WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2021 / 14
Date of Issue:	1st April 2021

Welsh Health Circular / Official Letter: N/A	**Subject:** Digitisation of Nursing Documentation – Purpose T Pressure Ulcer Risk Assessment
Sponsor: Jean White, Chief Nursing Officer, Welsh Government Claire Bevan, Senior Responsible Officer / Director of Quality, Safety, Patient Experience & Nursing, Welsh Ambulance Services NHS Trust	
Implementation Date: March 2021	

DATA STANDARD CHANGE NOTICE

A Data Standard Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) at its meeting on 18th March 2021.

WISB Reference: ISRN 2019 / 010

Summary: The introduction of a standardised digital Skin Risk Assessment to be used across the secondary care setting in Wales.

Applies to: This standard applies to all NHS Wales health boards and trusts that provide patient care in a secondary care setting.

Please address enquiries about this Data Standard Change Notice to the Data Standards Team in NHS Wales Informatics Service

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The Welsh Information Standards Board is responsible for appraising information standards. Submission documents and WISB Outcomes relating to the approval of this standard can be found at:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA STANDARD CHANGE NOTICE

Introduction

The Digitisation of Nursing Documentation project has been established with a view to delivering standardised agreed electronic nursing documentation, in support of Work stream 2 of the Prudent Healthcare Strategy. The project's first phase has been funded by the Welsh Government Efficiency Through Technology Fund (ETTF) with the aim of making an agreed first tranche of digitised nursing documents available nationally by November 2019.

One of the key success factors of the digitisation of nursing documents will be to collaboratively define and develop information data standards and patient level data that will inform current and future system developments. This will include learning from existing e-nursing documents projects and pilots across Wales. This will provide one standard set of assessments and documents with the potential to provide safe and effective care to the population of Wales irrespective of location, and improve patient, carer and staff experience. The aim is to release nurses from the administrative burden of completing paper-nursing documents to spend more time on direct patient care.

Nursing colleagues, from across all NHS Wales health boards and trusts, have identified the first set of nursing documents to be digitised for secondary care settings. Prioritised documents have been determined on where the greatest value is perceived to be attributed to patient care and nursing time.

Included in the first set of documents to be developed digitally is an All Wales Purpose T Pressure Ulcer Risk Assessment. This DSCN mandates the data fields and associated definitions to be collected as part of the continence assessment.

Scope

The digitised Pressure Ulcer Risk Assessment will be implemented across all NHS Wales health boards and trusts that provide patient care in a secondary care setting.

Developing e-nursing- documents for primary and community care settings are not in scope as these are in scope for existing programmes. The project will work closely with these programmes to ensure a consistent use of national information standards.

Actions

Local Health Boards / Trusts:

- Ensure that local processes and systems have been updated to comply with the standard set out in the Information Specification within this DSCN.

NHS Wales Informatics Service:

- Ensure that all national systems have been updated to comply with the standard set out in the Information Specification within this DSCN.

SPECIFICATION

Information Specification

The table below lists the Data Items and corresponding definitions and values that make up the information standard mandated by this DSCN. Please refer to Appendix A at the end of this DSCN for a more detailed specification.

User Interface Name	Field Identifier	Definition	Data Value Format (code or other value)	Value Sets
Date of Assessment	Assessment_Date	This is the date the actual assessment was carried out with the patient	8 digit numeric, CCYYMMDD 6 digit numeric: hh:mm:ss	
Mobility status - tick all applicable	Mobility_status	This is to indicate the patients current mobility status	n1	1 - Needs the help of another person to walk 2 - Spends all or the majority of time in bed or chair 3 - Remains in the same position for long periods 4 - Walks independently with or without walking aids
Skin Status - tick all applicable	Skin_status	This is to indicate the patients current skin status	n1	1 - Current PU category 1 or above? 2 - Reported history or previous PU? 3 - Vulnerable skin 4 - Medical device causing pressure/shear at skin site e.g. O, mask, NG tube 5 - Normal skin

Clinical Judgement - tick as applicable	Clinical_judgement	This is the clinical judgement of the patients condition	n1	1 - Conditions/treatments which significantly impact the patients PU risk e.g. poor perfusion, epidurals, oedema, steroids 2 - No problem
Frequency of position changes	Position_changes_frequency	This is to indicate the frequency of the patients position changes	n1	1 - Doesn't move 2 - Moves occasionally 3 - Moves frequently
Extent of all independent movement (Relief of all pressure areas)	Independent_movement_extent	This is to indicate the extent of the patient independent movement	n1	1 - Doesn't move 2 - Slight position changes 3 - Major position changes
Sensory perception and response - tick as applicable	Sensory_perception_response	This is to indicate the patients sensory perception and response	n1	1 - No problem 2 - 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	Moisture	This is to indicate if any moisture in said form on the skin	n1	1 - No problem / occasional 2 - Frequent (2-4 times a day) 3 – Constant
Perfusion - tick all applicable	Perfusion	Defined as the passage of a fluid through the circulatory system. The question indicates if there are any identified issues related to perfusion	n1	1 - No problem 2 - Conditions affecting central circulation e.g. shock, heart failure, hypotension 3 - Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease
Nutrition - tick all applicable	Nutrition	This is to indicate the patients current nutrition status	n1	1 - No problem 2 - Unplanned weight loss 3 - Poor nutritional intake

				4 - Low BMI (less than 18.5) 5 - High BMI (30 or more)
Medical device - tick as applicable	Medical_device	This is to indicate if a medical device affects the skin in relation to shearing and pressure damage	n1	1 - No problem 2 - Medical device causing pressure/shear at skin site e.g. O2, mask, NG tube
Diabetes - tick as applicable	Diabetes	This is to indicate whether or not the patient is diabetic	n1	1 - Not diabetic 2 – Diabetic
Previous PU history - tick as applicable	PU_history	This is to indicate the patients pressure ulcer history	n1	1 - No known PU history 2 - PU - History (complete below)
Scar	PU_scar	This is to indicate whether the pressure ulcer scarred the patient		
No scar	PU_no_scar	This is to confirm that there was no scar from the pressure ulcer		
Skin site	Skin_site	This is to indicate which skin site the patient has pain	n1	1 - Sacrum 2 - L Buttock 3 - R Buttock 4 - L Ischial 5 - R Ischial 6 - L Hip 7 - R Hip 8 - L Heel 9 - R Heel 10 - L Ankle 11 - R Ankle 12 - L Elbow 13 - R Elbow
Pain	Pain_present	This is to indicate whether there is pain is present in any skin site		

Vulnerable skin	Vulnerable_skin	This is to indicate if the patient has vulnerable skin		
PU Category	PU_category	This is to indicate which category the patients pressure ulcer is		
Normal Skin	Normal_skin	This is to indicate that the patient has normal skin		

Appendix

Purpose T Pressure Ulcer Risk Assessment - Specification