HSE National Improvement Programme
for Wound Management

Clinical Resource Pack: Pressure Ulcers

Date: June 2025

Reader Information

Document Control

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Contents

This document has been endorsed by the Tissue Viability Nurses Association of Ireland June 2025.

1.0 Background

This Clinical Resource Pack was designed by the HSE National Improvement Programme for Wound Management (NIPWM), a collaboration between National Quality and Patient Safety and the Office of the Nursing and Midwifery Services Director. It provides an evidence-based standard pathway of care and recommendations for healthcare professionals in the prevention and management of pressure ulcers for patients at risk of or with existing pressure ulceration.

More information on the NIPWM is available at:

https://www2.healthservice.hse.ie/organisation/ qps-improvement/national-improvement-programme-in-wound-management/

1.1 Scope of this Clinical Resource Pack

This Clinical Resource Pack includes recommendations that describe best practice for care in all HSE and HSE-funded healthcare settings.

1.2 Development and Update of this Clinical Resource Pack

This Clinical Resource Pack and the recommendations herein were developed using an evidence-informed approach, with consideration of research studies including systematic reviews, healthcare resources, consensus documents, best practice documents, international standards and guidelines and the current HSE 2018 National Wound Management Guidelines. Expert opinion was sought from subject matter experts, including consultation with the Tissue Viability Nurses Association of Ireland (TVNAI) and the NIPWM Oversight Group. The Oversight Group comprises of patients with lived experience; nursing representatives from both acute and community settings; dermatology, vascular and surgical consultants; health and social care professionals; incident management; and clinical audit.

1.3 Note on the term “Patient”

Different terms are used for people who attend health and social care services in different settings. The terms “patient”, “service-user”, “client”, ”resident”, “person supported by healthcare services”, “consumer”, “the public” and “people who use healthcare services” are used across our health and social care services. NIPWM has chosen to use the word “patient” as it was felt this term makes it clear that these Clinical Resource Packs are for use in healthcare services.
When we use the term “patient”, we are referring to people who use, or are supported by healthcare services, their personal support network, communities and anyone who may use healthcare services in the future. When reading this document, please substitute the word “patient” with the term most appropriate for your healthcare setting (HSE, 2022a).

1.4 Consent

Consent must be sought from all patients, parents or legal guardians prior to undertaking assessments/interventions recommended in this resource pack, in line with the HSE (2024) National Consent Policy.

2.0 Pressure Ulcers Overview

A pressure ulcer is defined as “a 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” (EPUAP/ NPIAP/PPPIA, 2019).

Pressure ulcers can range in severity from skin discolouration and damage to open wounds. Pressure ulcers are chronic wounds which are often preventable, once the identified risk is circumvented with appropriate measures. There are many risk factors attributed to pressure ulcer development, but they are most often prevalent in people with mobility issues, those who are malnourished or critically unwell. People over 70 who have limited mobility are particularly vulnerable, as are patients with spinal cord injuries regardless of their age (EPUAP/NPIAP/PPPIA, 2019).

Pressure ulcers remain a major healthcare issue with studies reporting varied prevalence. For every 1,000,000 patients who develop a pressure ulcer, 65,000 die from complications (International Guidelines, 2009). Pressure ulcers are common within acute and long stay settings in Ireland; the pressure ulcer prevalence was 12.0% (Moore *et al*., 2019). This figure reflects the international data, which reports an overall European pressure ulcer prevalence of 10.8% among hospitalised patients. Prevalence of between 6.0% and 18.5% have been reported in acute care settings and between 3.4% and 32.4% in long-term care settings (Moore *et al*., 2019). Reducing pressure ulcers can result in significant cost savings both from a financial and quality of life perspective to both service users and service providers. This requires a collective effort to engage in continuous quality improvement that is sustainable and a willingness from healthcare providers to engage.

In Ireland, all hospital or community acquired pressure ulcers are reportable incidents with Stage 3 to 4 pressure ulcers being considered serious reportable events (HSE, 2015). The HSE Patient Safety Strategy 2019-2024 identifies reducing the rate of acquired pressure ulcers as a priority patient safety area. Improvement Collaboratives led by National Quality and Patient Safety have achieved up to 73% reduction in pressure ulcers across participating teams. This implies that a collective approach can achieve positive outcomes, however continuous improvement and sustainability of pressure ulcer prevention programmes continues to pose significant challenges worldwide from early identification to financial and staffing issues (Maki-Turja-Rostedt *et al*., 2023).

3.0 Recommendations – Adult Patients

3.1 Identification of Patients at Risk

- Consider patients' risk factors for pressure ulcers at every contact with a health and social care professional.
- Address any patient, family or carer concerns expressed regarding pressure ulcer risk factors.

Risk factors include:

- History of prolonged unrelieved pressure
- Reduced mobility/immobility
- Deterioration in clinical condition
- End of life care (skin failure)
- Neuro-vascular compromise
- Discoloured, hot, swollen, numb or painful skin over a bony prominence
- Presence of a pressure ulcer, scarring from a healed pressure ulcer or any wound/ excessive moisture in an at risk area of skin
- Poor nutrition and/or weight loss Incontinence
- Presence of a medical device in prolonged contact with the patient's skin/poorly fitting medical device.

Appendix I is an Algorithm for Pressure Ulcer Management for Healthcare Professionals, which was adapted from the European Pressure Ulcer Advisory Panel (EPUAP) Algorithm for Pressure Ulcer Management for Professionals. It may be helpful to use as an "at-a-glace" guide for the prevention and management of pressure ulcers.

3.2 Risk Assessment

- Assess and record pressure ulcer risk as soon as possible, using a risk assessment tool and clinical judgement.
  - All patients within acute services should be assessed within six hours of admission
  - All patients within residential services should be assessed on admission/transfer
  - All patients within community services should be assessed during the first visit.
- The Braden, Waterlow and Norton scales are well-known risk assessment tools that can be used for a broad spectrum of patients and settings. The PURPOSE T is a more recent evidence based pressure ulcer risk assessment tool that identifies individuals at risk of developing a pressure ulcer including those with existing and previous pressure ulcers.
- This also includes consideration of medical devices. More information on the PURPOSE T is provided in Appendix II.
- Refer to multidisciplinary team (MDT) members as appropriate based on the findings of the initial risk assessment to prevent/manage pressure ulceration.
- Reassess risk at intervals as per local policies, procedures, protocols and guidelines (PPPGs), as patient's level of risk may change over time. Reassess risk:
  - Weekly at a minimum in acute hospitals settings

- Monthly at a minimum in residential setting
- Monthly at a minimum in community based settings (where a patients skin condition is stable, the frequency of reassessment is dependent on the individual patient assessment and clinical judgement)
- If there is a change in the patient's condition? Before and after a patient goes to theatre
- Before and after admission/transfer between hospitals, wards or community-based settings.

- Once a patient is identified as being at risk of developing a pressure ulcer, the aSSKINg Care Bundle should be implemented
- Patients who have had a previous pressure ulcer should be considered at risk of developing a pressure ulcer and the aSSKINg Care Bundle should be implemented
- Consider use of silicone multilayer foam dressings/pressure redistribution equipment to prevent pressure ulcers in at risk patient
- Skin must be inspected before and during use of Medical Devices that are in contact with the skin
- If a pressure ulcer is present, diagnose and stage the pressure ulcer using HSE (2024) pressure ulcer staging system. See Appendix III of this Clinical Resource Pack. Appendix III also contain the Pan Pacific Classifications System (2020) for different skin tones, older adults, neonates and children. It is important to note that whilst they use the term injury instead of ulcer, they have the same meaning and provide a good overview of pressure damage in different skin tones. Consider differential diagnosis, for example Incontinence associated dermatitis, skin tears etc.

3.3 Initial Care on Identification of Pressure Damage to Skin

- Reposition the patient to relieve pressure on the affected area. Record the position in which the patient was found and findings of the initial skin inspection.
- Clean and dress any wounds if present as per local wound care guidelines. Assess and ensure any equipment present is functioning.
- If possible, take a digital image of the skin (in line with local clinical photography guideline and with the patient's consent).
- Seek appropriate assistance +/- referral to specialist as required.
- Provide education to the patient/family regarding caring for the pressure damage.
- Record/document all assessment findings, actions/interventions, care plans and patient/ family discussions pertaining to pressure ulcers in the patient's healthcare record.
- Ensure handover to all caregivers/clinicians to ensure continuity of care and communicate findings at each handover and on transfer to other units or community settings. This includes a handover that open disclosure has occurred when a patient develops a pressure ulcer in a service, in line with open disclosure.
- If there are any safeguarding concerns discuss with the line manager/medical team/General Practitioner (GP) and refer to the HIQA (2019) National Standards for Adult Safeguarding.
- Inspect under any medical devices in contact with the skin and offload/reposition to minimise the risk of pressure damage to the skin.

3.4 Caring for Patients at Risk of/with a Pressure Ulcer

- Implement the aSSKINg bundle and address all individual risk factors for all patients at risk of or with pressure ulceration.
- Inspect the skin and pay particular attention to skin that may be in contact with medical devices regularly for visual signs of pressure damage.
- Educate patients/carers to reduce risk and encourage them to report any skin care concerns. Encourage patient to participate in their pressure ulcer prevention/management care plan.
- Record/document all assessment findings, actions/interventions, care plans and patient/ family discussions pertaining to pressure ulcers in the patient's healthcare record.
- Provide handover to all caregivers/clinicians to ensure continuity of care and communicate findings at each handover and on transfer to other units or community settings. This includes a handover that open disclosure has occurred when a patient develops a pressure ulcer in a service, in line with open disclosure.
- Clear communication between all health care professionals and all acute, community/ residential services is paramount to ensuring best practice for pressure ulcer prevention and management is achieved.
- If a pressure ulcer occurs/deteriorates, reassess and escalate all interventions, for example repositioning frequency, use of pressure redistributing equipment. Refer to MDT as appropriate.
- Report all pressure ulcers in line with local Policies, Procedures, Protocols and/or Guidelines (PPPGs). Appendix IV "Pressure Ulcers: What to Do and How to Report Them Guidance for Professionals" is a quick-reference flyer which may be helpful.

3.5 Promoting Wound Healing in Pressure Ulcers

- If a wound is present, undertake a holistic patient and wound assessment. Assess nutritional status using a validated tool, for example Malnutrition Universal Screening Tool (MUST) (Bapen, 2010). Assess for any risk factors for healing, for example infection, lifestyle factors, medications, co-existing medical conditions.
- Measure the wound at regular intervals (weekly) to monitor progress to healing.
- Implement a wound care plan in addition to the aSSKINg bundle. Consider analgesia, nutrition and address any risk factors identified in the assessment process.
- Monitor the wound until fully healed for signs of infection. Refer urgently to medical team/ General Practitioner if there are any signs of acute infection or sepsis. Educate patient/carers on recognising signs of infection and sepsis and the importance of self-referral to GP/Emergency Department (ED) if concerned.
- Select an appropriate wound dressing – refer to the HSE 2018 National Wound Management Guidelines.
- Record/document all assessment findings, actions/interventions, care plans and patient/ family discussions pertaining to pressure ulcers in the patient's healthcare record.
- Provide a complete handover to all caregivers/clinicians to ensure continuity of care and communicate findings at each handover and on transfer to other units or community settings. This includes a handover that open disclosure has occurred when a patient develops a pressure ulcer in a service, in line with open disclosure.
- All non-healing/deteriorating/stage 3-4 pressure ulcers should be referred to a specialist tissue viability nurse for assessment.

3.6 Healed Pressure Ulcer Care

- Re-educate patients/carers of the risks associated with pressure damage/recurrence and how to identify the same. Provide supportive literature appropriate to the patient/carer's needs; a sample patient and carer information leaflet is included in this Clinical Resource Pack in Appendix V. Advise patients/carers to contact their healthcare professional if concerned.
- Consider pressure relieving/redistribution equipment required based on individual risk assessment.

3.7 Management of Pressure Ulcers in End of Life Care

The goal of end-of-life care is to promote the best quality of life for patients prioritising comfort and pain management. Where a patient is receiving end of life care, the goal is to manage the symptoms and the wound, rather than healing the pressure ulcer. This may include managing malodour or exudate with appropriate wound care dressings. These goals should be explained to the patient and their family and patients' preferences should be respected and adhered to as far as possible (Mitchell & Elbourne, 2022).

4.0 Recommendations – Neonatal and Paediatric Patients

4.1 Pressure Ulcers in Neonatal and Paediatric Populations

Hospitalised children are at increased risk of pressure ulcer development. Zhang *et al*. (2022) undertook a systematic review and meta-analysis on prevalence and incidence of pressure injuries in hospitalised children. They reported a pooled incidence rate of 13.5% of pressure injuries with the occiput, ears and nose being the most frequently affected body sites. Although more research is required in this field, the authors suggest that the incidence rate is higher in children than in adults.

The skin of neonates and children differs from adult skin. Babies are unable to reposition themselves spontaneously and cannot verbalise pain or discomfort, therefore increasing their risk of pressure ulceration. The skin of paediatric patients changes over time with complete maturation of the epidermis at 34 weeks (Gefen *et al*., 2022). This implies that children will require different pressure relieving prevention strategies targeting specific age groups.

4.2 Pressure Ulcer Risk Factors

Risk factors for pressure ulcers and medical device related pressure ulcers in paediatric populations include the following:

- Sedation
- Hypotension
- Sepsis
- Spinal cord injury
- Traction devices
- Terminal illness
- Spina bifida
- Cerebral palsy
- Cardiovascular surgery
- Lengthy surgical procedures
- ECMO bridge for life connections
- Cerebral and cardiovascular activity probes

4.3 Risk Assessment in Neonatal and Paediatric Populations

- Pressure ulcer prevention strategies in neonatal and paediatric populations include: risk assessment, skin assessment, care planning, padding under medical devices when in use, care delivery and documentation.
- There are specific paediatric pressure ulcer risk assessment tools in use such as the Glamorgan risk assessment tool and the Purpose T paediatric risk assessment tool.
- Devices are the main causative factors of pressure ulcers in paediatric populations. They predominantly occur on the face and scalp followed by the heel and occiput (Smith et al., 2019).
- All paediatric patients who are at risk of pressure ulcer development must undergo a skin assessment (NICE, 2014). If medical devices are in use, more frequent assessment may be required. Frequency of assessment is based on clinical assessment of the patient's condition and the level of risk associated with the medical device(s) in use.

4.4 Assessment of Neonatal and Paediatric Patients with Medical Devices

Frequently assess under:

- Skin around nasogastric and orogastric tubes
- Head dressings
- Hats
- Blood pressure cuffs
- Transcutaneous oxygen pressure probes
- Tracheostomy plates
- Nasal prongs, masks, continuous positive airway pressure (CPAP), bi-level positive airway pressure (BIPAP)
- Arm boards Plaster casts
- Traction boots
- Splints
- In growing children, frequently readjust:
    - Orthotics
    - Wheelchairs
    - Wheelchair cushions Securement straps
    - Splints and medical shoe insoles
    - Prostheses

- Inspect beds, cribs and isolettes to ensure tubing, leads, toys and syringe caps are not under or on top of the patient's skin.
- Assess carefully the stiffness of nappy edges and clothing seams.

5.0 Medical Device Related Pressure Ulcers (MDPRUs)

A Medical Device Related Pressure Ulcer (MDRPU) is a localised injury to the skin or underlying tissue as a result of sustained pressure from a medical device. Pressure ulcer damage from medical devices can often occur in areas that are not easily visible or in areas with minimal soft tissue such as the bridge of the nose and ears. Respiratory devices such as oxygen tubing and masks are linked with a high number of MDRPUs. Other devices that may cause MDRPUs include urinary catheters, splints, casts, vascular access devices and tubing including nasogastric tubing.

National Quality and Patient Safety regularly issues Patient Safety Supplements to all staff in order to share relevant quality and patient safety information for learning purposes and to raise awareness. Appendix VI is a Patient Safety Supplement on MDRPUs, published in June 2024. It aims to support healthcare staff and patients/service users to identify the risk factors for developing MDRPU and reiterate how everyone can be proactive in helping to prevent these often-avoidable injuries.

5.1 Medical Device Related Risk Factors

- Generic sized devices or inflexible materials that do not allow a correct fit
- Long medical device wear time
- Medical devices requiring a tight/secure fit Moisture build up
- Poor/unclear/insufficient instructions on how to fit the medical device
- Patient's ability to communicate discomfort or reposition medical devices.

What helps reduce the risk? Ensure the device:

- Is suitable for the intended use
- Is properly sized and fitted
- Is rotated/repositioned frequently
- Is positioned on clean and dry skin
- Is removed when medically indicated
- Is used in line with manufacturer's instructions
- Consider using barrier dressings or gel sheets but only If it does not affect the performance of the device, or breach manufacturer's instructions for use.

5.2 Reporting MDRPUs

It is essential that all pressure ulcers, including MDRPUs are reported on the National Incident Management System (NIMS), communication, and open disclosure of the incident with the patient/ service user occurs promptly. Reporting MRDPUs may identify a common issue with particular medical devices and this will support engagement with medical device leads, committees and potentially medical device suppliers or manufacturers, which may contribute to improvements.

In cases where the MDRPU is considered related to a defective medical device and/or inadequate instructions for use, this should be reported to the Health Products Regulatory Authority (HPRA), available at https://www.hpra.ie.

5.3 The SECURE Mnemonic

A helpful mnemonic for an integrated pathway for MDPRU prevention is “SECURE” (Gefen *et al*., 2022).

S	E	C	U	R	E
Skin/Tissue	**Education**	**Champion/ Collaborate**	**Understand**	**Report**	**Evaluate**
Thorough assessment, daily or more frequently, depending on risk. A handover may be required to ensure continuity of care.	Education for: • health professionals • patients • carers • family • industry	Lead the adoption of evidence-based devices developed through collaboration with manufacturers and health professionals.	Develop a thorough understanding of the causes of MDRPU formation, patient assessment and correct product use.	Ensure that MDRPUs are correctly reported in a timely manner.	Evaluate devices for their ability to minimise MDRPUs by thoroughly analysing support data and conducting clinical evaluations in the facility’s patient population.

6.0 The aSSKINg Care Bundle

A care bundle is a collection of interventions that may be applied to the management of a particular condition (IHI 2012). Elements of a care bundle are based on research and clinical evidence. The use of a care bundle can increase patient safety and satisfaction, and build staff confidence in that particular area of care. Pressure ulcers can be due to many, often combined, factors. As such, interventions to reduce harm from pressure ulcers need to have many elements. In routine clinical practice, these elements may not always all be done in the same way, making patient care vary. A care bundle ties the different care elements together into a cohesive unit.

The aSSKINg care bundle is a tool to guide and document pressure ulcer prevention and management, and is aimed at reducing the risk of patient harm which is often preventable. An evidence-based approach can be adopted across a range of care settings. The original five-step SSKIN care bundle has been widely used in clinical practice for many years. In 2018, the NHS Improvement Pressure Ulcer Core Curriculum introduced two important additional elements, adding to the existing 5-step SSKIN care bundle with the letters: ‘a’ for assess risk and ‘g’ for give information.

- **a** Assess Risk
- **S** Skin Assessment and Skin Care
- **S** Surface Selection and Use
- **K** Keep Patient Moving
- **I** Incontinence Assessment and Care
- **N** Nutrition and hydration Assessment/Support
- **g** Giving Information

Several sample tools and resources are included in this Clinical Resource Pack that can support healthcare professionals in using the SSKIN and/or aSSKINg Care Bundle for the prevention and management of pressure ulcers. These are:

- Appendix VII: The aSSKINg Care Bundle Information Sheet
- Appendix VIII: Sample Skin Assessment Form (Acute) using the aSSKINg Care Bundle
- Appendix IX: Sample aSSKINg Bundle Care Plan – Acute Settings
- Appendix X: Sample SSKIN Bundle Chart – Community Settings (1)
- Appendix XI: Sample SSKIN Bundle Checklist – Community Settings (2)
- Appendix XII: Sample aSSKINg Bundle Audit Tool

6.1 Components of the aSSKINg Care Bundle

The following table outlines best practice actions associated with each letter of the aSSKINg Care Bundle, and has been adapted from the NHS (2023) National Wound Care Strategy Programme Pressure Ulcers Recommendations and Clinical Pathway:

Action	Best Practice
a **Assess Risk**	• Consider risk factors associated with compromised skin integrity. • Undertake screening and risk assessment using the PURPOSE T screening and risk assessment tool or similar evidence-based and validated risk assessment tools which contains at a minimum the same risk elements. • Refer the patient to appropriate members of the multidisciplinary team. • Be aware of safeguarding policies and take appropriate action when necessary. • Document risk status and timing of review in the clinical record. Ensure this is communicated at clinical handover, to the relevant MDT team and on transfer of the patient both internally and externally to the service.
S **Skin Assessment and Skin Care**	• Carry out a comprehensive skin assessment, including skin under medical devices where it is safe to do so. • Consider colour, texture and temperature of skin. • Ask the individual to identify any areas that are painful, itchy, uncomfortable or numb. • Consider risk factors associated with impaired skin integrity. • Identify complex health conditions that affect skin integrity. • Keep the skin clean, dry and well hydrated. • Implement evidence-based skin interventions to promote skin integrity. • Document the presence of vulnerable skin, including where there is a change in colour, temperature or texture or patient reported changes in sensation.
S **Surface selection**	• Consider risk factors associated with a range of support surfaces including but not limited to beds, mattresses, chairs, cushions, wheelchairs and in vehicles. • Consider the impact of offloading devices such as boots or other orthoses. • Consider the impact of medical devices and their contact with the skin. • Consider the range of available equipment, including the mechanism of action, benefits and associated risks. • Identify and undertake relevant seating and moving and handling risk assessments. • Consider the role of support surfaces and equipment on the patient's level of independence while managing the risk of pressure ulcer development. • Refer to appropriate members of the inter-professional team throughout the patient journey, including discharge journey.

Action	Best Practice
K **Keep Moving**	• Consider level of mobility and risk factors associated with reduced mobility. • Consider the range of available moving and handling equipment, including the mechanism of action, benefits and associated risks. • Use relevant tools to assess mobility, to balance the risk from other harm, for example falls risk assessment. • Consider the impact of reduced mobility on an individual's posture, activities of daily living (ADL), and psychosocial functioning, for example mood, isolation, social engagement. • Safely use a range of appropriate equipment (for example hoists and slings, standing hoists and frames, electronic bed frames, appropriate seating and mobility aids, sleep systems, wheelchairs etc.) to promote self-mobilisation and good posture, as well as promote individualised plan of mobility and assisted transfers. • Refer to the appropriate members of the multidisciplinary team (MDT) throughout the planning journey, including discharge planning. • Consider the individual's daily routine when planning repositioning or activity schedules. • Identify, understand and, where possible, address the cause of any change in mobility. • Offload bony prominences and pressure ulcer sites. • Encourage early mobilisation as able. • Implement individualised repositioning and mobilising. • Repeat mobility/repositioning as frequently as required for the individual's need. • Use 30 degree tilt side lying position for patients in bed.
I **Incontinence Assessment and care**	• Identify the cause of moisture-related skin damage, for example incontinence, sweat, saliva, stoma effluent, wound leakage. • Where possible, address the cause of moisture. • Consider whether incontinence-related skin damage is an issue. • Differentiate between aetiologies associated with incontinence. • Consider how increased moisture increases the risk of skin damage caused by friction. • Implement appropriate prevention and management strategies. • Refer to incontinence services where necessary. • Keep the skin clean, dry and well hydrated. • Maintain hydration.

Action	Best Practice
N Nutrition	• Consider the impact of key nutritional elements in wound healing. • Understand the impact of disease on nutritional need and nutrient absorption. • Use the relevant tools and documentation, which should include food and fluid charts, for example: food diaries, malnutrition universal screening tool (MUST) score, body mass index (BMI), bloods and feeding risks. • Advise on food fortification, nutritional supplementation and moderation of dietary restrictions in the event of pressure ulceration. • Collaborate to deliver appropriate care with relevant members of the MDT, for example dietitian, speech and language therapist, occupational therapist. • Consider the practical elements of maintaining nutrition and hydration including portion sizes, food texture, access and ease of use of supplements, and good dentition.
g Give Information	• Select and implement the most appropriate communication approach to increase awareness and facilitate concordance with pressure ulcer • Consider and perform the necessary checks to assess the patient's level of capacity. • Communicate effective and safe use of interventions effectively for the patient and family, and within the MDT. • Recognise when, where and how to escalate clinical concerns. • Promote effective pressure ulcer prevention approaches. • Consider effective resource allocation and escalate concerns when resources are unavailable. • Be aware of safeguarding policies and take appropriate action when necessary. If there are safeguarding concerns discuss with the line manager and medical team or the GP and refer to the HIQA (2019) National Standards for Adult Safeguarding. • Use the clinical record as the source of documentation to ensure information is available to all members of the MDT. • Use correct/accurate terms to ensure the clinical record can be appropriately used for coding/analytic purposes. • When capturing and using digital images, ensure appropriate consent has been obtained.

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Health Products Regulatory Authority (HPRA): Available at: https://www.hpra.ie

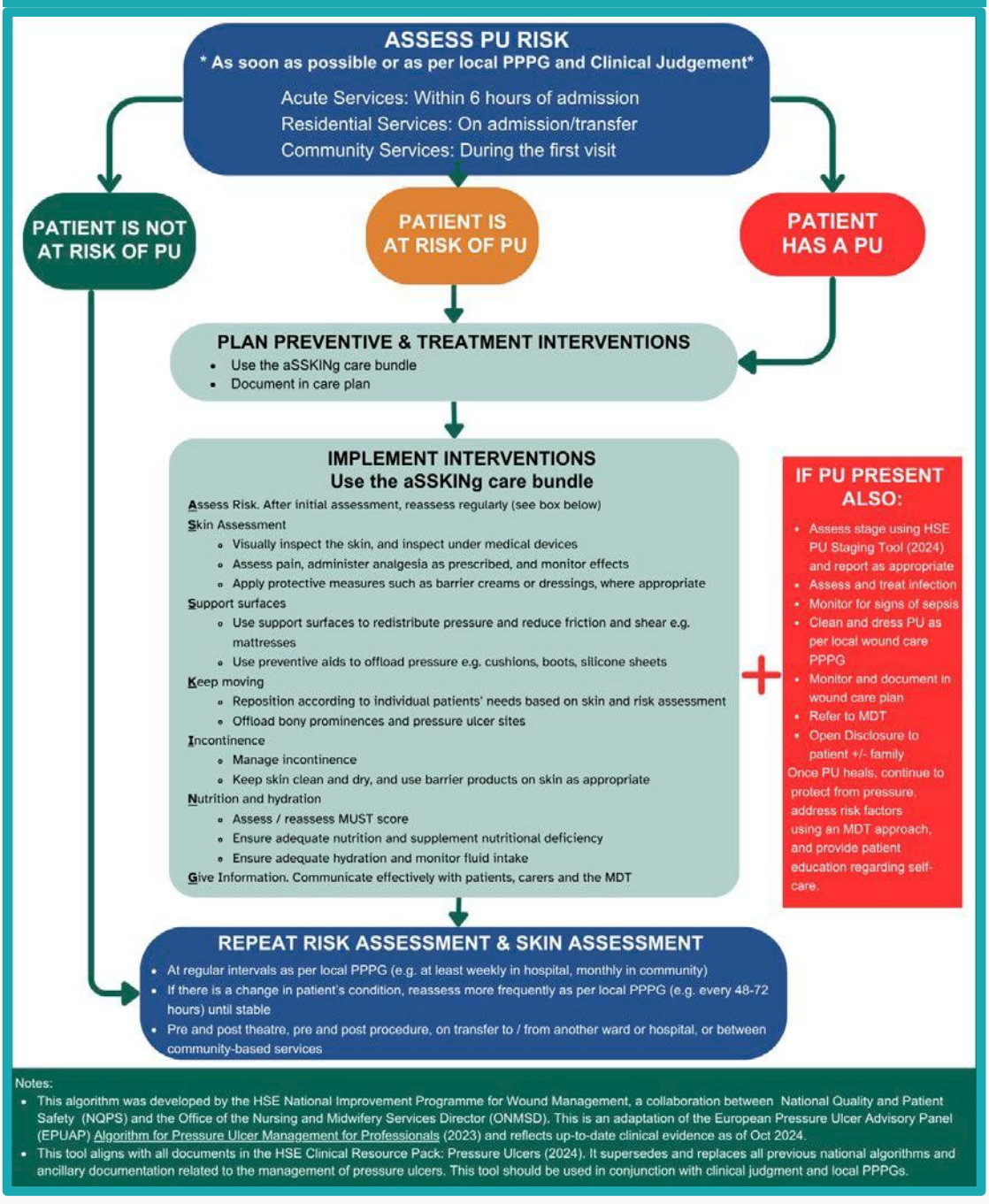
PURPOSE-T information available at: https://ctru.leeds.ac.uk/purpose/purpose-t

Appendix I: Algorithm for Pressure Ulcer Management for Healthcare Professionals

Algorithm for Pressure Ulcer (PU) Management for Healthcare Professionals

HSE adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Algorithm for Pressure Ulcer Management for Professionals (2023)

One page document. Last updated: October 2024



Notes:

- This algorithm was developed by the HSE National Improvement Programme for Wound Management, a collaboration between National Quality and Patient Safety (NQPS) and the Office of the Nursing and Midwifery Services Director (ONMSD). This is an adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Algorithm for Pressure Ulcer Management for Professionals (2023) and reflects up-to-date clinical evidence as of Oct 2024.
- This tool aligns with all documents in the HSE Clinical Resource Pack: Pressure Ulcers (2024). It supersedes and replaces all previous national algorithms and ancillary documentation related to the management of pressure ulcers. This tool should be used in conjunction with clinical judgment and local PPPGs.

Appendix II: PURPOSE T Risk Assessment

PURPOSE-T is an evidence-based pressure ulcer risk assessment tool that identifies individuals at risk of developing a pressure ulcer and those with existing and previous pressure ulcers. It was developed by the Clinical Trials Research Unit at the University of Leeds and Leeds Teaching Hospital NHS Trust using gold standard instrument-development methods in a structured five- phase approach including: a systematic review of pressure ulcer risk factors: a consensus study involving a mixed-specialty expert group and service users; conceptual framework development; cognitive pre-testing with clinical nurses; and clinical evaluation in acute and community settings. The psychometric properties of PURPOSE-T have been tested with the tool demonstrating reliability, convergent validity and clinical usability when used by expert and ward/community nurses in secondary and community care settings.

Unlike other pressure ulcer risk assessment tools, which assign numerical values to various risk factors, no numbers or subjective levels of risk are involved in PURPOSE-T. PURPOSE-T drives clinicians towards critical thinking and individualised care for patients, giving them 'permission' to use their own clinical judgement.

Step 1: Screening – to quickly screen out those clearly not at risk

- Assessment of mobility and skin status (including medical devices)
- Encouraging healthcare professionals to use their clinical judgement to highlight any other risk factors which significantly impact the individual patient.

Step 2: Full Assessment

- Analysis of independent movement Detailed skin assessment
- Previous pressure ulcer history Medical devices
- Perfusion and nutrition
- Sensory perception and response
- Moisture due to perspiration, urine, faeces or exudate
- The presence of diabetes.

Step 3: Assessment decision based on step 2 and aided by colour-coding

- **Green**: No pressure ulcer – not currently at risk
- **Amber**: No pressure ulcer – but at risk, requiring primary prevention
- **Red**: Pressure ulcer stage 1 or above, or scarring from previous pressure ulcer requiring secondary prevention/treatment.

The UK National Wound Care Strategy Programme (NWCSP) has recommended the PURPOSE-T to healthcare professionals to prevent pressure damage and promote healing. For further information and permission to use the PURPOSE-T risk assessment, see: https://ctru.leeds.ac.uk/purpose/

Appendix III: HSE Pressure Ulcer Staging Tool 2024

HSE Pressure Ulcer Staging Tool 2024

Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool

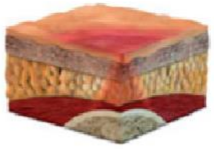
Two page document last updated: October 2024

Blanching Erythema as an Early Warning Sign

Areas of discoloured tissue that blanch (turn white) when fingertip pressure is applied indicate that damage is starting to occur but can be reversed. In darker skin tones, clinicians should assess for changes to colour, temperature, texture & sensation to skin.

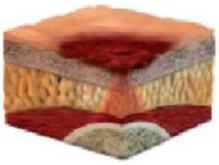
Stage 1 Pressure Ulcer:
Non-Blanchable Erythema

- Intact skin with non blanchable redness of a localised area usually over a bony prominence.
- Dark skin may not have visible blanching - its colour may differ from surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent skin.



Stage 2 Pressure Ulcer:
Partial Thickness Skin Loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough or bruising
- May also present as an intact or open/serum-filled blister
- Presents as a shiny or dry, shallow ulcer without "adherent" slough or bruising.
- Stage 2 pressure ulcers should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



Stage 3 Pressure Ulcer:
Full Thickness Skin Loss

- Subcutaneous fat may be visible but bone, tendon or muscle are not exposed or directly palpable. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth varies by anatomical location. Areas with significant subcutaneous tissue can develop deep Stage 3 pressure ulcers. However, in areas that do not have subcutaneous tissue, Stage 3 pressure ulcers can be shallow e.g. the bridge of the nose, ear, occiput and malleolus.

Stage 4 Pressure Ulcer:
Full Thickness Tissue Loss

- Full thickness tissue loss with exposed bone, tendon or muscle visible or directly palpable. Slough or eschar may be present on some parts of the wound bed.
- The depth varies by anatomical location. Stage 4 pressure ulcers can be shallow in areas that do not have subcutaneous tissue e.g. the bridge of the nose, ear, occiput and malleolus.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g. Fascia, tendon or joint capsule), which can result in osteomyelitis, infection or sepsis.

Appendix III: HSE Pressure Ulcer Staging Tool 2024 *continued*

HSE Pressure Ulcer Staging Tool 2024

Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool

Two page document last updated: October 2024

Unstageable Pressure Damage - Depth Unknown

- Full thickness tissue loss in which the base of the pressure ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the pressure ulcer bed.
- Until enough slough/eschar is removed to expose the base of the pressure ulcer, the true depth cannot be determined. These should be reported as at least Stage 3 pressure ulcers to ensure reporting occurs immediately. Once the extent of tissue damage is revealed, then the pressure ulcer can be restaged and reported as appropriate.
- Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serve as the body's natural biological cover and should not be removed.

Suspected Deep Tissue Damage

- A localised area of non-blanching erythema with purple/maroon discolouration of intact skin or blood-filed blister, due to damage from pressure and/or shear.
- The area may be preceded by tissue that is painful, firm, flaccid, boggy, and warmer or cooler compared to adjacent tissue.
- Deep tissue damage may be difficult to detect in individuals with dark skin tones. Clinicians should assess for changes to colour, temperature, texture and sensation to skin.
- Evolution may include a thin blister over a dark wound bed or may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment or it may take days or weeks to determine true extent of tissue damage. Record what you see in the healthcare record. Once the extent of tissue damage is revealed, the pressure ulcer can be staged and reported as appropriate.

Medical Device Related Pressure Ulcers (MDRPU)

- MDRPU are pressure ulcers that result from the use of devices used for diagnostic or therapeutic purposes. The damage caused often mimics the shape and distribution of the medical device.
- MDRPU can often occur in areas that are not easily visible or in areas with minimal soft tissue such as the bridge of the nose and ears.
- Unless the damage is to mucous membranes, they should be staged and reported in line with this Pressure Ulcer Staging Tool (2024).

Mucosal Pressure Ulcers

- These develop on mucosal membranes e.g. tongue, mouth, nasal passages, genitals and rectum, commonly as a result of a medical device.
- Mucosa does not have the same layers as the skin and therefore cannot be staged.
- These should be reported as mucosal pressure ulcers and their cause documented.
- If the pressure ulcer is unlikely to resolve without intervention or causes disfigurement, report it as a Serious Reportable Event (SRE).

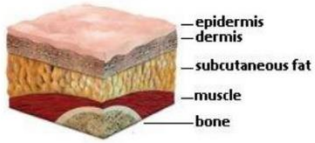
Appendix III (a): Pan Pacific Pressure Injury Classification System for Adults with Light Skin Tones (2020)

Available at: https://pppia.org/pppia-

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR ADULTS WITH LIGHT SKIN TONES

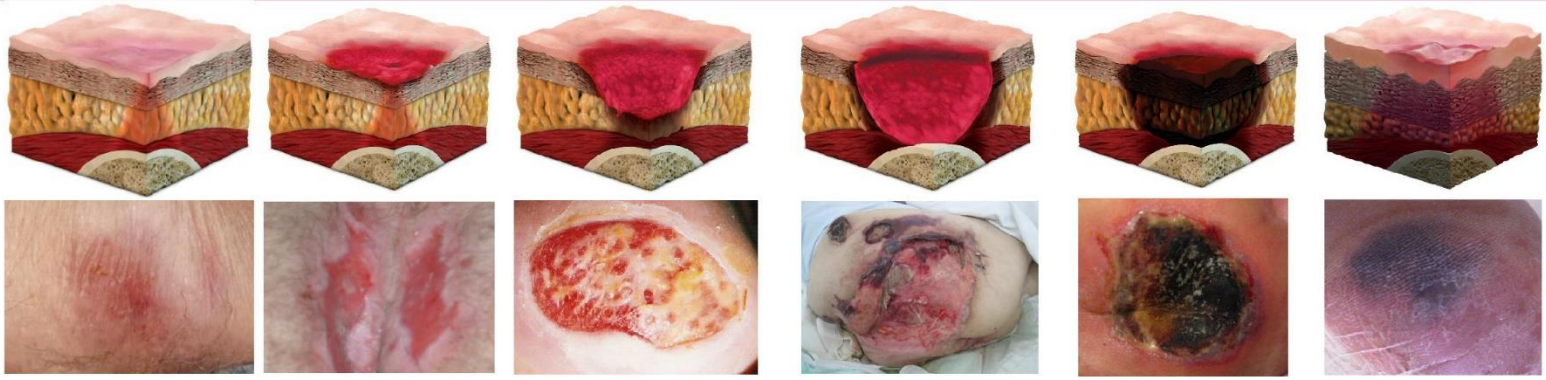
PAN PACIFIC Pressure Injury Alliance

Normal skin



Text adapted from: *International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014)* published in: National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. **3D graphics:** Keryln Carville and Emily Haesler, used with permission. **Photos:** All photos courtesy Dr K. Carville, used with permission. **Also available in this series:** PPPIA Classification System: Multicultural, PPPIA Classification System for Dark Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults.
More information and permission for use: www.pppia.org

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. May indicate 'at risk' individuals (a heralding sign of risk).	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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base 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 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.	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 as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

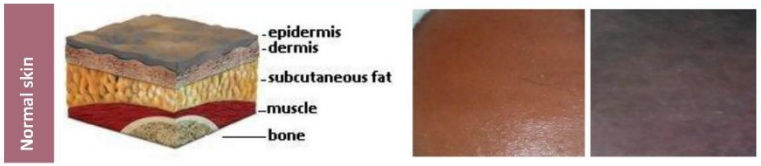


Appendix III (b): Pan Pacific Pressure Injury Classification System for Dark Skin Tones (2020)

Available at: https://pppia.org/pppia-

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR DARK SKIN TONES

PAN PACIFIC
Pressure Injury Alliance



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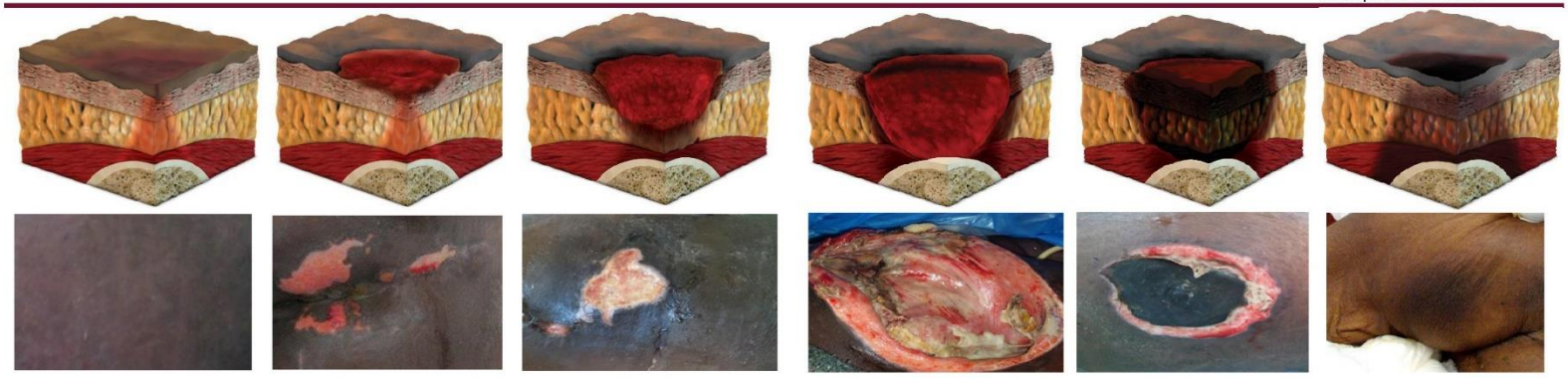
More information and permission for use: www.pppia.org

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).	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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base 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 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.	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 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 be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

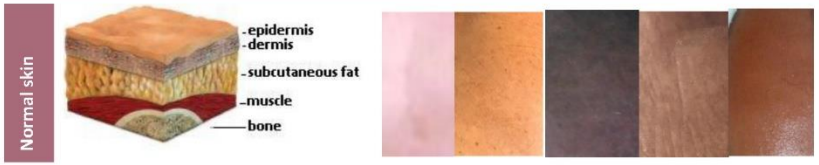


Appendix III (c): Pan Pacific Pressure Injury Classification System for Multicultural Skin Tones (2020)

Available at: https://pppia.org/pppia-

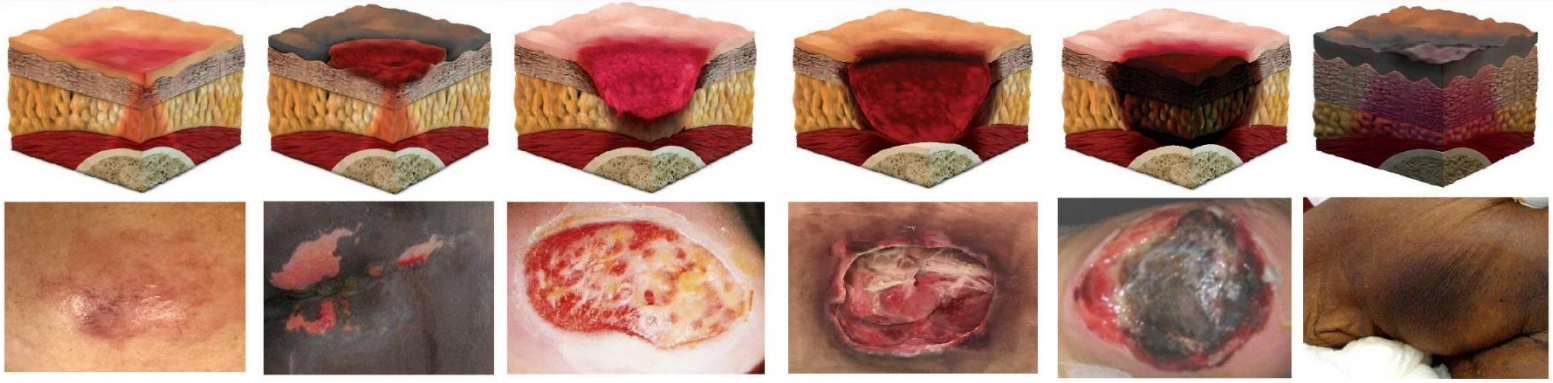
PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM: MULTICULTURAL

PAN PACIFIC
Pressure Injury Alliance



Text adapted from: *International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014)* published in: National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. **3D graphics:** Keryln Carville and Emily Haesler, used with permission. **Photos:** Photos courtesy K. Carville and S. Law, used with permission. **Also available in this series:** PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Neonates and Children, PPPIA Classification System for Dark Skin Tones, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults. **More information and permission for use:** www.pppia.org © PPPIA 2020

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. Stage I pressure injuries may be difficult to detect in individuals with darkly pigmented skin tone. May indicate 'at risk' individuals (a heralding sign of risk).	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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base 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 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.	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 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 be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



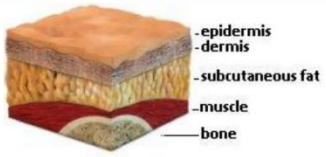
Appendix III (d): Pan Pacific Pressure Injury Classification System for Asian Skin Tones (2020)

Available at: https://pppia.org/pppia-

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR ASIAN SKIN TONES

PAN PACIFIC Pressure Injury Alliance

Normal skin



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Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
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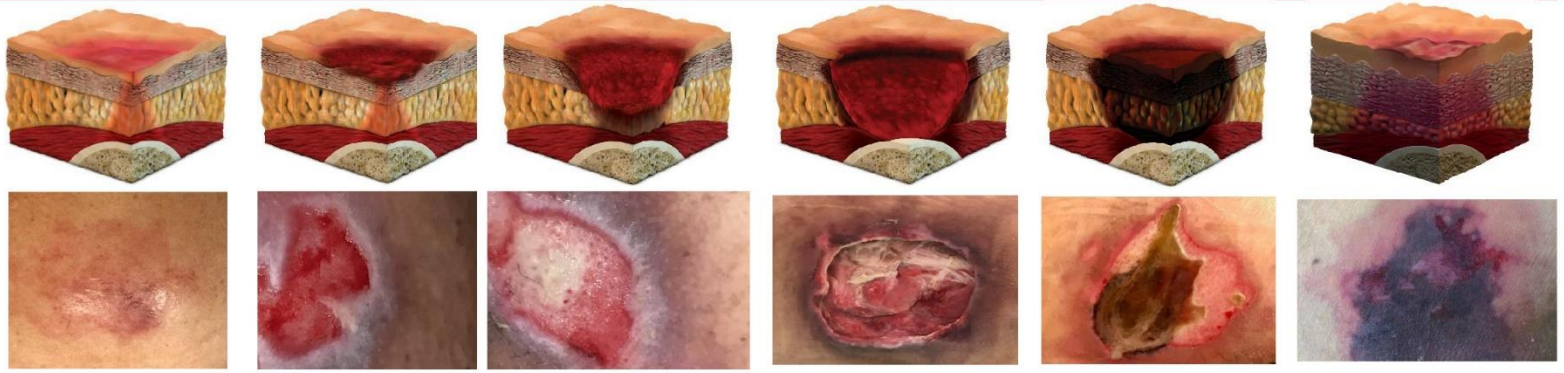
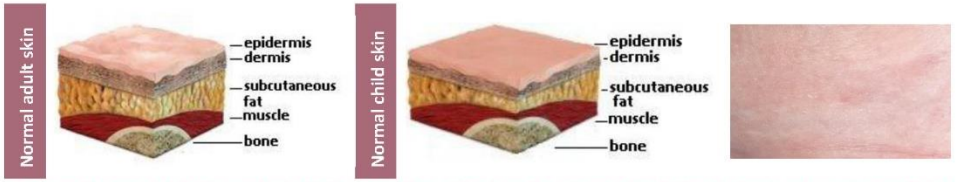


Available at: https://pppia.org/pppia-

PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR NEONATES AND CHILDREN

PAN PACIFIC
Pressure Injury Alliance



Compared to normal adult skin, paediatric skin has a smoother epidermis and less pigmentation. Epidermis, dermis and subcutaneous fat are thinner in children. Skin moisture concentration and sebum are lower, and water content is higher in children. Skin pH is higher in neonates.

Text adapted from: *International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014)* published in: National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. **3D graphics:** Keryln Carville and Emily Haesler, used with permission. **Photos:** Photos courtesy of C. Boylan, used with permission. **Also available in this series:** PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Dark Skin Tones, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Older Adults. **More information and permission:** www.pppia.org

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. Stage I pressure injuries may be difficult to detect in babies/children with darkly pigmented skin tone. May indicate 'at risk' babies/children (a heralding sign of risk).	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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base 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 Stage) cannot be determined. Stable (dry, adherent, intact, no erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	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 as compared to adjacent tissue. Deep tissue injury may be difficult to detect in babies/children with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Appendix III (f): Pan Pacific Pressure Injury Classification System for Older Adults (2020)

Available at: https://pppia.org/pppia-

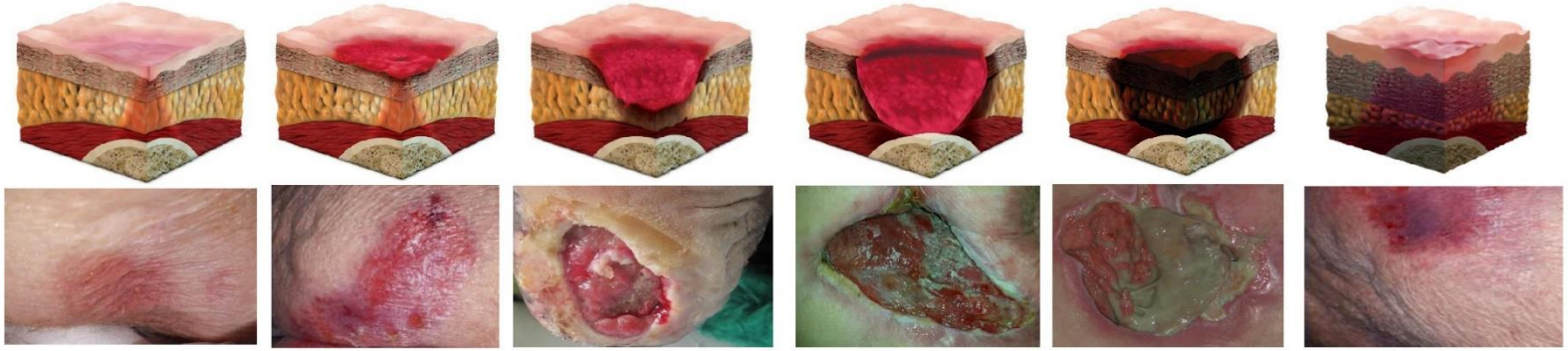
PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR OLDER ADULTS

PAN PACIFIC
Pressure Injury Alliance

Compared to the skin of younger adults, older skin has a thinner, more wrinkled epidermis and may appear paler or with pigmented (age) spots. Epidermis, dermis and subcutaneous fat layers are thinner. Skin moisture concentration is reduced and skin pH is raised in older adults.

Text adapted from: *International NPUAP/EPUAP Pressure Ulcer Classification System (2009,2014)* published in: National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA), Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2014: Emily Haesler (Ed.) Cambridge Media: Osborne Park, WA. **3D graphics:** Keryln Carville and Emily Haesler, used with permission. **Photos:** Photos courtesy of K. Carville, used with permission. **Also available in this series:** PPPIA Classification System: Multicultural, PPPIA Classification System for Adults with Light Skin Tones, PPPIA Classification System for Dark Skin Tones, PPPIA Classification System for Asian Skin Tones, PPPIA Classification System for Neonates and Children. **More information and permission:** www.pppia.org

Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected Deep Tissue Injury
Intact skin with non-blanchable redness of a localised area usually over bony prominences. 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. Stage I pressure injuries may be difficult to detect in older adults with darkly pigmented skin tone. May indicate 'at risk' older adults (a heralding sign of risk).	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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	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 depth of tissue loss. May include undermining and tunnelling. The depth of Stage 3 pressure injuries varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure injuries. Bone/tendon is not visible or directly palpable.	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 tunnelling. The depth of a Stage 4 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	Full thickness tissue loss in which the ulcer base 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 Stage) cannot be determined. Stable (dry, adherent, intact, no erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.	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 as compared to adjacent tissue. Deep tissue injury may be difficult to detect in older adults with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



Appendix IV: Pressure Ulcers: What to Do and How to Report Them

Pressure Ulcers (PUs): What to Do and How to Report Them Guidance for Professionals

Developed by the HSE National Improvement Programme for Wound Management

Two page document. Last updated: March 2025

Patient has Pressure Ulcers (PUs)
on admission to service or at first contact in community

- Undertake a full skin inspection within 6 hours of admission (hospital); on admission (residential services); or during the first visit (community services).
- Identify and document clearly in the nursing notes the stage and location of PUs using the HSE Pressure Ulcer Staging Tool (2024) e.g. "On skin examination, patient noted to have a Stage 2 pressure ulcer to coccyx". If uncertain about the stage of PU damage, seek assistance from a colleague.
- If a patient presents with PUs and they were previously in the care of another ward or service, it may be noted on the patient's transfer documentation and/or healthcare records that the PUs were reported on the National Incident Management System (NIMS) [or equivalent reporting system].
- Inform your line manager or the person in charge, the medical team, the patient and/or designated person/next of kin where appropriate (Open Disclosure). Document this in the nursing notes.
- Initiate an appropriate wound care and pressure ulcer care plan [aSSKINg care bundle].
- Refer patient to the multidisciplinary team as appropriate. Complete a referral for specialist input in the following instances:
  - Stage 3 or Stage 4 PUs, unstageable PUs, suspected deep pressure damage, or any non-healing or deteriorating PUs.
  - Patients with complex requirements e.g. patients with contractures, ventilated, or too unstable to reposition from a medical perspective.
  - Where there is uncertainty over the stage of the PU.

BEST PRACTICE

REPEAT RISK ASSESSMENT & SKIN ASSESSMENT

- At regular intervals as per local PPPG (e.g. at least weekly in hospital, monthly in community)
- If there is a change in patient's condition, reassess more frequently as per local PPPG (e.g. every 48–72 hours) until stable
- Pre and post theatre, pre and post procedure, on transfer to / from another ward or hospital, or between community-based services

Appendix IV: Pressure Ulcers: What to Do and How to Report Them

Pressure Ulcers (PUs): What to Do and How to Report Them Guidance for Professionals

Developed by the HSE National Improvement Programme for Wound Management

Two page document. Last updated: March 2025

Patient develops Pressure Ulcers (PUs)
whilst in the care of the service, either acute or community

- Identify and document clearly in the nursing notes the stage and location of the PUs using the HSE Pressure Ulcer Staging Tool (2024), including the date and time the PU was first noted. If uncertain about the stage of PU damage, seek assistance from a colleague.
- All newly acquired PUs, regardless of stage, and existing PUs which deteriorate to a Stage 3 or Stage 4 must be reported on the National Incident Management System (NIMS) [or equivalent reporting system]. A National Incident Report Form 01 - Person must be completed within 24 hours of the identification of the PU.
- Stage 3 and Stage 4 PUs, if acquired since admission or first contact, are also classified as Serious Reportable Events (SREs). They must be identified on NIMS as SREs, and reported externally as set out by the relevant regulatory bodies e.g. HIQA. A documented preliminary assessment will be undertaken and may involve other disciplines e.g. patient safety managers or incident managers.
- Inform your line manager or the person in charge, the medical team, the patient and/ or next of kin where appropriate (Open Disclosure). Document this in the nursing notes.
- Initiate an appropriate wound care and pressure ulcer care plan [aSSKINg care bundle].
- Refer the patient to the multidisciplinary team as appropriate. Complete a referral for specialist input in the following instances:
  - Stage 3 or Stage 4 PUs, unstageable PUs, suspected deep pressure damage, or any non-healing or deteriorating PUs.
  - Patients with complex requirements e.g. patients with contractures, ventilated, or too unstable to reposition from a medical perspective.
  - Where there is uncertainty over the stage of the PU.
- Continue to provide care, re-evaluate and document in the nursing notes. Ensure clear communication at clinical handover and on transfer of the patient both internal and external to the service.

Additional Resources

Scan the QR codes below to access additional resources

aSSKINg Care Bundle	HSE Pressure Ulcer Staging Tool (2024)	Open Disclosure Policy, Training and Resources	National Incident Management System (NIMS)

Notes:

- This Guidance was developed by the HSE National Improvement Programme for Wound Management, a collaboration between National Quality and Patient Safety Directorate (NQPS) and the Office of the Nursing and Midwifery Services Director (ONMSD). It reflects European Pressure Ulcer Advisory Panel (EPUAP) guidance and reflects up-to-date clinical evidence as of Oct 2024.
- This tool aligns with all documents in the HSE Clinical Resource Pack: Pressure Ulcers (2024). It supersedes and replaces all previous national guidance and ancillary documentation related to the management of pressure ulcers. This tool should be used in conjunction with clinical judgment and local PPPGs.

Appendix V: Sample Pressure Ulcers Information Leaflet for Patients and Carers

Pressure Ulcers: Information for Patients and Carers

"ASSKING" to Stop the Pressure!

The ASSKING care bundle is a tool healthcare professionals use to guide the prevention and management of pressure ulcers. It can also help patients and carers to know what to look out for.

A	Assess Risk	Anyone who is confined to a bed or chair, or is unable to move, is at risk of developing pressure ulcers. Other factors also increase your risk, including: • Loss of sensation or inability to feel pain • Loss of bowel or bladder control • Poor diet • Smoking • Age over 70 • Certain health conditions that can reduce blood flow, including diabetes, heart failure, kidney failure, and peripheral vascular disease.
S	Skin Care	Ask a healthcare professional to show you or your carer how to check your skin regularly. Look for: • Patches of skin that are red, or even shades of purple or blue • Skin feeling too warm, too cold, or numb • Swelling or blisters • Shiny areas • Patches that are dry and/or hard 
S	Surface	Ensure your body has the right support to relieve pressure and encourage healing, especially if you cannot move or change your own position. Special equipment such as air mattresses, cushions and booties can help reduce pressure on certain parts of your body. Your healthcare professional can advise which equipment you should use, if any. Also be aware of bedding and clothes - thick seams, zips, studs or buttons can cause or worsen pressure damage.
K	Keep Moving	The best thing you can do to prevent or relieve pressure is to keep active and change your position regularly. Where possible, and with help if needed: try standing up, walking short distances, walking on the spot, or even changing your position when sitting. If you cannot move yourself, your healthcare professional or carer can help you change position regularly. Your nurse or healthcare professional can give you tips on: • the correct seating and lying positions • how to adjust your lying or sitting position, and • how often you need to move or reposition 
I	Incontinence	Your skin can get damaged if it is wet for a long time. This can be from sweat, leaking wounds, urine and / or stool. Being incontinent increases your risk of getting a pressure ulcer. What can you do? Wash the area (your healthcare professional will advise you on products for cleansing, if required). Pat dry and do not rub the skin. Use recommended creams as needed.
N	Nutrition	A healthy diet with plenty of fluids can reduce your risk of skin damage. If you are underweight or overweight, you have a greater chance of getting a pressure ulcer. Try to have 3 meals a day with lots of different fruit and vegetables, and drink 6-8 cups of fluid a day (e.g. water, juice, tea / coffee). Inform your healthcare professional if you are worried about your diet or if you lose your appetite and don't know why.
G	Give Information	 If you or your carer notice possible signs of damage, even if you don't think it's a pressure ulcer, tell a healthcare professional immediately. Contact a nurse if you are in hospital, or your public health nurse or GP if you are at home.

Need more advice? Ask your nurse or other healthcare professional.

Appendix VI: Patient Safety Supplement on MDRPUs

Patient Safety Together: learning, sharing and improving

PSS001/2024

PATIENT SAFETY SUPPLEMENT

Date published: 13 June 2024

Medical Device Related Pressure Ulcers

A pressure ulcer (PU) can have a serious negative impact on a person's quality of life, affect their mental health, cause pain and can lead to infection. Resource implications can be significant[1] including increased length of hospital stay. This Patient Safety Supplement (PSS) focuses on medical device related pressure ulcers (MDRPU). It aims to support healthcare staff and patients/service users to identify the risk factors for developing MDRPU and reiterate how everyone can be proactive in helping to prevent these often avoidable injuries.

MDRPU is a localised injury to the skin or underlying tissue as a result of sustained pressure from a medical device. PU damage from medical devices can often occur in areas that are not easily visible or in areas with minimal soft tissue such as the bridge of the nose and ears. Respiratory devices (to help with breathing) such as oxygen tubing and masks are linked with a high number of MDRPU. Other devices that may cause MDRPU include urinary catheters (to drain urine from the bladder), splints, casts, vascular access devices (to give medications or fluids through veins) and tubing including nasogastric tubing (from nose to stomach).

Hugh's Story

Hugh* was admitted to hospital with chronic respiratory failure and severe pneumonia. While in hospital Hugh was started on non –invasive ventilation (NIV) to help improve his oxygen level and a continuous positive airway pressure mask (CPAP) was applied to deliver the oxygen needed. Hugh reported that the mask felt very tight and sore on his nose and forehead. Unfortunately his skin was not examined by the healthcare staff at this time and he was told that it was normal to feel some tightness. Additionally a formal inspection of Hugh's skin had not been documented prior to the commencement of the CPAP. On day three of his admission, Hugh complained of worsening pain on his nose and forehead. On examination, two Stage 2** pressure ulcers were noted on Hugh's nose and forehead. Hugh was given pain relief, his wounds were cleaned, the CPAP mask was refitted to prevent further pressure damage and a gel strip barrier was applied between the mask and Hugh's nose and forehead. Using the open disclosure process it was explained to Hugh that he had medical device related pressure ulcers and an apology was given to Hugh that this had happened. Hugh was also informed that this incident would be reported. Hugh was very upset and was worried the wounds would become infected, not heal, or leave a permanent scar. With Hugh's consent a care plan was developed, necessary wound care continued and the MDRPU wounds healed without scarring within two weeks. The local Tissue Viability Nurse also used the learning from Hugh's care to educate staff within the hospital of the risks of MDRPU and how to help prevent them developing.

Stage 2* Pressure Ulcers from CPAP mask

*Not real name / **A Stage 2 pressure ulcer has partial thickness skin loss, presenting as a shallow ulcer with a red pink wound bed. It may also present as an intact or open/ ruptured serum filled blister[2]

Appendix VI: Patient Safety Supplement on MDRPUs

What are the risk factors and how can we help prevent MDRPU?

MDRPU can occur in and impact all age groups, however there are a number of contributing factors to consider. Contributing factors may include potential wider health system issues including for example variations in, and limitations to; procurement (purchasing) processes, available policies, resources (staff and equipment), quality assurance processes etc. Below are some key risk factors that can be addressed locally:

Risk factors		What helps reduce the risk?
Medical Device		
- Poorly fitting generic sized devices - Inflexible materials - Length of time the device is required for - Need to secure the device tightly - Moisture build up - Insufficient application guidance	  	Ensure the device: - is suitable for the intended use - is properly sized and fitted - is rotated/repositioned frequently - is positioned on clean and dry skin - is removed when medically feasible - is used in line with manufacturer's instructions <u>If it will not affect</u> the performance of the device, or breach manufacturer's instructions for use, consider using barrier dressings or gel sheets
Healthcare Service		
Potential gaps in awareness of need for: - MDRPU education and audit - Patient understanding of risk and treatment - Correctly fitting and securing devices - Repositioning of devices regularly - Use of other options such as full face masks to deliver oxygen - Timely access to correct devices - Reporting of MDRPU	  	- MDRPU education and audit resources - Inform patient (where apt) of MDRPU risk and what to look out for - Get consent to use a tailored care plan - Assess and record MDRPU risk - Inspect the skin under and around the device twice daily - Increase frequency where patients are vulnerable to oedema (swelling) - Reposition the device regularly - Be aware of pressure points on patients in prone position (lying face-down) - Report any MDRPU
Person		

- Physical wellbeing or medical condition
- Difficulty in feeling pressure or friction (rubbing) due to medical condition, sedation, position or age
- Unable to reposition the device themselves
- Lack of knowledge on the risk of MDRPU
	
	 
	 
		- Know the signs of potential MDRPU
		- Report any of the following immediately:
		  - Discomfort
		  - Pain
		  - Swelling
		  - Redness or discolouration of the skin

Appendix VI: Patient Safety Supplement on MDRPUs

Reporting of MDRPU

It is essential that ALL MDRPU are reported on the National Incident Management System (NIMS) and communication and open disclosure of the incident with the patient/service user occurs promptly. There were over 375 MDRPU relating to respiratory medical devices affecting the nose, ears and chin reported on NIMS between Jan 1st 2020 and Dec 31st 2023. However, expert advice suggests there is potentially under-reporting of MDRPU generally. The reporting of MDRPU while enabling incident analysis also gives an opportunity to link with associated medical device companies to consider improvements to help reduce the risk of future MDRPU occurring. In cases where the MDRPU is considered related to a defective medical device and/or inadequate instructions for use, this should be reported to the Health Products Regulatory Authority (HPRA). NIMS is being updated in 2024 to make it easier for staff to report incidents where medical devices contributed to injuries to enable better data, insight and learning.

Key Messages - PREVENTION

Remember

- Risk assessments for PUs should be part of routine practice, including inspecting skin at the site of the medical device
- Patients being managed with medical devices should be considered at high risk of developing MDRPU, same should be reflected in an appropriate care plan
- Move or adjust the device to inspect the skin when the patient reports discomfort or pain
- Report ALL MDRPU on NIMS. If the device is considered defective and/or instructions for use are inadequate, also report to the HPRA and the manufacturer
- Inform the Tissue Viability Nurse, and/or procurement/HSE Medical Devices if there are frequent PU issues with a particular device
- Education/training initiatives targeting both staff and patient/family are essential

References, Resources and Strategies

1. Costing pressure ulcer care in an Irish acute care setting: a feasibility study, Wounds International (Nov 2021)
2. HSE National Wound Management Guidelines 2018
3. Pressure Ulcers: A practical guide for review (2022)
4. Device-related pressure ulcers: SECURE prevention Journal of Wound Care (2022)

This Patient Safety Supplement was developed by:

- HSE National Improvement Programme for Wound Management
- A Patient Partner with lived experience
- Patient Safety Together, Incident Management Team, National Quality and Patient Safety Directorate (NQPSD)

Approved for publication by the HSE National Patient Safety Alert Committee and the National Clinical Director, NQPSD

For further information on Patient Safety Supplements, see www.hse.ie/pst
For further information on wound management see HSE National Improvement Programme for Wound Management
All feedback on content or format of this supplement is welcome and can be sent to patientsafetytogether@hse.ie

Appendix VII: The aSSKINg Care Bundle Information

aSSKINg Care Bundle

This summary was developed by the HSE National Improvement Programme for Wound Management

One page document. Last updated: July 2024

What is a Care Bundle?

Pressure ulcers can be due to many, often combined, factors. As such, interventions to reduce harm from pressure ulcers need to have many elements. In routine clinical practice, these elements may not always all be done in the same way, making patient care vary. A care bundle ties the different care elements together into a cohesive unit.

- A care bundle is a collection of interventions that may be applied to the management of a particular condition.
- Elements of a care bundle are based on research and clinical evidence.
- The use of a care bundle can increase patient safety and satisfaction, and build staff confidence in that particular area of care.

What is the aSSKINg Care Bundle?

The aSSKINg care bundle is a tool to guide and document pressure ulcer prevention and management, and is aimed at reducing the risk of patient harm and minimising variations in care which is often preventable. It is an evidence-based approach that can be adopted across a range of care settings.

The original five-step SSKIN care bundle has been widely used in clinical practice for many years. In 2018, the NHS Improvement Pressure Ulcer Core Curriculum introduced two important additional elements to the bundle mnemonic: adding the letters: 'a' for assess risk and 'g' for give information to make aSSKINg.

The aSSKINg acronym helps you remember the elements of the bundle:

- **a**ssess risk
- **S**kin assessment & skin care
- **S**urface selection
- **K**eep moving
- **I**ncontinence assessment & care
- **N**utrition
- **g**ive information

Appendix VIII: Sample Skin Assessment Form (Acute) using the aSSKINg Care Bundle

Sample Skin Assessment Form (Acute) using the aSSKINg Care Bundle

Developed by Naas General Hospital Tissue Viability Working Group, Nov 2023

One page document. Last updated: October 2024

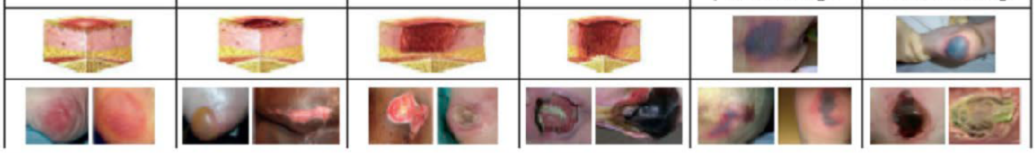
NGH Naas General Hospital

Skin Assessment Form for at risk patients.

Perform Skin Inspection per nursing shift, if Norton ≤15 and/or if skin status deteriorates.
Assess ASSKING> Assess: Norton Scale, Skin Inspection, Surface: review mattress & cushion, Keep moving: reposition more often, mobilise, Incontinence review, Nutrition & Hydration review, Give information (ASSKING))
Review Care plan. If required increase repositioning frequency to 2 hourly, consider equipment upgrade.

Date / Time	Area	Skin Status • Norton 15 = At Risk	Intervention		Staff Initials
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		•Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		
	Sacrum		• Continue current care plan		
	R. Heel		• Increase repositioning to 2 hourly		
	L Heel		• Reassess ASSKING		
	Other		• Consider upgrading pressure relieving equipment		

Stage 1	Stage 2	Stage 3	Stage 4	Suspected Deep Tissue Damage	Unstageable Pressure Damage



Appendix IX: Sample aSSKINg Bundle Care Plan – Acute Settings

Ospidéil OL
UL Hospitals
Working together, caring for you

ASSKING BUNDLE

Pressure Ulcer Prevention Care Plan
Complete when Waterlow ≥ 10

Pressure Ulcers to Zero

Addressograph

KEY - CARE DELIVERED Y - YES N- NO (RECORD REASON IN NURING CARE PLAN)

Frequency of care delivery (circle as appropriate) 1hrly 2hrly 3hrly 4hrly OTHER:

Date																			
Time (24 Hr Clock)																			
SURFACE	See surface selection guide in ULHG Pressure Ulcer Prevention Guideline (Q Pulse). Circle if: High Specification Foam (F) or Powered pressure relieving mattress (P) in use. Pressure relieving cushion in use, record (C)																		
RISK ASSESSMENT CARRIED OUT YES/ NO	**GIVING INFORMATION : PATIENT** YES/ NO						**FAMILY MEMBER** YES/ NO												
Mattress appropriate & functioning																			
Appropriate Seating																			
Heel Protectors/Medical Devices /Other in use: *Please State*																			
SKIN INSPECTION	Inspect at risk skin areas every 2-4 hrs depending on risk assessment. Existing pressure ulcer YES/NO. Record pressure ulcer stage in Nursing notes & Initiate Wound Assessment Chart.																		
All Pressure areas checked																			
Redness present Y/N																			
KEEP MOVING	Repositioning frequency is determined by skin inspection. If redness present at least 2hrly repositioning required																		
Record Right (R) Left (L) Back (B) Chair (C) Mobilising (M) Standing (S)																			
INCONTINENCE	Skin care regime in use YES/NO																		
Urine																			
Bowels																			
NUTRITION																			
Meal (M) Fluids (F) Supplements (S) taken																			
SIGNATURE																			
Discipline																			

ULHG ASSKING BUNDLE 2023 ADAPTED FROM HSE PRESSURE ULCER TO ZERO ASSKING BUNDLE

COMPLETE DAILY SKIN INSPECTION FOR INDEPENDENTLY MOBILE, SELF CARING PATIENTS WITH A WATERLOW SCORE OF 10 OR OVER/NORTON SCORE 0-15

Material No. 10360407A

Thomond Printers T: 061327699

Appendix X: Sample SSKIN Bundle Chart – Community Settings (1)

SSKIN Chart (Pressure damage prevention and management)

Patient Details	Risk Assessment (include Braden +/- clinical judgement)	Current pressure related skin issues	
Surface Mattress; Other; Chair & Cushion;		**Frequency of Care Delivery (Hourly)**	**Prescribed By** / **Date**

DATE	TIME	SKIN CONCERN Daily full body skin inspection(✓ in box) to *be completed at least once daily* *Document condition of the skin eg. Errythema, blister, intact, and boney prominence/s of concern*	ACTION TAKEN *Only document the action taken to relieve pressure in this section OR action taken to treat moisture associated skin damage*	REPOSITIONING BED R=Right L=Left B= Back CHAIR C=Chair CT=Chair tilt M=Mobilising						INCONTINENCE 1.Continent 2. Incontinent 3.Catheter insitu 4.Toilet 5.MASD 6.Barrier product used						NUTRITION D=Diet/ PEG feed F= Fluids S= Supplements			SIGNED
				R	L	B	C	CT	M	1	2	3	4	5	6	D	F	S	
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Appendix XI: Sample SSKIN Bundle Checklist – Community Settings (2)

The community SSKIN bundle checklist for PHN service

Pressure ulcer prevention SSKIN bundle: Community setting

For all clients with a waterlow of 10 or more (or at risk using clinical judgement): implement SSKIN bundle

Client Name:	Address:	D.O.B:

Waterlow score:	Date:	RGN/RPHN signature:	Print Name:

SSKIN Bundle Client information booklet given to client/carer: Yes ☐ No ☐ Version:_____

State all disciplines involved in care provision: GP ☐ Physiotherapy ☐ Occupational Therapy ☐ Dietitian ☐
Other (please state):_____

S surface	Provide a mattress and cushion in accordance with the Waterlow Risk score and Mattress/Cushion selection guide (Appendix 8 of Pressure ulcer guideline)	
Mattress ordered:	Date ordered:	Date delivered and fitted:
Cushion ordered:	Date ordered:	Date delivered & fitted
Other:		

Wheelchair user? : Yes ☐ No ☐ If yes, is pressure reducing cushion in use in wheelchair? : Yes ☐ No ☐
Client has declined pressure relieving equipment ☐
Comment:_____

S skin Inspection	• Assess and record skin state • Carry out the skin tolerance test and observe for red patches of skin (erythema) • Record the skin evaluation in care plan using the staging as follows and ensure location is recorded • Record the frequency of skin assessment in care plan- daily/weekly/monthly/ 3 monthly

No evidence of new pressure damage ☐ Blanching erythema ☐ Moisture associated skin damage ☐

Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐

Location:_____

K keep Moving	• Record current regime of movement • Document bed-times, sitting out times, exercises to be completed • Include use of appropriate handling aids/equipment

Morning	Afternoon
Evening	Overnight
Family/Carer	Home support (if applicable)

Is there a physiotherapy plan in place? Yes ☐ No ☐ Is there an Occupational Therapy plan in place? Yes ☐ No ☐

I Incontinence	• Determine if client has any continence issues • Determine if client any moisture associated skin damage

Is the client incontinent of urine? Yes ☐ No ☐ Is the client incontinent of faeces? Yes ☐ No ☐
Has the client any incontinence associated dermatitis? Yes ☐ No ☐
If yes refer to page 26 of SSKIN Bundle Resource Pack
If yes complete Level 1 Continence Assessment form and complete care plan

N Nutrition/Hydration	• Ensure the MUST tool is completed on the initial assessment and re-assessment as clinically indicated.

MUST score:	Review date of MUST:

Appendix XI: Sample SSKIN Bundle Checklist – Community Settings (2)

Review to be completed as clinically indicated and/or at a minimum of 3 monthly

S	**Surface**						
Date of review:							
Is the mattress in use?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
Is the cushion in use?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
Is other (state)_____ in use?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
Is the above equipment working effectively?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
Is the client comfortable?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
Other;						
S	**Skin Inspection**						
Date of review:							
Is there evidence of pressure damage to;							
B Buttocks	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
E Elbows	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
S Sacrum	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
T Trochater (hips)	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
S Spine	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
H Heels	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
O Occiput	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
T Toes	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
Other (please state)	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
If yes to any of above please add additional information; If client declines skin inspection record reason and action taken							
K	**Keep Moving**						
Date of review:							
Is client's movement regime adequate?							
Is client happy with current regime of movement?							
I	**Incontinence**						
Date of review:							
Has the client had a continence review?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □
N	**Nutrition & Hydration**						
Date of review:							
Is the client eating and drinking adequately?	**Yes** □	**No** □	**Yes** □	**No** □	**Yes** □	**No** □

IMPORTANT: Client/Carer and/or family have been informed that if there is any change to the clients condition that the RGN/RPHN should be contacted immediately to allow for timely nursing re-assessment to take place if required.

Appendix XII: Sample aSSKINg Bundle Audit Tool

Sample Audit Tool (Acute) using the aSSKINg Care Bundle

Developed by University of Limerick Hospital, Nov 2023

One page document. Last updated: October 2024

ULHG ASSKING Bundle

Audit Tool - November 2023

Hospital Name: _____ **Ward:** _____

	Statement	Y / N / N/A
1	Daily skin inspection is carried out on an at risk individual	
2	Nutritional score (MUST) carried out on admission	
3	Waterlow score carried out within 6 hours of admission	
4	Waterlow score reassessed weekly or following change in condition/ Transfer	
5	ASSKING bundle has been initiated if Waterlow score ≥ 10	
6	At a minimum a high specification foam mattress is used for an at risk individual **OR** An individual at higher risk of pressure ulceration has an active support mattress	
7	An individual assessed as being at risk of pressure ulcer development has a pressure ulcer prevention/management care plan	
8	Pressure ulcer if present is staged	
9	When asked, staff members have an understanding of the ASSKING bundle and when to initiate	
10	Which disciplines have completed this ASSKING bundle? Please list:	

Audit undertaken by: _____ **Date:** _____