PRESSURE ULCER PREVENTION AND MANAGEMENT POLICY

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N.B This Policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust.
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1. EXECUTIVE SUMMARY

1.1 This policy provides a framework for the prevention and treatment of pressure ulcers for patients in both hospital and community settings on the Isle of Wight. This is in light of the national focus on improving patient safety and patient experience, and reducing avoidable harm to patients. This also reflects the regional focus on reducing or eliminating avoidable pressure ulcers of all grades.
2. **INTRODUCTION**

2.1 The Pressure Ulcer Prevention and Management Policy is designed to support staff in the management of patients who come into the care of the Trust, either at risk of developing pressure ulcers, or who have already developed pressure ulcers prior to first contact with Isle of Wight NHS Trust staff.

2.2 When implemented effectively, the policy is expected to reduce the likelihood of pressure ulcers occurring in patients at risk, and prevent the deterioration of patients who have already acquired pressure ulcers, working towards the Trust’s aim of no needless skin breakdown.

3. **SCOPE**

3.1 The policy applies to all employees within the Trust whose work directly or indirectly has an impact upon the welfare of patient at risk of pressure ulcers.

3.2 The policy’s scope covers all patients who come under the care of the Trust in both hospital and community settings.

4. **PURPOSE**

4.1 This policy is designed to guide all Healthcare Professionals in the prevention and management of pressure ulcers for all at risk patients.

5. **ROLES AND RESPONSIBILITIES**

5.1 Staff in direct patient contact

All employees who come into direct contact with patients who are at risk of pressure ulceration are responsible for:

- ensuring that the appropriate risk assessments are completed and documented for these patients, ensuring contemporaneous record keeping in the patient notes.
- the results of these assessments are communicated to all other persons within the trust who have a need to know the outcome and any action that needs to be taken
- ensuring that any action indicated by risk assessment is carried out as outlined in the policy, and in a timely and appropriate manner as specified below
- keeping up to date with latest guidance on the management of patients at risk of or with actual skin breakdown
- report pressure ulcers or moisture lesions using the appropriate Incident management method designated by the Trust
- identifying any gaps in their knowledge and seeking the appropriate training, education and support to address these deficits.
5.2 **Ward Sisters/Charge Nurses/Team Leaders/Modern Matrons/Locality Lead Nurses**

Ward Sisters, Charge Nurses, Team Leaders, Modern Matrons and Locality Lead Nurses are responsible for:
- ensuring that the staff they manage are competent to carry out the risk assessments and the implementation of whatever tasks may be needed to ensure the reduction in risk of patients at risk of pressure ulcers.
- ensuring that the clinical standards indicated by the policy are maintained in practice through the monitoring and auditing of the key recommendations of the policy.
- ensuring monitoring and audit is completed.
- Pressure ulcers and moisture lesions are appropriately reported using the designated Trust reporting systems
- undertaking and participating in root cause analysis investigations when patients develop pressure ulcers, as outlined in the Protocol for the Root Cause Analysis of Pressure Ulcers.

5.3 **Head of Care and Quality (formerly Heads of Clinical Services)**

Heads of Care and Quality are responsible for ensuring the key recommendations of the policy are followed within their Directorate and have oversight of Serious Incidents Requiring Investigations.

5.4 **Clinical Nurse Specialist for Tissue Viability**

The Clinical Nurse Specialist for Tissue Viability is responsible for:
- Supporting the implementation of the Pressure Ulcer Prevention and Management Policy
- Supporting Modern Matrons in undertaking Root Cause Analyses
- Providing guidance and education around the prevention and management of pressure ulcers, devising appropriate education and training methods and materials.

6. **POLICY DETAIL / COURSE OF ACTION**

6.1 **Prevention of Pressure Ulcers**

**Identifying Patients at risk**

On initial planned contact with the patient the healthcare professional must undertake a formal risk assessment based on the patient’s clinical presentation and consideration of the risk factors. A record of this risk assessment must be recorded in the patient’s notes.

The timing of a risk assessment must be based on the needs of the individual patient. However, it must take place within six hours of the start of admission to the episode of care or transfer to a new ward/care area. It must be recognised that in some situations e.g. critical care risk assessment should be carried out immediately so as not to delay appropriate prevention measures being put in place.
Patients in the community in the care of District Nursing Service and other community services must have their risk assessment completed at the first nursing visit, and thereafter on a monthly basis as a minimum standard, or earlier if the seriousness of patient condition dictates.

Patients at risk include those who are seriously ill, neurologically compromised, i.e. individuals with spinal cord injuries, have impaired mobility or who are immobile (including those wearing a prosthesis, body brace or plaster cast), or who suffer from impaired nutrition, obesity, poor posture, or use of equipment such as seating or beds, which do not provide appropriate pressure relief. Older people and pregnant women are also at risk.

Each risk assessment requires the calculation of either a Waterlow Score for adult patients (over 16), or the Glamorgan Paediatric Pressure Ulcer Risk Assessment Scale for patients under 16. The revised Waterlow Score (Waterlow, 2005) (Appendix A) is the accepted risk assessment tool used in this Trust for adult patients. The Glamorgan Paediatric Pressure Ulcer Risk Assessment Scale for paediatric patients (Appendix B) is the accepted risk assessment scale used in the Trust for paediatric patients.

Patients with identified risk factors must undergo a full assessment where the individual’s risk is systematically and explicitly conducted via a structured risk assessment framework. These patients whose risk assessment scale indicates that they are at risk must have a pressure ulcer prevention care plan completed. This assessment and prevention plan should be available and communicated to all members of the healthcare team. This plan should address the following factors where they are an issue:

- Health status – presence of acute, chronic or terminal illness and its potential impact on ulcer healing
- Co-morbidities e.g. diabetes
- Mobility status – assessment of mobility should include all aspects of independent movement including walking, ability to reposition for example in bed or a chair, or transfer for example from bed or a chair.
- Posture (e.g. the patient is not sitting straight on their seating, but at an angle)
- Presence of any sensory impairment
- Level and duration of impaired consciousness
- Systemic signs of infection – in the presence of systemic and clinical signs of infection in the patient with a pressure ulcer, systemic anti-microbial therapy should be considered in discussion and agreement with the medical team responsible for the patient.
- Nutritional status: Nutritional support/supplementation for the treatment of patients with pressure ulcers should be based on the results of a nutritional assessment (using a recognised tool, e.g. “MUST” Tool), the patients’ general health status, their preferences and expert input supporting decision-making (dietician or specialists).
- Previous pressure damage (site/location, stage or grade of previous ulcer and previous interventions).
- Equipment in use, e.g. Thomas splints
- Pain status – a pain assessment should include: whether the individual is experiencing pain; the causes of pain; level of pain (using an appropriate tool); location and management interventions.
- Psychological factors – should include concordance and abilities of the individual to self-care (mood, motivation and aptitude).
• Social factors – should include the suitability of the home environment, level of supportive provision and the involvement of local support services.
• Continence status – should include whether the individual is continent of urine and/or faeces, and what products or interventions are being used to manage these. Incontinence may affect ulcer healing and impair the function of pressure relieving support surfaces, for example if patients are pads or additional bedding.
• Medication, including steroids, analgesia which causes drowsiness, fluid replacement causing oedema, epidurals, etc.
• Cognitive status, altered consciousness, and patients lacking mental capacity to consent to the interventions of nursing/medical staff
• Impaired blood flow to skin.

6.2 Reassessment and Skin Inspection

Nurses should reassess patients’ skin every time that there is a change in the patient’s condition that increases or decreases the patient’s risk of developing pressure ulcers. It is expected that nurses discovering changes in the patients’ skin or overall condition that affect their risk of skin breakdown will make an immediate assessment of changes required to that patients’ care and implement any indicated changes as soon as is practicably possible in order to prevent any further deterioration.

It is expected that on initial inspection in all settings all dressings will be removed and all areas will be assessed. Where areas cannot be accessed, the reason for this lack of access must be clearly documented so that it is evident which areas were not assessed. A patient who has capacity may decline skin inspection. This refusal must be clearly documented. Patients who do not have capacity may require their skin to be inspected as part of their overall risk assessment, and this must be discussed with the multidisciplinary team as to the necessity of undertaking this assessment in the patient’s best interest, and multidisciplinary consent obtained before this is undertaken.

A documented reassessment should occur on admission and discharge to each ward area, and on transfer to the care of or between the community teams.

A review of inpatients’ condition should be documented at intervals as specified by the suggested actions in Appendix B for paediatric patients, or the flowchart in Appendix D for adult patients.

A documented review of patients in the community should occur every month for patients who are identified as being at risk but have not got pressure ulcers, and are currently on District Nursing caseload. A patient with pressure ulcers should have a documented review on a weekly basis or on each visit whichever is the sooner.

6.3 Repositioning

A Pressure Ulcer Prevention Care Plan should be used to outline repositioning regime for the patient and must be recorded and adhered to for each person at risk, with the agreement of the patient and/or carers where this can be obtained. Where, for instance, in the community, a patients’ carers or relatives are not in agreement with a reasonable and practicable plan of care for pressure ulcer prevention, the healthcare professional concerned should give consideration as to whether this should constitute a Safeguarding Alert.

Mobilising, positioning and repositioning interventions should be considered for all individuals with pressure ulcers (including those in beds, chairs and wheelchairs).
Positioning of patients who spend substantial periods of time in a chair or wheelchair must take into account:

- Distribution of weight
- Postural alignment
- Support of the feet

All acute patients with pressure ulcers should actively mobilise, change their position or be re-positioned at least two hourly. Avoid positioning individuals directly on pressure ulcers or bony prominences (commonly the sites of pressure ulcer development).

The frequency of re-positioning should be determined by the patient's individual needs and recorded using a repositioning chart. The means of recording this should include a means of recording that this has been completed, each time that it is done, and a space for a signature so that each episode of re-positioning is traceable to a member of staff. Passive movements should be considered for patients with pressure ulcers who have compromised mobility.

6.4 Pressure Redistributing Devices

The decision about the type of pressure redistributing device to use must be based on the overall assessment of the individual and not solely on the basis of their risk assessment score. Non-use of pressure redistributing devices must be documented in the patient's records with a clear rationale.

Once the type of mattress or seating required has been determined, it is the responsibility of the nurse doing the assessment to ensure that the patient receives the support surface that they require as soon as is practically possible. Patients in hospital who do not receive the type of support surface they require within 24 hours are significantly more at risk of developing pressure ulcers than those who receive the support surface as soon as is possible.

The assessing nurse should:

1. Reassess all other patients in their own clinical area to see if a mattress or other equipment can be safely reallocated without detriment to patient care.

2. If this is not possible, then all other inpatient wards will need to be contacted, asking if they have any available equipment or if they have patients whose equipment can be safely reallocated without detriment to their care.

3. If the equipment has still not been identified, then:

   - In office hours, Monday to Friday nine to five, the Modern Matron covering that clinical area should be contacted for further advice regarding the allocation of pressure relieving mattresses.
   - Outside office hours, the Site Coordinator should be contacted for further advice.

All efforts to identify and allocate or obtain equipment for the patient should be recorded at the time that they are made, so that nurses can account for their actions upon request.
In hospital, an incident form should be completed if it has been identified that a patient has not received the equipment they require within 24 hours of identifying the need for the equipment, and that it remains unavailable. The incident form should detail what measures were taken to obtain the equipment, and what the barriers were to obtaining the necessary devices. In the community, if there is a delay in obtaining equipment for a patient which a healthcare professional identifies puts the patient at unacceptable risk of further skin breakdown, then an incident form detailing the issues concerned should be completed.

6.5 Care of Pressure Reducing/Relieving Equipment

Pressure Reducing Foam Mattresses, Pressure-Relieving Mattresses and Pressure Reducing Cushions must be cared for as detailed in Appendix C to enable the Trust to meet its duties relating to Infection Control, Medical Devices Control Assurance and Equipment Warranties.

6.6 Use of aids

The following MUST NOT be used as pressure relieving aids:

- Water filled gloves
- Synthetic or genuine sheepskins – these are comfort aids only
- Doughnut type device – these adversely affect lymphatic drainage and circulation and are likely to cause rather than prevent pressure ulcers.

6.7 Assessment of Pressure Areas

The aim of assessing the patients’ pressure areas should be to establish the presence and severity of pressure ulcers, to develop a plan of care from which treatment interventions will be initiated, to evaluate treatment, assess for complications and to communicate information about the pressure ulcer to those involved in pressure area management. Competent practitioners should use finger palpation to determine whether erythema when it is present is blanching or non-blanching.

Blanching erythema may not be gradable under the terms of the EPUAP grading system, but its discovery on a vulnerable patient where it is a new presentation should prompt an immediate reassessment of the patient and urgent action to stop the erythema progressing to permanent skin breakdown.

Pain, numbness, or pins and needles in an affected area must be assessed and taken as a possible indication of the early signs of skin breakdown. The discovery of these symptoms must be documented, their presence monitored and appropriate action taken immediately to mitigate the pressure ulcer risk that they may indicate.

The ulcer assessment should include:

- Cause of ulcer
- Site/location
- Dimensions of ulcer
- Stage or grade
- Exudate amount and type
- Local signs of infection
- Pain
- Wound appearance
- Surrounding skin
- Undermining/tracking (sinus or fistula), and
- Odour
This should be supported by photography and measurements (calibrated with a ruler in millimetres) using Trust approved photograph and measurement devices. Photographs must have clear patient identifiers in the image so that the wounds are correctly attributed to the right patient. Copies of the photographs must be printed in colour, signed and dated and added to patients’ contemporaneous notes, or added electronically to their electronic care record.

Reassessment of any ulcer should be performed at least weekly, but may be required more frequently, depending on the condition of the wound and the result of holistic assessment of the patient.

Pressure ulcers must be graded depending on the degree of tissue damage involved and clearly documented. This record should be available to the Multidisciplinary Team, is useful for both audit purposes and to establish progress towards healing. The Trust’s Pressure Ulcer Grading Scale is based on the EPUAP pressure ulcer grading scale, recommended by the Royal College of Nursing (2005) guidelines on Pressure Ulcer Prevention and Management (CG179).

NICE recommend the EPUAP is the classification tool of choice, as it identifies not only the skin colour change of grade 1 pressure ulcers, but also other physiological signs resulting from tissue damage that many other tools ignore, namely the changes in skin temperature and skin texture due to inflammation process.

Many clinicians identify any redness as a grade 1 pressure ulcer. A level of redness is normal, for example following crossed legs where the lower leg has a red mark when the upper leg is removed. This is not the redness of a grade 1 pressure ulcer.

The classification of pressure ulceration using the EPUAP grading is as follows:-

**Grade 1:** non-blancheable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may be used as indicators, particularly on individuals with darker skin.

**Grade 2:** partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

**Grade 3:** full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

**Grade 4:** extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures with or without full thickness skin loss.

In addition, the Trust have adopted the use of the term **Ungradeable** to describe those areas of skin breakdown where either intact eschar or slough is present and in which the depth is not known, or areas of unbroken skin which show signs of discolouration or ischaemia which may have the potential to breakdown as pressure ulcers. In those circumstances the pressure ulcers are graded as Ungradeable for the purposes of reporting. The patient’s wound then requires monitoring until the depth becomes clear, or the skin lesion resolves. The appropriate grading then needs to be reentered on Datixweb for the purposes of reporting and if relevant any investigation take place.

The Trust has adopted the use of the National Association of Tissue Viability Nurses’ Skin Excoriation Tool, which categorises the severity of moisture lesions. The categories are as follows:
0 = Healthy Skin Healthy, intact skin. No erythema (redness).
1 = Mild excoriation Erythema (redness) of skin only. No broken areas present.
2 = Moderate excoriation Erythema (redness), with less than 50% broken skin. Oozing and/or bleeding may be present.
3 = Severe excoriation Erythema (redness), with more than 50% broken skin. Oozing and/or bleeding may be present.

The Trust requires that all pressure ulcers and moisture lesions of all grades that are admitted to the care of the Trust, or develop or deteriorate in the care of the Trust are required to be reported on Datixweb.

Pressure ulcers that have become grade 2, 3, or 4 do not become grade 3, 2, or 1 again when they are healing – this is called retro-grading and is clinically inaccurate. The NICE guidelines specifically state that retro-grading when documenting the progress of pressure ulcers should not occur. As a consequence, an ulcer that becomes grade 2, 3 or 4 is documented as ‘healing’ or ‘healed’.

6.7.1 Unavoidable pressure ulcers.

The term unavoidable in the context of pressure ulcers means that the individual developed a pressure ulcer even though the individual’s condition and pressure ulcer risk had been evaluated; goals and recognised standards of practice that are consistent with individual needs have been implemented; the impact of these interventions had been monitored, evaluated and recorded; and the approaches had been revised as appropriate. Only where there is clear documentation and evidence that all of these standards have been achieved can a pressure ulcer be truly considered unavoidable. If there are any gaps in these standards of care then the ulcer must be considered on balance to have been avoidable harm.

Factors to consider when investigating to determine whether a pressure ulcer was unavoidable:

- Critical illness with haemodynamic or spinal instability may preclude turning or repositioning and lead to unavoidable pressure ulcers. Similarly, it would be an unfair expectation for skin inspection to be a priority during resuscitation attempts, for instance.
- Patients who refuse to be repositioned or to maintain a position change may also develop unavoidable pressure ulcers. However, all reasonable and practicable steps on the part of the nursing team need to be demonstrated, including reiterating the risks and assessing patient capacity.
- Patients following a palliative care pathway or who meet the criteria and are deemed to be terminally ill and may not be able to tolerate repositioning at the optimum frequency for pressure ulcer prevention. In these cases, pressure damage may be an unavoidable consequence of their terminal status as the condition of skin failure does exist.

Unavoidable pressure ulcers are also possible where the patient has:

- Not previously been seen by a health care professional.
- Has mental capacity and has refused assessment and / or has not complied with the agreed plan of care. Again, clear evidence of risk explanation and capacity assessment must be present in these cases.

Unavoidable damage would also be possible where the patient is known to a health care professional but an acute / critical event occurs affecting mobility or the ability to reposition. This may include the patient being undiscovered following:
- A fall
- Loss of consciousness due to, for example unexpected collapse; drug misuse; alcohol misuse

The agreement that a grade 3 or 4 pressure ulcer was unavoidable will be determined after suitable investigation and local review.

6.8 Management of Pressure Ulcers.

Adult patients in hospital assessed as being at high risk (a Waterlow score of 20 or above) without pressure ulcers or having a grade 1 pressure ulcer should, as a minimum provision, be placed on a high specification foam mattress and/or cushion with pressure reducing properties combined with very close observation of skin changes and a documented positioning and repositioning regime.

If there is any deterioration of affected areas or further pressure ulcer development, an alternating pressure system should be used.

Adult patients assessed as having grade 3 and 4 pressure ulcers, or ungradeable pressure ulcers which may include intact eschar, should as a minimum provision, be placed on an alternating mattress replacement system. Patients who have grade 3 or 4 pressure ulcers to the sacrum or buttock area should under no circumstances be sat out on the affected areas until they have been fully risk assessed and the most appropriate seating / cushion in place or unless there is an alternating seating system available as they will continue to deteriorate and will not heal.

Positioning regimes need to balance the need to minimise risk and the management of other functions of daily living such as eating and drinking, risk of aspiration, and poor digestion and bowel function. All can be affected by remaining in bed and can affect mood in addition to the serious pressure injury. Consider referral to physiotherapy or occupational therapy services as there may well be alterations to positioning / posture, increased support that can be provided and will reduce risk of further damage which will balance these other needs. It may be beneficial if positioning is an issue that if resolved the patient sits out for meals (with a clear maximum duration) on an appropriate surface, and then return to be with a positioning regime the rest of the time. This needs to be clearly and appropriately documented in the patients' care plan.

To ensure maximum effect the inflated cells of the alternating mattress must support the body weight of the patient in all bed positions (during use of backrest, knee break) and all patient positions (sitting up, side lying).

Professional consensus reached during the creation of the NICE guidelines recommends that ulcers requiring wound care use dressings that create the optimum wound healing environment e.g. hydrocolloids (although not in diabetics), hydrogels, hydrofibres, foams, alginates, or soft silicones in preference to basic dressing types e.g. gauze, paraffin gauze and simple dressing pads.

Pressure ulcers that require debridement should be considered for surgical debridement if autolytic debridement will take longer and prolong healing time.
NICE guidance (CG179) recommends the introduction of systemic antibiotics where assessment has indicated that there is systemic sepsis, worsening cellulitis or the possible or actual presence of osteomyelitis. There is no evidence to support the introduction of antibiotics in the absence of clinical signs of infection (with or without positive ulcer swab cultures), or that the introduction of antibiotics will of themselves heal a pressure ulcer. Where indicated, antibiotics should be prescribed in line with the local Antibiotic Policy and Guidelines.

Patients discovered as having pressure ulcers on their lower limbs should have a vascular assessment undertaken to confirm if vascular compromise is present.

Please refer to Appendix D for a more detailed specification of the algorithm specifying the measures to be taken for each adult patient, or the suggested actions in Appendix B for paediatric patients.

The results of any assessment and consequent care planning and recommendations by the registered nurse must be clearly documented and the content communicated with the patient and their carers or relatives as appropriate.

6.9 Planning Discharge from Hospital or caseload

The patient must be reassessed prior to discharge from a hospital setting to determine their needs for pressure relieving equipment in the community. This assessment may indicate that the patient needs different equipment from that provided in the hospital setting for example the patient might sleep in a double bed with a partner.

Prior to discharge, the District Nursing Service must have received a referral form from the discharging ward with as much notice as possible (not same day), detailing the patient’s needs, their Waterlow score, any pressure ulcers they may have and their current clinical condition, in order for the District Nursing service to be able to allocate the appropriate mattress in a timely manner. Failure to complete the form adequately may result in delays in getting the mattress requested because the District Nursing Team may not have the required equipment available, and there may be consequent delays in discharge.

The nurse responsible for discharging the patient needs to ensure that the discharge letter to the GP includes information regarding the patient’s general risk of skin breakdown, details of pressure ulcers if they are present, equipment needs, and other measures required to manage the patients’ risk of pressure ulceration.

The District Nursing Service will endeavour to provide the equipment requested on discharge. Once supplied, this equipment becomes the responsibility of the registered professionals caring for the patients’ pressure ulcer needs in that environment. These professionals need to maintain up-to-date records of patients' clinical need in relation to the equipment they are using.

Documentation in community settings related to the use of the pressure relieving equipment should demonstrate the patients' continuing clinical need for the equipment they are using. This documentation should be available for inspection upon request. If documentation is not available, or does not demonstrate clinical need for the equipment that is in use, the equipment may be reassigned at the discretion of the District Nursing service or the Clinical Nurse Specialist for Tissue Viability.
Patients discharged from District Nurse caseload but who are still at risk of pressure ulcers, should have the appropriate care planning and advice before discharge from caseload, including when to contact the District Nursing team for further assistance. In cases where a patient was discharged from District Nursing caseload without effective care advice, equipment and planning, and then goes on to develop a pressure ulcer, this skin breakdown will also be attributed to the discharging team as occurring as a result of their care. Consideration should be given to the patient having the following information available when being discharged from a district nursing team or hospital setting:

- how to prevent recurrence or further incidence of injury;
- what to look for / risks identified (if patient sits for long periods due to fatigue);
- factors that may increase risk – change in health condition / medication / temperature / activity etc;
- the equipment is in place and how it is to be used;
- who to contact if there are any concerns

7. CONSULTATION

7.1 The following staff groups were consulted in regarding the development of the policy.

- Ward Sisters
- Modern Matrons
- Community nursing teams.
- Infection Prevention and Control Team.
- Specialist Nurses
- Integrated Community Equipment Store
- Consultants
- Allied health professionals.

7.2 Changes within the policy are based on response from these key professionals.

8. TRAINING

8.1 All registered nurses should be competence assessed against the Essential Competency for Pressure Ulcer Prevention and Management.

8.2 All non registered practitioners should be competence assessed against the Essential Competency for Non-Registered Practitioners in Pressure Ulcer Prevention and Management.

8.3 All clinical staff should receive training or education in pressure ulcer risk assessment prevention and management relevant to their area of practice. This should be at induction, with a mandatory two yearly update.

8.4 There is an e-learning package for basic pressure ulcer prevention and management advice on the Training Tracker package, accessible through Training and Development.
9. MONITORING COMPLIANCE AND EFFECTIVENESS

9.1 Overall responsibility for monitoring effectiveness of this policy resides with the Clinical Nurse Specialist for Nutrition and Tissue Viability.

9.2 Overall responsibility for monitoring compliance resides with Modern Matrons and Ward Sisters.

9.3 Standards (as derived from the Clinical Guidelines from the Royal College of Nursing (2005)) to be audited are stipulated below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Audit Standards/Criteria</th>
<th>Target %</th>
<th>Exceptions</th>
<th>Method of auditing</th>
</tr>
</thead>
</table>
| 1   | Hospital
That all pressure areas are inspected on admission, on transfer to a new ward, at regular intervals during admission, at any sign of patient deterioration, and on discharge.
Community
That all pressure areas are inspected on admission to caseload, at regular intervals during admission to caseload, at any sign of patient deterioration, and on discharge from caseload. | 100% | Patient still an inpatient and discharge not planned for that day, so discharge assessment will not yet have taken place. | Quarterly Audit by Clinical Nurse Specialist for Tissue Viability. Findings disseminated to Lead for Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders. |
<p>| 2*  | The individual’s plan of care contains a classification/grade for all pressure ulcers using the EPUAP classification system | 100% | None | Quarterly Audit by Clinical Nurse Specialist for Tissue Viability. Findings disseminated to Lead for Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders. |
| 3*  | All grades of pressure ulcers acquired or which deteriorate in NHS care should be documented as a clinical incident. | 100% | None | Ongoing monitoring by Tissue Viability Service through incident reporting software. |
| 4*  | Patients with pressure ulcers have them assessed within six hours and ongoing | 100% | None | Quarterly Audit by Clinical Nurse Specialist for Tissue Viability. Findings disseminated to Lead for Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders. |</p>
<table>
<thead>
<tr>
<th></th>
<th>assessments no less than weekly. Supported by tracings, photographs or clear description of wound measurement.</th>
<th></th>
<th>Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5*</td>
<td>Patients with pressure ulcers have access to appropriate pressure-relieving support surfaces or strategies throughout a 24 hour period.</td>
<td>100%</td>
<td>Questions to be included here will be those used in a previous audit looking at time taken for pressure-relieving mattress to get to ward so that we can compare with previous audit.</td>
</tr>
</tbody>
</table>
| 6* | **Hospital**  
Patients with grade 1-2 ulcers have a high-specification foam mattress/cushion as a minimum and are closely observed for deterioration at not more than 48 hourly intervals. Patients to have documented repositioning regime. | 100% of patients meeting this criterion | Biannual inpatient audit by Tissue Viability Service. Findings disseminated to Lead for Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders. |
| 7* | **Hospital**  
Patients with grade 3-4 pressure ulcers have alternating pressure overlay or sophisticated low pressure support as a minimum and are closely observed every 24 hours | 100% of patients meeting this criterion | Biannual inpatient audit by Tissue Viability Service. Findings disseminated to Lead for Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders. |
<p>| 8* | Individuals with pressure ulcers have their ulcers dressed with modern wound dressings to create the optimum wound healing environment. | All patients who have pressure ulcers | Biannual inpatient audit by Tissue Viability Service. Findings disseminated to Lead for Patient Safety, Effectiveness and Experience; Heads of Clinical Services, and relevant Matrons, Ward Sisters, and Team leaders. Yearly community audit with findings disseminated to Clinical Lead for District Nursing and relevant Modern |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Matrons, District Nursing Team leaders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Patients should have assessment of the other factors that impact on the development and healing of pressure sores: Mobility, Nutrition, Continence and skin care, Manual handling and falls risk</td>
<td>100% None</td>
</tr>
</tbody>
</table>

10. **LINKS TO OTHER ORGANISATION POLICY / DOCUMENTS**

10.1 This policy should be read in association with the following documents:

- Decontamination of Reusable Medical Devices Policy (2014)
- Discharge Planning Policy (2014)
- Medical Devices Management Policy (2014)
- Incident Reporting and Management Policy (To be read in conjunction with SIRI Policy and Procedures) (2014)
- Standard Operating Procedure for Pressure Ulcer Incident Reporting
- Standard Operating Procedure for Intentional Rounding

11. **REFERENCES**


European Pressure Ulcer Advisory Panel (EPUAP-a) *Pressure Ulcer Treatment Guidelines*. EPUAP. Oxford


### Appendix A

**THE WATERLOW SCORE**

<table>
<thead>
<tr>
<th>BUILD/WEIGHT FOR HEIGHT</th>
<th>SCORE</th>
<th>SKIN TYPE VISUAL RISK AREAS</th>
<th>SCORE</th>
<th>GENDER AGE</th>
<th>SCORE</th>
<th>MUST SCORE (AS RECORDED USING MUST ASSESSMENT TOOL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE BMI 20-24.9</td>
<td>0</td>
<td>HEALTHY</td>
<td>0</td>
<td>MALE</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ABOVE AVERAGE BMI 25-29.9</td>
<td>1</td>
<td>TISSUE PAPER DRY</td>
<td>1</td>
<td>FEMALE</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>OBESE BMI &gt;30</td>
<td>2</td>
<td>OEDEMATOUS</td>
<td>2</td>
<td>14-49</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>BELOW AVERAGE BMI &lt;20</td>
<td>3</td>
<td>CLAMY, PYREXIA DISCOLOURED</td>
<td>3</td>
<td>50-64</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>BMI=Wt(Kg)/Ht (m)$^2$</td>
<td></td>
<td>GRADE 1</td>
<td></td>
<td>65-74</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BROKEN SPOTS</td>
<td></td>
<td>75-80</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>GRADE 2-4</td>
<td></td>
<td>81+</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>CONTINENCE</td>
<td>SCORE</td>
<td>MOBILITY</td>
<td>SCORE</td>
<td>SPECIAL RISKS</td>
<td>TISSUE MALNUTRITION</td>
<td>NEUROLOGICAL DEFICIT</td>
</tr>
<tr>
<td>COMPLETE/</td>
<td>0</td>
<td>FULLY RESTLESS/FIDGETY</td>
<td>0</td>
<td>TERMINAL</td>
<td>8</td>
<td>DIABETES, MS, CVA MOTOR/SENSORY PARAPLEGIA (MAX OF 6)</td>
</tr>
<tr>
<td>CATHETERISED</td>
<td>1</td>
<td>APATHETIC</td>
<td>1</td>
<td>CACHEXIA</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>URINARY INCONTINENCE</td>
<td>2</td>
<td>RESTRICTED BEDBOUND, e.g.</td>
<td>2</td>
<td>MULTIPLE ORG</td>
<td>5</td>
<td>MAJOR SURGERY OR TRAUMA</td>
</tr>
<tr>
<td>ONLY FAECAL INCONTINENCE</td>
<td>3</td>
<td>TRACTION CHAIRBOUND, e.g.</td>
<td>3</td>
<td>SINGLE ORG</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>WHEELCHAIR</td>
<td></td>
<td>FAILURE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PERIPHERAL</td>
<td></td>
<td>ORTHOPAEDIC/SPINAL ON TABLE &gt;2 HOURS*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>VASCULAR</td>
<td></td>
<td>ON TABLE &gt;6 HOURS*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DISEASE</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ANAEMIA (Hb &lt;8)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SMOKING</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MEDICATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CYTOTOXICS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LONG-TERM/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIGH DOSE STEROIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ANTI-INFLAMMATORY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MAX OF 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>* Scores can be discounted after 48 hours if patient is recovering normally</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| SCORE                  |       |                             |       |            |       |                                                      |       |
| 10+ = AT RISK          |       |                             |       |            |       |                                                      |       |
| 15+ = HIGH RISK        |       |                             |       |            |       |                                                      |       |
| 20+ = VERY HIGH RISK   |       |                             |       |            |       |                                                      |       |

Adapted from Waterlow Assessment Tool, Judy Waterlow (Revised 2005)
Appendix B

GLAMORGAN PAEDIATRIC PRESSURE ULCER RISK ASSESSMENT SCALE – 2008 VERSION (Willcock et al, 2007; Willcock et al, 2008)

<table>
<thead>
<tr>
<th>Risk factor (If data such as serum albumin or haemoglobin are not available then write NK (not known) and score 0)</th>
<th>Risk score</th>
<th>Date and time of assessments (reassess at least daily and every time condition changes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child cannot be moved without great difficulty or deterioration in condition/general anaesthetic</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Unable to change his/her position without assistance/cannot control body movement</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Some mobility, but reduced for age</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Normal mobility for age</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Equipment/objects/hard surface pressing or rubbing on skin</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Significant anaemia (Hb &lt;9g.dl)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Persistant pyrexia (temperature &gt;38.0C for more than four hours)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Poor peripheral perfusion (cold extremities/capillary refill &gt; two seconds/cool mottled skin)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Inadequate nutrition (discuss with dietitian if in doubt)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Low serum albumin (&lt;35g/l)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Weight less that 10th centile</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Incontinence (inappropriate for age)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Total score

ACTION TAKEN

(Yes or no – document in child’s nursing record)

<table>
<thead>
<tr>
<th>Risk score</th>
<th>Category</th>
<th>Suggested action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10+</td>
<td>At risk</td>
<td>Inspect skin at least twice a day. Relieve pressure by helping child to move at least every two hours. Use an age and weight appropriate pressure redistribution surface for sitting on/sleeping on</td>
</tr>
<tr>
<td>15+</td>
<td>High risk</td>
<td>Inspect skin with each positioning. Reposition child/equipment/devices at least every two hours. Relieve pressure before any skin redness develops. Use an age and weight appropriate pressure redistribution surface for sitting on/sleeping on</td>
</tr>
<tr>
<td>20+</td>
<td>Very high risk</td>
<td>Inspect skin at least hourly. Move or turn if possible, before skin becomes red. Ensure equipment/objects are not pressing on the skin. Consider using specialist pressure relieving equipment</td>
</tr>
</tbody>
</table>
APPENDIX C

INPATIENT CARE OF PRESSURE-REDUCING FOAM MATTRESSES, PRESSURE-RELIEVING MATTRESSES AND PRESSURE-REDUCING CUSHIONS

1. Cleaning of Pressure Reducing Foam Mattresses, Pressure-Relieving Mattresses and Pressure-Reducing Cushions

   - Mattresses should be routinely checked and cleaned at least WEEKLY and when visibly soiled whilst in continuous use by the same patient.

   - Mattresses must be checked and cleaned between each patient use and whenever it becomes visibly soiled.

   - Always wash your hands before and after cleaning any equipment. Gloves and apron should be worn to undertake mattress cleaning.

   - When cleaning a mattress, ensure all surfaces are treated. Work from one end to the other using an ‘s’ shaped motion to avoid re-contaminating cleaned areas.

   - Cleaning should be carried out using a disposable cloth dampened with a solution of neutral detergent (Hospec) and water or with an approved neutral detergent wipe. The mattress should then be rinsed with plain water and dried thoroughly using disposable absorbent paper (blue roll).

   - Actichlor (1,000 ppm solution) may be used to wipe over mattresses that have been in contact with blood or body fluids after they have been fully cleaned. This solution should be allowed to air dry before returning the mattress to the bed–frame.

   - **CAUTION** Phenols, alcohol or other chemical solutions such as Stericol, Hibiscrub or Hibisol must NEVER be used on any part of the mattress, as they are known to break down the materials they are constructed from. Use of these chemicals will invalidate the manufacturer’s guarantees.

   - Hand hygiene products must never be used for cleaning equipment including mattresses, as it leaves a film on surfaces that will support the growth of micro-organisms.

   - In the community setting all mattresses must be thoroughly cleaned before returning to the Integrated Community Equipment Store when no longer required. They must also be returned with a Trust permit to work/decontamination form.

2. Turning of Pressure-Reducing Mattresses

   - The standard foam mattresses for the Trust (Softform Premier Glide or Maxiglide) do not require turning. They are designed to remain in one position on the bed, as indicated by the imprints on the upper cover of the mattress.

3. Checking of Pressure-Reducing Foam Mattresses

   - Mattresses must be checked at a minimum between each patient and once a week for long-stay patients to ensure mattresses are maintained in good condition as per MDA SN1999 (31) and to inform the replacement programme. Frequency of mattress checking will be increased if audit results indicate a need.
• The outer cover on all sides must be visibly checked, then repeated for the inside of the cover. Any faults should be recorded on the quarterly audit sheet. The cover should be checked for tears, pinholes, splitting, staining that does not wash off, damage to the zip, growth of mould inside the cover, unpleasant smell. All these faults indicate that the cover is no longer impervious to fluids and micro-organisms.

• The foam must be visibly checked on all sides. Any faults should be recorded on the quarterly audit sheet. The foam should be checked for wetness, odour, staining, growth of mould, unpleasant smell and damage to the structure of the foam.

• If any of the above faults are noted the following action should be taken:-
  - Remove the mattress from use and mark “Damaged” in one corner.
  - If the cover is damaged, but there is no staining on the inner foam core, the mattress cover should be replaced
  - If the foam core is stained, the entire mattress must be disposed of.

• Report the fault using the quarterly audit form so that the mattress can be assessed and appropriate replacement parts ordered.

• If faults are noted at other times, the mattress must be removed from use immediately and action taken as above.

• Failure to care for mattresses as per these guidelines will make damage more likely and invalidate the four year Guarantee.
PRESSURE ULCER CARE ALGORITHM

APPENDIX D

Start Here

Does the patient have grade 3 or 4 pressure ulcers?

YES

Alternating mattress as a minimum requirement for bed rest. Alternating seating cushion for sitting out in chairs. Recorded repositioning regime, with 30° tilt, every 2 to 4 hours when in bed, and change of position at least hourly when seated.

IF SACRAL/BACK ulcer is grade 3 or 4, complete bed rest and complete relief of pressure for affected area at each repositioning until ulcer(s) have healed. IF HEEL/ELBOW or other limb ulcer is grade 3 or 4, complete relief of pressure for affected area whether seated or in bed until ulcer(s) have healed.

Risk assessment re-assessed and documented every 24 hours.

NO

Does the patient have grade 1 or 2 pressure ulcers?

YES

Is the patient immobile and unable to reposition?

YES

Alternating mattress as a minimum requirement for bed. Alternating seating cushion for sitting out in chairs. Recorded repositioning regime, with 30° tilt, every 2 to 4 hours when in bed, and change of position at least hourly when seated.

Risk assessment re-assessed and documented every 48 hours.

NO

Is the patient’s Waterlow score 25 or above?

NO

Softform Premiere Glide mattress as a minimum requirement for bed. Pressure reducing cushion for sitting out in a chair. Encourage patient to reposition themselves every 2 to 4 hours when in bed, and change of position at least hourly when seated.

Risk assessment re-assessed and documented every 48 hours.

YES

Is the patient’s Waterlow score 25 or above?

NO

Alternating mattress as a minimum requirement for bed. Pressure reducing cushion for sitting out in chairs. Encourage patient to reposition themselves every 2 to 4 hours when in bed, and change of position at least hourly when seated.

Documented risk assessment to be repeated every 48 hours.

YES

Is the patient’s Waterlow score 20 to 24?

NO

Alternating mattress as a minimum requirement for bed. Pressure reducing cushion for sitting out in chair. Recorded repositioning regime, with 30° tilt, every 2 to 4 hours when in bed, and change of position at least hourly when seated.

Risk assessment re-assessed and documented every 48 hours.

YES

Normal mattress, e.g., PentaFlex, Softform, Transfoam. Documented risk assessment to be repeated every 7 days.

Alternating mattress as a minimum requirement for bed. Pressure reducing cushion for sitting out in chairs. Encourage patient to reposition themselves every 2 to 4 hours when in bed, and change of position at least hourly when seated.

Documented risk assessment to be repeated every 7 days.

• A visual inspection of pressure areas must be carried out every time the patient is repositioned.
• Each episode of repositioning must be charted and signed for by nursing staff.
• Wound care plan must be initiated for EACH pressure ulcer of grade 2 or above.
• Continence, nutrition, and mobility issues must be immediately addressed and patient referred appropriately.

There must be documented evidence that these assessments have been carried out.
APPENDIX E

Equality Analysis and Action Plan

This template should be used when assessing services, functions, policies, procedures, practices, projects and strategic documents

Step 1. Identify who is responsible for the equality analysis.

Name: Glenn Smith
Role: Clinical Nurse Specialist Nutrition and Tissue Viability

Other people or agencies who will be involved in undertaking the equality analysis:

Step 2. Establishing relevance to equality

<table>
<thead>
<tr>
<th>Protected Groups</th>
<th>Staff</th>
<th>Service Users</th>
<th>Wider Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Race</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sex and Sexual Orientation</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Marriage and Civil Partnerships</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Human Rights</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Show how this document or service change meets the aims of the Equality Act 2010?

<table>
<thead>
<tr>
<th>Equality Act – General Duty</th>
<th>Relevance to Equality Act General Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminates unlawful discrimination, harassment,</td>
<td>N/A</td>
</tr>
<tr>
<td>victimization and any other conduct prohibited by</td>
<td></td>
</tr>
<tr>
<td>the Act.</td>
<td></td>
</tr>
<tr>
<td>Advance equality of opportunity between people</td>
<td>N/A</td>
</tr>
<tr>
<td>who share a protected characteristic and people</td>
<td></td>
</tr>
<tr>
<td>who do not share it</td>
<td></td>
</tr>
</tbody>
</table>
**Step 3. Scope your equality analysis**

<table>
<thead>
<tr>
<th>What is the purpose of this document or service change?</th>
<th>Provide guidance on the prevention and management of pressure ulcers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will benefits?</td>
<td>All patients at risk of developing pressure ulcers.</td>
</tr>
<tr>
<td>What are the expected outcomes?</td>
<td>Assurance of safe and effective practice in the prevention and management of pressure ulcers.</td>
</tr>
<tr>
<td>Why do we need this document or do we need to change the service?</td>
<td>This document includes best practice according to NICE and provides assurance that the Trust guidelines take into account safety issues raised as part of the NPSA safety alert system relevant to this topic.</td>
</tr>
</tbody>
</table>

It is important that appropriate and relevant information is used about the different protected groups that will be affected by this document or service change. Information from your service users is in the majority of cases, the most valuable.

Information sources are likely to vary depending on the nature of the document or service change. Listed below are some suggested sources of information that could be helpful:

- Results from the most recent service user or staff surveys.
- Regional or national surveys
- Analysis of complaints or enquiries
- Recommendations from an audit or inspection
- Local census data
- Information from protected groups or agencies.
- Information from engagement events.

**Step 4. Analyse your information.**

As yourself two simple questions:

- What will happen, or not happen, if we do things this way?
- What would happen in relation to equality and good relations?

In identifying whether a proposed document or service changes discriminates unlawfully, consider the scope of discrimination set out in the Equality Act 2010, as well as direct and indirect discrimination, harassment, victimization and failure to make a reasonable adjustment.

**Findings of your analysis**
<table>
<thead>
<tr>
<th>Description</th>
<th>Justification of your analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No major change</strong></td>
<td>Your analysis demonstrates that the proposal is robust and the evidence shows no potential for discrimination.</td>
</tr>
<tr>
<td>Adjust your document or service change proposals</td>
<td>This involves taking steps to remove barriers or to better advance equality outcomes. This might include introducing measures to mitigate the potential effect.</td>
</tr>
<tr>
<td>Continue to implement the document or service change</td>
<td>Despite any adverse effect or missed opportunity to advance equality, provided you can satisfy yourself it does not unlawfully discriminate.</td>
</tr>
<tr>
<td><strong>Stop and review</strong></td>
<td>Adverse effects that cannot be justified or mitigated against, you should consider stopping the proposal. You must stop and review if unlawful discrimination is identified</td>
</tr>
</tbody>
</table>

5. **Next steps.**

5.1 Monitoring and Review.
Equality analysis is an ongoing process that does not end once the document has been published or the service change has been implemented.

This does not mean repeating the equality analysis, but using the experience gained through implementation to check the findings and to make any necessary adjustments.

Consider:

| How will you measure the effectiveness of this change | |
| When will the document or service change be reviewed? | |
| Who will be responsible for monitoring and review? | |
| What information will you need for monitoring? | |
| How will you engage with stakeholders, staff and service users | |
5.2 Approval and publication

The Trust Executive Committee / Policy Management Group will be responsible for ensuring that all documents submitted for approval will have completed an equality analysis.

Under the specific duties of the Act, equality information published by the organisation should include evidence that equality analyses are being undertaken. These will be published on the organisations “Equality, Diversity and Inclusion” website.

**Useful links:**

**Equality and Human Rights Commission**

Sources of further help and guidance:

- Local guidance document - see intranet under Quality Team
- Member of the Quality team
- Liz Nials – Equality and Diversity Lead
- Paul Dubery – Deputy Director for IM&T
- NHS Employers website; [www.nhsemployers.com](http://www.nhsemployers.com) & follow the Equality and Diversity link.
- Equality and Human Rights Commission website: [www.equalityhumanrights.com](http://www.equalityhumanrights.com)

A summary of equality impact assessments will be made available to the public via the organisation’s intranet annually.