Pressure Ulcer Prevention and Management Policy

POLICY

Reference	CPG-TW-PUP&MP		
Approving Body	Harms Free Operational Group		
Date Approved	14th October 2021		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	25th October 2021		
Version	v4.0		
Summary of Changes from Previous Version	Minimal Changes made to policy in line with • Trust changes to reporting groups • Changes to Trust monitoring and Audit systems • Changes to Champion system • National guidance on reporting of PU which are Avoidable / Unavoidable (no lapses in care)		
Supersedes	v3.0, Issued 28th February 2018 to Review Date October 2021 (ext2)		
Document Category	• Clinical		
Consultation Undertaken	• Nursing, Midwifery & AHP Committee • Deputy Chief Nurse		
Date of Completion of Equality Impact Assessment	October 2021		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	No legal requirements to have this policy but provided to promote consistent high level safe care for patients and to prevent harm. Also based on national/ NICE guidance recommendations.		
Target Audience	Trustwide		
Review Date	October 2024		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Stephanie Anstess – Nurse Consultant Tissue Viability		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Nursing/ Tissue Viability Team		
Position of Person able to provide Further Guidance/Information	Tissue Viability Nurse Consultant Tissue Viability Lead Nurse		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
• Pressure Ulcer Prevention and Management Generic Guideline • Pressure Ulcer Prevention and Management in Maternity SOP • Pressure Ulcer Pathway (PUP) – including PURPOSE-T	*Reviewed and updated alongside this policy, October 2021* *Reviewed and updated alongside this policy, October 2021* *January 2019, currently being reviewed and updated*
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

Pressure Ulcers (PUs) have a substantial impact on the health-related quality of life of patients. Most are considered to be preventable and there is a clear link between pressure ulcers and vulnerable adults. There is also a significant impact of the financial burden on the health service, patients and their families. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016 and treating pressure damage costs the NHS more than £3.8 million every day (NHS England/Improvement, 2020) The National Institute for Health and Clinical Excellence (NICE 2014; 2015) identify that healthcare organisations should have an integrated approach to the management of PUs, with a clear strategy which is supported by senior management. Care should be delivered in a context of continuous quality improvements where improvements are the subject of regular feedback and audit within the clinical governance framework.

2.0 POLICY STATEMENT

The purpose of this policy is to provide staff within the Sherwood Forest Hospitals NHS Foundation Trust, standards, requirements and processes for effective pressure ulcer prevention and management.

The Generic Pressure Ulcer Pathway is evidence based and also provides the standards, requirements and processes based in this policy. If the pathway is followed correctly in theory patients should not develop avoidable hospital acquired pressure ulcers. This policy also describes the accountability framework for Pressure Area Management within Sherwood Forest Hospitals NHS Foundation Trust.

This clinical document applies to:

Staff group(s)

- All registered and non–registered clinical staff involved in providing care for patients at risk of or who have existing PUs (Including AHPs).
- Non-clinical staff e.g. The Mattress Team, Medirest, Medical Equipment Management Department, Clinical Illustration etc.

Clinical area(s)

- All clinical areas, both in and out patients across the Trust, where patients may be at risk of PUs or at risk of existing PUs deteriorating. This includes all ward and departments including the Emergency Department (ED), theatres, X- ray, cardiac catheter suite, discharge lounge, Kings Mill Treatment Centre, Welcome Treatment Centre etc.
- All hospital sites – King's Mill Hospital, Newark Hospital and Mansfield Community Hospital.
- Clinical teams should work in conjunction with external clinical providers on Trust sites, for example the Renal Unit.

Patient group(s)

- All patients across the Trust who are at risk of developing PUs or have existing pressure damage.
- **For additional specific advice for Maternity, Paediatrics and the ED , please see the Standard Operating Procedures within the appendices.**

Exclusions

- Patients may be at risk within all patient groups, therefore there are no exclusions.

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Definitions

'The Trust':	The Sherwood Forest Hospitals NHS Foundation Trust i.e. King's Mill Hospital, Mansfield Hospital and Newark Hospital.
'Staff':	All employees of the Trust including those managed by a third party organisation on behalf of the Trust.
'Pressure Ulcer':	A pressure ulcer is an area of localised damage to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear. (European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel 2009.
'PURPOSE-T'	Pressure Ulcer Risk Primary or Secondary Evaluation Tool.

INTERNATIONAL NPUAP AND EPUAP (2009) PRESSURE ULCER CLASSIFICATION SYSTEM 2009		
SUPERFICIAL PRESSURE ULCERS	**Category 1**	**Non – blanching erythema**
		Unbroken skin with non-blanching redness of a localised area, usually over a bony prominence. *NB Darkly pigmented skin may not have a visible blanching, therefore category 1s can be difficult to detect. Other signs should be monitored including pain, change in normal skin colour, soft / firm skin, increased warmth and bluish tinge.*
	Category 2	**Partial thickness**
		Loss of epidermis and partial thickness loss of dermis presents as a shallow ulcer with a red wound bed. It may also present as a ruptured or intact blister. *NB This term should not be used to describe moisture lesions, excoriation, or skin stripping caused by dressings.*

DEEP PRESSURE ULCERS	**Category 3**	**Full thickness skin loss**
		Full thickness skin loss. Subcutaneous fat may be visible but tendon, muscle and bone are **not.** If the pressure ulcer is over a deep layer of fat, a category 3 can present as extensive soft tissue damage including undermining and tunnelling. In contrast if the damage is in an area with little or no subcutaneous fat then a category 3 can be very shallow.
	Category 4	**Full thickness tissue loss**
		Full thickness loss with exposed bone, tendon or muscle and often includes undermining and tunnelling. It can also extend into supporting structures e.g. the joint capsule. Where bone is present there is a risk of osteomyelitis. Where structures have little or no adipose tissue the ulcer may appear shallow.
UNKNOWN DEPTH	**Suspected Deep Tissue Injury**	**Purple or maroon localised area of discoloured unbroken skin.**
		This is often the appearance of newly acquired deep pressure ulcer (Category 3 or 4) and can be mistaken for a bruise. As the skin damage evolves the damage can be ascertained and the pressure ulcer category.

Definition of a hospital acquired PU

- A hospital acquired pressure ulcer is damage that occurs whilst the patient receives care from the Trust as an inpatient.

Avoidable PUs and PUs that have developed despite no lapses in care (Previously called Unavoidable PUs)

NHS improvement (2018) recommend that all pressure ulcers are investigated to support organisational learning and appropriate actions

Avoidable Pressure Ulcer: For a pressure ulcer to be considered avoidable the Registered Nurse (RN)/Registered Midwife (RM) did not do one or more of the following:

- Evaluate the patient's clinical condition and pressure ulcer risk factors.
- Plan and implement interventions that are consistent with the patient's needs and goals, and recognised standards of practice.
- Monitor and evaluate the impact of the interventions, and revise the interventions as appropriate.

An 'Unavoidable' Pressure Ulcer is a PU that has developed despite no lapses in care:

- The patient developed a pressure ulcer even though the patient's clinical condition and pressure ulcer risk factors had been evaluated.

- Appropriate goals and recognised standards of care that are consistent with individualised needs have been implemented.
- The impact of the care had been monitored, evaluated and recorded and the approaches revised as appropriate.

Other 'Unavoidable' Criteria:

- Patients who are non-concordant following full explanation of the risks of PUs and with negotiation of care with the patient, family and carers.
- Patients with conditions such as peripheral vascular disease, or at the end stage of life where skin failure is apparent may develop PUs despite all the appropriate care. Critically ill patients with haemodynamic or spinal instability may preclude repositioning which could also lead to unavoidable Pus.
- Unavoidable pressure damage is also possible where a patient has lost consciousness or has fallen and unable to reposition themselves, prior to admission.

3.2 Abbreviations

- PUP Pressure Ulcer Pathway
- WCP Wound Care Pathway
- SDTI Suspected deep tissue injury
- TVT Tissue viability team
- TVNC Tissue viability nurse consultant
- TVLN Tissue viability lead nurse
- TVN Tissue viability nurse
- RN Registered nurse
- RM Registered midwife

4.0 ROLES AND RESPONSIBILITIES

It is the role of the Trust Board to ensure that Pressure Area Management is a core element of the organisation's Patient Safety and Quality Board and that appropriate equipment is available within the Trust. All employees working in clinical areas have an individual responsibility to maintain knowledge of the basic principles of pressure ulcer prevention and treatment and adhere to the pressure area management policy.

4.1 Nominated leads for pressure ulcer prevention and treatment:

Chief Nurse

- Has overall responsibility for ensuring that the Trust has clear processes for managing risks associated with the prevention and management of PUs.
- Ensures that appropriate arrangements to enable safe and effective care and that employees are fully aware of their statutory, organisational and professional responsibilities and that these are fulfilled.

Deputy Chief Nurse

- Is responsible for providing senior management support and day to day leadership for the prevention and management of PUs within the organisation. The Deputy Chief Nurse will ensure that senior management receive regular information and reports to inform decision-making and to provide assurance that this policy is being implemented across the organisation.

Tissue Viability Nurse Consultant/Tissue Viability Lead Nurse

- Has Trust wide responsibility for the development of strategies and policies for the prevention and treatment of PUs.
- Is responsible for the provision of expert advice regarding pressure ulcer prevention and treatment.
- Will provide an overview role in the Root Cause Analysis (RCA) investigation process for all hospital acquired pressure ulcers (excluding category 1 pressure damage) in line with the Trust's Incident Reporting Policy and Procedure. g-ir01-incident-reporting-policy-v63-march-2020-ext-to-sept-21.pdf(sfh-tr.nhs.uk)
- Including serious incidents. Will produce an analysis of themes and trends of hospital acquired (avoidable) PUs and plan appropriate actions / strategies to prevent future harm.
- Will support a robust system with a clear audit trail for validating and recording pressure ulcer data.
- Will maintain and monitor the PU tracker and liaise with ward and department leads to ensure that actions are evidenced to provide assurance in relation to learning from incidents
- Complete own actions from hospital acquired PU investigations, and provide evidence onto the PU Governance Tracker.
- Will confirm and challenge the RCA process for category 2 - 4 Pus alongside the Pressure Ulcer RCA Panel group.

The Harms Free Operational Group

- Will ensure the Trust achieves all local and national performance targets set for the reduction of hospital acquired PUs.
- Will ensure the pressure ulcer reduction plan remains a high priority on the quality agenda.
- Will monitor the pressure ulcer incidence data against internal and external targets and benchmark the Trust's performance.
- Will monitor ward/division compliance with processes and policies via monthly ward reports.
- Will review themes and trends for avoidable hospital acquired PUs.
- Will provide assurance to the Trust that there is a process of continued improvement and shared learning.
- Will provide timely and proactive support to appropriate staff groups to ensure a reduction in avoidable PUs by sharing learning from incidents to prevent future harm.

The Tissue Viability Team (TVT)

- Provide evidence based expert advice, education and support to clinical staff.
- Monitor and validate all hospital acquired PUs across the trust.
- Support an active tissue viability/harms free champion network.
- Monitor themes and trends from root cause analysis of category 2 Pus and plan appropriate actions. This will include education strategies to support learning from incidents in order to prevent future harm to patients.
- Complete own actions from hospital acquired PU investigations, and provide evidence onto the PU Governance Tracker.

Matrons/Divisional Heads of Nursing

- Will ensure that the necessary management arrangements and structures are in place to support all employees to fulfil their obligations for pressure ulcer prevention and treatment.
- Are responsible for ensuring that this policy is implemented throughout their areas of management.
- Will be required to ensure that staff understand the expectations of them and are both competent and confident to implement the policy requirements.
- Will proactively monitor pressure area care outcomes and monitor the completion of action plans using the PU Governance Tracker.

Sisters/ Charge / Lead Nurses

- Are responsible for ensuring the staff in their services are aware and appropriately trained to deliver the standards within the policy.
- Will monitor and investigate TV incidents within their area.
- Will ensure staff under their management will have access to appropriate pressure relieving /reducing/off-loading equipment.
- Will ensure improvements are made to services where deficiencies are identified through audit or monitoring processes.
- Will support and guide the TV / Harms Free Champions to deliver objectives within their area.
- Ensure medical staff are informed of new hospital acquired PUs and new patients admitted with deep PUs into their care.
- Complete own actions from hospital acquired PU investigations, and provide evidence onto the PU Governance Tracker to demonstrate assurance of actions and improvements / monitoring of care

Consultant Medical Staff

- Responsible for ensuring that their teams are aware of this policy and provide collaborative multi-disciplinary working to ensure the policy is adhered to.
- Regularly review the wound and holistic wound management plan.

Tissue Viability / Harms Free Champions

- Will support their colleagues with initial clinical advice and support teams to identify patients who meet the criteria for referral to the TV team.
- Will disseminate all relevant pressure ulcer prevention and treatment information to staff within their work area.
- With the support of the Sister/Charge/Lead Nurse and Tissue Viability Nurses, they will ensure that all staff in their work environment are aware of and adhere to the Pressure Area Management Policies, Guidelines and Standard Operating Procedures.
- Will provide support to staff with the implementation of action plans from TV audit results, metrics or from hospital acquired PU investigation.

This policy is relevant to all Sherwood Forest Hospitals NHS Foundation Trust staff and staff employed through other agencies working on a temporary basis providing care for patients with regards to pressure ulcer management and prevention.

5.0 APPROVAL

Following consultation, this policy has been approved by the Trust's Harm Free Operating Group.

6.0 DOCUMENT REQUIREMENTS

6.1 PU Risk

There are three risk assessment tools used across the Trust:

1. **The Pressure Ulcer Risk, Primary or Secondary Evaluation Tool (PURPOSE-T)** is the pressure area risk assessment tool for adult inpatients including maternity and should be completed within six hours of admission. The full PURPOSE-T can be found in the Pressure Ulcer Pathway (PUP). A PUP screening tool (Step 1. of the PURPOSE-T) can be used for maternity patients, out-patients attending departments for investigations and treatments, and surgical patients who are at a predicted risk for a maximum of 24 hours. Patients identified at risk of PUs will have a thorough head to toe skin assessment undertaken by the RN/RM and documented on a Pressure Ulcer Pathway (PUP).

Documents can be obtained:

Document Name	Hard Copies	Trust Forms Management System
Pressure Ulcer Pathway	Ward stationary supply	FKIN 030334
PURPOSE-T Screening Tool	Wards and departments stationary supply	FKIN 030109
Short Term Pressure Ulcer Pathway	Ward and departments stationary supply	FKIN 030336
EAU Short Term PUP	Department stationary supply	NA

2. **The GLAMORGAN ASSESSMENT TOOL** is the pressure area risk assessment tool for paediatric patients, and should be completed within 6 hours of admission by the RN/RM.

   Documents can be obtained:

Within the Paediatric Early Warning Score	Paediatric Ward stationary supply	NA

3. **The ANDERSON TOOL** is the pressure area risk assessment tool for adult patients in Resuscitation and Majors within ED and should be completed within two hours of arrival to the department.

Documents can be obtained:

Document Name	Paper Copies	Trust Forms Management System
ED Pressure Ulcer Pathway (Includes Anderson Tool)	ED stationary supply	NA

6.2 The Re-assessment of the Patient's PU risk

The pressure area risk should be re-evaluated by RN/RM in the following circumstances:

- On internal transfer between wards
- Following deterioration in pressure areas
- Following a significant change in the patients overall condition (improvement or deterioration) e.g. a patient with new increase in National Early Warning Score or a patient who has returned to their usual baseline following a period of immobility.
- Every week

The re-assessment will be recorded in the Pressure Ulcer Pathway (PUP), and the care plan and equipment will be updated as necessary and also recorded on the PUP.

6.3 Patients at risk of PUs or have existing PUs will have:

- A PUP for the treatment and prevention of PUs
- An individualised plan of care to reduce the risk of PUs, prevent deterioration and promote healing/comfort of existing PUs (record on the PUP), which will include:
  - Frequency of repositioning day and night
  - Pressure relieving equipment
  - Skin care regime
  - Heel off-loading regime
  - Concordance management
  - Any specific tissue viability needs

- Pressure relieving/reducing equipment and off-loading devices used in accordance with the Trust's Pressure Area Management Guideline and recorded on the PUP.
- An explanation and written information on pressure ulcer prevention and treatment which is also given to the family/carer as appropriate.
- Any changes to the care plan, including equipment recorded on the PUP.
- A Wound Care Pathway (WCP) and will include a holistic wound care assessment, and individualised plan of care for each wound, a record of each dressing change and wound evaluations.

6.4 Monitoring

- The RN/RM will complete a skin assessment a minimum of every 8 hours and record on the PUP.
- A skin assessment will also be completed and recorded at each re-position by a suitably trained health care provider. Non-registered health care providers will escalate any changes in skin condition immediately to the RN/RM
- Skin assessments will be undertaken at least daily of pressure areas under and around dressings, bandages, plaster casts, bodily worn devices and skin traction and more frequently if risk is identified. The frequency of checks should be specified on the care plan.
- Skin evaluations will be completed using the codes within the PUP. Where there is no evidence of pressure damage a code of 1 is used.
- Where there is evidence of pressure damage or deteriorating pressure damage (code of 2 -9) it must be reported to the RN/RM and recorded by the Health Care Support Worker in the PUP as soon as possible. The RN/RM must take appropriate action, which will include:
    - Reassess the patient using PURPOSE-T (adults), Glamorgan (paediatrics)
    - Review the care plan and increase the repositioning/ upgrade the equipment
    - Discuss with the patient/family/carers
    - Keep the patient off the affected area
    - Escalate to the Nurse in Charge
    - RN/RM to monitor the pressure areas at each reposition until the pressure damage has resolved and the code returns to 1
    - Where there is no improvement following review and change in care plan, and escalation and advise from Ward Nurses refer to the Tissue Viability Team

6.5 REPORTING AND REFERRALS OF PUs

Categories 1-4 and Suspected Deep Tissue Injuries (SDTIs)

- Report all PUs/SDTIs either from admission; transfer from another provider or on development within the Trust **within 24 hours on the Datix System.** Notification will be sent directly to the TVT for all hospital acquired PUs, and patients admitted with category 3 and 4 and SDTIs.

- The TVT assess all hospital acquired Category 2 PUs within a maximum of two working days, and both hospital acquired and inherited category 3/4 PUs and SDTIs within one working day.
- A rapid review of patients with hospital acquired G2-4 and SDTIs using the nursing and medical notes will be completed by the TVNC/ TV Lead Nurse, the Sister/Charge Nurse and Matron (or Deputy) to validate and confirm where possible the depth of the PU.
- Refer to the Clinical Illustration department for a photograph to be taken at the earliest opportunity, adhering to the Photography and Video Recording Policy and Policy for Consent to Examination, Treatment and Care. For category 3/4/SDTIs, photographs should be taken within 24 hours. Out of hours use either the camera in ED or refer to the Clinical Illustration where appropriate (i.e. when the patient has come to moderate or significant harm).
- Patients with a cluster of PUs or a deep PU need to be assessed for any evidence of omission of care or neglect and referred for the Multi-Agency Safeguarding Hub (MASH) as appropriate and the Trust's Safeguarding Team informed.
- Follow the Duty of Candour Policy where patients have developed a category 3/4/SDTI and have come to moderate or significant harm within the Trust.
- Immediately refer G3/4/SDTI's to the dietician for high protein/calorie diet.

6.6 INVESTIGATION OF HOSPITAL ACQUIRED PUs

Category 2

- All category 2 PUs will have a root cause analysis completed by the ward staff and overseen by the Matron and Tissue Viability Team.
- Where it is clear that there were no lapses of care identified within the investigation, by the Head of Nursing (HON)/TVNC or TVLN the details of the incident will be briefly discussed and recorded in the minutes of the PU Validation Panel Meeting.
- Where it is unclear if the PU was avoidable or not it will be presented by the author /Ward Leader to the PU Validation Panel Meeting, chaired by the Deputy Chief Nurse/ Head of Nursing, with the TVNC/TVLN, The Matron in attendance. The root cause will be identified with an agreed action plan where the PU is deemed avoidable. If no lapses in care are identified, good practice and any learning points will also be shared /actioned.
- Learning and good practice is to be shared with the Harms Free Meeting and items escalated to the Nursing, Midwifery and Allied health Professionals Committee. The TVLN will monitor the themes and trends for analysis and appropriate action.

Category 3 and 4 PUs and suspected deep tissue injuries or multiple superficial Pus

- A scoping report will be presented to the Divisional Scoping Meeting. The potential level of harm and the degree of learning will guide the meeting to the level of further escalation and investigation required.

- Where the level of harm is considered low, investigation and reporting will follow that required for a category 2 PU.
- Where the level of harm is considered moderate to serious the Divisional Scoping will escalate to the Trust Scoping Meeting where the decision will be made as to the level of investigation required. Divisional investigations will be recorded and monitored by the Governance Support Unit.
- If the PU meets or potentially meets the threshold of a serious incident it will be reported on Strategic Executive Information System (STEIS).

The Tissue Viability Society 2012 advises the criteria for serious harm are PUs that result in:

- Loss of limb
- Loss of life
- Requiring surgery for the PU e.g. debridement, reconstruction
- Cluster of PUs in a clinical area
- At the provider organisation discretion

- Where an SDTI evolves as a superficial ulcer (category 1-2) only, i.e. not a deep pressure ulcer and has been reported on STEIS the Tissue Viability Nurse Consultant / Lead Nurse will advise the Governance Support Unit to request removal of the pressure ulcer incident from STEIS from the Quality Manager Local Area Team NHS England & Improvement, and inform the Clinical Commissioning Quality Team of the decision.
- Where a patient has been discharged or transferred with an unreported deep PU the Trust TVT will be alerted by the new provider for investigation. The TVT will confirm and challenge the alert with the new provider. Where it is agreed the deep PU developed within the Trust the process for investing a hospital acquired PU category 3 or 4 PU will be followed.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc.) and by who)
PU key performance indicators (KPIs) / Ward Accreditation	TVNC/TVLN: for KPIs and audits Perfect Ward: Ward Sisters/Charge Nurses	Audit- Perfect ward, analysis of TV results and summary for Nursing and Midwifery Board Meeting	Monthly to be presented by TVLN or deputy at Harms Free meeting	Ward Sisters/Charge Nurses Divisional Performance Review meetings – monthly
PU incidence rates	TVNC and TVLN	Datix Clinical assessments	Ongoing, report monthly	Harms Free group and NMAHP committee monthly

8.0 TRAINING AND IMPLEMENTATION

All staff working with patients with or at risk of PUs in clinical areas will read and understand the Pressure Ulcer Prevention and Management Policy. Staff that need further education, to escalate to line manager and attend training.

Training by the TVT is available as follows:

- Induction programme for RN/RMs, Health Care Support Workers and Nursing Associates
- Induction for Student Nurses and Trainee Nursing Associates
- Mandatory training workbooks and teaching
- Tissue Viability training for Preceptorship nurses
- Tissue viability study days
- Tissue Viability / Harms Free Champion study days (in conjunction with Nutrition and Diabetes Specialist Nurse leads)
- On an ad hoc basis during the provision of specialist advice regarding individual patients during the provision of clinical care
- Bespoke education can be arranged for and in specific clinical areas
- Tissue Viability intranet site
- Insight days can be arranged with the TVT

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- **Dealey C, Posnett J and Walker A (2012)** Cost of PUs in the United Kingdom Journal of Wound Care Vol 21 No 6, 261-266
- **Department of Health and Social Care (2018)** Safeguarding Adults Protocol: Safeguarding and the interface with a safeguarding enquiry
- **European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention.** Prevention and treatment of PUs: Quick reference guide. Washington DC: National Pressure Ulcer Advisory Panel; 2014.
- **Journal of Wound Care (2020)** Device related pressure ulcers SECURE prevention: Consensus Document
- **National Institute for Health and Clinical Excellence** (2014) Prevention and management of Pressure Ulcers. NICE clinical guideline 179

- **National Institute for Health and Clinical Excellence. PUs.** NICE Quality Standard 89 June 2015
- **Nursing and Midwifery Council (2008)** The Code –Standards of conduct, performance and ethics for nurses and midwives
- **NHS Improvement (2018)** Pressure ulcers: revised definition and measurement: Summary and recommendations
- **NHS England/ Improvement** (2020) National Pressure Ulcer Prevalence and Quality of Care Audit – Cohorts 1 and 2 National Stop the Pressure Programme: Audit report
- **SCALE Skin Changes at Life's End:** Final Consensus Statement October 2009
- **Tissue Viability Society (2012)** Achieving Consensus in Pressure Ulcer Reporting
- **Wounds UK (2014) Best practice statement:** Eliminating Pus
- **Wounds UK (2017) Consensus document:** Recognising, managing and preventing deep tissue injury (DTI)

Related SFHFT Documents:

- Wound Care Policy
- Incident Reporting Policy and Procedures
- Photography and Video Recording Policy
- Policy for Consent to Examination, Treatment and Care
- Policy for Duty of Candour (Being Open)
- Safeguarding Adults Policy

11.0 KEYWORDS

Pressure Ulcer Prevention and Treatment; PUP; damage; care; relieving; relief;

12.0 APPENDICES

Appendix A – Equality Impact Assessment Form

APPENDIX A – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Pressure Ulcer Prevention and Management Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: October 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	Patients with black skin must be assessed differently as black skin doesn't blanch.	Training is included for staff on the assessment required for black skin which includes looking at the colour, temperature, localised pain and texture.	None
Gender	None	None	None
Age	None	None	None
Religion	None	None	None
Disability	None	None	None
Sexuality	None	None	None
Pregnancy and Maternity	None	None	None
Gender Reassignment	None	None	None
Marriage and Civil Partnership	None	None	None

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- Information from within this policy and the evidence base.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Stephanie Anstess; Heidi McMillan

Signature:

Date:
October 2021