.com/made-easys/view/hybrid-support-surfaces-made-easy

National Health Service England (2022) Patient Safety Incident Response Framework, B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)

National Health Service Improvement (2018) Pressure ulcers: revised definition and measurement: summary and recommendations. National Health Service Improvement June 2018 London

National Health Service Improvement (2015) Serious Incident Framework, National Health Service Improvement March 2015 London

National Health Service Improvement (2018) Pressure Ulcer Core Curriculum, NHSI, England, Pressure-ulcer-core-curriculum.pdf (nationalwoundcarestrategy.net)

National Health Service Improvement (2020) SKIN care when proning, NHSI, England, Prone-checklist.pdf (nationalwoundcarestrategy.net)

National Health Service Improvement (2020) Pressure-ulcer-prevention-guidance-when-proning-patients-V6-5.5.20-1-2.pdf (nationalwoundcarestrategy.net)

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Oriov A and Gefen A (2022) Difference in prophylactic performance across wound dressing types used to protect from device related pressure ulcers caused by continuous positive airway pressure mask, Journal, International Wound Journal, September 2022- Differences in prophylactic performance across wound dressing types used to protect from device-related pressure ulcers caused by a continuous positive airway pressure mask | Request PDF (researchgate.net),

Stephens M, Bartley CA (2018) Understanding the association between pressure ulcer and Sitting in Adults. What does it mean for me and my carers? Seating guidelines for people, carers, health &social care professionals, Journal of tissue viability, 27, 59-73

The Royal Wolverhampton NHS Trust CP13a- Wound assessment and management policy (pending approval)

The Royal

Wolverhampton NHS Trust	Clinical policy 41, Safeguarding children
The Royal Wolverhampton NHS Trust	Clinical policy 53 Safeguarding adults at Risk
The Royal Wolverhampton NHS Trust	Human Resource Policy HR19- Capability policy
The Royal Wolverhampton NHS Trust	HS11 Management of Medical Devices Policy (xrwh.nhs.uk)
The Royal Wolverhampton NHS Trust	OP10 Risk Management and Patient Safety Reporting Policy (xrwh.nhs.uk)
The Royal Wolverhampton NHS Trust	Professional Values and Standards (xrwh.nhs.uk)

Part A - Document Control

Reference Number: OP96 **Title:** Pressure Ulcer and Moisture Associated Skin Damage Prevention and Management for Adult & Paediatric Patients in Hospital and Community Services	**Version:** **7.0**		**Status: Final**	**Author:** Tissue Viability Lead/Deputy Chief Nurse **Director Sponsor:** Chief Nursing Officer
Version / Amendment History	Version	Date	Author	Reason
	7.0	June 2023	Tissue Viability Lead Nurse	Review
	6.7	May 2023	Tissue Viability Lead Nurse	Reviewed by Director of Nursing – Extended to June 2023 pending full review
	6.6	March 2023	Tissue Viability Lead Nurse	Reviewed by Director of Nursing – Extended to April 2023 pending full review
	6.5	November 2022	Tissue Viability Lead Nurse	Reviewed by Director of Nursing – Extended to March 2023 pending full review
	6.4	May 2022	Tissue Viability Lead Nurse	Reviewed by Chief Nursing Officer extended to May 2022 pending full review
	6.3	Jan 2022	Tissue Viability Lead Nurse	Reviewed by Chief Nursing Officer extended to March 2022 pending full review
	6.2	Dec 2020	Tissue Viability Lead	Review

			Nurse	
	6.1	May 2019	Tissue Viability Lead Nurse	Review
	6	Feb 2019	Tissue Viability Lead Nurse	Review
	5	Oct 2013	Tissue Viability Nurse/Deputy CNO	Review
	4	May 2013	TV Nurse	Review
	3	May 2010	TV Nurse	Review
	2	Dec 2005	TV Nurse	Review
	1	May 2003	TV Nurse	Introduction

Intended Recipients: All Clinical staff	
Consultation Group / Role Titles and Date: Tissue Viability steering group November 2022, January 2023 Consultation group- Maternity, Neonates, Paediatric, Emergency Department, Maternity, Medical device education links- Virtually	
Name and date of Trust level committee where reviewed	Trust Policy Group – June 2023
Name and date of final approval committee	Trust Management Committee – June 2023
Date of Policy issue	July 2023
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]	June 2026
Training and Dissemination: Local Training, Matron, Senior Nurse, Midwives, Health Visitors and Allied Health Care Professionals group, Link Nurse Forum	

To be read in conjunction with:

CP04 Discharge policy CP04 Discharge Policy (xrwh.nhs.uk)

CP05 transfer of patients between wards, departments, Specialist Units and other hospitals- CP05 Transfer of Patients Between Wards, Departments, Specialist Units and Other Hospitals (xrwh.nhs.uk)

CP12 Care of People with Learning Difficulties CP12 Care of People with Learning Disabilities (xrwh.nhs.uk)

CP17 Identification and management of patient at risk of under nutrition CP17 Identification and Management of Patients at Risk of Under Nutrition (xrwh.nhs.uk)

CP18 Clinical photography, video and audio recordings CP18 Clinical Photography, Video and Audio Recordings (xrwh.nhs.uk)

CP41 Safeguarding Children- CP_41_Policy_printable_version.pdf (xrwh.nhs.uk)

CP45 management of enteral feeding tubes CP45 Management of Enteral Feeding Tubes (xrwh.nhs.uk)

CP53 Safeguarding Adults at risk-CP_53_Policy_Printable_Version.pdf (xrwh.nhs.uk)

CP61 Management of deteriorating patient CP61 Management of the Deteriorating Patient (xrwh.nhs.uk)

CP66 Policy for the care of patients requiring enhanced care CP66 Policy For Care Of Patients Requiring Enhanced Care (xrwh.nhs.uk)

CP69 Medical handover policy CP69 Medical Handover Policy (xrwh.nhs.uk)

IP01 Hand hygiene IP01 Hand Hygiene (xrwh.nhs.uk)

IP03 Prevention and control of MRSA, VRE and other antibiotic resistant organisms IP03 Prevention and Control of MRSA, VRE and other Antibiotic Resistant Organisms (xrwh.nhs.uk)

IP08 Infection prevention operational policy IP08 Infection Prevention Operational Policy (xrwh.nhs.uk)

IP20 Urinary catheter Policy IP20 Urinary Catheter Policy (xrwh.nhs.uk)

All medical device related nursing clinical practice listed on Clinical skills.net or Nursing clinical procedures Nursing Clinical Procedures (xrwh.nhs.uk)

HS01Management of health and safety- HS01 Management of Health & Safety (xrwh.nhs.uk)

HS11 Management of medical devices HS11 Management of Medical Devices Policy (xrwh.nhs.uk)

OP10 Risk Management and Patient Safety Reporting Policy (xrwh.nhs.uk)

OP109 Conflicts of Interest OP109 - Conflicts of Interest Policy (xrwh.nhs.uk) OP110 PREVENT policy OP109 - Conflicts of Interest Policy (xrwh.nhs.uk) CP01 Management of patients with a tracheostomy or laryngectomy CP01 Management of Patients with a Tracheostomy or Laryngectomy (xrwh.nhs.uk)	
Initial Equality Impact Assessment (all policies): Completed Yes **Full Equality Impact assessment (as required):Completed NA** If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904	
Monitoring arrangements and Committee	Data via Datix dashboard, Inphase and Model health Reported to Tissue Viability Steering Group, Quality and Safety Group
Document summary / key issues covered: Pressure ulcer and moisture associated skin damage prevention and management, training and incident reporting.	
Key words for intranet searching purposes	Pressure ulcer (PU) Moisture associated skin damage (MASD) Rapid review Incident aSSKINg Prevention Surface Skin inspection Keep moving Incontinence and moisture Nutrition and hydration Giving information Pressure relieving equipment

First Line Options *for* Wounds (FLOW) –new/ acute wounds less than 2 cm deep (under 28 days Community, any inpatient)

Tissue Viability

The Royal Wolverhampton NHS Trust

1-Wound assessment/ preparation and diagnosis

- Holistic, quality of life assessment or check care plan
- Wash the wound with tap water or Irrigate with warmed normal saline if immune-compromised/ inpatient/ new wound following ANTT
- Debride debris from wound margin with A) moistened sterile gauze B) conservative sharp debridement if competent if required
- Assess wound / peri-wound informal every dressing change/ formal as per SOP frequency)
- Explain impression/ differential diagnosis of wound to patient/ carer, issue relevant leaflet and document.
- Plan care based on affects on quality or life/ wound cause and presentation.
- Protect peri-wound skin if at risk of moisture associated skin damage- refer to **MASD prevention pathway**
- Prevent dry skin using patients moisturising cream (non -problematic skin) or treat with relevant emollient based on skin type listed on local formulary
- Teach self-care where possible
- Evaluate and repeat assessment as per wound assessment and care planning guide
- Remember 7 days treatment supply on discharge from inpatient areas
- **Refer to TVN if you are shocked by the wound/ the wound fails to heal or fails to respond to correct treatment/ complex/ rapidly deteriorating**

2- Exudate	3- Products- select appropriate option	4. Tips
Low exudate	Non adherent	First option to use with compression therapy/ bandaging
	Hydrogel sheet/ Hydrogel sheet border	Manages local pain, hydrates wound– Pull and stretch removal. Do not of foot and ankle wounds if patient has region is oedema or poor arterial flow.
	Hydrocolloid– transparent	Rub to activate adhesive. Conforms to awkward/ small areas. Protects skin well from moisture. Hydrates wounds and debrides superficial slough
Moderate	Hydrocollloid- Plus (community only)	
	Non adhesive foam/ Lite silicone foam border	3D fit- conforms up to 2cm deep wounds with no undermining. Manages exudate levels and prevents peri-wound maceration, ensure correct size is selected. Foam section must be 2cm larger than the wound. Use non-adhesive for PEG sites
Moderate/ high	Silicone foam border- *For community only unless specialist request*	
High/ very high	Assess cause for high exudate eg: albumin levels, oedema, infection and manage appropriately. Refer to complex wound care pathway for primary dressing and select appropriate absorbent pad.. **Remember to step down to lower exudate plan as the exudate reduces** **1. Sterile pad** **2. Superabsorbent** **Special only superabsorbant with border-** adhesive superabsorbent/ **Non backed superabsorbent** 20cm x 50 for extreme cases only ****Optimal compression therapy reduces exudate from leg wounds with arterial**	

5. Alternative pathways

Wound greater than 2cm deep follow **Cavity wound guide**

Patient high risk of infection or has a chronic wound/ biofilm- **Non-healing wound guide**

Slough or necrosis present- follow **Slough or necrosis guide**

Leg ulcer- follow **leg ulcer guide** in conjunction with this.

Infected wound– **Wound infection management guide**

Some wound types have specific pathways- check relevant guide for additional advice on TV website

Prevent avoidable wounds

OP96 – Attachment 2

Procedure/ Guidelines number and version	**Standard operational procedure for selecting and monitoring pressure ulcer prevention equipment**	**Status:** Final		**Author:** Lorraine Jones issue Viability Lead Nurse **For Trust-wide Procedures and Guidelines Chief Officer Sponsor:** Head of Nursing-Quality
Version / Amendment History	Version	Date	Author	Reason
	1.3	Jan 23	Lorraine Jones, Tissue Viability Lead nurse	One local policy to have one shared process
Intended Recipients: This local standard operational procedure is to ensure the tissue viability team provide expert support for all pressure ulcer incidents which must remain owned by the local service in each division.				
Consultation Group / Role Titles and Date: Tissue Viability Steering group- Nov 22 remotely. Jan 23				
Name and date of group where reviewed	As above			
Name and date of final approval committee (if trust-wide document)/ Directorate or other locally approved committee (if local document)	Tissue Viability Steering group- date Jan 23			
Date of Procedure/Guidelines issue	July 2023			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	June 2026			

Training and Dissemination: Local team competency training, including governance team support	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes**	
To be read in conjunction with: OP 96- Pressure ulcer prevention and management operational policy (RWT) OP07 Health Records Policy OP05 Adult Safeguarding Supervision Policy OP85 Information Sharing Policy and Wolverhampton Overarching Information Sharing Protocol HS11 Management of medical devices	
Initial Equality Impact Assessment: Completed- No Full Equality Impact assessment (as required): Completed NA	
Contact for Review	Tissue Viability Lead Nurse- Lorraine Jones
Monitoring arrangements	Tissue Viability Steering group will monitor the effectiveness of the process annually
Document summary/key issues covered. The purpose of this document is to ensure all pressure ulcers incidents are validated to ensure: • Proactive tissue viability responsiveness to all patients with complex wounds • To ensure trust acquired data is accurate on each incident system for live data dashboards • To enable prompt local review of the incident and local accountability of learning • To enable prompt hematic reviews of incidents to drive local quality improvement plans • To ensure incidents at high risk of moderate harm and above are presented at the trust pressure ulcer thematic action group in a timely manner to escalate relevant incident for local division duty of candor process.	
Key words for intranet searching purposes	Validation Pressure ulcers Moisture associated skin damage Tissue Viability Incident Datix Pressure ulcer rapid review

1.0 Purpose

The purpose of this procedure is to ensure patients who are deemed at risk of pressure ulcers receive the correct equipment for their risks and needs when managed in a community setting. It also recommends an equipment review process to ensure the patient is managed on the appropriate equipment for their risks and the equipment is in good condition and working order.

2.0 Introduction

Pressure ulcers evolve due to multi-faceted reasons and one important aspect of prevention is to ensure the patient has the appropriate equipment in a community setting to reduce the risks of pressure ulcers forming or evolving. Patients may have some equipment at home.
Some patients who are ready for discharge may require equipment to assist with their activities of daily living and prevent potential harm. It is essential that the correct equipment is either ordered for short or long term loan considering the patients' needs and management of resources.

3.0 Scope

The scope of this procedure is facilitate a safe discharge and prevent on going pressure ulcers evolving.

4.0 Definitions

Equipment loans- Patients must be advised all equipment is on loan and must be returned to the provider when deemed necessary by a nurse or no longer required. The equipment available is from an agreed list to ensure effective management of the contract and risks.

Hybrid mattress- is a mattress which is a redistributing foam replacement mattress, with integrated air cells to work as an alternating mattress. The mattress can fit on a standard single bed or hospital bed. They are ordered for patients who may improve following a rehabilitation period and the device can be returned to the provider or when a patient may have risks of deterioration at the end of life, whereby a device can be added to use as a alternating mattress. The alternating mode will offer pressure relief in 10-minute alternating cycles.

Low airloss mattress- is a therapy mattress for bedbound patients who are in bed for the majority of the day, have very fragile skin at risk of deteriorating or have a history of category 4 pressure ulceration. It is a specialist item which requires an individual funding request

Replacement redistribution foam mattress- This is a foam mattress which will redistribute pressure and available in single or double sizes. This mattress is suitable for patients with up to category 2 pressure ulcers who can move independently or with the assistance or one person or an aid.

Redistribution foam cushions – are foam cushions which redistribute pressure. There are 2 choices 1) basic foam cushion for patients at risk, up to category 2 pressure ulcers for patients who can stand at least every 4 hours.
2) High viscous foam cushion for patients with Category 2 + skin changes

3) Gel cushions- are for patients with a history of category 3 or 4 pressure ulcers and only have carers 4 times per day. Please note riser recliner chairs may be unsafe with a cushion added but can be risk assessed by a nurse.

Riser recliner pressure relief- must be approved via individual funding request (current product

is a Contur- Repose)> recommended if a patient with a riser recliner without integrated pressure relief or patients mobility has deteriorated to aid transfer (e.g Molift or hoist) long term.

Tilt and turn over devices (TOTO)- is a device which fits under a mattress and assists with repositioning every 2 hours for bed bound patients who require assistance with all care. Caution using the device if a patient is agitated.

Topper foam mattress- Is a redistribution mattress which will lie on top of a patient's mattress. The height of the bed must be assessed to ensure the patient remains safe on bed to stand transfers. This mattress is suitable for up to category 2 pressure ulcers on a person who is independently mobile.

Pressure ulcer categorisation- The trusts refer to the EPUAP 2019 definitions and supported by the NHSEI in the Pressure ulcer categorization poster-attachment 3B.

5.0 Responsibility

5.1 Chief Executive Officer

The Chief Executive Officer is accountable to the Trust Board for ensuring that the Executive Management Team meets all of its NHS obligations and legal requirements, including those relating to Patient Safety, Financial Governance, and Health and Safety legislation.

5.2 Group Chief Nurse and site Director of Nursing/ Director of Allied Health Care Professionals

The Group Chief Nurse, Director of Nursing and Director of Allied Health Care Professional has designated executive responsibility for Governance and risk management (including Health and Safety, serious incident Management and Safeguarding) and is required to report via Trust committees to the Management Team and Trust Board.

5.3 Finance Director

The Financial Director has designated responsibility for Financial Risk and report on areas of financial risk to the Management Team and Trust Board. The Finance Director also fulfils the role of Senior Information Risk Owner (SIRO) ensuring that identified information security risks are followed up and incidents managed.

5.4 Executive Directors

All Directors have responsibility to ensure all aspects of clinical, corporate and financial risk within their portfolios are assessed and managed and are reported to the Trust Board through the Trust Assurance Framework.

5.5 Non-Executive Board Members (NEDs)

The Non-Executive Board Members are accountable for ensuring Board Assurance is delivered by reviewing the Trusts risk management activity through specific Non-

Executive review committees, i.e. Audit Committee, Risk Assurance Committee, Finance and Performance forums. NED responsibilities will be reflected in the membership of appropriate committees.

5.6 Deputy Director of Assurance

The Deputy Director of Assurance is responsible for the development of the Trust risk management reporting systems which support the Trust Board, managers and staff in their risk management activity relating to Clinical and Corporate risks. The Head of Governance and Legal Services, Divisional Healthcare Governance Managers and identified senior management leads (for specialist organisations e.g. MHRA, HPA, SHOT, HSE) will have delegated responsibility for reporting serious or externally reportable incidents to the appropriate bodies e.g. CQC, NPSA, NHS England, CCG, ICO and external specialist bodies. To ensure accountabilities and responsibilities of the Governance and Legal are followed as listed in OP10.

5.7 Heads of Nursing & Midwifery& Allied Healthcare Professionals

Heads of Nursing & Midwifery& Allied Healthcare Professionals are responsible for ensuring the policy is implemented in a consistent manner across all areas and will lead the root cause analysis outcome decision and action plan process.

5.8 Matrons

Matrons will ensure sustained concordance with the policy and accurate monitoring of incidence, escalation and prevalence is in place.

5.9 Senior Ward Sisters and Charge Nurses

Senior Ward Sisters and Charge Nurses are responsible and accountable for ensuring all staff are aware of the policy, adequately trained and supported to sustain pressure ulcer and MASD prevention. Audit or investigate clinical practice or adverse events and share lessons from any investigation process.

5.10 **Clinical staff** are responsible for:

- Ensuring safe patient care and experience;
- Reporting incidents
- Support the investigation of clinical practice or adverse events (includes leading, attending meetings/interviews, provision of information and taking improvement actions.)
- Complying with Trust policy (including training attendance).

5.11 Tissue Viability Link Nurses

Tissue Viability Link Nurses will disseminate equipment information within their clinical area. They will have an active role in the implementation of the policy and will assist with monitoring practice.

5.12 Practice Educator Facilitators

The Practice Educator Facilitators will assist the development of nursing colleagues based on lessons learnt to optimise staff development and safe care.

5.13 Tissue Viability Team

The Tissue Viability Team are responsible for ensuring the procedure is followed and must communicate with the Integrated Care Board regarding contract reviews/ concerns. The Tissue Viability Team must recommend the relevant equipment list available on the contract and specialist items for complex patients needs.

6.0 Specific Procedure

6.1. Acute equipment

6.1.1 A competent health care professional must assess the patient for the surfaces in accordance with the local guidance listed in the surface selection guide- attachment 2a.

6.1.2 If a patient requires a rented low air loss mattress which is not listed as trust owned equipment, the tissue viability team or Matron on call (in the absence of the tissue viability team) must arrange delivery of the agreed rental device by raising a purchase order with the current provider and arrange delivery, training in line with HS11 Management of medical devices. The tissue viability service will recharge the relevant wards for the rental agreement.

6.1.3 The tissue viability team will monitor the need for the bespoke equipment and arrange collection when the equipment is not required for the patient it has been registered to. Lost equipment will be recharged to the ward listed as managing the care.

Note: Bespoke rental equipment must not be used for any other patients

6.2. Community equipment

6.2.1 Wolverhampton GP registered patients

The surface selection guide- Attachment 2b The assessor must have had appropriate training from Drive Devilbiss Sidhil LTD or mentor for ordering equipment and gained access to the ordering link.
https://www.uniqus.net/Wolverhampton/UniqusWEBORDER/Default.aspx.

6.2.2 Check the equipment already registered to in use at the patients home to prevent unnecessary deliveries.

6.2.3 For patients with complex health needs, bespoke specialist equipment must be requested by completing the Equipment Special orders form attachment 2C. A quote from an agreed list a Drive Devilbiss Sidhil LTD or other industry partners listed within the surface selection guides. The form must be sent to the email listed within the form for approval. Approval acceptance or denial will be sent to the prescriber; therefore, a generic email contact is advised to avoid delays. If approved, the prescriber must raise a purchase order following the trust process and inform Drive Devilbis of the order to register delivery and servicing arrangements.

6.2.4 Walsall GP registered patients

Contact Walsall district nurse service to refer for community equipment. Walsall community services review all patients with prescribed equipment. A form will be sent for completion and sent to Integrated care Equipment service (ICES)

6.2.5 Dudley GP registered patients-

Contact the trust to make the appropriate arrangements for the equipment via the tissue viability team and refer to a community service for ongoing monitoring. The health care professional must fill in an equipment request form to request equipment. This is processed by Trust admin and checked with the criteria checked then emailed to Drive Devilbis by the Dudley Trust. Orders placed before 14.00 will be delivered the same day, especially if the patient is end of life. The trust is charged for urgent deliveries extra after 2pm.

6.2.6 South Staffordshire GP registered patients

To register to order equipment complete the registration form and send to the email as directed in the excel sheet- Attachment 2D

If registered order the equipment via Medequip (Medequip - Integrated Community Equipment Services (medequip-uk.com)

6.2.7 Other Trust GP patients

If ordering equipment for patients outside Wolverhampton contact appropriate Trust and follow their local guidance.

6.2.8 Ensure arrangements are made to accept the equipment within the home ready for the patients to be discharged from hospital or on-going community care.

Note: Alternating equipment must not be used if the patients is a known smoker. A Fire service 'safe and well' assessment must take place to assess for relevant fire safety equipment prior to considering an alternating/ low air loss system.

6.3 Reviewing equipment

6.3.1 All community services must reassess risk as per risk assessment guidance and assess the equipment requirements as per surface selection guide. If a patients has rehabilitated, equipment must be stepped down, replaced with relevant equipment according to risk and other equipment must be returned to the provider use the https://www.uniqus.net/Wolverhampton/UniqusWEBORDER/Default.aspx

6.3.2 Equipment must be returned and replaced if faulty, covers are contaminated, and ingress is visible on the inside of the cover or the covers are torn or damaged.

6.3.3 Equipment must be returned to the provider if the patient moves to a GP outside their current provider or no longer requires the equipment.

References

Coleman, S.et al (2014). Developing a pressure ulcer risk factor minimum data set and risk assessment framework. *Journal of Advanced Nursing*, *70*(10), 2339-2352

European pressure

ulcer advisory panel (2014)- digital version 2016 http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf

National Health Service Improvement (2018) Pressure ulcers: revised definition and measurement: summary and recommendations. National Health Service Improvement June 2018 London

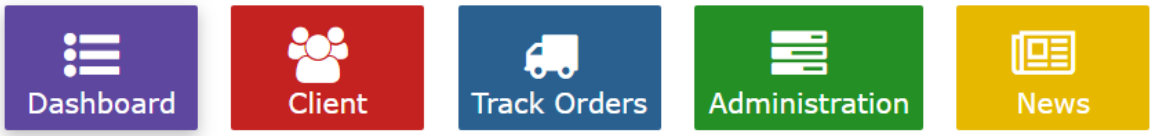
UNIQUS Web Ordering Documentation

Pages

Introduction

Home Page

When you log into the UNIQUS Web ordering software you are presented with the Home page where you can see the below navigation bar.



Dashboard – allows you to review your activities at a glance.

Client – Allows you to review and update details for each client, see what products they have on site and raise activities i.e. new equipment request, collection or repair.

Track Orders – Allows you to track orders raised by yourself, orders raised against a client or a particular order number.

Administration – Allows you to review the **catalogue** of equipment by risk type.

News – will be updated with relevant news items, currently contains your prescribing criteria.

Creating a new client

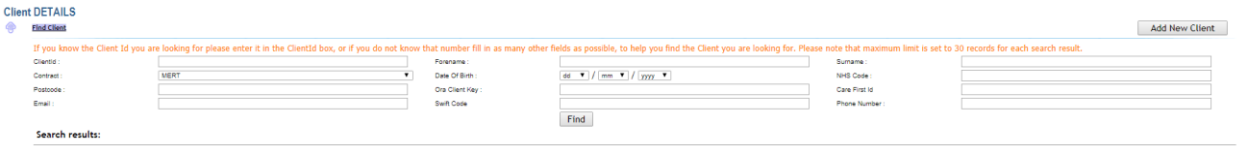
Step 1 – Navigating to the client's page

To create a new client go onto the **"Clients"** links on the navigation bar.

Step 2 – Adding a new client

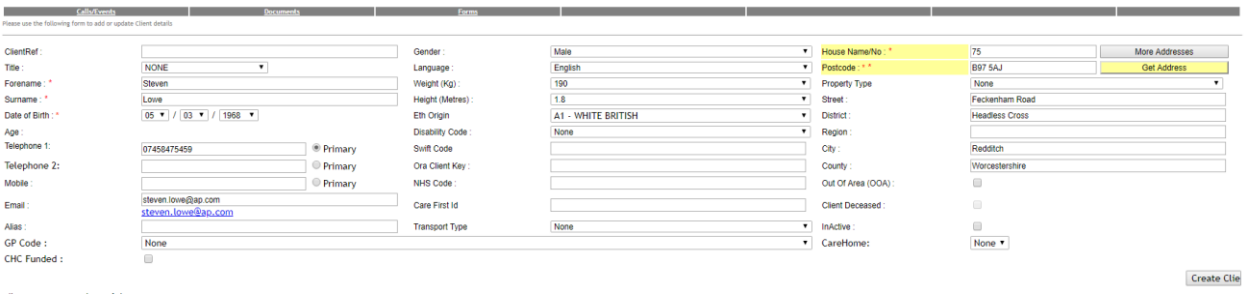
On the client's page, you will be presented with multiple fields to find a client on the system. As we are adding a new client, click on **"Add New Client"**. This will then open a page to enter the new client details in.

Note: You will have to attempt to search for the client before adding a new one to the system!



Step 3 – Entering clients information

On the new client's page, enter all the details in the required fields for the client. When all the required fields have been entered you can press **"Create Client"**.



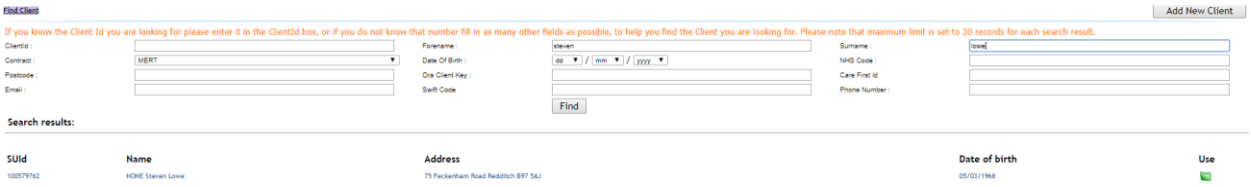
Property Type; There is a drop-down box on the form that is used to identify the client's Property Type - it is important that this is completed, as some property types may need permission to gain access,

Creating a new delivery

Step 1 – Finding a client

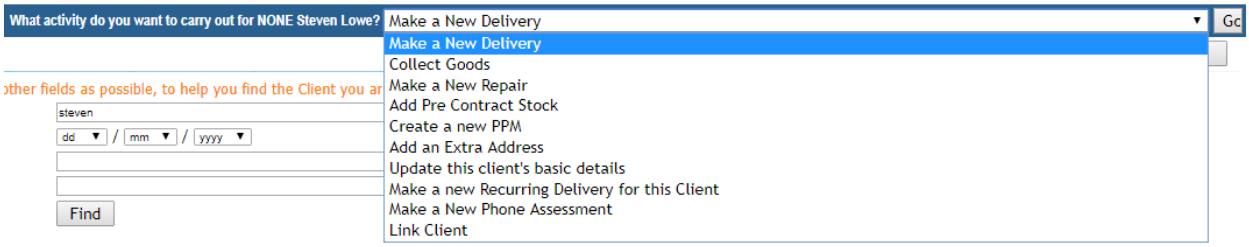
To create a new delivery, firstly you will need to search for a client to create an order for. Go to **"Clients"** on the navigation menu, on this page you will be presented with multiple search fields to find the correct client. Type in the relevant search criteria and click the "find" icon.

When you have found the client you would like to create the new delivery for, click the **"Use"** icon at the end of their name. This will then open the client's detail page.



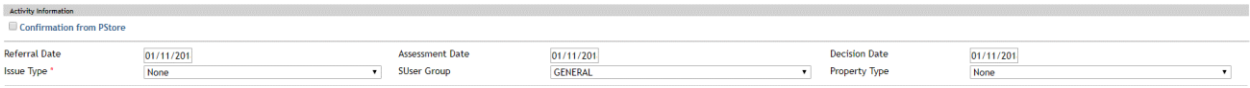
Step 2 – Creating the initial Delivery

On the client's detail page, there will be a dropdown called **"What activity do you want to carry out for (Client Name)"**. Here you will be able to select **"Make a new delivery"**. Once selected click **"Go"**.



Step 3 – Entering the Activity Information

On the new delivery page, you will be presented with 3 sections of the page. The first section is the "Activity Information". The dates on the Activity Information section will always default to today's date, but they can be altered as required. This information will be used to set the "Target Date" for the activity to be completed (see below under Step 7). **SUser Group; the system will default to "Adult". If the client is a child then please select this from the drop down box.**

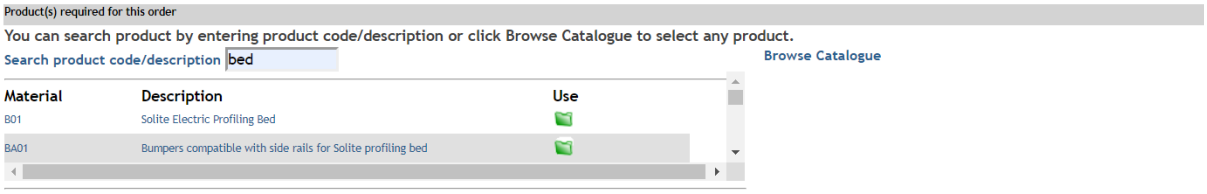


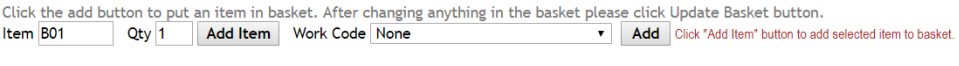
Step 4 – Adding products to the basket

The next section you will need to fill out is the **"Product(s) required for this order"**.

There are three different ways to add an item of equipment to the order.

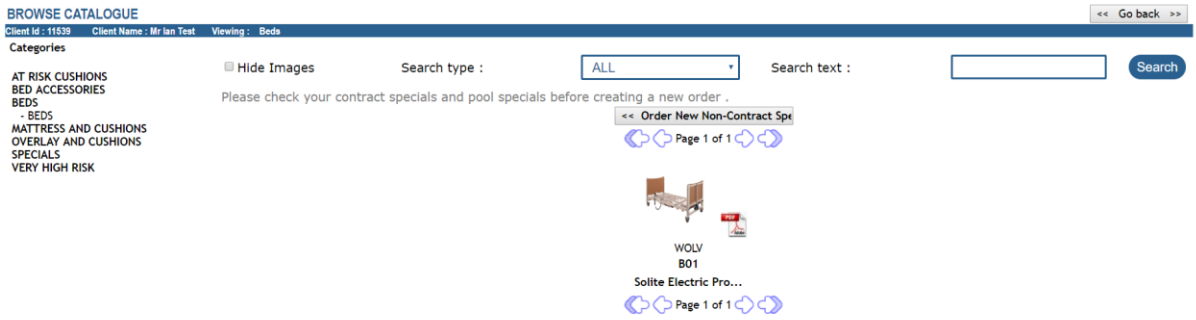
The first possible way the prescriber can add a new item to the basket is using the **"Search Product Code"** text box. To use this enter the product code or keywords into the text and the items relating to the search will display below. Click the green "Use" icon. This will also give you the option to select a quantity.



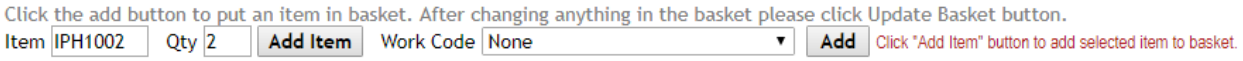


The second way a prescriber can add items to the basket is by using **"Browse Catalogue"**. The browse catalogue will display all items available for prescribing and you can view their details, images and any information about them. .

This gives the prescriber a chance to see new items, compare and find the best items in each category to recommend to clients, eventually remembers best items and quickly selects them from the search.



The third way to add an item to the basket is entering the item code into the "Item" text box. If you enter the correct code you can add the item into the basket without searching for it. This is the quickest way to add a new item to the basket.



Step 5 – Item notes

When you have added the items to the basket some will require notes to be added or forms to be completed. This will be identified by a Flashing note or form icon on the item line that needs notes adding or forms completed.

To complete the form simply click on the flashing icon and it will open a form for you to complete. You will be unable to order the item unless you have completed the form accurately.

Once the form has been completed the icon will stop flashing.

Please identify the loan period required from the drop down box under Loan.

This is the length of time that you think the client will need the equipment for, and will identify when a review will be required.

Step 6 – Removing Items from Basket (If Required)

If you have added an item by mistake and need to remove the line, simply click **"Remove"** at the end of the line for the item you no longer want in the basket. This will remove that item from the basket.

Step 7 – Entering the Delivery Address, Notes & Speed

The final section that needs to be filled out is the **"Activity Address, Notes & Speed"**.

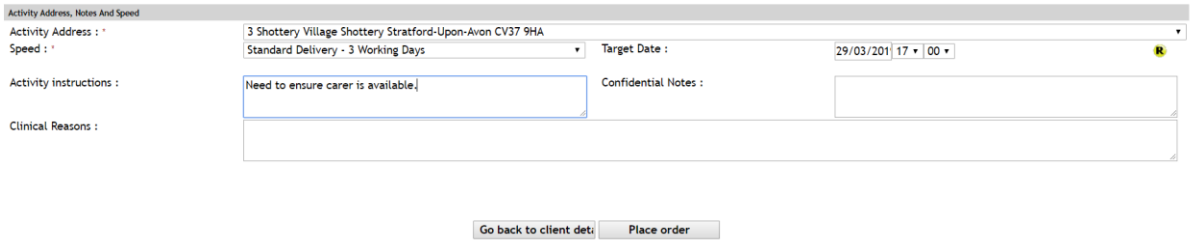
Activity Instructions; This should be used to record any particular issues about the delivery – for example, if access to the property involves stairs, or a lift, together with any specific instructions

about how the delivery should be managed. **Confidential Notes;** these notes are only seen by prescribers.

Clinical Reasons; these are optional, and can be used to describe why the client needs the equipment.

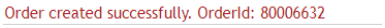
Select the client's delivery address (there might be more than one address on the system , then the speed for the delivery, which tells the store the urgency for making the delivery.

Once that is selected, the the target date for the delivery will be displayed as below :



Step 8 – Placing the order

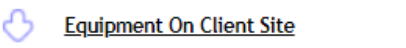
Once everything above has been completed, to place the order click **"Place Order"** at the bottom of the page. You will see the below message at the top of the screen which gives you the order ID.



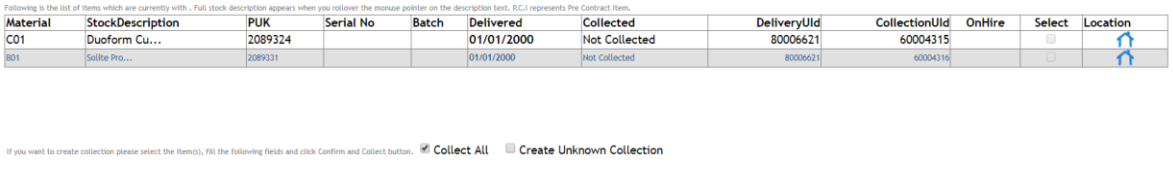
Creating a collection

Step 1 – Selecting items to collect

After locating the client (as per step 1 above) you would like to collect equipment from, click on the drop-down **"Equipment on Site"**.

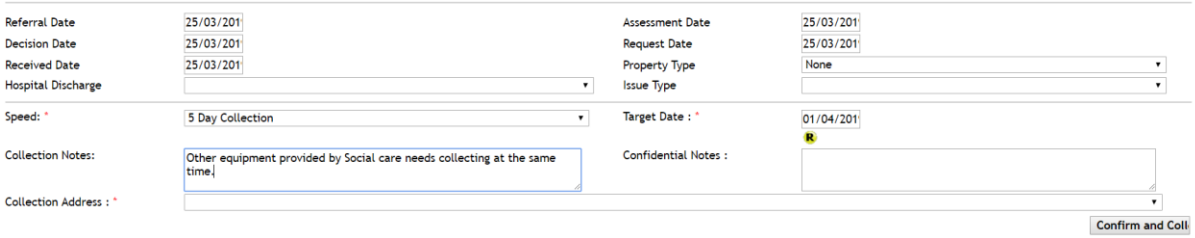


The dropdown should open listing all of the equipment the client has currently.
To select the equipment items, you would like to collect, click on the **"Select"** checkbox or "Collect all" (underneath table) if you want all items collected.



Step 2 – Creating the collection for selected items

Below the **"Equipment on Site"** dropdown box there are fields where you can add collection speeds and notes.



Once required fields are entered you can go down to the bottom of the page and click **"Confirm and Collect"**.

When the collection is created successfully, you will get a Red notification pop up as seen below.

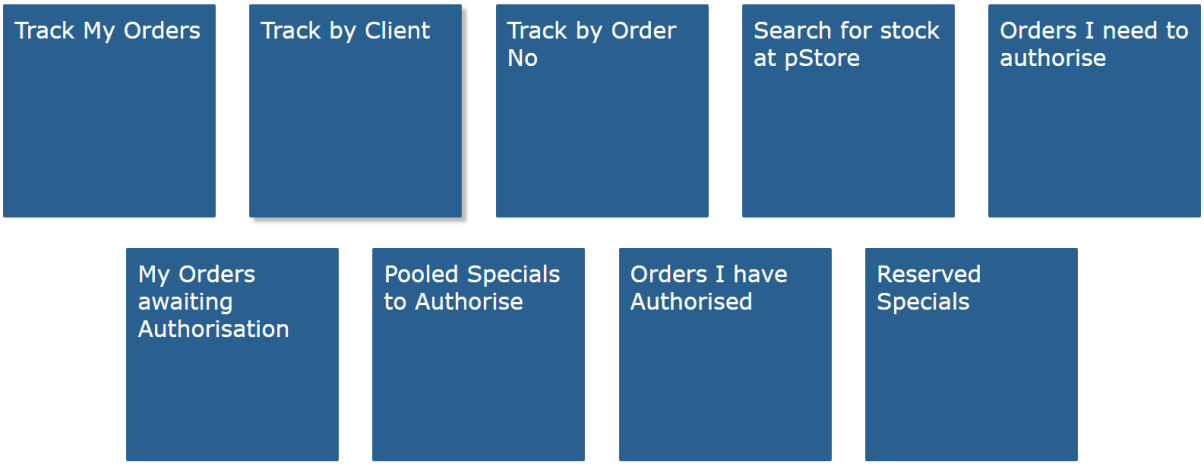
Collection for the selected items has been created successfully. CollectionUId: 60945411

Tracking an Order

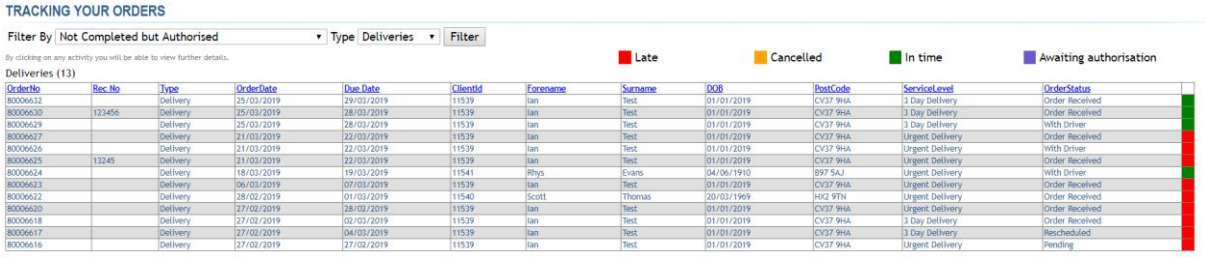
Step 1 – Navigating to Track Orders

To track an order, navigate yourself to the **"Track Orders"** area on the top of the screen.

The track orders page has many different tiles to locate an order (please only use Track My Orders, Track by Client and Track by Order No.).

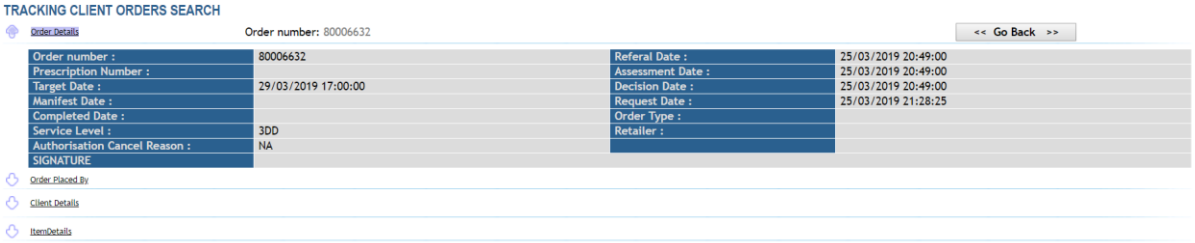


To track an order, click **"Track My Orders"**. On this page, you will be displayed with a list of all your orders you have placed. Here you can also filter by Order Type.



Step 2 – Viewing an Open Order

On the Track my Orders page, to select an order to view, simply click on the line for the order to view. This will then open all the details about the order that you placed.

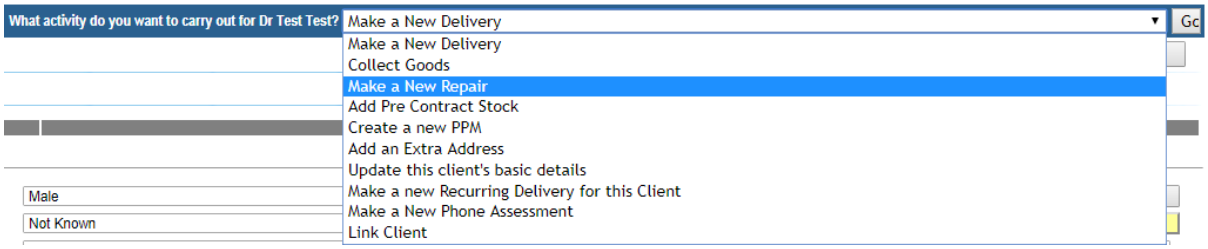


On this page, you will be presented with four drop-down menus about the order. **Order Details;** this will provide you with all the order details .e.g. Order number, Prescription Number, Target Date, Manifest Date, Completed Date, Referal Date etc. **Order Placed By;** this area will display all the details of the prescriber that has placed the order. **Client Details;** this will display all the client's details that the order has been placed for. **Item Details;** this will list all items on the order selected. Here you can also **"Cancel Activity"** or **"Extend Loan Period"**.

Creating a new Repair

Step 1 – Creating the initial Repair

On the client's details page, in the **"What activity do you want to carry out for (name)"** select **"Make a new repair"**, then press **"Go"**. This will then open a new page listing the equipment items you can create a new repair for.



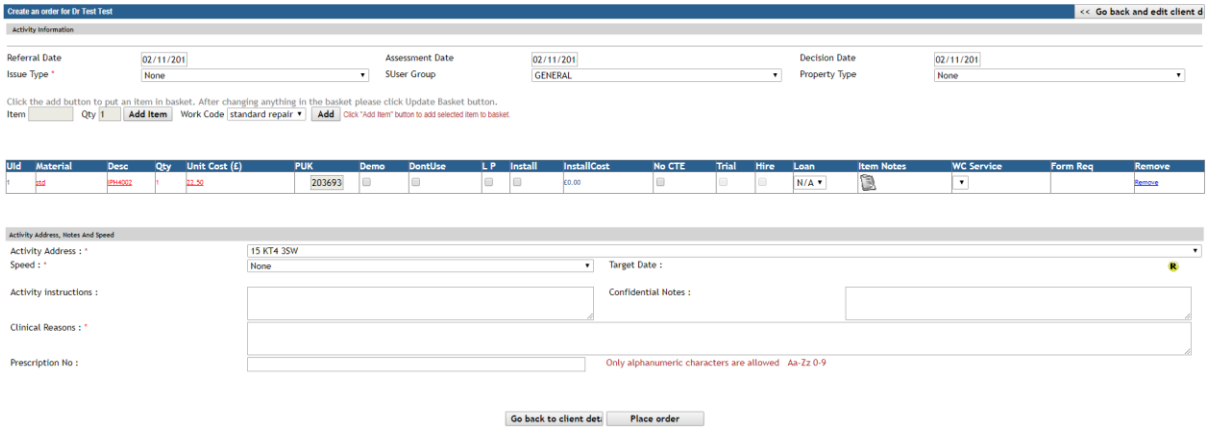
Step 2 – Selecting the materials

On the equipment item you would like to create a repair for, simply click on the Spanner icon on the line of the item as shown below.

Once added to the repair you can fill out all the required information.

Step 3 – Entering Activity Information

The information that you will need to fill out on this page is the same as when creating a new delivery.



When the repair order is placed you will be presented with a red notification in the middle of the screen with the repair UID.

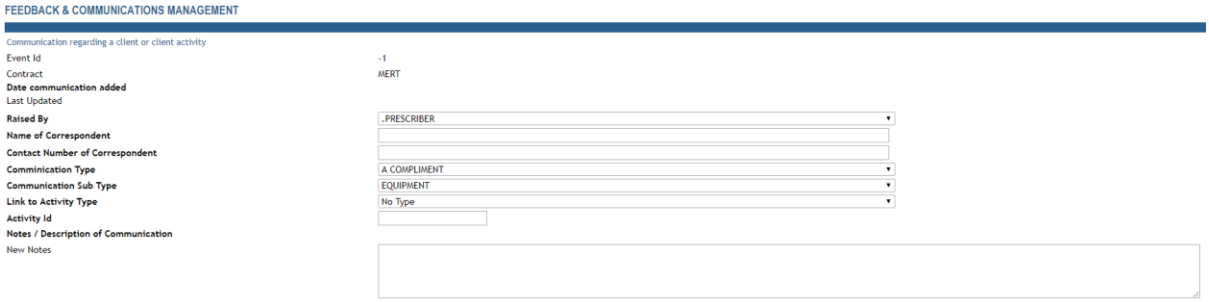
Feedback

Step 1 – Navigating to Feedback page

To find the Feedback page, go to **“Administration”** on the top navigation area. On the **“Administration”** page select the tile **“Feedback”**. This will then open the page for all the Feedback on the system from the prescriber.

Step 2 – Adding Feedback

To add feedback to the system click on the **“Add Non Client Event”** button, this will then open a new page for you to enter all the information about the event onto the system.



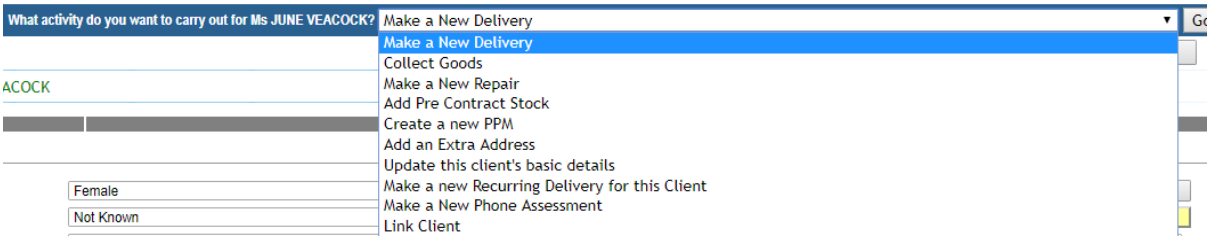
Once filled in, press the **"Add Event"** button, this will then take you back to the previous page listing all your events.

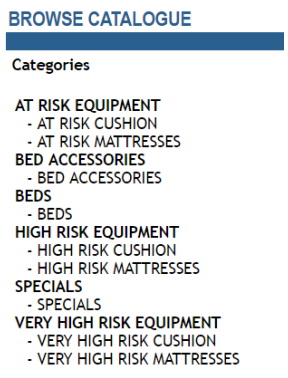
Creating a Special Order

There is an agreed procedure for ordering special equipment items. The process described below will enable you to identify if an appropriate item of special equipment is available from the store and allow you to reserve or order it. If there is not an appropriate item available, then a requisition will need to be submitted for approval in the usual way.

Step 1 – Creating the Special Order

To create a special order, on the client's detail page. In the drop-down select **"Create a new Delivery"** then press **"Go"**.



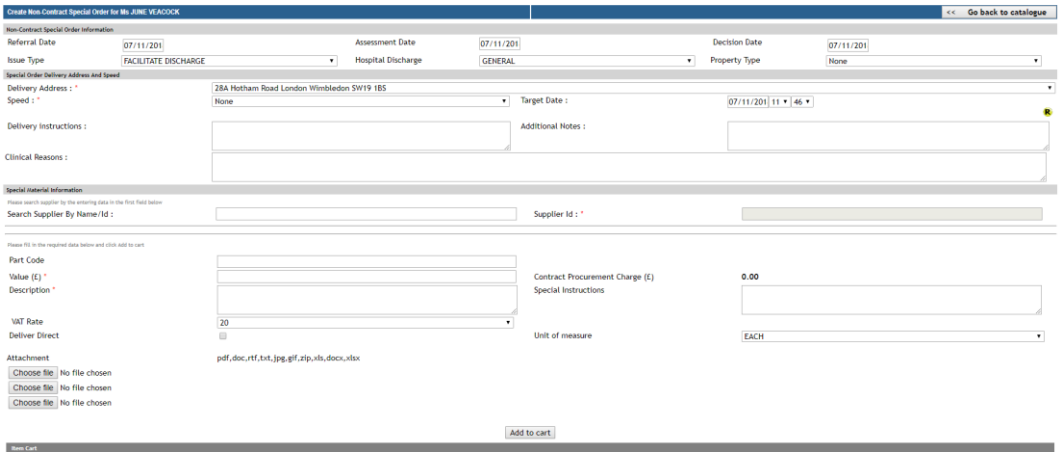


When you have done this, go into the **"Browse Catalogue"** page and click **"Specials"** on the categories on the left-hand side of the page.

In the middle of the page, there will now be a button to create a special order. This will be displayed as **"Order New Non-Contract Special"**.

Step 2 – Entering Special Order Details

There are 3 sections of the special order page, these are **Non-Contract Special Order Information;** this will contain all of the order information e.g. Referral Date, Assessment Date, Decision Date, Issue Type, Hospital Discharge & Property Type. **Special Order Delivery Address and Speed;** this will contain the activity address for the order to be delivered to, the speed of the delivery, target date, delivery instructions, additional notes and clinical reasons. The third area of creating a special order is the **Special Material Information;** here you will need to enter all the information about the special material you would like to make the order for, you can also attach documents for this special.



Step 3 – Adding item to cart

When all the information is entered correctly for the special material you are ordering, press **"Add to Cart"**, this will then add the material to the special order then you can press **"Place Order"**

ADULT INPATIENT SURFACE SELECTION GUIDE FOR WARDS

In Step 1 select a score from 1, 2 and 3. If the patient has special circumstances use hybrid mattress in high mode until a bespoke plan is agreed with TVN. Reassess weekly or if needs change.

Step 1

Risk Assessment PURPOSE T 1		**Dependency in bed/ care needs 2**		**Pressure Point Severity (Category of pressure ulcer) 3**	
No Risk	**0**	**Independently** mobile/ repositions	0	Normal skin	0
At Risk no pressure ulcers- primary plan	**1**	**Medium** Controlled comorbidities In bed above 8 hours per day	1	Category 1/ 2 Mild Moisture associated skin damage Other wound types near bony prominences/ devices	1
'At Risk with pressure ulcers'- secondary plan	**2**	**High** Bed/ chair dependent requiring assistance with all care	2	Multiple category 2 Small Category 3/ unstageable	2
				Multiple or large category 3/ unstageable/ DTI's Category 4	3
*****Special Circumstances Refer to TVN 01902 695361**** TVN to assess with 1 working day or manager on call out of hours**		**Special Risk Guide** Unable to change the patients position due to Severe uncontrolled pain e.g septic arthritis Severe soft pitting oedema to multiple limbs/ above hips High risk and needs to sit upright due to medical needs 24/7 Patient decline mattress in alternating mode Severe contractures			

Step 2- Surface guide plan

All hybrid mattress must start on 'Hi' mode from admission if patient meets the primary or secondary plan of risk. Bariatric sizes can be sourced via teletracking. If low or underweight-'Lo' mode. **See escalation for spine instabilities section below**. Prevent contractures from admission with passive and active e exercises during personal care/ rehabilitation activities. Check the mattress is functioning each day and record function on the Intervention plan for skin damage and falls risk

Score/ Escalation	**Mattress plan**	**Cushion- assess seating/ posture and risk of falls**	**Heel protection plan**
0-2	**Foam**	**No cushion/ chair with integrated pressure redistribution**	Apply emollient daily Profile bed when lying supine to reduce pressure at heels Float heels using pillow/ device
2+ Underweight/ uncomfortable	**Lo mode**	**High risk cushion/ chair with integrated pressure redistribution Unless using a therapy chair**	
2+ Up to 158Kg (25 stone)- not bariatric	**High mode**	**High risk cushion Unless using a therapy chair**	
Bariatric	**Bariatric bed and mattress**	**Bariatric cushion/ chair**	
****** Escalation Spinal instability*****	**Foam mode/ spinal bed (seek T and O advice) and follow spinal pathway until medical team deem patient is safe for an alternating mattress**		**Caution-**Do not use heel troughs if leg is

		oedematous or if patient is agitated

Step 3 Surface Discharge Planning

- Reassess and plan short term loan for patients with a rehabilitation plan or long-term plan for patients without a rehabilitation plan or expectation
- Follow appropriate community surface selection guide for selecting surfaces
- Arrange equipment delivery and explain to patient/ carer the equipment is loaned

Step 4 Escalation plan for special circumstances

Some patients have special circumstances whereby the fundamental elements of care are difficult to achieve due to the special risk listed in step 2.

- Refer to TVN.
- TVN to assess within 1 working day face to face and approve device with ward Matron

Low airloss criteria	Therapy mattress criteria
Underweight and cannot change positions Severe oedema in multiple limbs Severe pain e.g septic arthritis Category 4 or multiple deep pressure ulcers.	Extreme complex paediatric or adult case where a low airloss mattress is not suitable
Current rental provider- Direct health care +44 (0) 800 043 0881 / F: +44 (0) 845 459 9832 / info@directhealthcaregroup.com	Obtain quote to rent from Medstrom.- 08453711717. If required on discharge submit and individual funding request to local approval group

Note: Kyphosis and unable to position on side, procure a rental cost for a sleep system.

- Tissue viability to raise a purchase order for the rental using the trust approved process
- Finance to cross charge the relevant wards each month
- Tissue Viability to arrange delivery and PAT testing
- Transfer patient
- If a low air mattress is required for discharge, check local area process for low airloss
- Wolverhampton- gain quote from equipment provider and submit an individual funding request to rent if short term or purchase if deemed for long term use.
- Report any functional concerns to the equipment provider if rented
- Tissue Viability to record the request and rental on a database
- Tissue viability to check expected length of stay each week and arrange collection of the device once the patient is discharged
- Once the bespoke equipment is not required, clean equipment, store in a bag and attach a dated decontamination label and contact tissue viability to arrange collection

COMMUNITY ADULT SURFACE SELECTION GUIDE

Select a score from 1, 2 and 3 in step 1. If the patient has special circumstances use hybrid mattress in high mode until a bespoke plan is agreed with TVN. Reassess weekly or if needs change.

Step 1

Risk Assessment PURPOSE T 1		**Dependency in bed/ care needs 2**		**Pressure Point Severity (Category of pressure ulcer) 3**	
No Risk	**0**	**Independently** mobile/ repositions	0	Normal skin	0
At Risk no pressure ulcers- primary plan	**1**	**Medium** Controlled comorbidities In bed above 12 hours per day	1	Category 1/ 2 Mild Moisture associated skin damage Other wound types near bony prominences/ devices	1
'At Risk with pressure ulcers'- secondary plan	**2**	**High** Bed/ chair dependent requiring assistance with all care (carers 4 times per day)	2	Multiple category 2 Small category 3/ unstageable	2
				Multiple or large category 3/ unstageable/ DTI's Category 4	3
*****Special Circumstances Refer to TVN 01902 695361**** TVN to triage with 1 working day or manager on call out of hours**		**Special Risk Guide** Unable to change the patients position due to clinical risks Severely underweight Patient must sit upright due to medical needs 24/7 Severe soft pitting oedema to multiple limbs/ above hips Severe contractures			

Step 2- Surface guide plan

If underweight-check mattress specification and set to correct level. If patient is bedbound teach carer exercises to prevent contractures. Check the mattress is functioning when risk score is reassessed. Record function and assessment of mattress in nursing records.

Score/ Escalation	**Mattress plan**	**Cushion- assess seating/ posture and risk of falls**	**Heel protection plan**
0	No surface	No cushion	Nil
1	Modular Foam overlay (assess height of bed)	Modular cushion	Ensure carers apply emollient daily. If using a hospital bed profile bed when lying supine to reduce pressure at heels Float heels using pillow/ device
2 no risk of end of life deterioration	Replacement foam	Medium risk cushion unless using a riser recliner/ specialist chair	
2- 3 end of life potential to deteriorate	Hybrid foam + pump device on standby when needs deteriorate	High risk cushion	
3+ and bedbound	hybrid foam with pump device	High risk unless using a therapy chair	
Reassessment. Mattress function and suitability should be reassessed when PURPOSE T is reassessed	Short term 12 week maximum loans	Reassess no later	**Caution** Do not use heel troughs if leg is oedematous or if patient is agitated
	Residential homes short term loans (except End of Life)	Advise care home of recommended mattress type to supply no later than 12 weeks and arrange collection of the surface	
	Long term loan	Reassess every 12 months	

Step 3 Surface step down planning

- Reassess and plan short term loan for patients with a rehabilitation plan or long-term plan for patients without a rehabilitation plan or expectation
- Follow appropriate community surface selection guide for stepping down
- Arrange equipment delivery/ exchange and explain to patient/ carer the equipment is loaned

Step 4 Escalation plan for special circumstances

Some patients have special circumstances whereby the fundamental elements of care are difficult to achieve due to the special risk listed in step 1. Senior nurses can complete an individual funding request if a person meets the listed criteria below. The individual funding request must be copied to rwh-tr.TissueViabilityTeam@nhs.net. Tissue Viability must maintain a specialist equipment database to aid equipment reviews at least annually.

All staff must receive the relevant medical device training and record on their internal training database and inform medical device trainers

Criteria	Device	Approver	Advice
Unable to reposition can use standard mattress	TOTO	Band 7 District Nurse	Check Drive Devilbiss site for availability. If unavailable obtain a quote and submit an individual funding request
Patient unable to use riser recliner to assist with sit to stand position	Repose Contur	Band 7 District Nurse	Riser recliners are for patients that can mobilise in general. An MDT approach may be required if patient becomes immobile to assess seating and confirm a safe product to use.
Bariatric	Bariatric hybrid/ alternating	Band 7 district nurse	Obtain quote via procurement and submit individual funding request
Underweight/ severe oedema/ Non healing category 4 pressure ulcers or multiple deep pressure ulcers	Athena- Drive devilbiss	Tissue Viability Nurse	Discuss needs with Drive Devilbiss Nurse/ Representative. Obtain rental quote if short term or purchase quote if long term and District nurse to submit an individual funding request to facilitate delivery if approved
Upright static position due to PEG/ Jejunostomy/ severe respiratory disease/ severe contractures	Artemis- Drive devilbiss	Tissue Viability Nurse	
Spinal injury patient unable to tolerate alternating mattress	Procure Poly Air type mattress E.G Roho/ Starlock	Tissue Viability Nurse	Obtain quote and complete individual funding request
Patient unable to use riser recliner to assist with sit to stand position	Repose Contur		Riser recliners are for patients that can mobilise in general. An MDT approach may be required if patient becomes immobile to assess seating and confirm a safe product to use.
Kyphosis (curvature of spine) and immobile	Procure a sleep system	Allied health care professional	MDT assessment

- Arrange delivery once approved by the Integrated Care Board
- Transfer patient
- Report any faults to Drive Devilbis
- Once the bespoke equipment is not required arrange collection by Drive Devilbiss
- Reassess equipment need at least annually and update specialist equipment database
- If patient are discharged with equipment, the patient/ or carer must be taught how to inspect the equipment and must be issued a contact number to report any faults or return of the equipment

INDEPENDENT LIVING SERVICE
Neville Garratt Centre
Bell Street
Wolverhampton, WV1 3PR
Telephone: 01902 553666 Fax: 01902 551511
E-mail ILSOTT@wolverhampton.gov.uk

Request for Non-Standard Item of Equipment (Special Order)

Assessment Date	
Name of Assessor	
Assessor's Base	
Contact Tel. No.	

CLIENT DETAILS

Name			
Address			
Date of Birth		Tel. No.	

EQUIPMENT DETAILS

Description of Equipment Requested (Please include product code)			
Cost		Delivery Charge	
Supplier Name and Address			
Tel. No.		Fax No.	

PLEASE ATTACH ANY QUOTE OR MANUFACTURER'S SPECIFICATION

Approved by ILS OT Team Leader	
Date	

Continue overleaf…..

For Stores Use Only

Date Ordered		Order Number	
Date Received		Referrer Advised	
Notes:			

REASONS FOR PROVISION OF NON-STANDARD EQUIPMENT

Client's Medical Condition	
Social Circumstances	

Checked availability of suitable equipment in Store?	

PLEASE INDICATE ANY OF THE FOLLOWING THAT WOULD APPLY IF EQUIPMENT IS NOT PROVIDED	
Risk of injury to client	
Risk of injury to carer	
May cause deterioration of medical condition	
Detrimental effect on quality of life/dignity	

Standard equipment has been tried unsuccessfully YES / NO If Yes please indicate what equipment and why it was unsuccessful
Is alternative measure available short term? YES / NO If Yes please indicate what
Any other information considered relevant

<u>ORDER WILL NOT BE PLACED WITHOUT APPROVAL OF ILS OT TEAM LEADER</u>

Assessor Signed:

Date sent to ILS:

MA100	New User Form for those needing access to the equipment ordering system on the TCES website

Reason for Form:	New User
Professional Profile:	Health
Authoriser:	
Prescriber Name:	
Job Title:	Sister
Email:	XX
Work Address:	
PostCode:	
Telephone Number:	
Work Mobile:	
Team Name:	**New Cross Hospital Nursing**
Team if not on above list:	
Clinical Banding:	
More than one Clinical Banding?	
Catalogue:	Staffordshire

OP96 – Attachment 3

Procedure/ Guidelines number and version	**Procedure for managing pressure ulcer and moisture associated skin damage incidents** *attachment for OP96 section 4.7*	**Status:** Final		**Author: Lorraine Jones issue Viability Lead Nurse** **For Trust-wide Procedures and Guidelines Chief Officer Sponsor: Head of Nursing-Quality**
Version / Amendment History	Version	Date	Author	Reason
	1.2	Jan 23	Lorraine Jones Tissue Viability Lead nurse	One local policy to have one shared process
Intended Recipients: This local standard operational procedure is to ensure the tissue viability team provide expert support for all pressure ulcer incidents which must remain owned by the local service in each division.				
Consultation Group / Role Titles and Date: Tissue Viability Steering group- Nov 22 remotely. Jan 23				
Name and date of group where reviewed	As above			
Name and date of final approval committee (if trust-wide document)/ Directorate or other locally approved committee (if local document)	Tissue Viability Steering group- date Jan 23			
Date of Procedure/Guidelines issue	July 2023			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	June 2026			

Training and Dissemination: Local team competency training, including governance team support	
Publishing Requirements: Can this document be published on the Trust's public page: **No- not required**	
To be read in conjunction with: OP 96- pressure ulcer prevention and management operational policy (RWT) OP13- Information Governance operational policy OP07 Health Records Policy OP05 Adult Safeguarding Supervision Policy OP10 Risk Management and Patient Safety Reporting Policy OP85 Information Sharing Policy and Wolverhampton Overarching Information Sharing Protocol Op110 PREVENT policy	
Initial Equality Impact Assessment: Completed- No Full Equality Impact assessment (as required): Completed NA	
Contact for Review	Tissue Viability Lead Nurse- Lorraine Jones
Monitoring arrangements	Tissue Viability Steering group will monitor the effectiveness of the process annually
Document summary/key issues covered. The purpose of this document is to ensure all pressure ulcers incidents are validated to ensure: • Proactive tissue viability responsiveness to all patients with complex wounds • To ensure trust acquired data is accurate on each incident system for live data dashboards • To enable prompt local review of the incident and local accountability of learning • To enable prompt hematic reviews of incidents to drive local quality improvement plans • To ensure incidents at high risk of moderate harm and above are presented at the trust pressure ulcer thematic action group in a timely manner to escalate relevant incident for local division duty of candor process.	
Key words for intranet searching purposes	Validation Pressure ulcers Moisture associated skin damage Tissue Viability Incident Datix Pressure ulcer rapid review

1.0 Purpose

The purpose of this local procedure is to ensure all pressure ulcer (PU) and moisture associated skin damage (MASD) incidents are reported and managed in a timely manner. The procedure will enable prompt review of all new to trust (acquired) incidents to expedite early specialist assessments, sustain accurate live incident data, harms levels and thematic review to enhance quality improvements.

2.0 Introduction

Pressure ulcers evolve due to multi-faceted reasons and are reported as an incident. Pressure ulcers can vary in state, size and often the cause is unknown until an incident is reviewed or investigated. It is a continual challenge to accurately report the diagnosis of a pressure ulcers and many wound types are reported as pressure ulcer unnecessarily. The services are asked to check the diagnosis and previous reporting prior to an incident submission to prevent over reporting. The pressure ulcer rapid review process will strengthen the accuracy of incident management, must confirm harm levels within and escalate new to trust (acquired) incident for a review or investigation to check reasonable steps were taken to prevent the incident and confirm the harm level of the incident within 5 working days, and facilitate themes and actions required to make improvements. Moisture associated skin damage wounds were expected to be reported as an incident since October 2018 to monitor and identify opportunities of improvement.

3.0 Scope

The scope of this procedure is to manage the incidents reported on the incident management system.

4.0 Definitions

Datix**-** RWT use Datix for reporting and managing incidents. Data is extracted for these systems for quality monitoring.

Duty of candour- an open and honest process for communicating information regarding the incident informally (at point of incident) or formally (if deemed moderate harm and above) following OP10 Risk Management and Patient Safety Reporting Policy.

Harm level-the harm level can be approved for all new to trust (acquired) incidents, following review/ investigation of the incident at the Pressure ulcer thematic action group. See attachment 3A for guidance on harm levels.

New to trust (acquired) incident- Is when a patient develops a PU or MASD whilst their care was managed regularly (daily to monthly) by a trust service or transferred from one service to another within the same time period.

Point of assessment incident (inherited)- Is an incident when a patient presents with a PU or MASD wound on admission to the caseload or has developed in between planned community care above a 28 day's review period e.g.: community catheter care, every 12 weeks or podiatry reassessment.

Pressure ulcer categorisation- The trusts refer to the EPUAP 2019 definitions and supported by

the NHSEI in the Pressure ulcer categorization poster-Attachment 3b
Pressure ulcer Rapid Review- is a process which facilitates a screening process of the circumstances which led to a pressure ulcer incident to agree harm levels, actions plans and a thematic review – attachment 3C, 3D, 3E.

Root cause analysis- a comprehensive root cause analysis will be completed if an incident is deemed moderate harm of above or reported as a serious incident using the trust approved General level 1 RCA template.

5.0 Responsibility

As per OP96

5.1 Tissue Viability Team

The Tissue Viability Team are responsible for ensuring the procedure is followed and all relevant new incidents have been screened and approved by the 5th of the following month to report accurate data. The have a responsibility for completing a thematic review quarterly to communicate themes and plan relevant quality improvement actions.

6.0 Specific Procedure

6.1 Trust service must check the diagnosis of a pressure ulcer and submit a pressure ulcer incident if present on admission to the trusts or developed during their care period. The incident must be submitted within 4 hours of the skin assessment or on the day of the community contact following discussion with link nurse, senior nurse or TVN.

6.2 The tissue viability team must review all reported pressure ulcer incidents to allocate a tissue viability nurse to triage or assess all patients reported with a category 3, 4 or unstageable pressure ulcer within 3 working days, unless there is a rationale.

6.3 The tissue viability team will check all incidents with recorded history on the Clinical Portal/ PAS/ other digital records system to assign the incident as ‘new to trust’ or ‘point of assessment’ and allocate the incident to the relevant service(s). If the patient’s wound has an atypical presentation, the incident must be discussed and agreed with the tissue viability team leader or Lead Nurse prior to escalation.

6.4 The tissue viability team must contact all services with a new to trust category 2, 3, 4 or unstageable incidents, to request completion of a pressure ulcer rapid review attachment 3C, 3D or 3E following the Generic process guide attachment 3F

6.5 The service with a new to trust incident must screen the relevant records and submit the pressure ulcer rapid review report within 5 working day of report request. Extenuating circumstances must be approved by Matron or Tissue Viability Lead Nurse. If reports or not received within the expected time, the tissue viability team must list the outstanding reports on the weekly incident report submitted to the Heads of nursing, Matron(s) and ward leaders.

6.6 The completed pressure ulcer rapid review report must be listed on the weekly screening meeting to ensure the wound diagnosis and harm level are approved within 7 days of receiving the report.

6.7 If the incident is deemed moderate or above, the rapid review screening lead and reported will consider if the report requires a level 2 RCA, agree an action plan and the incident must be presented to the Pressure ulcer thematic action group within 14 days of the screening meeting. The tissue viability team must inform Governance, matron, heads of nursing and quality Head of nursing

6.8 All moderate harm and above incident must return with action plan completion assurance within 12 weeks of the moderate harm escalation.

6.9 The tissue viability team must ensure all relevant details are corrected or updated within the incident. Notes must be recorded within the notes section on the incident to have an audit trail of incident amendments.

6.10 the tissue viability team must complete a report to communicate the outcomes of the incident meetings to ensure lessons and actions are communicated to share across each division. The report must be sent to the tissue viability steering group representatives (Matrons), Heads or nursing, meeting attendees.

6.11 The divisional representatives must submit a monthly report to the tissue viability steering group.

6.12 The tissue viability team must complete a quarterly thematic review report to submit to the tissue viability steering group.

6.13 All incident data must be checked prior to the 5th of the following month to ensure the data is accurate for internal reporting processes.

6.14 MASD incident data is not validated, therefore all incident data must be checked for duplications prior to the 5th of the following month to prevent over reporting of incidents.

6.15 The tissue viability service must escalate all Black Country care home incidents reported and confirmed as category 3, 4 or unstageable pressure ulcers via email using the Care home pressure Ulcer Template attachment 3G to quality-team (NHS BLACK COUNTRY ICB - D2P2L) <bcicb.quality-team@nhs.net

6.16 The tissue viability service must escalate all point of assessment incidents from other trusts, reported and confirmed as category 3, 4 or unstageable pressure ulcers via email using the point of assessment pressure ulcer Template attachment 3 H to **rwh-tr.SUIReporting@nhs.net** for the governance team to forward to the relevant trust

References

Coleman, S.et al (2014).	Developing a pressure ulcer risk factor minimum data set and risk assessment framework. *Journal of Advanced Nursing*, *70*(10), 2339-2352
European pressure ulcer advisory panel (2014)- digital version 2016	http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf

National Health Service England (2022)	Patient Safety Incident Response Framework, B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)
National Health Service Improvement (2018)	Pressure ulcers: revised definition and measurement: summary and recommendations. National Health Service Improvement June 2018 London
National Health Service Improvement (2015)	Serious Incident Framework, National Health Service Improvement March 2015 London

Pressure ulcer harm guide for incident reporting

The Royal Wolverhampton NHS Trust

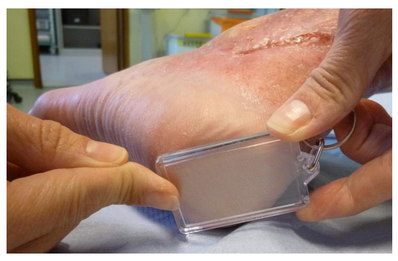
Pressure ulcers (PU): all pressure ulcers (PU) must be assessed individually to determine the level of harm, initially at point of incident. The final harm level will be agreed by the trust following the trust approved investigation and scrutiny of the incident. The severity depends on factors including size, depth, anatomical location, longer term effects and lapses in care leading to the development of the pressure ulcer. It is possible a category 4 pressure ulcer may heal fully with appropriate management, whereas a category 3 pressure ulcer may deteriorate and lead to sepsis. Equally a large category 2 may cause scarring or a chronic wound.

No harm	Low	Moderate	Severe	Death
No lessons learnt leading up to the incident. The investigation demonstrates the predisposing factors/ patient choice despite knowing risks/ secondary effects of medical condition expecting to cause the wound. e.g. Covid related skin changes or end of life skin changes There must be good evidence of continual prevention strategies All point of assessment incidents with no trust involvement as the trust did not cause the harm. Note- follow safeguarding guidance for any safeguarding concerns	New to trust unexpected or unintended pressure ulcer pressure ulcer incident with minimal lessons to be learnt that contributed to the PU forming. The PU must be expected to fully heal within 28 days. Typically category 1 or 2 with no long-term effects or scarring (may need to consider the size of some category 2's). Deep tissue injury (DTI) and some unstageable incidents will require monitoring and the original incident must be updated with the worst category if known at point of investigation scrutiny. The level of harm must be reviewed and altered accordingly following investigation. A category 3 PU may on occasions be defined as low harm depending upon size, location and likelihood of healing completely without scarring. The rationale for this must be clear in the investigation of the incident.	A new to trust unexpected or unintended PU incident which cause by lapses in care and requires complex interventions, however, the wound is expected to heal fully. The patient experiences no long term / permanent complications although there may be some scarring. Typically category 3 or 4 and some unstageable PU's deemed likely to debride to a category 3 or 4. The interventions include: specialist wound management support, specialist equipment, delays rehabilitation due to the pressure ulcer / other treatment e.g. surgical intervention, Intravenous antibiotics, negative pressure wound therapy, delayed hospital discharge due to the PU or a change of place of care as a result of the pressure ulcer. The impact is such that the person is unable to return to work or resume usual baseline activity level as a direct consequence of the incident.	A new to trust unexpected or unintended PU which results in long term or life changing complications as a direct result of lapses in care and the person is unable to resume usual baseline activity level as a direct consequence (e.g. amputation, skin grafts, loss of mobility after healing), extensive scarring with significant, lasting psychological impact.	A new to trust unexpected or unintended PU caused by lapses in care and results in death because the PU directly contributed to, or hastened death (e.g. Sepsis). A death attributed directly to a procedure which was necessary due to the pressure ulcer, for example treatment by surgical debridement, amputation, skin-grafts and flaps.

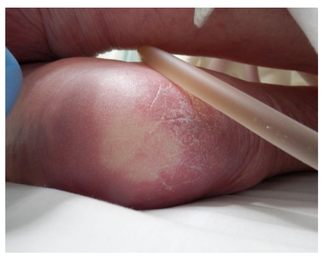
Pressure ulcer categorisation

Blanching erythema

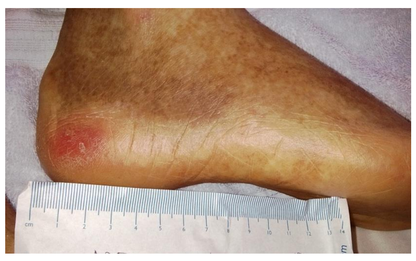
Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish.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



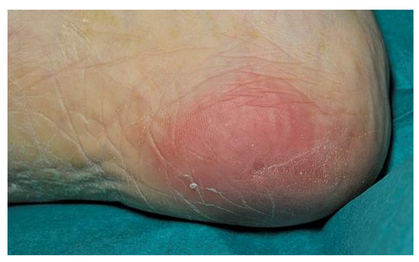
Example of skin blanch



Blanch in darker skin



This redness is persistent and does not blanch



This redness will not blanch when pressure is applied

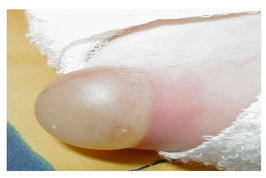
Category 1: Non-blanchable erythema

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

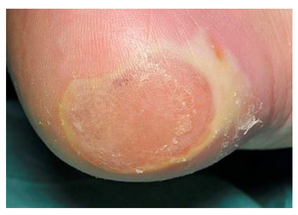
Category 2: Partial thickness skin loss

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

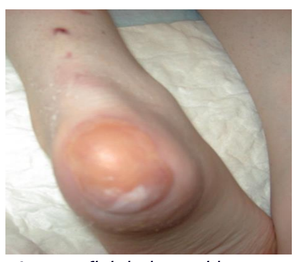
**Bruising indicates suspected deep tissue injury.*



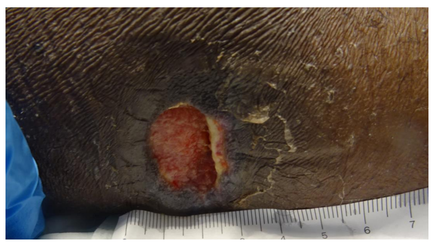
An intact serum-filled blister



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



A superficial ulcer with a collapsed blister



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

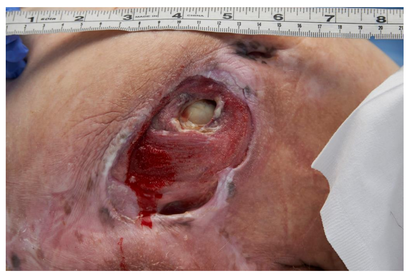
Category 3: Full thickness skin loss

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

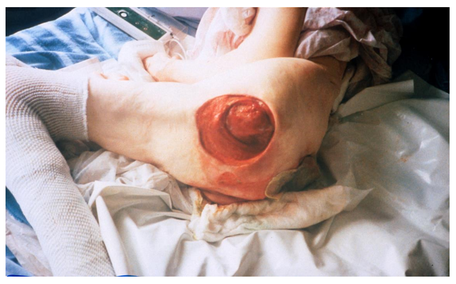
May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep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

Category 4: Full thickness tissue loss

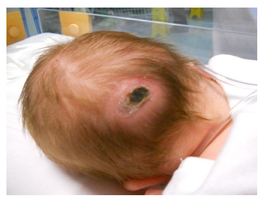
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not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



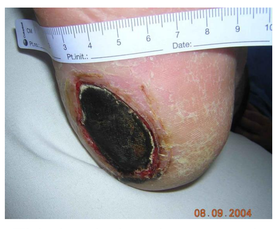
In this wound, the bone is clearly visible



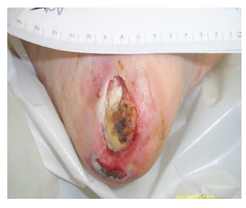
This wound shows exposed muscle



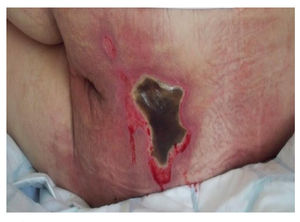
This occipital ulcer is covered by softening necrosis



This heel ulcer is covered by hard dry eschar



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



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

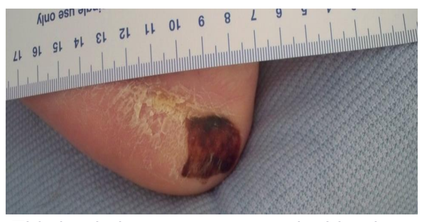
Unstageable: depth unknown

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

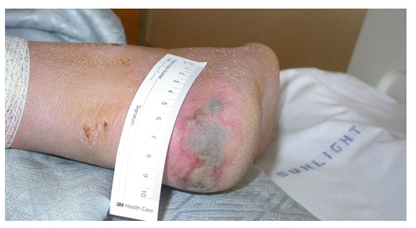
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected deep tissue injury: depth unknown

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



This heel ulcer appears as a dry blood blister



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

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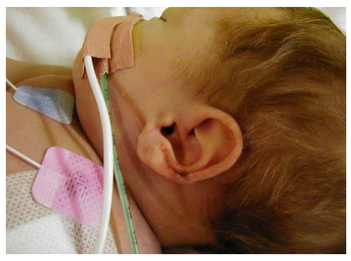
Pressure ulcer categorisation

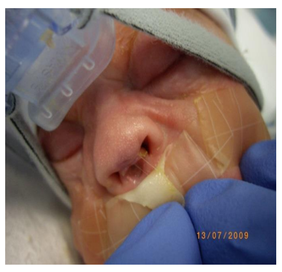
Device-related pressure ulcers (DRPU)

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

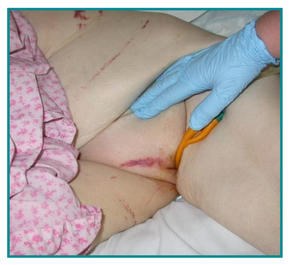
While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition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



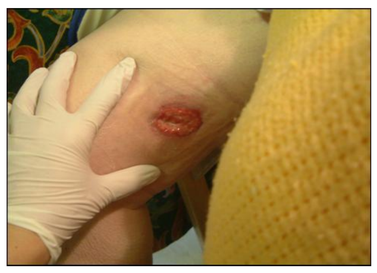
This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear



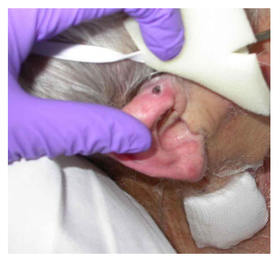
This neonate has damage to the nares that cannot be categorised



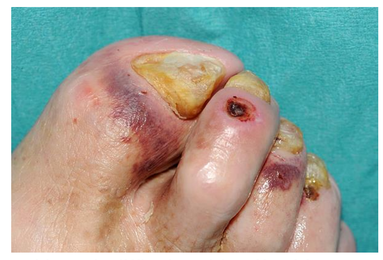
The damage caused by this urinary catheter could be categorised as a DTI (d)



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



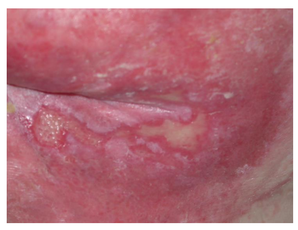
Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



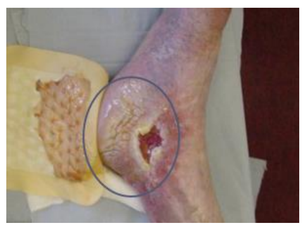
Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

Moisture-associated skin damage

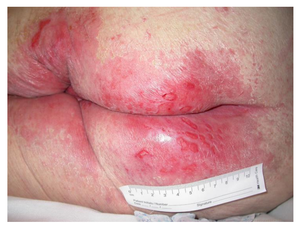
This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat



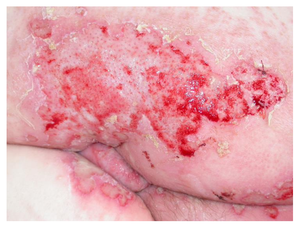
These multiple superficial lesions with diverse edges are typical of Incontinence Associated Dermatitis



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

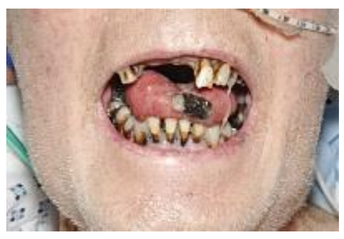


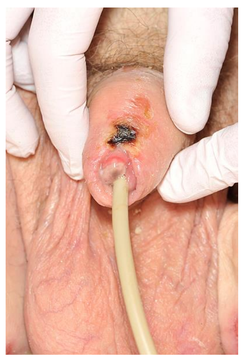
Wounds related to IAD such as these are often extremely painful



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

Mucosal pressure ulcers





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

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The Royal Wolverhampton NHS Trust

RAPID REVIEW- PRESSURE ULCER (PU) (not device related) INCIDENT- ADULT COMMUNITY AREAS

Your ward or another service has reported this patient on Datix/ Safeguard. Please check details. Complete all steps if you agree with the diagnosis of the wound. If the diagnosis is incorrect, complete step 1, discuss with a TVN and submit the form and share the outcome with the reporter for learning. The document must be completed no later than ***5 working days*** *from the escalation. Extension will be granted in special circumstances only. Please* use- √ in relevant fields(s). Email report to:

RWT: Tissue Viability- *rwh-tr.TissueViabilityTeam@nhs.net*

Step 1- The incident- Shaded area to be completed by TV team

Incident number		**Incident date**		**Locality/ service**		**NHS Number**	
Category of worst pressure ulcer		**Site and size cm2**			**Other pressure ulcers (sites and category)**		
Correct diagnosis of wound- *if yes proceed to step 2, if no return step 1 completed to TV generic email*	**Y/ N**	*If no following discussion with TVN, inform reporter for learning. TVN to record wound type and amend incident*					
Recurrent pressure ulcer history		Self-neglect pre -admission		Safeguarding referral			

Step 2- The incident review

Synopsis of patient journey leading to pressure ulcer- pertinent details e.g., reason for community contacts up to 2 weeks prior to this incident and any changes in clinical needs e.g., sepsis/ infection/ respiratory/ cardiac/ diabetic control/ vascular/ social/EOL/ mobility psychological. State if length of stay was extended due to the pressure ulcer.					
Date of admission to caseload:		**Recent acute discharge date (if within 2 weeks):**		**Social care package provider and frequency**	
Date needs recently changed to lead to pressure ulcer formation (red skin/ change of mobility)		**Other community services involved/ care home name**		**Informal carer arrangements**	

Pre-disposing factors (tick √)				Pyrexial (T)		Deranged vital signs P/ R/ BP		Deteriorating patient	
Neurological		Gastroenterology		Nutrition		Urology		Urinary incontinence	
Mental health		Colorectal		Hydration		Renal		Faecal incontinence	
Respiratory		Arterial		Venous		Diabetes		Musculoskeletal (contractures)	
Cardiac		Lymphoedema/ oedema		Dermatological		Immunocompromised		Orthopaedic	
Moisture associated skin damage (MASD) pre-PU formation				Sepsis		Long lie pre-admission		End of life	
Bed/ chairbound		Restricted/ reduced mobility		Medication- inotropes/ long term steroids		Social reasons		Cancer treatments	

	Fundamental elements	Y/ N/ NA unless √ required	Learning summary
a- assessment	Purpose T completed within recommended time frames (√) **Admission day**		**1/12** **3/12** **Change of needs**
	Purpose T completed correctly, and care plan evaluated		
	Contacts achieved as planned if no state rationale and actions to mitigate risks		
S- Skin inspection	Skin inspection prescribed frequency achieved		**State prescribed frequency**
	Skin care and barrier products available/ advised and used if incontinent?		
	Dry skin (particularly heels) managed with emollient?		
	MASD managed as per assessment and care plan		
	Quality of life and wound assessment completed every 28 days		
	Wounds between ankle and knee/ painful legs on elevation- generalist vascular assessment completed		
	Referred to TVN if complex or deteriorating/ static wound-state date of referral and response date of virtual/ face to face advice by TVN		
	Appropriate formulary wound care products planned and evaluated correctly		
	Access to planned dressing products within 48 hours or order/ plan		
	Foot health involved with wound if a foot wound?		
	If discharged from acute within last 2 weeks with a wound- discharge documentation stated wound type, care plan and 7 days products issued?		
S- Surface	Mattress Foam overlay Foam replacement	**Hybrid**	**Dynamic only** **Low air loss**
	If mattress was faulty, appropriate action was taken and documented		
	Turning device if appropriate		
	Cushion- sacral/ buttock incidents only	**Low risk foam**	**Medium/ high foam** **High risk gel** **Bespoke chair**
	Slide sheet provided and explained		
	Other moving and handling aids e.g. hoist/ banana board/ standaid		
	Heels offloaded if heel incident only		
K- Keep moving	Prescribed reposition schedule was (hours) 2 4 6		
	Prescribed 2-4 hourly change of position was adhered to in residential home and sustained		

	Sacral/ buttock incident- restricted seating plan advised and checked if wound Unstageable/ C3/C4/ DTI		
I- Incontinence and moisture	Continence assessed and appropriate toileting plan/ products prescribed and evidence of use		
N- Nutrition and hydration	Food and fluid intake assessed/ MUST as per plan and advice discussed and recorded		
g- Giving information	Patient was issued a leaflet or prevention advice was discussed verbally		
	Patient made decision against medical advice- patient autonomy pathway was commenced and reviewed to help gain engagement		
	Referral and suitable response by relevant specialist for MDT approach		
	Were risk(s) and discussed at handover as patient and their skin began to show signs of pressure damage		

Step 3- Human factors

Synopsis of relevant human factors which contributed to this incident: Team capacity/ New starters/ locality safe care red flag/ multiple wards moves/ Pressure ulcer training compliance

Step 4- Summary of cause

Confirm cause/ significant contributing factors of the wound- tick √ relevant fields(s)					
Predisposing factors		Long lie pre-admission		Acuity of patient- too unwell to move	
Prolonged same position with no clinical rationale		Lapses in fundamental elements of care e.g., Skin care/ continence/ nutrition/ wound assessment/		Non concordance	
				Lapses with heel offloading in bed	
				Human factors- work allocation	
Reporter name(s) and designation:				**Date:**	

Step 5- Pressure ulcer thematic action group

<table>
<tr><th>Panel checklist</th><th colspan="5">Heads of Nursing meeting outcome (tick (tick √ relevant rows)</th></tr>
<tr><td>The omissions/ lapses in care or lessons learnt significantly contributed to this incident and caused the pressure ulcer?</td><td>If Yes- complete this column and state outcome below</td><td>SI</td><td>DOC</td><td>If No- complete this column and state outcome below</td><td>DOC</td></tr>
<tr><td rowspan="5">Note - *If it is found that Moderate Harm was suffered by the patient, but there was no causation by RWT then Duty of Candour is NOT contractually applicable. However, it may be applied as best practice, at the discretion of the panel</td><td>Cat 2 and unstageable depending on image/ wound assessment – Low harm</td><td>No</td><td>*No</td><td rowspan="2">No harm- - complete one row below to summarise lessons learnt outcome</td><td rowspan="2">*No</td></tr>
<tr><td rowspan="2">Category 4/ Category 3 or complex unstageable likely to debride to a category 3 or 4- Moderate Harm</td><td rowspan="2">TBC</td><td rowspan="2">Yes</td></tr>
<tr><td>Not serious incident reportable. Lessons learnt not contributory, local actions only.</td><td></td></tr>
<tr><td rowspan="2">Death/ loss of limb/ long term harm due to pressure ulcer any category/ Change of place of care due to incident- Severe harm</td><td rowspan="2">YES</td><td rowspan="2">YES</td><td>Not serious incident reportable. No lessons identified- no further actions</td><td></td></tr>
<tr><td rowspan="2">Not serious incident reportable. No lessons identified for RWT, lessons for other services EG: care home/ social care</td><td rowspan="2"></td></tr>
<tr><td colspan="3">Safeguarding- Concern and notification referral form SA1/ MARF</td><td></td></tr>
<tr><td colspan="2">Panel comments and recommendation summary. Confirm if further investigation is required if an incident is moderate harm and above</td><td colspan="4"></td></tr>
<tr><td colspan="2">Tissue Viability Nurse signature and date</td><td colspan="4"></td></tr>
</table>

Tissue Viability admin will upload relevant theme data for a thematic review, themes will be shared with each division at an agreed frequency

The Royal Wolverhampton NHS Trust

RAPID REVIEW- PRESSURE ULCER (PU) (not device related) INCIDENT- ADULT INPATIENT AREAS

Your ward or another service has reported this patient on Datix/ Safeguard. Please check details. Complete all steps if you agree with the diagnosis of the wound. If the diagnosis is incorrect, complete step 1, discuss with a TVN and submit the form and share the outcome with the reporter for learning. The document must be completed within preferably ***2 working days*** *of receipt whilst the patient is with you and no later than* ***5 working days****. Extension will be granted in special circumstances only. Please* use**-** √ in relevant fields(s). Email report to:

RWT: Tissue Viability on rwh-tr.TissueViabilityTeam@nhs.net

Step 1- The incident-

Incident number		**Incident date**		**Number of days since admission**		**Ward(s)**	
NHS Number							
Category of worst pressure ulcer		**Site and size cm2**		**Other pressure ulcers (sites and category)**			
Correct diagnosis of wound- *if yes proceed to step 2, if no return step 1 completed to TV generic email*	**Y/ N**	*If no following discussion with TVN, inform reporter for learning. TVN to record wound type and amend incident*					
Recurrent pressure ulcer history		Self-neglect pre -admission		Safeguarding referral			

Step 2- The incident review

Synopsis of patient journey leading to pressure ulcer- pertinent details e.g., reason for admission and any changes in clinical needs e.g., sepsis, respiratory, cardiac, diabetic control or vascular. State if length of stay was extended due to the pressure ulcer.											
Ambulance delay (home/ handover):	Y		N		NA		**Date of admission**		**Number of hours on a trolley in ED**		**Date of discharge from hospital**	
	state known hours):											

Pre-disposing factors (tick √)				Pyrexial (T)		Deranged vital signs P/ R/ BP		Deteriorating patient	
Neurological		Gastroenterology		Nutrition		Urology		Urinary incontinence	
Mental health		Colorectal		Hydration		Renal		Faecal incontinence	
Respiratory		Arterial		Venous		Diabetes		Musculoskeletal (contractures)	
Cardiac		Lymphoedema/ oedema		Dermatological		Immunocompromised		Orthopaedic	
Moisture associated skin damage (MASD) pre-PU formation				Sepsis		Long lie pre-admission		End of life	
Bed/ chairbound		Restricted/ reduced mobility		Medication- inotropes/ long term steroids		Social reasons		Cancer treatments	

	Fundamental elements	**Y/ N/ NA**	**Learning summary**
a- assessment	Purpose T completed correctly within 6 hours of admission		

	Purpose T completed correctly on ward transfer/ every 7 days or if needs changed and care plan evaluated		
S- Skin inspection	Skin inspection 1-2 x daily		
	Skin care and barrier products applied if incontinent?		
	Dry skin (particularly heels) managed with emollient?		
	MASD managed as per risk assessment and care plan (To be launched 2022)		
	Wound assessment completed every 7 days		
	Referred to TVN if complex or deteriorating wound-state date		
	Appropriate wound care planned and evaluated		
	If discharged with a wound- discharge documentation stated wound type, care plan and 7 days products issued?		
S- Surface	Correct mattress mode for risk and clinical needs recorded		
	If mattress was faulty, appropriate action was taken and documented		
	Cushion/ chair with integrated pressure if sacral/ buttock incident only		
	Slide sheet evidence to reduce shear and friction when appropriate		
	Heels offloaded if heel incident only		
K- Keep moving	Prescribed reposition schedule was (hours) 2 ☐ 4 ☐ 6 ☐		Prone + 2 hourly limb and head position change ☐
	Prescribed 2 or 4 hourly change of position was adhered to and sustained		
	Sacral/ buttock incident- restricted seating position if wound Unstageable/ C3/C4/ DTI		
I- Incontinence and moisture	Continence assessed and appropriate toileting plan/ products prescribed and evidence of use		
N- Nutrition and hydration	Food and fluid charts show suitable monitoring of nutrition and fluids and escalation as required		
g- Giving information	Patient was issued a leaflet or prevention advice was discussed verbally		
	Patient made decision against medical advice- patient autonomy pathway was commenced and reviewed to help gain engagement		
	Referral and suitable response by relevant specialist for MDT approach		
	Were risk(s) and plan on handover		

Step 3- Human factors

Synopsis of relevant human factors which contributed to this incident: Team capacity/ New starters/ ward safe care red flag/ multiple wards moves/ Pressure ulcer training compliance

Step 4- Summary of cause

Confirm cause/ significant contributing factors of the wound- tick √ relevant fields(s)					
Predisposing factors		Long lie pre-admission		Acuity of patient- too unwell to move	
Prolonged same position with no clinical rationale		Lapses in fundamental elements of care e.g., Skin care/ continence/ nutrition		Non concordance	
				Lapses with heel offloading in bed	

Reporter name(s) and designation:	**Date:**

Step 4- Pressure ulcer thematic action group

Panel checklist	**Heads of Nursing meeting outcome (tick (tick √ relevant rows)**				
The omissions/ lapses in care or lessons learnt significantly contributed to this incident and caused the pressure ulcer?	**If Yes- complete this column and state outcome below**	SI	**DOC**	**If No- complete this column and state outcome below**	**DOC**
Note - ***If it is found that Moderate Harm was suffered by the patient, but there was no causation by RWT then Duty of Candour is NOT contractually applicable. However, it may be applied as best practice, at the discretion of the panel**	Cat 2 and unstageable depending on image/ wound assessment – **Low harm**	No	*No	**No harm-** - *complete one row below to summarise lessons learnt outcome*	*No
	Category 4/ Category 3 or complex unstageable likely to debride to a category 3 or 4- **Moderate Harm**	**TBC**	**Yes**	Not serious incident reportable. Lessons learnt not contributory, local actions only.	
	Death/ loss of limb/ long term harm due to pressure ulcer any category/ Change of place of care due to incident- **Severe harm**	**YES**	**YES**	Not serious incident reportable. No lessons identified- no further actions	
				Not serious incident reportable. No lessons identified for RWT, lessons for other services EG: care home/ social care	
Safeguarding- Concern and notification referral form SA1/ MARF					
Panel comments and recommendation summary. Confirm if further investigation is required if an incident is moderate harm and above					
Tissue Viability Nurse signature and date					

Tissue Viability admin will upload relevant theme data for a thematic review, themes will be shared with each division at an agreed frequency

The Royal Wolverhampton NHS Trust

RAPID REVIEW- DEVICE RELATED PRESSURE ULCER INCIDENT- ADULT INPATIENT AREAS

Your ward or another service has reported this patient on Datix/ Safeguard. Please check details. Complete all steps if you agree with the diagnosis of the wound. If the diagnosis is incorrect, complete step 1, discuss with a TVN and submit the form and share the outcome with the reporter for learning. The document must be completed within preferably ***2 working days*** *of receipt whilst the patient is with you and no later than* ***5 working days****. Extension will be granted in special circumstances only. Please* use**-** √ in relevant fields(s). Email report to:

RWT: Tissue Viability on rwh-tr.TissueViabilityTeam@nhs.net,

Step 1- The incident-

Incident number		**Incident date**		**Number of days since admission**		**Wards/ services**	
NHS number							
Category of worst pressure ulcer		**Site and size cm2**			**Device name, size and brand name**		
Correct diagnosis of wound- *if yes proceed to step 2, if no return step 1 completed to TV generic email*	**Y/ N**	*If no following discussion with TVN, inform reporter for learning. TVN to record wound type and amend incident*					
Recurrent pressure ulcer history		Self-neglect pre -admission			Safeguarding referral		

Step 2- The incident review

Synopsis of patient journey leading to pressure ulcer- pertinent details e.g., reason for admission and any changes in clinical needs e.g., sepsis, respiratory, cardiac, diabetic control or vascular. State if length of stay was extended due to the pressure ulcer.											
Device used pre - admission	Y		N		NA		**Date of admission**		**Date the device was started**		**Date of discharge from hospital**	
	state known hours):											

Pre-disposing factors (tick √)				Pyrexial (T)		Deranged vital signs P/ R/ BP		Deteriorating patient	
Neurological		Gastroenterology		Nutrition		Urology		Urinary incontinence	
Mental health		Colorectal		Hydration		Renal		Faecal incontinence	
Respiratory		Arterial		Venous		Diabetes		Musculoskeletal (contractures)	
Cardiac		Lymphoedema/ oedema		Dermatological		Immunocompromised		Orthopaedic	
Moisture associated skin damage (MASD) pre-PU formation				Sepsis		Long lie pre-admission		End of life	
Bed/ chairbound		Restricted/ reduced mobility		Medication- inotropes/ long term steroids		Social reasons		Cancer treatments	

	Fundamental elements	**Y/ N/ NA**	**Learning summary**
a- assessment	Purpose T completed correctly within 6 hours of admission		

	Purpose T completed correctly on ward transfer/ every 7 days or if needs changed and care plan evaluated		
	Patient was deemed at least Amber risk using Purpose T due to medical device		
	Documented evidence patient measured correctly for device		
	Appropriate document was commenced to monitor device safely e.g Cast ( )/ Head and Neck ( )/ orthotic ( ),		
S- Skin inspection	Skin inspection if device can be removed at every or planned contact		
	Skin care and barrier products applied to protect skin if device is at risk of moisture		
	Dry skin managed with emollient?		
	Hydrocolloid used to protect skin		
	Quality of life and wound assessment completed every 28 days		
	Referred to TVN if complex or deteriorating wound-state date		
	Appropriate wound care planned and evaluated		
S- Surface	Device size and fit was suitable for clinical need		
	Staff managing device have experience and competence using device		
	Tubing devices were positioned correctly to reduce risk of skin damage		
	Alternative solutions/ device plan was modified when category 1 skin changes were identified		
	If device was faulty was this documented and reported- **if yes state actions**		
K- Keep moving	Fit and application/ removal was explained to patients/ carer		
I- Incontinence and moisture	Oxygen tubing changed as per licence to reduce risk of moisture		
	Catheter tubing positioned and correctly to reduce risk of bypassing/ shear and friction		
N- Nutrition and hydration	Food/ fluid intake and MUST assessed and appropriate action taken if intake is low or unhealthy		
g- Giving information	Was the device type or brand new to staff e.g. a recent procurement/ supply switch		
	Patient/ service was issued a leaflet or device advice was discussed verbally		
	Patient made decision against medical advice- patient autonomy pathway was commenced and reviewed to help gain engagement		
	Advice from relevant service received or accessed to formulate and monitor correct use of device		
	Were risk(s) and plan on handover		

Step 3- Human factors

Synopsis of relevant human factors which contributed to this incident: Team capacity/ New starters/ ward safe care red flag/ multiple ward moves/ pressure ulcer training compliance

Step 4- Summary of cause

Confirm cause/ significant contributing factors of the wound- tick √ relevant fields(s)					
Predisposing factors		Lapses with communication		Prolonged same position of device with no clinical rationale	
Lapses in fundamental elements of care e.g., Skin care/ continence/ nutrition		Lapse in documented evidence of appropriate device management		Non concordance	
				Lapse in communication/ education about device management	

Reporter name(s):	**Date:**

Step 4- Pressure ulcer thematic action group

Panel checklist	**Heads of Nursing meeting outcome (tick (tick √ relevant rows)**				
The omissions/ lapses in care or lessons learnt significantly contributed to this incident and caused the pressure ulcer?	**If Yes- complete this column and state outcome below**	SI	**DOC**	**If No- complete this column and state outcome below**	**DOC**
Note - ***If it is found that Moderate Harm was suffered by the patient, but there was no causation by RWT then Duty of Candour is NOT contractually applicable. However, it may be applied as best practice, at the discretion of the panel**	Cat 2 and unstageable depending on image/ wound assessment – **Low harm**	No	*No	**No harm-** - *complete one row below to summarise lessons learnt outcome*	*No
	Category 4/ Category 3 or complex unstageable likely to debride to a category 3 or 4- **Moderate Harm**	**TBC**	**Yes**	Not serious incident reportable. Lessons learnt not contributory, local actions only.	
	Death/ loss of limb/ long term harm due to pressure ulcer any category/ Change of place of care due to incident- **Severe harm**	**YES**	**YES**	Not serious incident reportable. No lessons identified- no further actions	
				Not serious incident reportable. No lessons identified for RWT, lessons for other services EG: care home/ social care	
Safeguarding- Concern and notification referral form SA1/ MARF					
Panel comments and recommendation summary. Confirm if further investigation is required if an incident is moderate harm and above					
Tissue Viability Nurse signature and date					

Tissue Viability admin will upload relevant theme data for a thematic review, themes will be shared with each division at an agreed frequency

GUIDE FOR PRESSURE ULCER INCIDENT MANAGEMENT

Incident submission- Service reports a new (acquired) and point of assessment (inherited) pressure ulcer on incident reporting system

Incident assignment- Tissue Viability Admin to check all trust system to check if any incident is new to trust and update all relevant fields within the incident to capture all new to trust incidents accurately

Rapid review request- Tissue Viability admin to pull down an excel list of new to trust incidents and send an email requesting completion of the relevant rapid review document to ward leaders/ service leaders

Ward/ community service check image/ wound diagnosis and complete rapid review

Not a pressure ulcer – complete step 1 and return document to tissue viability generic email within 5 days

Ward/ community service rapid review- confirmed pressure ulcer. Screen the notes, submit a completed rapid review form step 1-4 and submit to Tissue viability generic emails within 5 days

Rapid review not received within 5 days- TV admin to inform TVN to arrange support/ extension. **Note: all Category 3/ 4 or unstageable incidents at risk of moderate harm outcome must be received within the 5 days. All contacts to be recorded on incident**

Rapid review received. TV admin to list on Pressure ulcer screen meeting agenda (TVN (chair) + band 5 or above to attend. To share learning on all incidents, agree harm and escalate moderate harm and above to Pressure ulcer thematic action group PUTAG and Governance.

Moderate harm+ - Agree Rca and escalate within 48 hours of screening meeting or add details to rapid review with action plan to submit within 14 days to present at PUTAG. Division to complete Duty of Candour 1. Confirm SA1/ MARF for division to escalate. TV admin to check/ update all datasets incident and upload rapid review document. Inform incident lead of PUTAG date. and inform governance team via generic email.

No/ Low harm-TV admin to check/update all dataset fields in incident, attach rapid review document and close incident.

TVN to collate themes for a 3 monthly report to be submitted to PUTAG with actions/ raise key themes

Pressure Ulcer thematic action group- HON/ Deputy DON (chair). Present moderate harm/ RCA. Confirm harm level/ serious incident. Agree plans from thematic review. TV admin to update incident and upload RCA and send completed Rca to Governance.

Quality improvement assurance- Ward/ division action plan to return to PUTAG to confirm closure of incidents in view audit/ incident data for quality improvement assurance.

Divisional reports to TV steering group, division representation to report back to divisional governance. All data to be collated direct from incident management system and cleansed by TVN between 5th and 10th on following month for assurance all new incidents have been escalated.

Care Home POA Pressure Ulcer Escalation Template

Ward/ service areas requested to support investigation		**Reporter/Person(s):**		**Date of Heads of Nursing accountability meeting *(maximum 3 weeks post escalation):***	
				Date the report must be submitted *(7 days prior to meeting date):*	

NHS number		**Datix number**		**Category(s)**	**Site(s)**	**Size(s)**
		Incident date				
DOB		**Date confirmed**				
Gender		**GP name and address**			**Confirming Nurse**	

If you are not aware of this pressure ulcer, please contact Tissue Viability on 01902 695361 to discuss.

The Royal Wolverhampton NHS Trust

Point Of Assessment Pressure Ulcer Escalation send to rwh-tr.SUIReporting@nhs.net and rwh-tr.TissueViabilityTeam@nhs.net							
Date Incident occurred		Date Incident Reported on datix		Date seen/ discussed/ confirmed		PU detected on first skin assessment within 6 hours of hospital admission/ first community contact	Yes
		Datix number					
The pressure ulcer is attributed to: (delete)				General practitioner name and surgery address , including area			
Incident Description	Category	Site	Size	Risk score	NHS number	DOB	Gender
Patient Status i.e. relevant PMH/ reason for admission/ palliative/ wheelchair/ bedbound/ history of long lie prior to admission							
Social care							
Safeguarding							

PRESSURE ULCER PREVENTION FOR ADULTS AND CHILDREN

Name:

Clinical Ward / Department:

Line Manager:

Date of commencement of competencies:

Date of completion of competencies:

Trust Professional Values and Standards:
Safe and effective
Kind and Caring
Exceeding Expectation

Introduction

The competency will allow nurses to develop the minimum expected standards in Pressure ulcer prevention for adults and children. Then also give further guidance for senior nurses, and tissue viability link nurse.

Aim

To improve the patient's experience, reduce avoidable harm and develop staff to their full potential

Objectives

- To improve knowledge and skills in pressure ulcer prevention.
- To develop staff to become link nurses or specialist nurses as part as of their career progression plan.
- To support revalidation

Assessor Signatures

For validation purposes, all Assessors involved in the assessment of the nurse undertaking these competences are required to provide a signature and the relevant details below.

While the use of personal stamps is encouraged, this should be in addition to, rather than a replacement for, the Assessor's signature

All Assessors are personally and professionally accountable for ensuring that they are competent to assess a nurse undertaking these competences.

Full Name	Position	Signature	Stamp

PRESSURE ULCER PREVENTION FOR ADULTS AND CHILDREN

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
Assessment and risk assessment -	To identify patients at risk of pressure ulceration .				
Holistic assessment- Understands the importance of assessing all holistic needs on initial assessment which includes:, Medical history, Previous pressure ulcer history, Medication, Venous bloods, Diabetic control, Neuropathic, Mobility and posture, Pain, Nursing, Social, Psychological.					
Knows how to report all signs of significant change to team, doctor and relevant specialist.					
Demonstrates how to risk assess a patient using the Purpose T(adults) risk assessment and the frequency in accordance to current policy OP96.					
Demonstrates how to risk assess a child using the Purpose T (paediatric (children's) risk assessment and the frequency in accordance to current policy OP96.					
Adults only- Knows how to complete a patient autonomy risk . Identifies potential causes of non-concordance such as pain, dementia, and understands reasons for advice Knows the importance of discussing risks and potential outcomes with the patient/ carer Documents all refusals on appropriate documents.	.				
Surface	Selection of correct surfaces				

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
	to prevent pressure ulceration.				
Knows the difference between a high specification foam and alternating or Hybrid/ alternating function mattresses, seating with integrated pressure relief and pressure redistributing cushions					
Has and understanding of the surfaces available such as : (specifications are on the tissue viability website) Roho/ Starlock- wheelchair cushions- community Bariatric beds- inpatient and community Sports bed- ICCU TOTO- tilt and turnover- lateral turning device Low air loss					
Community- Can identify unknown surfaces found in patients home/ care home, and can check specification to whether it is suitable for the patients current needs.					
Hybrid mattresses (foam and alternating)- awareness of how to select the correct setting based on mattress selection guide and clinical decision. Step down approach - from acute admission to identify the patients' needs and place setting on Hi. If conditions improves step down to foam. Step up approach - when a patients needs deteriorate i.e.: end of life in community or acute changes, step up to alternating.					
Knows to keep mattresses in static or foam mode if the patient has an unstable spine and await medical confirmation for any step up to an alternating system.					
Knows that an alternating mode may affect patients living with dementia- and to assess on an individual basis.					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
Inpatient areas- aware of the trust process for cleaning, auditing mattresses and escalating problems found such as: Seams, foams and covers for any contamination or damage.					
Community- Can check the mattress is in the correct position and in functioning order. Can identify problems such as : Seams, foams and covers for any contamination or damage and knows how to arrange collection and replacement of the surface.					
Patients with multi complex needs that do not suit the standard surfaces available are referred to tissue viability to identify a suitable surface and arrange approval or funds.					
Moving and handling- aware to use slide sheets head to heels to prevent shear and friction at all times when moving and handling on a bed, couch or trolley.					
Heel protection- is aware how to select and use devices available such as: Silicone gel pads on formulary Heel troughs Pillow					
Shoe/ slipper/ falls prevention sock fitting- aware to check fitting and to recommend alternatives to patient or refer to orthotics.					
Pressure point protection from shear and friction- aware to use a film dressing if the patient is at risk of shear and friction i.e.: Parkinson's disease.					
tilt wedges Dolphin					
Can record the mode of action and mattress assessment on the relevant trust approved document					
Aware to check the function when the patient is nursed in bed.					
Community- aware to advise carers/ relatives and care home staff the correct use of any surface supplied or that is in use.					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
Skin inspection	To identify skin changes early				
Knows how to examine pressure points and record accurately on the skin assessment chart in accordance with current trust policy OP96.					
Knows how to examine device related pressure points and record accurately on the skin assessment chart in accordance with current trust policy OP96.					
Demonstrates an understanding of pH balanced skin care and hydration to prevent dry skin and skin protectants for patients with moisture or continence needs- see continence section for correct use of skin protectants.					
Demonstrates an understanding of NICE guidelines for diabetic feet and appropriate selection of heel balms for diabetic patients with dry heels.					
Can describe and recognise the difference between blanching and non-blanching erythema, and other methods to detect skin changes on darker pigmented skin tones.					
Demonstrates an understanding of the current categorising system used by the trust and can identify the differences between a category 2, 3, 4 and unstageable pressure ulcers. Plus mucosal uncategorisable pressure ulcers					
Knows the difference between 'Point of Assessment' and 'New' pressure ulceration.					
Knows how to report all category 2, 3, 4, mucosal uncategorisable and unstageable pressure ulcers, plus moisture associated skin damage on Datix with all correct details including patient name and identification number.					
Knows how to differentiate a moisture associated skin damage wound from a pressure ulcer and is aware of escalation processes if the wound deteriorates, such as wound swab and consideration of pressure as an element.					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
Keep moving	To prevent pressure ulcers.				
Knows how to explain the importance of changing position to the patients or carer.					
Can demonstrate correct use of the intervention charts for inpatient use and can give advice to community carers on repositioning. Can recommend a repositioning tool in care homes.					
Can demonstrate correct posture in seating and lying position to prevent contractures and the use of 30-degree tilt when lying on their side.					
Can identify the correct devices when moving and handling patients, such as hoists, slide sheets, banana boards.					
Knows when to refer to other services such as OT, Physio, Orthotics.					
Incontinence and moisture	To understand how to prevent and manage incontinence and moisture damage.				
Demonstrates knowledge of assessment tools and recommended personalised management plans, considering the toilet first approach where possible.					
Knows how cleanse to protect skin from moisture using the moisture associated skin damage pathway for guidance.					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
Is aware of climate control in hot and cold weather or when the patient is pyrexial to prevent moisture damage.					
Knows how to report all new moisture associated skin damage on Datix.					
Nutrition and hydration	To prevent and manage nutrition and hydration.				
Understands the importance of nutritional assessment (MUST for adults) or paediatric nutrition assessment to prevent pressure ulcers. Also understands the importance of recording patients weights charts and when to complete food and fluid charts. Can identify poor nutritional intake or unhealthy dietary intake and take actions.					
Understands the importance of hydration and completion of fluid balance charts in an inpatient setting/ care home. Can recognise signs of dehydration in the home and knows how to improve hydration.					
Giving information	Improve communication, escalation, investigation and sharing lessons learnt.				
Knows how to report skin changes at handover to seniors, medical team, or					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff member
GP if deemed necessary.					
Knows how to plan discharge from inpatient areas to community or readmission from community to inpatient areas, including communication with social care agencies, care homes as circumstances change.					
Knows when to apply duty of candour, to be open and honest with the patient or next of kin if a serious incident occurs.					
Demonstrates understanding of the current safeguarding policy in relation to care and pressure ulcer prevention.					
Is aware of the current incident investigation process and the need to share and act upon learning					
Has an understanding of the incident data for ward or service and the benefits of using the safety cross					

Signature of assessor……..stamp……date……

Signature of learner……..stamp……date……...

Education Academy
Faculty of Nursing, Midwifery and AHPs

The Royal Wolverhampton NHS Trust

PRESSURE ULCER PREVENTION FOR NEONATES

Name:

Clinical Ward / Department:

Line Manager:

Date of commencement of competencies:

Date of completion of competencies:

Trust Professional Values and Standards:
Safe and effective
Kind and Caring
Exceeding Expectation

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Introduction

The competency will allow nurses to develop the minimum expected standards in Pressure Injury Prevention in neonates. Then also give further guidance for senior nurses, and tissue viability link nurse.

Aim

To improve the neonate's experience, develop staff to their full potentia

Objectives

- To improve knowledge and skills in Pressure Injury Prevention in neonates
- To develop staff to become link nurses or specialist nurses as part as of their career progression plan.
- To support revalidation

Assessor Signatures

For validation purposes, all Assessors involved in the assessment of the nurse undertaking these competences are required to provide a signature and the relevant details below.

While the use of personal stamps is encouraged, this should be in addition to, rather than a replacement for, the Assessor's signature

All Assessors are personally and professionally accountable for ensuring that they are competent to assess a nurse undertaking these competences.

Full Name	Position	Signature	Stamp

PRESSURE ULCER PREVENTION FOR NEONATES

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff Member
Assessment and risk assessment to identify patients at risk of pressure ulceration					
Holistic assessment- Understands the importance of assessing all holistic needs on initial assessment which includes: Complexity of health needs Respiratory support methods Medication Venous bloods Pain					
Report all signs of significant change to team, doctor and relevant specialist.					
Pressure ulcer risk assessment for neonates Awareness of the recording risks, skin assessments and action on Badgernet and frequency in accordance to current policy OP96					
Surface- selection of correct surfaces to prevent pressure ulceration and identification of devices that can cause pressures					
Understands the specification of the cot mattresses and support surfaces available					
Inpatient areas-aware of the trusts standards for cleaning, auditing mattresses and escalating problems found such as: Seams, foams and covers for any contamination or damage.					
Awareness of how to move and handle the neonate to prevent skin damage.					
Aware of where to document surfaces on the forms used within your areas					
Aware of the frequency to check under devices and use skin protectants or wound products to protect the skin from device related skin damage. Is aware of the ventilator risks and how to minimise them causing skin damage.					
Appropriate sized equipment to be available to all neonates receiving CPAP					
Skin inspection- To identify skin changes early					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff Member
Aware of how to examine bony or device related pressure points and record accurately on the skin assessment chart in accordance with current trust policy OP96.					
Aware of products suitable for neonatal skin.					
Can describe and recognises the difference between blanching and non-blanching erythema.					
Is aware of the current categorising system used by the trust and can recognise the differences between a category 2, 3, 4 and unstageable - for dressing selection refer to wound assessment section of the competency document.					
Is aware of the difference between point of assessment and new pressure ulceration – refer to OP96.					
Able to report all category 2, 3, 4 and unstageable pressure ulcers on Datix with all correct details including patient name and identification number. Able to escalate following current processes within service and trust.					
Can differentiate a moisture associated skin damage to a pressure ulcer and is aware of escalation processes if the wound deteriorates, such as wound swab and consider pressure as an element.					
Is aware of how to evaluate the frequency of nappy care to maintain skin integrity.					
Is aware of reporting device related pressure ulcers					
Keep moving					
Is aware of the recording the change of neonate position and relief from devices.					
Incontinence and moisture					
Is aware of how to select the correct nappy to manage urine and faeces.					
Is aware that skin protection products to be used to prevent moisture when babies nursed on CPAP and high flow oxygen. Is aware that CPAP circuits to be changed every 7 days as per manufacturer					

	Rationale	Evidence competency attained	Competent yes/no	Signature of Trainer	Signature of Staff Member
recommendations to prevent infection.					
Is aware of climate control of the neonate of 24 degrees.					
Nutrition and hydration					
Understands the importance of feed assessment and management to ensure the neonate is nourished.					
Understands the importance of hydration and completion of fluid balance charts to monitor hydration of the neonate.					
Giving Information					
Is aware of how to report skin changes at handover, to seniors and medical team.					
Is aware of how to plan and communicate when transferring the neonate to other hospitals or discharging home.					
Is aware of the duty of candour to be open and honest with the parents if a serious incident occurs.					
Is aware of the current safeguarding policy in relation to care and pressure ulcer prevention.					
Is aware of serious incident escalation process, 48 hour report, reasons for accountability meetings both locally and at a senior level within the trust.					
Is aware of their service area safety thermometer data and incident data and understand the difference between avoidable and unavoidable pressure ulcer incidents. Also understands the Trust has zero tolerance to all avoidable pressure ulcers.					

Signature of assessor……stamp……date……

Signature of learner……..stamp……date……