

**Study Session:**

**Skin and Wound  
Management  
homecare, supported  
living and day  
opportunity settings**

**Starting 13:30**

**Please tell us where  
you are from  
Join at [slido.com](https://www.slido.com)  
#7366402**



# Welcome

## Study Day: Skin & Wound Management.

Date: 9 Sept 2025

**This Session will begin shortly**





# Housekeeping



Please keep your mobiles on silent during the presentations



Exits



Comfort Break



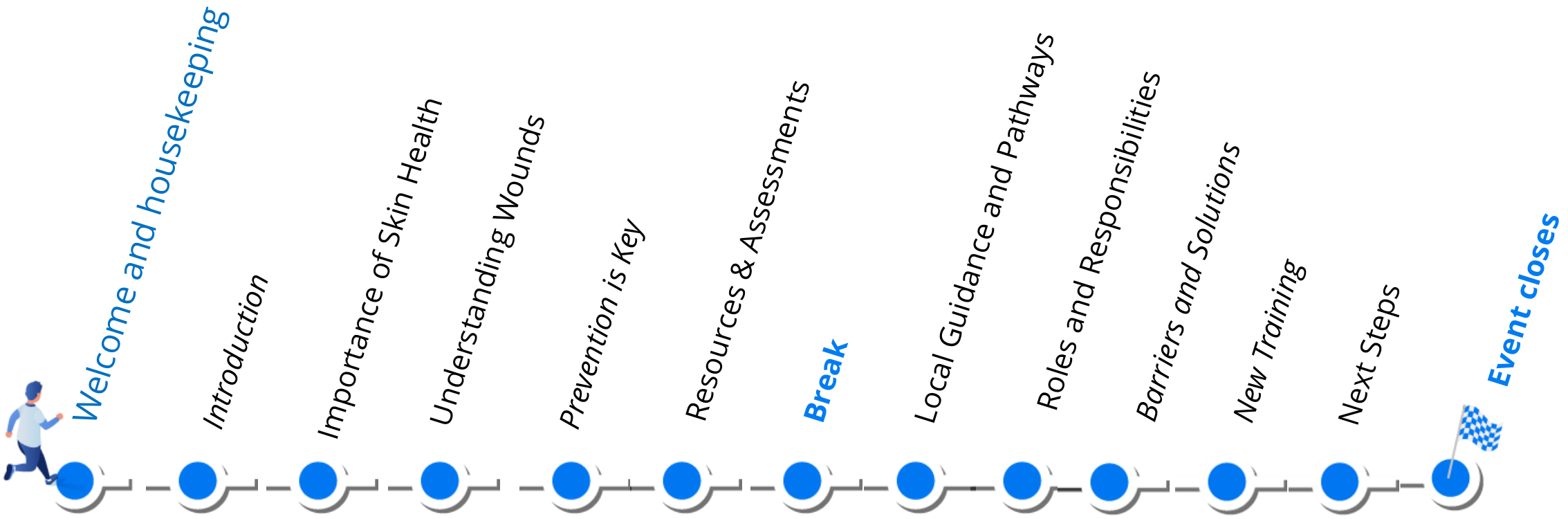
No planned fire drills

# Maisy Brolia

## *Integration Programme Manager*



# Agenda



**Use your table pack to capture notes and actions for the session**

# What do you hope to get out of today's session?

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# Purpose

Pressure ulcers, wound care, and skin tears are common in social care.

Support for these issues is often misunderstood.

Historically, wound care was a healthcare activity.

Now crucial in social care for preventing and healing wounds.

Ageing population and increasing frailty highlight the importance of skin health support in social care.

# Objectives

- Understand your services role in maintaining skin integrity
- Understand factors that contribute to compromised skin integrity
- Understand the impact of poor skin integrity, how it can be prevented and how it can be reversed
- Understand the wider implications of pressure ulcers
- Discuss common barriers and possible resolutions
- Understand when you refer and gain support

# What does CQC say?

## Good Practice Identified

Use of  
External  
Medicines

Continuous  
Improvement  
Initiatives

Quality  
Improvement  
Projects

## Areas for Improvement

Inconsistent Wound  
Assessment and  
Documentation

Delayed Access to  
Dressings

Training and  
Competency Gaps

Inadequate  
monitoring of skin  
integrity and pressure  
ulcer prevention

As a social care leader attending today, your role is to share key learnings with your services, including reviewing relevant policies and supporting the development of staff skills

# Exhibiting today...



Developing ostomy, continence, urology and wound care products and services, that make life easier for people with intimate healthcare needs.

[www.coloplast.co.uk](http://www.coloplast.co.uk)



AJM Healthcare is the leading provider of NHS wheelchair services throughout the UK, specialising exclusively in wheelchair services.

[www.ajmhealthcare.com/](http://www.ajmhealthcare.com/)



We provide comprehensive skin and wound care throughout your Patient's journey from hospital, clinic and home.

We are here to support you with innovative, evidence-based products that foster healing and help improve patient outcomes

[www.solventum.com](http://www.solventum.com)



**Hertfordshire Community**  
NHS Trust

We support people at every stage of their lives, from health visiting, school nursing and specialist dental or speech services to community nursing rehabilitation and palliative care.

[www.hct.nhs.uk](http://www.hct.nhs.uk)

# Exhibiting today...



At HCPA everything we do is centred on helping Hertfordshire adult care providers to raise their standards of quality by offering fully funded training, network events and study days, low cost or fully funded business services, advice and tailored support.

[www.hcpa.info/training-zone](http://www.hcpa.info/training-zone)

[www.hcpa.info/upcoming-training](http://www.hcpa.info/upcoming-training)



## Recruitment Service

We support over 700 adult social care employers to find the right individuals for their vacancies. All vacancies we have available are based in Hertfordshire.

[www.hcpa.info/herts-good-care](http://www.hcpa.info/herts-good-care)



We support care leaders to improve quality by providing tools and support that improve business efficiency, resilience, safety and compliance.

[www.hcpa.info/business-development](http://www.hcpa.info/business-development)



**ASK us anything!** We are your support service, here to answer your questions on all topics Adult Social Care related.

**01707 708108 / [assistance@hcpa.co.uk](mailto:assistance@hcpa.co.uk)**

**(Mon to Fri – 9am to 5pm)**

[www.hcpa.info/provider-hub](http://www.hcpa.info/provider-hub)



**WARNING!**  
**CONTAINS IMAGES**  
**THAT SOME MAY FIND**  
**DISTURBING**



# Kim Fenwick

*Tissue Viability Practice Educator*

# Skin Integrity

**The overall health and condition of the skin.**



Protection



Controlling temperature



Healing itself when damaged



Absorbing, storing and excreting



Providing sensation through nerve receptors



Communication



# Compromised Skin Integrity

Can lead to many problems including wound chronicity and infection, which may result in more serious outcomes

Affected by

- Age
- Nutrition
- Hydration
- Mobility
- Underlying medical conditions



Impacting on physical, mental and social wellbeing

# List impacts of compromised skin

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# Physical Impact

- Pain
- Exudate
- Odour
- Sleep disturbance
- Stress and anxiety
- Physical limitations



# Emotional and Social Impact

Embarrassment  
Shame  
Social withdrawal  
Isolation  
Depression  
Grief



# Key factors

Wound care in the UK is a well established financial burden costing the NHS 8.3 billion annually

5.6 billion is associated with unhealed wounds

81% of the total NHS cost was incurred in the community

The office for National Statistics (2018) stated that, between 2018 and 2028 the number of people aged 75 – 84 is set to increase by 33.9% and aged 85 by 22.8%

With the ageing population there may be an increase in skin damage resulting in wounds, either chronic or acute

Wound status can deteriorate rapidly if not promptly addressed

The diagram consists of two large circles connected by a central arrow. The left circle is orange and contains a warning. The right circle is green and contains a positive outcome. The arrow is orange and points from the warning to the outcome.

The following is an example of early intervention, timely referral, good communication between health professionals and joined up working for good healing outcomes

# Patient Story

Ann Nelmes Tissue Viability Specialist Nurse ( pressure ulcer lead )

**Past Medical History** - Type 2 Diabetes, on insulin and oral medication. Osteoarthritis. Peripheral neuropathy

**Wound History** - 5<sup>th</sup> June blister found to foot to right metatarsophalangeal joint . Unknown cause but had a fall 2 days before and was found on the floor. Most likely a combination of Diabetes and pressure

Referred to TVN 11<sup>th</sup> July and seen on 15<sup>th</sup> July

**Equipment** - Mr X has a pressure relieving mattress, foam utility pads and Ehob wedge to support positioning.

**Input** – Care staff 4 times a day. Community nurses daily for insulin support and twice weekly for wound care

Feet warm to touch with pedal pulses present. Had recent wounds to the other foot that have healed well.

Wife arranged private podiatrist to cut toenails and monitor feet as is bedbound

MUST = 0 Good appetite

Frailty score 7

# Tissue Viability Assessment

- **15<sup>th</sup> July**
- **Wound** assessment completed including measurements
- Venous and arterial questionnaire completed and pulses listened to with doppler
- Photo pre and post sharp debridement
- Alprep to wound bed
- Sharp debridement of sloughy tissue to wound bed and curette to periwound
- Urgoclean Ag applied and Biatain silicone. To change to the 3 step approach and Biatain Ag in one week

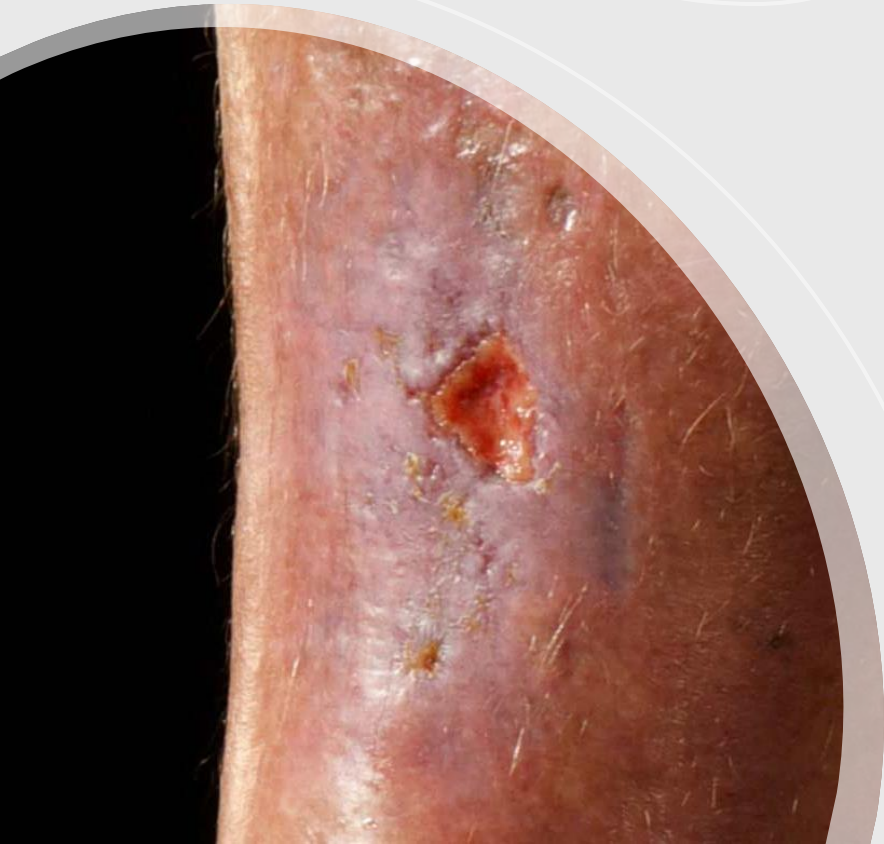


# Outcomes

## Post sharp debridement 15<sup>th</sup> July



- Timely referral and response
- Assessment
- Use of equipment
- Podiatry input
- Communication with carers, family, podiatry and community team
- Follow up



# Overview of common wounds

**What are your challenges?**

# Understanding wound types, conditions and implications

**Leg ulcers**

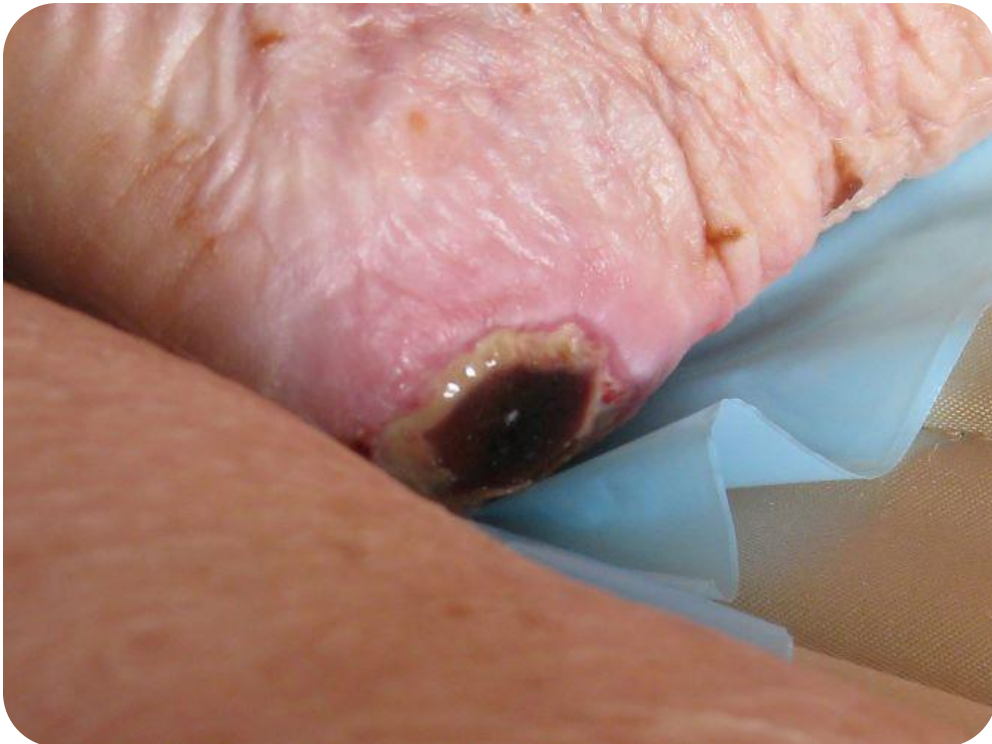


**Lymphoedema**



# Understanding wound types, conditions and implications

## Pressure Ulcers

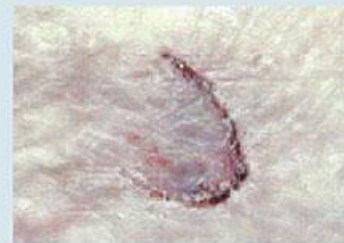


## Skin Tears

### ISTAP skin tear classification

The International Skin Tear Advisory Panel (ISTAP) developed this classification system to aid in categorizing wounds based on their characteristics.

- **Type 1** wounds are linear or have a flap with no loss of skin. If the wound has a flap, it should always be repositioned to cover the wound base.
- **Type 2** wounds have partial loss of skin, and the flap doesn't cover the wound base when repositioned.
- **Type 3** wounds have total loss of the flap.



# Understanding wound types, conditions and implications

## Surgical Wounds



## Diabetic foot wounds



# Quiz - Pressure Ulcer Identification



# National Guidance



**NHS**  
Improvement

**NHS**  
England



- **Stop the Pressure** programme in (NHS England, 2017)
- Following the huge campaign the ASSKING framework was introduced, a 7 step model to reduce Pressure ulcer prevention variations in practice
- Changes in reporting recommendations 2018 NHS improvement
- National Wound Care Strategy Programme (NWCSP) supported by NHS England published guidance in reporting, prevention and management (NWCSP,2023)
- Patient Safety Incident Response Framework (PSIRF) introduced by NHS England a broader approach to addressing patient safety incidents by understanding specific factors.
- Despite this there is still deviation from evidence based practice leading to harm (NWCSP,2025)



Elements combine into a preventative and training strategy for pressure ulcer prevention (NHS improvement, 2018)

# Prevention is Key

## Skin inspection guide



Check most vulnerable areas and document pressure areas at least once a day

Patient name:  Date:  /  /



*Please sign affected area of patient's body*

Are there any signs of pressure damage?

Redness/erythema  Yes  No

Non-blanching persistent erythema  Yes  No

*Use your skin tab or apply light finger pressure to the area of discoloration for 10 seconds*

Pain/soreness  Yes  No

Warmer/cooler over bony prominence  Yes  No

Boggy feeling  Yes  No

Hardened  Yes  No

Discolouration\*  Yes  No

*In those with darkly pigmented skin, discoloration may not be visible and other indicators will be warmer/cooler, hardening/edema (boggy skin).*

Broken skin  Yes  No

Name

Action

For more information visit [www.stopthepressure.com](http://www.stopthepressure.com)

*Please continue overlaid if necessary*

**GREEN**  
**No signs of pressure damage:** Continue to inspect skin daily and encourage regular repositioning.

**AMBER**  
**Early signs of pressure damage:** Monitor patient closely and start patient on pressure ulcer prevention plan / SSKIN bundle. Carers must inform qualified nurse/ community nurse.

**RED**  
**Pressure damage:** This must be documented immediately on a wound assessment chart and treatment started to prevent further damage, including pressure ulcer management plan / SSKIN bundle. Inform tissue viability nurse specialist and GP.

**NHS**  
 Midlands and East

## Improve my skin



### How to keep skin healthy

- 1 Too dry**
  - Apply a moisturiser (cream or ointment) regularly to soften the skin, reduce scaling and ease itching. Apply in a downward direction.
  - Do not use excessive amounts of skin cream.
  - Skin should be patted dry, not rubbed.
  - Do not use traditional soaps and avoid creams that can irritate the skin.
  - Ensure the patient is receiving an adequate fluid intake.
- 2 Too moist**
  - Use a barrier film or cream to keep fluid away from the skin.
  - Use a faecal management system if the cause is profuse or prolonged diarrhoea.
  - Use incontinence products when required.
  - Use an appropriate surface to manage the skin temperature and humidity.
- 3 Document all barrier creams/ films and topical emollients used and mark on body map.**

**GREEN**  
**Where skin is intact and well hydrated:** Inspect skin regularly, prevent prolonged exposure to moisture and manage skin temperature.

**AMBER**  
**Skin at risk of breakdown:** Use appropriate products to maintain skin integrity. Select suitable support surface if due to pressure damage.

**RED**  
**Skin has broken down:** Document area of damage and assess wound. If the wound is caused by moisture it is more likely to be a moisture lesion. Do not confuse with a pressure ulcer. Ensure you know the difference as all pressure ulcers must be reported (use Safety Cross).

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# Assessment of Risk

Use a validated tool to support clinical judgement –  
Waterlow/Purpose T

Consider non-concordance

Think holistically –  
pain, immobility,  
neurological issues

Mental capacity

# Purpose T risk assessment used by Community ICT.

## Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Patient name   
  DOB   
  Hospital / NHS number   
  Ward

### Step 1 – screening

<b>Mobility status</b> – tick all applicable Needs the help of another person to walk <input type="checkbox"/> Spends all or the majority of time in bed or chair <input type="checkbox"/> Remains in the same position for long periods <input type="checkbox"/> Walks independently with or without walking aids <input type="checkbox"/>	<b>Skin status</b> – tick all applicable Current PU category 1 or above? <input type="checkbox"/> Reported history of previous PU? <input type="checkbox"/> Vulnerable skin <input type="checkbox"/> Medical device causing pressure/shear at skin site e.g. O <sub>2</sub> mask, NG tube <input type="checkbox"/> Normal skin <input type="checkbox"/>	<b>Clinical Judgment</b> – tick as applicable Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epiduralis, oedema, steroids <input type="checkbox"/> No problem <input type="checkbox"/>	<b>No pressure ulcer not currently at risk</b> Tick if applicable <input type="checkbox"/> Not currently at risk pathway
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IF ONLY blue box is ticked → No pressure ulcer not currently at risk  
 IF ANY yellow boxes are ticked, go to Step 2  
 IF ANY yellow or pink boxes are ticked, go to Step 2  
 IF ONLY blue box is ticked → Not currently at risk pathway

### Step 2 – full assessment

Complete ALL sections

<b>Analysis of independent movement</b> Tick the applicable box (where frequency and extent categories meet) Extent of all independent movement Relief of all pressure areas Doesn't move <input type="checkbox"/> Slight position changes <input type="checkbox"/> Major position changes <input type="checkbox"/> Frequency of position changes Moves occasionally <input type="checkbox"/> Moves frequently <input type="checkbox"/>	<b>Sensory perception and response</b> – tick as applicable No problem <input type="checkbox"/> Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural <input type="checkbox"/>	<b>Moisture due to perspiration, urine, faeces or exudate</b> – tick as applicable No problem / Occasional <input type="checkbox"/> Frequent (2–4 times a day) <input type="checkbox"/> Constant <input type="checkbox"/>
<b>Perfusion</b> – tick all applicable No problem <input type="checkbox"/> Conditions affecting central circulation e.g. shock, heart failure, hypotension <input type="checkbox"/> Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease <input type="checkbox"/>	<b>Nutrition</b> – tick all applicable No problem <input type="checkbox"/> Unplanned weight loss <input type="checkbox"/> Poor nutritional intake <input type="checkbox"/> Low BMI (less than 19.5) <input type="checkbox"/> High BMI (30 or more) <input type="checkbox"/>	<b>Medical device</b> – tick as applicable No problem <input type="checkbox"/> Medical device causing pressure/shear at skin site e.g. O <sub>2</sub> mask, NG tube <input type="checkbox"/>

<b>Current Detailed Skin Assessment</b> – tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category.																																																																																																											
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### Step 3 – assessment decision

If ANY pink boxes are ticked/completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.	If ANY orange boxes are ticked (but no pink boxes), the patient is at risk.	If only yellow and blue boxes are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.
<b>PU Category 1 or above or scarring from previous pressure ulcers</b> Tick if applicable <input type="checkbox"/> Secondary prevention and treatment pathway	<b>No pressure ulcer but at risk</b> Tick if applicable <input type="checkbox"/> Primary prevention pathway	<b>No pressure ulcer not currently at risk</b> Tick if applicable <input type="checkbox"/> Not currently at risk pathway

Nurse printed name   
  Nurse signature   
  Date   
  Time



# What assessment is your service using?

Join at [slido.com](https://slido.com)  
#7366402



# Group discussion...

Assessments  
and  
Monitoring





## Consider seating and posture



*Midlands and East*



**S**urface: Make sure your patients have the right support.

## Protect Areas at risk of pressure damage

Use pillows only as a temporary arrangement until equipment can be sourced.



## Protect Areas at risk of pressure damage

Use pillows only as a temporary arrangement until equipment can be sourced.

## Consider seating and posture





**KEEP** - Keep skin, clean, dry and well hydrated.

**Ensure** - Ensure all areas are checked and this may mean removing clothing and hosiery.

**Look** - Look for early signs of damage and implement care straight away to prevent further damage

## Darker skin tones



**Act straight away.  
Don't leave it  
until...**





## Lateral turning devices

- Hob elevated no more than 30°
- Place body in 30°, laterally inclined position
- Hips and shoulder 30° from supine
- Support with pillows or wedges





Incontinence/  
Moisture: Your  
patients need to  
be clean and  
dry.

## Keep service users clean and dry

- Use a barrier film or cream to keep fluid away from the skin
- Use correct incontinence products
- Check pads regularly
- Know the difference between a moisture lesion and a pressure ulcer
- Remember - These are not recorded as pressure ulcers





“ Nutrition/Hydration: Help patients have the right diet and plenty of fluids. ”

# Maintain High Quality Nutritional Care



## Feed me well



### Five things you should know about nutrition

- 1** Adequate nutrition is important for preventing as well as healing pressure ulcers. Hydration is also important.
- 2** A nutritional assessment will identify patients who are not receiving enough nutrition in the form of calories, protein, hydration and vitamins and minerals.
- 3** For patients who are unable to take in enough nutrients through regular meals, other methods must be considered.
- 4** Consider nutritional supplements, particularly those with high protein content.
- 5** Malnutrition is a common feature in people with dementia. They may refuse to eat, forget to chew or swallow, or are easily distracted.

For more information visit [www.stopthepressure.com](http://www.stopthepressure.com)



#### GREEN

**Patient is well nourished and eating well:**  
Maintain current healthy eating plan.



#### AMBER

**Patient is not eating well:**  
Review eating plan and supplement with protein drinks and watch fluid levels.



#### RED

**Patient is malnourished:**  
Refer to dietician for full assessment and implement diet plan.



Midlands and East

# Giving Information

- Consider capacity full/reduced
- **Educate** the person you are caring for, other carers, family and friends to gain their support
- Check understanding
- Escalate/refer
- Revisit
- Document

**Explain, Explore,  
Discuss**

## Pressure Ulcer Prevention

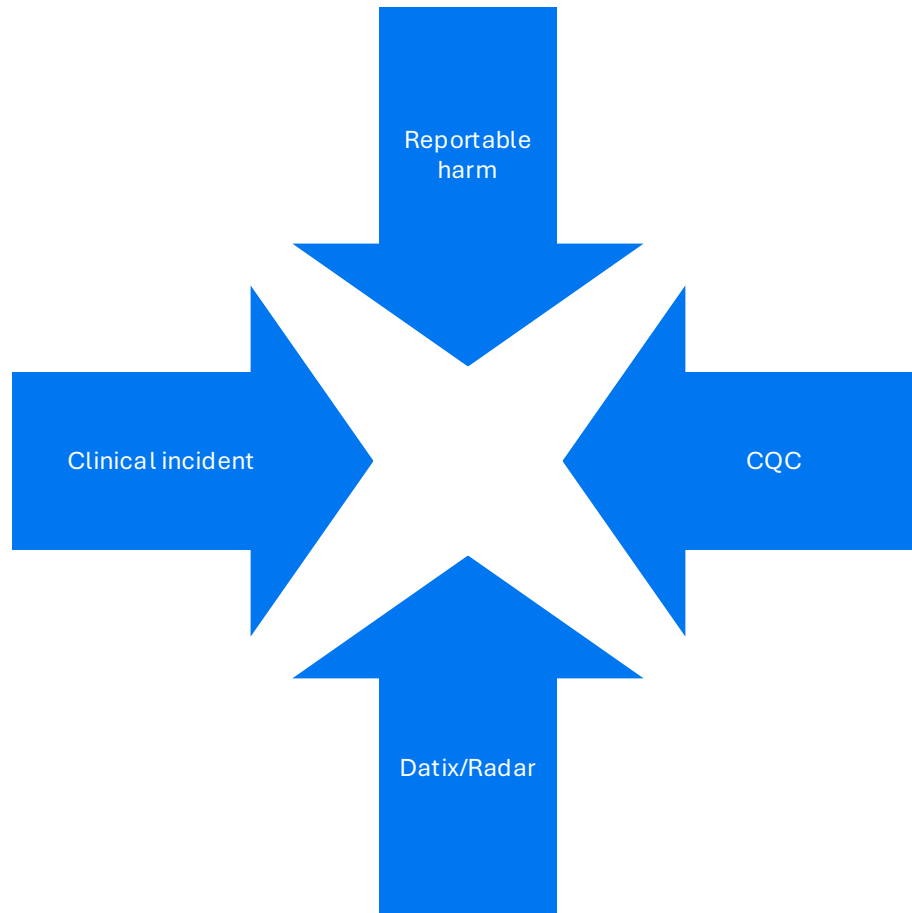
Pressure ulcers (also known as bed sores, pressure sores and pressure injury) are caused by sustained periods of pressure as a result of not moving for a period of time. This time can be short – less than 4 hours. When you are ill, have difficulty moving or are not motivated to move, you are particularly at risk of getting a pressure ulcer.

This picture shows how bad a pressure ulcer on a bottom can get. Pressure ulcers are caused when skin and muscle cells die because of pressure. Damage can sometimes start deep in the body and work its way out to the skin. For this reason they can be very deep and result in bone and/or serious blood infection which can lead to death.

This is why we advise you to use certain pieces of equipment and change your position frequently enough to prevent this damage from happening. This is why it's important to follow health professional's advice.



# Reporting...



## Common Themes

- No skin assessment
- No regular reassessment
- No risk assessment
- Poor classification
- No action on level of risk
- Poor documentation
- Reporting

TAKE A  
**Break**  
its  
COFFEE  
TIME

Ask us your questions  
during the break :

Join at [slido.com](https://www.slido.com)  
#7366402





# Local Guidance

- Local Pressure Ulcer policy
- Herts and West Essex Wound Care Products formulary
- Pathways – Lower limb (NWCSP) infection, skin tear pathway, debridement, exudate
- Referral criteria
- Specialist Services Contacts – TVN, Leg Ulcer, Lymphoedema



**Hertfordshire Community**  
NHS Trust



**Central London**  
**Community Healthcare**  
NHS Trust



**Essex Partnership University**  
NHS Foundation Trust

## **Roles and Responsibilities and safeguarding considerations**

Identifying and managing risk to ensure patient safety

Following established guidance

When and how to escalate concerns and to raise a safeguarding?

Communication with health professionals, service users, other carers, family and friends

How good is your documentation?

# Group discussion...

**Identify  
Barriers  
and  
Solutions**



# Question?

What are the key challenges you and your staff face around supporting people's skin integrity and wound management?

What barriers do you encounter when trying to address these challenges?

What are some potential solutions to these barriers?

# Reminder Culture and Dignity

## Understanding Cultural Needs in Skin Care:

- Recognise and respect diverse cultural practices and beliefs related to skin care.
- Adapt care plans to accommodate cultural preferences and traditions.
- **Reminder: Consider different skin colours when assessing and treating skin conditions.**

## Respecting Dignity and Preferences:

- Ensure that care is provided in a manner that maintains the dignity of the individual.
- Listen to and honour the preferences and choices of the person receiving care.
- **Reminder: Always consider dignity when taking pictures of individuals.**

# New Training- Starts 19<sup>th</sup> September!

Tier 1- Skin Integrity and Pressure Ulcer Prevention

Tier 2- Skin integrity, pressure ulcer prevention and wound care (Non Clinical)

Tier 2- Wound Management COD for Social Care Nurses

Tier 3- Skin Health Champion

# Resource Library

Search the Resource Library...



## SAFEGUARDING & CAPACITY

The Hertfordshire Safeguarding Adults Board (HSAB) is responsible for the safeguarding of adults with support and care needs in the County.



## MEDICATION

Utilise the HCPA Medication page for Care Homes and Community Services in Hertfordshire.



## ADULT DISABILITY & MENTAL HEALTH

Utilise the Adult Disability and Mental Health members zone area to tap in to a wide variety of resources and guidance to help you to best care for the individuals you support.



## INFECTION PREVENTION & CONTROL

Find information on all things IPC including links to up-to-date guidance, posters for your organisation and audits and competencies to use.



## CARE & SUPPORT PLAN

Involving people in decisions about their care is intrinsic to the principles of the MCA and should be evident in every care and support plan.



## HEALTH & WELLBEING

Utilise the HCPA Health and Wellbeing page to tap into a wide variety of resources and guidance to help you to best care for the individuals you support.



## RUNNING YOUR CARE BUSINESS

At HCPA, as well as supporting you with the care elements of your business, we are also here to support you with the operational, financial and safety elements of your organisation.



## TECHNOLOGY & EQUIPMENT

Up to date information on data protection & electronic care planning including apps & devices.



## REGULATION & INSPECTIONS

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard.

All Resources available here:



# Key Takeaways

**Understanding Skin Integrity:**  
It's crucial to understand the role of skin integrity in overall health.

**Impact of Compromised Skin Integrity:** Poor skin integrity can have significant physical, emotional, and social impacts.

**Prevention and Assessment:**  
Prevention is key in managing skin and wound health..

**Roles and Responsibilities:**  
Understanding the roles and responsibilities in skin and wound management is vital.

**Local Guidance and Resources:**  
Familiarise yourself with local guidance, policies, and pathways related to pressure ulcers, wound care products, and specialist services.

**Training and Education:**  
Continuous training and education are important for improving skills and knowledge in skin and wound management..

**Cultural and Dignity Considerations:** Recognise and respect diverse cultural practices and beliefs related to skin care.

# Next Steps

- Take your table packs away and review with your team
- Set actions to change the way you do things
- Share resources and local service information with staff teams
- Book staff on upcoming training
- Review policies and procedures
- Connect with your local hospice

*Start the conversations with your staff, the people you support and health Professionals...*



# THE HCPA CARE PROVIDER HUB PROVIDING PEACE OF MIND.....



ASK us anything! We are your support service, here to answer your questions on all topics Adult Social Care related.

- Govt guidance, laws, standards and expectation
- Covid: PPE, vaccinations and infection control
- Liaison with Hertfordshire County Council
- Funding, contracting and commissioning
- Staff wellbeing and recognition
- HR, Staffing and recruitment
- Training and education
- Business continuity
- Data protection
- Monitoring
- Equipment
- Insurance

**Your hub, your support service.....**

**01707 708108 / [assistance@hcpa.co.uk](mailto:assistance@hcpa.co.uk) (Mon to Fri - 9am to 5pm). [www.hcpa.info/hub](http://www.hcpa.info/hub)**

**HCPA: 'Sharing best practice in care through partnership'**



# Newsletters

Stay up to date with sector news!  
Ensure you and your leadership team are signed up to receive HCPA's newsletters.

Subscribe to our mailing list



**What are your key  
takeaway actions  
from today?**

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