# 

# Data Collection Tool for CQUIN Audit CCG15

# Assessment and documentation of pressure ulcer risk (v3.0)

Of the denominator, those where the following actions were taken within 24 hours of admission (or by 1st June 2022 for those admitted prior to 1st April 2022) and then repeated at least every 30 days of the patient spell:

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient ID** | |  | |
| **CQUIN CCG15 - Criteria 1:**  Documentation of a full pressure ulcer risk assessment (within 6hrs) [[1]](#footnote-1) using a validated scale, such as Waterlow, Purpose T or Braden, that assesses all the following: | | | **Achieved[[2]](#footnote-2)** |
| **Domain** | **Data Item** | |  |
| **Risk factors** | Mobility | |  |
| Skin status | |  |
| Nutritional status | |  |
| Continence | |  |
| Sensory perception | |  |
| **Timeliness** | Risk assessment completed within 6 hours of admission | |  |
| **CQUIN CCG15 – Criteria 2:**  Is there an individualised plan of care which includes all of the following: | | | **Achieved** |
| **Domain** | Data Item | |  |
| **Plan of care b** | Risk and skin assessment outcomes | |  |
| Recommendations about pressure relief at specific at-risk sites | |  |
| Mobility and need to reposition the patient; | |  |
| Comorbidities; | |  |
| Patient preference | |  |
| **Timeliness** | Care plan completed within 24 hours of admission | |  |
| **CQUIN CCG15 – Criteria 3:**  Actions to manage the risks identified by the pressure ulcer risk assessment are documented by clinical staff within 24 hours of admission. | | | **Achieved** |
|  |
| **CQUIN CCG15 – Criteria 4:**  Evidence of reassessment at least every 30 days of the patient spell. | | | **Achieved** |
|  |
| **Outcomes** | | | |
| **CQUIN CCG15 - Criteria 1:** All risk assessment criteria achieved. | | |  |
| **CQUIN CCG15- Criteria 2:** Where risk was identified a plan of care was in place. | | |  |
| **CQUIN CCG15 - Criteria 3:**  Where risk was identified there was evidence of actions being undertaken and documented in line with the plan of care. | | |  |
| **CQUIN CCG15 – Criteria 4:** Where the patient admission was longer than 30 days there was evidence of re-assessment of pressure ulcer risk including a skin assessment. | | |  |
| **ALL CQUIN Criteria achieved** | | |  |

## Explanatory Notes

**CQUIN CCG15 - Criteria 1:**  Documentation of a full pressure ulcer risk assessment

The Pressure Ulcer Risk assessment timing has been compiled based on the [NICE Quality Standard](https://www.nice.org.uk/guidance/qs89/chapter/Quality-statement-1-Pressure-ulcer-risk-assessment-in-hospitals-and-care-homes-with-nursing) for risk assessment: People admitted to hospital or a care home with nursing have a pressure ulcer risk assessment within 6 hours of admission (Quality Standard 1).

*These criteria are the minimum that should be recorded in a risk assessment*

People considered to be at risk of developing a pressure ulcer are those who, after assessment using clinical judgement and/or a validated risk assessment tool, are considered to be at risk of developing a pressure ulcer.

Based on the International Guideline for Pressure Ulcer Prevention (Section 4: Risk Assessment) and the NICE Quality Standard, risk factors include:

*Reduced mobility*: A mobility impairment refers to a reduction or deviation in type of frequency of movement. This includes moving in the bed and chair and the ability to maintain specific body positions (e.g., 300 side lying position). A reduction in mobility affects the ability to redistribute pressure and increases the likelihood of shear and friction occurring therefore increases susceptibility to pressure ulceration. Changes in mobility should also be considered as increasing risk. The duration of limitation of mobility should also be considered as should the patient’s frequency of mobility.

*Skin status:* The presence of a current pressure ulcer or evidence of a previous pressure ulcer indicates that the patient is at high risk. Skin assessment should be from head to toe and ensure care is taken to inspect all bony prominences. The assessment should consider changes in the colour of the skin, ensuring particular regard for more subtle changes in patients with dark skin tones, changes in skin temperature, texture and turgor and the presence of pain over the area.

*Nutritional status and hydration*; Nutritional deficits are associated with and may impact on the susceptibility and tolerance of the skin, including mechanical properties of the tissue; the geometry (morphology) of the tissues; physiology and repair; and transport and thermal properties. In patients at extremes of weight / BMI, this may also affect exposure to adverse mechanical boundary conditions. Nutrition status and recent unplanned changes in weight should be assessed suing a validated tool (e.g., the [MUST tool](https://www.bapen.org.uk/screening-and-must/must-calculator)) and included in the risk assessment.

*Continence status:* The presence of moisture from incontinence on the skin may impact on both the susceptibility and tolerance of the skin (mechanical properties of the tissues) and the type of load. The coefficient of friction is shown to be greater over moist skin. The skin damage is increased by the presence of irritant components in urine and faeces.

*Sensory perception:* sensory perception impairment includes those with local sensory impairment or the ability to perceive pressure related discomfort (for example diabetes, spinal cord injury or peripheral arterial disease) and those with central sensory impairment or the ability to respond to pressure related discomfort (e.g., coma, sedation, anaesthesia, paralysis). Consideration should be given to the duration of impairment for example anaesthesia is a temporary and time limited impairment and changes in risk status.

If the patient is deemed to be not at risk, there should be evidence of the risk and skin assessment clearly documented with a reassessment date.

**CQUIN CCG15 – Criteria 2:** Individualised plan of care:

Where the patient is deemed to be at risk the items to be considered within the plan of care are based on the [NICE Guidelines](https://www.nice.org.uk/guidance/cg179) key priorities for implementation.

These criteria should be addressed as a minimum in the care plan:

1. Risk and skin assessment outcomes. Identifications of specific risks should be mitigated in the plan of care. Appropriate skin care regimens should be described. It may be helpful to follow the SSKIN[[3]](#footnote-3) acronym.
2. Recommendations about pressure relief at specific skin sites. This can include the use of pressure redistributing aids in the bed or chair and or devices to relieve or redistribute pressure at specific body sites such as the heels.
3. Mobility and the need to reposition the patient: Where a mobility deficit is identified the care plan should indicate if the deficit is temporary or permanent, the extent of the deficit and the steps taken to mitigate risk. These may include patient rehabilitation or reablement, use of devices to support mobility, use of moving and handling aids, use of repositioning devices or manual repositioning. A repositioning schedule should contain detail of the frequency of repositioning and any challenges associated with particular positions.
4. Comorbidities: Where the risk assessment has identified comorbidities that impact on pressure ulcer risk these should be identified within the care plan and where possible appropriate actions taken for example maintaining normoglycaemia.
5. Patient preference: The care plan should reflect the patient’s individual needs and preferences.

### CQUIN Compliance

To achieve the CQUIN, 40% - 60% of patients reviewed must have achieved **ALL** the clinically relevant steps described within the indicator specification. Missing any one of these constitutes a failure.

Please see the CQUIN section on [National Wound Care Strategy](https://www.nationalwoundcarestrategy.net/cquin/) web site for further information.

For access, email [NatWoundStrat@yhahsn.com](mailto:NatWoundStrat@yhahsn.com)

1. https://www.nice.org.uk/guidance/qs89/chapter/Quality-statement-1-Pressure-ulcer-risk-assessment-in-hospitals-and-care-homes-with-nursing [↑](#footnote-ref-1)
2. Indicate, yes, no, or not applicable i.e., patient not at risk therefore care plan not required, patient length of stay less than 30 days reassessment not required [↑](#footnote-ref-2)
3. SSKIN = Skin, Surface, Keep moving, Incontinence and Nutrition and hydration [↑](#footnote-ref-3)