Care Home - Pressure Damage RED DAY Review Tool

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	
Name and grade of professional who recorded pressure ulcer(s) / damage	

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)**

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				
2. Has the risk assessment been reviewed regularly and documented? How often?				

3. Has the risk assessment tool been accurately completed?				
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?				
2. Is there evidence that the prevention plan of care was / is being implemented with clear records of care provided and documented?				
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?				
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?				
Pressure Redistributing Equipment				
5. Is a pressure redistributing mattress in place? E.g. Cut foam 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 Ulcer Grading				
1. Has the pressure damage been graded using the Scottish Adaptation of the EPUAP pressure ulcer classification tool (2021)				

2. Evidence that the pressure ulcer or any deterioration been regularly regraded?				
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). Is there evidence of ongoing regrading?				
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				
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?				
2. Has information on pressure ulcers / leaflet been provided to the person / and those important to them, and this is documented?				
3. Was the person concordant with the agreed plan of care?				
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?				
5. Has / was this escalated for further discussion/ support / advice / intervention e.g., with care home liaison nurse / community nurse / tissue viability nurse				

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).**

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				
2. If additional pressure redistribution equipment required, was this available? Provided within an agreed / acceptable timescale?				
3. Is the equipment being used by the person?				
4. Was regular repositioning carried out and / or independent movement encouraged? If required, was moving and handling equipment techniques / equipment used appropriately?				
5. If person requires support with continence management, was this assessed and managed effectively, using appropriate products / aids, where necessary?				
6. If the person requires additional nutritional / hydration support, are they receiving this?				
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?				
8. Were appropriate referrals made for advice / support from external nursing or AHP professionals?				

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'**

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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.