<table>
<thead>
<tr>
<th>Document Category:</th>
<th>CLINICAL</th>
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<tbody>
<tr>
<td>Document Type:</td>
<td>POLICY</td>
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</table>

**Keywords:** Treatment; PUP; damage; care; relieving; relief;

<table>
<thead>
<tr>
<th>Version</th>
<th>Published Date:</th>
<th>Review Date:</th>
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<tbody>
<tr>
<td>3.0</td>
<td>28th February 2018</td>
<td>February 2021</td>
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**Supersedes:** v2.1, Issued 7th August 2017 to Review Date January 2018

**Approved by (committee/group):** Nursing, Midwifery and AHP Business Meeting Nursing, Midwifery and AHP Board

<table>
<thead>
<tr>
<th>Date Approved:</th>
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<tr>
<td>26.02.2018</td>
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<tr>
<td>16.03.2018</td>
</tr>
</tbody>
</table>

**Scope/Target Audience:** Trustwide (for the majority)

**Evidence Base/References:**
- National Institute for Health and Clinical Excellence. PUs: Prevention and management of PUs (April 2014) NICE clinical guideline 179
- National Institute for Health and Clinical Excellence. PUs. NICE Quality Standard 89 June 2015
- SCALE Skin Changes at Life’s End: Final Consensus Statement October 2009
- Wounds UK (2014) Best practice statement: Eliminating PUs

**Lead Division:** Surgery

**Lead Specialty:** Tissue Viability

**Author:** Stephanie Anstess/ Heidi Mcmillan

**Sponsor:** Chief Nurse

**Associated Clinical Guideline(s):**
- Generic Pressure Ulcer Prevention and Management Guideline

**Associated Clinical Procedure(s):** Not Applicable

**Associated Clinical Pathway(s):** Pressure Ulcer Pathway
<table>
<thead>
<tr>
<th>Description</th>
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<td>3 Roles and Responsibilities</td>
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<td>13-14</td>
</tr>
</tbody>
</table>
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. Dealey et al (2012) calculate that grade 2 PUs cost £1,214 rising to £14,108 for a grade 4 pressure ulcer.

The National Institute for Health and Care Excellence (NICE 2014; 2015) identify that health care 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.

### Aims / Objectives / Purpose

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.

### 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.

#### 3.1 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

**The 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

Dedicated to Outstanding care
The Tissue Viability Nurse Consultant
- 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 grade 3 and 4 PUs in line with the Trust’s Incident Reporting Policy and Procedure, including serious incidents
- will produce an analysis of themes and trends of hospital acquired (avoidable) PUs and plan appropriate actions
- will support a robust system with a clear audit trail for validating and recording pressure ulcer data

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 confirm and challenge the RCA process for grades 2 - 4 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

The Tissue Viability Team (TVT)
- provide expert advice, education and support to clinical staff
- monitor and validate all hospital acquired PUs across the trust
- support an active tissue viability link nurse network
- monitor themes and trends from root cause analysis of grade 2 PUs and plan appropriate actions

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
- they will proactively monitor pressure area care outcomes and monitor the action plans for completion

Sisters/ Charge Nurses
- are responsible for ensuring the staff in their services are aware and appropriately trained to deliver the standards within the policy
- 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 Link Nurse to deliver their objectives within their role
**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

**Tissue Viability Link Nurses**
- will disseminate all relevant pressure ulcer prevention and treatment information to staff within their work area
- with the support of the Sister/Charge Nurse/Department Lead 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 who provide care for patients with regards to pressure ulcer management and prevention.

**3.2 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, theatres, X-ray, cardiac catheter suite, discharge lounge, Kings Mill Treatment Centre, Welcome Treatment Centre etc.
- All hospital sites – Kings Mill Hospital, Newark Hospital and Mansfield Community Hospital

**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 Emergency Department, please see the Standard Operating Procedures within the appendices**

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

**Related Trust 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)
4.1 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:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Hard Copies</th>
<th>Trust Forms Management System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer Pathway</td>
<td>Ward stationary supply</td>
<td>Fkin 030334</td>
</tr>
<tr>
<td>PURPOSE-T Screening Tool</td>
<td>Wards and departments stationary supply</td>
<td>Fkin 030109</td>
</tr>
<tr>
<td>Short Term Pressure Ulcer Pathway</td>
<td>Ward and departments stationary supply</td>
<td>Fkin 030336</td>
</tr>
</tbody>
</table>

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.

Documents can be obtained:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Hard Copies</th>
<th>Trust Forms Management System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the Paediatric Early Warning Score</td>
<td>Children’s Ward stationary supply</td>
<td>NA</td>
</tr>
</tbody>
</table>

3. **The ANDERSON TOOL** is the pressure area risk assessment tool for adult patients in Resuscitation and Majors within the Emergency Department (ED) and should be completed within two hours.

Documents can be obtained:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Hard Copies</th>
<th>Trust Forms Management System</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Pressure Ulcer Pathway (Includes Anderson Tool)</td>
<td>ED stationary supply</td>
<td>Fkin TBC</td>
</tr>
</tbody>
</table>
4.2 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 patient’s overall condition (improvement or deterioration)
- 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.

4.3 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

4.4 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
- Skin assessments will be undertaken at least daily of pressure areas under and around dressings, bandages, plaster casts and bodily worn devices and traction unless advised otherwise by the TVT
- 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 a Senior Ward Nurse
  - Where there is no improvement following review and change in care plan refer to the Tissue Viability Team
4.5 REPORTING AND REFERRALS OF PUs

**Grades 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 grade 3 and 4 and SDTIs.
- The TVT assess all hospital acquired Grade 2 PUs within a maximum of two working days, and both hospital acquired and inherited grade 3/4 PUs and SDTIs within one working day
  - The TVT will alert the Community Tissue Viability Team/Trust TVT/Clinical Commissioning Group to patients admitted with deep PUs (grade 3/4/SDTIs) for investigation
  - A rapid review of patients with hospital acquired G2-4 and SDTIs using the nursing and medical notes will be completed by the TVNC, the Sister/Charge Nurse and Matron (or Deputy's) to validate and confirm where possible the depth of the PU
  - Where the PU is confirmed as a hospital acquired grade 3/4/SDTI the Matron will initiate the escalation up to the Chief Nurse as appropriate and inform the Governance Support Unit to arrange a scoping meeting
- 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 grade 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 grade 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

4.6 INVESTIGATION OF HOSPITAL ACQUIRED PUs

**Grade 2**

- All grade 2 PUs will have a mini root cause analysis completed by the ward staff and overseen by the Tissue Viability Team. When learning or good practice is to be shared it will be presented to the Nursing and Midwifery Board under the ‘Harms Free’ agenda item. The TVNC will monitor the themes and trends for analysis and appropriate action

**Grade 3 and 4 PUs and suspected deep tissue injuries or multiple superficial PUs**

- The Sister/Charge Nurse (or deputy) will present a 72 hour report to the Trust Wide Scoping Meeting if a serious harm is suspected. Where the harm is considered to be moderate by the TVNC and Divisional Head of Nursing (or deputies) the 72 hour report will be presented to Divisional scoping and escalated to Trust Scoping if required. If the PU meets or potentially meets the threshold of a serious incident it will be reported on Strategic Executive Information System (STEIS). Where it does not meet the threshold for a Serious Incident the decision will be made as to the level of investigation required. Divisional investigations will be recorded and monitored by the Governance Support Unit

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

- Loss of limb
Pressure Ulcer Prevention and Management Policy

- 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 (grade 1-2) only, i.e. not a deep pressure ulcer and has been reported on STEIS the Tissue Viability Nurse Consultant 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, 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 grade 3 or 4 PU will be followed

5 Education and Training

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
- Mandatory training workbooks and teaching
- Tissue viability study days
- Link nurse study days
- 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

6 Definitions/Abbreviations

6.1 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

<table>
<thead>
<tr>
<th>SUPERFICIAL PRESSURE ULCERS</th>
<th>Grade 1</th>
<th>Non – blanching erythema</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>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 grade 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.</td>
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</table>

<table>
<thead>
<tr>
<th>Grade 2</th>
<th>Partial thickness</th>
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<tbody>
<tr>
<td>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</td>
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</table>

<table>
<thead>
<tr>
<th>DEEP PRESSURE ULCERS</th>
<th>Grade 3</th>
<th>Full thickness skin loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 grade 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 grade 3 can be very shallow.</td>
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</table>

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<thead>
<tr>
<th>Grade 4</th>
<th>Full thickness tissue loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>UNKNOWN DEPTH</th>
<th>Suspected Deep Tissue Injury</th>
<th>Purple or maroon localised area of discoloured unbroken skin.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is often the appearance of newly acquired deep pressure ulcer (Grade 3 or 4) and can be mistaken for a bruise. As the skin damage evolves the damage can be ascertained and the pressure ulcer graded</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Definition of acquired and inherited PUs

- An acquired pressure ulcer is damage that occurs whilst the patient receives care from the Trust as an inpatient
- An inherited pressure ulcer is when the patient is admitted to the Trust with an existing pressure ulcer

Avoidable and Unavoidable PUs

The Department of Health (2010) has recognised that whilst most PUs are avoidable, there are some which may be unavoidable. Their definition of avoidable and unavoidable pressure ulcer is:

**Avoidable Pressure ulcer:** For a pressure ulcer to be considered avoidable the RN/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 means:**
- 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

6.2 Abbreviations

- PUP  Pressure Ulcer Pathway
- WCP  Wound Care Pathway
- SDTI  Suspected deep tissue injury
- TVT  Tissue viability team
- TVNC  Tissue viability nurse consultant
- TVN  Tissue viability nurse
## Monitoring

<table>
<thead>
<tr>
<th>Minimum Requirement to be Monitored</th>
<th>Responsible Individual</th>
<th>Process for Monitoring e.g. Audit</th>
<th>Frequency of Monitoring</th>
<th>Responsible Individual or Committee/Group for Review of Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>PU key performance indicators (KPIs)</td>
<td>TVNC- for KPIs and audit Metrics – Ward Sisters/Charge Nurses</td>
<td>Audit- metrics Nursing and Midwifery Board Meeting</td>
<td>Monthly Nursing and Midwifery Board Meeting - monthly</td>
<td>Ward Sisters/Charge Nurses Nursing and Midwifery Board Meeting (formal report- monthly) Patient Safety and Quality Board (formal report quarterly) Divisional Performance Review meetings – monthly</td>
</tr>
<tr>
<td>PU incidence rates</td>
<td>TVNC and Deputy</td>
<td>Datix Clinical assessments</td>
<td>Ongoing, report monthly</td>
<td>Board Meeting - monthly</td>
</tr>
</tbody>
</table>
8 Equality, Diversity and Inclusivity and Impact Assessments

Equality Impact Assessment (EqIA) Form (please complete all sections)

- Guidance on how to complete an EIA
- Sample completed form

Name of service/policy/procedure being reviewed: Pressure Area Management Policy
New or existing service/policy/procedure: Pressure Ulcer Prevention and Management Policy
Date of Assessment: 24.01.2018

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)

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>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?</th>
<th>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?</th>
<th>c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and Ethnicity:</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Gender:</td>
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<td>Age:</td>
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<td>Religion:</td>
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<td>Disability:</td>
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<td>Sexuality:</td>
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<td>Pregnancy and Maternity:</td>
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<td>Gender Reassignment:</td>
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<tr>
<td>Marriage and Civil Partnership:</td>
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<td>None</td>
</tr>
<tr>
<td>Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

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?
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

<table>
<thead>
<tr>
<th>Level of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>From the information provided above and following EqIA guidance document), please indicate the perceived level of impact:</td>
</tr>
<tr>
<td>Low Level of Impact</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Name of Responsible Person undertaking this assessment: Stephanie Anstess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date: 24.01.2018</td>
</tr>
</tbody>
</table>