Study Session:

Skin and Wound Management in residential and nursing settings

Starting 09.30

Please tell us where you are from

Join at slido.com
#7366401

Welcome

Study Day: Skin & Wound Management.

Date: 9 Sept 2025

This Session will begin shortly

Hertfordshire

Centre of Excellence
Valid until 11/2025
skillsforcare

Housekeeping

Please keep your mobiles on silent during the presentations

Exits

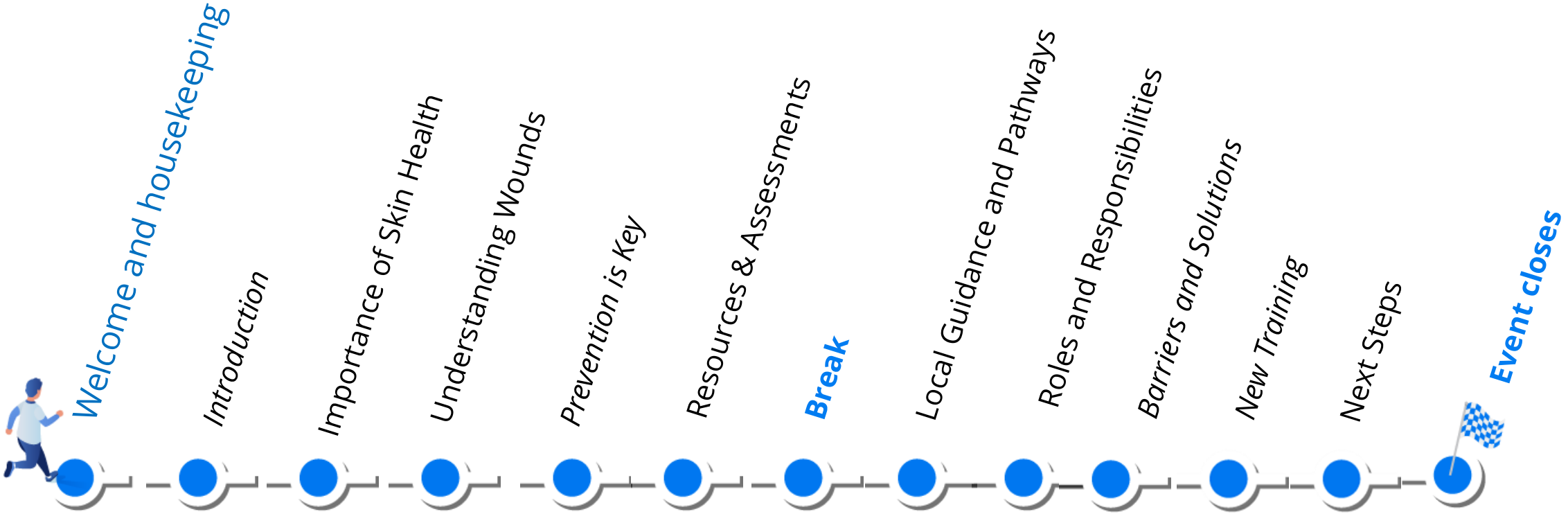
No planned fire drills

Comfort Break

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 todays session?

Join at slido.com
#7366401

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.

Aging 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...

Coloplast

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

AJM HealthCare

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

solventum

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

NHS
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

Exhibiting today...

Education and Events

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
www.hcpa.info/upcoming-training

Business Development Services

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

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

HCPA PROVIDER HUB

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
(Mon to Fri – 9am to 5pm)

www.hcpa.info/provider-hub

WARNING!

CONTAINS IMAGES THAT SOME MAY FIND DISTURBING

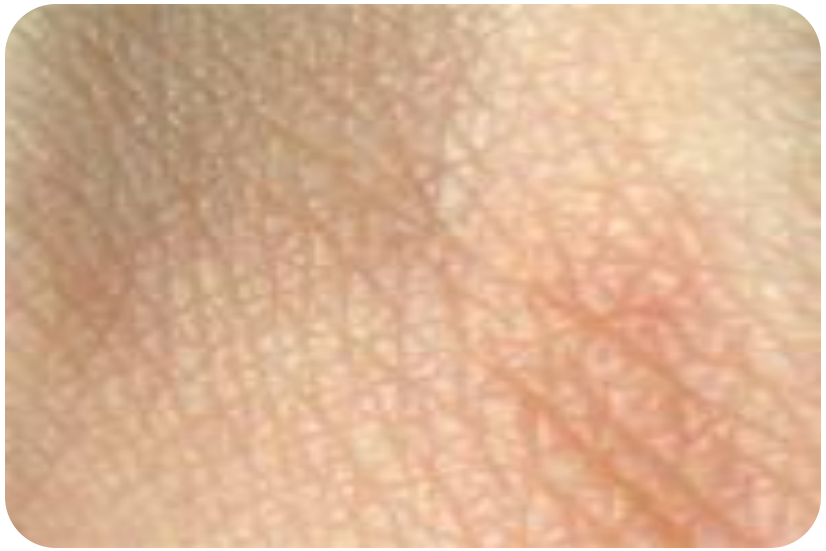
Kim Fenwick

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

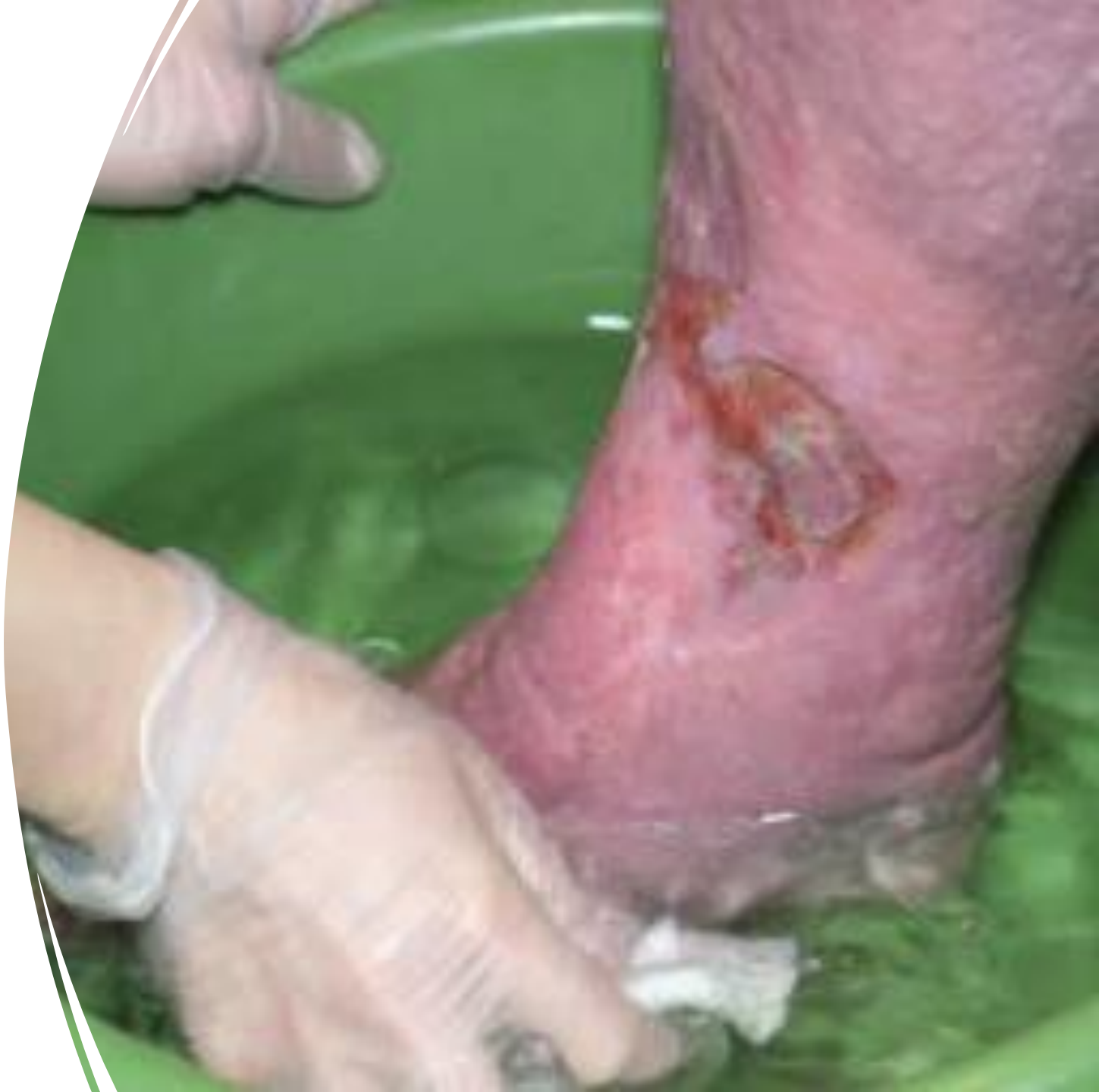
Impacting on physical, mental and social wellbeing

List impacts of compromised skin

Join at slido.com
#7366401

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

Guest JF, Fuller GW, Vowden P(2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update update from 2012/2013 *BMJ Open* 10: e045253
Office for National Statistics (2018) Household projections for England 2018 based.

Wound status can deteriorate rapidly if not promptly addressed

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 - 5th 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 11th July and seen on 15th 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.

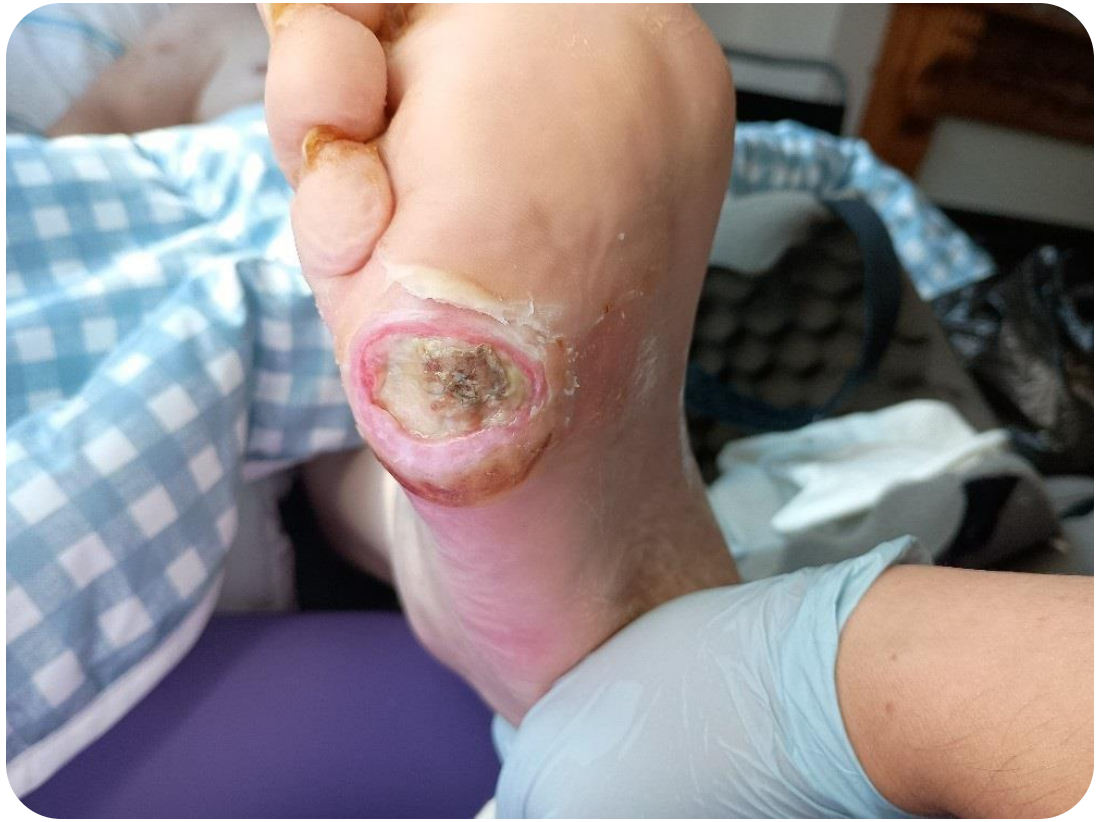
Wife arranged private podiatrist to cut toenails and monitor feet as is bedbound

MUST = 0 Good appetite

Frailty score 7

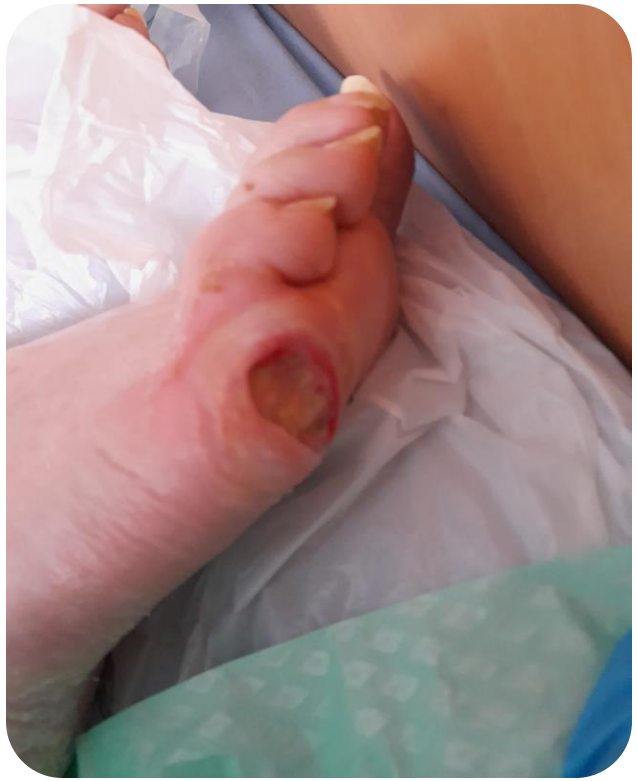
Tissue Viability Assessment

- **15th 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

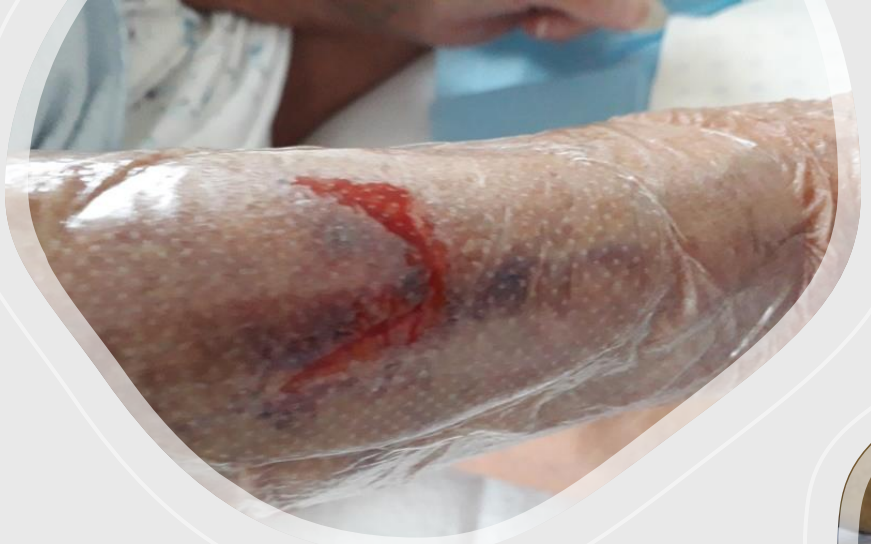


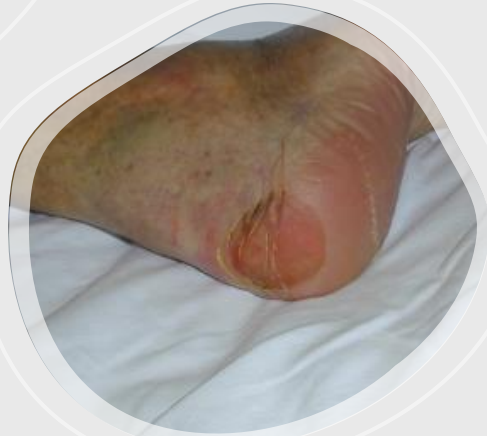
Outcomes

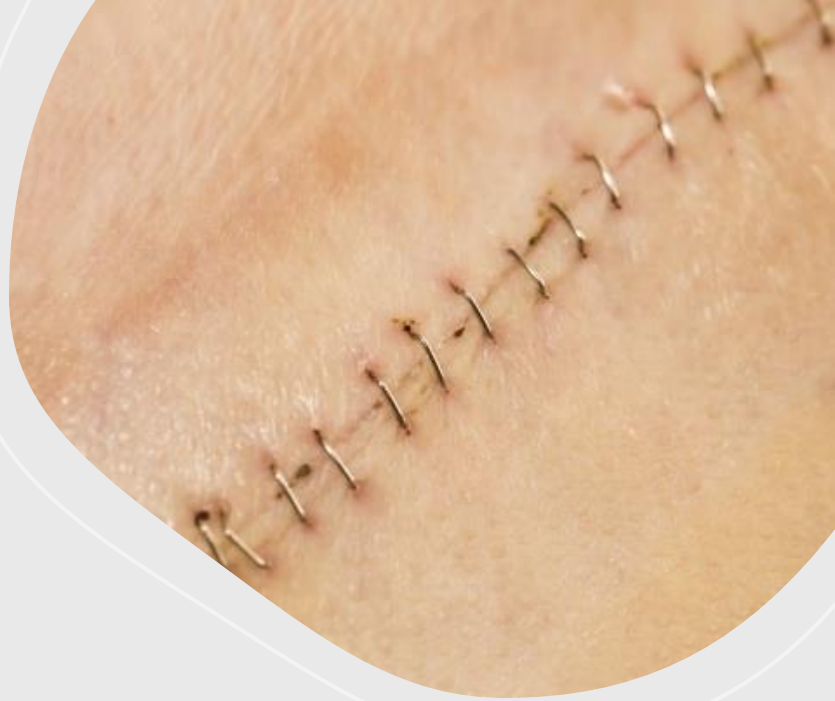
Post sharp debridement 15th July

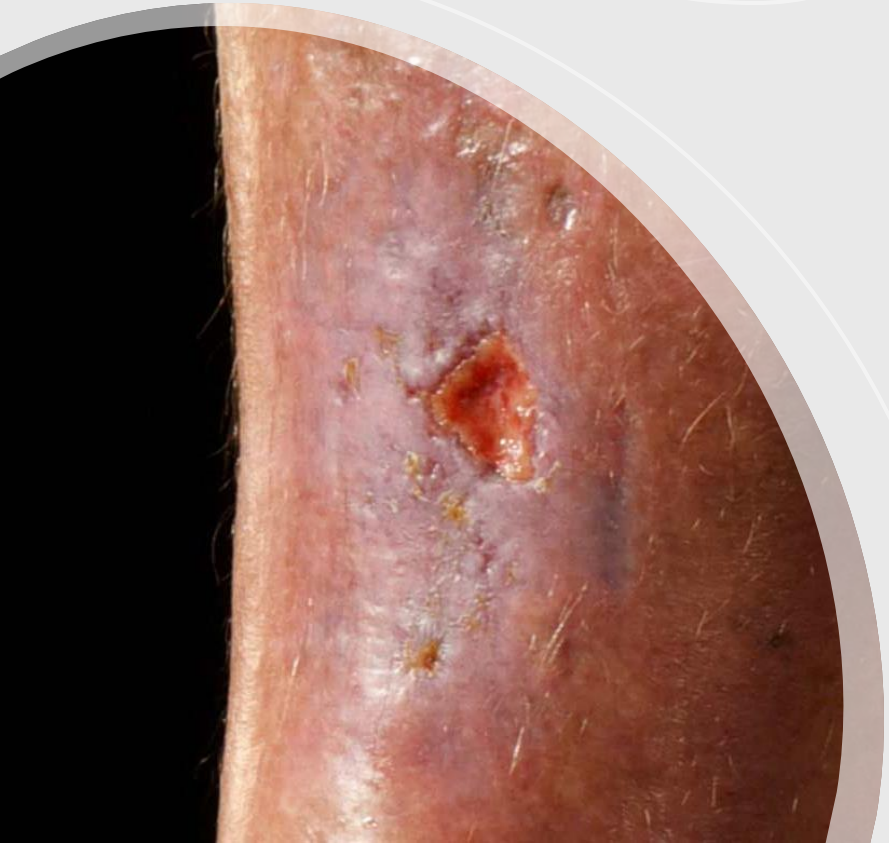


- Timely referral and response
- Assessment
- Use of equipment
- Podiatry input
- Communication with carers, family, podiatry and community team
- Follow up







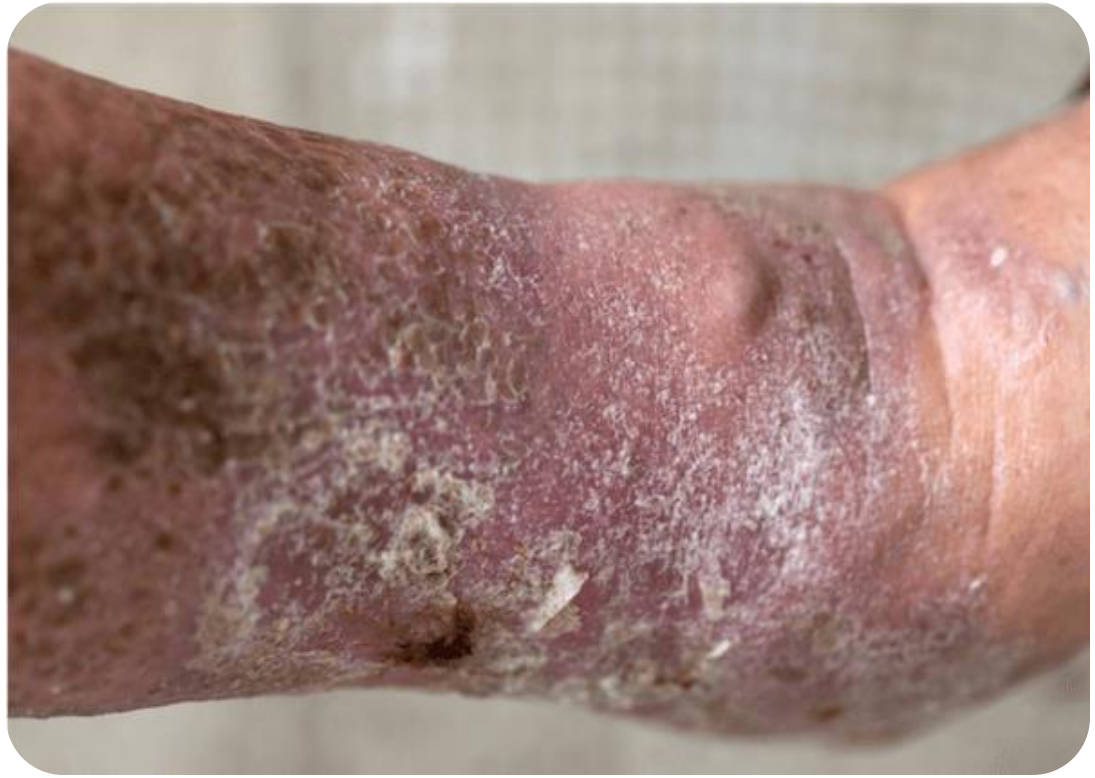


Overview of common wounds

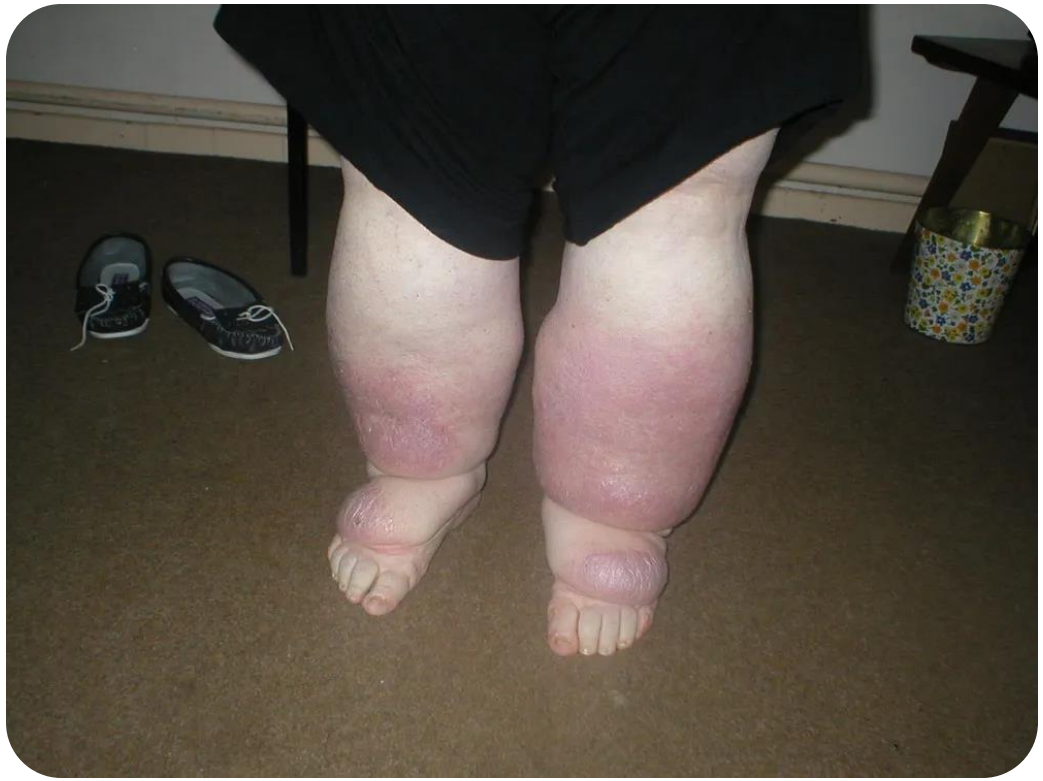
What are your challenges?

Understanding wound types, conditions and implications

Leg ulcers

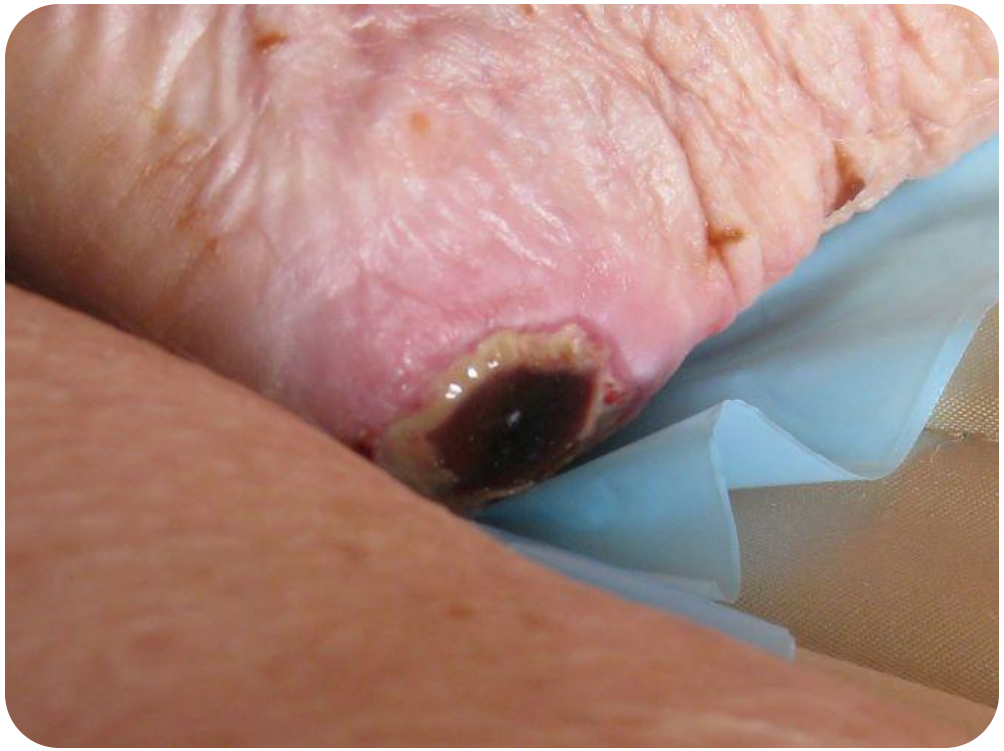


Lymphoedema



Understanding wound types, conditions and implications

Pressure Ulcers

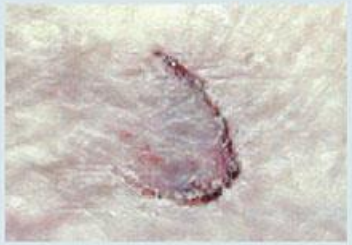


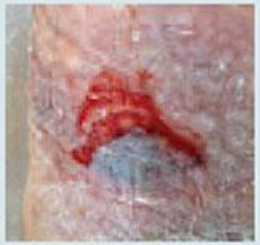
Skin Tears

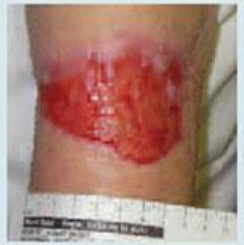
ISTAP skin tear classification

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

- **Type I** 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.

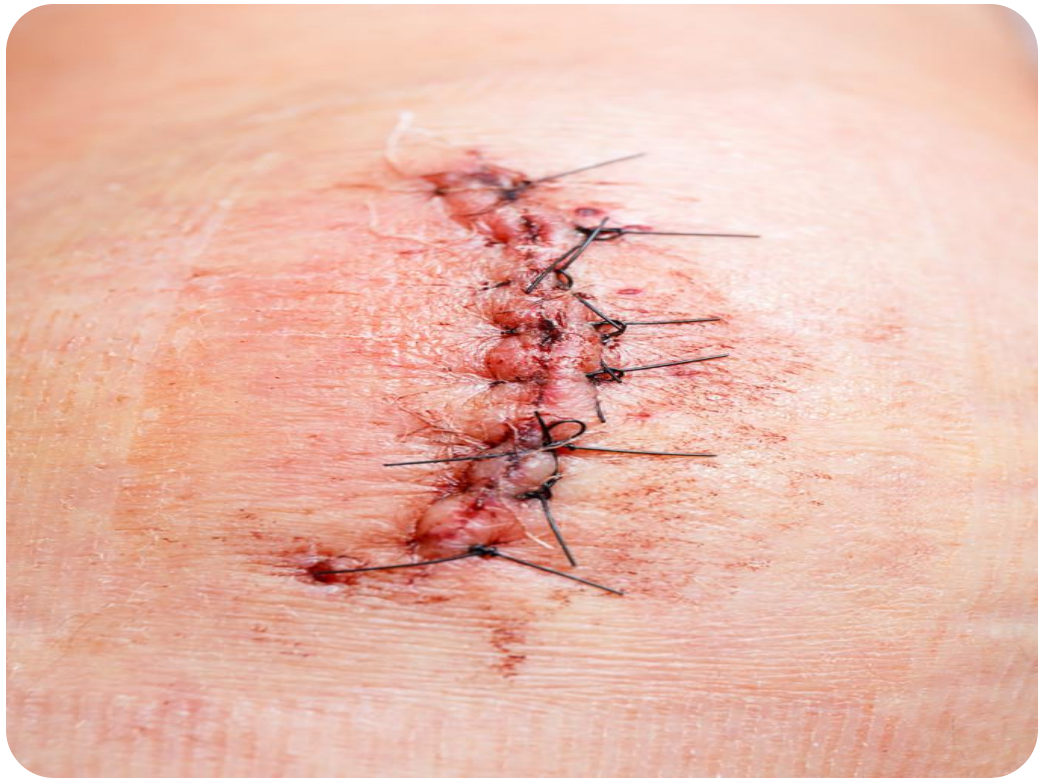




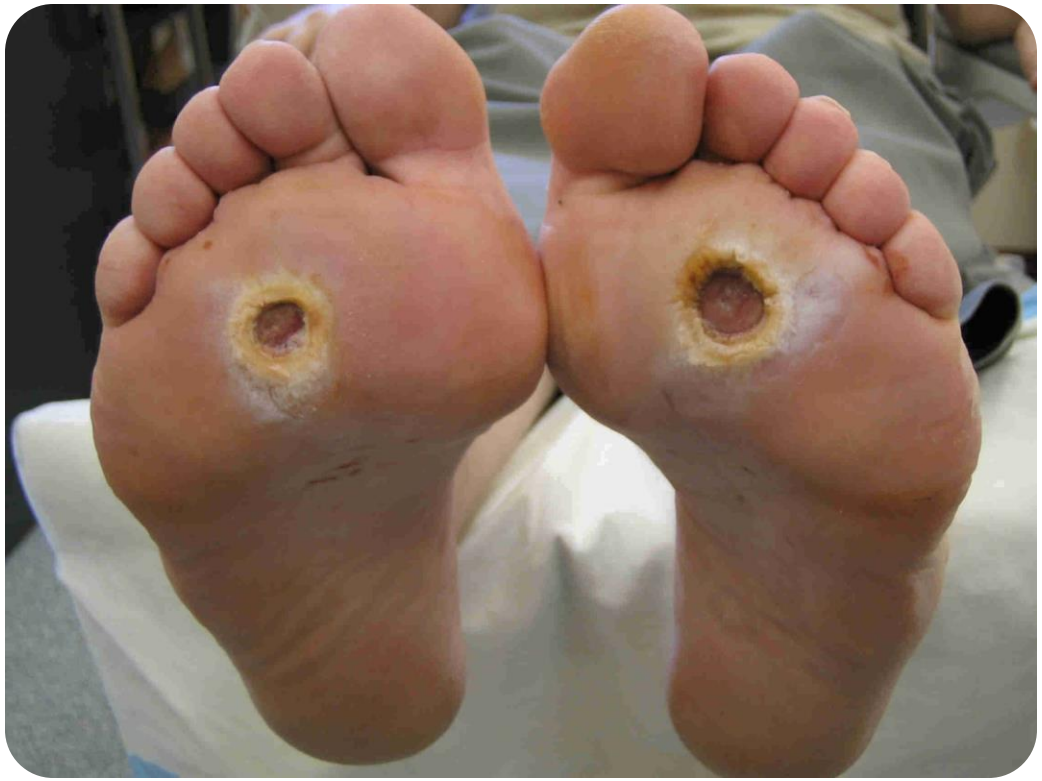


Understanding wound types, conditions and implications

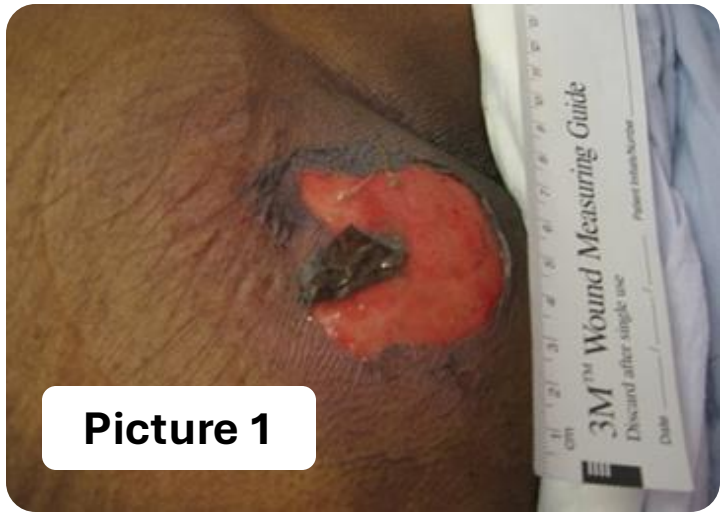
Surgical Wounds



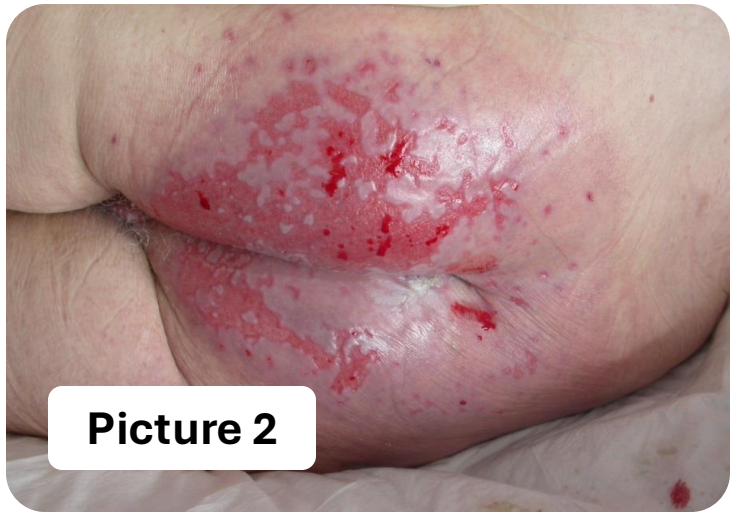
Diabetic foot wounds



Quiz - Pressure Ulcer Identification

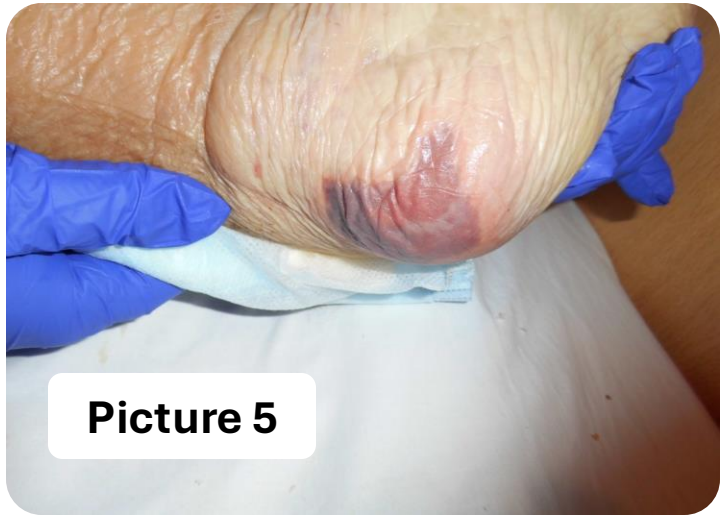


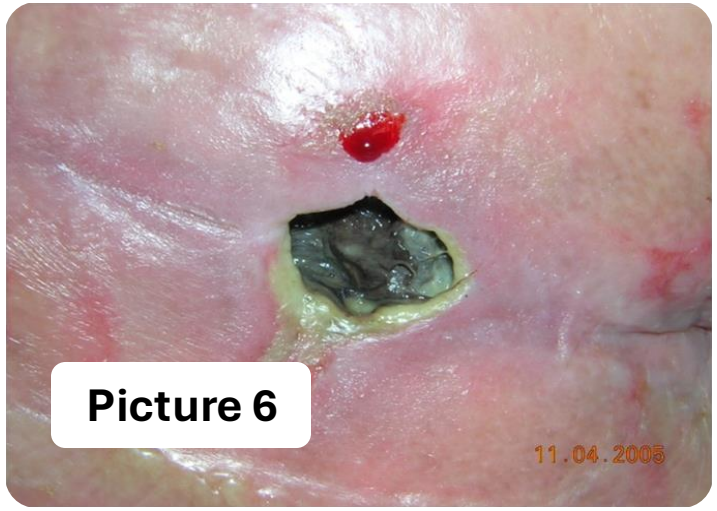
Picture 1


Picture 2


Picture 3

Picture 4


Picture 5



Picture 6

National Guidance

NHS Improvement

NHS England

#StopThe Pressure

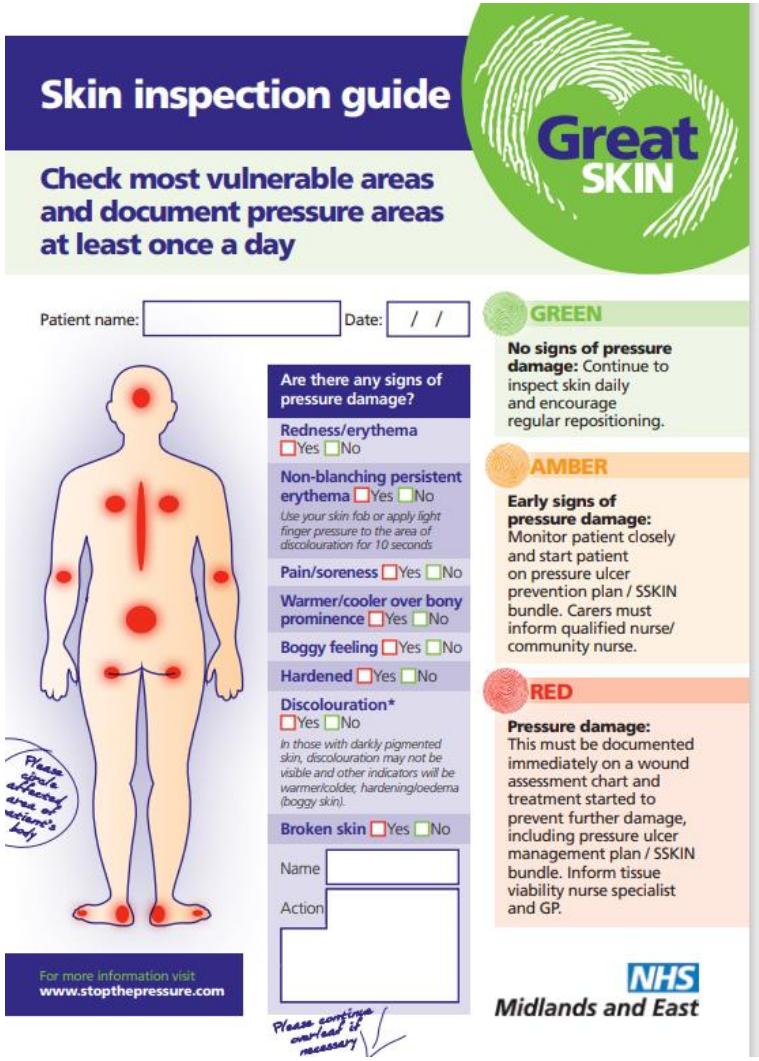
- Stop the Pressure programme in (NHS England, 2017)
- Following the huge campaign the ASSKING framework was introduced, a 7 step model to reduce Pressure ulcer prevention variations in practice
- Changes in reporting recommendations 2018 NHS improvement
- National Wound Care Strategy Programme (NWCSP) 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)

Assessment of risk

Give Information

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

Prevention is Key



Skin inspection guide

Great SKIN

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

Patient name: Date: / /

Are there any signs of pressure damage?

- **Redness/erythema** ☐Yes ☐No
- **Non-blanching persistent erythema** ☐Yes ☐No
  Use your skin fob or apply light finger pressure to the area of discolouration 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, discolouration may not be visible and other indicators will be warmer/colder, hardening/oedema (boggy skin).
- **Broken skin** ☐Yes ☐No

Name

Action

Please continue overleaf 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.

For more information visit **www.stopthepressure.com**

NHS Midlands and East

Improve my skin

Great SKIN

How to keep skin healthy

1 Too dry

a. Apply a moisturiser (cream or ointment) regularly to soften the skin, reduce scaling and ease itching. Apply in a downward direction.
b. Do not use excessive amounts of skin cream.
c. Skin should be patted dry, not rubbed.
d. Do not use traditional soaps and avoid creams that can irritate the skin.
e. Ensure the patient is receiving an adequate fluid intake.

2 Too moist

a. Use a barrier film or cream to keep fluid away from the skin.
b. Use a faecal management system if the cause is profuse or prolonged diarrhoea.
c. Use incontinence products when required.
d. 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

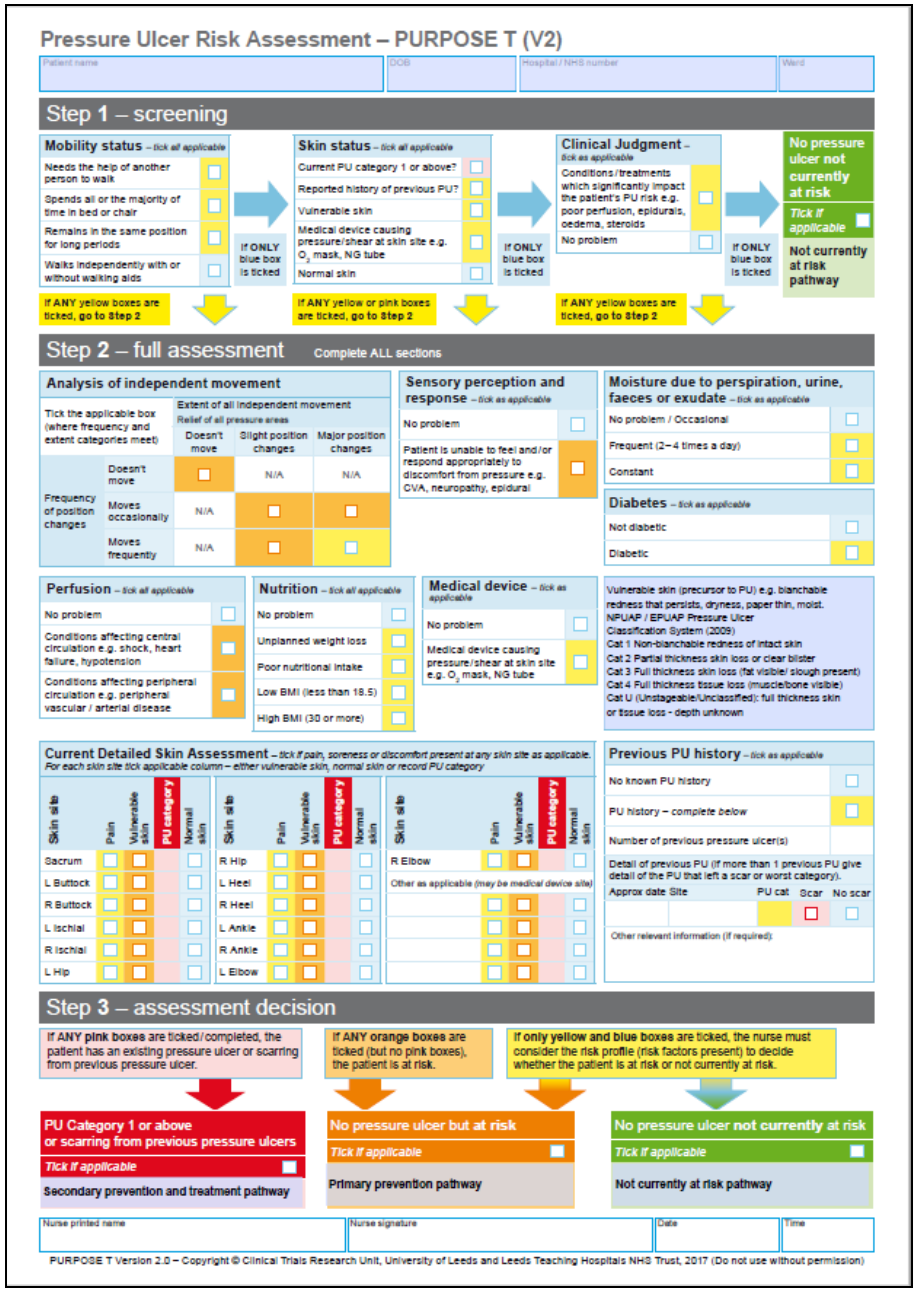
Skin has broken down: Document area of damage and assess wound. If the wound is caused by moisture it is more likely to be a moisture lesion. Do not confuse with a pressure ulcer. Ensure you know the difference as all pressure ulcers must be reported (use Safety Cross).

NHS Midlands and East

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

Mobility status – tick all applicable
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If ONLY blue box is ticked

Skin status – tick all applicable
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – tick as applicable
- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If ONLY blue box is ticked

- No pressure ulcer not currently at risk — Tick if applicable
- Not currently at risk pathway

If ANY yellow boxes are ticked, go to Step 2 | If ANY yellow or pink boxes are ticked, go to Step 2 | If ANY yellow boxes are ticked, go to Step 2

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – tick as applicable
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – tick as applicable
- No problem / Occasional
- Frequent (2–4 times a day)
- Constant

Diabetes – tick as applicable
- Not diabetic
- Diabetic

Perfusion – tick all applicable
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – tick all applicable
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – tick as applicable
- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown

Current Detailed Skin Assessment – 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

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable (may be medical device site)				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Previous PU history – tick as applicable
- No known PU history
- PU history – complete below
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required)

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.

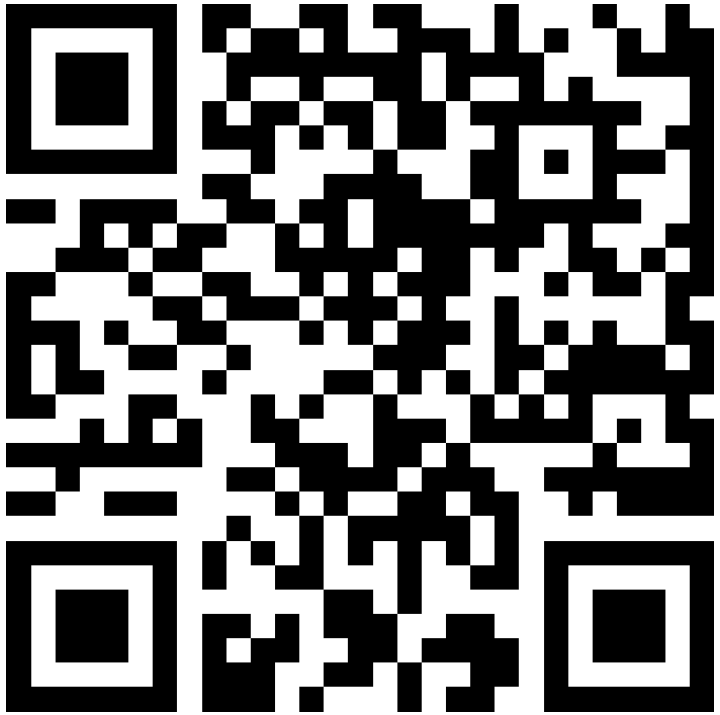
If only yellow and blue boxes are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

- PU Category 1 or above or scarring from previous pressure ulcers — Tick if applicable — Secondary prevention and treatment pathway
- No pressure ulcer but at risk — Tick if applicable — Primary prevention pathway
- No pressure ulcer not currently at risk — Tick if applicable — Not currently at risk pathway

Nurse printed name | Nurse signature | Date | Time

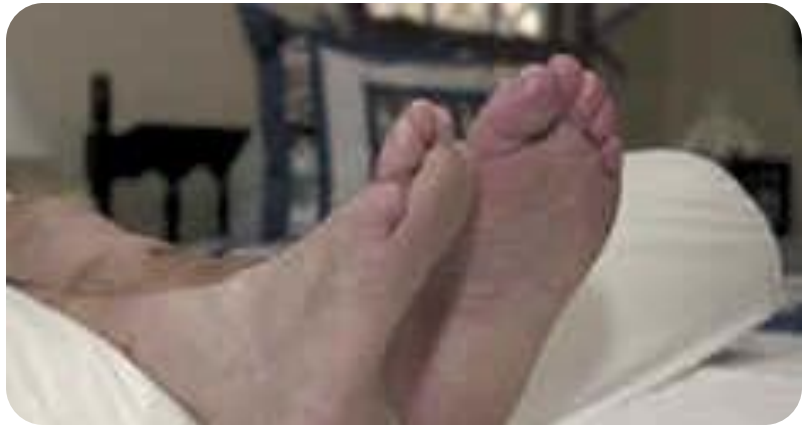
What assessment is your service using?

Join at slido.com
#7366401



Group discussion…

Assessments and Monitoring



Consider seating and posture

Midlands and East

SSKIN

Surface: Make sure your patients have the right support.

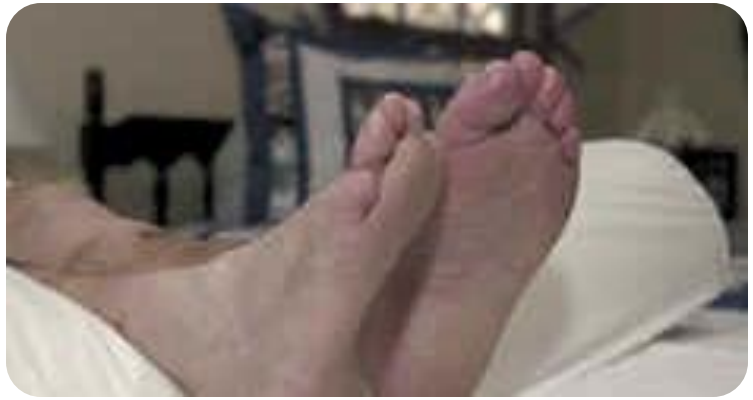
Protect Areas at risk of pressure damage

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

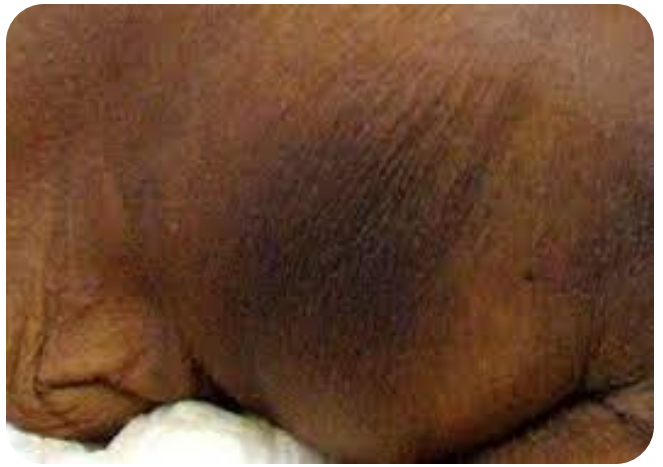


KEEP - Keep skin, clean, dry and well hydrated.

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



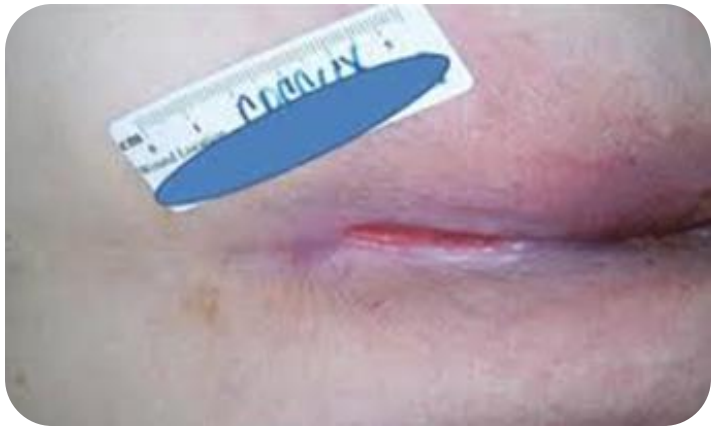
Act straight away. Don't leave it until…

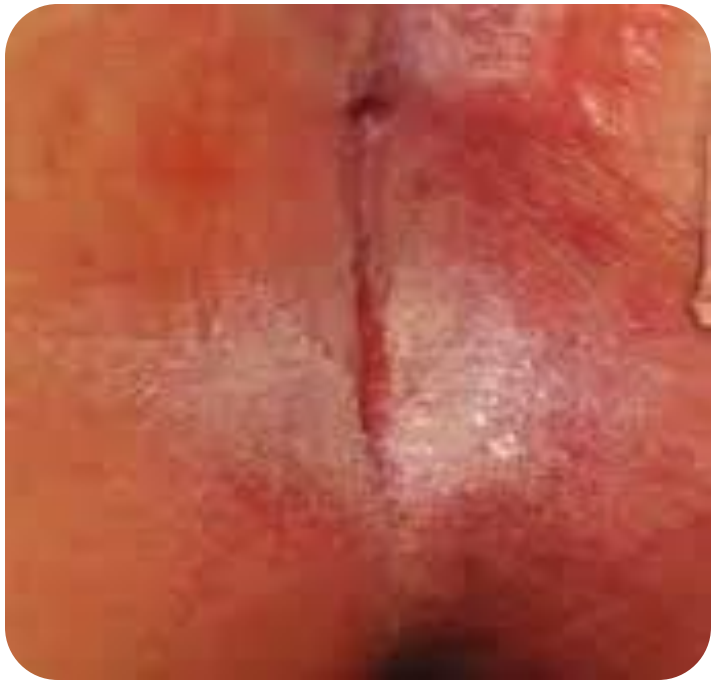
Lateral turning devices

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

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





Maintain High Quality Nutritional Care

Feed me well

Great SKIN

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.

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.

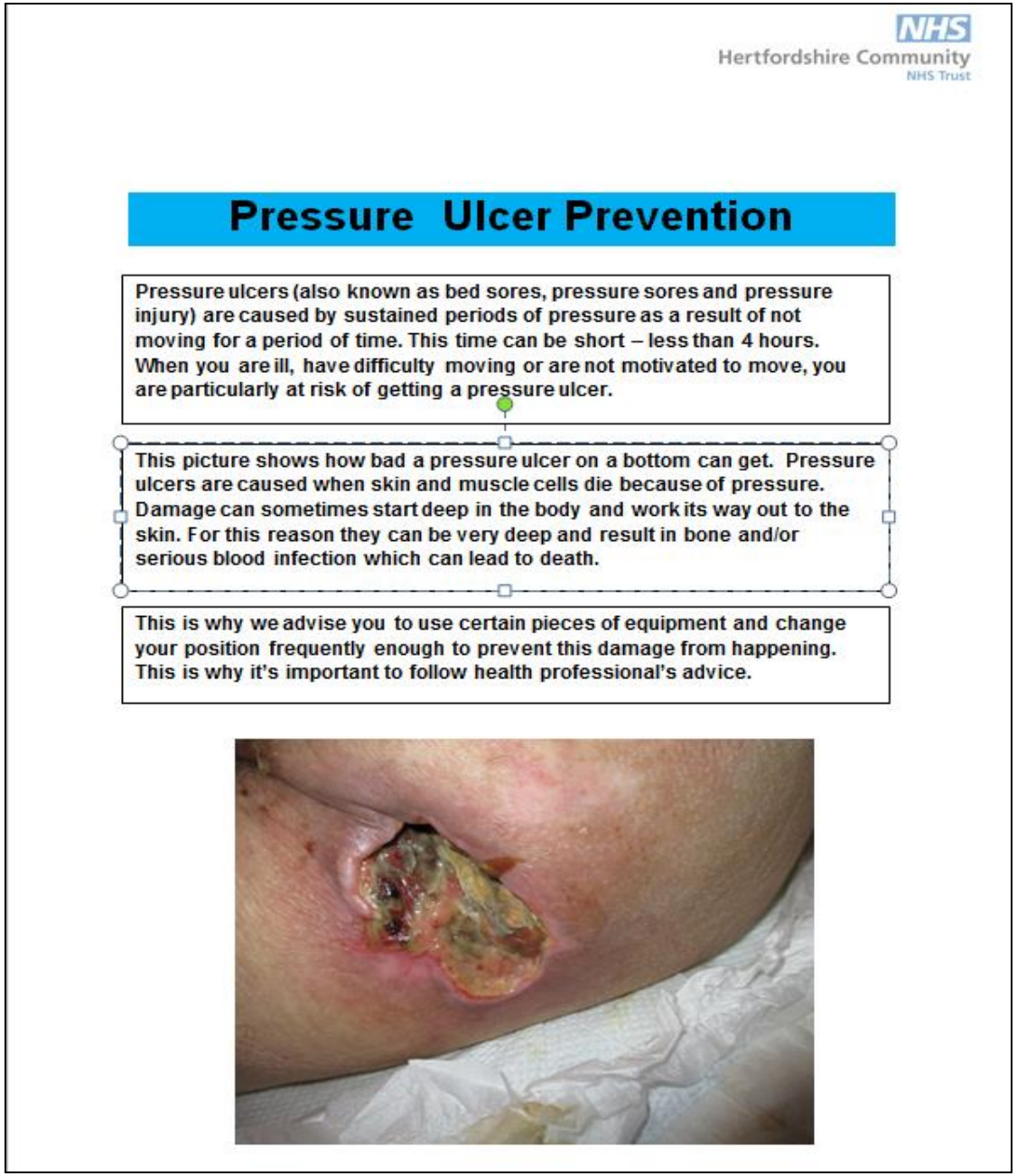
For more information visit **www.stopthepressure.com**

NHS Midlands and East

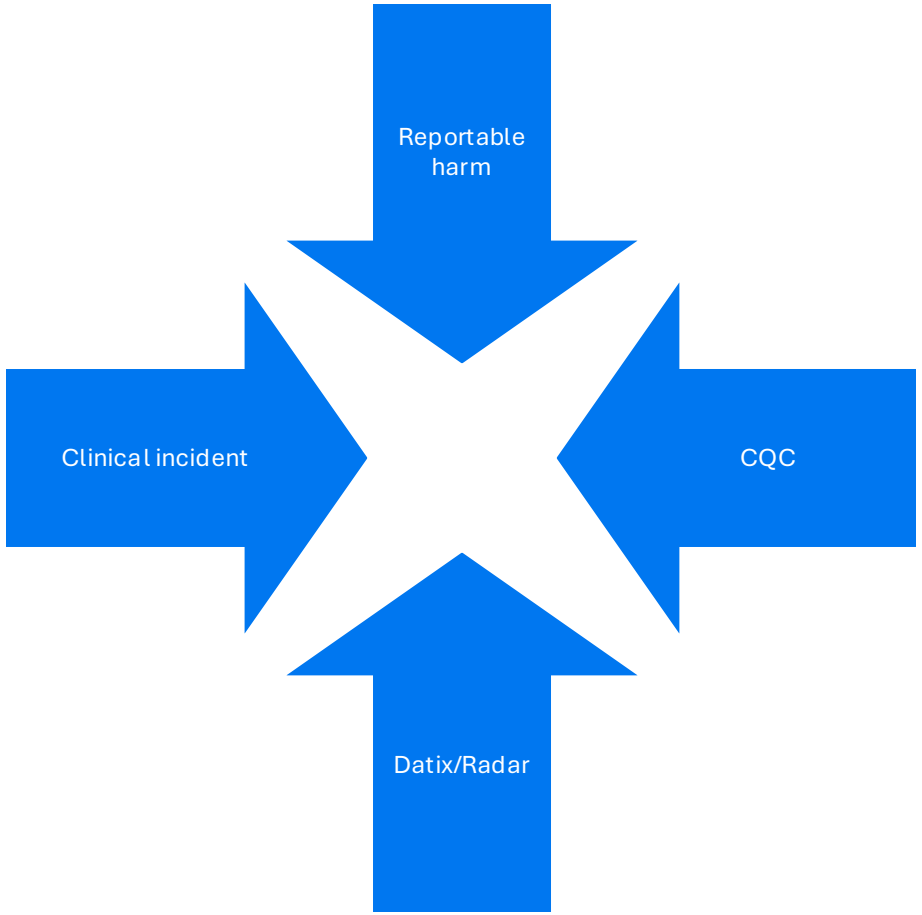
Giving Information

- 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



Reporting…



Common Themes

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

Ask us your questions during the break :

Join at slido.com

#7366401

Herts Care Partners

hcpa

Hertfordshire

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

EUROPEAN PRESSURE ULCER ADVISORY PANEL

NHS Hertfordshire Community NHS Trust

NHS Central London Community Healthcare NHS Trust

NHS 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 19th September!

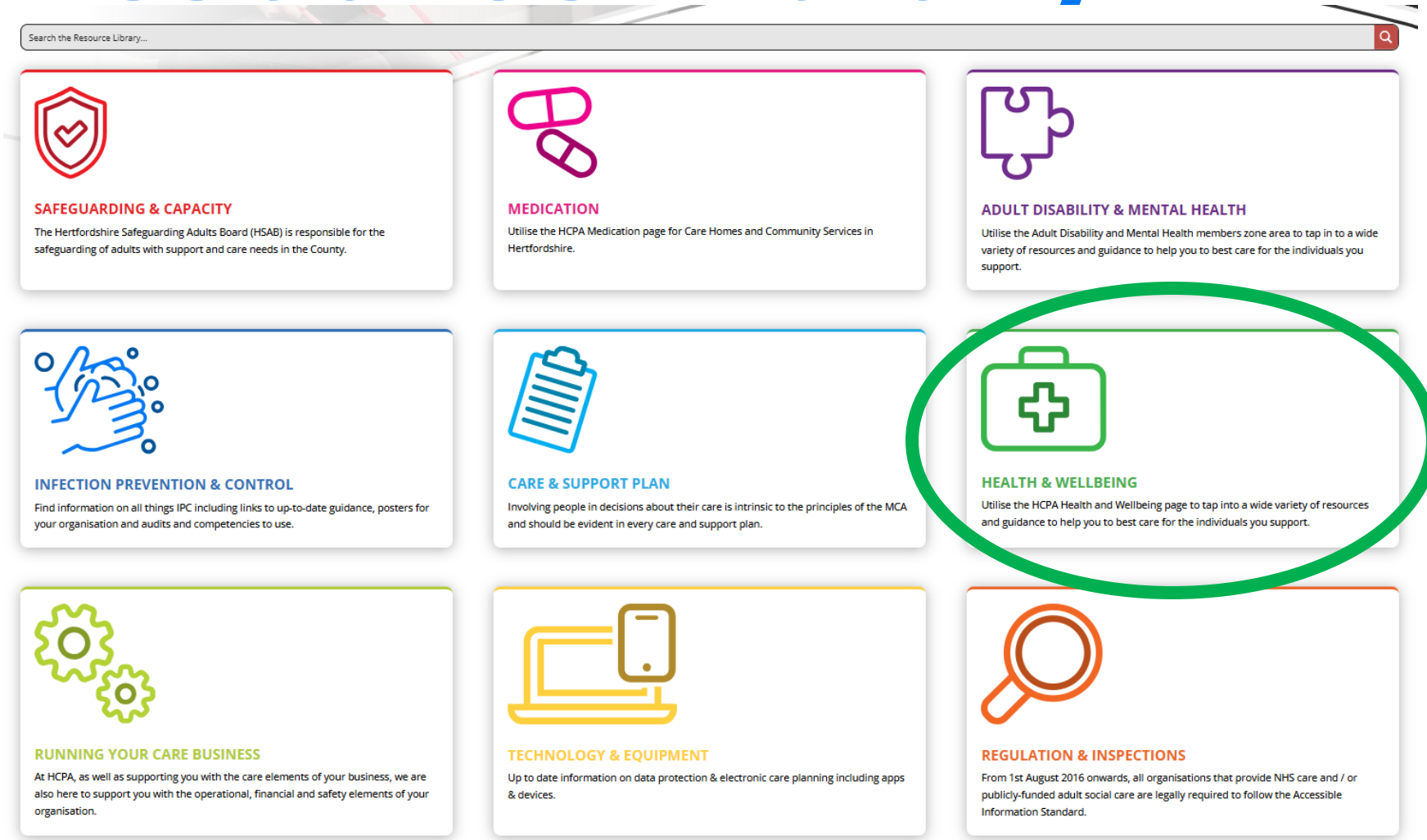
Tier 1- Skin Integrity and Pressure Ulcer Prevention

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



All Resources available here:

Herts Care Partners

hcpa

Hertfordshire

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 g 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 (Mon to Fri - 9am to 5pm). **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?

Join at slido.com #7366401