1 **Introduction**

1.1 The development of pressure ulcers is recognised as a key indicator of the quality of care delivered and a fundamental aspect of patient care. Pressure ulcers are detrimental to patients in terms of their physical, psychological and social well-being, resulting in reduced quality of life (EPUAP 2014). The cost to the patient in terms of pain and suffering is immeasurable. It is therefore the duty of healthcare professionals to promote the prevention of pressure ulcers and reduce their occurrence.

1.2 The information included in this policy reflects the best available evidence to date on the prevention and management of pressure ulcers. It provides a framework for enabling best clinical practice and is based on guidelines developed by the European Pressure Ulcer Advisory Panel (2014) and the National Institute of Clinical Excellence (2014).

2 **Scope**

This policy applies to all staff working within the Newcastle upon Tyne Hospitals NHS Foundation Trust who are directly or indirectly involved with delivery of patient care. The Guidelines set out in Appendix 1 are to be followed by clinical staff involved in the care of patients with or at risk of developing pressure ulcers.

3 **Aim of the policy**

This policy has been developed to ensure that the Newcastle upon Tyne Hospitals NHS Foundation Trust complies with requirements to ensure:

- **a)** good practice and consistency in the management of patients who are at risk of acquiring pressure damage
- **b)** that there is a deep-seated understanding that effective pressure area care begins with the prevention of skin damage.
- **c)** appropriate identification, reporting, categorisation, investigation and monitoring of all pressure ulcers and moisture lesions which have developed in our care.
4 Definitions

4.1 Pressure ulcers

Pressure ulcers are also known as pressure sores, decubitus ulcers and bedsores. They also include Diabetic foot ulcers which are often caused by pressure. Pressure ulcers also include device related ulceration.

The European Pressure Ulcer Advisory Panel (2014) explains that there is a number of contributing or confounding factors also associated with pressure ulcer development.

For the purpose of this document, a moisture lesion is defined as being caused by urine and/or faeces, perspiration or wound exudate which is in continuous contact with intact skin of the perineum and buttocks. Moisture lesions cause superficial loss of epidermis and/or dermis. Moisture can contribute to pressure damage and pressure can contribute to moisture lesions.

4.2 Category, stage or grade

The term is interchangeable when used to describe the severity of a pressure ulcer. In the Newcastle upon Tyne Hospitals NHS Foundation Trust the term “category” is used.

4.3 Pressure Ulcer Risk tools

The primary aim of these tools is to assist in the assessment of the risk of a patient developing a pressure ulcer. All tools are to be used in conjunction with clinical judgment.

- **Braden**: this tool is used on all Adult wards as well as in Community. NOTE: The Braden scale has not been shown to consistently identify patients at risk of pressure ulcers on the heels. Clinical judgment is essential when checking heels (Black 2013). If a patient reports having a previous foot ulcer or known to have peripheral arterial disease or diabetes, they are at high risk of developing a further foot ulcer and measures should be implemented to minimize this risk.

- **CALCULATE**: In critical care, there is the assumption that all patients will have a Braden <17 and therefore be at risk of developing pressure damage. Therefore, the CALCULATE tool has been developed to determine the level of risk in critically ill adults. CALCULATE is a set of critical care risk factors identified from best available evidence and tested for face and content validity.

- **Glamorgan**: for all children <12 years of age. For older children, Braden or Glamorgan can be used at the discretion of the paediatric team.
4.4 **FOCUS tool**

This is a tool is based on the concept of “intentional rounding” (NICE 2014). It is used for all patients at risk of developing pressure ulcers or for those patients who have existing damage across all wards and in-patient departments except critical care. It has been developed by the Newcastle upon Tyne Hospitals NHS Foundation Trust as a tool for documentation of care.

5 **Duties – (Roles and responsibilities)**

5.1 **Trust Board**

The Trust Board are responsible for ensuring there is a strategy for the prevention and management of pressure ulcers which includes a zero tolerance of pressure ulcers across the organisation. The responsibility for development and implementation of this strategy is delegated to the Pressure Ulcer Task Force.

5.2 **Pressure Ulcer Task Force**

- Develop a Strategy for the prevention of pressure ulcers, which identifies the standards for leadership and care expected by the Trust.
- Develop a strategy for the provision of pressure redistribution devices, which includes training standards across the Trust.
- Develop corporate care plans (NUTH289/NUTH289c Pressure Ulcer Prevention and Treatment; NUTH228 Wound Assessment; NUTH370 FOCUS chart, NUTH340 Care of the Diabetic patient and NUTH388/NUTH377 Patient leaflets).
- Develop SystmOne templates (Skin Integrity Assessment; Pressure Area Action Plan; Pressure Ulcer Assessment).
- Ensure that Trust-acquired pressure ulcers are identified, categorised and monitored.
- Support Directorates in identifying possible gaps in care through the undertaking of Root Cause Analysis (RCA); set action plans and ensure that lessons learnt are disseminated across the Organisation.
- Review new technologies to ascertain relevance in clinical environment.
- Support a zero tolerance of pressure ulcers across the Organisation.

5.3 **Matrons/Cluster Co-ordinators**

- Support Ward Managers and District Nurses in pressure ulcer prevention strategies set for Ward Sisters/Charge nurses / District Nurses and Community Staff Nurses.
- Review and respond to DATIX incidents reports arising within their clinical areas of responsibility.
- Review and monitor investigations arising from reported pressure ulcers.
- Ensure action plans arising from a RCA are robust, completed and sustained across time and that learning is shared across the Trust.

5.4 Ward Sister / Charge Nurses/ District Nurses

- Accountable for ensuring that all pressure ulcers category I, II, III and IV as well as moisture lesions are reported on Incident Reporting System (DATIX), whether they are Trust acquired or identified on admission to the ward/case load.
- Ensure that all staff providing direct patient care receive regular updates in pressure ulcer prevention and treatment and complete the e-learning package available on ESR entitled “How to categorise pressure ulcers”.
- Work with Diabetes link nurses to ensure that ward staff are aware of the prevention and management of Diabetic foot ulceration.
- Provide leadership and support for their staff in their duties, nominate a Tissue Viability Link Nurse and support them in effectiveness in their role.
- Take responsibility for the completion of Root Cause Analysis (RCA), completed for all Trust-acquired pressure ulcers category II, III and IV as well as moisture lesions within 5 working days of the incident occurring.
- Ensure arising action plans are robust and completed in full.
- Consider whether there are concerns regarding poor practice and apply the principles listed in the Safeguarding policy.

5.5 Link Nurses

- Provide regular updates in pressure ulcer prevention and treatment and encourage team members to complete the e-learning package available on ESR entitled “How to categorise pressure ulcers”.
- Have an understanding of the increased risk of foot pressure ulceration in patients with diabetes and cascade this to staff.
- Have an understanding of the specific risks of developing pressure ulceration to the feet and their management as per Foot pressure ulcer guidance available on the Trust intranet site, available at http://nuth-intranet/cms/SupportServices/PatientServices/NursingMidwiferyStrategy2016-2019/SafeEffectiveHarmFreeCare/TissueViability/Podiatry.aspx
- Assess and accurately categorise pressure ulcers.
- Assist ward team/colleagues with managing deep pressure ulcers.
- Ensure that correct skin care guidance is adhered to.
- Have a full understanding of the different pressure redistributing equipment and be able to prioritise equipment.
- Facilitate a culture of repositioning regimes that are embedded in practice.
5.6 **Nursing Staff**

- Ensure that they receive appropriate education and training in order to maintain their competence in pressure ulcer prevention and management.
- Ensure that a full skin assessment is undertaken on patients in their care:
  - In hospital: within 1 hour of admission or transfer. If not able to undertake the assessment within 1 hour, the reasons for the delay must be documented in the patient’s notes.
  - In community: on first contact with patient. If not able to undertake, the reason for the delay must be documented on SystmOne.
- Responsible and accountable for undertaking a Braden score of all patients within 2 hours of admission to their ward/department/caseload or on first contact with patient (in Community). (CALCULATE for Critical Care; Glamorgan for children under 12 years of age).
- Responsible and accountable for discussing preventative care with patients and carers/parents/guardians and document essence of discussion.
- Provide the patient and/or carer with a patient information leaflet “Time2Turn: working together to prevent pressure ulcers” (NUTH377 for hospital NUTH388 for community).
- Responsible and accountable for initiating and delivering appropriate level of care as set out in the Pressure Ulcer prevention and treatment plan of care (in hospital: NUTH289) or Pressure Ulcer prevention and treatment pathway (on SystmOne in community) or Critical Care plan of care.
- Responsible for documenting the condition of a pressure ulcer to include categorisation of all ulcers; size (measurements – width, length and depth); description; presence or absence of signs of infection (and whether a wound swab has been taken).
- Whenever possible and with appropriate consent, take digital photographs or arrange for Medical Photography for all patients who are admitted to their ward/caseload with existing pressure damage.

Photographs should be printed and filed in the patient’s medical records; digital photographs should not be stored on ward PC. Photographs should be uploaded on SystmOne in Community. *Where there is a concern for Safeguarding, Medical Photography should always be used.*

Photographs should also be sent to Tissue Viability via email so that categorisation can be validated.

- Responsible for documenting all pressure ulcers on the Body map in the Wound Assessment, Intervention and Evaluation care plan (NUTH228) and in the Pressure Ulcer Assessment Template on SystmOne in Community.
- Responsible for accurately reporting of all category I, II, III, IV pressure ulcers and moisture lesions, those present on admission to the clinical
area and those identified as occurring during the current care episode as a clinical incident on DATIX.

- Responsible for the reporting of any deterioration of previously reported pressure ulcers as a clinical incident on DATIX.
- Liaise with other Health Care Professionals where appropriate (for example referring to podiatry where there is foot pressure damage).
- Responsible for completing and following the Care of the Diabetic patient plan of care (NUTH340) for all patients with diabetes within 24 hours of admission. This includes referral to Podiatry if any of the risks are identified.
- When discharging patients with diabetes and a foot ulcer, arrange referral to local diabetes podiatry services for ongoing management (NICE 2011).
- Responsible for co-coordinating and liaising with the multidisciplinary team in the plans for pressure ulcer prevention and management.
- Responsible for undertaking care for pressure relief and wound care advice as recommended by specialists in order to optimise care.
- Responsible for documenting care given (to include appropriate devices and footwear)
- Respond to patients declining care or treatment to reduce their risk of sustaining pressure damage and document discussion. Discuss with Tissue Viability Team. Complete Patient Non-concordance Checklist in Community.
- Refer all category II, III and IV pressure ulcers and moisture lesions to the Dietician for appropriate nutrition support to aid wound healing.

### 5.7 Tissue Viability Team

Provide assurance that the Trust’s approach to pressure ulcer and moisture lesions prevention and management is evidence based.

- Lead the development and implementation of the Trust-wide strategy for prevention and management of pressure ulcers and moisture lesions.
- Provide advice to and joint assessment with staff and patients where standard interventions have failed, or staff request advice and support
- Ensure that appropriate educational packages and support are available for staff.
- Ensure that all Trust acquired Cat I, II, III, IV and moisture lesions are consistently correctly categorised.
- Attend RCA meetings for Cat III and IV Trust acquired pressure ulcers. Assist with the identification of good practice and opportunity for learning and take appropriate steps to disseminate this across the Trust.
- Support the Assistant Director of Nursing/Patient Services in reviewing RCA for Trust acquired Cat III and IV.
- Lead in the evaluation of pressure redistributing equipment.
- Engages in effective working relationship with CGARD, Podiatry, Vascular, Dermatology, Plastics to ensure best practice in pressure ulcer prevention and treatment.
• Ensures that communication between community and acute staff is maintained at all times and preventative or treatment care plans follow the patient’s journey.
• Provide support and education for Tissue Viability Link Nurses.

5.8 Medical Staff

• Assist with establishing clear aetiology for skin damage.
• Document all existing and new pressure damage on patients in their care.
• Address specific medical problems that will increase the risk of pressure ulcer development and aid healing.
• Assist other health care professionals with discussing pressure ulcer prevention where there are concordance issues with repositioning and document discussions.
• Clearly document any co-morbidity that may reduce tissue perfusion and substantially increase risk of pressure ulcer development.
• Where relevant discuss with patients risk of developing pressure damage associated with treatment, documenting within consent processes, in line with Trust Consent to Examination and Treatment Policy where risk of harm is significant.
• Include information relating to pressure ulcers in the patient’s discharge summary.
• Take an active role in preventing pressure ulcers.
• Ensure that any dressings or bandages are removed on admission to evaluate any ulceration (NICE 2011).
• Liaise with diabetes medical colleagues where a patient has diabetes and a foot ulcer (NICE 2011).
• When discharging patients with diabetes and a foot ulcer communicating with GPs regarding onward referral to local podiatry services (NICE 2011).

5.9 Profession Allied to Medicine

• Physiotherapists and occupational therapists will:
  - Actively support Nursing teams with repositioning regimes and document input on in-patient FOCUS charts
  - Offer advice and assistance on moving and handling, positioning, splinting and posture correction. Also advise on appropriate chairs and wheelchairs to all patients at risk of pressure ulcer development.

• Podiatrists will offer advice as follows:
  - Foot pressure relief and appropriate devices, footwear.
  - Foot risk factors such as neuropathy, arterial disease, history of foot ulceration
  - Appropriate foot ulcer management

• Podiatrists will liaise with Diabetes team about any patients known to them with Diabetes and foot ulceration.
• Dieticians will give clinically appropriate advice and support on nutritional screening and management
• Liaise with the Multi-Disciplinary Team, patients and carers in the plans for pressure ulcer prevention and management.

5.10 The Patient and/or Carer

The patient and/or carer will be encouraged to inform the multidisciplinary team of all concerns relating to the management of their pressure area care.

6 Prevention and Management of Pressure Ulcers and Moisture Lesions

6.1 Standards of care

1. Assess skin integrity
2. Calculate patient risk
3. Implement turning regime “Time2Turn”
4. Offer good skin care

a) Assess Skin integrity on admission to ward/department/caseload
   - A full skin assessment must be undertaken within 1 hour of admission or transfer in/on first contact with patient in Community. If not able to do the assessment within 1 hour, the reasons for the delay must be documented in the patient’s notes.
   - Thoroughly document assessment findings. Complete Skin Integrity Template on SystmOne in Community.
   - Heels: remove the patient’s shoes, socks, bandages, dressings and examine their feet.
   - Take digital photographs if damage found and initiate Wound Care Plan (NUTH228).
   - DATIX any pressure ulcers and moisture lesions found
   - If a patient is diabetic, complete and follow NUTH340.
   - Damage to pigmented skin is harder to detect, therefore special consideration is given in the policy and in the training. If positive action is not taken, there is the potential for increased skin damage in terms of patients with pigmented skin.

b) Calculate patients’ risk of developing pressure ulcers
   - Braden assessment must be undertaken within 2 hours of admission/on first contact with patient in Community (CALCULATE for Critical Care; Glamorgan for children <12 years of age).
- If a patient has Diabetes they may have sensory loss (neuropathy) in the feet, which will increase the risk of foot ulceration.

c) **Implement turning regime**
- Repositioning patients is the single most important element of preventative care, therefore for all patients at risk of developing pressure ulcers (Braden <17)
  - In hospital, implement FOCUS chart as per NUTH289/NUTH289c. (If patient is in Critical Care, follow Critical Care specific guidance).
  - In community, complete and implement Pressure Ulcer Action Plan Template on SystmOne.
- Elevate heels at all times.
- Ensure patient is comfortable on the surface provided.
- If sitting in a chair, ask patients to stand every hour and/or advise on repositioning in the chair. Offer assistance if necessary.
- Encourage all patients to change position.
- Offer patient information leaflet.
- Ensure good moving and handling techniques used.

d) **Offer good skin care**
- Ensure patients receive prompt help with cleansing after any episodes of incontinence.
- Follow the Skin Care Guidelines.

6.2 **Patient Reassessment Standards**

- NUTH289/NUTH289c and FOCUS should be used as a continuous assessment of patients risk and NUTH340 for ongoing diabetic foot assessment.
- Re-positioning times should be used to continuously re-assess skin integrity.
- At handover, patient’s individual risk and plan of care should be discussed.
- At transfer, the patient’s skin should be reviewed, documented and if necessary photographs taken. If at all possible, skin inspection is undertaken by the “receiving” team with the “delivering” team together so to agree skin condition on transfer.
- In the event of a patient receiving care in another clinical area e.g. theatre or radiology the patient’s skin should be reassessed and documented within 1 hour of their return to the ward/department.

6.3 **Extra considerations**

- Ensure adequate hydration and nutrition
- All patients with damage must be referred to dietician when the patient is hospitalised.
- Patients with Diabetes and foot damage must be referred to podiatry within 24-48 hours
- Patients with Peripheral Arterial Disease and/or heel damage need to be referred to vascular within 24-48 hours.
• Patients and carers should be educated and actively encouraged to prevent pressure ulcers.
• “Teach back” techniques should be used to educate patients on why they are being asked to change position.
• Patient carers and families should be included in conversations regarding pressure area care.
• Patient information leaflets should be used on admission and during the patient stay (NUTH377 and NUTH377c).
• Patients should be asked to inspect their own skin when they self-care (i.e. washing and dressing) and report any changes or concerns immediately.

6.4 Positioning the patient

6.4.1 Whilst in bed
Use the 30 degree tilt (figure 1): this method of changing position to redistribute pressure is more comfortable for the patient and puts less strain on the handlers. The patient is turned from soft tissue to soft tissue and pressure is avoided on bony prominences

![Fig.1: 30 Degree Tilt](image)

Ensure feet are not pushed up against end of bed, if patient has some sensory impairment this pressure could cause ulceration

6.4.2 Whilst seated in a chair
Seating assessments for aids and equipment should be carried out by trained assessors who have specific knowledge and expertise such as Physiotherapists and Occupational Therapists.

In principle a good seating position consists of:

• The patient sat to the back of the chair seat: hips, knees and ankles to be flexed at 90 degrees
• The seat width having 2.5cm space either side of thighs to prevent damage to trochanters
• The depth of the seat giving 2.5cm space to the back of the knee, ensuring the thigh is fully supported
- The height of the seat should be the same as the length of the lower leg, the feet to be flat to the floor (if elevating legs ensure the calf supports the weight of the leg, note this can increase pressure though the buttocks)
- The patient should be able to rest their forearms on the arms of the chair

Patients at risk of developing pressure damage or moisture lesions or with existing damage should restrict sitting in the chair to less than 2 hours.

The patient must be stood up hourly to relieve pressure and encouraged to walk around the bed space / to the bathroom for at least 2 minutes for blood to re-circulate to the affected area.

Patients requiring a pressure-reducing surface in bed should be provided with a pressure redistributing seat cushion when sat in (any) chair.

Patients must never be sat on a pillow. These are not pressure redistributing devices.

Pillows should not be put behind patients in chairs as this encourages the patient to slip forward.

### 6.4.3 Prevention of Heel damage

Elevate the heels from the surface of the bed. A pillow may be placed lengthways under the calves for this purpose to ‘float’ the heel (see Fig. 2). Placing the pillow lengthways distributes the weight over a greater surface area and reduces the risk of uneven pressure against the calf vein.

![Fig 2: Using knee break to elevate heels off the pillow](image)
Carefully assess prior to the use of anti-embolic stockings and only apply them if this is indicated by local Venous thromboembolism (VTE) prophylaxis protocols. If anti-embolism stockings are used, remove them and inspect toes, ankles and heels at least every 24 hours.

Particular care must be taken for patients with circulatory disorders (e.g. diabetes, cardiovascular or peripheral arterial disease) as they may be at increased risk of foot / heel pressure damage. This also greatly reduces the chances of the foot ulcer healing. Often foot ulcers can last many years or lead to lower limb amputations, especially in the case of diabetes.

Many patients with Diabetes have sensory loss (neuropathy) in their feet due to Diabetes, and may or may not be aware of this. This greatly increases their risk of developing a foot ulcer.

Ensure patients have suitable footwear to protect feet from injuries and pressure. Any patients with diabetes or a foot ulcer should not walk barefoot.

Ensure heels are well moisturised and protected from friction.

7 Training

An e-learning package is available on the ESR entitled “Categorising Pressure Ulcers”. It is the responsibility of ward sisters/cluster Co-ordinators to ensure that their nursing staff have the necessary skills and knowledge to prevent pressure damage from occurring and if in doubt to ensure that staff complete this e-learning.

8 Monitoring and Audit

All incidents of pressure damage both inherited and acquired are reported through the DATIX incident reporting system.

Numbers of incidents are reported monthly to the Trust Board.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Method</th>
<th>By</th>
<th>Frequency</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly prevalence of pressure ulcers</td>
<td>Safety Thermometer audit</td>
<td>Tissue viability</td>
<td>Monthly</td>
<td>Trust board via Quality Accounts</td>
</tr>
<tr>
<td>Number and severity of pressure ulcers reported via DATIX</td>
<td>Review of incident reports Dashboard Quality account</td>
<td>CGARD Tissue viability</td>
<td>Monthly</td>
<td>Trust board via Quality Accounts</td>
</tr>
<tr>
<td>Learning from RCAs</td>
<td>Review of RCA outcomes and incident reporting</td>
<td>Directorates</td>
<td>Monthly</td>
<td>Clinical Risk Group</td>
</tr>
</tbody>
</table>
9 Consultation

This policy has had wide consultation via the Pressure Ulcer Task Force members, with representation from all health professionals groups who are involved in the prevention and treatment of pressure ulcers.

10 Implementation and awareness raising

Awareness of this policy is raised at all relevant professional forums held in the Trust.

11 Associated policies and guidance

The following policies should be read in conjunction with this policy:

- Guidelines for Skin Care
- Requesting Therapy Beds policy in Acute Care

This guidance offers guidance on devices available.

12 References

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 26 May 2017

2. **Name of policy / strategy / service development/investment plan:**
   - Pressure Ulcer and Moisture Lesion Management and Prevention

3. **Name and designation of Author:**
   - Fania Pagnamenta, Nurse Consultant Tissue Viability

4. **Names & Designations of those involved in the impact analysis screening process:**
   - Fania Pagnamenta, Nurse Consultant Tissue Viability

5. **Is this a:**
   - Policy ✅
   - Strategy ☐
   - Service ☐
   - Board Paper ☐
   - Business Plan ☐

   **Is this:**
   - New ☐
   - Revised ☐

   **Who is affected:**
   - Employees ☐
   - Service Users ✅
   - Wider Community ☐

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?**
   - The Trust has committed to reduce the incidence of harm from pressure ulcers and moisture lesions.
   - This policy outlines the Trust’s current position in relation prevention and treatment of pressure ulcers and moisture lesions.

7. **Does this policy, strategy, or service have any equality implications?**
   - Yes ✅
   - No ☐

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
### 8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups related to this policy/service/strategy – please refer to the Equality Evidence (available via the intranet Click A-Z; E for Equality and Diversity. Summary on front page and more detailed information in resources section)</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance equal opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race / Ethnic origin (including gypsies and travellers)</strong></td>
<td><strong>Pressure Ulcers:</strong> Skin damage (pressure ulcer and moisture lesions) are reported to Trust board via the Quality accounts; Safety Thermometer data is collected monthly and shared nationally.</td>
<td>Category I pressure Ulcers (EUPAP 2009) are defined as intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones.</td>
<td>This information is taught during all Tissue Viability teaching forums.</td>
</tr>
<tr>
<td><strong>Sex (male/ female)</strong></td>
<td><strong>Pressure Ulcers:</strong> there is no correlation between sex and the incidence of pressure ulcers.</td>
<td>Monthly Pressure Ulcers data have been reviewed and confirm this fact.</td>
<td>Not in relation to this paper</td>
</tr>
<tr>
<td><strong>Religion and Belief</strong></td>
<td><strong>Pressure Ulcers:</strong> there is no known link between pressure ulcers and religion or belief, beside its relationship with race.</td>
<td>See Race section.</td>
<td>See Race section</td>
</tr>
<tr>
<td><strong>Sexual orientation including lesbian, gay and bisexual people</strong></td>
<td><strong>Pressure Ulcers:</strong> there is no known links between sexual orientation and pressure ulcers.</td>
<td>Not in relation to this paper</td>
<td>Not in relation to this paper</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td><strong>Pressure Ulcers:</strong> old age is an intrinsic factor in the development of pressure ulcers (NICE 2014). Older patients are positively discriminated in terms of being offered an</td>
<td>Monthly Pressure Ulcers data have been reviewed and confirm this fact.</td>
<td>This information is taught during all Tissue Viability teaching forums.</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
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<tr>
<td><strong>Pressure Ulcers:</strong> physical disability does offer extra risks in the prevention of pressure ulcers. These patients are positively discriminated in terms of being offered an increased input to the prevention of pressure ulcers. Learning difficulties and sensory impairments can also affect the comprehension of one-to-one teaching each patient receives within their individualised prevention of pressure ulcers strategies.</td>
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<tr>
<td><strong>Equality lead, objectives and action plan</strong></td>
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<tr>
<td><strong>This information is taught during all Tissue Viability teaching forums.</strong></td>
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<thead>
<tr>
<th>Gender Re-assignment</th>
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<tbody>
<tr>
<td><strong>Pressure Ulcers:</strong> there is no known links between gender reassignment and pressure ulcers.</td>
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<td><strong>Not in relation to this paper</strong></td>
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<thead>
<tr>
<th>Marriage and Civil Partnership</th>
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<tbody>
<tr>
<td><strong>Pressure Ulcers:</strong> there is no known links between marriage and civil partnership and pressure ulcers.</td>
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<td><strong>Not in relation to this paper</strong></td>
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<tr>
<td><strong>Not in relation to this paper</strong></td>
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<table>
<thead>
<tr>
<th>Maternity / Pregnancy</th>
</tr>
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<tbody>
<tr>
<td><strong>Pressure Ulcers:</strong> there is no known links between maternity/pregnancy and pressure ulcers. There are however additional risks of developing pressure ulcers during labor, especially if this is prolonged.</td>
</tr>
<tr>
<td><strong>Monthly Pressure Ulcers data have been reviewed: there has been almost no incidence of pressure ulcers amongst women in the labor and post-labour wards.</strong></td>
</tr>
<tr>
<td><strong>This information is taught during all Tissue Viability teaching forums.</strong></td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above. If ‘yes’ how will these be rectified？

   No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

   Do you require further engagement  No
11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

| No |

**PART 2**

**Signature of Author**

| Fania Pagnamenta |

**Print name**

| Fania Pagnamenta |

**Date of completion**

| 26 MAY 2017 |

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)