Pressure Ulcer Reporting and Investigation

All Wales Guidance

2014

Guideline Development

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The guideline has been reviewed by:

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- Wales Adult Protection Co-ordinators Group.
- All Wales NHS Lead Professionals for Safeguarding Adults at Risk.
- Adult Protection Leads in all NHS Health Boards in Wales.
- All Wales Tissue Viability Nurses Forum.

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1. Introduction

Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death (National Patient Safety Agency, (NPSA) 2010; Whitlock et al, 2011). Every year up to 20% of patients in acute care in England and Wales are affected by pressure ulcers. Since 2005, the NPSA has received around 75,000 reports of patient safety incidents relating to pressure ulcers, yet a growing body of evidence suggests these are largely preventable (NPSA, 2010).

The cost of treating a pressure ulcer ranges from £1,064 to £10,551, depending upon its severity, and the total cost to the UK is £1.4 – £2.1 billion annually, which is 4% of the total NHS expenditure (Bennett et al, 2004).

Extensive work through initiatives such as 1000 Lives Plus and Fundamentals of Care has helped raise the profile of pressure damage and driven the development of rigorous and practical ways of recording and preventing pressure ulcer incidents. Initiatives such as SKIN bundles were introduced in Wales in 2009 through Transforming Care and aimed to improve patient care by reducing pressure ulcers. However, when pressure damage unfortunately occurs, the learning from such an incident must be effective if the risk to further patients suffering the same harm is to be reduced. The All Wales Tissue Viability Nurses Forum (AWTVNF) and the All Wales Adult Protection Co-ordinators in Health and Social Care have collaborated to determine a standardised approach to pressure ulcer reporting and investigation in order to safeguard individuals accessing health and social care in Wales.

These guidelines have been developed and agreed by the All Wales Tissue Viability Nurses Forum and the All Wales Adult Protection Co-ordinators in Health and Social Care, and have been adapted from the Tissue Viability Society's guidance *Achieving Consensus in Pressure Ulcer Reporting* (TVS, 2012)

http://www.tvs.org.uk/sitedocument/TVSConsensusPUReporting.pdf.

This guidance should be read in conjunction with the following documents:

- *The Essential Elements of Pressure Ulcer Prevention and Management - All Wales Guidance* (AWTVNF, 2011) http://www.nhswalesgovernance.com/Uploads/Resources/K59m5Jtrv.pdf
- Local Pressure Ulcer Prevention and Management Guidelines
- *Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse* (2010) http://www.ssiacymru.org.uk/index.cfm?articleid=3015

2. Purpose

This document applies to all NHS Trusts and Health Boards in Wales and aims to:

- promote consistency and guide performance reporting against Welsh Government targets for zero tolerance to pressure damage
- provide guidance on when pressure damage meets the threshold for referral into adult safeguarding processes
- facilitate effective learning to enable the risk of further patients suffering the same harm to be reduced

3. Scope

These guidelines have been developed for use within all NHS Trusts and Health Boards in Wales. These organisations are also required to ensure that care services within commissioned services also meet the requirements set out in this guidance.

4. Background

A recent (AWTVNF, 2012) survey across Wales with representation from seven NHS Health Boards found that although most pressure damage incidents occurring in Welsh hospitals are being recorded through the Care Metrics Module and DATIX systems, there is no standardised Root Cause Analysis / Investigation tool in use throughout Wales or consistent agreement on thresholds for adult safeguarding referrals relating to pressure damage.

The *Review of In Safe Hands* (Welsh Assembly Government, 2010) (http://www.ssiacymru.org.uk/media/pdf/8/g/Review_of_In_Safe_Hands_2010.pdf) places an expectation that all cases of serious (category/grade 3 and 4) pressure ulcers will be investigated to rule out neglect as a possible cause where vulnerable adults (under the definition set out in the *Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse* 2010) are involved. The Social Services and Well-being (Wales) Act (May 2014) places a statutory duty to report to a relevant Local Authority via adult protection procedures where it is believed an adult at risk is experiencing or at risk of abuse or neglect.

Health Inspectorate Wales (HIW) in their review of adult protection arrangements in the NHS in Wales (HIW 2010) http://www.hiw.org.uk/Documents/477/Pova%20web%20e.pdf) did not specifically refer to pressure ulcers but highlighted that NHS organisations and health care professionals have difficulty grasping that poor practice and abuse happens in health care

settings and this leads to abuse being underplayed as poor practice or a complication of treatment.

This guidance aims to ensure consistency in assessing pressure ulcers for adult protection triggers across the NHS in Wales and the independent sector.

5. Definitions

- The European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel (EPUAP/NPUAP) (2009) definition should be used to describe any pressure ulcer.

A Pressure Ulcer is defined as:

'A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.'

EPUAP/NPUAP (2009)

A Moisture Lesion is defined as:

'*Moisture lesions, moisture ulcers, perineal dermatitis, diaper dermatitis and incontinence associated dermatitis (IAD) all refer to skin damage caused by excessive moisture by urine and/or faeces being in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft.'*

(Ousey et al, 2012)

An Avoidable Pressure Ulcer is defined as:

"Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the person's needs and goals and recognised standards of practice; monitor and evaluate the impact of the

interventions; or revise the interventions as appropriate."

(Department of Health/ National Patient Safety Agency, 2010)

An Unavoidable Pressure Ulcer is defined as:

"Unavoidable" means that the individual receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence"

(Department of Health/ National Patient Safety Agency, 2010)

6. Reporting & Investigation Processes

6.1 Identification

- All levels of skin damage as a result of pressure / shear or a combination of both **MUST BE** reported.
- Skin damage determined to be as a result of incontinence and/or moisture alone, should **not** be recorded as a pressure ulcer and should be referred to as a moisture lesion to distinguish it and recorded separately as per local policy. A lesion that has been determined as combined, that is, caused by incontinence and/or moisture and pressure **MUST BE** recorded as a pressure ulcer.
- Skin damage that is determined to be as a result of pressure from a device, such as from casts or ventilator tubing and masks **MUST BE** recorded as pressure damage.
- **Avoidable and unavoidable pressure damage** should be differentiated and reported. If skin damage has been deemed to be unavoidable the rationale for this is to be included in the investigation report. For standardised reporting purposes in Wales, the Department of Health (2010) definition (above) for avoidable/unavoidable pressure ulcers **MUST BE** used.

6.2 Pressure Damage Classification

The pressure damage classification as set out in the Essential Elements of Pressure Ulcer Prevention and Management (AWTVNF, 2011) should be used during assessment of the individual (Appendix 1). In addition, the following categories should be used:

NPUAP/EPUAP (2009) additional categories.

Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown

Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a grade/category 3 or 4. 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 (SDTI) – depth unknown

Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. 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.

6.3 Process to be followed once pressure damage is confirmed and to identify a referral to adult protection

- As soon as pressure damage is identified immediate action should be taken to reduce the patient's risk of further damage and to optimise healing.
- All Wales Algorithm for Reporting and Investigating Pressure Damage must be followed for all hospital and community acquired pressure damage (Appendix 2).
- If the pressure damage is hospital acquired, the person who has identified it must complete a DATIX report as per the organisation's policy. If the patient was transferred from another clinical area within the same Health Board with the pressure damage, the

person in charge of that area must be notified and they are responsible for completing the Care Metrics Module and Safety Cross in accordance with local arrangements.

- If the pressure damage is community acquired, e.g. person's own home, a nursing or residential home, the health care professional who identified it must complete a DATIX report in accordance with the organisation's policy. A social care employee or 3rd sector employee may alert a health care professional to pressure damage and in these circumstances, the health care professional must complete the DATIX report.

- Health Boards must have in place local arrangements for reviewing and investigating community acquired pressure damage. The principles of the review process and screening for adult safeguarding must be applied by the identified healthcare professional, e.g. Lead Nurse / Senior Nurse / Matron / equivalent.

- The patient and/or next of kin should be notified of the damage and be fully engaged in the action that is required to ensure their safety by preventing further damage and aiding healing. This must also be documented.

- Every DATIX report requires a level of investigation. However, as a requirement minimum all category/grade 3, 4, unstageable, suspected deep tissue injury and multiple category/grade 2 pressure ulcers (on the same individual), investigation using the All Wales Review Tool for Pressure Damage (Appendix 4) should be undertaken by the senior nurse and the multi-disciplinary team responsible for care of the patient. If there is uncertainty about when the pressure damage occurred, it may be deemed appropriate for the identifying nursing team and the nursing team or caring team that had previously been responsible for the patient's care to carry out the investigation collaboratively. Some organisations have local arrangements for reviewing all catergory/grade 2 pressure damage.

- If the patient from community has had no health or social care involvement and has developed pressure damage, then referral to the safeguarding team should be considered, highlighting the patient's potential vulnerability.

- Investigation of pressure damage incidents should be systematically documented using the All Wales Review Tool for Pressure Damage (Appendix 4). Use of this tool will facilitate detailed examination of whether the appropriate pressure ulcer prevention strategy was employed prior to the pressure damage occurring. Use of the tool will also highlight what learning needs to take place in order for similar incidents to be prevented. Any findings and actions identified in the investigation should be reviewed and agreed by the Tissue Viability Service.

- Health Boards/Trusts need to ensure that systems are in place for ensuring learning is shared throughout the organisation so that similar mistakes are not being repeated in

different clinical areas. If a referral to adult protection is required, implementation of the investigation may only take place in agreement with adult protection procedures.

- Individuals completing the investigation process and associated documentation should be competent to do so, and should seek training and support where necessary.
- The All Wales Principles of Screening Pressure Damage Incidents for Referral to Adult Safeguarding Tool (Appendix 3) must be used by the Lead Nurse/Senior Nurse/ Matron or equivalent to determine if there is a Safeguarding issue. Immediate assessment using this tool ensures a systematic approach to identify early warning signs of poor practice in a clinical area and to exclude neglect as a causative factor of the pressure damage. It also enables identification of the potential need for referral to the safeguarding team. If the triggers suggest on immediate assessment that a full referral to adult protection is required, this must be actioned immediately following local adult protection referral arrangements. If a referral is not made, the rationale must be made explicit in DATIX and the Lead Safeguarding Adults or Children's Team must be informed. Any local arrangements for fulfilling the requirements of concerns investigation with redress must also be progressed once safeguarding has been considered as described above.

  The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010) refers to actual harm and potential harm. Potential harm, if identified, indicates that there is a failure to provide prescribed care and therefore, a referral to adult protection must be made.

- Communication following patient transfer between Welsh Health Boards/Trusts about specific incidents of pressure damage can be facilitated through use of the All Wales Pressure Damage Alert system (Appendix. 5).
- A Serious Incident (SI) investigation should be undertaken for all Category/Grade 3 and 4 pressure damage. This must be undertaken in accordance with adult protection procedures if a vulnerable adult is involved. The outcome of the SI investigation must be reported as per agreed individual Health Board policy.
- To ensure transferring Health Board/NHS trusts investigates at origin the root cause of the pressure damage. The Health Boards/NHS Trusts who has transferred an individual(s) with existing pressure damage should be notified of the identified pressure damage via the pressure ulcer communication tool.
- If Category/Grade 3 or 4 pressure damage is identified the transferring (the origin of the pressure damage) Health Board/NHS Trust is responsible for completing a SI investigation as per local policy.

References and Bibliography

All Wales Tissue Viability Nurses Forum (2011) *The Essential Elements of Pressure Ulcer Prevention and Management. All Wales Guidance.* This document can be accessed electronically at: http://www.nhswalesgovernance.com/Uploads/Resources/K59m5Jtrv.pdf

Bennett, G, Dealey, C, Posnett, J. (2004) The cost of pressure ulcers in the UK. *Age and Ageing,* 33 (3), pp. 230-235

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel EPUAP/NPUAP (2009) *Prevention and treatment of pressure ulcers: Quick Reference Guide.* Washington DC: National Pressure Ulcer Advisory Panel

Health Inspectorate Wales (HIW) (2010) R*eview of adult protection arrangements in the NHS in Wales.* This document can be accessed electronically at: http://www.hiw.org.uk/Documents/477/Pova%20web%20e.pdf) In *Health Inspectorate Wales Report* (2010)

National Patient Safety Association (2004) *Root Cause Analysis*. This document can be accessed electronically at: www.**npsa**.nhs.uk/**rca**toolkit/

National Patient Safety Agency (2010) *Defining avoidable and unavoidable pressure ulcers.* This document can be accessed electronically at: http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/PressureUlcers/Defining%20avoidable%20and%20unavoidable%20pressure%20ulcers.pdf

Ousey, K., Bianchi, J., Beldon, P., Young, T. (2012) *The identification and management of moisture lesions*. Wounds UK, Vol 8, No 2

Solihull NHS Trust (2011) *Practice Guidance No 4: Pressure Ulcers Safeguarding Adults*. This document can be accessed electronically at: http://www.solihull.nhs.uk/getmedia/3a94669d-aed6-4625-af58-e5504622a03a/Section-16-Practice-Guidance-No-4-Pressure-Ulcers-April-2011.aspx

Tissue Viability Society (2012) *Achieving Consensus in Pressure Ulcer Reporting*. This document can be accessed electronically at: http://www.tvs.org.uk/sitedocument/TVSConsensusPUReporting.pdf

Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010) This document can be accessed electronically at: http://ssiacymru.org.uk/pova

Welsh Assembly Government (2010) *Review of In Safe Hands*. This document can be accessed electronically at: http://www.ssiacymru.org.uk/media/pdf/8/g/Review_of_In_Safe_Hands_2010.pdf

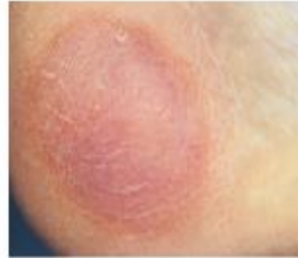
Welsh Government (May 2014) Social Services and Well-being (Wales) Act 2014. This document can be accessed electronically at: http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf

Whitlock, J., Rowlands, S., Ellis, G., Evans, A. (2011) *Using the SKIN Bundle to prevent pressure ulcers.* Nursing Times, *107: (35)*

All Wales Pressure Ulcer Classification (EPUAP/NPUAP 2009)

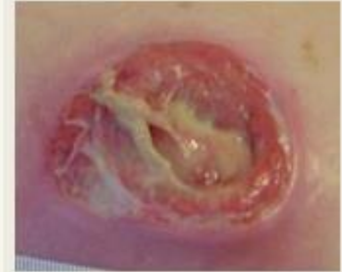
Category/Grade 1: Non-blanchable redness of intact skin

Intact skin with non-blanchable erythema of a localised area, usually over a bony prominence.
Discolouration of the skin, warmth, oedema, hardness or pain may also be present.
Darkly pigmented skin may not have visible blanching.
The area may also be painful, firm, soft, warmer or cooler as compared to adjacent tissue.



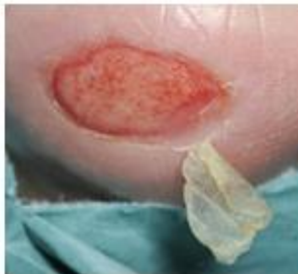
Category / Grade 3: Full thickness skin loss (fat visible)

Full thickness tissue loss.
Subcutaneous fat may be visible but not bone, tendon or muscle Slough may be present. May include undermining & tunneling. The depth will vary by anatomical location, i.e. Category/Grade 3 ulcers on the nose, ear, occiput and malleolus can be shallow. Areas of significant adiposity (fat) can result in deep Category/Grade 3 ulcers.



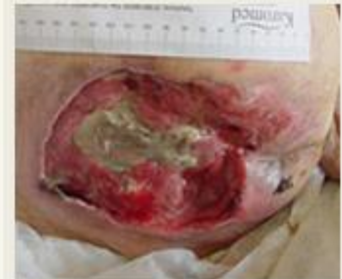
Category/Grade 2: Partial thickness skin loss or blister

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 or sero-sanguinous filled blister.
A shiny or dry shallow ulcer without slough or bruising.
NOTE: This grade should not be used to describe incontinence associated dermatitis, maceration or excoriation.



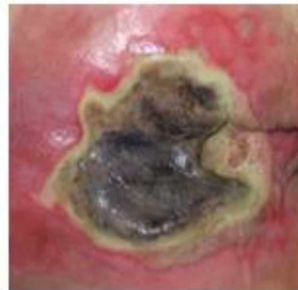
Category / Grade 4: Full thickness tissue loss (muscle / bone visible)

Full thickness tissue loss - exposed or directly palpable bone, tendon or muscle. Slough or eschar may be present. Often includes undermining /tunneling. The depth of a will vary by anatomical location. i.e. Category/Grade 4 ulcers on the bridge of the nose, ear, occiput and malleolus can be shallow. Areas of significant adiposity (fat) can result in deep Category/Grade 4 ulcers extending into muscle/ supporting structures (fascia, tendon or joint capsule) making osteomyelitis likely to occur.



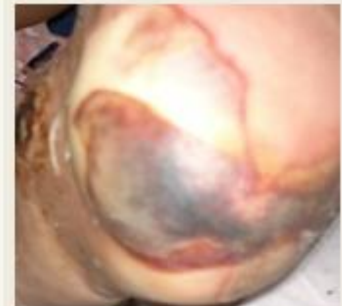
Unstageable/Unclassified

Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a grade/Category 3 or 4. Stable (dry, adherent, intact without erythema) eschar on the heels serves should not be removed.



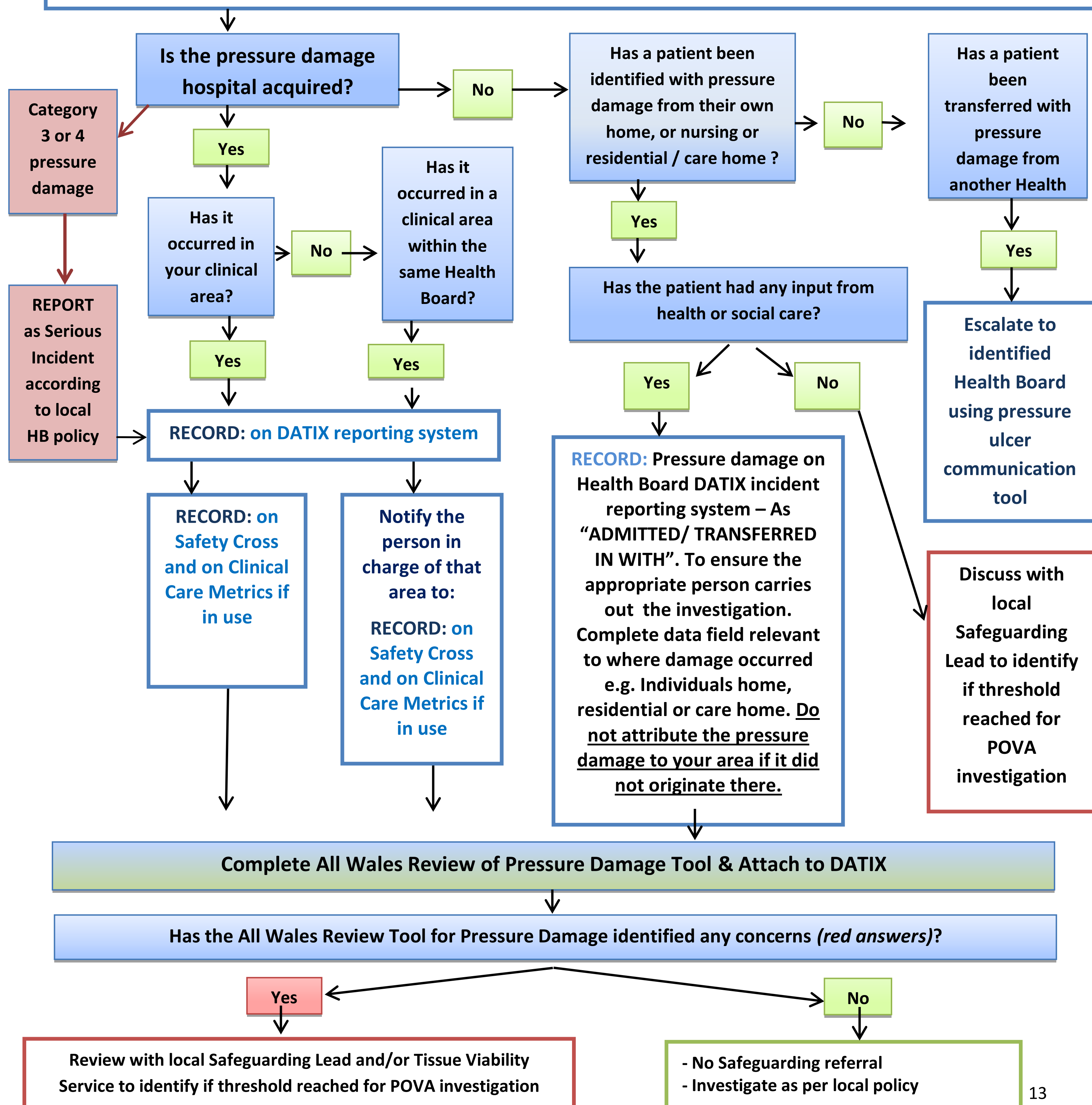
Suspected Deep Tissue Injury (SDTI)– depth unknown

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



All Wales Algorithm for Reporting and Investigating Pressure Damage

Process to be followed by Ward Manager/Case Holder to identify **an appropriate** referral to adult protection



All Wales Principles of Screening Pressure Damage Incidents for Referral to Adult Safeguarding

This tool is to be used by the Senior Nurse/ Matron/ or equivalent responsible for the final review and approval of the review and / or investigation. The table aids a decision to refer to adult safeguarding.

IF IN DOUBT - contact the Lead for Protection of Vulnerable Adults for advice.

	Not Safeguarding at this stage	Possibly Safeguarding	Definitely Safeguarding
1. What is the severity (category/grade) of the pressure damage?	Single or isolated incident of Grade 1 or 2 pressure ulcer	Grade 3 & 4, Unstageable and SDTI pressure ulcers – Consider question 2	Grade 4, Unstageable and SDTI AND other issues of significant concern
2. Does the individual have mental capacity and have they been compliant with treatment and prevention strategies? Has a capacity assessment been completed?	Has mental capacity and has refused treatment and prevention strategies. Mental Capacity assessment is recorded.	Does not have mental capacity or mental capacity has not been assessed – Continue to question 3.	Assessed as NOT having mental capacity and treatment and prevention NOT provided.
3. Has full assessment been completed and if at risk, has SKIN bundle / care plan been developed and implemented in a timely manner?	Documentation and equipment are available to demonstrate full assessment and review is complete, SKIN bundle has been fully complied with and/or care plan has been developed and implemented.	Documentation demonstrates that assessment and review has been completed but the SKIN bundle / care plan have NOT been fully implemented. (Some aspects may have been refused, e.g. equipment) – continue to Question 4	Poor or no documentation is available to demonstrate that a full assessment has been completed or that the SKIN care bundle, care plan and general care regime (e.g. nutrition, hydration) have NOT been developed and NOT been implemented – Is a CONCERN
4. Has nurse or formal / informal carer raised concerns and sought support at an appropriate time? e.g. from TVN, Community Nurse, GP.	Evidence available to show concerns were raised and support was sought from a relevant professional.	Evidence is NOT CLEAR that concerns were raised or support sought at the appropriate time. e.g. where knowledge / skills have been lacking; wound not responding to treatment.	No support sought.
5. Is this incident part of a trend or pattern – i.e. have there been other similar incidents or other areas of concern?	Evidence suggests this is an isolated incident.	There have been other similar incidents or areas of concern.	Evidence demonstrates this is part of a pattern or trend in that clinical area. If this is not known, a discussion with the Lead for Safeguarding must take place.
	NOT SAFEGUARDING	Two or more of the above Refer to SAFEGUARDING	Any of the above – Refer to SAFEGUARDING

Adapted with approval from Solihull NHS Trust (2011) Practice Guidance No 4: Pressure Ulcers Safeguarding Adults.

----------- Available in Electronic Format -----------

Appendix 4

All Wales Review Tool for Pressure Damage

Name of care environment:	Patient Name:	ID:	Date:
You will require the healthcare record and the guidelines on pressure ulcer management for completion of this document			
THE PATIENT			

		Details
Patient Age		
Date of admission		
1. Origin of the Ulcer(s) - report most severe		**Details**
Where did the ulcer(s) originate? *(Ward/Home/Care Home etc.)*		
When was the ulcer(s) first identified? *(state date and time)*		
Number of pressure ulcers?		
Site of ulcer(s)?		
What category/grade was assigned to the most severe ulcer when it was first identified?		
What category/grade is the most severe ulcer today? *(i.e. has it deteriorated?)*		
CONTRIBUTORY FACTORS - answer all questions: Please note that the colour coding does not relate to colours on Screening Tool		
2. Does the patient have the following risk factors?	**Yes/No click to drop down**	**Details**
Reduced mobility or immobility		
Sensory impairment (neurological disease results in reduced sensation & insensitivity to pain)		
Acute illness		
Evidence of impaired mental capacity		
Reduced level of consciousness		
Extremes of age (above 65, less than 5 years of age)		
Critical illness		
Peripheral arterial disease		
Incontinence		
Severe chronic or terminal illness (multi-organ failure, poor perfusion & immobility)		
Previous history of pressure damage		**Location:**
Malnutrition (extremes of weight) or dehydration		
Procedures / Surgical interventions		

ASSESSMENT AND MANAGEMENT - All RED Answers indicate actions that require addressing		
3. Is there documented evidence that the following were implemented for the patient?	**Yes/No click to drop down box**	**If not - give reason….**
Assessed for pressure ulcer risk within 6 hours of admission to hospital/care home or 1st visit in community?		State tool used and risk status:
Does the initial risk assessment score appear to be accurate?		
Is there evidence of appropriate skin assessment on admission to hospital/care home or 1st visit in community?		
Was an appropriate care plan developed and documented in line with risk assessment score?		
Is there evidence of on-going, accurate, risk assessments as per local policy?		
Is there evidence of on-going skin assessment?		
Are changes to skin integrity acted upon and documented as per local policy ?		
Is there evidence of re-assessment, evaluation and adjustment of care plans?		
Is there evidence of frequent repositioning day and night? i.e. SKIN Bundle/Respositioning/Turning charts/Carer's Log (community) etc.		
Was a SKIN Bundle Tool put in place?		
Was the SKIN Bundle Tool completed in full during this period?		
Is there evidence of nutritional assessment and support?		
Is there evidence of referrals made to TVN and MDT staff if applicable?		***Who?***
In response to the risk identified was an appropriate mattress provided as per local policy?		
In response to the risk identified was an appropriate cushion provided as per local policy?		***Explain***
In response to the risk identified was appropriate heel offloading provided as per local policy?		
Is there evidence that the patient/carer(s) were involved in the care plan and agreed with it?		
Was patient/carer information provided?		
Assessed for pressure ulcer risk within 6 hours of admission to hospital/care home or 1st visit in community?		

ORGANISATIONAL FACTORS		
	Yes/No click to drop down box	**Details**
Are all staff trained & competent in pressure ulcer prevention?		***How many are? When?***
Is the incident recorded on DATIX?		***Date: RefNo.:***
Is the incident recorded on Clinical Care Metrics?		***How ?***
How many pressure ulcers (any category/grade) have developed in this clinical area/caseload over the last 3 months?		

ACTIONS AND OUTCOME - All RED Answers indicate actions that require addressing
List Good Practice identified

KEY ROOT CAUSES of this pressure damage	**ACTIONS**	**Lead person**	**By when**
	Signature	**Date**	
OUTCOME			
Avoidable Pressure damage	**Please state:**		
Unavoidable Pressure damage	**Please state:**		
Person completing RCA	**Sign**		
Reviewed by:			
Tissue Viability Nurse			
Senior Nurse			
Head of Nursing/Div Nurse/Matron			

Following completion - the form should be attached electronically to DATIX or Metrics Database - As per Local policy.

Pressure Damage Passport

For Transfer of Patients with Pressure Damage

This form must be completed in full when patients with existing pressure damage are moving from...

- **Your Ward → Other ward**
- **Your Ward → Community/care home**
- **Your hospital → Other hospital in the Health Board**
- **Your Health Board → Other Health Board**
- **Community settings → Hospital**

About the patient:

Name /Address/DOB/NHS Number of patient

Transferred from :
Ward/Care Home............................
Hospital/GP....................................
Health Board..................................

About the Pressure Damage:

Origin of Pressure ulcer	
Category/Grade of pressure ulcer/s	
DATIX report reference number	
Full investigation of pressure ulceration carried out?	Yes / No
If Pressure damage Category/Grade 3 or 4, has it been reported as a Serious Incident?	Yes / No
POVA Referral?	Yes / No