NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Prevention and Management of Pressure Ulcers

Policy number and category	C 36	Clinical
Version number and date	3	June 2020
Ratifying committee or executive director	Clinical Governance Committee	
Date ratified	June 2020	
Next anticipated review	June 2023	
Executive director	Director of Nursing	
Policy lead	Lead Nurse for Physical Health	
Policy author *(if different from above)*	Tissue Viability Nurse	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	Yes	

Policy context

- To ensure that skin integrity and pressure ulcer prevention and management is in place across the trust as part of day to day clinical practice, thereby minimising the physical, psychological and financial cost of pressure ulcers to the service user/trust.
- To ensure that the Birmingham and Solihull Mental Health Foundation Trust complies with appropriate national guidance and best practice agreed by professional consensus

Policy requirement (see Section 2)

- All service users must be screened for their risk of developing pressure ulcers and this will be undertaken when clinicians complete a physical health assessment on RiO.
- A trust approved risk assessment Purpose T should be undertaken for all service users within 6 hours of admission to the inpatient units of the trust.
- The trust acknowledges that the pressure ulcer risk assessment is used in conjunction with clinical judgment and not in isolation.
- Assessment of service users' needs must include 'aSSKINg' principles (Assessment, Surface, Skin Inspection, Keep Moving, Incontinence, Nutrition and Hydration and Giving Information). Consideration must be given to co-morbidities and presentations that could impact on pressure ulcer development.
- All service users who are identified at risk of pressure damage should have interventions aimed at minimising the risk of pressure ulcer development and treating the results of any pressure damage incorporated into their care plan.
- Clinical documentation must be completed to evidence the implementation and effectiveness of the care plan and this must be available to all individuals caring for the service user

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1 INTRODUCTION

1.1 Rationale (Why)

The Purpose of this document is to ensure that consistently high standards of care are achieved and maintained for service users at risk or who have pressure damage and to ensure that the treatment provided complies with national guidance and best practice recommended by agreed professional consensus.
Pressure ulcer management is a key element of avoiding harm and forms one of the four harms captured through the national NHS prevalence audit ‘The NHS Safety Thermometer’.

Pressure ulcers represent a significant cost to the NHS within both the primary and secondary care sectors. Estimates regarding the financial cost of treating a pressure ulcer range from £2,000 (Category 1) to £22,000 (Category 4) **(NHS Improvement, 2018)**

Whilst pressure ulcers are more likely to affect older people residing within the trust, pressure ulcers can affect other groups. They may occur in ANY service user but are more likely in high risk groups, such as the elderly, those with a Body Mass Index (BMI) outside usual perimeters, malnourished, continence/moisture related issues, and those with particular underlying conditions/ comorbidity. Therefore the principles of practice issued within this policy can be applied to all age/divisional groups within the trust.

Prison Healthcare services will be provided with specialist advice and support in regards to pressure ulcer prevention and management by Birmingham Community Healthcare NHS trust.

This policy should be read in conjunction with the following documents
Pressure ulcers: revised definition and measurement **(NHS Improvement, 2019)**
European Pressure Ulcer Advisory Panel (EPUAP) guidelines 2019 Prevention and Treatment of Pressure Ulcers Clinical Practice Guideline **(European Pressure Ulcer Advisory Panel, 2019)**
NICE guidelines **(NICE, 2014) (NICE, June 2015)**

1.2 Scope (Where, When, Who)

This policy applies to all service users and multidisciplinary healthcare professionals involved in the prevention and management of service users who are at risk of developing a pressure ulcer, together with those service users with and existing pressure ulcers.

The care of service users in regards to pressure ulcer management whilst residing within their own homes/under the care of BSMHFT community based services will in most instances fall within the remit of the registered general practitioner and primary care services.

The policy outlines an effective pressure ulcer prevention and management programme within the trust ensuring standardised practice in accordance with local, national and internationally set objectives, guidelines and recommendations. **(European Pressure Ulcer Advisory Panel, 2019)**

The Tissue Viability Team will ensure the pressure ulcer policy and guidelines are current and reflect the latest evidence-linked practice.

1.3 Principles (Beliefs)

Prevention and management of pressure ulcers requires a collaborative multidisciplinary approach. All trust healthcare professionals are responsible for assessing and managing risk

and implementing processes to reduce incidence and prevent the occurrence of pressure ulcers, improving the quality of care the organisation provides.

Pressure ulcers will be categorised using the EPUAP (2019) grading system **(European Pressure Ulcer Advisory Panel, 2019)** (Appendix 5) and photographed with consent. Moisture Associated Skin Damage (MASD) will not be categorised as pressure damage.

All service users with any category of pressure damage both acquired and inherited (refer to Glossary) to the Trust will be reported through the clinical incident process (Eclipse). Moisture Associated Skin Damage (MASD) will also be reported through the clinical incident process (Eclipse).

All confirmed Trust acquired category 3 and 4 pressure ulcers will be reported by the Clinical Governance Team on STEIS and will be subject to a Root Cause Analysis investigation to understand any lessons that can be learnt from the event. Root cause analysis reports will be shared with the Physical Health Committee together with any resultant actions arising from the incident. This will enable shared learning across the Trust.

Pressure Ulcers category 2-4 identified with The Dementia and Frailty division will also be recorded on the NHS Patient Safety Thermometer

2 POLICY (What)

2.1 All service users must be screened for their risk of developing pressure ulcers and this will be undertaken when clinicians complete the Physical Health Assessment on admission to the trust (Refer to Physical Health Assessment Policy – C38).

2.2 Pressure ulcer risk assessment (Purpose T) should be completed on all service users. This should be completed as soon as possible (but within a maximum of 6 hours after admission) to identify individuals at risk of developing pressure ulcers (Appendix 2). If the service user is too unwell or it is deemed inappropriate at that time to be undertaken, then staff may defer this task and reattempt as soon as clinically possible to do so. The rationale for the delay must be documented clearly within RiO.

2.3 Due to the risk of frailty all service users admitted to Dementia and Frailty Services should have a Pressure ulcer risk assessment (Purpose T) completed on admission due to co-morbidities and increasing risk factors.

2.4 The Pressure ulcer risk assessment (PURPOSE T) should be accompanied by a skin inspection either in the form of visual observation or verbal questioning to identify any possible pressure related damage. This should be documented on the aSSKINg paper or digital ward chart (Appendix 3) or following verbal questioning with the service user, response should be documented in the clinical records in RiO.

2.5 All service users who are identified as having pressure damage or who are at risk of developing pressure damage must have an individualised plan of care developed and implemented this in accordance with aSSKINg principles (Appendix 4). This should be documented within RiO.

2.6 An assessment of nutritional status must be undertaken using the trust agreed nutritional screening process and appropriate nutritional support implemented (refer to Food and Nutrition Policy – C23).

2.7 Service users identified at risk or those who have pressure damage should be informed of their individual level of risk and advised on measures for prevention of further tissue damage and their plan of care

2.8 Where the service user's first language is not English, healthcare professionals should involve link workers/approved interpreters in communicating the level of risk to the service user.

2.9 For service users who have pressure damage present this should be categorised using the EPUAP pressure ulcer classification system (Appendix 5). Healthcare professionals can assess and grade pressure damage but pressure ulcers category 2 and above will be verified by the Tissue Viability Service.

2.10 All service users with pressure ulcers category 2 and above should be referred to the Tissue Viability Service for assessment. Pressure ulcers of category 1 can be discussed with the Tissue Viability Service, but will not routinely need to be assessed.

2.11 All pressure ulcers should be reported via Eclipse.

2.12 All device-related pressure ulcers should be reported via Eclipse stating that the damage was caused due to a medical device (i.e. oxygen tubing, catheter etc.) and the appropriate category of the damage also documented.

2.13 All confirmed trust acquired category 3 and 4 pressure ulcers will be reported to the Governance team on STEIS and a Serious Incident Review will be conducted.

2.14 Where possible/appropriate pictorial evidencing using a photograph of pressure ulcer(s) of category 2 and above should be included in the clinical documents section in RiO (European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, 2014) (Appendix 6). The Tissue Viability Service will use pictorial evidence to give telemedicine advice at the first point of contact; a full clinical assessment will always follow.

2.15 Healthcare professionals admitting service users with existing pressure damage should contact the appropriate team caring for the service user (if there is anyone) and obtain further information regarding treatment, history of pressure damage, risk assessment, equipment , dressings already used and care plans and documentation already in place. This should still be reported via Eclipse but reported as an inherited pressure ulcer to the trust.

2.16 Service users with category 3 or 4 pressure ulcers both inherited or trust acquired who the healthcare professional has concerns regarding clinical practice, this must be identified and addressed and the concern raised to the local authority as per the Safeguarding Adults Policy if deemed appropriate (R&S 26).

2.17 All service users who are at risk of pressure damage or who have existing pressure damage should be assessed and provided with appropriate pressure relieving equipment as required. This should be documented in RiO and if equipment is in place this should be checked daily that it is in full working order.

2.18 For service users who are at risk of pressure damage and are incontinent of urine or faeces, appropriate skin cleansers and barrier products will be offered and used in order to prevent moisture associated skin damage.

2.19 Any service user presenting with pressure damage will have their wound assessed using the wound assessment chart (Appendix 7). Appropriate care will be planned, implemented and evaluated. The trust wound management formulary will be used as a framework for dressing selection **http://connect/corporate/corporate-clinical-services/physical-health/tissue-viability/Documents/Wound%20%20Product%20ordering%20codes%202019.pdf**

2.20 Referral for surgical interventions will be considered by the Tissue Viability Service if there is failure of previous conservative management interventions to the wound or if there is significant deterioration. However this will depend on the service user's condition and also co-morbidities.

2.21 When planning discharge of service users from inpatient settings who have existing pressure damage or who are at high risk of pressure damage, the registered GP and attached community services team should be informed before the service user is discharged. Discharge information should include the sites and category(s) of all pressure ulcers, a copy of the latest risk assessment tool and a summary of the

treatment provided in the trust. Provision for pressure relieving equipment should also be considered on discharge

3 PROCEDURE

3.1 All service users must be screened for their risk of developing pressure ulcers and this will be undertaken when clinicians complete the Physical Health Assessment on admission to the trust (Refer to Physical Health Assessment Policy – C38).

3.2 The screening and risk assessment must be attempted within 6 hours admission of admission to inpatient BSMHFT settings (NICE, 2014) (NICE, June 2015). If the service user is too unwell or it is deemed inappropriate at that time to be undertaken, then staff may defer this task and reattempt as soon as clinically possible to do so. The rationale for the delay must be documented clearly within RiO.

3.3 Service users assessed as at risk of developing pressure ulcers or with existing pressure damage present must have a management plan formulated by the healthcare professional responsible for the care of the service user (refer to Pressure Ulcer Management Guide – Appendix 8).

3.4 Where healthcare professionals are unable to implement a plan of care due to service user non-concordance for whatever reason, this must be clearly documented. All attempts to mitigate potential risk, alternative/reduced strategies, encouragement, supervision, assistance, reassurance, support, education and on-going assessment must be documented on RiO. Non-concordance must be escalated to ward manager/matron.

3.5 Effective prevention is the key to overall management of pressure damage. Frequency of re-assessments depends on the individual service user's circumstances; however the following information provides some guidance.

Purpose T Pathway	Action
Green Pathway **Not At Risk**	Purpose T to be reassessed following any change to clinical condition. Pressure areas will be checked if clinical condition changes.
Amber Pathway **At Risk; however they have no pressure ulcers**	Purpose T to be reassessed weekly or sooner if clinical condition changes. Pressure areas will be checked once daily - either by inspection or verbal questioning (or sooner if the clinical condition changes). If weekly skin inspection is needed then this must be care planned with the rational as to why.
Red Pathway **Pressure Ulcer Category 1 & above or scarring from previous pressure ulcers**	Purpose T to be reassessed every 3 days (or sooner if clinical condition changes.) Pressure areas will be inspected three times daily

Table 1

3.6 The assessments (Table 1) will be documented within RiO Purpose T form and on the aSSKINg paper chart (Appendix 3) or on the digital ward platform.

3.7 Service users at risk of pressure damage or with existing damage present must be assessed and provided with appropriate pressure relieving devices in accordance with trust guidance. (Appendix 9). The effectiveness and use of this equipment must be reviewed regularly (NICE, 2014).

3.8 Service users at risk of pressure damage or with existing damage will be encouraged to actively mobilise, change their position or be repositioned (NICE, 2014)

3.9 Repositioning contributes to the service user's comfort, dignity and functional ability and should be undertaken in such a way to relieve or reduce pressure (European Pressure Ulcer Advisory Panel, 2019)

3.10 Two to four hourly repositioning will be undertaken for at risk service users, however this frequency may change as a result of skin assessments and individual needs including medical condition, comfort and the type of support surface used (European Pressure Ulcer Advisory Panel, 2019)

3.11 A repositioning schedule will be devised and positioning of the service user recorded. This will be documented on the aSSKINg paper chart (Appendix 3) or on the digital platform and will be discussed and agreed with the service user.

3.12 Moving and handling devices will be used appropriately to assist in repositioning so as to reduce shear and friction. After repositioning, equipment such as hoist slings must not be left underneath the service user. Physiotherapy or Occupational Therapy colleagues may need to complete seating assessment to ensure height of surface and posture remains within safe levels.

3.13 The Tissue Viability Service will recommend other pressure relieving aids such as heel protectors and gel pads as another assistance to relieve pressure from bony prominences and to 'off-load' pressure. Aids such as water-filled gloves, synthetic sheepskins and doughnut devices must not be used to relieve pressure (NICE, 2014), (European Pressure Ulcer Advisory Panel, 2019)

3.14 Service users at risk of pressure damage or with existing damage, and incontinent of urine and faeces will receive a continence assessment and receive appropriate interventions to prevent moisture associated skin damage. This includes the correct/appropriate use of pH balanced skin cleansers and skin barrier products and incontinence aids.

3.15 Service users who have existing pressure damage or who have developed category 2 and above pressure damage must be referred to the Tissue Viability Service for advice.

3.16 Pressure damage should be assessed using the wound assessment chart and appropriate care will be planned, implemented and evaluated according to the trust wound management formulary. Reassessment of the pressure ulcer should be done weekly in conjunction with support/advice and assessment from the Tissue Viability Service.

3.17 Any service user with a deteriorating pressure ulcer will have a further Eclipse form completed, this should reference previous Eclipse number for pressure damage and state 'deterioration to 'Category …'

3.18 Reverse categorisation should not be used as pressure damage is healing i.e. Category 4 pressure ulcer will be referred to as a 'healing' category 4 pressure ulcer.

3.19 All service users who have developed a category 3 or 4 pressure ulcer to their foot and/or heel must be referred to the podiatry service.

3.20 Once a pressure ulcer has healed the service user should continue to be reassessed for pressure area risk prevention.

3.21 Healthcare professionals must ensure when service users are discharged from the trust with pressure damage or who are at risk of pressure damage this is documented in the discharge documentation, this should include site of damage, category, Purpose T Pathway, dressing regime and any equipment used.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	All clinical staff members to include temporary/bank contracted worker and those employed to provide care within the terms of a Service Level Agreement are responsible for: - Following the guidance/principles of good practice outlined by the policy. - Reporting any concerns via appropriate channels in regards to any identified barriers to compliance with principles underpinning the policy. - Identification of any training needs via line management. Attendance at training and awareness sessions.	(NICE, June 2015)
Service, Clinical and Corporate Directors	To set strategic context in which the policy will support staff members to follow the guidance and principles or recommended practice offered	
Policy Lead	To ensure that the principles underpinning the Policy are based on recognised/agreed Good Practice, Professional Consensus and National/International/Local guidelines Development and implementation of training and awareness sessions. Audits to monitor implementation.	
Executive Director	To support the implementation and recognition of Trust-wide Policy to standardise trust-wide practice in regards to the prevention and management of pressure ulcer(s), ensuring compliance with all legal and statutory requirements.	
Others…..	Responsible for the provision of expert advice in relation to the assessment, prevention and management of pressure ulcers within the organisation To provide training to all staff members	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	March 2020
Number of versions produced for consultation	1
Committees or meetings where this policy was formally discussed	
Physical health committee	Date 4th Feb 2020
Nursing advisory Council	Date 24th Jan 2020

Where else presented	Summary of feedback	Actions / Response
Matrons meeting		
AHP review	Add Occupational Therapist to 3.12 for seating assessment	Added

6 REFERENCE DOCUMENTS

European Pressure Ulcer Advisory Panel. (2019). *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline The International Guideline 2019.* Europe: EPUAP.

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. (2014). *EPAUP.* Retrieved January 21, 2020, from European Pressure Ulcer Advisory Panel: https://www.epuap.org/pu-guidelines

NHS Improvement. (2018, February 2019 28). *Pressure ulcers: productivity calculator.* Retrieved January 21, 2020, from NHS Improvement: https://improvement.nhs.uk/resources/pressure-ulcers-productivity-calculator/

NHS Improvement. (2019, March 29). *Pressure ulcers: revised definition and measurement Summary and recommendations.* Retrieved January 21, 2020, from NHS Improvement: https://improvement.nhs.uk/documents/2932/NSTPP_summary__recommendations_2.pdf

NICE. (2014). *Pressure ulcer: prevention and management Clinical guideline [CG179].* NICE. London: NICE.

NICE. (2014). *Pressure ulcers; prevention and management - information for the public.* Retrieved January 21, 2020, from NICE: https://www.nice.org.uk/guidance/cg179/ifp/chapter/What-is-a-pressure-ulcer

NICE. (June 2015). *Pressure ulcer Quality standard [QS 89].* NICE. London: NICE.

Any related policies and procedures.

C48 Care of Inpatient Bariatric Service User (2017)
http://connect/corporate/governance/Policies/Bariatric%20Policy.pdf

C57 Clinical Risk Assessment and Management (2019)
http://connect/corporate/governance/Policies/Clinical%20%20Risk%20Assessment%20Policy.pdf

C04 Management of the Deteriorating Patient & Resuscitation Policy (2018)
http://connect/corporate/governance/Policies/Management%20of%20the%20Deteriorating%20Patient%20Policy.pdf

C38 Physical Health Assessment and Management (2017)
http://connect/corporate/governance/Policies/Physical%20health%20assessment.pdf

7 TRAINING AND AWARENESS

The Tissue Viability Service will provide a range of training and educational opportunities for all health care professionals.

Training needs analysis will be undertaken and questionnaires sent to a random selection of clinical staff. This information will provide a framework for the educational sessions provided.

Healthcare professionals must attend an update on pressure ulcer prevention and management every 2 years, as changes are occurring within this speciality as a result of on-going research. This training will underpin the implementation of the policy.

Due to the nature of the trust and the differing specialities not all healthcare professionals will require the same amount of education around pressure ulcer prevention and management, minimum requirements would be:

- Healthcare professionals working with Dementia and Frailty – full training around pressure ulcer prevention and management.
- All other healthcare professionals within the trust – pressure ulcer awareness.

As a minimum all healthcare professionals within the trust should have awareness around pressure ulcers.

8 GLOSSARY

- **Pressure Ulcer –** A localised injury to the skin and or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear (NICE, 2014)
- Safety Thermometer – The NHS local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care prevalence
- Inherited - **Inherited** pressure damage: pressure ulcer present on admission when admitted into services within Birmingham and Solihull Mental Health Foundation Trust.
- Acquired - **Acquired** pressure damage: pressure damage that occurs whilst the patient is receiving care from Birmingham and Solihull Mental Health Foundation Trust as an in-patient
- Induration – localised hardening of soft tissue.
- Erythema – redness of the skin.
- Oedema – an accumulation of an excessive amount of watery fluid in cells and tissues.
- Moisture Associated Skin Damage (MASD) – inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, faeces, sweat or wound exudate.

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Pressure ulcer risk assessment tool utilised and completed by staff when indicated with identified time frame of 6 hours	Tissue Viability Lead	Insight report	Bi-annual	To report to Physical Health and Nursing Advisory Council	Tissue Viability Lead, Matrons, Clinical Areas	Tissue Viability Lead, Matrons, Clinical Areas
Pressure Ulcer Incidence	Matrons	Eclipse	Monthly	To report to Physical Health Committee, and NAC	Tissue Viability Lead	Tissue Viability Lead

Training Analysis	Tissue Viability Lead	Training Needs Analysis	yearly	To report to Physical Health Committee and Governance	Tissue Viability Lead, Matrons and Clinical Staff	Tissue Viability Lead, Matrons and Clinical Staff

10 APPENDICES

Appendix 1 Equality Impact Screening Form

Appendix 2 Identifying individuals at risk

Appendix 3 aSSKINg paper wound assessment chart

Appendix 4 aSSKINg principles

Appendix 5 Pressure Ulcer classification guide

Appendix 6 Protocol for taking clinical images

Appendix 7 Wound treatment pathway

Appendix 8 Pressure ulcer management guide

Appendix 9 Pressure relieving devices for the prevention of pressure ulcers

Appendix 1 – Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**Pressure ulcer prevention and management policy**		
Person Completing this proposal	**Lyndi Wiltshire**	**Role or title**	**Lead nurse for physical health**
Division	**Corporate**	**Service Area**	**Physical health**
Date Started	**3rd March 2020**	**Date completed**	**3rd March 2020**
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
To provide guidance and information to prevent and manage pressure ulcers			
Who will benefit from the proposal?			
All service users admitted to an inpatient unit.			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*		*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	

Please click in the relevant impact box or leave blank if you feel there is no particular impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	**x**			
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	**x**			

Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**x**			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	**x**			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**x**			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	**x**			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	**x**			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**x**			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being ‘out’ or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	**x**			

This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?					
Human Rights	x				
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?					
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)					
	Yes	**No**			
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**	
				x	
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**					
Action Planning:					
How could you minimise or remove any negative impact identified even if this is of low significance?					
How will any impact or planned actions be monitored and reviewed?					
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.					
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.					

Appendix 2 - Identifying individuals at risk

Risk assessment is a fundamental part of preventing pressure ulcers. There are many external factors which predispose a service user to develop a pressure ulcer. The critical determinants or pressure ulcer formation are the intensity and duration of pressure, and the tolerance of the skin and its supporting structure for pressure, shear and friction.

The factors that contribute to pressure ulcer development are divided into two groups:

- **Extrinsic** – external influences that cause skin distortion – pressure, shearing, friction and moisture.
- **Intrinsic** – reduced mobility, previous history of pressure damage, sensory impairment, reduced level of consciousness, acute illness, chronic long term illness, medication, pain, nutrition, extremes of age, incontinence and terminal illness

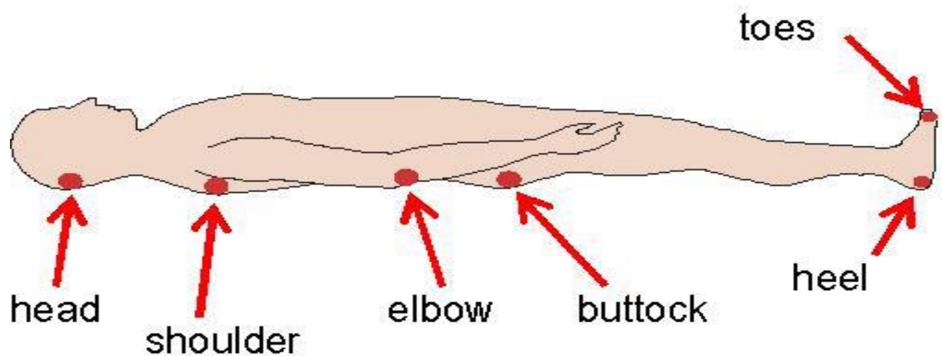
Assessing an individual's risk of developing pressure ulcers should involve both formal and informal assessment

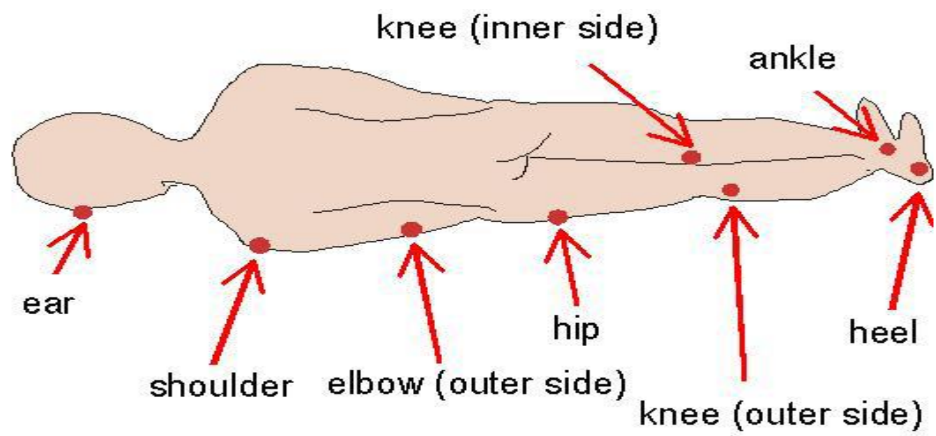
- Formal pressure ulcer risk assessment is undertaken by qualified nursing staff and involves a holistic assessment of the patient including a skin assessment, recording of intrinsic and extrinsic factors and the Purpose T. Also using clinical judgement a final level of risk can be decided and care planned appropriately.
- Risk assessment is an on-going process and should be continually monitored informally.
- The timing of the risk assessment should be based on each individual case.
- A Purpose T assessment will be documented for all service users within 6 hours of admission, if this is not possible to document why on progress nots on Rio
- Reassessment should be carried out according to risk score and any change in accordance with service user's condition.
- If considered not at risk on initial Purpose T assessment, reassessment should occur if there is a change in an individual's condition which increases risk.
- All formal assessments of risk should be documented/recorded and made accessible to all members of the multi-disciplinary team.

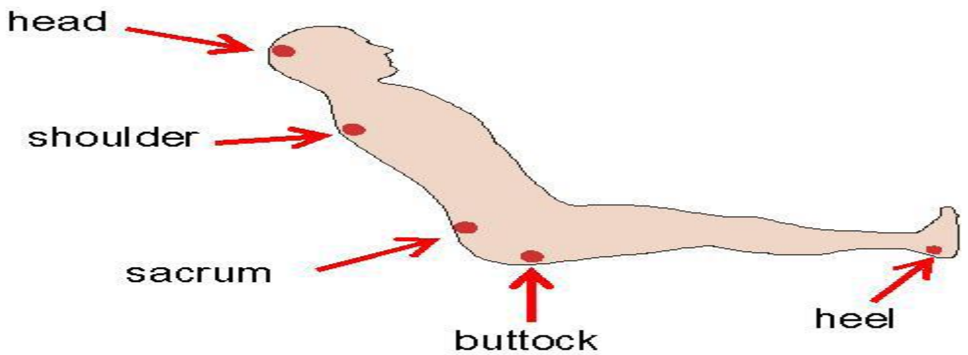
Risk assessment tools should only be used as an aide memoire and should not replace clinical judgement.

- The Pressure Ulcer Risk Score (Purpose T) is an aid to help health professionals clinical judgement but is only part of the documented evidence that a formal assessment of risk has taken place.
- As all service users are different any specific areas of risk not included in the score should be recorded. These additional factors can affect the level of individual risk.

Common sites for pressure ulcer development







Appendix 3: aSSKINg chart

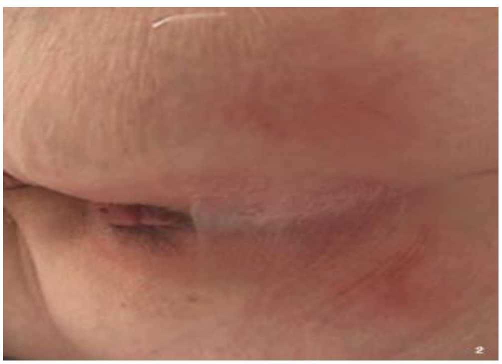
Date														
Time (24hrs)														
ASSESSMENT (**R**-Red, **A**- Amber, **G**- Green)														
Purpose T care plan														
SURFACE Mattress -(foam, air, hybrid): **√** or **x** or **NA** (not applicable)														
Mattress is in use														
Cushion is in use														
Equipment is in good working order														
Service user declines to use equipment														
Risk and consequence of non-use of equipment explained to service user/carer														
SKIN INSPECTION Frequency: **N**= Normal, **RB**= Red, Blanching, **C1**=Category 1, **C2**= Category2 **C3**= Category3, **C4**= Category4, **ML**= Moisture Lesion **D**= Dressing in place, **R**= Refused **SDTI**= Suspected deep tissue injury, **U**=Ungradable, **S**= Scaring from old PU, **O**=other														
Sacrum														
Left Buttock														
Right Buttock														
Left Heel														
Right Heel														
Left Ankle														
Right Ankle														
Left Hip														
Right Hip														
Left Shoulder														
Right Shoulder														
Left Elbow														
Right Elbow														
Other………..														
Other………..														
KEEP MOVING **Frequency:** **L** = Left, **R** = Right, **B** = Back, **M** = Mobilised **S** = Stood, **R** = Refused, **SO** = Sat Out, **L3** = 30° tilt left side, **R3**= 30° tilt right side, **REP**= repositioned but returned to previous position **HO=**Heels offloaded														
Service user repositioning self (Y/N)														
Staff repositioning (use codes)														
INCONTINENCE/MOISTURE **√** or **x** or **NA**														
Urine														
Bowels														
Moisture due to sweat etc														
NUTRITION **√** or **x** or **NA**														
Service user is taking diet well														
Service user is taking fluids well														
Service user is taking dietary supplements as plan														
GIVING INFORMATION **√** or **x** or **NA**														
Health promotion offered														
Completed by Designation														

(This form is being developed on the digital platform which is due for release in summer 2020)

Appendix 4 – aSSKINg Principles

Aims	Objectives	Actions
A	**Assessment of Risk**	*Ensure a pressure ulcer risk assessment (Purpose T) is completed on ALL patients within 6 hours of admission.* Reassess according to need, change in condition, hospital/A&E visit and leave of more than 24 hours.
S	**Surface**	*Make sure your Service users have the right support* Select the appropriate mattress and seating. Reassess aids when Purpose T is reassessed. Change the aids according to clinical needs. Service users with pressure ulceration must not sit out for longer than 2 hours at a time. Assess the Service users seating position and refer to Physio or OT if clinically indicated.
S	**Skin Inspection**	*Early inspection means early detection.* Assess all pressure areas morning, afternoon and night and document on skin inspection chart. Observe for pain, swelling and signs of any skin changes. Document category of pressure ulceration and wound bed tissue type on wound assessment table. Photograph pressure ulcers with consent. Map pressure ulceration on body map chart if unable to photograph.
K	**Keep Moving**	*Keep your Service users moving.* Encourage independent mobility where clinically possible. Encourage independent repositioning. Involve Physiotherapy and OT to manage posture if clinically indicated. Ensure patient is repositioned and this is documented on repositioning chart. Use appropriate moving and handling aids to move the patient. Elevate heels by using profiling beds or recommended heel off-loading devices.
I	**Incontinence/Moisture**	*Your Service users need to be clean and dry.* Use pH balanced cleansers and ensure skin is well dried. Use barrier product depending on clinical need. Manage continence according to need.
N	**Nutrition/Hydration**	*Help Service users have the right diet and plenty of fluids.* Undertake nutritional risk assessment according to Trust policy and action plan appropriately. For those at risk encourage nutrition and hydration as per guidance. Refer to dietician if clinically indicated.
G	**Giving Information**	To be able to communicate effective and safe use of interventions effectively for the patient, family and within the MDT. Understand and recognise when clinical concerns need to be escalated and be able to promote effective pressure ulcer prevention approaches

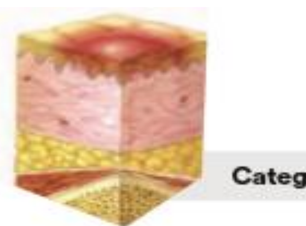
Appendix 5 – Pressure Ulcer Classification Guide

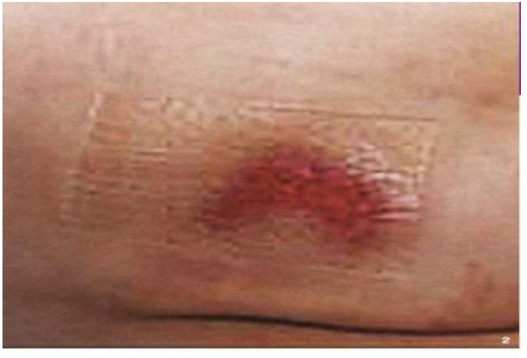


Category 1 pressure ulcer
Nonblanchable erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).[1]



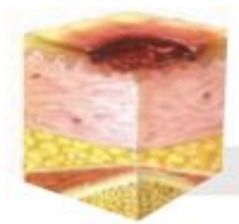


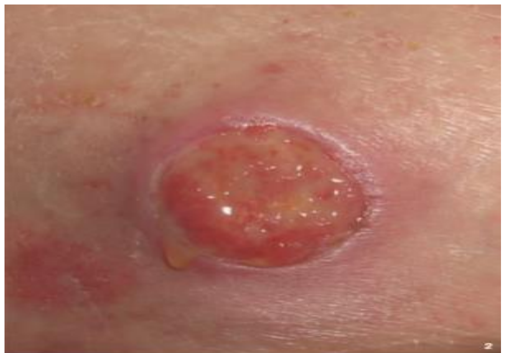
Category 2 pressure ulcer
Partial thickness skin loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.[1]

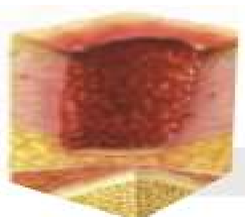
*Bruising indicates suspected deep tissue injury.

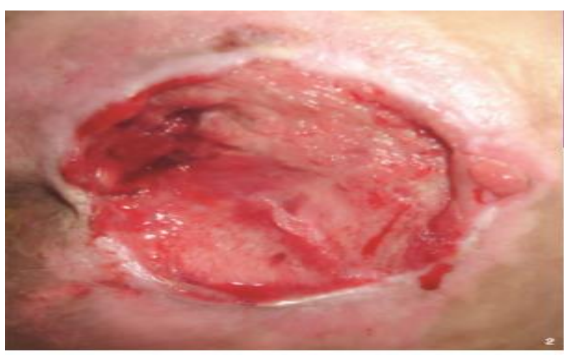




Category 3 pressure ulcer
Full thickness skin loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category 3 pressure ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.[1]

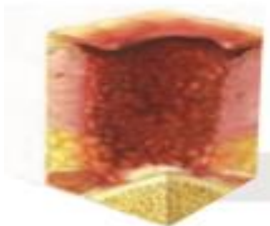


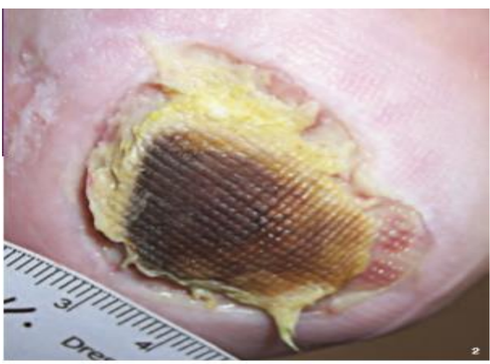


Category 4 pressure ulcer
Full thickness tissue loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.[1]



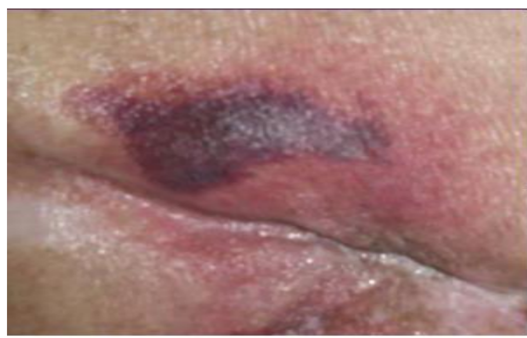


Unstageable

Obscured full thickness skin and tissue loss

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.[1]



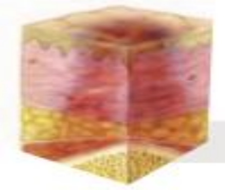
Deep tissue injury (DTI)

Persistent non-blanchable deep red, maroon, or purple discoloration

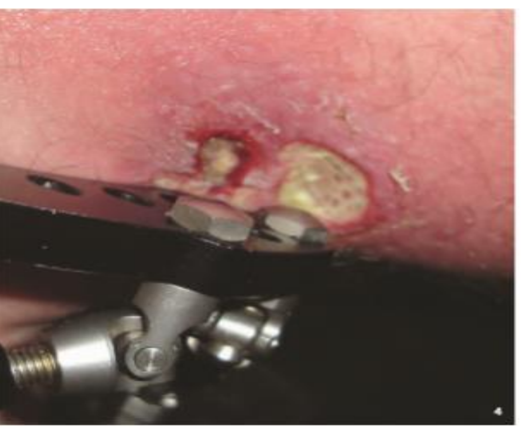
Purple or maroon localised area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.[1]

Unstageable



Deep tissue injury



Medical device related pressure ulcer[1]

Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.[2]

Device-related pressure ulcers should be reported and identified by the notation of (d) after the report – e.g. Category 2 PU (d) – to allow their accurate measurement.[3]

Appendix 6 - Protocol for taking Clinical Images

Pictorial evidence will be provided by the Tissue Viability service or Matrons/Ward Managers and Nursing Staff in the form of a photograph using a digital camera, agreed by Trust Information Technology colleagues as appropriate and compatible with current systems.

Pictorial Evidence relating to Tissue Viability may be undertaken to evidence the assessment or on-going management of wounds/ loss of skin integrity or to record improvement or deterioration. It will also enable the Tissue Viability Service to provide telemedicine advice.

Pictorial evidence in the form of a photograph regarding Tissue Viability will be undertaken with the verbal consent and knowledge of the Service user and documented within the clinical notes. Where consent is not able to be obtained, due to issues surrounding capacity it should be discussed with the multidisciplinary team in order to enable a decision to be taken in the best interests of the Service User.

If a Service User does not wish to have an issue surrounding Tissue Viability Photographed and it is felt that they have the capacity to make this decision then this will be documented within the Clinical notes.

Pictorial evidence in the form of a photograph will be undertaken at the following junctures within the Service Users journey:

- At initial Tissue Viability Service assessment.
- All pressure damage from Category 2 and above.
- All moisture lesions.
- At 4 -6 weekly intervals to evidence the Service User journey.
- For telemedicine advice from Tissue Viability service.
- Following significant/ demonstrable changes to the Service User in regards Skin Integrity/ wounds management which the Tissue Viability Service feel should be documented and evidenced pictorially.
- To evidence completion of the healing process.

Photographic/ pictorial evidence will only be undertaken for the Purposes as stated.

A designated Digital camera will be utilised to obtain the pictorial/photographic evidence and not for any other Purpose.

The Service Users personal identity (face, identifying features, name, Date of Birth, address Trust Premises and staff members) will be concealed at all times to maintain confidentiality, privacy and dignity in accordance with Trust policy.
Photographs undertaken of the Tissue Viability related issue will be preceded by a photograph of the Service Users Trust identification Number to differentiate and confirm individual Service user photographs.
Photographs/ pictorial evidence will be Up- loaded onto the Service users RIO Clinical Notes at the next available opportunity not exceeding 2 weeks. These will be stored within the Clinical Documentation section under the heading of photographs.

Photographs/ Pictorial evidence will be Up- loaded from the Digital Cameras memory card and immediately deleted and will not be stored on any other system.

Appendix 7 Wound Treatment Pathway

WOUND TREATMENT PATHWAY

Always treat/manage the underlying cause of the wound and address whenever possible, all factors that may delay the healing process

NECROSIS	SLOUGH	GRANULATING	EPITHELIALISING	CAVITY	INFECTED
Treatment Objective	**Treatment Objective**	**Treatment Objective**	**Treatment Objective**	**Treatment Objective**	**Treatment Objective**
Refer to Tissue Viability to Assess if safe to debride **? conservative management** • Aid removal of devitalised tissue if safe. This will reduce bacterial load & reduce risk of infection • Establish extent of any undermining • Allow wound drainage • Reduce odour • Protect peri wound skin • Promote healing	• Aid removal of devitalised tissue if safe • To reduce bacterial load – reduce risk of infection • To establish extent of wound and any undermining • Allow wound drainage • Reduce odour • Manage pain • Promote healing • Protect peri wound skin	• To protect wound bed and peri wound skin • Manage exudate • Manage pain • Maintain moist/ warm environment • Minimise frequency of dressing changes to enable epithelialisation • Promote healing	• Protect new epithelial cell migration and maturation • Removal of dry exudate • Maintain a warm/ moist environment • Minimise dressing frequency • Protect peri wound skin	• Debride any devitalised tissue • Manage exudate • Manage odour • Manage pain • Relieve pressure if this is a contributing factor to cause of wound • Promote healing from the base up • Protect peri wound skin	• Reduce bioburden • Identify causative organism (swab) • Prevent spreading infection • Prevent sepsis • Debride any devitalised tissue • Manage exudate • Manage odour • Manage pain • Promote healing • Protect peri wound skin
Treatment Plan	**Treatment Plan**	**Treatment Plan**	**Treatment Plan**	**Treatment Plan**	**Treatment Plan**
• Dress aseptically using a dressing pack. • Cleanse peri wound skin (.9% Sodium Chloride) if soiled • Protect peri wound skin with Cavilon film • **Primary dressing:** Aquaform Gel, Flaminal Hydro, Comfeel Plus, Comfeel Plus Transparent *(if conservative management use Softpore)* • **Secondary dressing:** may not be required but consider – C-View film, Softpore, C-View post op	• Dress aseptically using a dressing pack. • Cleanse peri wound skin (0.9% Sodium Chloride) if soiled or cleanse wound with Prontosan wound irrigation solution if infection is suspected. • **Debridement**; consider Debrisoft/UCS cloth • Protect peri wound skin with Cavilon film • **Primary dressing** – UrgoClean, Kytocel, Flaminal Hydro/Forte, Algivon (honey) , Comfeel Plus Comfeel Plus Transparent(if low exudate) • **Secondary dressing:** Zetuvit Plus, Biatain Silicone	• Dress aseptically using a dressing pack. • Only cleanse the wound with 0.9% Sodium Chloride if the wound bed is soiled • Gently remove any crusts or skin plaques from wound edges • Protect peri wound skin if exudate levels are high with Cavilon film • **Primary dressing:** Biatain Silicone • **Secondary dressing:** to suit exudate level but may not be required (pad/foam)	• Dress aseptically using a dressing pack. • Only cleanse wound (0.9% Sodium Chloride) if soiled • Consider if dressing is actually required but advise on use of protective barrier film (Cavilon) and use of emollient to intact healed skin • **Primary Dressing:** Biatain Silicone, Comfeel Plus Transparent	• Dress aseptically using a dressing pack. • Cleanse/irrigate wound (0.9% Sodium Chloride) or Prontosan wound irrigation solution if infection is suspected • Protect peri wound skin with barrier film (Cavilon) • **Primary dressing** is dependent on the size of the cavity Consider –Aquacel, Kytocel, UrgoClean, Flaminal Forte. • **Secondary dressing:** depends on size and exudate level- Biatain Silicone or Zetuvit Plus	• Dress aseptically using a dressing pack. • Cleanse wound with Prontosan wound irrigation solution(if lower leg wash in dermol 500 and consider use of Debrisoft/UCS wipes • Antimicrobial dressing to suit presentation of wound bed Primary Dressing-Kytocel, Atruaman Ag, Flaminal Forte/Hydro, Algivon (honey) • Secondary dressing- Biatain Silicone, Zetuvit Plus • Reassess progress every 2 weeks and stop antimicrobial once infection is cleared

APPENDIX 8 – Pressure Ulcer management guide

Category 1 (see EPUAP 2019 classification system)	**Category 2** (see EPUAP 2019 classification system)	**Category 3 and 4** (see EPUAP 2019 classification system)

Key Aim: Prevention of further pressure related damage by removal of the source of applied pressure and allowing reperfusion of tissues.
➢ Staff may consider seeking support from the Tissue Viability Service.
➢ Report pressure damage via Eclipse.
 	
Prevention & Management Plan:
• Skin inspection of bony prominences and/ or vulnerable areas. Any issues to be recorded on 'Body Map'.
• Complete full risk assessment tool. To be re-assessed 3 times a week or following any change in condition.
• Review Seating surfaces-i.e. is this the appropriate level of support for pressure redistribution?
• May require seating assessment by Physiotherapist / consider need to source high specification foam or Air flow cushion.
• Review mattress- i.e. is it the appropriate level of support for Pressure Redistribution? May need to consider sourcing high specification foam or dynamic mattress.
• Consider other contributory factors i.e. moisture/ incontinence, nutrition and take the appropriate action to address the issue. i.e.
  ○ Refer to Dietetic Team
  ○ Investigate cause of moisture/ incontinence issues and utilise appropriate skin cleansers/ barrier cream/ barrier spray to reduce risk of loss of skin integrity.
• A **documented programme of 'Pressure Area Care' should be commenced** - this can be incorporated by staff altering position of service user; encouraging Service User to relieve own pressure areas by standing and/or 30% tilt in a chair or in bed .
• Staff should identify the frequency at which the pressure area care should occur and ensure that all non-concordance is also documented:
Recommended baseline minimum:
  ○ 2 hourly whilst in bed on appropriate support surface for need/risk.
  ○ 1 hourly whilst seated on appropriate Pressure Redistributing cushion.
 	
Staff should monitor for any deterioration and act / report appropriately.
	Key Aim: Recognise the level of pressure related damage to tissues and prevention of further damage by removal of the source(s) of applied pressure and any other contributory factors.
	
	➢ Implementation of a planned programme of care to support/ promote wound healing/ reperfusion.
	➢ Staff to ensure the ward manager and matron for the area is aware.
	➢ Report pressure damage via Eclipse.
	➢ Staff to refer to Tissue Viability Service for assessment and also to verify category of pressure damage.
	
	Implement the basic Pressure Ulcer Management Plan (as detailed in the left hand column)
	
	Staff may need to consider if any additions to the basic plan are required based upon individualised risk assessment i.e. pressure redistributing heel aid equipment, referral to AHP's i.e. Physiotherapist, Dietetics, Podiatrist etc
		Key Aim: Recognise and report appropriately the level of pressure related damage to tissues and prevention of further damage by removal of the source(s) of applied pressure and any other contributory factors.
		
		➢ Implementation of a planned programme of care to support/ promote wound healing/ reperfusion.
		➢ Staff to ensure the ward manager/ matron/and clinical service manager are informed.
		➢ Report pressure damage via Eclipse
		➢ Staff to refer to Tissue Viability Service for assessment and also to verify category of pressure damage.
		➢ Pressure Ulcers which are present prior to admission/ transfer to BSMHFT must be discussed and responsibility agreed with relevant Trust.
		
		Implement the basic Pressure Ulcer Management Plan (as detailed in the left hand column).
		
		Staff may need to consider if any additions to the basic plan are required based upon individualised risk assessment i.e. Pressure redistributing heel aid equipment, referral to AHP's i.e. Physiotherapist, Dietetics, Podiatrist etc.

(European Pressure Ulcer Advisory Panel, 2019)

APPENDIX 9 – Pressure Care Mattress Selection Chart

THIS CHART IS A GUIDE ONLY AND SHOULD BE USED IN CONJUNCTION WITH CLINICAL JUDGEMENT AND HOLISTIC INDIVIDUAL PATIENT ASSESSMENT

Please ensure Pressure Ulcer Risk Assessment has been completed and appropriate mattress is obtained

	Green Pathway Not currently at risk NO pressure ulcers	Amber Pathway At Risk NO Pressure Ulcers		Red Pathway Pressure Ulcer Category 1 & above or scarring from previous pressure ulcers	
		Able to relieve own pressure areas	Assisted to relieve pressure areas	Able to relieve own pressure areas	Assisted to relieve pressure areas
Other mattresses including Reposa, Protector 7 and Pineapple	✔				
DynaForm Mercury Foam (crib 7 and sealed) *pressure redistributing*	✔	✔	✔	Dynaform Mercury MUST be used in seclusion and forensics. Also to be used in acute settings where the wires or fire pose a risk! ✔	
Quattro Plus *crib 5*			✔	✔	✓
			Crib 5 - Pressure Ulcer Risk MUST outweigh the risk of Fire and Ligature. Mattresses are not sealed and need to be connected to an electrical supply		
Quattro Acute *crib 5* *Please seek Tissue Viability advice*					✓
				Crib 5 - Pressure Ulcer Risk MUST outweigh the risk of Fire and Ligature. Mattresses are not sealed and need to be connected to an electrical supply	

Mattress	Supplier	Purchased or rented	How to order
DynaForm Mercury	Direct Health Care (DHC)	Purchased *(approx.£209) size of bed base needed*	Find out bed base size- use 100080296 if the size is available if not raise a non-stock requisition on Integra DHC- 0845 459 9831 or sales@directhealthcareservices.co.uk
Quattro Plus	Talley	Rented *(approx. £6 per day) 7 day min rental*	Talley 01794 503000 or sales@talleygroup.com – Purchase Order # Required
Quattro Acute	Talley	Rented *(approx.£7 per day) 7 day min rental*	