Pressure Ulcer Reporting and Investigation

All Wales Guidance

January 2018

Guideline Development

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This document replaces the original April 2014 version.

The guideline has been reviewed and endorsed by:

- All Wales Associate Directors of Nursing
- All Wales NHS Lead Professionals for Safeguarding Adults at Risk.
- All Wales Tissue Viability Nurses Forum.

Contents

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 costs of treating a pressure ulcer are estimated to range from £43 to £374 daily with hospital-acquired pressure ulcers increasing the length of stay by an average of 5–8 days per pressure ulcer (Bennett, Dealey and Posnett, 2012). In Wales pressure ulcers affected 8.9% of all in hospital patients (Clark, Semple, Ivins et al, 2017).

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.

The initial guidelines were 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 updated guidance 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.

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

- *The Essential Elements of Pressure Ulcer Prevention and Management - All Wales Guidance* (AWTVNF, 2017) 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* (2013) http://ssiacymru.org.uk/home.php?page_id=8297

- Social Services and Well-being (Wales) Act 2014 Working together to safeguard People http://www.legislation.gov.uk/anaw/2014/4/contents
- *All Wales Child Protection Procedures (2008) www.awcpp.org.uk*

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 should be considered for referral into safeguarding processes.
- Facilitate effective learning through the development of a standardised investigation processes to reduce the risk of further patients suffering the same harm

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. Further, as a result of revisions to the Regulation and Inspection of Social Care (Wales) Act 2016, a Regulation 38 notification will be required to be completed for residents with pressure injuries in the Care Home sector from April 2018. The adoption of these guidelines is therefore advocated in the Care Home sector.

4. Background

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

Since implementation of the 2014 pressure damage investigation and reporting guidance the following documents have been introduced which this updated guidance aims to incorporate to ensure consistency in reporting and investigating pressure damage.

The '*Flynn report - In search of accountability. A review of the neglect of older people living in care homes investigated as Operation Jasmine'* had clear recommendations in

relation to pressure damage. (Welsh Government, 2015) (http://gov.wales/topics/health/publications/socialcare/reports/accountability/?lang=en)

The '*Health and Care Standards'* came into force from 1 April 2015 (Welsh Government 2015) incorporating a revision of the *'Doing Well, Doing Better: Standards for Health Services in Wales (2010)*' and the *'Fundamentals of Care Standards (2003)*'. The Health and Care Standards sets out the Welsh Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings including commission services. *Standard 2.2 Preventing Pressure and Tissue Damage details "People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage". http://www.wales.nhs.uk/governance-emanual/theme-2-safe-care*

Each Health Board and Trusts have an obligation to report hospital acquired pressure damage to Welsh Government. There are ongoing discussions around the pressure damage indicators that will be agreed nationally. This is likely to be numbers of patients who develop pressure damage and numbers of grade 3, 4, Unstageable pressure ulcers that develop (currently this does not include community acquired pressure damage although this is likely to change from 2018). From April 2018, a Regulation 38 notification will be required to be completed for residents acquiring/being admitted with pressure damage in the Care Home sector.

Currently across Welsh Health Boards and Trusts all pressure damage is reported via the Datix incident reporting system

5. Definitions

The National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (NPUAP/EPUAP/PPPIA, 2014) definition should be used to describe any pressure ulcer.

A Pressure Ulcer is defined as:

"*A pressure ulcer is localized 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*."

(NPUAP/EPUAP/PPPIA, 2014)

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)

"Moisture lesions may develop slough if infection present."

(www.pressureulcer.scot)

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. Identification of pressure ulcers and DATIX incident reporting

6.1 Pressure Damage Classification

The pressure damage classification as set out in the Essential Elements of Pressure Ulcer Prevention and Management (AWTVNF, 2017) should be used during assessment of the individual (Appendix 1). In addition, the following categories should be used:

(NPUAP/EPUAP/PPPIA) (2014) additional categories.

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

Full thickness tissue loss in which the base of the ulcer is covered 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 is removed to expose the base of the wound, the true depth, and therefore Category/Stage, 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.

It should be noted that Unstageable pressure damage would be expected to evolve to be either a grade/category 3 or 4* *(AWTVNF, 2017)***

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.

6.2 Identification of Pressure Damage

- 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.

6.3 Reporting Pressure Damage on DATIX: Process to be followed once pressure damage is confirmed.

- 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 and a record of this action documented.
- The All Wales Algorithm template for Reporting and Investigating Pressure Damage must be followed for all pressure damage (Appendix 2). This template may need to be adapted by Health Boards/NHS Trusts to reflect local practice.
- 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 the originating area must be notified and they are responsible for investigating the pressure damage and recording this on DATIX.

- 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.

- 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 minimum requirement all category/grade 2, 3, 4, Unstageable and suspected deep tissue injury pressure ulcers, should be investigated using either the:

  - All Wales Review Tool for Pressure Damage Investigation (Appendix 3)

  or

  - All Wales Device Related Pressure Ulcer Investigation Tool (Appendix 4) in relation to device related pressure damage only.

- Either tool must be completed within the specified timescale as per local arrangements to ensure that there is no delay in the organisation meeting it's statutory duty to report an " adult or child at risk" as required under the Social Services and Wellbeing (Wales) Act (2014).

- Use of these tools will facilitate detailed examination of whether the appropriate pressure ulcer prevention strategy was employed prior to the pressure damage occurring and highlight what learning needs to take place in order for similar incidents to be prevented.

- 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.

- If the patient from community has had no health or social care involvement and has developed pressure damage, then discussion with the Health Board/ Trust safeguarding team should be considered, highlighting the patient's potential vulnerability.

- 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/Moisture Damage Passport (Appendix. 5).

- 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.

6.4 Reporting Pressure Damage in Care Homes

- In the Care Home (nursing homes) sector, residents with Category/Grade 3, 4 and/or Unstageable pressure damage should be reported in line with the proposed changes to the Regulation and Inspection of Social Care (Wales) Act 2016. A Regulation 38 notification will be required to be completed from April 2018.

- An investigation should be conducted in order to establish whether the pressure damage was avoidable or unavoidable. It is advised that the Pressure Ulcer Investigation Tool is used to conduct this investigation.

7. Serious Incident (SI) Reporting

- A Serious Incident (SI) should be submitted to Welsh Government (WG) for all individuals with Category/Grade 3, 4 and/or Unstageable pressure damage who are in receipt of NHS funded health care.

- An SI will consist of notification of the damage submitted to WG; Investigation of the damage; and finally a Closure form that is submitted to WG.

- A Regulation 38 notification must be completed and submitted to CSSIW for all individuals with Category/Grade 3, 4 and/or Unstageable pressure damage living in the Care Home Sector. Residents in receipt of Residential Care will be governed by the NHS process.

7.1 Notification of a Serious Incident

- An SI notification form should be submitted by the first area to identify the Category/Grade 3, 4 or Unstageable pressure damage – this may not necessarily be the area of origin.

- This SI notification should be submitted to Health Board/NHS Trust SI leads within 24 hrs of the incident.

7.2 Serious Incident investigation

- An SI investigation should be undertaken for all Category/Grade 3, 4 and Unstageable pressure damage by the relevant team and Health Board/NHS Trust responsible for the care setting where the damage occurred.

- The All Wales Pressure damage investigation tool should be used for this investigation.
- The investigation will determine if the pressure damage was avoidable or unavoidable.

7.3 Submission of a Serious Incident closure form

- The SI closure form should be submitted once the investigation is complete, within 60 days.
- An SI closure form must include evidence of the outcome and learning from the SI investigation.
- Information regarding whether the damage was determined as avoidable or unavoidable must be reported via the closure form as per agreed individual Health Board/NHS Trust policy.
- Individuals who have Suspected Deep Tissue Damage (STDI) should not have a notification of Serious Incident (SI) unless the damage evolves to either Category/Grade 3, 4 or Unstageable pressure damage. In this scenario a delay in SI notification may be expected.
- In complex situation across Health Board's and NHS Trusts joint investigations is encouraged to ensure that lessons are learnt across Wales.

8. Safeguarding

The Social Services and Well-being (Wales) Act (2014) has 11 parts. Part 7 relates to safeguarding .The provision in part 7 requires Local Authorities to investigate where they suspect that an adult or child is at risk of abuse or neglect.

Section 126 (1) of the Act defines an "Adult at Risk" as an adult who:

(a) Is experiencing or is at risk of abuse or neglect;

(b) Has needs for care and support whether or not the authority is meeting any of those needs;

And …….

(c) As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it

Section 130 (4) of the Act defines "a Child at Risk" as a child who:

(a) Is experiencing or is at risk of abuse , neglect or other kinds of harm;

And …….

(b) Has needs for care and support (whether or not the authority is meeting any of those needs)

Section 197 of the Act provides a definition of neglect:

'Neglect' means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of a person's well-being (for example. impairment of the person's health or, in the case of a child, an impairment of the child's development)."

The Act imposes a **duty** on relevant partners, (which will include Health Boards and Trusts) to report to a Local Authority if there is reasonable cause to suspect that an adult or child is at risk.

8.1 Screening for safeguarding

Local arrangements to be added.

8.2 Referral to Safeguarding

- Health Boards and Trusts must have in place local arrangements for reviewing and investigating acquired pressure damage. The principles of the review process and screening for safeguarding must be applied by the identified healthcare professional, e.g. Lead Nurse / Senior Nurse / Matron / equivalent.
- Early discussion with the NHS Organisations Safeguarding Lead or Team is advised.

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Scottish Excoriation and moisture related Skin Damage Tool
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The Social Services and Well-being (Wales) Act (2014) anaw 4
http://www.legislation.gov.uk/anaw/2014/4/contents

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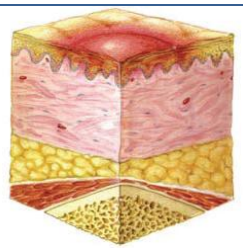
Whitlock, J., Rowlands, S., Ellis, G., Evans, A. (2011) *Using the SKIN Bundle to prevent pressure ulcers.* Nursing Times, *107: (35)*

INTERNATIONAL NPUAP/EPUAP PRESSURE ULCER CLASSIFICATION SYSTEM 2014

A pressure ulcer is localized 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

Category/Stage 1: Non-blanchable Erythema

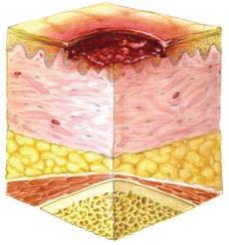
Intact skin with non-blanchable redness of a localized area over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.



Category/Stage 2: Partial Thickness Skin Loss

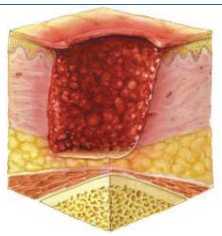
Partial thickness loss of dermis presenting as a **shallow open ulcer** with a red pink wound bed, **without slough**. Also presents as an **intact or open/ruptured serum-filled blister.** Presents as a **shiny or dry shallow ulcer without slough or bruising.*** This Category should not be used to describe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

**Bruising indicates suspected deep tissue injury.*



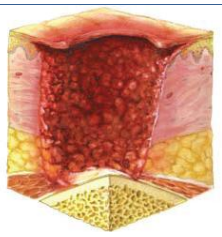
Category/Stage 3: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible **but bone, tendon or muscle are not**. **Slough may be present** but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers.



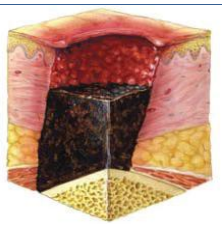
Category/Stage 4: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage IV 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. Osteomyelitis possible.



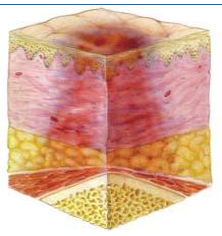
Unstageable: Depth Unknown

Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Category 3 or Category 4 pressure injury will be revealed. Stable eschar (dry, intact) on the heel or ischemic limb should not be softened or removed.



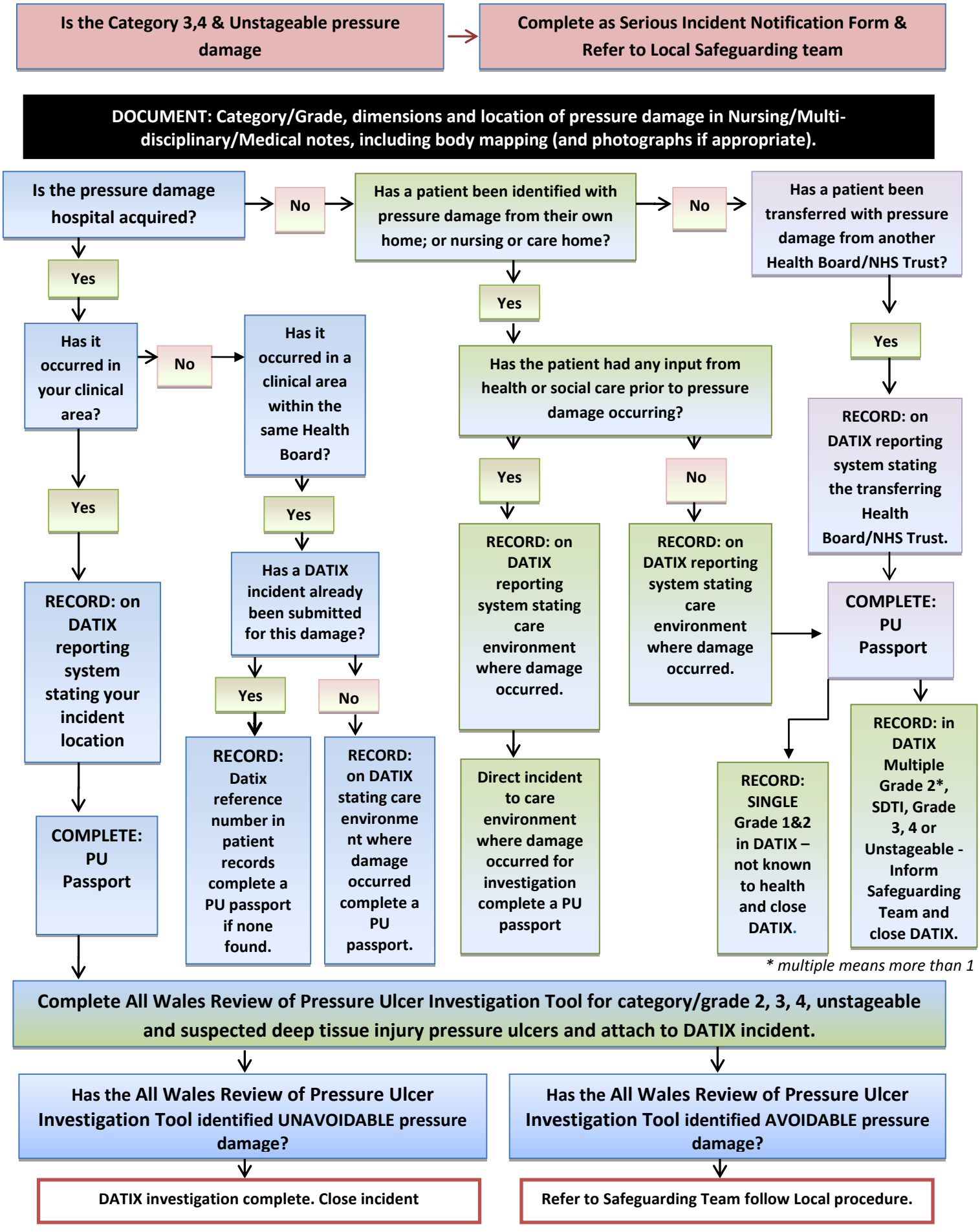
Suspected Deep Tissue Injury: Depth Unknown

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.



All Wales Review Tool for Pressure Damage Investigation

Complete one form for each newly developed pressure ulcer. The investigation to be performed by relevant team where pressure damage occurred

All boxes must be completed

Datix No:		
THE PATIENT	**DETAILS**	
Patients Name:	**DOB:**	**NHS/Hospital No.:**
Name of care environment e.g. Ward; Hospital; Patients Home; care home.		
How long has the individual been in this care environment i.e. days, weeks, months, years?		
Reason why individual is receiving care?		

You will require the individual's healthcare records and your local Pressure Ulcer Policy for completion of this document. This review tool is to examine all documentation in place up to pressure damage identification and the preceding 72 hours before damage occurred.

1. Details of the pressure damage you are investigating	**Complete all boxes**	
When the ulcer was first identified? *(state date and time).*		
Anatomical site of the pressure ulcer ? *Please state bony prominence and location on body.*		
Grade/Category * of the pressure ulcer?		
Is this pressure ulcer device related e.g. Cast; Oxygen tubing; Catheter; etc.?	**YES / NO**	If YES complete Device related Investigation Tool

*** 3, 4 or Unstageable = SERIOUS INCIDENT NOTIFICATION REQUIRED**
3, 4, Unstageable or Multiple pressure ulcers = SCREENING FOR SAFEGUARDING REQUIRED

2. Is there documented evidence of the following:	**Further explanation - Complete all boxes**	
A pressure ulcer risk assessment was completed within 6 hours of admission to hospital/care setting or 1st visit in the community?	**YES / NO**	
Risk assessment score completed correctly? i.e. *reflective of clinical condition and added up correctly.*	**YES / NO**	
The skin was assessed for pressure damage within 6 hours of admission to hospital/care setting or 1st visit in the community?	**YES / NO**	

Was an individualised pressure ulcer prevention care plan developed detailing prevention interventions?	**YES / NO**	
List all equipment used to reduce pressure ulcer risk prior to the pressure ulcer being identified.	List Equipment	
Was the above mentioned equipment provided in a timely manner?	**YES / NO**	
Is there evidence of on-going skin inspection in relation to care plan and Health Board/NHS Trust Policy ?	**YES / NO**	
Is there evidence that planned repositioning was carried out without gaps 72 hours before identification of damage? *e.g.. SKIN Bundle; Repositioning Charts/Turning Charts; Carer's Log (community) /Intentional Rounding Chart. etc.*	**YES / NO**	
Is there evidence that pressure ulcer risk assessment was regularly reviewed as per Health Board/NHS Trust policy ?	**YES / NO**	
Was this care plan reviewed in response to deterioration in patients condition? *e.g. Skin condition; acute episode.*	**YES / NO**	
List actions taken to further reduce risk of pressure ulceration once damage was identified. *e.g. more frequent skin inspection & repositioning; floating heels; reduced sitting times.*	List Actions	
Was patient/carer/family agreeable with the pressure ulcer prevention plan? *If not agreeable - Give reasons why & actions taken to address this.*	**YES / NO**	
Is there evidence that the nutritional assessment was acted on?	**YES / NO**	
3. ORGANISATIONAL FACTORS	**DETAILS**	
Explain any issues relating to Equipment: i.e. lack of understanding of how to use equipment; delays in equipment provision; failure of pressure ulcer equipment.	WHAT ACTION DID YOU TAKE TO REDUCE THIS RISK? Free text	
Explain any issues relating to Nurse staffing levels: Were the nurse staffing level maintained during this period?	**YES / NO**	i.e. What was the planned roster and what was the actual roster? What action was taken to rectify any deficits? Were agency staff involved in the incident?
If no, did the failure to maintain the nurse staffing level contribute to the ulcer/any harm to the patient?	**YES / NO**	

How many pressure ulcers have developed in this clinical area or on this case load in the last 3 months?	Free text
4. ADDITIONAL INFORMATION	**DETAILS**
List factors/events that you have not already mentioned that you think relevant to why this pressure damage developed i.e. time spent on ED trolley / ambulance/ floor.	Free text
5. What do you think the main cause(s) of this pressure ulcer was? *Include all contributory patient & organisational factors .*	Free text

6. OUTCOME - Was the pressure ulcer AVOIDABLE ?

To determine if the pressure damage could have been avoided complete the following.
An outcome of AVOIDABLE - means that the person receiving care developed a pressure ulcer & the provider of care cannot evidence that they fulfilled the following:

IF YOU ANSWER **NO** TO ANY OF THE BELOW 4 QUESTIONS THE PRESSURE ULCER IS CONSIDERED AVOIDABLE	Was there evidence of this	EVIDENCE TO SUPPORT YOUR ANSWER *See examples of evidence*
Was the individuals' pressure ulcer risk factors identified and regularly reviewed; and skin damage reported as per local policy and guidance?	**YES / NO**	*Risk assessment completed and up to date.*
Where preventative interventions, consistent with the individuals needs/goals and recognised standards of practice planned & implemented?	**YES / NO**	*Care plans in place; Evidence of timely patient repositioning; Required equipment provided.*
Was the effectiveness of the preventative interventions reliably evaluated & monitored?	**YES / NO**	*Intentional rounding; SKIN Bundles; Turning charts up to date. Equipment monitored & faults acted on; External devices monitored & issues acted on.*
Were interventions revised & acted on when there was a change to the individuals' clinical or skin condition?	**YES / NO**	*Further actions put in place to reduce pressure: Increase in frequency of repositioning; Appropriate equipment in place in timely manner; Pressure damage reported at source.*

Was the pressure ulcer AVOIDABLE ?	**YES / NO**
If pressure ulcer was AVOIDABLE - List the Lessons learnt	ADD EXAMPLES Free text
Actions required addressing the lessons to be learnt - *this must be completed to close this review.*	ADD EXAMPLES Free text
How is learning to be shared - *this must be completed to close this review.*	Free text
Name of person completing this form:	Free text
Name of senior person approving the investigation & outcome decision:	Free text
Date form completed:	Free text

All Wales Device Related Pressure Ulcer Investigation Tool

THE PATIENT	DETAILS	
Patients Name:	**DOB:**	**NHS/Hospital No.:**
Name of care environment e.g. Ward; Hospital; Patients Home; care home.		
How long has the individual been in this care environment i.e. days, weeks, months, years?		
Reason why individual is receiving care?		

Please circle relevant answers

1. **Pressure ulcer Risk assessment score when device pressure damage was identified:**
   - No risk At risk High risk Very high risk

2. **Category of device**

   - Respiratory
   - Immobilisation
   - Anti-embolic
   - Graduated compression
   - Feeding
   - Fixation
   - Probe
   - Tubing
   - Clothing/footwear/Toys

3. **Name of device:**

4. **Is the device removable or able to be re-positioned?**
   - Yes
   - No

5. **If the device is a cast or anti-embolic stocking was patient information provided?**
   - Yes
   - No
   - Not applicable

6. **Was the skin under the device checked following local guidance?**
   - Yes
   - No
   - Unable to observe due to non-removable device

7. **How often was the skin under the device regularly checked and recorded:**

   - 1 – 2 hours
   - 3 – 4 hours
   - 5 – 8 hours
   - 12 hours
   - Daily
   - Other – please state frequency:

8. **Were staff familiar with this type of device?**
   - Yes
   - No – describe how information was sought on management of device below:

9. **Was the device the right size or fit for the patient?**
    - Yes
    - No
10. **Was the device applied correctly following manufacturers guidance?**
    - Yes
    - No
11. **On application of the device - Did the patient assessment identify any of the following risk factors?**
    - Oedema under the device
    - Previous skin damage or trauma under the device
    - Reduced arterial supply to the area under the device
    - Excess skin moisture
    - Patient agitation

Describe how the identified risk factors were managed:

12. **What action was taken when the skin damage was identified:**
    - Device discontinued
    - Device changed to another or adapted
    - Device/fixator repositioned
    - None

Describe action taken:

13. **Was the action successful in preventing further damage?**
    - Yes
    - No

14. **Was the pressure damage:**
    - Avoidable
    - Unavoidable

This decision will be validated at scrutiny panel and/or senior nursing team.

Pressure /Moisture Damage Passport
For Transfer of Patients with Pressure /Moisture Damage

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

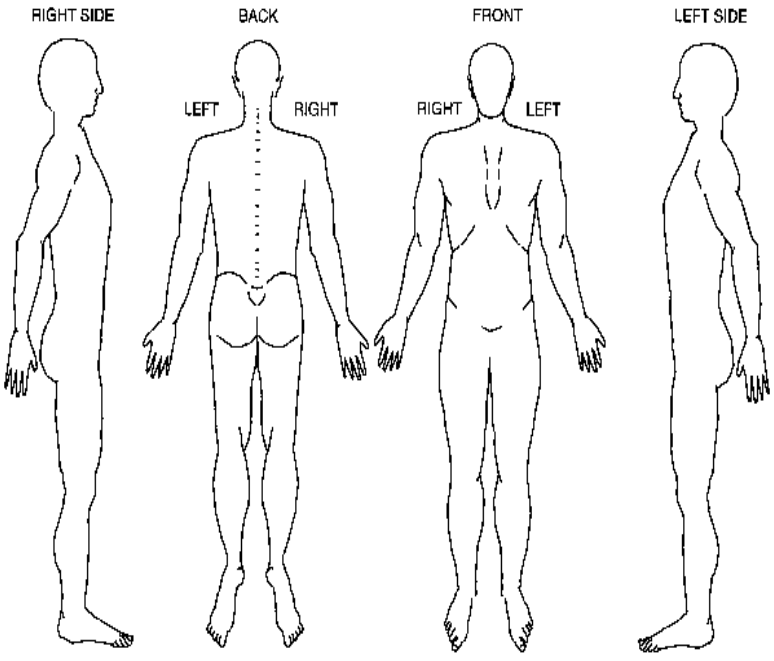
- **Your Ward → Other ward same Health Board**
- **Your hospital → Other hospital same Health Board**
- **Community/Care Home setting → Hospital**
- **Your Ward → Community/Care Home**
- **Your Health Board → Other Health Board**

Patient Details:	**Transferred from:**
Name:.....	Ward/Care Home:.....
Hospital/NHS No.:.....	Hospital/GP:.....
Address:	Health Board: .....

Is this skin damage: Pressure damage ☐ Moisture Damage ☐

About the Skin Damage:

Origin of Pressure ulcer/Moisture Damage *Where the damage occurred*	
Category/Grade of pressure ulcer/s (do not grade moisture damage)	
DATIX report reference number	
Full Investigation of Pressure Ulceration Review Tool completed?	Yes / No
If Pressure damage Category/Grade 3, 4 or Unstageable has it been reported as a Serious Incident?	Yes / No
Safeguarding Referral?	Yes / No



Indicate all areas of damage.

Date completed:	**Signature:**
Date sent:	**Signature:**