journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Assessment, Prevention and Management of Moisture Associated Skin Damage

Ref: CLIN-0094-005-v2

Status: Approved
Document type: Procedure
Overarching policy: Tissue Viability Policy

Contents

1 Introduction

Moisture associated skin damage (MASD) is caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus, saliva, and their contents (Gray et al, 2011). If MASD is not recognised and/or is inappropriately managed, then it can lead to further skin deterioration i.e. open wounds. People with MASD can experience persistent symptoms such as discomfort and/or pain, wound exudate, wound bleeding, and wound odour, all of which can negatively impact a person's quality of life. Subsequently it is imperative that staff working within Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust have the knowledge and skills required to support patients with MASD and have access to evidence-based information to guide their clinical practice.

TEWV NHS Foundation Trust provides care to a diverse range of patients across several specialties and localities, all of whom have varying degrees of need and support. As reiterated by NHS England, 2019 [online], care provision is variable, with some groups of people continuing to experience inequalities. TEWV NHS Foundation Trust is therefore fully committed to ensuring that patients receive care that is individualised, holistic and evidence based, and that fair and equal treatment is offered to all. No one should have a poorer service or a lesser experience because of their differences, inclusive of MASD prevention and management. It is in keeping with this principle that this procedure has been written.

This procedure reflects the Trust's strategic direction of travel, Our Journey to Change, by supporting its values and goals.

Living our values is integral to the care we deliver. We will show respect to patients by actively listening to their concerns and acting upon them. We will ensure we are always compassionate, kind and supportive. We will be open and honest in our conversations, always receptive (listening) to how much information a person may want, and in what kind of format.

This procedure also supports the Trust's strategic goals. It is important that we work closely with the person so that the experience can be as good as it possibly can be, working to ensure the person has as much choice and control as possible. We will work closely with our Trust colleagues, so they feel supported in working with the person.

2 Purpose

Following this procedure will help the Trust to: -

- Ensure all staff understand their role and responsibilities when providing care for patients who may be experiencing, or are recognised as being 'at risk', of MASD.
- Ensure that patients at risk of MASD are assessed appropriately and where applicable, an individualised evidence-based and agreed prevention strategy is in place.
- Ensure that staff have the knowledge and understanding required to support a patient who has MASD and are able to implement appropriate management.

3 Who this procedure applies to

This procedure applies to all healthcare professionals working within TEWV NHS Foundation Trust who have a responsibility to assess, treat and manage wounds.

Consideration has also been given to those who may be affected by this procedure to ensure that the document content aligns to the Trust's values, so that people who may be affected are treated with compassion, respect and responsibility.

4 Related documents

This procedure describes what you need to do to implement the 'policy section' of the Tissue Viability Policy.

The Tissue Viability Policy defines the roles, responsibilities and interventions which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ Adult Incontinence Care Advice and Support Protocol
- ✓ Assessment, Prevention and Management of Pressure Ulcers Procedure
- ✓ Consent to Examination of Treatment Policy
- ✓ Equality, Diversity, Inclusion and Human Rights Policy
- ✓ Hand Hygiene Procedure

- ✓ Manual Handling of People Procedure
- ✓ Mental Capacity Act 2005 Policy
- ✓ Privacy and Dignity Policy
- ✓ Safeguarding Adults Policy
- ✓ Stoma Care Advice and Support Protocol
- ✓ Tissue Viability Policy

5 Moisture Associated Skin Damage

MASD is a common yet sometimes complex skin condition (Wounds International, 2022 [online]). The damage to skin is due to overexposure of moisture, which impairs the skin barrier. Overhydration causes the pH of the skin to increase, which disrupts the acidic environment that the skin requires, and in doing this the skin is more susceptible to damage, and the risk of infection increases. Chemical irritants present in the moisture source can also exacerbate the damage that is caused.

The appropriate management of MASD will be dependent upon the cause and the category of the MASD, therefore staff supporting a person with suspected MASD must be able to provide appropriate patient and wound assessment to identify the cause and category, to ensure the correct care plan is implemented. Full guidance on wound assessment can be found within the Tissue Viability Policy, which is accessible via the Trust intranet.

All staff providing wound assessment and care **must** do so in accordance with the Trust Tissue Viability Policy.

If the patient declines any recommended interventions or care then this MUST be documented on their electronic patient record. If there are concerns regarding the patient's skin (e.g. impaired skin integrity, open wound, infection, sepsis), a capacity assessment and an MDT approach may be required for interventions to be performed in the patients' best interests.

5.1 Skin Assessment

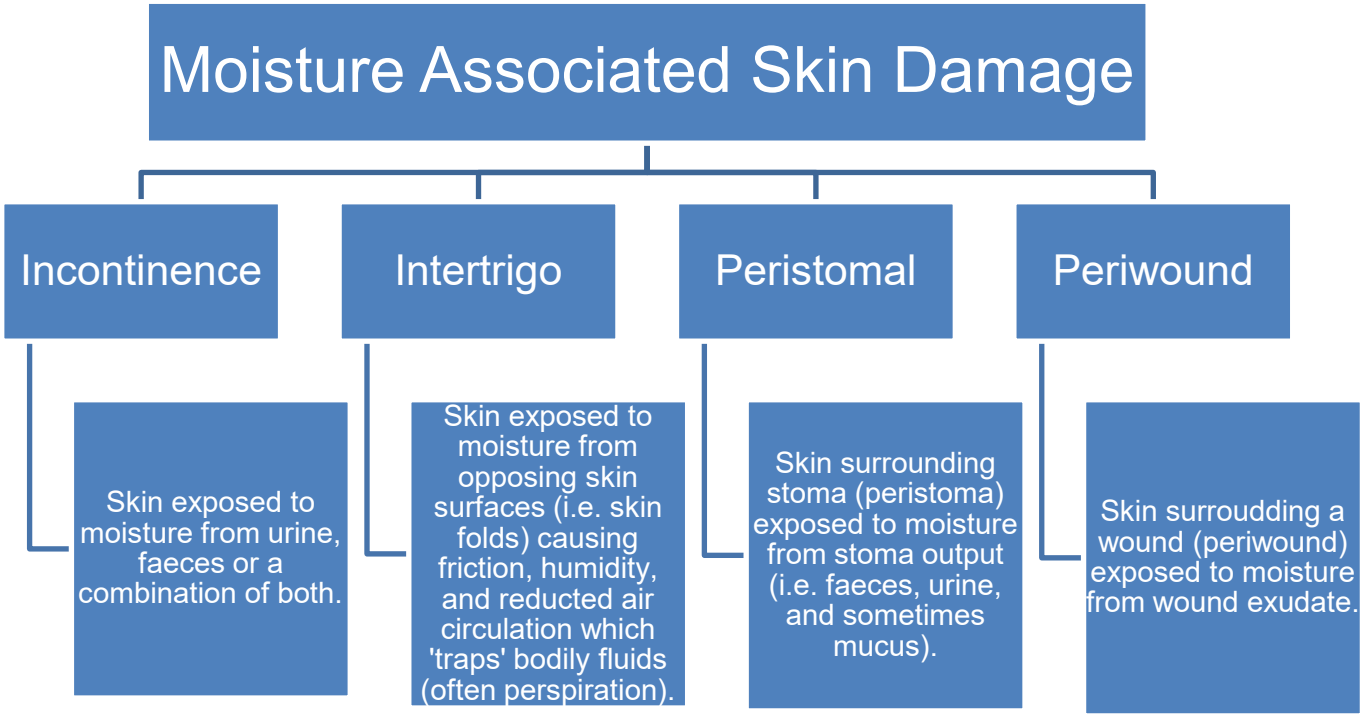
In order to identify MASD, skin inspection is required. This is because staff must see the affected area in order to confirm the cause and category of skin damage (as per section 5.2 and 5.3). The following must be considered:

- The patient should be offered a full skin inspection upon admission, whilst ensuring the patient's wishes are taken into consideration regarding gender of the staff carrying out the assessment. If this cannot be undertaken, then a clear rationale should be documented in the patient's electronic patient record.
- Skin inspection must always be document on a body map (appendix 3).
- Skin inspection should occur regularly, and the frequency will be determined in response to changes in the patient's condition. Patients who are assessed as 'at risk' of developing MASD should have ongoing reviews as part of the reassessment process.
- Patients or relatives/carers should be encouraged to participate where necessary, following appropriate information/training. Skin inspection can be undertaken during routine care, taking into account patient consent and should be documented in their electronic patient record and any problems acted upon.
- Skin inspection should be based on an assessment of the most vulnerable at-risk areas for each patient.
- Patients who decline to have a skin inspection completed should have this documented on their electronic patient record and the risks fully explained to them.
- Skin inspection forms part of the Waterlow Pressure Ulcer Risk Assessment (appendix 4) which is the chosen national validated risk assessment tool used within TEWV. It is important that this risk assessment is appropriately completed for **all** inpatients to maintain skin integrity.

Skin damage can have a number of causes, some relating to the individual patient who may be unwell. However, skin damage may also be caused by external factors such as poor nursing care, lack of resources e.g. equipment and staffing. It is acknowledged and recognised that not all skin damage can be prevented, and patients should be reviewed on an individual basis taking into account the risk factors for that patient. Neglect may be considered for those vulnerable patients with MASD however not all incidences of MASD are caused by neglect.

5.2 Causes of MASD

MASD is an umbrella term, underneath which sits four different causes of skin damage directly associated with prolonged exposure to moisture. The problem is always attributable to presence of moisture, but the cause varies in the source of the moisture (Young, 2017 [online]). Correct identification is integral to the implementation of appropriate management (as discussed in section 5.3).



MASD can be mistaken for a category 2 pressure ulcer and vice versa if located on buttocks, particularly if risk factors are present for each type of wound (for example immobility and incontinence). A pressure ulcer is likely to be located on the bony prominences of sacrum or ischial tuberosity (sitting bones) with a regular shape, and MASD is likely to be located within natal cleft (in between buttocks) with an irregular and sometimes ‘mirrored’ shape.

Staff must access the Trust Assessment, Prevention and Management of Pressure Ulcers Procedure for further information on pressure ulcers to ensure the wound is correctly identified, as this will directly impact upon the management plan. If staff require support with this a referral can be made to the Tissue Viability Team.

5.3 Categorising MASD

The Skin Moisture Alert Reporting Tool (SMART) (Medicare Plus, 2019 [online]), which is recognised and endorsed by NICE, 2019 [online], categorises MASD dependent on the severity of skin damage. Correct identification is integral to the implementation of appropriate management (as discussed in section 5.3). As per SMART, MASD categories are as follows:

Category	Description
Mild	• Erythema to affected skin • All affected skin remains intact with no open wounds, but is at risk of breaking down
Moderate	• Erythema to affected skin • Less than 50% of the affected skin is 'open' • Area may have some exudate and/or bleeding
Severe	• Erythema to affected skin • More than 50% of the affected skin is 'open' • Area is likely to have exudate and/or bleeding
Open wounds caused by MASD will always be superficial in depth with granular tissue to the wound bed. If the wound depth becomes full thickness, or wound develops slough and/or necrosis, this indicates another contributing factor (such as pressure) and can no longer be classed as 'only' MASD. For further guidance on tissue types please refer to the Trust Tissue Viability Policy, available via the Trust intranet.	

5.4 Management of MASD

The management of MASD will include management of the source of moisture in accordance with the cause, and the use of barrier products in accordance with the category. The management of MASD is discussed below.

Any management plan that is being implemented must be clearly documented within a patient's electronic patient record, and this management plan must be handed over to all staff involved in their care.

It is important to acknowledge the patient's personal preferences and wishes. Wherever possible these preferences need to be considered to promote collaborative decision making, privacy and dignity, and also, to prevent iatrogenic harm.

Further information can be obtained from the Consent to Examination or Treatment Policy, the Privacy and Dignity Policy, and also the Tissue Viability page via the Trust intranet.

5.4.1 Incontinence Associated MASD Management

Patients experiencing incontinence must be offered continence products to contain and manage the moisture exposed to their skin, either in the short term whilst awaiting specialist assessment or long term if all other treatment options have been explored (NICE, 2019 [online], NICE, 2007 [online]). Further guidance on incontinence product selection can be found within the Adult Incontinence Care Advice and Support Protocol, available via the Trust intranet. If a patient is experiencing prolonged incontinence that is not likely to resolve (for example incontinence secondary to an acute infection that may improve as the infection is treated), then they must be referred to appropriate continence services for further assessment as per the above-mentioned protocol.

Patients experiencing incontinence associated MASD must be supported to meet their personal hygiene needs. If a patient can do so independently, staff must support them by prompting regular, good hygiene, and by ensuring appropriate products are available. If a patient is unable to do so independently, staff must offer as much assistance as is required. Skin should be cleansed after every episode of incontinence using a pH balanced cleanser with warm water; within TEWV staff must use Hydromol as a soap substitute. Skin should be thoroughly, but gently dried using patting motions, to ensure removal of all moisture in a way that prevents further trauma to skin.

A barrier product must be applied to the affected area of skin. As per the SMART, the choice of product will be dependent on the category of MASD as below.

Incontinence associated MASD management table:

Category of skin damage	Management
Mild skin damage	Apply a barrier cream after every third cleanse/toileting, or twice a day
Moderate skin damage	Apply a barrier film once a day (not after every cleanse/toileting)
Severe skin damage	Apply a barrier ointment at every cleanse/toileting

A dressing should not be applied to incontinence associated MASD, as doing so would increase moisture to the area thereby worsening the problem.

5.4.2 Intertriginous MASD Management

Patients experiencing intertrigo must be supported to meet their personal hygiene needs. If a patient can do so independently, staff must support them by prompting regular, good hygiene, and by ensuring appropriate products are available. If a patient is unable to do so independently, staff must offer as much assistance as is required. Skin should be cleansed at least once a day using a pH balanced cleanser with warm water; within TEWV staff must use Hydromol as a soap substitute. Skin should be thoroughly but gently dried using patting motions, to ensure removal of all moisture in a way that prevents further trauma to skin.

A barrier product must be applied to the affected area of skin. As per the SMART, the choice of product will be dependent on the category of MASD as below.

Intertriginous MASD management table:

Category of skin damage	Management
Mild skin damage	No barrier product warranted, implement good skin hygiene
Moderate skin damage	Apply a barrier film once a day (not after every cleanse/toileting)
Severe skin damage	Apply a barrier ointment at every cleanse/toileting

A dressing should not be applied to intertrigo, as doing so would increase moisture to the area thereby worsening the problem.

Although it does not fit within any of the four commonly used causes under the MASD umbrella term, excess saliva if left on the skin can also be a cause of MASD. Hypersalivation is something that may affect patients accessing TEWV NHS Foundation Trust Services, therefore staff must be vigilant to monitor for any skin deterioration associated with this.

If MASD associated with excess saliva is noted, this should be managed in the same way as intertriginous MASD (see above).

5.4.3 Peristomal MASD Management

Staff supporting patients experiencing peristomal MASD must seek advice from specialist stoma services, to ensure appropriate stoma products are being used to reduce the moisture exposed to their skin. Guidance can be found within the Stoma Care Advice and Support Protocol, available via the Trust intranet. Stoma products should be changed as per the patient's individual stoma care plan which should be established upon admission.

Patients experiencing peristomal MASD must be supported to meet their stoma care needs. If a patient can do so independently, staff must support them by prompting stoma care at an appropriate frequency, ensuring appropriate products are available. If a patient is unable to do so independently, staff must offer as much assistance as is required. Peristomal skin should be cleansed with warm water at every pouch change. Skin should be thoroughly but gently dried using patting motions, to ensure removal of all moisture in a way that prevents further trauma to skin.

A barrier product must be applied to the affected area of skin. As per the SMART, for peristomal MASD **a barrier film should always be used**. Apply a barrier film at each stoma pouch change (note only apply once a day if pouch being changed more often). This will prevent adherence of stoma pouches from being impaired. Staff should also consider potential skin damage from removal of adhesive stoma products, and if this is suspected should use an adhesive remover spray which is available to order via Cardea.

5.4.4 Periwound MASD Management

Staff supporting patients experiencing periwound MASD must ensure an appropriate wound care plan is in place to manage wound exudate, including appropriate dressing change frequency, wound cleansing and dressing selection. Wound care advice can be found within the Tissue Viability Policy, and guidance on dressing selection can be found within the dressings formulary, accessible via the Tissue Viability page on the Trust intranet. If staff

feel further support and advice is needed to manage wound exudate, they must refer to the Tissue Viability Team for specialist wound care advice.

A barrier product must be applied to the affected area of skin. As per the SMART, the choice of product will be dependent on the category of MASD as below.

Periwound MASD management table

Category of skin damage	Management
Mild skin damage	No barrier product warranted, implement appropriate wound and periwound cleansing
Moderate skin damage	Apply a barrier film at each dressing change (only apply once a day if dressing being changed more often)
Severe skin damage	Apply a barrier film at each dressing change (barrier ointment not indicated in periwound MASD)

5.5 Prevention of MASD

It is important for staff to recognise patients who are at risk of developing MASD so that interventions can be implemented to prevent skin damage occurring. This will involve management of, and if possible, the reduction of the exposure of moisture to the skin. Some examples of patients at risk of developing MASD may include (but are not limited to):

- Patients who experience incontinence
- Patients with a highly exuding wound
- Patients with areas of skin in contact with each other, i.e. skin folds, joint contractures e.g. hand contractures
- Patients experiencing difficulty with their stoma i.e. leakage from pouch
- Patients experiencing hypersalivation

Patients at risk of developing MASD must be supported to implement effective moisture management/reduction and good levels of skin hygiene.

5.6 Repositioning

MASD is not caused by pressure, however many patients will have risk factors for both MASD and pressure ulcer development. Also, if a person is experiencing MASD then

prolonged pressure to the area may contribute to wound deterioration and will delay wound healing. Subsequently repositioning is important, and the following must be considered:

- Patients, where possible, should be encouraged to reposition independently and redistribute their own weight.
- If a patient is unable to reposition independently, healthcare professionals should assist the patient to prevent the development of pressure ulcers and/or other wound deterioration associated with pressure. Care should be taken to ensure that when repositioning a patient, that the effect of shear and friction forces are reduced by using, if needed, appropriate equipment (e.g. slide sheet, hoist). Staff must be trained and competent in the use of any equipment. Correct moving and handling practices should be undertaken when repositioning patients. Further guidance on manual handling techniques can be found within the Trust Manual Handling of People Procedure (accessible via the Trust intranet).
- Repositioning of the patient should be undertaken in a way that minimises the pressure on bony prominences and any existing wounds. For example, pillows can be used effectively to relieve pressure from the heels by placing underneath the calf to raise the heels from the surface below or alternatively, pillows can be used behind a person's back to support them to lay at a 30-degree tilt.
- A repositioning schedule should be agreed with the patient and documented within their electronic patient record, including frequency of recommended repositioning.
- A positional change chart (appendix 5) must be used if a patient requires assistance with repositioning.
- When a patient is repositioned, any areas of erythema or skin damage must be documented on the positional change chart (appendix 5), a body map (appendix 3) and also, on the electronic patient record.
- If a patient declines to reposition, this must be clearly documented on their electronic patient record. It may not always be possible to reposition patients because of their medical condition but this should be clearly documented. If the issue relates to pain management, then this must be addressed in order to promote concordance. Staff must clearly document any advice given to the patient regarding repositioning and the potential risks for the patient in declining such care.
- Patients who spend a significant amount of time seated should have their seating and sitting assessed by a trained assessor who has specific knowledge and expertise i.e. Physiotherapists/Occupational Therapists.
- Further guidance on repositioning can be found within the Trust Assessment, Prevention and Management of Pressure Ulcers Procedure (accessible via the Trust intranet).

5.7 Reporting of MASD

All incidences of MASD must be reported via the Trust's incident reporting system and documented within the patient's electronic patient record. It must be stated whether this was present upon admission, developed whilst the patient was accessing our services, or present on transfer from another care setting i.e. acute hospital or nursing home.

All MASD incidents will be reviewed by the Tissue Viability Team, and if required the team will contact to arrange further assessment. Patients who are experiencing MASD do not need an automatic referral to the Tissue Viability Team unless there are concerns or advice is required. If there is an immediate concern regarding a patient who has MASD, for example a patient who has signs of systemic infection, then urgent assessment should be sought via a Medic, inpatient Physical Healthcare Practitioner or by transfer to local acute Trust.

All incidences of MASD must be reported via the Trust's incident reporting system.

6 Definitions

Term	Definition
MASD	• Moisture Associated Skin Damage
TEWV	• Tees, Esk and Wear Valleys Trust
SMART	• Skin Moisture Alert Reporting Tool
WREN Training	• Wound Resource Education Nurse Training

7 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.
- Each team/ward manager will ensure that staffs training needs are met in accordance with the Trust's training needs analysis.
- Each healthcare professional is responsible for their own professional development and an individual's needs should be addressed through appraisal and training needs analysis.
- An education programme, which incorporates wound care and MASD, is available for all healthcare professionals. Staff to contact the Tissue Viability Team if required.
- Patients and their relatives/carers who are able and willing should be educated about risk assessment and prevention strategies.

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Open to all Registered Healthcare Professionals with an interest in Tissue Viability	Face to face as part of WREN programme	3 x full day training days which incorporates various topics i.e. pressure ulcer prevention, MASD, self harm and burns.	Annually as part of a rolling programme
Open to all Nursing Support Staff with an interest in Tissue Viability	Face to face as part of WREN programme	3 x full day training days which incorporates various topics i.e. pressure ulcer prevention, MASD, self harm and burns.	Annually as part of a rolling programme

8 How the implementation of this procedure will be monitored

	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Tissue Viability Ad Hoc Review and Spot Checks	Tissue Viability Team	The Fundamental Standards of Holistic Care, Clinical Advisory Group
2	Waterlow Pressure Ulcer Risk Assessment	Tissue Viability Team	The Fundamental Standards of Holistic Care, Clinical Advisory Group

9 References

Gray, Mikel et al (2011). Moisture-Associated Skin Damage. *Journal of Wound, Ostomy and Continence Nursing*. 38(3), pp.233-241.

Medicare Plus (2019) Skin Moisture Alert Reporting Tool [online] https://www.medicareplus.co.uk/resources/details/skin-moisture-alert-reporting-tool [Accessed 9th May 2022]

NHS England (2019) The NHS Long Term Plan (LTP) [online] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [Accessed 27th April 2022]

NICE (2007) Faecal incontinence in adults: management [online] https://www.nice.org.uk/guidance/cg49 [Accessed 4th May 2022]

NICE (2019) Endorsed resource – S.M.A.R.T (Skin Moisture Alert Reporting Tool) [online] https://www.nice.org.uk/guidance/cg49/resources/endorsed-resource-s.m.a.r.t-skin-moisture-alert-reporting-tool-7022579437 [Accessed 9th May 2022]

NICE (2019) Urinary incontinence and pelvic organ prolapse in women: management [online] https://www.nice.org.uk/guidance/ng123 [Accessed 4th May 2022]

Wounds International (2020) International Best Practice Recommendations. Preventions and Management of Moisture-Associated Skin Damage (MASD). Recommendations From and Expert Working Group. https://www.woundsinternational.com/resources/details/best-practice-recommendations-prevention-and-management-moisture-associated-skin-damage-masd [accessed 9th May 2022]

Young, T (2017) Back to basics: understanding moisture-associated skin damage. *Wounds UK,* 13(2) https://www.wounds-uk.com/journals/issue/450/article-details/back-basics-understanding-moisture-associated-skin-damage [Accessed 9th May 2022]

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	02 April 2025
Next review date	02 April 2028
This document replaces	CLIN-0094-005-v1 Moisture Associate Skin Damage procedure
This document was approved by	The Fundamental Standards of Holistic Care, Clinical Advisory Group
This document was approved	02 April 2025
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	07 March 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	31 May 2022	New document	Withdrawn
2	02 April 2025	Full review and update - Update to section 4: Related Documents - Removal of appendix 5 - Waterlow Pressure Ulcer Risk Assessment Interventions Protocol - Removal of appendix 6 - Moisture Associated Skin Damage Management – Quick Reference Guide - Removal of appendix 7 - Adult Incontinence Care Advice and Support Protocol - Removal of appendix 8 - Stoma Care Advice and Support Protocol	Approved

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance
Title	Assessment, Prevention and Management of Moisture Associated Skin Damage
Type	Procedure
Geographical area covered	Trust Wide
Aims and objectives	To support clinical staff in the assessment, prevention and management of moisture associated skin damage.
Start date of Equality Analysis Screening	07/03/2025
End date of Equality Analysis Screening	07/03/2025

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Trust staff and patients.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO**

	• **Veterans** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	Skin damage can have a number of causes, some relating to the individual patient who may be unwell. It is acknowledged and recognised that not all skin damage can be prevented, and patients should be reviewed on an individual basis taking into account the risk factors for that patient and their protected characteristics. Skin damage may also be caused by external factors such as poor nursing care, lack of resources e.g. equipment and staffing. Neglect may be considered for those vulnerable patients with MASD however not all incidences of MASD are caused by neglect. Neglect violates fundamental human rights. Public authorities such as the NHS have a duty to protect individuals from neglect. Through implementing this procedure, the Trust will take measures and intervene if they believe someone is at harm due to neglect.
Describe any positive impacts	The positive impacts of this procedure are that patients who have or are at risk of developing moisture associated skin damage will receive safe, effective and appropriate individualised care which takes into consideration a patient's protected characteristics.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Research NICE guidance (see section 9 for references used within document)
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	This procedure has been discussed with the Fundamental Standards of Holistic Care Clinical Assurance Group who support patients from a range of protected characteristics on a daily basis.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	N/A

Section 4	**Training needs**

As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/A
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	Procedure
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	N/A	
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	N/A	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	

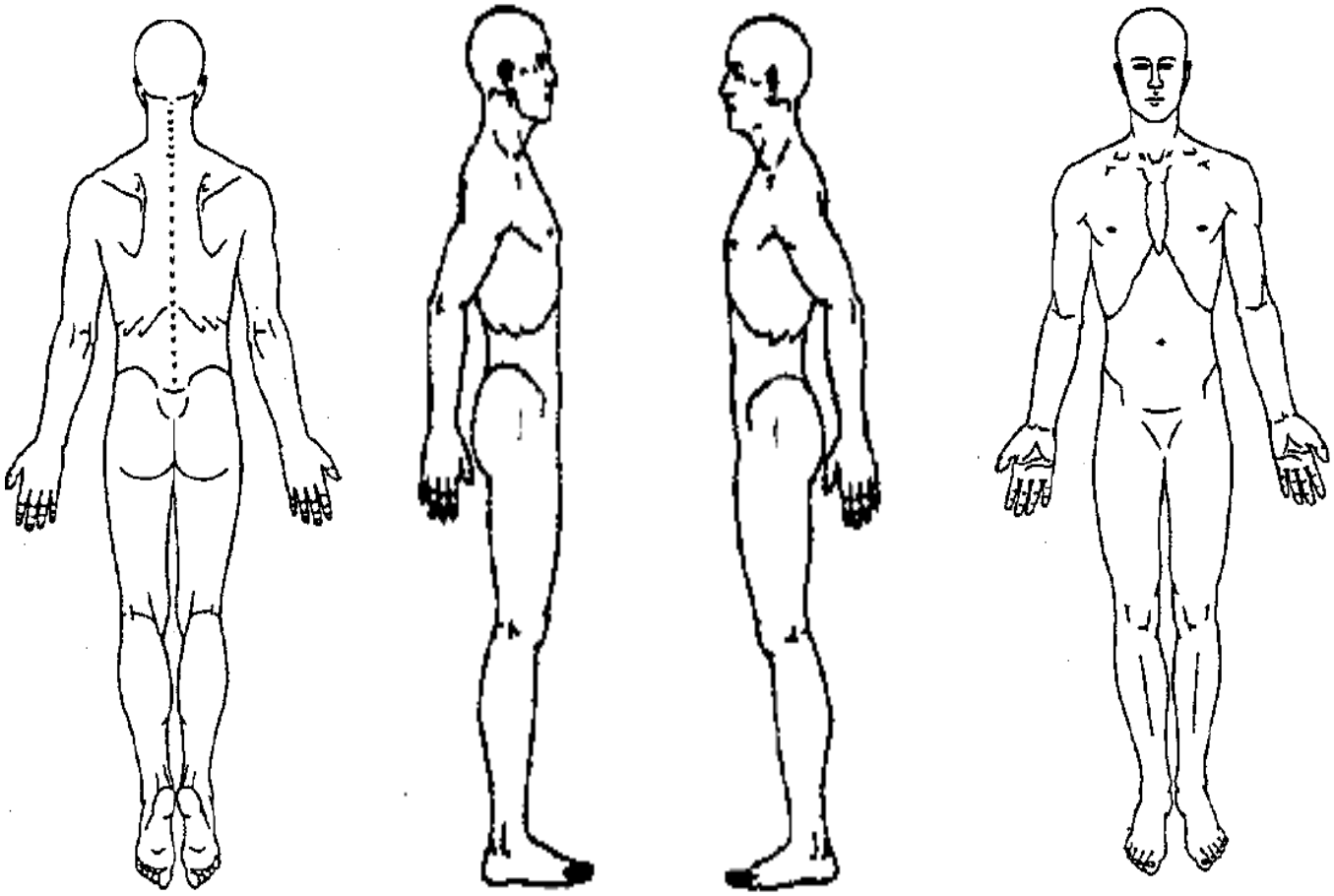
	Title of document being reviewed:	Yes/No/ Not applicable	Comments
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	10/04/2025.ah
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	The Fundamental Standards of Holistic Care Clinical Advisory Group
10.	**Publication**		
	Has the document been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 – Body Map Skin Integrity Assessment Sheet

Body Map Skin Integrity Assessment Sheet

Patient Name:	PARIS ID Number:
Completed by:	Designation:

Please see diagram to illustrate location of any skin damage including pressure ulcers, abrasions, rashes, wounds and red/darkened areas



The body map skin integrity assessment sheet should be completed in conjunction with the advice and guidance outlined in the relevant policy and/or procedure (Skin Tear Prevention and Management Procedure, Tissue Viability Policy and the Assessment, Prevention and Management of Pressure Ulcers Procedure)

Appendix 4 – Waterlow Pressure Ulcer Risk Assessment

WATERLOW CONTINUOUS ASSESSMENT CHART									
SEVERAL SCORES PER CATEGORY CAN BE CALCULATED					ID LABEL				
Categories			Date	Date	Date	Date	Date	Date	Date
Body Mass Index (kg/m²)		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Average	20-24.9	**0**							
Above Average	25-29.9	**1**							
Obese	>30	**2**							
Below Average	<20	**3**							
Continence		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Complete/Catheterised		**0**							
Incontinence of urine		**1**							
Incontinent of faeces		**2**							
Doubly incontinent		**3**							
Mobility		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Fully mobile		**0**							
Restless/Fidgety		**1**							
Apathetic		**2**							
Restricted		**3**							
Bed bound		**4**							
Chair Bound		**5**							
Nutrition **A – Has patient lost weight recently**									
Yes	**Go to B**								
No	**Go to C**								
Unsure	**Go to C and score 2**	**2**							
B – Weight Loss Score		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
0.5 – 5kg		**1**							
5 – 10kg		**2**							
10 – 15kg		**3**							
>15kg		**4**							
Unsure		**2**							
C – Patient eating poorly or lack of appetite		**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
No		**0**							
Yes		**1**							

Categories		Date	Date	Date	Date	Date	Date	Date
Skin type visual risk areas	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Healthy	**0**							
Tissue Paper	**1**							
Dry	**1**							
Oedematous	**1**							
Clammy/pyrexia	**1**							
Discoloured – stage 1	**2**							
Pressure Ulcer – stage 2-4	**3**							
Sex/Age	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Male	**1**							
Female	**2**							
14 to 49	**1**							
50 to 64	**2**							
65 to 74	**3**							
75 to 80	**4**							
81 plus	**5**							
Tissue Malnutrition	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Eg terminal Cachexia	**8**							
Single Organ failure	**5**							
Multiple organ failure	**8**							
Peripheral vascular disease	**5**							
Anaemia (HB<8)	**2**							
Smoking	**1**							
Neurological deficit	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Diabetes	**4-6**							
Multiple Sclerosis	**4-6**							
Motor/sensory paraplegia	**4-6**							
Cerebro vascular accident	**4-6**							
Major surgery/Trauma	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
On table >2 hrs (past 48hrs)	**5**							
On table >6 hrs (past 48 hrs)	**8**							
Orthopaedic spinal	**5**							
Medication	**Scores**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Cytotoxics	**Max 4**							
Steroids (Long term high dose)	**Max 4**							
Anti-inflammatory	**Max 4**							
Total								
Risk Category **10+ At risk** **15+ High Risk** **20+ Very high risk**								
Signature								

Appendix 5 – Positional Change Chart

Positional Change Chart

PATIENT NAME:	HOSPITAL NUMBER:
WARD	PLAN- FREQUENCY OF POSITIONAL CHANGES AS PER CARE PLAN

Date & Time	Time position changed	Patient position	Skin condition	SIGNED