Care Home - Pressure Damage RED DAY Review Tool – GUIDANCE FOR COMPLETION

The Prevention and Management of Pressure Ulcers Standards (October 2020) Standards 7.3 states *'For all pressure ulcers that have developed while a person is in care, a review is undertaken with appropriate investigation, identification of learning and reporting of actions implemented, as part of ongoing improvement'*

All newly acquired pressure ulcers that have developed while a person is in care, will be recorded as a RED DAY on the Pressure Ulcer Safety Cross.

This Pressure Damage RED Day Review Tool will be completed when a person experiencing care develops a pressure ulcer. If the cause of pressure damage can be identified regarding care, documentation or equipment, this can support reflection, learning and improvement.

Care Home	
Residents Name	
Date pressure ulcer(s) first recorded	**This information should be taken from the initial wound assessment form (body map)**
Name and grade of professional who recorded pressure ulcer(s) / damage	**Record the name/grade of the professional who graded and recorded the initial pressure damage. This should be recorded on the initial wound assessment form (body map) or in the persons personal plan. The professional grading the ulcer should be appropriately trained and competent.**

Sites of pressure ulcer(s) / damage **(Number if more than one)**	**Grade of pressure ulcer(s) using the Scottish Adaptation of the EPUAP Pressure Ulcer Classification Tool (2020)** **https://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/pressure_ulcer_grading_tool.aspx** **It is important to refer to the above national grading tool to record the initial damage accurately to start a treatment plan.**
Example(s): Sacrum	**Grade 2 - partial thickness skin loss**
Left heel	**Grade 3 – full thickness skin loss**
Right heel	**Ungradable – full thickness skin / tissue loss - depth of the ulcer is completely obscured by slough and/or eschar**

Part 1

Review of documentation and records by Manager/ Deputy	Yes	No	N/A	Comments
Risk Assessment				
1. Was a pressure ulcer risk assessment carried out and documented for the person within 8 hours of admission to care home? E.g., Waterlow or Braden risk assessment or PPURA / PUDRA				The HIS pressure ulcer standards state that a risk assessment should be carried out within 8 hours of admission to a care home. Record if this was achieved and which risk assessment tool was applied along with the risk score/level of risk.
2. Has the risk assessment been reviewed regularly and documented? How often?				This frequency of re assessment of risk should be recorded as part of the personal plan in line with the persons risk level / condition. Examine the ongoing risk assessment documentation to establish this is being completed and recorded as part of on going monitoring.
3. Has the risk assessment tool been accurately completed?				Check that the scores awarded in each category of the risk assessment add up accurately. If there are any changes in the score / risk level over time, refer to the personal plan to see the circumstances and if these were acted on appropriately. E.g. if the person was unwell, were extra measures put in place, such as equipment, more frequent repositioning etc
Documentation / Personal Plans				
1. If the person was identified as at risk, was /is an appropriate prevention plan of care in place, based on their level of risk, overall condition and using professional judgement?				Personal plans should contain the following key points: • Risk score/level of risk • Frequency of - re assessment of risk and care plan - skin checks - repositioning/ mobilisation • Skin cleansing regime • Pressure redistributing equipment in use / settings /checks (bed / chair) • Cross reference to other relevant care needs such as falls, nutrition, continence etc

2. Is there evidence that the prevention plan of care was / is being implemented with clear records of care provided and documented?				Evidence to support that they key points above are being implemented and documented. Example(s) risk assessment tool completed, repositioning chart in place, equipment in use matches care plan etc.
3. Is the prevention care plan being updated, based on a change in the person's overall condition, risk score, and using professional judgement to prevent further pressure damage or deterioration?				Personal plans should show ongoing monitoring e.g. as part of monthly reviews or if the persons condition changes.
4. If the person has a new or existing pressure ulcer, is there a person-centred effective care plan initiated for the assessment and treatment of the pressure ulcer?				Wound assessment and treatment documentation are in place. Pressure ulcer is being assessed / graded and appropriate dressings and treatment are in place.
Pressure Redistributing Equipment				
5. Is a pressure redistributing mattress in place? E.g. Cut foam Static air filled device Alternating pressure overlay Alternating pressure replacement mattress If alternating pressure: • Is the mattress set to the person's current weight? (Refer to user manual) (Weight recorded within last 2 weeks, where possible) • Was any other pressure redistributing equipment used? (e.g., seat cushion, foot/ heel protector) • Were equipment requirements reassessed where any change in risk level / condition / deterioration in skin was identified? • If no change in equipment occurred, give reasons i.e., not suitable re persons weight / condition or persons wishes.				Pressure reducing foam mattress should be standard. Check date recorded when any other equipment was applied to bed/ chair. Record of model and risk level of equipment in use. E.g. Response overlay or seat cushion.. If alternating mattress / seating system is in use, this should be set as per the manufacturers instructions such as weight / pressure etc. Seat cushions or other aids should also be recorded as part of the care plan, Any change in equipment should be recorded and dated.
Pressure Ulcer Grading				
1. Has the pressure damage been graded using the Scottish Adaptation of the EPUAP pressure ulcer classification tool (2021)				Evidence that the pressure ulcer(s) have been graded using the classification tool at every would assessment. Remember that there is no reverse grading as healing progresses, healing pressure ulcers, example a grade 3

				pressure ulcer is referred to as a healing grade 3.
2. Evidence that the pressure ulcer or any deterioration been regularly regraded?				Where there is a change of presentation or deterioration of the ulcer during re assessment, there is evidence that action is taken. Example(s) change of treatment, signs of infection a swab is taken, specialist advice sought etc.
3. Were the grade(s) / site(s) of the pressure ulcer(s) recorded on a Pressure Ulcer Grade Recording chart (e.g., body map, dated and signed).				Initial grading of the pressure damage should be recorded on the initial wound assessment chart (body map). Ongoing grading is recorded on the wound assessment / treatment chart. Timescales for re grading should form part of the wound treatment care plan. It is not necessary to re grade a pressure ulcer at every dressing change eg daily dressings as progress may not be visible.
4. If the pressure ulcer is grade 3, 4, ungradable or suspected deep tissue injury, is there documented evidence that the person is being positioned 2 hourly or encouraged to mobilise and time up sitting is time limited to avoid further pressure damage or deterioration. If the pressure damage is mucosal ulceration, e.g., caused by a naso gastric tube or catheter, there is evidence that the device is being repositioned regularly to minimise prolonged pressure				Tissue Viability good practice would advise that where a pressure ulcer is graded 3 or above, the person should be repositioned every 2 hours and/or restricted to 1 hour up sitting. This should be applied in the context of a care home setting but taking into account the persons wishes and their psychoscial needs. Naso gastric tubes / catheters can contribute to mucosal ulceration and evidence of staff awareness and any interventions re this documented.
Involvement				
1. Is there documented evidence to support that all the above care and support was discussed and agreed with the person and / or those important to them?				Date information discussion recorded with person experiencing care/those important to them. Any review dates for further discussion / updates.
2. Has information on pressure ulcers / leaflet been provided to the person / and those important to them, and this is documented?				Record of any written information/leaflet etc given to person experiencing care/those important to them
3. Was the person concordant with the agreed plan of care?				There may be times when a person experiencing care does not agree / comply with prescribed care and support.

4. If no, was it discussed and explained to the person or those important to them about the importance of concordance and a record of this information documented?				Record of internal discussions taking place and any actions staff took?
5. Has / was this escalated for further discussion/ support / advice / intervention e.g., with care home liaison nurse / community nurse / tissue viability nurse				Record of any discussions with visiting professionals with a record of their input and intervention. E.g. visiting professionals record or record of telephone discussion and outcomes / changes to prescribed treatments

If the answer is **NO** to any of the above questions, the records and practice do not meet **good practice guidance outlined in the Prevention and Management of Pressure Ulcers Standards: (October 2020).**

The person competing the Red Day Review Tool should read the information below and go on to complete Part 2 of the tool.

Avoidable pressure damage – where the person experiencing care develops a pressure ulcer and there is no documented evidence to support that there has been:

- Evaluation of the person's overall condition and pressure ulcer risk factors
- Person centred care planning to prevent pressure damage occurring/deteriorating
- Implementation of the plan of care to prevent pressure damage occurring/deteriorating
- Monitoring and evaluation of the ongoing plan of care / interventions to prevent pressure damage occurring/deteriorating

Unavoidable pressure damage – where the person receiving care develops a pressure ulcer even though the care provider has:

- Evaluated the person's condition and pressure ulcer risk factors.
- Planned and implemented interventions that are consistent with the person's needs and recognised standards of practice.
- Monitored and evaluated the impact of the interventions, or revised the interventions as appropriate.

Or where:

- The person and / or those important to them, following information and advice, and understanding the potential consequences, chooses not to have the recommended interventions.

Based on

Black JM et al (2011) Pressure ulcers: avoidable or unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference. Ostomy Wound Management 57(2) 24-37

Where the pressure ulcer is considered to have been avoidable the care home manager / deputy should now go on to complete Part 2

Part 2 The following questions will identify if any additional risk factors were present and if measures were implemented to reduce or address this additional risk.

Review of additional risk factors and care delivered	Yes	No	N/A	Comments
1. Was the person's pressure redistributing support surface suitable for their condition? (mattress/ seat cushion/other aids) i.e., prior to pressure ulcer developing or deteriorating				Documented evidence that equipment selected was based on persons level of risk, skins tolerance to pressure, persons agreement. If equipment was not available, actions

				taken by staff / manager to procure this.
2. If additional pressure redistribution equipment required, was this available? Provided within an agreed / acceptable timescale?				Other equipment /aids such as seat cushions / heel protectors were made available when required.
3. Is the equipment being used by the person?				Is there a record of acceptance and concordance.
4. Was regular repositioning carried out and / or independent movement encouraged? If required, was moving and handling equipment techniques / equipment used appropriately?				Cross reference with care plan for mobility. Check re positioning charts and use of M&H equipment.
5. If person requires support with continence management, was this assessed and managed effectively, using appropriate products / aids, where necessary?				Cross reference to continence care plan and care needs. Skin cleansing regime and use of continence aids to minimise prolonged moisture on the skin.
6. If the person requires additional nutritional / hydration support, are they receiving this?				MUST score being carried out. Cross reference with eating and drinking care plan and care needs. Was intake sufficient for an individual with a pressure ulcer?
7. Are the persons pain management needs being managed with regard to supporting repositioning/ mobility, psychological effect on health and wellbeing, desire to eat and drink etc. Is analgesia being administered pre dressing changes / repositioning etc, where needed?				Record of prescribed analgesia. Check prescription records for evidence of pre dressing analgesia being administered.
8. Were appropriate referrals made for advice / support from external nursing or AHP professionals?				Check referrals made and advice / support given. Were these in a timely manner?

What happened?

What went well?
What could have been done differently? **Actions/Reflection/Areas for Improvement** As a result of this experience: Any changes to care and support? Review of practice / policy? Any educational needs identified?
Improvement Plan: What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?

Signature of Manager/ Deputy…… Date completed……

This information should be now notified to

- **Local Authority Commissioning Team / Care Manager**
- **Care Inspectorate via the eNotifications system as an 'incident that is detrimental to the health and welfare of a person using a service'**

AND the inform the outcome of this any actions from this process to the person experiencing care and/or those important to them as per the Duty of Candour legislation / regulations.